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Mental Health Professionals' Perceptions of Clinical Utility:

A Comparison of the Current and Alternate DSM-5 Models for Personality Disorder



A research report submitted in partial fulfilment of the requirement for the degree

Master of Arts in Clinical Psychology

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University of the Witwatersrand, Johannesburg

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Plagiarism Declaration

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Acknowledgements

I would like to express my gratitude to the following people, without whom this research report would not have been possible:

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Mental Health Professionals' Perceptions of Clinical Utility: A Comparison of the Current and Alternate DSM-5 Models for Personality Disorder

Chapter 1: Introduction

Personality typically refers to the dynamic organization within the individual that determines his/her unique thoughts, emotions, and patterns of behaviour across situation and time (Allport, 1961; Corr & Matthews, 2009). Although all individuals have various degrees of personality difficulties resulting in daily obstacles, when such difficulties cause significant problems to oneself or others, they are generally referred to as personality pathology (Bach, 2015). Current personality pathology nomenclature defines personality disorders as enduring and inflexible patterns of maladaptive cognitions, emotions, and interpersonal functioning that leads to significant distress (to oneself or others) and/or functional impairment (American Psychiatric Association, 2013).

Personality disorders are chronic, and are estimated to occur in 10 to 20 percent of the general population (Sadock, Sadock, & Ruiz, 2015). Although very little information has been published regarding the prevalence of PDs in South Africa, a study conducted by the South African Stress and Health (SASH) estimated that personality disorders occur in approximately 6.8% of the South African population, which is consistent with other low-middle income countries, such as Brazil and China (Suliman, Stein, Williams, & Seedat, 2008). In psychiatry, personality disorders are among the most frequently treated mental illnesses in both inpatient and outpatient settings (Bach, 2015; Skodol, Morey, Bender, & Oldham, 2013). Not only do more than 50 percent of psychiatric patients satisfy criteria for a personality disorder (PD) diagnosis, but more than half of those diagnosed typically meet criteria for more than one PD diagnosis (Alnaes & Torgersen, 1988; Sadock et al., 2015; Zimmerman, Rothschild, & Chelminski, 2005). In addition to frequent co-occurrence of PDs, high comorbidity exists between PDs and other clinical disorders (Sadock et al., 2015). Personality disorder is not only a predisposing factor for other mental disorders (such as substance use, affective disorders, suicide, anxiety disorders, impulse-control disorders, and eating disorders), but typically interferes with treatment outcomes of many of these clinical disorders; increasing dysfunction, morbidity, and mortality of these patients (Sadock et al., 2015; Skodol et al., 2013).

Many personality disorder symptoms are ego syntonic (acceptable to the ego and consistent with the individual's self-concept) and alloplastic (adapt to difficult situations by attempting to change the environment rather than themselves), which complicates treatment, as patients may struggle to recognize and take responsibility for their behaviour and interpersonal dysfunction (Sadock et al., 2015). In addition, as difficulties in interpersonal relationships are an essential feature of personality disorders, the disorder may adversely affect relationships with mental health professionals, resulting in further treatment difficulties (Tyrer, Reed, & Crawford, 2015). Due to their chronic and complex nature, personality disorders require long term treatment, typically in the form of psychotherapy, which is costly to society (Skodol et al., 2013).

Despite their high prevalence, risk, and cost, there is still no definitive scientific consensus regarding the aetiology of personality disorders (Torgersen, 2009). Therefore, there is a pressing need to gain a deeper understanding of the nature of personality disorders, and how best to conceptualise them, in order to maximize effective detection and intervention (Krueger, 2013). Despite its widespread international use, the Diagnostic and Statistical Manual of Mental Disorders (DSM) has proven to be a less than ideal system for personality disorder conceptualisation and diagnosis (Krueger, 2013). The numerous criticisms aimed at previous editions of the DSM regarding its categorical model for diagnosing personality disorders led to the establishment of the Personality and Personality Disorders Work Group (P&PDWG) for the DSM-5, which was tasked with developing a new diagnostic model for personality disorders (Krueger, 2013; Skodol et al., 2013; Wright & Simms, 2014). Although the P&PDWG's proposed hybrid model for personality disorders was intended to replace the existing categorical PD classification system, due to much controversy and disagreement between leading professionals, it was instead placed in Section III, "Emerging Measures and Models" of the DSM-5 as an "Alternative DSM-5 Model for Personality Disorders" (DSM-5-AMPD) for further research to be conducted to clarify its performance relative to the DSM-IV PD criteria reprinted in the main DSM-5 text (American Psychiatric Association, 2013; Zachar, Krueger, & Kendler, 2015).

As the rejection of the DSM-5-AMPD was primarily due to concerns over clinical utility (Zachar et al., 2015), this research aimed at exploring mental health professionals' perceptions of clinical utility of the alternative model for personality disorders in relation to the current DSM-5 categorical model for personality disorders. The following chapter will provide a

history of personality disorder classification throughout all editions of the DSM and discuss the process and controversies resulting in the rejection of DSM-5-AMPD. The scope of literature reviewed in this research will be limited to studies regarding the clinical utility of the DSM-5-AMPD. Subsequent chapters will describe the methodology and procedure implemented in this study, followed by the results obtained from this research, which will be presented and discussed in light of the relevant literature and conclude with proposed recommendations for future research.

Chapter 2: Literature Review

2.1. History of Personality Disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM)

The classification of personality disorders is vital to effective research and clinical practice in this field. Since its inception in 1952, the Diagnostic and Statistical Manual of Mental Disorders (DSM) has not only been the official American nomenclature for psychiatric illnesses, but has received widespread international acceptance and is widely used (Widiger, 2012). Due to much controversy regarding the classification of personality disorders in the most recent edition of the DSM, it is important to gain a deeper understanding of the conceptualisation of personality disorders in previous editions of this manual, particularly as many of the conceptual and methodological struggles of earlier editions are still applicable (Blashfield, Keeley, Flanagan, & Miles, 2014). Therefore, the purpose of this section is to provide a brief history and discussion of the classification of personality disorders throughout all editions of the DSM. A summary of changes of personality disorder diagnoses from DSM-I to DSM-IV-TR is presented in Table 1.1.

2.1.1. DSM-I.

Subsequent to World War II and the return of American veteran soldiers experiencing severe symptoms of psychological distress, it was recognised that a fundamental obstacle to progress in psychiatry was the absence of a common diagnostic language, even among professionals who shared the same orientation (Blashfield et al., 2014; Stengel, 1959). Therefore, American psychiatry set out to create a centralised diagnostic classification system for mental illness that would be acceptable and implemented by all mental health professionals (Blashfield et al., 2014). This led to the publication of the first edition of the Diagnostic and Statistical Manual for Mental Health Disorders (DSM-I) by the American Psychiatric Association (APA) in 1952 (American Psychiatric Association, 1952). Its aim was to provide a nationally acceptable diagnostic classification system for mental disorders that focused on clinical utility (Widiger, 2012).

Psychodynamic theory, which had gained widespread acceptance in both the academic and clinical settings in psychiatry, and was recognised as the leading school of thought by the American Board of Psychiatry in 1946, formed the foundation on which the DSM-I was established (Grob, 1991; Kawa & Giordano, 2012). Therefore, disorders in the DSM-I were formulated according to psychodynamic etiological explanations, and were accordingly organised into two major groups: (1) conditions caused by organic brain dysfunction, and (2) functional disorders resulting from socio-environmental stressors (American Psychiatric Association, 1952; Blashfield et al., 2014; Kawa & Giordano, 2012). Functional disorders were further categorised into psychotic, neurotic, and character disorders; the latter of which contained a section on personality disorders (Blashfield et al., 2014).

The personality disorders section of the DSM-I included three subsections: (1) personality pattern disturbances, (2) personality trait disturbances, and (3) sociopathic personality disturbances (American Psychiatric Association, 1952). Personality pattern disturbances (inadequate, schizoid, cyclothymic, paranoid, other) were described as deeply ingrained disturbances in personality that were highly resistant to treatment and could progress into psychosis under stressful conditions (American Psychiatric Association, 1952; Widiger, 2012). Personality trait disturbances (emotionally unstable, passive-aggressive, compulsive, other) referred to the inability to maintain emotional balance and independence through any degree of stress as a result of disturbance in emotion development (American Psychiatric Association, 1952). Sociopathic personality disturbances (antisocial reaction, dyssocial reaction, sexual deviation, addiction (alcoholism and drug addiction), other) were viewed as disorders of social functioning as a result of severe underlying personality disorder (American Psychiatric Association, 1952).

A description of each personality disorder was included in the form of a short paragraph that provided limited, and somewhat over-condensed information that left much to the interpretation of the diagnostician (American Psychiatric Association, 1952; Blashfield et al., 2014). For example, Antisocial Reaction Personality Disorder was described as follows:

"This term refers to chronically antisocial individuals who are always in trouble, profiting neither from experience nor punishment, and maintaining no real loyalties to any person, group, or code. They are frequently callous and hedonistic, showing marked emotional immaturity, with lack of sense of responsibility, lack of judgment, and an ability to rationalize their behaviour so that it appears warranted, reasonable, and justified. The term includes cases

previously classified as "constitutional psychopathic state" and "psychopathic personality." As defined here the term is more limited, as well as more specific in its application."

(American Psychiatric Association, 1952, p. 38)

Although the DSM-I was largely successful in creating a common nomenclature for mental disorders, criticisms arose regarding its unclear diagnostic criteria, resulting in questionable reliability and validity (Widiger, 2012). Another important criticism aimed at the DSM-I was the requirement for psychiatrists to choose between a neurotic condition versus a personality disorder diagnosis when symptoms consistent with both diagnoses were present (Ward, Beck, Mendelson, Mock, & Erbaugh, 1962). Stengel (1959) recommended that future nomenclatures for mental disorders shed any theoretical and etiological assumptions in favour of behaviourally specific descriptions, as this would improve diagnostic reliability between clinicians and facilitate effective research (Widiger, 2012).

2.1.2. DSM-II.

The eighth edition of the International Classification of Diseases (ICD-8), and the second edition of the Diagnostic and Statistical Manual for Mental Health Disorders (DSM-II) were both published in 1968 (American Psychiatric Association, 1968; Widiger, 2012). In addition to proposals from various countries, the United States collaborated with the United Kingdom in developing a common proposal for the classification of mental disorders (Kawa & Giordano, 2012). However, there was little improvement regarding the use and authority of the ICD-8 with regard to the classification of mental illnesses (Kawa & Giordano, 2012).

In this edition of the DSM, substance dependencies and sexual deviations were removed from the personality disorders section and reclassified as independent groups under other non-psychotic mental disorders, as it was determined that despite their close association with personality pathology, they were not themselves disorders of personality (American Psychiatric Association, 1968; Spitzer & Wilson, 1968; Widiger, 2012). The three subsections of personality disorders (personality pattern disturbances, personality trait disturbances, and sociopathic personality disturbances) were deleted so that specific personality disorders were no longer organised into these groups (American Psychiatric Association, 1968). Also deleted from this edition, was the passive-dependent subtype of the passive-aggressive personality trait disturbance, whereas explosive, hysterical, and asthenic personality disorders were new

additions to this publication (American Psychiatric Association, 1968). In accordance with Stengel's (1959) recommendation, this edition of the DSM attempted to shed its association with Freudian theory by deleting the term 'reactions'. The following description of Antisocial Reaction Personality Disorder illustrates the efforts made to develop clearer diagnostic descriptions:

"This term is reserved for individuals who are basically unsocialized and whose behaviour pattern brings them repeatedly into conflict with society. They are incapable of significant loyalty to individuals, groups, or social values. They are grossly selfish, callous, irresponsible, impulsive, and unable to feel guilt or to learn from experience and punishment. Frustration tolerance is low. They tend to blame others or offer plausible rationalizations for their behaviour. A mere history of repeated legal or social offenses is not sufficient to justify this diagnosis. Group delinquent reaction of childhood (or adolescence) (q.v.), and Social maladjustment without manifest psychiatric disorder (q.v.) should be ruled out before making this diagnosis."

(American Psychiatric Association, 1968, p. 43)

The fundamental issue that extended from the DSM-I to the DSM-II was the absence of empirical support for the validity and reliability of personality disorder diagnoses presented (Widiger, 2012). Although there was notable improvement to diagnostic descriptions in the DSM-I, the DSM-II was nevertheless criticised for its unclear diagnostic criteria (Spitzer & Wilson, 1975). Furthermore, Spitzer and Wilson (1975) argued that there was a lack of follow-up studies to support the addition of explosive, hysterical, and asthenic personality disorder categories. An additional criticism aimed at the DSM-II section for personality disorders, was the absence of a depressive personality disorder diagnosis, despite the presence of a cyclothymic personality disorder category (Spitzer & Wilson, 1975).

2.1.3. DSM-III.

In 1974, the APA appointed a Task Force on Nomenclature and Statistics to develop a revised diagnostic manual that would reflect findings from current research with the aim of increasing diagnostic reliability and facilitating further research studies of mental disorders (Widiger, 2012). The third edition of the Diagnostic Statistical Manual for Mental Health Disorders (DSM-III) was published in 1980 and presented a revolutionary approach to diagnosing mental illnesses (American Psychiatric Association, 1980; Kawa & Giordano, 2012). The publication

of the DSM-III represented a paradigm shift in psychiatry whereby psychodynamic theory was rapidly being replaced by neo-Kraepelinianism as the dominant school of thought, which viewed mental disorders as fixed categories (Blashfield et al., 2014). As the main authors of the DSM-III were leaders in neo-Kraepelin ideology, their edition of the DSM-III broke away from psychodynamic theory and formulated a medical model for the conceptualization and treatment of mental disorders (Blashfield et al., 2014).

Previous editions of the DSM made use of vague, short descriptions in the form of a paragraph to define disorders, whereas DSM-III contained a detailed description, set of diagnostic criteria, demographic prevalence, and differential diagnostic information (American Psychiatric Association, 1980; Blashfield et al., 2014). An important contribution towards the development of specific diagnostic criteria was research conducted by Feighner et al. (1972), which made use of clinical studies to establish specific criterion sets for 15 mental disorders. Another innovation of the DSM-III was the addition of the multiaxial system, whereby underlying personality disorders and specific developmental disorders were placed on a separate axis (Axis II) to clinical syndromes (Axis I) (American Psychiatric Association, 1980; Kawa & Giordano, 2012). This was to ensure that Axis II disorders would not be overlooked in cases where clinical conditions that required immediate attention were present, and that clinical disorders and personality disorders no longer formed mutually exclusive diagnostic categories, as in previous editions of the DSM (Widiger, 2012).

In this edition, cyclothymic personality disorder was removed from the personality disorders section and reclassified under affective disorders on Axis I (American Psychiatric Association, 1980). Three personality disorders were deleted from the DSM-III (asthenic, inadequate, and explosive), whereas four new diagnostic categories were introduced (avoidant, dependent, narcissistic, and borderline) (American Psychiatric Association, 1980). Personality disorders were now organised into three clusters: Cluster A (paranoid, schizoid, and schizotypal) represented individuals who exhibited odd or eccentric personality features. Cluster B (histrionic, narcissistic, antisocial, and borderline) included dramatic, emotional and/or erratic behaviours, whereas Cluster C (avoidant, dependent, compulsive, and passive-aggressive) described individuals who appeared anxious or fearful (American Psychiatric Association, 1980). Although each personality disorder contained a set of diagnostic criteria, different diagnostic thresholds were specified for each personality disorder, resulting in a different

number of criteria necessary for each personality disorder diagnosis (American Psychiatric Association, 1980).

DSM-III field trials conducted with over 450 participants indicated that the personality disorders category was evaluated more reliably in comparison to both the DSM-I and DSM-II (American Psychiatric Association, 1980). However, inter-rater reliability for specific personality disorders, with the exception of antisocial personality disorder, was low; with kappa coefficients ranging from .26 to .75 (Widiger, 2012; Williams & Spitzer, 1980). A clinical study conducted by Mellsop, Varghese, Joshua, & Hicks (1982) found even lower levels of inter-rater reliability than those reported in the field trials, ranging from .01 (schizoid) to .49 (antisocial). Higher inter-rater reliability for the diagnosis of antisocial personality disorder was attributed to greater specificity of its diagnostic criteria, whereas lower reliability coefficients for other personality disorder diagnoses were attributed to individual biases among clinicians rather than to inadequate criterion sets (Mellsop et al., 1982; Widiger, 2012). Therefore, in an effort to limit idiosyncratic clinical interviewing, it was recommended that standardized and structured interviewing techniques be implemented (Mellsop et al., 1982; Widiger, 2012).

Previously, clinicians were tasked with finding one specific personality disorder to adequately describe the patient's pathological personality functioning (American Psychiatric Association, 1952, 1968). As many patients presented with features that were not limited to one personality disorder, now a patient could be diagnosed with more than one personality disorder if criteria for additional personality diagnoses were satisfied (American Psychiatric Association, 1980).

2.1.4. DSM-III-R.

The publication of the DSM-III was extremely successful and widely accepted by the United States psychiatry community (American Psychiatric Association, 1987). However, a critique aimed at the DSM-III was the absence of research used to guide the construction of all diagnostic criterion sets, including personality disorders (with the exception of antisocial personality disorder) (Widiger, 2012). Soon after the completion of the manual, it emerged that data produced from studies were inconsistent with particular diagnostic criteria (American Psychiatric Association, 1987). In addition, it was alleged that "criteria were not entirely clear, were inconsistent across categories, or were even contradictory" (American Psychiatric Association, 1987, p. xvii). Therefore, the American Psychiatric Association initiated a

revision to the DSM-III with the aim of correcting errors and providing further clarification regarding diagnostic criteria (Kawa & Giordano, 2012). Although the Personality Disorders Advisory Committee proposed two new personality disorder diagnoses (sadistic and self-defeating) which were approved by the DSM-III-R Work Group, this decision was eventually rejected by the APA Board of Trustees due to their "controversial nature and questionable empirical support" (Widiger, 2012, p. 16). Therefore, the only apparent amendment in the personality disorders section of the DSM-III-R, published in 1987, was the renaming of compulsive personality disorder to obsessive-compulsive personality disorder (American Psychiatric Association, 1987).

2.1.5. DSM-IV.

Although the DSM-III was a highly innovative and successful alternative to the ICD-9, its revolutionary approach decreased its compatibility with nomenclature used throughout the rest of the world, thereby failing to achieve its purpose of creating a common language of communication among mental health professionals (Widiger, 2012). Work on the ICD-10 was already underway by the time the DSM-III-R was published. Therefore, in an effort to revise the DSM-III-R in a manner that would be more compatible with the ICD-10, the APA Board of Trustees appointed a DSM-IV Task Force in May 1988 (Blashfield et al., 2014). In addition to ICD-10 compatibility, the Task Force aimed to produce a manual founded on undeniable empirical support that was more user-friendly for clinicians (Frances, Widiger, & Pincus, 1989).

Representatives of the DSM-IV and ICD-10 agreed to collaborate on developing more congruent personality disorder nomenclatures, resulting in the implementation of numerous revisions to DSM-III-R criteria sets to increase the congruency of corresponding diagnoses between the two diagnostic manuals; for example, the criterion of rigidity and stubbornness for obsessive-compulsive personality disorder, and many of the criteria for schizoid personality disorder in the DSM-IV, were taken from the ICD-10 research criteria (Widiger, 2012; Widiger, Mangine, Corbitt, Ellis, & Thomas, 1995). Although the DSM-IV Personality Disorders Work Group recommended that the ICD-10 *personality change after catastrophic experience* diagnosis be included in the DSM-IV, this recommendation was ultimately rejected by the DSM-IV Task Force (Gunderson, 1998; Shea, 1996). The ICD-10 included the addition of a borderline subtype to the emotionally unstable personality disorder category to increase compatibility with the DSM-IV; however, a narcissistic personality disorder diagnosis was not

included as it was reasoned that interest in this diagnosis was predominantly confined to the United States (Widiger, 2012). Although an initial draft of the ICD-10 included passive-aggressive personality disorder, it was ultimately rejected, as authors of the DSM-IV were recommending that this diagnosis be considered for removal from their own publication at the time (Widiger, 2012).

Despite the aim of the DSM-III and DSM-III-R authors to maximize the clinical utility of diagnostic criteria for practicing mental health professionals, at times it appeared as though the needs of the researcher were given greater importance in the form of lengthy and complex criterion sets (First et al., 2004; Frances, Pincus, Widiger, Davis, & First, 1990; Widiger, 2012). While researchers are able to devote numerous hours to assess personality disorder diagnostic criteria, this may be unrealistic for mental health workers (Mullins-Sweatt & Widiger, 2007). Therefore, authors of the DSM-IV and ICD-10 set out to develop criteria sets that would maximize reliability without being overly cumbersome for clinical practice (Widiger, 2012).

The World Health Organization (WHO) had aimed to address this issue by publishing separate versions of the ICD-10 for researchers and clinicians (Widiger, 2012). The researcher's version contained specific criterion sets, whereas the clinician's version was limited to narrative descriptions (Sartorius, 1988; Widiger, 2012). Although this option was considered by the DSM-IV Task Force, it was ultimately rejected on grounds that two separate versions would complicate the generalization of research findings to clinical practice and vice versa (Frances et al., 1990). The DSM-IV Task Force also criticised this approach as it implied that diagnoses formulated in clinical practice need not be as reliable or valid as diagnoses obtained for research (Widiger, 2012). Therefore, the DSM-IV Task Force decided to simplify the most lengthy and cumbersome DSM-III-R criterion sets, such as criteria for antisocial personality disorder, and present the criteria in order of highest to lowest diagnostic value (Widiger & Corbitt, 1995; Widiger et al., 1995). As time constraints in clinical practice often prevent clinicians from systematically assessing each diagnostic criterion, ranking criterion sets according to diagnostic value would allow for a more economical process whereby clinicians would focus primarily on the most crucial and informative criteria to formulate diagnoses (Widiger, 2012). However, due to various exceptions and inconsistencies (new diagnostic criteria with insufficient evidence to justify their ranking were placed last; the first criterion for borderline personality disorder was selected for its theoretical importance rather than its diagnostic value), the descending order of diagnostic value was not acknowledged in the manual (Widiger, 2012).

An important critique of both the DSM-III and DSM-III-R was the extent of their empirical support (Widiger, 2012). It was suspected that the decisions for these publications were more consistent with theoretical perspectives of the members of the Work Group or Advisory Committee than with published research, and there were various disagreements between members of the Personality Disorders Advisory Committees who ascribed to competing theoretical traditions (Widiger, 2012). In an effort to improve empirical support, the DSM-IV underwent the following three stages of review of empirical data: (1) systematic and comprehensive reviews of research literature, (2) re-analyses of multiple data sets, and (3) field trials (Blashfield et al., 2014). To limit biases and ensure objectivity, an explicit method of literature search was required, and each review was then critically evaluated by members with opposing views to the suggested proposal (Widiger, 2012). Field trials were also designed to address previous objections and specific concerns regarding a particular proposal, rather than simply addressing whether a criterion set was feasible (Widiger, 2012).

The results of this process included many substantial revisions for the DSM-IV personality disorder section: only 10 of the 93 DSM-III-R personality disorder diagnostic criteria remained unchanged, 21 received minor revisions, 10 were deleted, 9 were added, and 52 underwent significant revisions (Widiger, 2012; Widiger et al., 1995). Negativistic personality disorder, formerly referred to as passive-aggressive personality disorder, was relocated to the DSM-IV, Appendix B section for further study (American Psychiatric Association, 1994). A new diagnostic category recommendation, depressive personality disorder, was also added to this appendix; whereas the self-defeating and sadistic personality disorders were deleted entirely from the manual (American Psychiatric Association, 1994).

2.1.6. DSM-IV-TR.

The Diagnostic and Statistical Manual for Mental Health Disorders – Fourth Edition - Text Review (DSM-IV-TR) was published in the year 2000 (American Psychiatric Association, 2000). As its intention was not to change any criteria, no modifications were made to the personality disorders section, and only supporting narrative text was updated (Blashfield et al., 2014).

Table 1.1. Personality Disorder Diagnoses; DSM-I - DSM-IV-TR.

DSM-I	DSM-II	DSM-III	DSM-III-R	DSM-IV-(TR)
		Personality disorders presented in Axis II	Personality disorders presented in Axis II	Personality disorders presented in Axis II
Personality Pattern Disturbance		***Cluster A***	***Cluster A***	***Cluster A***
Inadequate	Inadequate	*Deleted*		
Schizoid	Schizoid	Schizoid	Schizoid	Schizoid
Cyclothymic	Cyclothymic	*Reclassified*		
Paranoid	Paranoid	Paranoid	Paranoid	Paranoid
		Schizotypal	Schizotypal	Schizotypal
Personality Trait Disturbance		***Cluster B***	***Cluster B***	***Cluster B***
Emotionally unstable	Hysterical	Histrionic	Histrionic	Histrionic
		Borderline	Borderline	Borderline
		Narcissistic	Narcissistic	Narcissistic
		Antisocial	Antisocial	Antisocial
		Cluster C	***Cluster C***	***Cluster C***
		Avoidant	Avoidant	Avoidant
Compulsive	Obsessive-Compulsive	Compulsive	Obsessive-Compulsive	Obsessive-Compulsive
Passive-Aggressive; Passive-depressive subtype	*Deleted*	Dependent	Dependent	Dependent
Passive-Aggressive; Passive-aggressive subtype	Passive-Aggressive	Passive-Aggressive	Passive-Aggressive	
Passive-Aggressive; aggressive subtype				
	Explosive	*Deleted*		
	Asthenic	*Deleted*		
Sociopathic Personality Disturbance				
Antisocial Reaction	Antisocial	*Placed in Cluster C*		
Dyssocial Reaction				
Sexual Deviation	*Reclassified*			
Addiction	*Reclassified*			
			Appendix:	***Appendix:***
			Self-Defeating	Passive-Aggressive/ Negativistic
			Sadistic	Depressive

Adapted from Widiger 2012.

2.2. DSM-5: The Process and Outcome of Developing a New Classification System for PDs

2.2.1. Shortcomings of the DSM categorical model for personality disorders.

Since the publication of DSM-III in 1980, personality disorders (PDs) have been conceptualised and diagnosed according to a discrete categorical model focused on individual differences in phenotypic manifestations of personality pathology (Wright & Simms, 2014). Subsequent to the publication of the DSM-III, and the updated DSM editions thereafter, critiques of the DSM's approach to the diagnosis of PDs rapidly emerged (Skodol et al., 2013). Extensive research indicated that the DSM's exclusively categorical approach had numerous shortcomings that detracted from its clinical utility and prevented important research efforts towards improved conceptualisation and identification of etiological and maintenance mechanisms (Krueger, 2013; Morey, Benson, Busch, & Skodol, 2015; Morey, Skodol, & Oldham, 2014; Skodol et al., 2013). The findings of this research highlight the following:

(1) *Extensive co-occurrence of PDs* such that patients who meet criteria for a specific PD typically meet criteria for other PDs, resulting in comorbidity being the rule, rather than the exception (Krueger, 2013; Krueger, Hopwood, Wright, & Markon, 2014b; Morey et al., 2015; Skodol et al., 2013; Wright & Simms, 2014). Although comorbidity is an issue throughout the DSM, it is particularly acute with regard to PDs (Krueger, Hopwood, Wright, & Markon, 2014a). The implications of high co-occurrence rates is that it not only impairs clinical utility by leading to confusion and contradictions over diagnosis and treatment, but it also impedes valuable research in this area, as researchers are faced with the dilemma of excluding participants with multiple PD diagnoses, resulting in samples that are unrepresentative of the broader PD population (Krueger, 2013; Morey et al., 2015).

(2) *Poor coverage of personality pathology* in that patients frequently present with patterns of symptoms that do not correspond with a specific PD, resulting in the most common and uninformative (albeit technically correct) diagnosis of personality disorder not otherwise specified (PD-NOS) (Skodol et al., 2013; Wright & Simms, 2014). Research indicated that not only is PD-NOS the most frequently diagnosed PD in clinical practice, but it is also the most common diagnosis in PD research settings (Verheul & Widiger, 2004). Although a PD-NOS diagnosis indicates considerable impairment in personality functioning, it does not

communicate any information regarding the nature of the personality pathology, resulting in negative treatment implications (Morey et al., 2015).

(3) *Heterogeneity within categories*. Due to the polythetic criteria for PDs, extreme heterogeneity exists among patients receiving the same PD diagnosis; meaning that patients who receive the same PD diagnosis typically share very few diagnostic features (Krueger et al., 2014a, 2014b; Morey et al., 2015; Skodol et al., 2013). Therefore, treatment plans for patients receiving the same PD diagnosis may differ considerably, hampering the clinical utility of the diagnosis (Morey et al., 2015).

(4) *Poor convergent validity* of PD criteria sets, resulting in patient groups diagnosed by different methods that are weakly related to one another (Skodol et al., 2013). The categorical DSM personality disorder model typically demonstrates substantially lower validity in explaining important antecedent, concurrent, and predictive variables in comparison with dimensional descriptive models; including approaches that represent a dimensionalization of the DSM constructs themselves by using a criterion count approach (Morey et al., 2012, 2015).

(5) *Temporal instability* of PD diagnoses occurring at rates incompatible with the basic definition of personality disorder (Skodol et al., 2013). In some cases it was reported that significant diagnostic change occurred in as little as six months (Shea et al., 2002). Furthermore, low average short-term test-retest correlations for personality disorder diagnoses, including structured interview diagnoses, have been recorded (Zimmerman, 1994).

(6) *Arbitrary diagnostic thresholds*. Unlike modern medicine, in which severity dimensions are common (such as three classes of obesity and various stages of cancer), PD diagnoses makes use of polythetic criteria with thresholds set arbitrarily at simply half or more of the criteria, with little or no empirical basis (Morey et al., 2015; Skodol et al., 2013). Therefore, the number of criteria necessary for a PD diagnosis varies across PD categories. For example, three out of seven criteria need to be satisfied for the diagnosis of antisocial personality disorder, whereas five out of nine criteria are required for a narcissistic personality disorder diagnosis (American Psychiatric Association, 2013). As a result, two individuals falling at the minimum diagnostic threshold for the same personality disorder diagnosis may vary substantially in the severity of their condition, resulting in limited validity and clinical utility (Skodol et al., 2013). Furthermore, individuals who fall below the threshold may have greater

problems of disorder severity than some who meet diagnostic thresholds (Cooper & Balsis, 2009).

(7) *Limited Diagnostic Reliability*. In comparison to many dimensional models, agreement between diagnosticians regarding the presence or absence of a personality disorder according to the DSM categorical model tends to be substantially lower (Morey et al., 2015). Furthermore, there is limited convergence across different structured diagnostic methods (Morey et al., 2015).

A number of the aforementioned shortcomings are not limited to the diagnosis of personality disorders, but extend to the entire DSM approach to the classification of mental disorders, as issues pertaining to comorbidity, heterogeneity, and categorical assumptions that do not align with evidence occur throughout the DSM (Krueger et al., 2014b). However, none of these problems were addressed in the subsequent revisions of the DSM, DSM-IV-TR (Skodol et al., 2013). As a result of these numerous shortcomings, DSM-IV PD diagnoses (1) have often not been used in clinical settings (Diagnosis Deferred on Axis II), (2) have been underused (hence the prevalence of PDNOS), or (3) have been erroneously used (such as diagnoses formulated on the basis of too few of the required criteria being satisfied) (Skodol et al., 2013).

2.2.2. South African Context.

The DSM's approach to personality pathology, and the entire spectrum of mental health disorders, has been criticised for its over-emphasis on the individual and its failure to address the influence of social context on the classification of mental disorders (Waumsley, 2007). As Long and Zietkiewicz (2002, p. 164) eloquently argue, "in spite of a massive accumulation of data regarding culture and mental health, Western psychiatry has, for the large part, continued to ignore the articulation of sociocultural factors in its theoretical and applied approaches to the problem." This argument is consistent with findings from a survey conducted by the World Health Organisation (WHO), in which the prevalence of personality disorder clusters varied between western and non-western countries (Huang et al., 2009).

As mainstream theories of personality and personality disorder have reflected worldviews characteristic of Euro-American societies, their application, and subsequently the relevance of

the DSM, to a South African context has been questioned (Long & Zietkiewicz, 2002; Naidoo, Townsend, & Carolissen, 2008). The majority of the South African population live in a collectivist culture and ideology, in which individuals view themselves as inextricably linked to and dependent on others, resulting in inter-dependence among individuals that is not only accepted, but encouraged (Naidoo et al., 2008; Waumsley, 2007). Therefore, the individualistic, and westernised DSM diagnosis of dependent personality disorder may not be well suited to a South African context, where dependency is a societal norm, and may result in higher rates of dependent personality disorder diagnoses in the South African population. However, this argument is inconsistent with research conducted by Suliman et al. (2008), which determined that cluster A (paranoid, schizoid, schizotypal) personality disorders were the most prevalent in South Africa, followed by cluster B (antisocial, narcissistic, borderline, histrionic), and cluster C (avoidant, dependent, obsessive-compulsive); respectively. However, Suliman et al. (2008) concluded that these findings were unusual, and that further studies were needed to investigate the epidemiology and prevalence of personality disorders in South Africa, an area of research that has largely been neglected.

2.2.3. Personality and Personality Disorders Work Group (P&PDWG).

In September 1999, the American Psychiatric Association (APA) and the National Institute of Mental Health (NIMH) sponsored an initial DSM-5 Research Planning Conference to set research priorities for DSM-5 (Skodol et al., 2013). In the introduction to the published white papers from this conference, it was argued that in addition to the aforementioned shortcomings, a strict adherence to DSM-IV definitions of mental disorders may have hindered research, and therefore, a paradigm shift was necessary (Kupfer, First, & Regier, 2002; Skodol et al., 2013). One possible form for such a paradigm shift was the option to integrate categorical and dimensional approaches towards the diagnosis of mental disorders (Regier, Narrow, Kuhl, & Kupfer, 2009; Zachar et al., 2015). It was concluded that the section on personality disorders would be the most appropriate place to initiate such a shift, as extensive research literature on dimensional models for this subfield was already in existence (Zachar et al., 2015).

Zachar and colleagues (2015) outlined the following key developments in the work of the Personality and Personality Disorders Work Group (P&PDWG): In 2006, David Kupfer and Darrel Regier were named, respectively, chair and vice chair of the DSM-5 Task Force. They

selected Andrew Skodol as chair of the P&PDWG in 2007, to oversee the committee of eleven members. The P&PDWG conducted literature reviews for each DSM-IV personality disorder with the aim of determining which disorders had the most empirical support. However, vested interests of group members quickly became apparent, and members aligned themselves into various subgroups according to divergent theoretical and clinical perspectives. Some members believed that DSM-IV PD categories were neither empirically supported nor clinically useful, and that they should thus be deleted altogether, with the DSM-5 adopting a completely dimensional approach; whereas others argued that a transitional model that bridges familiar categories and dimensional traits would facilitate clinician acceptability. A number of members claimed that irrespective of scientific evidence, specific PD categories, such as narcissistic personality disorder, had enough grounding in clinical experience that they could not simply be deleted. Another contentious issue was whether the DSM-5 PD proposal should be founded on an existing dimensional model supported by literature, or whether it should be a new but relatively untested model (Zachar et al., 2015).

In the first proposal, produced by Skodol in 2009, personality disorder was defined by (a) deficits in self and interpersonal functioning, and (b) the presence of pathological personality traits (American Psychiatric Association, 2013; Miller, Few, Lynam, & MacKillop, 2015; Skodol et al., 2011; Wakefield, 2012; Wright et al., 2015). To determine degree of severity, arguably the most important predictor of concurrent and prospective dysfunction, self and interpersonal dysfunction were to be rated on a scale of 0-4 (American Psychiatric Association, 2013; Krueger et al., 2014b; Skodol et al., 2011). Six broad pathological personality trait domains (negative emotionality, introversion, antagonism, disinhibition, compulsivity, and schizotypy), each consisting of a number of facets, were rated on a scale of 0-3 (Widiger, 2012; Zachar et al., 2015). Through this process, patients presenting with self and interpersonal dysfunction and pathological personality traits would receive the diagnosis of personality disorder – trait specified (PD-TS) (American Psychiatric Association, 2013; Miller et al., 2015).

The following five DSM-IV PD categories were retained: antisocial, avoidant, borderline, obsessive-compulsive, and schizotypal (Zachar et al., 2015). These were assessed using a prototype-matching approach in which an individual was matched to a narrative description of a personality type according to a scale of 1-5 (Skodol et al., 2013; Zachar et al., 2015). If a personality disorder was present, the degree to which an individual possessed the pathological

traits associated with that type was rated from 0-3 (Zachar et al., 2015). The proposal deleted the remaining five DSM-IV PD categories, namely; narcissistic, paranoid, schizoid, histrionic, and dependent (Zachar et al., 2015).

The prototype proposal was posted for public comment on the DSM-5 website in 2010 (Skodol et al., 2013). It received mixed reviews from both the P&PDWG and the website, and the task of evaluating feedback was complicated by the many conflicting views articulated, as various groups opposed elements of the model that were strongly supported by other groups (Zachar et al., 2015). Arguably the most notable critique focused on the representation of PDs as narrative prototypes, which was viewed as a drastic shift that had questionable empirical support and would result in substantial changes in central PD constructs if adopted (Krueger, 2013). The model was also criticised for being too complex for clinical use (Zachar et al., 2015).

In 2009, the APA leadership appointed an oversight committee, chaired by Carolyn Rabinowitz, to investigate the overall work of the DSM-5 Task Force and serve as an advisory group to the APA Board of Trustees (Skodol et al., 2013). The committee reported that there was a lack of structure for making and justifying decisions regarding proposed changes, and recommended that the publication of the new DSM manual be delayed (Zachar et al., 2015).

Zachar et al. (2015) outlined the following developments: During the annual APA meeting in May 2010, it was evident that there was much disagreement regarding the P&PDWG proposal, and as a result, Kupfer and Regier established an advisory committee in which Kim Yonkers and Joel Nigg chaired telephone meetings of the P&PDWG. This led to the development of a hybrid model that abandoned the controversial prototypes in favour of diagnostic criteria that differed from DSM-IV PD criteria. Each of the specific personality disorder categories would be defined by particular self and interpersonal deficits and a number of specific dimensional personality traits. In addition, the six pathological trait domains were reduced to five (negative affectivity, detachment, antagonism, disinhibition, and psychoticism), and narcissistic personality disorder was reinstated in the hybrid model.

As other DSM-5 work groups had developed proposed revisions of criteria-based, categorical approaches, rather than adopting new dimensional diagnostic models, DSM-5 field trials that were already underway were not assessing validity for new dimensional approaches (Skodol et al., 2013; Zachar et al., 2015). Hence, the P&PDWG proposed a field trial envisioned by Morey

to assess the clinical utility of the hybrid model, and evaluate its validity in relation to the DSM-IV categorical model for personality disorders (Zachar et al., 2015). However, the DSM leadership was unable to expand the field trials beyond what had initially been planned in order to meet the needs of one work group (Zachar et al., 2015).

2.2.4. SRC Evaluation.

Concerns regarding the developmental process of the DSM-5 led to the establishment of the Scientific Review Committee (SRC) (Skodol et al., 2013). The task of the SRC was to provide an independent scientific review of all proposed changes to the DSM and report their findings to the APA Board of Trustees (Skodol et al., 2013; Zachar et al., 2015).

In 2012, the P&PDWG submitted a Memo Outlining Evidence Change (MOEC) to the SRC (Skodol et al., 2013). The MOEC consisted of 26 pages outlining evidence to support proposal changes to the DSM-IV (Zachar et al., 2015). The SRC ultimately rejected the proposal, as they argued that (1) the report's validity relied on studies comprising normal samples rather than clinical samples, (2) more research was required to support such large changes, and (3) some members of the SRC felt that various P&PDWG members were promoting their own research rather than making use of other dimensional models supported by existing literature (Zachar et al., 2015). However, the SRC's instruction to assess validating evidence in support of incremental changes to categories directly contrasted the instruction of the P&PDWG to attempt a complete overhaul of DSM-IV PD categories and move towards a dimensional approach (Zachar et al., 2015). Therefore, from both the perspective of the SRC and P&PDWG, it was apparent that the SRC was inappropriate and ill-equipped to conduct such a review (Zachar et al., 2015).

2.2.5. CPHC Evaluation.

The Clinical and Public Health Review Committee (CPHC), chaired by Jack McIntyre and co-chaired by Joel Yager, was established in 2011 to evaluate the clinical utility and public health consequences of all DSM-5 proposals (Skodol et al., 2013; Zachar et al., 2015). The CPHC provided another route into DSM-5 for proposals that merited inclusion due to strong clinical or public health reasons despite the absence of validating data (Yager & McIntyre, 2014).

An extensive memo was submitted by the P&PDWG to the CPHC (Skodol et al., 2013). It included the findings of field trials and a study conducted by Morey and colleagues, which indicated that (1) a majority of clinicians rated the DSM-5 hybrid model as more clinically useful than the DSM-IV classification of personality disorders, (2) the hybrid model could be rated reliably, and (3) it could provide more information relevant to decision-making (Skodol et al., 2013). However, the CPHC did not support the P&PDWG's intention of adopting the hybrid model as the official DSM-5 model for classification of personality disorders, as they determined that it was too complicated and unfamiliar for immediate use by mental health professionals, regardless of the empirical support in its favour (Skodol et al., 2013; Zachar et al., 2015).

Although the entire DSM-5 Task Force unanimously approved the final version of the hybrid model to be printed in the main personality disorder classification section of DSM-5, Section II, due to the reports from the SRC and CPHC, the APA Board of Trustees decided to reprint the DSM-IV categorical personality disorder model in the DSM-5, with essentially no changes to criteria (Skodol et al., 2013; Zachar et al., 2015). A controversial change to the broader DSM-5 edition was the deletion of the multiaxial system. The multiaxial system was previously used to address the issue of personality disorders being overlooked in cases where clinical conditions that required immediate attention were present (Widiger, 2012). The rationale behind this deletion was the hope that it would be more difficult for medical insurance companies to deny coverage for personality disorders in the future, as their status, and consequently their medical reimbursements, would be equal to disorders previously classified on Axis I (Wakefield, 2013).

In addition to concerns regarding the complexity, unfamiliarity, and immediate clinical utility of the hybrid model, its rejection as a first-line system for diagnosing personality disorders was primarily due to controversy regarding the deletion of four personality disorders (Gunderson, 2013; Morey et al., 2014; Skodol et al., 2013). The justification provided for the deletion of four personality disorder diagnoses (paranoid, schizoid, histrionic, and dependent) was (1) their underutilization, (2) limited empirical support, and (3) to reduce excessive co-occurrence of PDs (Gunderson, 2013; Welch, Klassen, Borisova, & Clothier, 2013). However, this rationale received the following counter-arguments: (1) the underutilization or rarity of particular personality disorders does not mean that they are non-existent; (2) although there appears to be

less research regarding the four deleted PD categories, Shedler et al. (2010, p. 1027) argued that an "absence of evidence is not evidence of absence", meaning that a lack of research may reflect a failure of personality disorder researchers, rather than the absence of the clinical importance of a particular personality disorder; and (3) it is uncertain whether the deletion of PD categories would reduce excessive co-occurrence or simply increase PD-NOS diagnoses (Gunderson, 2013; Widiger, 2012). In addition, John Livesley (2012), a former member of the P&PDWG whose objections to the hybrid model resulted in his resignation, argued that the criteria for determining which PD categories to delete were not explicit and the final decision was a result of arbitrary selection. However, it is important to note that through the deletion of these four specific personality disorder categories, the hybrid model was not suggesting that paranoid, histrionic, dependent, and schizoid traits do not exist and should not be assessed, but instead provided a different method for assessing personality dysfunction and pathological traits belonging to these categories (Widiger, 2012). Therefore, even if the deletion of these specific PDs resulted in an increase of Personality Disorder – Trait Specified (PD-TS) diagnoses (the hybrid model's counterpart for PD-NOS), these diagnoses would provide more detailed and individualised diagnostic information than a specific PD diagnosis on the DSM-IV categorical model for PDs.

With the objective of investigating the aforementioned concerns, the proposed model was placed in Section III, "Emerging Measures and Models" of the DSM-5 as an "Alterative DSM-5 Model for Personality Disorders" (DSM-5-AMPD) for further research to review, refine and develop the DSM-5-AMPD (American Psychiatric Association, 2013; Gunderson, 2013; Krueger, 2013; Widiger, 2013; Wright & Simms, 2014).

2.3. Studies Assessing Clinical Utility in the DSM-5-AMPD

As the rejection of the hybrid model was primarily due to concerns over clinical utility, the literature reviewed in this section will be limited to research regarding the clinical utility of the Alternative DSM-5 Model for Personality Disorders (DSM-5-AMPD). Clinical utility involves effective (1) ease of use, (2) communication (patient and professional), and (3) treatment planning (Mullins-Sweatt & Widiger, 2009). The following discussion makes use of three studies aimed at addressing various aspects of clinical utility of the DSM-5-AMPD.

A study conducted by Morey et al. (2014) investigated the perceived clinical utility of all aspects of the DSM-5-AMPD with regard to existing patients. This research made use of a national sample of 337 mental health clinicians who provided anonymous diagnostic information on one of their own patients, using an online survey to capture (1) demographic information, (2) clinical judgements regarding client variables (such as psychosocial functioning, short-term risk, optimal level of treatment intensity, and suitability for various treatment modalities), and (3) all diagnostic information pertinent to both the DSM-5 categorical model for personality disorders (DSM-5-PD) and the DSM-5-AMPD.

For the DSM-5-PD model, clinicians were instructed to complete a checklist of 79 PD criteria extracted directly from the DSM-5-PD model in relation to their patient. Morey et al. (2014) then used DSM-5-PD decision rules to construct algorithms to formulate DSM-5 categorical PD diagnoses according to the information provided. For the DSM-5-AMPD, clinicians were instructed to make use of the Level of Personality Functioning Scale (LPFS), presented in Section III of the DSM-5, to rate their patients' overall level of personality functioning impairment (Criterion A). Similarly to the DSM-5-PD checklist, specific diagnostic criteria proposed for the definition of the six specific personality disorder types in the DSM-5-AMPD were arranged in random order and included disorder-specific manifestations of the impairments in self and interpersonal functioning, as well as separate dichotomous ratings of the clinical significance of selected pathological traits. To capture pathology in personality traits, clinicians completed ratings of descriptiveness of five broad trait domains (negative affectivity, detachment, antagonism, disinhibition, and psychoticism) and 25 component trait facets on 4-point scales, as outlined in Section III of the DSM-5 (Criterion B). Immediately following the completion of each rating (four in total), clinicians were asked 6 questions regarding their perceived clinical utility of the assessment provided.

In comparing the DSM-5-PD model's diagnostic criteria and the six specific PD types outlined in the DSM-5-AMPD, results from Morey et al. (2014) indicated that clinicians (regardless of professional discipline) rated the DSM-5-PD criteria as easier to use, and more useful for communication with other professionals than the six specific PD types described in the DSM-5-AMPD. Although Morey et al. (2014) hypothesised that these results may be due to clinicians' considerable familiarity with this diagnostic system (as it has remained relatively unaltered since 1994), perhaps an approach that incorporated both quantitative and qualitative techniques would provide more insight into the results of these ratings by clinicians.

With regard to patient communication, comprehensiveness, treatment formulation, and global description of personality, the DSM-5-AMPD criteria were regarded as more comprehensive and usefully descriptive than the DSM-5-PD model by clinicians as a whole. This finding is particularly interesting, as the DSM-5-AMPD makes use of only six PDs in comparison to the 10 PDs described by the DSM-5-PD model (Morey et al., 2014). Therefore, a qualitative discussion may provide further insight into this seemingly incongruent response.

In addition to the above finding, patterns of differences between psychiatrists and non-psychiatrists emerged. For all four instruments, psychiatrists rated both diagnostic models higher in utility than non-psychiatrists, which may suggest that psychiatrists perceive greater utility in diagnosis in comparison to other mental health professionals. Furthermore, results suggested that for patient communication, comprehensiveness, and treatment formulation, psychiatrists tended to view the DSM-5-PD model as equally or more useful than the DSM-5-AMPD, whereas non-psychiatrist found the DSM-5-AMPD to be superior in each of these respects (Morey et al., 2014). Thus, a qualitative exploration may provide a richer discussion and understanding behind differences in ratings between psychiatrists and non-psychiatrists with regard to these four elements of utility.

In terms of global personality pathology description, the DSM-5-PD model was regarded as easier to use and more useful for communicating with other professionals. Although with regard to the remaining utility elements (patient communication, comprehensiveness, treatment formulation, and global description of personality) the DSM-5-PD model and DSM-5-AMPD were viewed as comparable in utility by clinicians as a whole, psychiatrists tended to rate the diagnostic formulation of either system higher than non-psychiatrists. In addition, non-psychiatrists tended to perceive the DSM-5-AMPD global rating of personality functioning as more useful that the DSM-5-PD model, whereas psychiatrists favoured the DSM-5-PD model (Morey et al., 2014). The diversity of views between professions evidenced in this study suggest the need for more in-depth and open-ended explorations of these issues.

Finally, with regard to the trait ratings of the DSM-5-AMPD, five of the six utility components (excluding communication with professionals) were viewed as having significantly greater utility than the DSM-5-PD model by both psychiatrists and non-psychiatrists. Even with respect to communicating with other professionals, the DSM-5-AMPD personality trait

descriptions and the DSM-5-PD model received ratings of equal utility (Morey et al., 2014). As the trait description element of the DSM-5-AMPD model was unanimously rated as significantly more useful than the DSM-5-PD model, further qualitative information may provide a more detailed understanding of the practical utility of this tool within a clinical setting.

Thus, clinicians generally perceived higher clinical utility for the DSM-5-PD model than the DSM-5-AMPD in relation to communicating patients' diagnostic information among mental health professionals. However, all three elements of the DSM-5-AMPD were regarded as either equally or significantly more useful than the DSM-5-PD model in relation to communication with patients, treatment formulation, comprehensive description of personality problems experienced by the individual, and description of the individual's global personality. In particular, the trait dimension element of the DSM-5-AMPD was viewed as having comparable utility to the DSM-5-PD model with regard to communication with professionals, and significantly greater utility than the DSM-5-PD model for the remaining six utility components. Furthermore, discrepancies between psychiatrists and non-psychiatrists emerged regarding the general utility of both systems, as well as differences in utility between elements of the two diagnostic models (Morey et al., 2014).

A study conducted by Zimmerman et al. (2014) aimed to address concerns raised by the CPHC that the DSM-5-AMPD's Level of Personality Functioning Scale (LPFS) may be too unfamiliar and complicated for mental health professionals to use without receiving extensive training. In this study, a sample of 22 undergraduate psychology students were instructed to view pre-recorded, expert-level interviews of 10 independent female patients and provide LPFS ratings of pathological functioning for each patient. Students' LPFS total rating scores reflected high interrater reliability, and there was a significant association between the students' LPFS ratings and two distinct expert-rated measures of the severity of personality pathology. Therefore, the findings from this study indicated that contrary to CPHC concerns regarding unfamiliarity and complexity of the LPFS, extensive clinical experience and training may not be required for the successful application of the LPFS in clinical practice.

A study conducted by Bach, Markon, Simonsen, and Krueger (2015) was developed to evaluate the clinical utility of the DSM-5-AMPD. In this research the Level of Personality Functioning Scale (LPFS) and the Personality Inventory for DSM-5-AMPD (PID-5) were administered to

a sample of 142 psychiatric outpatients diagnosed with personality disorders and other non-psychotic disorders. The Mini International Neuropsychiatric Interview 6.0.0 (MINI) for current and lifetime clinical syndromes, and the Structured Clinical Interview for DSM-IV Axis II (SCID-II) were used to classify patients according to the DSM-5-PD model. The administration of the LPFS was based on observations from the SCID-II, and were exclusively conducted by Bo Bach, whereas the PID-5 was completed by the patients. All 142 PID-5 profile assessments were discussed with each patient and applied to treatment planning. The personality profiles of 6 patients were then subjected to a more detailed analysis. These cases were selected on the basis of general observations, their different levels of severity in personality problems, and because they collectively satisfied criteria for the 6 specific personality disorder types on the DSM-5-AMPD.

Results from the 6 patient cases indicated that although the DSM-5-AMPD may entail a more complex and longer process, it provides more detailed, individualised, and accurate diagnoses. While the DSM-5-PD model may allow for easier and faster professional communication regarding patients, the DSM-5-AMPD produced unique and individualised patient profiles, which provides more specific and fair professional and patient communication. Communication of the PID-5 profiles allowed patients to recognize their dysfunctional patterns of behaviour and identify with the detailed description produced, which ultimately improved patients' alliance and treatment focus. The PID-5 profiles also facilitated the planning of individualised treatment that maximized patient cooperation.

However, as the diagnostic formulation of the patients in this study was solely conducted by the first author and the patients themselves, the application of the DSM-5-AMPD, and the perceived clinical utility of this process, was essentially limited to the experience of one clinician. Therefore, the application of the DSM-5-AMPD by a number of clinicians, as in the study conducted by Morey et al. (2014) may provide deeper insight into the perceived clinical utility of this model. In addition, the application of the DSM-5-PD model and the DSM-5-AMPD to a common patient case file may allow for a comparison of implied diagnostic outcomes between clinicians for a single patient; resulting in a richer discussion regarding diagnostic discrepancies. Furthermore, limiting the application of the DSM-5-AMPD to clinicians, and making use of an inpatient, rather than an outpatient case file, may improve the accuracy of implied diagnoses, as patients with personality pathology typically have poor insight into their behaviour, and the daily observation of inpatients by professionals may

provide more objectivity and insight into observable patient behaviour and interpersonal functioning.

2.4. Conclusion

With the objective of investigating concerns regarding clinical utility, the proposed model was placed in Section III, "Emerging Measures and Models" of the DSM-5 as an "Alterative DSM-5 Model for Personality Disorders" (DSM-5-AMPD) for further research. Despite concerns over complexity and unfamiliarity, studies suggest that aspects of the DSM-5-AMPD may be relatively easy to use, even by untrained clinicians. However, research addressing all components of the DSM-5-AMPD indicated that clinicians experienced the DSM-5-AMPD as more difficult to use in comparison to the DSM-5-PD. Nevertheless, although the DSM-5-AMPD may entail a more complex and lengthy process in comparison to the DSM-5-PD model, it may provide more individualised and accurate diagnoses, resulting in improved patient communication and treatment. In addition, while the DSM-5-PD model may allow for easier and faster professional communication regarding patients, the DSM-5-AMPD may facilitate more informative and accurate diagnostic communication between mental health professionals. However, as the DSM's relevance to the South African population has previously been questioned, further research is required to address the applicability and utility of the DSM-5-PD model and DSM-5-AMPD in a South African context.

2.5. Rationale

Although the study conducted by Morey et al. (2014) examined the perceived clinical utility between the DSM-5-PD model in relation to the DSM-5-AMPD, clinicians' experiences of clinical utility were restricted to a series of 6 questions, which limited the opportunity to gain richer and more detailed information regarding clinicians' perceptions of clinical utility of both diagnostic models. Therefore, this study will make use of a focus group discussion to allow for further exploration and elaboration of clinicians' perceptions. While the study conducted by Morey et al. (2014) described patterns of differences in perceptions of clinical utility of both models between psychiatrists and other mental health professionals, through a group discussion, this study will provide more insight into discrepancies between professional disciplines.

The application of the DSM-5-AMPD in the study conducted by Bach et al. (2015) was limited to a single clinician and the use of patients' self-reports; essentially limiting the perceived clinical utility of this process to the experience of one clinician. In addition, studies conducted by both Bach et al. (2015) and Morey et al. (2014) made use of independent patient case files, which restricts the valuable use of comparing and contrasting the perceived clinical utility of these diagnostic models between clinicians according to one or more common patient file. Thus, the proposed study will make use a multidisciplinary team of mental health professionals, who will apply both PD models to a common patient case file. This will allow for emergence and exploration of diagnostic discrepancies and differences in judgements of clinical utility across clinical staff.

Furthermore, unlike the Morey et al (2014) study, the diagnostic rating exercise will not be an end in itself, but rather a common basis of experience in applying the current and alternative models to one common case file that can then serve as the basis for an in-depth discussion that will then be subjected to qualitative analysis. The purpose of this will be to add more value to understanding the perceived advantages, disadvantages, and future possible utility of both models in a clinical setting.

Therefore, this research is necessary, as it will not only create a forum in which clinicians will be able to use both diagnostic models alongside one another, but will allow these professionals to draw on a common experience to inform a rich, critical discussion regarding the conceptualisation and practical utility of both models for PDs. In addition, as the DSM's relevance to the South African population has previously been questioned, this research will explore the applicability and utility of the DSM-5-PD model and DSM-5-AMPD to a South African context.

Chapter 3: Method, Procedure, and Instruments

3.1. Research Question

What are mental health professionals' perceptions regarding the clinical utility of the alternative model for personality disorders described in Section III of the Diagnostic and Statistical Manual for Mental Disorders – Fifth Edition (DSM-5-AMPD) in relation to the current DSM-5 model for personality disorders (DSM-5-PD)?

- Part one produced utility judgement scores according to a common patient case file and questioned whether there were differences in mental health professionals' utility ratings between the DSM-5-PD model and DSM-5-AMPD.

- Part two explored mental health professionals' perceptions and judgements of utility in a more exploratory fashion with regard to their experience with the patient case file, as well as the summary feedback on the outcome of the case.

3.2. Research Design

This research adopted a mixed methods approach, as it involved the sequential use of both qualitative and quantitative techniques in a single study for the purpose of obtaining a deeper understanding of human phenomena (Creswell, 2009; Johnson, Onwuegbuzie, & Turner, 2007). An explanatory sequential strategy was employed, as quantitative data were collected and analysed in the first phase of the research, followed by the collection and analysis of qualitative data in the second phase, which built on the initial quantitative results (Creswell, 2009). Although the two forms of data were separate, they were connected, as the quantitative data was used to inform the qualitative data collection; and the qualitative data was used to examine the quantitative results in more detail (Creswell, 2009). Therefore, the combination of both quantitative and qualitative approaches utilized in this study was able to provide a more comprehensive understanding of mental health professionals' perceptions of the current and alternate DSM-5 models for diagnosing personality disorders (PDs) than either approach used alone (Creswell, 2013).

As this study was an adaptation of the research conducted by Morey et al. (2014), the initial procedures employed in this research closely resembled the methods used by Morey and colleagues. Therefore, the first phase of this study adhered to a positivist paradigm and adopted a quantitative, non-experimental, cross-sectional design, as participants completed the surveys at a single point in time and variables were not manipulated (Creswell, 2013). This phase of the research sought to determine whether there were differences in mental health professionals' perceptions of clinical utility between the DSM-5-PD model and the three components of the DSM-5-AMPD. As assumptions for the use of parametric tests were not established, results were statistically analysed through the use of non-parametric Friedman tests (Zimmerman & Zumbo, 1993).

The second phase of this study adopted an exploratory qualitative design, as it employed an inductive approach towards understanding mental health professionals' perceptions of clinical utility of both personality disorder diagnostic models (Creswell, 2013). A focus group was conducted with the aim of acquiring a more detailed, richer, and in-depth account of mental health professionals' experiences, observations, and insights of the process and results from the initial quantitative phase of the research. Thus, the data produced from the focus group was in the form of words and descriptions, and was analysed, interpreted, and conceptualised through the use of thematic content analysis (Whitley & Kite, 2012).

3.3. Sample

The multidisciplinary team of mental health professionals at Tara The H. Moross Centre (Tara), working in the personality disorder unit, was invited to voluntarily participate in the research. Although PDs are exclusively diagnosed by psychiatrists and clinical psychologists, the invitation was extended to include all members of the multidisciplinary team at Tara (which comprises a psychiatrist, two psychiatry registrars, a clinical psychologist, two clinical psychologists completing their community service requirements, two clinical psychology interns, an occupational therapist, a social worker, a dietician, and ten psychiatric nurses), as the DSM is not only extensively used by other mental health professionals, but prior research has demonstrated that psychiatrists and other mental health professionals have different views of the DSM (Morey, 1980; Morey et al., 2014; Ochoa & Morey, 1990).
A non-probability, purposive, convenience sample of 13 participants at Tara was obtained. The sample included 2 psychiatrists, 1 clinical psychologist, 1 community service psychologist, 2 intern psychologists, and 7 psychiatric nurses.

3.4. Instruments

3.4.1. DSM-5-PD Criteria Checklist.

For the current DSM-5 PD model, mental health professionals were presented with a checklist of 79 PD criteria taken directly from the DSM-5, arranged in random order to minimize possible answer biases (Appendix A) (Morey et al., 2014). From these individual criteria, DSM-5 diagnostic threshold decision rules were used to assign implied categorical DSM-5 PD diagnoses.

For the DSM-5-AMPD, mental health professionals were asked to provide judgements for both components (Criterion A and B) of the system, which made use of the following instruments:

3.4.2. Specific Descriptions of Self and interpersonal Functioning Checklist.

Similarly to the DSM-5-PD model checklist, specific diagnostic criteria proposed for the definition of the six specific DSM-5, Section III PD types (schizotypal, antisocial, narcissistic,

borderline, avoidant, and obsessive-compulsive) was taken directly from the DSM and arranged in random order. This included disorder-specific manifestations of the impairments in self and interpersonal functioning (Criterion A), as well as disorder-specific pathological personality traits (Criterion B) (Appendix B) (American Psychiatric Association, 2013).

3.4.3. The Level of Personality Functioning Scale (LPFS).

The LPFS was used to assess the level of personality functioning to meet the requirement for Criterion A of the alternative model for PDs, as described in Section III of the DSM-5. The LPFS is a 60-item self-report personality functioning assessment scale. It assesses levels of self and interpersonal personality functioning proposed in Section III of the DSM-5. Self-functioning comprises (1) identity and (2) self-direction, whereas interpersonal functioning consists of (1) empathy and (2) intimacy. The LPFS uses these elements to differentiate between 5 levels of impairment ranging from *little or no impairment* (level 0), *some impairment* (level 1), *moderate impairment* (level 2), *severe impairment* (level 3), and *extreme impairment* (level 4) (Appendix C) (American Psychiatric Association, 2013).

3.4.4. Personality Disorder Trait Domains and Facets Scale (TDFS).

A 25-item personality trait assessment scale was used to assess pathological personality traits required to meet Criterion B of the alternative model. The scale comprises 5 broad trait domains, namely: (1) negative affect, (2) detachment, (3) antagonism, (4) disinhibition, and (5) psychoticism, with each trait domain consisting of a number of trait facets, as represented verbatim from the DSM Section III PD trait descriptions. For the trait ratings, a definition for each trait domain and facet was provided, and clinicians were requested to rate the patient on a 4-point scale ranging from 1 (*very little or not at all descriptive*) to 4 (*extremely descriptive*). The 25 trait facets were presented to participants in alphabetical order, rather than by domain, to avoid associations that may arise from grouping traits together that are theoretically and empirically related (Appendix D).

3.4.5. Perceived Clinical Utility Questionnaire.

The Perceived Clinical Utility Questionnaire was used to assess the clinical utility of each diagnostic instrument provided according to the common patient case file. The questionnaire consists of 6 items regarding clinical utility. Mental health professionals were requested to rate each of the above instruments on a 5-point Likert-type scale, ranging from 1 (*not at all useful*) to 5 (*extremely useful*), These questions, which were identical to those used by Samuel and Widiger (2006) and Morey et al. (2014) were as follows:

1. How easy do you feel it was to apply these concepts to these individuals?
2. How useful do you feel these concepts would be for communicating information about these individuals to other mental health professionals?
3. How useful do you feel these concepts would be for communicating information about the individual to him/herself?
4. How useful are these concepts for comprehensively describing all the important personality problems these individuals have?
5. How useful would these concepts be for helping you to formulate an effective intervention for these individuals?
6. How useful were these concepts for describing these individuals' global personality?

3.5. Procedure

Subsequent to obtaining ethical clearance from the University of the Witswatersrand HREC Medical and the Tara Ethics Committee, the researcher briefed participants and administered an information sheet and consent form. Mental health professionals who consented to participate in the study were then requested to complete the instruments based on an independent review of a common case file of a recently discharged patient who had interacted with all the staff of the multi-disciplinary team during the duration of the patient's six-month admission. Data from the participants was collected through a survey that presented all diagnostic information pertinent to both the DSM-5-PD model and the DSM-5-AMPD.
The following four instruments were presented in the sequence listed below:

1. DSM-5-PD Criteria Checklist.
2. The Level of Personality Functioning Scale (LPFS).

3. Specific Descriptions of Self and interpersonal Functioning Checklist.
4. Personality Disorder Trait Domains and Facets Scale (TDFS).

Immediately following the completion of each of these 4 assessments for the patient, participants were requested to complete the Perceived Clinical Utility Questionnaire. Therefore, this questionnaire was completed a total of 4 times in order to determine the level of perceived clinical utility of each diagnostic instrument with regard to the common case file. The time-frame for completing these assessments was a period of two weeks, at times convenient to each participant. Once this process was completed, the researcher collected and analysed this information. For each of the four diagnostic instruments, the researcher used the corresponding DSM decision rules to count the number of times minimum criteria for a PD diagnosis were satisfied. In other words, appropriate decision rules for each PD model were employed by the researcher to assign implied PD diagnoses.

Participants were then invited to attend a focus group discussion scheduled approximately two weeks after their completion of the assessments, in which they were presented with the following: (1) a full description of a borderline personality disorder diagnosis according to the DSM-5-PD model, (2) a full description of a borderline personality disorder diagnosis according to the DSM-5-AMPD, and (3) a personality disorder-trait specified (PD-TS) implied diagnosis description of the patient selected for the common case file. The researcher explained that through the use of corresponding DSM decision rules, the criteria for a borderline PD diagnosis had been satisfied on both the current and alternate PD models more times than any other PD diagnosis. Therefore, participants were presented with the borderline PD diagnostic criteria in both the DSM-5-PD model and the DSM-5-AMPD. A PD-TS description of the patient was also presented to participants in order to provide mental health professionals with an example of the DSM-5-AMPD's alternative to the DSM-5-PD model's PD-NOS diagnosis for cases where patients present with personality pathology but do not meet criteria for a specific PD diagnosis (Appendix E).

Throughout the focus group, participants were requested to draw on (1) their experience of the diagnostic instruments in the first phase of the study, (2) the implied diagnoses resulting from these instruments, and (3) their extensive clinical experience in discussing the clinical utility of the DSM-5-AMPD and the current DSM-5 PD model in relation to one another (Appendix F). Thus, the focus group reflected on the process of applying both models to the common case

file and the implied diagnostic results of these processes to provide a more in-depth discussion regarding the perceived utility and possible refinement of the alternative model.

Therefore, this study made use of a focus group consisting of the multidisciplinary team for PDs at Tara. The focus group took place in a private discussion room located at Tara at an agreed upon date and time that was suitable to both the researcher and the mental health professional team. Data was collected through the use of an audio recorder, which was then transcribed and analysed by the researcher.

3.6. Data Analysis

The first phase of the data analysis made use of quantitative methods. The data obtained was entered into Excel, and thereafter imported to SPSS, a computer-based statistics program, to allow for analysis. Due to the small sample size (n=13), the assumptions for parametric repeated measures procedures were not met, and as a result, non-parametric Friedman tests were used to determine whether there were statistical differences in mental health professionals' utility ratings between the DSM-5-PD model and the various components of the DSM-5-AMPD (Corder & Foreman, 2011). The level of significance was set at $p<0.05$.

Qualitative methods were employed for the second phase of the data analysis. The researcher transcribed audio-recorded data from the focus group into a typed transcript. Thematic content analysis procedures were then used to systematically identify, analyse and report on themes emergent from the multi-disciplinary team's responses (Braun & Clarke, 2006). Braun and Clarke's (2006) six-phase guide was used as a framework for analysing the data, namely: (1) familiarization with the data, transcription, and generating initial ideas regarding the content, (2) generating initial codes across the data set and organising content into these relevant codes, (3) organising codes to form potential overarching themes, (4) reviewing and refinement of themes, (5) defining and further refining themes, and (6) produce a final coherent analysis in relation to the research question and literature.

3.7. Ethical Considerations

Ethical clearance was received from the Human Research Ethics Committee (Medical) at the University of the Witwatersrand (protocol number: M150546) (Appendix G). Permission to conduct this research was also granted by Tara (Appendix H).

Although this research made use of a patient case file, the sample in the study consisted of mental health professionals. As it was standard procedure for patients at Tara to complete an informed consent form that allows for the use of personal clinical information to be used for research purposes (Appendix I), an independent information sheet and consent form regarding the research process, the purpose, duration and procedure of the study was not required to be administered to patients. Only one patient file was used with the aim of providing common case material for mental health professionals to rate (in the survey) and discuss (in the focus group) in order to evaluate the comparative clinical utility of the two PD models. Therefore, this study was not a traditional retrospective case review.

All information contained in the patient's case file remained confidential, as only the multidisciplinary team had access to this information – all of whom were registered with the HPCSA at the time of the study. As the principle of anonymity was of primary importance, disclosure of the patient's name, and access to the patient's case file, was not granted to the researcher. Confidential information was not discussed with any party other than individuals involved within the research process. In addition, any information obtained was only used for research purposes, and all potentially personally identifying patient information was excised in the write up of the discussion material.

As mentioned previously, mental health professional participants were briefed regarding the research process, and an information sheet outlining the purpose, duration and procedure of the study was provided to all prospective participants (Appendix J). Subsequent to the briefing, those who agreed to take part in the study were requested to sign a consent form prior to participation (Appendix K), which indicated that participants understood what was required of them and that they agreed to participate in the research. Participants were also required to sign a consent form to be audiotaped during the focus group (Appendix L).

Participation in the study was voluntary, and the researcher explained that there would be no negative implications for choosing not to participate. Furthermore, participants were informed

of their right to withdraw from the study at any time during the research process without experiencing any prejudice or being forced to provide a reason for withdrawal.

All participant information was stored in a locked cabinet by the researcher and treated with strict ethical consideration for confidentiality. Access to this information was limited to the researcher and supervisor.

Although the anonymity of mental health professionals was limited by the face-to-face process characteristic of a focus group, participants' contributions to the discussion were recorded through the use of professional categories/pseudonyms, so that any identifying information was not represented in the data. However, the consent form for audio recording of the focus group communicated the researcher's intention to use direct quotations in the write-up of the results.

3.8. Self-Reflexivity

The second phase of this study made use of a qualitative approach, which can be susceptible to the subjective values, motivation, and personal biases of the researcher (Tolman & Brydon-Miller, 2001). Therefore, this section will briefly outline the researcher's reflections and acknowledgement of her influence on the research process and outcome.

As the researcher has no personal history involving personality disorders with regard to herself, her family, and her friendship group, the subject of personality disorders was not a particularly personal or sensitive area for her.

During the process of this study, the researcher was a master's student in clinical psychology. However, as indicated earlier, the researcher did not have access to the patient case file used by the multidisciplinary team of participants in this study. Therefore, it was easier for the researcher to bracket her own clinical judgements and interpretations related to the case, as she did not have access to any information pertaining to the patient.

Although the researcher conducted a fair amount of prompting of discussion in the focus group, the nature of this prompting was to encourage discussion of the core issues of clinical utility

without being unduly influenced by her own impressions and clinical judgements of the case file or the process followed in the first phase of the study.

Chapter 4: Results

This study aimed to explore mental health professionals' perceptions of clinical utility of the DSM-5-AMPD in relation to the DSM-5-PD. This study adopted a mixed methods design, whereby both quantitative and qualitative techniques were employed. Therefore, quantitative results, followed by qualitative findings, will be presented in this chapter.

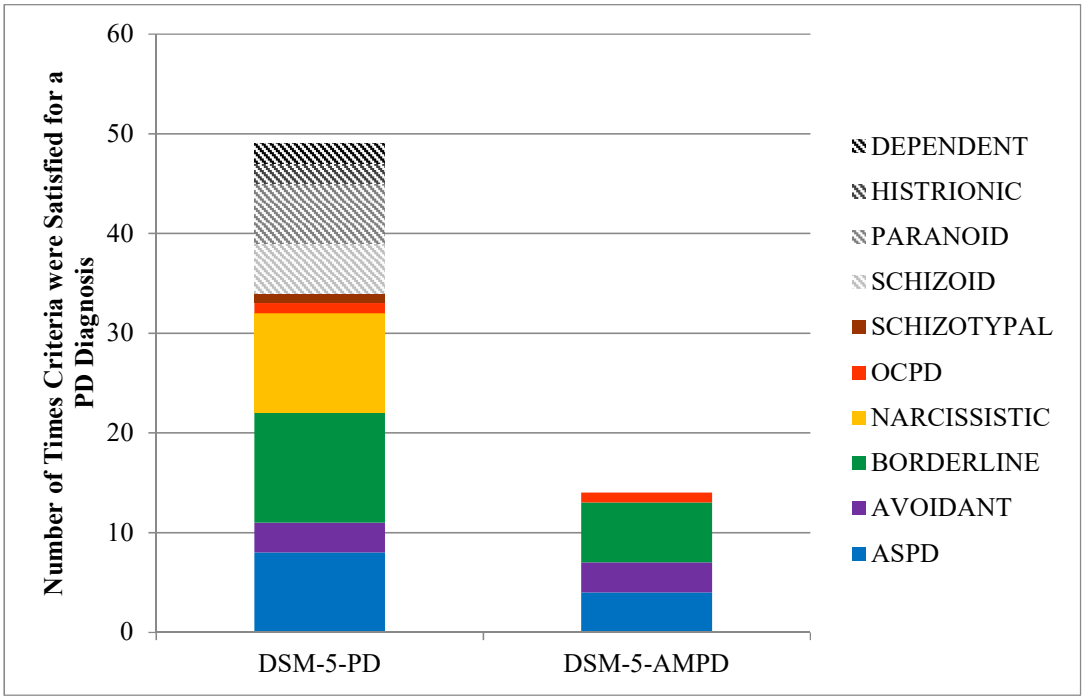
4.1. Quantitative Results

The first phase of the data analysis made use of quantitative methods. The quantitative data obtained from the four diagnostic instruments and the Perceived Clinical Utility Questionnaires was entered into a Microsoft Excel document. Information regarding the Perceived Clinical Utility Questionnaires was then imported into the Statistical Package for the Social Sciences (SPSS), a computer-based statistics program, to allow for analysis of the data.

4.1.1. Implied Diagnoses.

The number of times criteria were endorsed to satisfy an implied PD diagnosis was higher for the DSM-5-PD model in comparison to the DSM-5-AMPD (Figure 4.1). For the DSM-5-PD model, PD criteria were satisfied a total of 49 times. However, of these 49 implied diagnoses, 15 were diagnoses under the four PD categories deleted from the DSM-5-AMPD (dependent, histrionic, paranoid, and schizoid). Therefore, only the remaining 34 implied PD diagnoses are common to both models. For the DSM-5-AMPD, enough PD criteria were endorsed to satisfy a total of 14 implied diagnoses. Thus, irrespective of the four deleted PD categories, the total number of diagnoses were noticeably lower on the DSM-5-AMPD in comparison to the DSM-5-PD Model.

Figure 4.1. A Comparison of the Number of Times Criteria were Satisfied for PD Diagnoses on the DSM-5-PD Model and the DSM-5-AMPD



There were noticeable differences with regard to the PD categories shared by both models (Figure 4.1). The number of times criteria were satisfied for an antisocial PD diagnosis on the DSM-5-PD model was double that of the DSM-5-AMPD (8:4). Similarly, the number of implied borderline PD diagnoses on the DSM-5-PD model was almost double the amount on the DSM-5-AMPD (11:6). The most noticeable difference between the two models was the number of implied narcissistic PD diagnoses, as criteria were satisfied a total of ten times on the DSM-5-PD model, whereas minimum criteria for a narcissistic PD diagnosis were not even satisfied once on the DSM-5-AMPD (10:0). There were also no implied diagnoses for schizotypal PD on the DSM-5-AMPD (1:0). No differences were found between the two models with regard to implied avoidant and obsessive-compulsive PD diagnoses (3:3; and 1:1, respectively). Therefore, with regard to the six PD categories shared by both models, there were both fewer implied PD diagnoses of any kind on the DSM-5-AMPD in comparison to the DSM-5-PD model, and a smaller range of PD disorders implicitly diagnosed (Figure 4.1).

In coding the data for implied diagnoses, it became evident that the number of criteria endorsed, and thus the number of implied PD diagnoses satisfied, was substantially higher for nurses as compared to clinicians (Figure 4.2). For the DSM-5-PD model, clinicians' scores indicated that criteria for a PD diagnosis were satisfied a total of 16 times, whereas the nurses reported that

the PD criteria for diagnoses had been satisfied 33 times. Similarly, clinicians' ratings suggested that the criteria for a PD diagnosis on the DSM-5-AMPD model had been satisfied 4 times, whereas the nurses' scores indicated that criteria had been satisfied a total of 10 times. It therefore appears that nurses' ratings were less conservative than those of clinicians, as there were more than double the number of implied diagnoses from nurses as compared to clinicians. Among nurses, there were a higher number of implied PD diagnoses produced for the DSM-5-PD model in comparison to the DSM-5-AMPD with regard to the six PD categories shared by both models (20:10). This trend was not only evident, but even more prominent among clinians (14:4).

Figure 4.2. A Comparison of the Number of Times Criteria were Satisfied for PD Diagnoses on the DSM-5-PD Model and the DSM-5-AMPD, Clinicians vs. Nurses

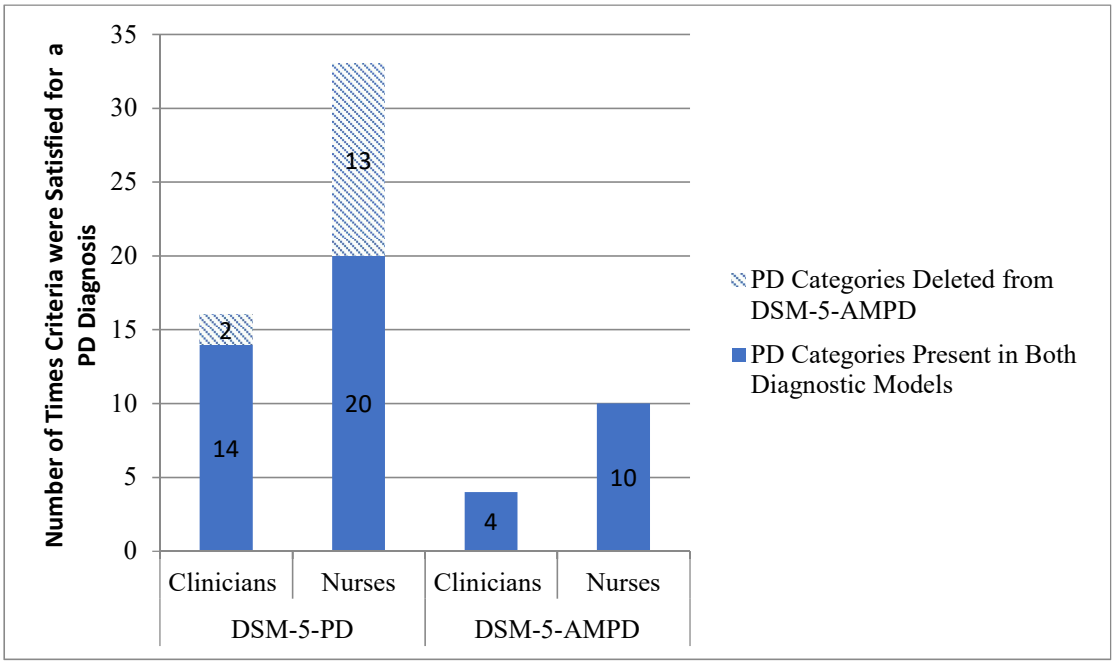
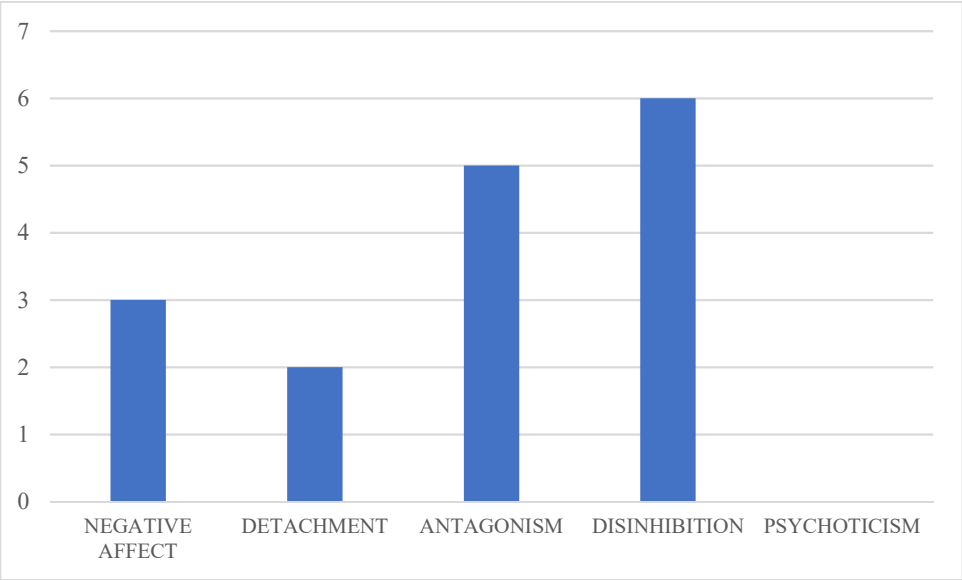


Figure 4.3. presents the distribution of trait domains on the DSM-5-AMPD TDFS according to the clinicians' ratings. It excludes nurses' scores, as their ratings tended to be less conservative than those of the clinicians, as previously illustrated (Figure 4.2). Clinicians' ratings indicated that the patient presented with traits of disinhibition, antagonism, negative affect, and detachment, consistent with cluster B personality disorders (borderline, narcissistic, antisocial). The patient scored highly on both disinhibition and antagonism, consistent with an anti-social PD diagnosis according to the DSM-5-AMPD. As a narcissistic PD diagnosis is limited to the trait of antagonism, it appears that the patient's profile is more consistent with an anti-social PD diagnosis, as both the traits of antagonism and disinhibition were present. However, the

patient's third highest score was for the trait of negative affect, which is consistent with a borderline PD diagnosis. Thus, the trait domain facets scale suggests that the patient satisfies criteria for an anti-social diagnosis with borderline traits.

Figure 4.3. Distribution of Trait Domains on the DSM-5-AMPD TDFS, Clinicians Only.



4.1.2. Utility of the Four Diagnostic Instruments.

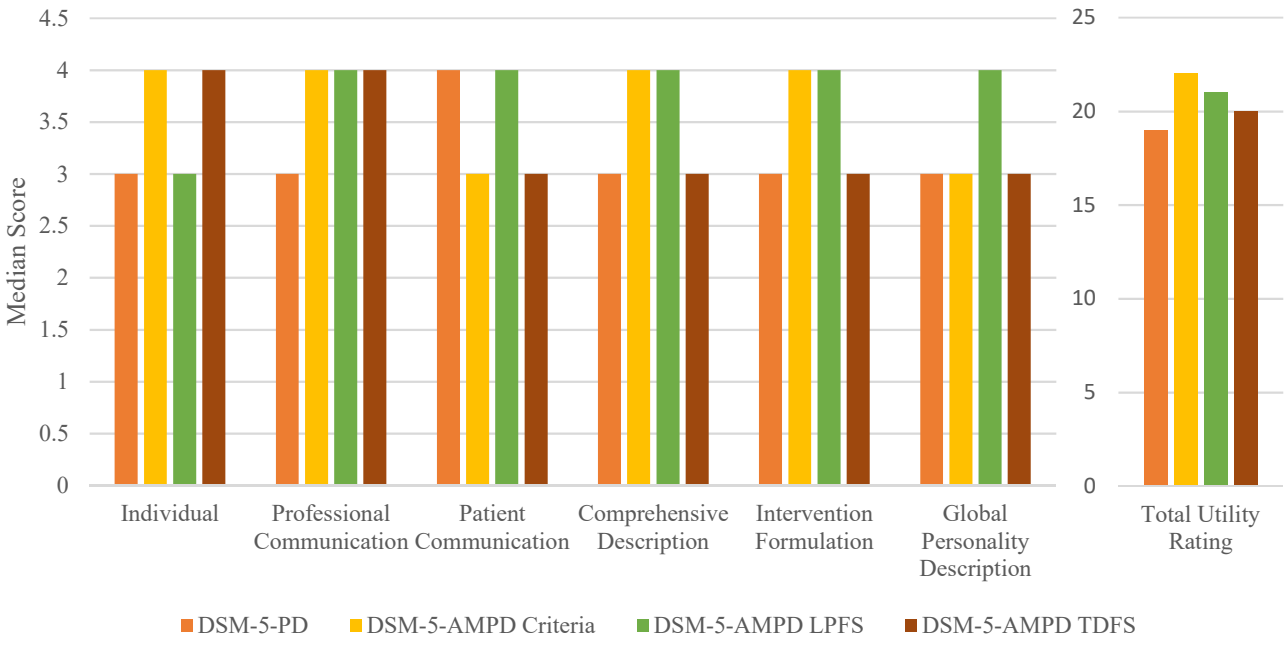
Clinical utility judgement scores for the four diagnostic instruments are summarised in Table 4.1. As this study made use of a small sample and ordinal data, medians were selected as the preferred measure of central tendency for all further analyses (Mayes & Myers, 2015). With regard to applicability of concepts to the individual, median scores suggest that the DSM-5-AMPD Specific Criteria checklist and TDFS received higher utility scores than the DSM-5-PD model and the DSM-5-AMPD LPFS (Figure 4.4). Median scores for professional communication indicate that all three aspects of the DSM-5-AMPD received higher ratings than the DSM-5-PD model. For patient communication, the median score utility ratings were higher for both the DSM-5-PD model and DSM-5-AMPD LPFS in comparison to the DSM-5-AMPD Specific Criteria checklist and TDFS. Both the DSM-5-AMPD Criteria checklist and the LPFS received higher utility median ratings than the DSM-5-PD model and the DSM-5-AMPD TDFS with regard to the comprehensive description of personality pathology. Similarly, median scores were higher for both the DSM-5-AMPD Criteria checklist and the LPFS in comparison to the DSM-5-PD model and the DSM-5-AMPD TDFS with regard to

effective treatment planning. For global personality description, the median utility score for the DSM-5-AMPD LPFS was higher than the DSM-5-PD and the remaining two instruments of the DSM-5-AMPD. The total median judgement score for the six areas of utility was higher for all three aspects of the DSM-5-AMPD than the DSM-5-PD model (Figure 4.4).

Table 4.1. Descriptive statistics for clinical utility judgements between the DSM-5-PD Model and the DSM-5-AMPD.

Utility Question	n	DSM-5-PD		DSM-5-AMPD Specific Criteria		DSM-5-AMPD LPFS		DSM-5-AMPD TDFS	
		Mean ± SD	Median (Range)	Mean ± SD	Median (Range)	Mean ± SD	Median (Range)	Mean ± SD	Median (Range)
Individual	13	3.62 ± 0.77	3 (3-5)	3.67 ± 0.78	4 (2-5)	3.38 ± 0.96	3 (2-5)	3.62 ± 0.51	4 (3-4)
Professional Communication	13	3.46 ± 0.88	3 (2-5)	3.46 ± 0.66	4 (2-4)	3.69 ± 0.75	4 (3-5)	3.69 ± 0.50	4 (3-4)
Patient Communication	13	3.69 ± 0.95	4 (2-5)	3.31 ± 0.95	3 (2-5)	3.69 ± 0.75	4 (3-5)	3.46 ± 0.52	3 (3-4)
Comprehensive Description	13	3.23 ± 1.09	3 (2-5)	3.46 ± 1.05	4 (1-5)	3.77 ± 0.73	4 (3-5)	3.46 ± 0.78	3 (2-5)
Intervention Formulation	13	3.38 ± 0.77	3 (2-5)	3.31 ± 1.11	4 (1-5)	3.77 ± 0.73	4 (3-5)	3.46 ± 0.78	3 (2-5)
Global Personality	13	3.38 ± 0.77	3 (2-5)	3.31 ± 1.03	3 (1-5)	3.77 ± 0.73	4 (3-5)	3.31 ± 1.03	3 (1-5)
Summed Score	13	20.77 ± 4.5	19 (15-30)	20.23 ± 5.47	22 (9-29)	22.08 ± 4.03	21 (18-30)	21 ± 3.63	20 (14-27)

Figure 4.4. A Comparison of Median Utility Judgements, DSM-5-PD vs. DSM-5-AMPD Diagnostic Criteria vs. DSM-5-AMPD Level of Personality Functioning Scale (LPFS) vs. DSM-5-AMPD Trait Domain and Facets Scale (TDFS) Ratings



Due to the small sample size (n=13), criteria for normality were not established, and therefore, a non-parametric, Friedman test was used to determine whether there were significant statistical differences in participants' utility ratings between the DSM-5-PD model and the DSM-5-AMPD (Huck, 2014). This test was selected as one sample was measured on three or more occasions and the dependent variable was measured at the ordinal level in the form of a Likert scale (Corder & Foreman, 2011; Little, 2013). There were no statistically significant differences between the DSM-5-PD model and the DSM-5-AMPD for any of the six areas of clinical utility or for the summed utility score (Table 4.2).

Table 4.2. Friedman Test of Utility Judgements, DSM-5-PD vs. DSM-5-AMPD Diagnostic Criteria vs. DSM-5-AMPD Level of Personality Functioning Scale (LPFS) vs. DSM-5-AMPD Trait Domain and Facets Scale (TDFS) Ratings

Utility Question	n	Sig.	Chi Square	df
Individual	13	0.916	0.511	3
Professional Communication	13	0.58	1.962	3
Patient Communication	13	0.311	3.577	3
Comprehensive Description	13	0.471	2.526	3
Intervention Formulation	13	0.241	4.2	3
Global Personality	13	0.256	4.05	3
Summed Score	13	0.969	0.252	3

4.2. Qualitative Results

Qualitative methods were employed for the second phase of the data collection and analysis. The researcher transcribed audio-recorded data from the focus group into written format. The focus group transcript was then subjected to a thematic content analysis, through which the following six themes were identified: (1) General Difficulties in Treating Personality Disorders, (2) General Shortcomings of a DSM Approach to Personality Disorders, (3) Perceived Strengths of the DSM-5-PD Model, (4) Perceived Shortcomings of the DSM-5-PD Model, (5) Perceived Strengths of the DSM-5-AMPD, and (6) Perceived Shortcomings of the DSM-5-AMPD. Within each broad theme, a number of relevant subthemes were also identified.

Prior to the discussion of these themes, which are supported by data in the form of extracted quotes, it is pertinent to note that an over-representation of clinicians' quotes is indicative of the clinicians contributing more information than the nurses throughout the focus group.

4.2.1. General Difficulties in Diagnosing Personality Disorders.

This theme emerged throughout the course of the focus group. It identifies overarching difficulties in treating PDs, which are essential to understanding complexities specific to the treatment of PDs and how this complicates the development of an appropriate diagnostic model. Thus, before outlining mental health professionals' perceptions of the DSM-5-PD

model and DSM-5-AMPD, it is important to recognize the general difficulties they noted in treating personality disorders. Within this theme, four sub-themes were identified: (1) Limited Time Between Clinician and Patient Compromises Diagnostic Accuracy, (2) Complexities of Disclosing PD Diagnoses to Patients, (3) Clinicians' Apprehension in Treating PDs, and (4) PD Diagnoses Rely Heavily on the Clinician's Judgement.

4.2.1.1. Limited Time Between Clinician and Patient Compromises Diagnostic Accuracy.

This sub-theme represents the impact of time on diagnostic accuracy and treatment for personality disorders. The following quotes illustrate how limited face-to-face time between clinicians and patients negatively impacts diagnostic accuracy. In addition, mental health professionals stated that not only are there time constrains with regard to diagnosis formulation, but time allocated for clinician-patient communication is also limited.

Clinician 1: *"If someone is just sitting in an office seeing them [the patient] once a week or once a month or something like that for 30 minutes it's really hard to just look at the criteria and say, no this is what this person is struggling with."*

Clinician 1: *"So I think it's not as useful when you are trying to check a box after seeing someone for half an hour or one hour."*

Clinician 3: *"You have a very limited, very little time to work with diagnosis."*

Nurse 2: *"There is not enough time to talk about the diagnosis of their patient."*

4.2.1.2. Complexities of Disclosing PD Diagnoses to Patients.

Within this sub-theme, mental health professionals highlighted difficulties in patient communication with regard to personality disorders. The following quotes illustrate that similarly to all patients, patients with personality disorders expect their diagnoses to be communicated to them.

Nurse 1: *"Patients come and they want to know what is wrong with them"*

Clinician 3: *"If patients do want a diagnosis, which a lot of patients do…"*

However, patients with personality disorders differ from other patients, as the nature of the disorder means that patients experience limited self-awareness and insight. Therefore, patients diagnosed with a personality disorder typically lack insight into their diagnosis, which may cause patients to reject PD diagnoses due to a lack of identification.

Clinician 4: *"And even when they are interacting with other patients they don't see those things that make them borderline [for example]."*

Although these mental health professionals agreed that patients expect their diagnoses to be communicated to them, there were differences of opinion within the group regarding whether personality diagnoses should be disclosed to patients. All professionals agreed that there is a stigma associated with receiving a personality disorder diagnosis. However, there were differences of opinion as to whether non-disclosure of a PD diagnosis facilitates this stigma, or whether the stigma of receiving a PD diagnosis interferes with patient communication and treatment.

Clinician 3: *"The big thing around personality disorder is the stigma."*

Nurse 1: *"Once they [the patients] are labelled, they feel judged."*

Clinician trainee 1: *"I just think that we can't get away from how society perceives personality disorders. So, I find that this negative stigma of telling someone that they've got borderline personality - that probably outweighs any sort of treatment usefulness."*

Clinician 3: *"And I think maybe hiding [the] diagnosis is actually going to fuel the stigma. So, it's like someone with HIV. The more you hide it and don't tell people it becomes like a taboo thing – 'Don't tell anyone I'm HIV positive'. Whereas if you encourage people to be open about it [it will] become like any other psychiatric illness. So maybe by not opening and disclosing [PD] diagnoses that's actually creating more stigma."*

Clinician 3: *"So I think it's a fine line to tread. So, I think it's not always helpful keeping [PD] diagnoses away from patients because any other patient at a psychiatrist gets their diagnosis. So why should we be trying to protect borderline?"*

In addition to the issue of stigma attached to personality disorder diagnoses, another factor that negatively affects patient communication and treatment is patients' accessibility to PD

information available via the internet. One clinician explained that online information regarding PDs is harmful to patients, and therefore, effective patient communication regarding PD diagnoses is paramount to successful treatment.

Clinician 3: *"And you know, if they force you to give a diagnosis I think it's more helpful to explain than to just say 'you've got borderline personality disorder, go google', because that's probably the most unhelpful thing, because you'll find the most horrendous things if you go on the internet and search it and that's what patients do."*

Clinician 3: *"So, I think it's about clinicians giving as much useful, constructive information and warning them about the internet."*

4.2.1.3. Clinicians' Apprehension in Treating PDs.

This sub-theme represents mental health professionals' apprehension to treating patients with personality disorders, due to the long-term nature of treatment required. Although only one clinician was vocal regarding this issue, nods of assent during these comments indicated that there was widespread agreement throughout the multi-disciplinary team.

Clinician 1: *"And I think a lot of clinicians are afraid, well I use [the term] afraid in a very loose way, but are afraid of personality disorders and diagnosing personality disorders, purely because of the fact that one, it's completely long-term work."*

Clinician 1: *"It has to be long term work. You are thinking about 5/6 years' worth of work with one patient."*

4.2.1.4. PD Diagnoses Rely Heavily on the Clinician's Judgement.

Within this sub-theme, mental health professionals highlighted the significance of clinical judgement in formulating PD diagnoses. As mentioned previously, patients presenting with personality disorders typically have limited self-awareness and insight into their symptoms. Thus, astute clinical judgement is particularly necessary with regard to diagnosing personality disorders, as patient's self-reports may be unreliable due to their limited insight.

Clinician 1: *"We don't have another option [to the DSM]. So, we go with what is available to us and I think we make it work according to using the combination of the diagnostic*

manual as well as clinical observations and I think we use that together in conjunction to establish diagnoses."

Clinician 3: *"We've relied on clinical judgement enough to sort of pull us the rest of the way."*

Clinician Trainee 1: *"they [the DSM] don't take into account your experience with the patient in the room….do you have counter transference – like what are you feeling in the room with them [the patient], which often gives you a big clue as to what may be the underlying or prominent diagnosis."*

Clinicians also noted that not only are there various intersections of criteria between different personality disorders, but PD criteria also overlap with symptoms of other mental disorders. The following quotes highlight this issue, as well as resulting complications that arise, such as diagnostic disagreement between clinicians, as well as possible misdiagnoses.

Clinician Trainee 1: *"Some of the symptoms overlap with other psychiatric disorders as well, and not just personality disorders."*

Clinician Trainee 1: *"You can check all the boxes and the patient might be psychotic and that's why they are self- harming … and if you're not taking into account the bigger picture and the way the patient is portraying themselves in the room [such as] are they thought disordered?"*

Clinician 1: *"Ja, that often leads to misdiagnosis as well. You would get someone who says, 'Oh no this person has borderline personality disorder'. And why do you say that? 'Oh, because they are self-harming'. Whereas there's a lot of other diagnoses that fit that criteria and I think that's in terms of overlapping, there's always room for error in terms of diagnosis."*

4.2.2. General Shortcomings of a DSM Approach.

This theme identifies overarching shortcomings of a DSM approach to diagnosing and treating personality disorders. Therefore, prior to outlining mental health professionals' perceptions of the DSM-5-PD model and DSM-5-AMPD, it is pertinent to acknowledge the perceived general shortcomings of a DSM approach to diagnosing and treating personality disorders. Within this theme, three sub-themes were identified: (1) A Medical Model/Approach is Inappropriate for

PDs and May Result in Misdiagnosis, (2) The DSM Does Not Provide a Guideline for Patient Communication, and (3) The DSM Does Not Account for Cultural Differences.

4.2.2.1. A Medical Model/Approach is Inappropriate for PDs and May Result in Misdiagnosis.

This sub-theme represents the inappropriateness of a medical approach towards the diagnosis and treatment of personality disorders. In order to understand the inappropriateness of a medical model with regard to personality disorders, mental health professionals highlighted the difference between personality disorders and other mental illnesses, noting that patients presenting with a PD diagnosis may experience less severe impairments in important areas of daily functioning than patients presenting with other psychiatric illnesses.

Clinician 3: *"It's [personality disorders] not the same as someone who's psychotic and you know if you had to leave them that way they actually probably wouldn't live because they wouldn't bath themselves. They're not that disordered that it's life or death, whereas other disorders may mean that if you're manic or you do something in a psychotic state – kill someone or ... so, it's a different level of ... maybe disorder is a bit harsh because it has facilitated them and got them to a certain point in their lives even though they may have had a lot of difficulties along the way, they still survived that."*

Clinician 1: *"They [patients diagnosed with personality disorders] were somewhat functional in their lives prior to presenting at a clinician. So, why would they want to shift any of their current functioning and how can any clinician change their mind?"*

Mental health professionals noted that a medical model is not the correct fit or approach with regard to personality disorders. They agreed that unlike a number of other psychiatric disorders, the primary and most effective treatment for personality disorders is psychotherapy and not psychiatric medication. However, medical aid schemes are not structured to provide the necessary, long-term treatment required for personality disorders.

Clinician 4: *"Within the medical profession [there are] difficulties with dealing with personality disorders and accepting how they fit in with the medical model, for instance even with medical aid."*

Clinician 4: *"I know some universities don't even teach personality disorders because they say it's not part of the medical model.*

Clinician Trainee 1: *"The responsible treatment for personality disorders is therapy, it's not medication."*

Clinician 2: *"I think a [medical] approach is unhelpful because the cornerstone of management of personality disorders is psychotherapy."*

Clinician 1: *"Medical aid is just not going to pay for 6 years of therapy. Um and that's just I suppose the reality of the situation."*

Clinician 3: *"In private they actually diagnose them as Bipolar II. It's the only way to get the medical aids to pay."*

Mental health professionals asserted that although a medical model may be inappropriate, a psychodynamic approach is not only effective, but used extensively on their ward in understanding and treating patients with personality disorders.

Clinician Trainee 1: *"It's more helpful [than the DSM] to consider Nancy McWilliams's understanding of borderline organisation [in treating personality disorders]."*

Clinician 3: *"And maybe it's around calling it a disorder. Maybe it should rather be around borderline personality structure. Because it's the way we deal with things. It doesn't mean - maybe it doesn't need to be seen as a disordered. So maybe it's more around the terminology that people have different personality structures."*

Nurse 2: *"We use the PDM (Psychodynamic Diagnostic Manual) as well, and I think we rely more on that than the DSM."*

4.2.2.2. DSM Does Not Provide a Guideline for Patient Communication.

Within this sub-theme, mental health professionals highlighted the limitations of the DSM with regard to patient communication. The clinician trainees, in particular, explained that the DSM does not provide professionals with a guideline or tools for communicating PD diagnoses to patients in a way that is both diplomatic and informative.

Clinician Trainee 1: *"I don't think communicating these exact categories [to the patient] would be useful."*

Clinician Trainee 2: *"It's almost like you need a separate DSM for clinicians and then for working with patients."*

Clinician Trainee 1: *"We need to separate that [DSM diagnoses] from what you actually then communicate to patients and whether we have a responsibility to do so or not."*

4.3.3. DSM Does Not Account for Cultural Differences

An important sub-theme that was identified relates to the utility of the DSM in South Africa. In the following quotes, clinicians addressed the DSM's failure to account for cultural context with regard to mental illness, arguing that symptoms consistent with the DSM's definition of mental illness may be attributed to culture. However, it is important to note that the inclusion of the Cultural Formulation Interview in the DSM-5 may address this issue.

Clinician 3: *"It's obviously dependant on your culture and what's appropriate to your culture. So, for example, we've had patients who are quite dependant. Um and it's also dependent on their culture – they come from big families where everyone takes care of everyone and they all live in the same house until they're 40 and that's the norm; it would be weird if they didn't do that. So, I think maybe the DSM in general, not just the personality disorders, often doesn't take culture into account. I think it's important with each patient to be aware - that's why collateral is obviously so important - what is appropriate to this family, do the family think this is abnormal behaviour, how everyone in the family functions or their beliefs or practises and things and then base it on that because generally the family will tell you it's excessive. Ja, so like you say, it just depends. A lot of families are quite dependant on each other and for them that's the way that they function and it would be quite abnormal if it wasn't that way. So, I don't know if that's just a South African thing or if that's just a fault across the DSM and varies from country to country. Because obviously different countries, maybe Hispanic or European*

or Mediterranean would be more kind of like dependant whereas your very westernised - like UK or where everyone's independent - have emigrated and they are more independent and don't have a big, large family, so maybe worldwide that the cultural thing is indicative of DSM, maybe not just specifically in South Africa."

Clinician 1: *"We have had patients who have come from traditional healers, or you know, whereas the family had initially thought that some of the symptoms they were presenting was more of a calling or cultural related symptom and I think that's not translated into the DSM. The option [is then] to consider that as either a cultural aspect or something that is completely psychotic."*

4.2.3. Perceived Strengths of the DSM-5-PD Model.

This theme emerged naturally during the discussion, in which the strengths and weaknesses of each diagnostic model for personality disorders were explored. Through the analysis, two specific perceived strengths of the DSM-5-PD model were identified: (1) Clinician Familiarity with the DSM-5-PD Model, and (2) The DSM-5-PD Model Provides a Common, Shorthand Diagnostic Language.

4.2.3.1. Clinician Familiarity with the DSM-5-PD Model.

This sub-theme highlights mental health professionals' familiarity with the current DSM-5-PD model. The following quotes argue that clinicians are not only familiar with the DSM-5-PD model, but that this familiarity allows for easier use of the current diagnostic model.

Clinician 3: *"There is a lot of familiarity with DSM-4 [DSM-5-PD model]."*

Clinician 1: *"I think in some ways the strength of the DSM-4 [DSM-5-PD model] is that… people are familiar with it so it's already, um, it's easier to use."*

4.2.3.2. DSM-5-PD Model Provides a Common, Shorthand Diagnostic Language.

An interesting sub-theme that was identified draws attention to the importance of a common, shorthand diagnostic language between professionals. Although only one mental health professional articulated this as a strength of the DSM-5-PD model, the following statement was met with unanimous agreement and support from the other participants. However, this finding

differed from the quantitative trends outlined previously in this chapter, where the DSM-5-PD model received relatively lower clinical utility median scores than all three aspects of the DSM-5-AMPD with regard to professional communication.

Clinician Trainee 1: *"I think it says a lot when you say to someone 'oh well this person is narcissistic' – like clinically you have an understanding together of what this person, like, struggles with. And that's a short hand [label] and that's always going to be useful I think."*

4.2.4. Perceived Shortcomings of DSM-5-PD Model.

A significant amount of material contributed to the emergence of this theme. It presents clinicians' perceived shortcomings of the DSM-5-PD model. Within this theme, two sub-themes were identified: (1) Poor/Inaccurate Diagnoses, and (2) Poor Patient Communication.

4.2.4.1. Poor/Inaccurate Diagnoses.

Within this sub-theme, mental health professionals highlighted the vague and ambiguous nature of the DSM-5-PD model, which leads to different understandings of diagnostic criteria among mental health professionals. Therefore, the same patient may receive one PD diagnosis from one clinician, and a completely different diagnosis from another clinician, as each mental professional may have his/her own understanding and interpretation of the DSM-5-PD model's diagnostic criteria. The following quotes illustrate clinicians' experience of the DSM-5-PD model as vague, ambiguous, and open to clinician interpretation.

Clinician 2: *"It's [DSM-5-PD model] just really quite vague and ambiguous."*

Clinician 1: *"We can't be 100% when we are diagnosing someone because one condition might be seen in the person and giving them one diagnosis whereas according to the understanding of the criteria and then someone else might be seeing them and giving them a completely different diagnosis also because of their own understanding of the criteria and their own way of checking boxes."*

Clinicians also noted that another factor that contributes towards the inaccurate diagnosis of personality disorders is the overlap of criteria between different PD diagnoses. The following quotes highlight the way in which overlap of criteria between PD diagnoses results in patients

either receiving multiple PD diagnoses or being described in terms of PD 'traits' instead of receiving a specific PD diagnosis.

Clinician 3: *"There is overlap between a lot of the [personality] disorders. So, if you look at narcissistic and anti-social [criteria], some of the things are overlapping in terms of behaviours - even with your borderline."*

Clinician 3: *"So sometimes you can get someone who you think meets almost all the cluster B stuff because they have a lot of traits that overlap."*

Clinician 3: *"It can be difficult to make like a diagnosis based on just specific things unless you've got a cluster of a lot of different criteria and that you can confidently make the diagnosis. Often you are left with cluster B traits or borderline-narcissistic-anti-social traits because you can't diagnose one [specific PD] but you can't exclude any because you've got traits that overlap in-between the clusters."*

Clinician 3: *"So sometimes it is hard to meet criteria or exclude personality diagnosis based on the current classification system."*

Clinician 2: *"When it [personality disorder] overlaps with many [personality disorders], which one do you choose? So, I think that's what I found most unhelpful with regards to this classification system [DSM-5-PD model]."*

This sub-theme is consistent with quantitative trends identified earlier in this chapter, as criteria for all ten PD categories were satisfied on the DSM-5-PD model in comparison to criteria being satisfied for only four PD categories on the DSM-5-AMPD. Moreover, when the comparison was limited to the six PD categories shared by both models, criteria were again satisfied for more PD categories on the DSM-5-PD model than the DSM-5-AMPD.

A clinician trainee also commented on the broad and vague nature of criteria required for a borderline PD diagnosis, resulting in an over-representation of patients presenting with a borderline PD diagnosis.

Clinician Trainee 1: "*I don't think it's [DSM-5-PD model] useful because everyone is borderline."*

The poor coverage of personality pathology and rigidity of the categorical approach of the DSM-5-PD model, and its role in producing uninformative diagnoses, was also highlighted by clinicians. They argued that the DSM-5's categorical approach towards personality disorders is unsuitable, as it produces diagnoses that do not represent the fluid and nuanced nature of personality. The following quotes illustrate clinicians' perceptions of the limited utility of DSM-5-PD diagnoses.

Clinician 2: *"I think a categorical approach is unhelpful."*

Clinician Trainee 1: *"I find this classification system not very well organised in terms of day-to-day understandings [of personality disorders]."*

Clinician 3: *"It [DSM-5-PD model] is quite rigid in terms of people don't always just fit into boxes – people have traits of different things."*

Clinician Trainee 1: *"Some people are a bit more narcissistic or a bit more dependant but then you are not allowed to sort of put that or to express that usefully."*

Clinician 3: *"It [DSM-5-PD model] might not be as inclusive [as DSM-5-AMPD]."*

One clinician argued that the rigidity of the DSM-5-PD categorical model may result in the under-diagnosis of personality disorders, as patients struggle to identify with their PD diagnoses.

Clinician 4: *"So sometimes it can be easy to underdiagnose patients when you are trying to negotiate for a suitable diagnosis because most of them come and say, 'I've been given this diagnosis it doesn't make sense for me can you please explain it or can you change it.'"*

4.2.4.2. Poor Patient Communication.

This sub-theme represents the way in which the DSM-5-PD model results in poor patient communication. This may be a direct result of the previous sub-theme, as clinicians explained that co-occurrence of PD diagnoses, together with the poor coverage and descriptions of personality pathology, not only leads to difficulties in effective communication of diagnoses to patients, but results in poor patient identification and acceptance of their diagnoses. However, this sub-theme contradicts quantitative trends discussed earlier in this chapter, as the DSM-5-

PD model was rated as equally or more useful than the DSM-5-AMPD with regard to patient communication.

Clinician 2: *"I think my concerns around this model [DSM-5-PD] of like diagnosing personality disorders also makes it very difficult to explain to patients with regard to with their type of personality disorders especially when it overlaps with many."*

Clinician 4: *"most of them [patients] will struggle to identify with those things that are registered under DSM-4 [DSM-5-PD model] and they will probably go –'no, no, no' to most of them [criteria for personality disorders]."*

Clinician 4: *"[patients will say] 'I've been given this diagnosis it doesn't make sense for me can you please explain it or can you change it'."*

Nurse 1: *"When they get the diagnosis at the end written on a piece of paper they [patients] are just totally confused."*

4.2.5. Perceived Strengths of the DSM-5-AMPD.

This theme identifies clinicians' perceived strengths of the proposed DSM-5 alternative model for personality disorders. Within this theme, three sub-themes were identified: (1) Improved/More Informative Diagnoses, (2) Improved Patient Communication, and (3) Improved Communication Between Clinicians.

4.2.5.1. Improved/ More Informative Diagnoses.

Within this sub-theme, mental health professionals highlighted the informative and descriptive nature of the DSM-5-AMPD. The DSM-5-AMPD was perceived to provide more individualised diagnoses, which may allow clinicians to gain a deeper understanding of their patients. Clinicians also experienced the DSM-5-AMPD's Personality Disorder – Trait Specified Diagnosis (PD-TS) as more informative that its DSM-5-PD model counterpart; Personality Disorder-Not Otherwise Specified (PD-NOS).

Clinician 2: *"I really like the trait-based approach [DSM-5-AMPD] because it really does allow you to understand what exactly they [patients] are struggling with instead of just these 9 criteria."*

Clinician 3: *"I think it's [DSM-5-AMPD] very useful and it gives you more options in terms of traits and various um … it's very inclusive."*

Clinician 1: *"the DSM-5 [-AMPD] seems to be more intensive and have more criteria to fit into which I imagine is better for the patient."*

Clinician 3: *"I think the nice thing about the traits is that it actually describes them [patients] quite nicely."*

Clinician Trainee 2: *"Well it's [PD-TS] definitely more helpful to have as an alternative. So, if the person doesn't fit into the [specified personality] diagnoses we already have, then to have a formal alternative to describe, like you said, broader traits rather than specific boxes. I mean it is helpful to have something outside of the box."*

Members of the multi-disciplinary team stated that not only does the level of personality functioning scale (LPFS) improve the professional diagnostic formulation and understanding of patients' personality dysfunction, but that it also allows clinicians to formulate the degree of PD severity in patients – an aspect of diagnosing personality disorders that is absent in the DSM-5-PD model.

Clinician Trainee 1: *"It's [level of personality functioning for personality disorder – trait specified] useful for clinicians for formulation."*

Clinician 1: *"Not everyone just fits into this little box. So, personality, also maybe the traits, are along a spectrum – either you are very introverted or very extroverted or you can be somewhere on the spectrum and it depends on the person. I think I lot of psychiatrists try to move away – perhaps think about people differently. You know people don't just fit into boxes and there's more severe degrees of borderline or more severe degrees of bipolar. And that's why the [level of personality functioning scale] and traits are so helpful because you are either one of the alternate poles of the traits and you can be somewhere along that spectrum."*

4.2.5.2. Improved Patient Communication.

This sub-theme represents the way in which the DSM-5-AMPD is perceived to result in improved patient communication. It appears to be a direct natural consequence of the previous sub-theme, as more informative and individualised personality disorder diagnoses allow for

better patient identification and understanding of diagnoses. Therefore, improved PD diagnoses are more accessible to patients, which allow for richer patient communication and treatment of personality disorders. However, this sub-theme differed from the quantitative trends in this study, as the DSM-5-PD's specific criteria checklist and TDFS both received relatively lower median utility scores than the DSM-5-PD model with regard to patient communication.

Clinician 2: *"what I like about the trait-base [DSM-5-AMPD] is it really spells it out for clinicians and the fact that, 'so you struggle with impulsivity you can think around these things', instead of this cornucopia of medications just being doled out willy-nilly."*

Clinician 3: *"So it gives you that consistency. So, if you're a therapist seeing a patient and you're discussing with them around the difficulties they have and the diagnosis and things there's that consistency whereas in DSM-4 [DSM-5-PD model] there's just a sentence – 'this' - but there's no description of what is fear of abandonment, so that can be open to interpretation as well. Whereas here you are describing each thing and they've given you a set way of describing and making sense."*

Clinician 3: *"It's [DSM-5-AMPD] actually really nicely worded, it's a lot longer but it's really useful in terms of being a clinician, in terms of communicating with your patient and for consistency as well so I think that's nice."*

Clinician 4: *"And I've seen with the DSM-5 [AMPD] there's a lot more criteria, there's a lot more things you can discuss with the patient and they'll go – 'yes, yes, I do that; okay this diagnosis does talk to me'.*"

Clinician 2: *"A trait-based approach [DSM-5-AMPD] might be more helpful in, like, thinking around management strategies and just, you know, talking to them."*

Although a number of professionals agreed that the level of personality functioning scale (LPFS) would be useful to communicate to patients, this view was not unanimous (see sub-theme 4.2.6.3. *Disagreement over Whether Utility of LPFS is Limited to Clinicians or Extends to Patients*.).

Clinician 1: *"The first part [LPFS] I would find useful [for communicating to patients]. In terms of - I mean the level of functioning in society is ideally why they are coming to you in the first place so they recognise that."*

However, all participants were in agreement regarding the Personality Disorder- Trait Specified diagnosis being more accessible and identifiable than its DSM-5-PD counterpart (PD-NOS) to patients, which ultimately allows for improved patient communication.

Clinician Trainee 1: *"It's useful to work with them (the trait descriptions) - 'so you find this difficult – okay so let's work on this thing' - like impulsivity or something."*

Clinician Trainee 1: *"To say we can help you with more practical things around like antagonism or something – I think maybe that would be helpful."*

Clinician 3: *"I think for the patient's benefit these pages [PD-TS] are most useful in terms of explaining to them [the patients], in terms of 'you struggle with emotions as evidence by …. 'or you know, 'can you think of situations where …' - involve them in a discussion so they'll be able to identify with it and agree, but you're not saying to them that there is something completely wrong with you because you struggle with this trait. So, it's more about breaking it down."*

Clinician Trainee 2: *"With patients definitely this trait language is more accessible and it gives you more to speak about in a way they [patients] can relate to."*

4.2.5.3. Improved Communication Between Clinicians.

With regard to communication between mental health professionals, participants experienced the level of personality functioning scale (LPFS) as useful, as it allows for richer personality pathology understanding and communication between clinicians. Although only one participant stated this opinion clearly, there was common agreement throughout the multi-disciplinary team. This was consistent with quantitative trends, as both the LPFS and the TDFS were rated as equally or more useful than the DSM-5-PD model with regard to professional communication.

Clinician Trainee 1: *"I actually find this [description of level of personality functioning and pathological personality traits for specific PDs in DSM-5 AMPD] quite a nice break-up of, like, what difficulties they have - for clinicians maybe communicating to each other - because I think that's where diagnosis is useful."*

4.2.6. Perceived Shortcomings of the DSM-5-AMPD.

This theme identifies clinicians' perceived shortcomings of the proposed DSM-5 alternative model for personality disorders. Within this theme, three sub-themes were identified: (1) Personality Disorder – Trait Specified (PD-TS) is Complex and Time-Consuming for Clinicians to Learn, (2) PD-TS Lacks a Shorthand Diagnostic Language Which Complicates Clinician Communication, and (3) Disagreement over Whether Utility of LPFS is Limited to Clinicians or Extends to Patients.

4.2.6.1. Complexity and Time-Intensiveness of Personality Disorder – Trait Specified (PD-TS).

This sub-theme represents mental health professionals' experiences of the DSM-5-AMPD's Personality Disorder – Trait Specified (PD-TS) diagnostic formulation process as unfamiliar, complex, and time consuming for clinicians to learn and use.

Clinician 3: *"Because I haven't used DSM-5[AMPD] so I'm very unfamiliar with it."*

Clinician Trainee 2: *"But it [PD-TS] is very complex, like [Clinician 4] was saying; it's much easier to sit with a list of like nine criteria than to go through all of these."*

Clinician 3: *"Sitting with this [PD-TS] would be very time consuming."*

Clinician 3: *"I think it's [PD-TS] … a little bit time consuming."*

Clinician 3: *"A lot of clinicians don't have time to sit with one patient with these type of things [PD-TS descriptions]."*

Clinician 3: *"It's very time consuming [PD-TS] because you [mental health professionals] would have to learn it all again"*

Members of the multi-disciplinary team also asserted that the individualised nature of the DSM-5-AMPD's PD-TS diagnosis does not allow for a short-hand, time-effective diagnostic language for clinician communication. As mental health professionals are bound by time constraints, they require parsimonious communication between clinicians, which the DSM-5-AMPD's PD-TS diagnosis is lacking. Therefore, although quantitative and qualitative findings

indicated that a PD-TS diagnosis is useful in communicating more informative diagnostic information between professionals, its delivery is too lengthy.

Clinician 3: *"You can't go to a clinician and say, 'okay the patient has got negative affectivity um and in addition antagonism'. It's just not practical. So there needs to be a way – a common language for clinicians to communicate in."*

Clinician Trainee 2: *"But then, ja, you can't go to clinicians and talk about that because there's no time to do that with each other so - ja, I agree [with clinician 3]."*

4.2.6.3. Disagreement over Whether Utility of LPFS is Limited to Clinicians or Extends to Patients.

Although a number of professionals agreed that the level of personality functioning scale (LPFS) would be useful to communicate to patients (see sub-theme 4.2.5.2. *Improved Patient Communication*), two participants disagreed. In their view, the LPFS's utility is limited to clinicians only, and does not have any use value with regard to patient communication.

Clinician Trainee 1: *"I think communicating these exact categories [level of personality functioning for Personality Disorder- Trait Specified] would not be useful ever except to a clinician. It's a useful description of someone but not to them [the patient]."*

Clinician Trainee 1: *"It's useful for clinicians for formulation but I don't see how this would help a person if you tell them that you have a weak sense of identity. It's all for clinicians and I think that has its own use but to separate that from what you actually then communicate to patients"*

Chapter 5: Discussion

This study explored mental health professionals' perceptions of clinical utility of the DSM-5-AMPD in relation to the DSM-5-PD model. Quantitative results indicated that there was insufficient evidence to support either diagnostic model as more clinically useful than the other with regard to the six areas of utility measured in this study. The non-significant results obtained may be attributed to the small sample size and less powerful non-parametric tests used in this research. Although quantitative results were not statistically significant, a number of interesting trends in the data were identified. These quantitative trends will be discussed in relation to qualitative findings. The discussion regarding the perceived clinical utility of the DSM-5-PD model in relation to the DSM-5-AMPD is organised into four sections, namely: (1) ease of use, (2) professional communication, (3) patient communication and treatment planning, and (4) applicability to a South African context.

With the exception of the sub-theme concerning whether the DSM accounts for cultural differences with regard to mental illness, the first two qualitative themes that emerged from the focus group data ((1) *General Difficulties in Treating Personality Disorders* and (2) *General Shortcomings of a DSM Approach to Personality Disorders*) will not be discussed in this chapter, as these broad issues are beyond the scope of this paper and are well documented elsewhere (Atkinson, 1989; Aviram, Brodsky, & Stanley, 2006; Christensen, Griffiths, & Jorm, 2004; Cline & Haynes, 2001; Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004; Lequesne & Hersh, 2004; Lewis & Appleby, 1988; Powell & Clarke, 2006; Saraceno et al., 2007; Wald, Dube, & Anthony, 2007).

5.1. Ease of Use

The CPHC's rejection of the DSM-5-AMPD was primarily due to concerns regarding its unfamiliarity and complexity for immediate use by mental health professionals (Skodol et al., 2013; Zachar et al., 2015). The findings of this study are not only consistent with CPHC concerns, but also correspond with research conducted by Morey et al. (2014) and Bach et al. (2015), as mental health professionals experienced the DSM-5-PD model as more familiar and easier to use than the DSM-5-AMPD, which was viewed as complicated and time consuming.

This finding is of critical importance, as complexity typically threatens user acceptability, and thus ultimately impacts clinical utility (Verheul, 2012).

Although ease of use is an important consideration in the development of effective nomenclatures, the purpose of a diagnostic instrument is to improve the reliability and validity of clinical diagnoses, and not merely to provide the simplest and fastest approach to formulating diagnoses (Bach et al., 2015). Therefore, ease of use should not be prioritized over validity with regard to diagnostic tools (Mullins-Sweatt & Widiger, 2009; Pilkonis, Hallquist, Morse, & Stepp, 2011). This is particularly important with regard to the results of this study, as although findings indicated that the DSM-5-AMPD was viewed as unfamiliar, complicated, and time consuming, mental health professionals also perceived the diagnoses of the DSM-5-AMPD as more detailed, individualised and accurate in comparison to the DSM-5-PD model. The DSM-5-AMPD's 6 PD categories were not only perceived as more accurate and comprehensive than the 10 PD categories provided by the DSM-5-PD model, but the Personality Disorder- Trait Specified (PD-TS) diagnosis was also viewed as more informative than its DSM-5-PD counterpart (PD-NOS).

These findings are consistent with research conducted by Bach et al. (2015), in which results from 6 patient cases indicated that although the DSM-5-AMPD may entail a more complex and longer process, it provides more descriptive and precise personality disorder diagnoses. In this way, perhaps the DSM-5-AMPD's provision of informative and accurate diagnoses outweighs its unfamiliarity and complexity. A concern with diagnostic validity suggests that it is far more preferable for practitioners to adopt a rigorous and lengthy process to provide a specific and accurate diagnosis than make use of a fast and easy approach resulting in a simple, imprecise, and uninformative diagnosis.

It is also important to note that the mental health professionals' unfamiliarity with the DSM-5-AMPD diagnostic process may have impacted their perceptions regarding its ease of use and time effectiveness, as they found it difficult to recognise that all of the DSM-5-AMPD instruments may not be required for each patient. Therefore, the multidisciplinary team may have overestimated the time required to formulate DSM-5-AMPD diagnoses.

5.2. Professional Communication

The primary purpose of a diagnostic classification system is to provide a common language of communication for mental health professionals (First et al., 2004). Therefore, professional communication is an important factor to consider when comparing two diagnostic nomenclatures to one another. Similarly to results obtained by Bach et al. (2015), findings from this study suggest that although the DSM-5-PD model may allow for easier and faster professional communication regarding patients, the DSM-5-AMPD provides more precise and reliable communication between mental health professionals, as the diagnoses formulated according to this model are more accurate, detailed, informative, and tend to involve less co-occurrence.

Mental health professionals not only found the trait aspect of the DSM-5-AMPD useful for professional communication due to its descriptive value, but in accordance with previous literature, the level of personality functioning scale (LPFS) was regarded as particularly useful, as it allows for professional communication regarding the degree of severity of personality dysfunction, an important aspect that the DSM-5-PD model is lacking (Krueger et al., 2014b; Skodol et al., 2011). However, it was determined that the DSM-5-PD model may provide a common, shorthand, diagnostic language between professionals in the form of 10 clear diagnostic categorical labels that allow for faster professional communication. Yet, these 10 personality disorder categories greatly limit the practitioner's ability to fully describe the patient's unique personality pathology. To reference the metaphor used by Bach et al. (2015, p. 19) in their description of the difference between DSM-5-PD model and the DSM-5-AMPD with regard to professional communication, "a palette with few colours may be easy to use, but it does not truly cover reality with all its subtle nuances". In other words, similarly to the previous discussion regarding ease of use, it appears as though a cost-benefit analysis between efficiency versus accuracy is required with regard to which diagnostic model provides superior professional communication.

5.3. Patient Communication and Treatment Planning

Effective patient communication is widely recognised as one of the most important factors in the successful treatment of any illness, as it facilitates patient understanding, cooperation, and

adherence to treatment (Haskard Zolnierek & DiMatteo, 2009). However, the ego syntonic and alloplastic nature of personality disorders may complicate this process, as patients with personality pathology typically struggle to recognize and take responsibility for their behaviour and interpersonal dysfunction (Sadock et al., 2015). Furthermore, as difficulties in interpersonal relationships are an essential feature of personality disorders, the disorder may adversely affect relationships with mental health professionals, resulting in further treatment difficulties (Tyrer et al., 2015). As personality disorders typically require long-term treatment in the form of psychotherapy, which requires a cooperative alliance between the practitioner and the patient, it is crucial that a personality disorder diagnostic classification system facilitate effective patient communication and treatment planning (Skodol et al., 2013).

Qualitative findings regarding the shortcomings of the DSM-5-PD model indicated that this categorical model provides uninformative diagnoses, which ultimately leads to poor patient communication. Participants indicated that patients may struggle to understand difficult PD terminology and identify with the rigid and concise categorical labels produced by the DSM-5-PD model, which may lead to patient rejection of PD diagnoses and prevent cooperation and treatment adherence. However, these findings differed from the trends observed in the quantitative data, in which median judgement scores indicated that the DSM-5-PD model was rated as equally or more useful than the DSM-5-AMPD with regard to patient communication. Yet, it is important to note that the quantitative data did not yield statistically significant results. Therefore, one may determine that the qualitative results regarding patient communication utility hold more weight than inferences drawn from quantitative trends limited to observation. Furthermore, the quantitative procedure was limited to the process of blind scoring of a patient, whereas the qualitative procedure provided professionals with the outcome of this process in the form of the patient's implied diagnoses according to each diagnostic model. As mental health professionals communicate diagnoses to the patient, and not the diagnostic procedures involved, the qualitative finding regarding patient communication may be more accurate and reflective. Therefore, one may determine that mental health professionals perceived poor patient communication for the DSM-5-PD model in relation to the DSM-5-AMPD.

Qualitative results indicated that the DSM-5-AMPD may provide improved patient communication in comparison to the DSM-5-PD model, as more informative and individualised personality disorder diagnoses facilitate patient identification and understanding of diagnoses. Similarly to the findings of Bach et al. (2015), mental health professionals

indicated that the unique and individualised personality profiles produced by the DSM-5-AMPD allows patients to recognise themselves in the detailed description, which may improve the working alliance and treatment focus, both of which are crucial for successful treatment. In addition, the language used by the DSM-5-AMPD is accessible to the layperson, which may improve patient comprehension, as this eliminates the need to explain confusing professional terminology to patients. Furthermore, the DSM-5-AMPD may reduce stigmatisation of patients, as patients' pathology may be communicated in terms of severity and traits, rather than using PD categorical labels (Bach et al., 2015).

The individualised personality profiles produced by the DSM-5-AMPD may also improve treatment planning, as this may facilitate the development of personalised treatment plans that address the individual's unique personality traits. A detailed personality profile regarding the severity of personality dysfunction and pathological personality traits may allow for the development of individualised treatment that maximizes patient cooperation, as professionals may be able to identify personality features that will impact treatment, and factor these into the development of an effective treatment plan (Bach et al., 2015). For example, professionals may recognise the importance of developing a treatment plan that caters to a patient's trait of grandiosity by making the goal of psychotherapy attractive, important, and beneficial to a patient presenting with personality traits of antagonism and detachment (Bach et al., 2015).

In addition to factors regarding clinical utility, two noteworthy trends were identified in the quantitative data, namely: (1) lower co-occurrence of PDs for the DSM-5-AMPD, and (2) differences between clinicians and nurses regarding the number of implied diagnoses assigned to the patient, irrespective of diagnostic model. These observations will be discussed below.

5.4. South African Context

An important qualitative finding, consistent with previous literature, suggested that the DSM's approach to personality pathology, and the entire spectrum of mental health disorders, fails to account for cultural context with regard to mental illness (Naidoo et al., 2008; Waumsley, 2007). Therefore, symptoms consistent with DSM definitions of mental illness in a South African context, such as those associated with dependent personality disorder, may be attributed to the collectivist nature of South African culture. Another important feature of South

African culture is its ancestral belief system and prevalent use of indigenous healers in understanding and treating symptoms of mental disorders (Long & Zietkiewicz, 2002). For example, auditory hallucinations may be understood as an indication that an individual has been selected to become a traditional healer, rather than a marker of disturbances in mental health. Although the Cultural Formulation Interview was included in the DSM-5 to correct for this issue, it is important that future research make use of this interview to determine its efficacy in accounting for cultural differences across mental disorders.

5.5. Lower Co-occurrence of PDs

As extensive co-occurrence of PDs has been a frequent criticism of the DSM categorical model for diagnosing personality disorders, perhaps the most interesting trend identified in the quantitative data was the number of times criteria were satisfied for implied PD diagnoses according to each diagnostic model. The data indicated that irrespective of the four deleted PD categories on the DSM-5-AMPD, the number of times minimum criteria were endorsed to satisfy an implied PD diagnosis on the DSM-5-AMPD were fewer in comparison to the DSM-5-PD model. These results may be due to stricter and more precise diagnostic thresholds for DSM-5-AMPD diagnoses, as during the researcher's application of DSM-5-AMPD decision rules to formulate implied PD diagnoses from participants' scores, it was observed that diagnostic thresholds for the DSM-5-AMPD were stricter than the DSM-5-PD model. The disparity between implied narcissistic personality disorder diagnoses according to the DSM-5-PD model and the DSM-5-AMPD (10:0; respectively) illustrates this observation, as although many of participants' scores satisfied criteria for impaired deficits in self and interpersonal functioning (criterion A of DSM-5-AMPD), not enough criteria were satisfied to meet the threshold for pathological personality traits (criterion B of DSM-5-AMPD).

Therefore, the issue of widespread co-occurrence of PDs and arbitrary thresholds may be rectified by the DSM-5-AMPD. However, it is important to note that this conclusion is informed by observational trends in the data and is not derived from statistically significant results. As studies regarding rates of PD co-occurrence and differences in diagnostic thresholds between the DSM-5-PD model and the DSM-5-AMPD have yet to be published, further research in this area is required to determine whether the use of the DSM-5-AMPD will result

in significantly less identification of the co-occurrence of PDs and more precise thresholds than the DSM-5-PD model.

5.6. Nurses Versus Clinicians

A noteworthy trend observed in the quantitative data was that nurses appeared to be less conservative than clinicians with regard to assigning implied PD diagnoses to the patient. This suggests that nurses may diagnose patients with more personality disorders than other clinicians. Nurses typically have more direct contact with inpatients in comparison to other clinicians, and as a result, may be able to observe patients' behaviour on the ward in a way that is inaccessible to psychiatrists and psychologists (Horrocks, Anderson, & Salisbury, 2002). Therefore, nurses' feedback to the multidisciplinary team regarding patient behaviour on the ward is extremely valuable to diagnostic formulation, professional and patient communication, and treatment. Although psychiatric nurses play a vital role in the multidisciplinary team, they are not tasked with formulating personality disorder diagnoses in an inpatient or outpatient setting (Basco et al., 2000). Perhaps the decision to limit the formulation of diagnoses to psychiatrists and psychologists is valid, as there are differences in their professional roles in relation to patients and their degree of training with regard to differential diagnosis. Furthermore, although nurses contribute important information towards the diagnosis and treatment of patients, their increased observation and contact with psychiatric patients may impair their objectivity, and possibly result in increased reported co-occurrence of PDs.

5.7. Conclusion

The aim of this research was to compare mental health professionals' perceptions of the clinical utility of the DSM-5-PD model in comparison with the DSM-5-AMPD. Results indicated that although the DSM-5-PD model may be more familiar, easier to use, and provide a shorthand, common diagnostic language for faster professional communication, the DSM-5-AMPD provides more individualised and informative personality disorder diagnoses, which may lead to more accurate personality disorder diagnoses, precise professional communication, improved patient communication, and effective treatment. Therefore, a cost-benefit analysis between efficiency versus accuracy is required to determine which diagnostic model has higher clinical utility. In addition, quantitative trends suggested that the DSM-5-AMPD may reduce extensive diagnosis of co-occurring personality disorders; an important criticism frequently aimed at the DSM-5-PD categorical model.

However, both the DSM-5-PD model and the DSM-5-AMPD fail to address cultural differences in relation to mental illness, such as black South Africans' immersion in collectivist and ancestral ideology and cultural practices. Therefore, it is crucial that DSM revisions, such as the DSM-5-AMPD, account for cultural differences across mental disorders.

5.8. Limitations and Future Recommendations

The quantitative element of this research did not yield significant statistical results, which limited the findings and discussion of this process to inferences founded on trends observed in the data. As this outcome may be attributed to the small sample size and less powerful non-parametric tests used in this research, it is recommended that future research make use of a larger sample of mental health professionals.

Although notable trends were observed in the data, this information was limited to the representation of a single patient case file. It is recommended that future studies make use of more than one common patient file, to allow for further comparison, contrast, and insight into observable trends between patients of different race, gender, age, and cultural and socio-economic contexts.

This research primarily focused on mental health professionals' perceptions of clinical utility. Therefore, this study did not run statistical tests on observable trends in the data, such as the differences in co-occurrence of PDs between the DSM-5-PD model and the DSM-5-AMPD. As the issue of co-occurrence has been a longstanding criticism of the DSM categorical approach to diagnosing personality disorders, it is recommended that further research statistically determine whether the DSM-5-AMPD results in less co-occurrence of PDs than the DSM-5-PD model.

This study made use of a case file from a recently discharged patient. Thus, perceptions of clinical utility of the DSM-5-AMPD in relation to patient communication, professional communication, and treatment of patients with personality pathology were derived from the hypothetical speculation of mental health professionals. It is therefore recommended that future research in this area make use of active patient case files, so that utility regarding patient communication, professional communication, and treatment for each diagnostic model can be effectively measured and compared to one another.

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Appendix A. DSM-5-PD Model Criteria for Personality Disorders Checklist

Instructions: Below is a list of 79 criteria for Personality Disorders taken directly from the DSM-5. Please read each of the following statements carefully and use the left column to select the responses that best describes the selected patient for this study.

	1	Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.
	2	Affective instability due to a marked reactivity of mood (e.g., Intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
	3	Almost always chooses solitary activities.
	4	Appears indifferent to the praise or criticism of others.
	5	Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval or rejection.
	6	Behaviour and appearance that is odd, eccentric or peculiar.
	7	Believes he or she is 'special' and unique and can only be understood by, or should associate with, other special, high status people (or institutions).
	8	Chronic feelings of emptiness.
	9	Considers relationships to be more intimate than they actually are.
	10	Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations.
	11	Consistently uses physical appearance to draw attention to self.
	12	Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
	13	Displays rapid shifting and shallow expression of emotion.
	14	Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about the self.
	15	Failure to conform to social norms with respect to lawful behaviours, as indicated by repeatedly performing acts that are grounds for arrest.
	16	Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
	17	Frantic efforts to avoid real or imagined abandonment.
	18	Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
	19	Has a grandiose sense of self-importance (e.g., Exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
	20	Has a sense of entitlement (i.e., unreasonable expectations of especially favourable treatment or automatic compliance with his or her expectations).
	21	Has difficulty expressing disagreement with others because of fear of loss of support or approval.
	22	Has difficulty initiating projects or doing things on his or her own (because of a lack of self confidence in judgment or abilities rather than a lack of motivation or energy).
	23	Has difficulty making everyday decisions without excessive an excessive amount of advice and reassurance from others.
	24	Has little, if any, interest in having sexual experiences with another person.
	25	Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.
	26	Has style of speech that is excessively impressionistic and lacking in detail.

	27	Ideas of reference (excluding delusions of reference).
	28	Identity disturbance: markedly and persistently unstable self-image or sense of self.
	29	Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
	30	Impulsivity or failure to plan ahead.
	31	Inappropriate or constricted affect.
	32	Inappropriate, intense anger or difficulty controlling anger (e.g., Frequent displays of temper, constant anger, recurrent physical fights).
	33	Interaction with others is often characterized by inappropriate sexually seductive or provocative behaviour.
	34	Interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends).
	35	Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
	36	Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity).
	37	Is inhibited in new interpersonal situations because of feelings of inadequacy.
	38	Is often envious of others or believes that others are envious of him or her.
	39	Is over-conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).
	40	Is preoccupied with being criticized or rejected in social situations.
	41	Is preoccupied with details, rules, lists, order, organization, or schedules, to the extent that major point of the activity is lost.
	42	Is preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal love.
	43	Is preoccupied with unjustified doubts about loyalty or trustworthiness of friends or associates.
	44	Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
	45	Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.
	46	Is suggestible (i.e., easily influenced by others or circumstances).
	47	Is unable to discard worn-out or worthless objects even when they have no sentimental value.
	48	Is unrealistically preoccupied with fears of being left to take care of himself or herself.
	49	Is unusually reluctant to take personal risks or engage in any new activities because they may prove embarrassing.
	50	Is unwilling to get involved with people unless certain of being liked.
	51	Lack of close friends or confidants other than first degree relatives.
	52	Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated or stolen from another.
	53	Lacks close friends or confidants other than first-degree relatives.
	54	Lacks empathy; is unwilling to recognize or identify with the feelings and needs of others.
	55	Needs others to assume responsibility major areas of his or her life.
	56	Neither desires nor enjoys close relationships, including being part of a family.
	57	Odd beliefs or magical thinking that influences behaviour and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or sixth sense; in children and adolescents, bizarre fantasies or preoccupations).
	58	Odd thinking and speech (e.g., vague, circumstantial, metaphorical, over-elaborate, or stereotyped).

	59	Pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealization and devaluation.
	60	Perceives attacks on his/her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.
	61	Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights).
	62	Reads hidden demeaning or threatening meanings into benign remarks or events.
	63	Reckless disregard for safety of self or others.
	64	Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
	65	Requests excessive admiration.
	66	Shows arrogant, haughty behaviours or attitudes.
	67	Shows emotional coldness, detachment or flattened affectivity.
	68	Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her overly strict standards are not met).
	69	Shows restraint with intimate relationships because of the fear of being shamed or ridiculed.
	70	Shows rigidity and stubbornness.
	71	Shows self-dramatization, theatricality and exaggerated expression of emotion.
	72	Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.
	73	Suspiciousness or paranoid ideation.
	74	Takes pleasure in few, if any, activities.
	75	Transient, stress-related paranoid ideation or severe dissociative symptoms.
	76	Uncomfortable in situations in which he or she is not the centre of attention.
	77	Unusual perceptual experiences, including bodily illusions.
	78	Urgently seeks another relationship as a source of care and support when a close relationship ends.
	79	Views self as socially inept, personally unappealing, or inferior to others.

Appendix B: DSM-5-AMPD Specific Descriptions of Personality Disorders Checklist

Instructions: This checklist will be used in this study to meet the requirement for Criterion A and B of the DSM-5-AMPD. Below is a list of 51 diagnostic criteria proposed for the definition of the 6 specific DSM-5-AMPD types. It includes disorder-specific manifestations of impairments in self and interpersonal functioning taken directly from the DSM-5-AMPD. Please read each of the following statements carefully and use the left column to select the responses that best describes the patient selected for this study.		
	1	Ego-centrism; self-esteem derived from personal gain, power, or pleasure.
	2	Goal setting based on personal gratification; absence of prosocial internal standards, associated with failure to conform to lawful or culturally normative ethical behaviour.
	3	Lack of concern for feelings, needs, or suffering of others; lack of remorse after hurting or mistreating another.
	4	Incapacity for mutually intimate relationships, as exploitation is a primary means of relating to others, including by deceit and coercion; use of dominance or intimidation to control others.
	5	Low self-esteem associated with self-appraisal as socially inept, personally unappealing, or inferior; excessive feelings of shame.
	6	Unrealistic standards for behaviour associated with reluctance to pursue goals, take personal risks, or engage in new activities involving interpersonal contact.
	7	Preoccupation with, and sensitivity to, criticism or rejection, associated with distorted inference of others' perspectives as negative.
	8	Reluctance to get involved with people unless being certain of being likes; diminished mutuality within intimate relationships because of fear of being shamed or ridiculed.
	9	Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.
	10	Instability in goals, aspirations, values, or career plans.
	11	Compromised ability to recognize the feelings and needs of others associated with interpersonal hypersensitivity (i.e., prone to feeling slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities.
	12	Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealization and devaluation and alternating between over-involvement and withdrawal.
	13	Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal inflated or deflated, or vacillating between extremes; emotional regulation mirrors fluctuations in self-esteem.
	14	Goal-setting based on gaining approval from others; personal standards unreasonably high in order to see oneself as exceptional, or too low based on a sense of entitlement; often unaware of own motives.
	15	Impaired ability to recognize or identify with the feelings and needs of others; excessively attuned to reactions of others, but only if perceived as relevant to self; overestimates or underestimates own effect on others.
	16	Relationships largely superficial and exist to serve self-esteem regulation; mutually constrained by little genuine interest in others' experiences and predominance of a need for personal gain.
	17	Sense of self derived predominantly from work or productivity; constricted experience and expression of strong emotions.

	18	Difficulty completing tasks and realizing goals, associated with rigid and unreasonably high and inflexible internal standards of behaviour; overly conscientious and moralistic attitudes.
	19	Difficulty understanding and appreciating the ideas, feelings, or behaviours of others.
	20	Relationships seen as secondary to work and productivity; rigidity and stubbornness negatively affect relationships with others.
	21	Confused boundaries between self and others; distorted self-concept; emotional expression often not congruent with context or internal experience.
	22	Unrealistic or incoherent goals; no clear set of internal standards.
	23	Pronounced difficulty understanding impact of own behaviours on others; frequent misinterpretations of others' motivations and behaviours.
	24	Marked impairments in developing close relationships, associated with mistrust or anxiety.
	25	Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing and following plans.
	26	Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing and following plans. As sense of urgency and self-harming behaviour under emotional stress.
	27	Avoidance of close or romantic relationships, interpersonal attachments and intimate sexual relationships.
	28	Dishonesty and fraudulence; misrepresentation of self; embellishment or fabrication when relating events.
	29	Disregard for - and failure to honour - financial and other obligations or commitments; lack of respect for-and lack of follow-through on-agreements and promises
	30	Engagement in dangerous, risky and potentially self-damaging activities, unnecessarily and without regard for consequences; boredom proneness and thoughtless initiation of activities to counter boredom; lack of concern for one's limitations and denial of the reality of personal danger.
	31	Excessive attempts to attract and be the focus of the attention of others; admiration seeking.
	32	Expectations of - and heightened sensitivity to - signs of interpersonal ill-intent or harm; doubts about loyalty and fidelity of others; feelings of persecution.
	33	Fears of rejection by-and/or separation from-significant others, associated with fears of excessive dependency and complete loss of autonomy.
	34	Feelings of entitlement, either overt or covert, self-centeredness; firmly holding to the belief that one is better than others; condescension toward others.
	35	Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feelings of inferior self-worth; thoughts o suicide and suicidal behaviour.
	36	Frequent use of subterfuge/deception to influence or control others; use of seduction , charm glibness, or ingratiation to achieve one's ends.
	37	Intense feelings of nervousness, tenseness, or panic, often in reaction to social situations; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of embarrassment.
	38	Intense feelings of nervousness, tenseness, or panic, often in reaction to social situations; worry about the negative effects of past unpleasant experiences and future negative

		possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.
	39	Lack of concern for feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one's actions on others; aggression; sadism.
	40	Lack of enjoyment from, engagement in, or energy for life's experiences; deficits in the capacity to feel pleasure or take interest in things.
	41	Little reaction to emotionally arousing situations; constricted emotional experience and expression; indifference or coldness.
	42	Odd or unusual thought processes; vague, circumstantial, metaphorical, over-elaborate, or stereotyped thought or speech; odd sensations in various sensory modalities.
	43	Odd, unusual, or bizarre behaviour or appearance; saying unusual or inappropriate things.
	44	Persistence at tasks long after the behaviour has ceased to be functional or effective; continuance of the same behaviour despite repeated failures.
	45	Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.
	46	Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults; mean, nasty, or vengeful behaviour.
	47	Preference for being alone to being with others; reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact.
	48	Reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact.
	49	Rigid insistence on everything being flawless, perfect, and without errors or faults, including one's own and others' performance; sacrificing of timeliness to ensure correctness in every detail; believing that there is only one right way to do things; difficulty changing ideas and/or viewpoint; preoccupation with details, organisation, and order.
	50	Thought content and views of reality that are viewed by others as bizarre or idiosyncratic; unusual experiences of reality.
	51	Unstable emotional experiences and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.

Appendix C: DSM-5-AMPD Level of Personality Functioning Scale

The LPFS will be used in this study to meet the requirement for Criterion A of the DSM-5-AMPD. The LPFS is a 60-item 5-point rating scale that describes impairments in self and interpersonal functioning where 1=*little or no impairment;* 2=*some impairment*; 3=*moderate impairment*; 4=*severe impairment*; and 5=*extreme impairment*. Please refer to the patient selected for this study and select the response in each section that best describes him/her.

LEVEL OF SELF-FUNCTIONING

IDENTITY

Please select which ***ONE*** of the following statements best describes the person you are rating:	
1	Has ongoing awareness of a unique self; maintains role-appropriate boundaries.
2	Has relatively intact sense of self, with some decrease in clarity of boundaries when strong emotions and mental distress are experienced.
3	Depends excessively on others for identity definition, with compromised boundary delineation.
4	Has a weak sense of autonomy/agency: experience of a lack of identity or emptiness. Boundary definition is poor or rigid: may show over-identification with others, over-emphasis on independence from others, or vacillation between these.
5	Experience of a unique self and sense of agency/autonomy are virtually absent, or are organised around perceived external persecution. Boundaries with others are confused or lacking.

Please select which ***ONE*** of the following statements best describes the person you are rating:	
1	Has consistent and self-regulated positive self-esteem, with accurate self-appraisal.
2	Self-esteem diminished at times, with overly critical or somewhat distorted self-appraisal.
3	Has vulnerable self-esteem controlled by exaggerated concern about external evaluation, with a wish for approval. Has sense of incompleteness or inferiority, with compensatory inflated, or deflated, self-appraisal.
4	Fragile self-esteem is easily influenced by events, and self-image lack coherence. Self-appraisal is un-nuanced: self-loathing, self-aggrandizing, or an illogical, unrealistic combination.
5	Has weak or distorted self-image easily threatened by interaction with others; significant distortions and confusion around self-appraisal.

Please select which ***ONE*** of the following statements best describes the person you are rating:	
1	Is capable of experiencing, tolerating, and regulating a full range of emotions.
2	Strong emotions may be distressing, associated with a restriction in range of emotional experience.
3	Emotional regulation depends on positive external appraisal. Threats to self-esteem may engender strong emotions such as rage or shame.

4	Emotions may be rapidly shifting or a chronic, unwavering feeling of despair.
5	Emotions not congruent with context or internal experience. Hatred and aggression may be dominant affects, although they may be disavowed and attributed to others.

SELF-DIRECTION

Please select which *ONE* of the following statements best describes the person you are rating:	
1	Sets and aspires to reasonable goals based on a realistic assessment of personal capacities.
2	Is excessively goal-directed, somewhat goal-inhibited, or conflicted about goals.
3	Goals are more often a means of gaining external approval than self-generated, and thus may lack coherence and/or stability.
4	Has difficulty establishing and/or achieving personal goals.
5	Has poor differentiation of thoughts from actions, so goal setting ability is severely compromised, with unrealistic or incoherent goals.

Please select which *ONE* of the following statements best describes the person you are rating:	
1	Utilizes appropriate standards of behaviour, attaining fulfilment in multiple realms.
2	May have unrealistic or socially inappropriate set of personal standards, limiting some aspects of fulfilment.
3	Personal standards may be unreasonably high (e.g., not consonant with prevailing social values). Fulfilment is compromised by a sense of lack of authenticity.
4	Internal standards for behaviour are unclear or contradictory. Life is experienced as meaningless or dangerous.
5	Internal standards for behaviour are virtually lacking. Genuine fulfilment is virtually inconceivable.

Please select which *ONE* of the following statements best describes the person you are rating:	
1	Can reflect on, and make constructive meaning of, interpersonal experience.
2	Is able to reflects on internal experiences, but may over-emphasize a single (e.g., intellectual, emotional) type of self-knowledge.
3	Has impaired capacity to reflect on internal experience.
4	Has significantly compromised ability to reflect on and understand own mental processes.
5	Is profoundly unable to constructively reflect on own experience. Personal motivations may be unrecognized and/or experienced as external to self.

LEVEL OF INTERPERSONAL FUNCTIONING

EMPATHY

Please select which *ONE* of the following statements best describes the person you are rating:	
1	Is capable of accurately understanding others' experiences and motivations in most situations.

2	Is somewhat compromised in ability to appreciate and understand others' experiences; may tend to see others as having unreasonable expectations or a wish for control.
3	Is hyper-attuned to the experience of others, but only with respect to perceived relevance to self.
4	Ability to consider and understand the thoughts, feelings, and behaviour of other people is significantly limited; may discern very specific aspects of others' experience, particularly vulnerabilities and suffering.
5	Has pronounced inability to consider and understand others' experience and motivation.

Please select which *ONE* of the following statements best describes the person you are rating:	
1	Comprehends and appreciates others' perspectives, even if disagreeing.
2	Although capable of considering and understanding different perspectives, resists doing so.
3	Is excessively self-referential; significantly compromised ability to appreciate and understand others' experience and to consider alternative perspectives.
4	Is generally able to consider alternative perspectives; highly threatened by differences of opinion or alternative viewpoints.
5	Attention to others' perspectives is virtually absent (attention is hypervigilant, focused on need fulfilment and harm avoidance).

Please select which *ONE* of the following statements best describes the person you are rating:	
1	Is aware of the effect of own actions on others.
2	Has inconsistent awareness of effect of own behaviour on others.
3	Is generally unaware of or unconcerned about effect of own behaviour on others, or unrealistic appraisal of own effect.
4	Is confused about or unaware of impact of own actions on others; often bewildered about peoples' thoughts and actions, with destructive motivations frequently misattributed to others.
5	Social interactions can be confusing and disorienting.

INTIMACY

Please select which *ONE* of the following statements best describes the person you are rating:	
1	Maintains multiple satisfying and enduring relationships in personal and community life.
2	Is able to establish enduring relationships in personal and community life, with some limitations on degree of depth and satisfaction.
3	Is capable of forming and desires to form relationships in personal and community life, but connections may be largely superficial.
4	Has some desire to form relationships in community and personal life is present, but capacity for positive and enduring connections is significantly impaired.
5	Desire for affiliation is limited because of profound disinterested or expectation of harm. Engagement with others is detached, disorganised, or consistently negative.

Please select which ***ONE*** of the following statements best describes the person you are rating:	
1	Desires and engages in a number of caring, close, and reciprocal relationships.
2	Is capable of forming and desires to form intimate and reciprocal relationships, but may be inhibited in meaningful expression and sometimes constrained if intense emotions or conflicts arise.
3	Intimate relationships are predominantly based on meeting self-regulatory and self-esteem needs, with an unrealistic expectation of being perfectly understood by others.
4	Relationships are based on a strong in the absolute need for the intimate other(s) and/or expectations of abandonment or abuse. Feelings about intimate involvement with others alternate between fear/rejections and desperate desire for connection.
5	Relationships are conceptualized almost exclusively in terms of their ability to provide comfort or inflict pain and suffering.

Please select which ***ONE*** of the following statements best describes the person you are rating:	
1	Strives for cooperation and mutual benefit and flexibly responds to a range of others' ideas, emotions, and behaviours.
2	Cooperation may be inhibited by unrealistic standards; somewhat limited in ability to respect or respond to others' ideas, emotions, and behaviours.
3	Tends not to view relationships in reciprocal terms, and cooperates predominantly for personal gain.
4	Little mutuality: others are conceptualized primarily in terms of how the affect the self (negatively or positively); cooperative efforts are often disrupted due to the perception of slights from others.
5	Social/interpersonal behaviour is not reciprocal; rather, it seeks fulfilment of basic needs or escape from pain.

Appendix D: DSM-5-AMPD Personality Disorder Trait Domains and Facets Scale

This scale will be used in this study to meet the requirement for Criterion B of the DSM-5-AMPD. The Personality Disorder Trait Domains and Facets Scale is a 25-item, 4-point rating scale that describes 5 broad trait domains, namely: (1) negative affect, (2) detachment, (3) antagonism, (4) disinhibition, and (5) psychoticism. Please refer to the patient selected for this study and select the response in each section that best describes him/her.

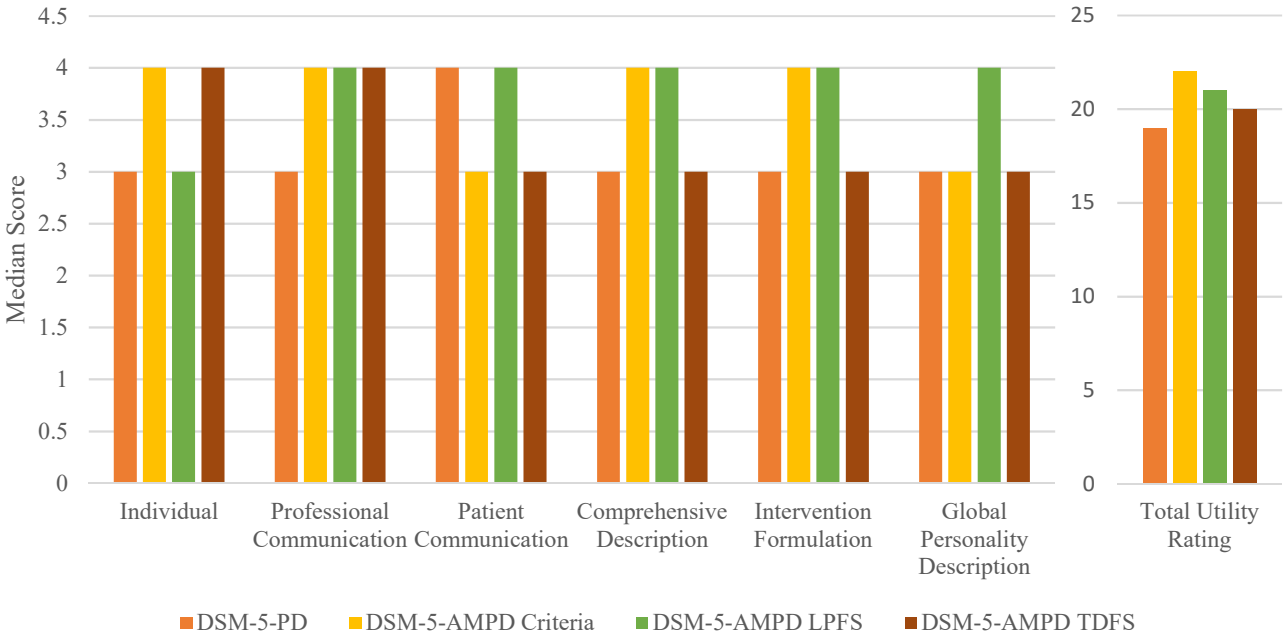
	Please rate how true or false each of the following statements are of the person you are rating. He or she…	**Very False or Often False**	**Sometimes or Somewhat False**	**Sometimes or Somewhat True**	**Very True or Often True**
1	…is reckless.	0	1	2	3
2	…acts on impulse.	0	1	2	3
3	…can't stop making rash decisions even though they know better.	0	1	2	3
4	…often feels like nothing they do really matters.	0	1	2	3
5	…is irresponsible.	0	1	2	3
6	…is not good at planning ahead.	0	1	2	3
7	…often has thoughts that don't make sense.	0	1	2	3
8	…worries about almost everything.	0	1	2	3
9	…gets emotional easily, often for very little reason.	0	1	2	3
10	…fears being alone in life more than anything else.	0	1	2	3
11	…gets stuck on one way of doing things, even when it's clear it won't work.	0	1	2	3
12	…has seen things that weren't really there.	0	1	2	3
13	…steers clear of romantic relationships.	0	1	2	3
14	…is not interested in making friends.	0	1	2	3
15	…gets irritated easily by all sorts of things.	0	1	2	3
16	…doesn't like to get too close to people.	0	1	2	3
17	…doesn't care if their actions hurt others.	0	1	2	3
18	…is rarely enthusiastic about anything.	0	1	2	3
19	…craves attention.	0	1	2	3
20	…thinks they are more important than other people.	0	1	2	3
21	…often has thoughts that don't make sense.	0	1	2	3
22	…uses people to get what they want.	0	1	2	3
23	…often "zones out" for periods of time.	0	1	2	3
24	…talks about feeling like things are unreal, or more real than usual.	0	1	2	3
25	…finds it is easy to take advantage of others.	0	1	2	3

Krueger RF, Derringer J, Markon KE, Watson D, Skodol AE.
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Appendix E: Focus Group Handout

Please draw on the process of the survey and the following information to inform our focus group discussion.

A Comparison of Median Clinical Utility Judgements: DSM-5-PD vs. DSM-5-AMPD Diagnostic Criteria vs. DSM-5-AMPD Level of Personality Functioning Scale (LPFS) vs. DSM-5-AMPD Trait Domain and Facets Scale (TDFS) Ratings.



As Borderline Personality Disorder criteria were satisfied on both DSM-5 PD models more times than any other PD diagnosis, the Borderline PD diagnostic criteria in both the DSM-5-PD model and the DSM-5-AMPD are presented below.

DSM-5-PD MODEL: BORDERLINE PERSONALITY DISORDER

Diagnostic Criteria for Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in variety of contexts, as indicated by five (or more) of the following:

1.	Frantic efforts to avoid real or imagined abandonment; *note:* do not include suicidal or self-mutilating behaviour covered in criterion 5.
2.	A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3.	Identity disturbance: Markedly and persistently unstable self-image or sense of self.
4.	Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating); *note:* do not include suicidal or self-mutilating behaviour covered in criterion 5.
5.	Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.
6.	Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days).
7.	Chronic feelings of emptiness.
8.	Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9.	Transient, stress-related paranoid ideation or severe dissociative symptoms.

DSM-5-AMPD: BORDERLINE PERSONALITY DISORDER

Typical features of Borderline Personality Disorder are instability of self-image, personal goals, interpersonal relationships, and affects, accompanied by impulsivity, risk taking, and/or hostility. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, as described below, along with specific maladaptive traits in the domain of Negative Affectivity, and also Antagonism and/or Disinhibition.

Proposed Diagnostic Criteria

A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:

1. ***Identity:*** Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress.
2. ***Self-direction:*** Instability in goals, aspirations, values, or career plans.
3. ***Empathy:*** Compromised ability to recognize the feelings and needs of others associated with interpersonal hypersensitivity (i.e., prone to feel slighted or insulted); perceptions of others selectively biased toward negative attributes or vulnerabilities.
4. ***Intimacy:*** Intense, unstable, and conflicted close relationships, marked by mistrust, neediness, and anxious preoccupation with real or imagined abandonment; close relationships often viewed in extremes of idealization and devaluation and alternating between over-involvement and withdrawal.

B. Four or more of the following seven pathological personality traits, at least one of which must be (5) Impulsivity, (6) Risk taking, or (7) Hostility:

1. ***Emotional lability*** (an aspect of **Negative Affectivity**): Unstable emotional experience and frequent mood changes; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.
2. ***Anxiousness*** (an aspect of **Negative Affectivity**): Intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of falling apart or losing control.
3. ***Separation insecurity*** (an aspect of **Negative Affectivity**): Fears of rejection by—and/or separation from—significant others, associated with fears of excessive dependency and complete loss of autonomy.
4. ***Depressivity*** (an aspect of **Negative Affectivity**): Frequent feelings of being down, miserable, and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame; feelings of inferior self-worth; thoughts of suicide and suicidal behavior.
5. ***Impulsivity*** (an aspect of **Disinhibition**): Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing or following plans; a sense of urgency and self-harming behaviour under emotional distress.
6. ***Risk taking*** (an aspect of **Disinhibition**): Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger.
7. ***Hostility*** (an aspect of **Antagonism**): Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults.

DSM-5-AMPD PERSONALITY DISORDER-TRAIT SPECIFIED (PD-TS)

This is a sample of what the selected patient's diagnosis would be on the DSM-5-AMPD if criteria for a specific PD diagnosis were not satisfied. The ratings from all mental health professionals were organised, and DSM-5-AMPD decision rules were used to formulate the following Personality Disorder- Trait Specified (PD-TS) implied diagnosis. The DSM-5-AMPD's PD-TS diagnosis is the counterpart of the Personality Diagnosis – Not Otherwise Specified (PD-NOS) in the DSM-5-PD model.

CRITERION A: LEVEL OF PERSONALITY FUNCTIONING IMPAIRMENT

Impairment in Self-functioning:

Identity:

1. Has a weak sense of autonomy/agency: experience of a lack of identity or emptiness. Boundary definition is poor or rigid: may show over-identification with others, over-emphasis on independence from others, or vacillation between these.
2. Has vulnerable self-esteem controlled by exaggerated concern about external evaluation, with a wish for approval. Has sense of incompleteness or inferiority, with compensatory inflated, or deflated, self-appraisal.
3. Emotional regulation depends on positive external appraisal. Threats to self-esteem may engender strong emotions such as rage or shame.

Self-direction:

1. Has difficulty establishing and/or achieving personal goals.
2. Internal standards for behaviour are unclear or contradictory. Life is experienced as meaningless or dangerous.
3. Has impaired capacity to reflect on internal experience.

Impairment in Interpersonal Functioning:

Empathy:

1. Ability to consider and understand the thoughts, feelings, and behaviour of other people is significantly limited; may discern very specific aspects of others' experience, particularly vulnerabilities and suffering.
2. Is generally able to consider alternative perspectives; highly threatened by differences of opinion or alternative viewpoints.
3. Is generally unaware of or unconcerned about effect of own behaviour on others, or unrealistic appraisal of own effect.

Intimacy:

1. Has some desire to form relationships in community and personal life is present, but capacity for positive and enduring connections is significantly impaired.
2. Relationships are based on a strong in the absolute need for the intimate other(s) and/or expectations of abandonment or abuse. Feelings about intimate involvement with others alternate between fear/rejections and desperate desire for connection.
3. Little mutuality: others are conceptualized primarily in terms of how the affect the self (negatively or positively); cooperative efforts are often disrupted due to the perception of slights from others.

CRITERION B: PATHOLOGICAL PERSONALITY TRAITS

The collective ratings indicated that the patient satisfied criteria for the following pathological personality trait domains: (1) Disinhibition, and (2) Antagonism. These trait domains are consistent with a DSM-5-AMPD Antisocial Personality Disorder diagnosis. In addition to these domains, the ratings suggested that the patient also presented with the following Negative Affectivity trait domain facets: (1) Emotional Lability, (2) Separation Insecurity, (3) Hostility, and (4) Perseveration. Therefore, the PD-TS diagnosis indicated that although the patient satisfied criteria for an Antisocial Personality diagnosis (Disinhibition; Antagonism), Narcissistic (Domain Trait of Antagonism satisfied) and Borderline (four facets of the Negative

Affectivity Domain Trait satisfied) traits were present. Below is the detailed criterion B of the implied diagnosis.

DOMAIN	**DISINHIBITION** **(vs. Conscientiousness)**	Orientation towards immediate gratification, leading to impulsive behaviour driven by current thoughts, feelings, and external stimuli, without regard for past learning or consideration of future consequences.
FACETS	**Irresponsibility**	Disregard for – and failure to honour – financial and other obligations or commitments; lack of respect for – and lack of follow-through on – agreements and promises; carelessness with others' property.
	Impulsivity	Acting on the spur of the moment in response to immediate stimuli; acting on a momentary basis without a plan or consideration of outcomes; difficulty establishing and following plans; a sense of urgency and self-harming behaviour under emotional distress.
	Distractibility	Difficulty concentrating and focusing on tasks; attention is easily diverted by extraneous stimuli; difficulty maintaining goal-focused behaviour, including both planning and completing tasks.
	Risk Taking	Engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard to consequences; lack of concern for one's limitations and denial of the reality of personal danger; reckless pursuit of goals regardless of the level of risk involved.
	Rigid Perfectionism (lack of)	Rigid insistence on everything being flawless, perfect, and without errors or faults, including one's own and others' performance; sacrificing of timeliness to ensure correctness in every detail; believing that there is only one right way to do things; difficulty changing ideas and/or viewpoint; preoccupation with details, organization, and order. The lack of this facet characterizes low levels of Disinhibition.
DOMAIN	**ANTAGONISM** **(vs. Agreeableness)**	Behaviours that put the individual at odds with other people, including an exaggerated sense of self-importance and a concomitant expectation of special treatment, as well as a callous antipathy toward others, encompassing both an awareness of others' needs and feelings and a readiness to use others in the service of self-enhancement.

FACETS	**Manipulativeness**	Use of subterfuge to influence or control others; use of seduction, charm, glibness, or ingratiation to achieve one's ends.
	Deceitfulness	Dishonesty and fraudulence; misrepresentation of self; embellishment or fabrication when relating events.
	Grandiosity	Believing that one is superior to others and deserves special treatment; self-centeredness; feelings of entitlement; condescension toward others.
	Attention Seeking	Engaging in behaviour designed to attract notice and to make oneself the focus of other's attention and admiration.
	Callousness	Lack of concern for the feelings or problems of others; lack of guilt or remorse about the negative or harmful effects of one's actions on others.
	Hostility	Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults; mean, nasty, or vengeful behaviour. *See also* Negative Affectivity.
DOMAIN	**NEGATIVE AFFECTIVITY** **(vs. Emotional Stability)**	Frequent and intense experiences of high levels of a wide range of negative emotions (e.g. anxiety, depression, guilt/shame, worry, anger) and their behavioural (e.g. self-harm) and interpersonal (e.g. dependency) manifestations.
FACETS	***Emotional Lability**	Instability of emotional experiences and mood; emotions that are easily aroused, intense, and/or out of proportion to events and circumstances.
	Anxiousness	Feelings of nervousness, tenseness, or panic in reaction to diverse situations; frequent worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful and apprehensive about uncertainty; expecting the worst to happen.
	***Separation Insecurity**	Fears of being alone due to rejection by – and/or separation from – significant others, based in a lack of confidence in one's ability to care for oneself, both physically and emotionally.
	Submissiveness	Adaptation of one's behaviour to the actual or perceived interests and desired of others even when doing so is antithetical to one's own interests, needs, or desires.
	***Hostility**	Persistent or frequent angry feelings; anger or irritability in response to minor slights and insults;

	mean, nasty, or vengeful behaviour. *See also* Antagonism.
***Perseveration**	Persistence at tasks or in a particular way of doing things long after the behaviour has ceased to be functional or effective; continuance of the same behaviour despite repeated failures or clear reasons for stopping.
Depressivity	Feelings of being down, miserable and/or hopeless; difficulty recovering from such moods; pessimism about the future; pervasive shame and/or guilt; feelings of inferior self-worth; though of suicide and suicidal behaviour. *See also* Detachment.
Suspiciousness	Expectations of – and sensitivity to – signs of interpersonal ill-intent or harm; doubts about loyalty and fidelity of others; feelings of being mistreated, used, and/or persecuted by others. *See also* Detachment.
Restricted Affectivity (lack of)	Little reaction to emotionally arousing situations; constricted emotional experience and expression; indifference and aloofness in normatively engaging situations. The lack of this facet characterises low levels of Negative Affectivity. *See also* Detachment.

***Trait domain facet criteria satisfied**

Appendix F: Focus Group Schedule

The following questions were used during the course of the focus group to help facilitate the discussion between members of the multi-disciplinary team at Tara:

Question One:

There are numerous criticisms aimed at the current DSM-5 model for PDs. For example, it creates widespread co-occurrence of PDs, so that patients who meet the criteria for a specific PD typically meet criteria for other PDs. As a result of these various shortcomings, DSM-5 PD diagnoses (1) have often not been used in clinical settings (Diagnosis Deferred on Axis II), (2) have been underused (hence the prevalence of PDNOS), or (3) have been erroneously used (such as diagnoses formulated on the basis of too few of the required criteria).

How does this information relate to your experiences and perceptions regarding the current DSM-5 PD model's clinical utility?

Question 2:

The aim of the DSM-5-AMPD was to address the shortcomings of the current DSM-5 PD model. However, it was not adopted The rejection of the DSM-5-AMPD was primarily due to concern over (1) the rationale and adequate clinical or empirical justification behind the deletion of four PDs, and (2) the complexity, unfamiliarity, and immediate clinical utility of the model resulting from the shift toward a more dimensional formulation of personality disorders.

Drawing on this information, and your experience of using both models, what are your opinions regarding the justification behind using the DSM-5-AMPD?

Question 3:

Drawing on the descriptive summary statistics provided, and your experience of using both models, please expand on your perceptions regarding the advantages and limitations both systems. (How useful is each model in describing differences between and within PDs? Are there components of the model that are more useful than others? In what way?)

Question 4:

There seems to be a pattern of difference according to professional disciplines: (1) psychiatrists tend to rate both models higher in utility than non-psychiatrists; (2) psychiatrists tend to rate the current DSM-5 PD model as more useful than the DSM-5-AMPD with regard to diagnostic description and personality functioning, whereas the opposite was true for other mental health professionals.

How do you make sense of these findings?

Question 5:

As the DSM is largely founded on Western ideology, how does this impact the clinical utility of each model in a South African context?

Appendix G. Human Research Ethics Committee (Medical) Clearance Certificate

R14/49 Ms Rivka Hadar

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M150546

NAME: (Principal Investigator)	Ms Rivka Hadar
DEPARTMENT:	Human and Community Development Tara the H Moross Hospital
PROJECT TITLE:	Clinical Perceptions of Clinical Utility: A Comparison of the Current and Alternate DSM-5 Models for Personality Disorder
DATE CONSIDERED:	29/05/2015
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Dr Michael Pitman
APPROVED BY:	Professor P Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	05/10/2015

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.
I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report.**

Principal Investigator Signature

Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix H. Tara The H. Moross Centre Ethics Committe Approval to Conduct Research

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

To: Dr Otieno

CEO Tara Hospital

15 July 2015

Dear Dr Otieno

Re:Approval Request to Conduct Research

I hereby request permission for the following researcher Rivka Hadar to conduct research at Tara. The title of her research is, **"Clinicians' Perceptions of Clinical Utility: A Comparison of the Current and Alternate DSM-5 Models for Personality Disorder".**

The study is towards her MA (ClinPsych) at the University of Witswaterstrand.

Attached is the proposal. She requires our permission in order to apply Ethics approval. She is aware that research may only commence once we have received documentation indicating her Ethics Approval.

Yours sincerely,

.....

Date:21/7/15.

Dr Jow'hara Chundra

Chairperson - Tara research Committee

Recommended/N

.....

Dr Thebe Madigoe

Clinical Head

Date:29/7/15

Approved/Not Approved As Amended Research may only Commence upon receiving Ethics approval and presenting it to this office

.....

Dr Florence Otieno

CEO

Date: 29/7/15

Appendix I: Patient Consent Form

TARA THE H MOROSS CENTRE

INFORMED CONSENT FORM

A. To be completed at the time of registration of all patients and attached to patient's file.

I, (Full name)_____ hereby consent to:

- Psychiatric evaluation/treatment and/or psychological assessment and/or counselling of
  - Myself (Name): _____
  - Relative (Name): _____
- Clinical information about myself to be discussed among professional staff. All patients' rights are protected on terms of regulations set by the Health Professionals Council of South Africa (Tick): _____.
- Give permission for clinical information about myself to be used for retrospective research record review and clinical audit, provided that my confidentiality and anonymity is assured (Tick): _____.

Signed: _____ Date: _____

Witness: _____ Designation: _____

B. Should any information be required from a hospital or doctor or medical aid, I hereby give my consent for the release of such information.

Signed: _____ Date: _____

Witness: _____ Designation: _____

C. I do/do not give my consent for the release of ICD10 code information to my medical aid.

Signed: _____ Date: _____

Witness: _____ Designation: _____

Appendix J: Participant Information Sheet

Psychology
School of Human & Community Development
Private Bag 3, Wits 2050, South Africa. Telephone: +27 11-717-4500/2/3/4. Fax: +27-11-717-4559

Dear Colleagues

My name is Rivka Hadar and I am a currently a psychology student (Master of Clinical Psychology) at the University of the Witwatersrand. As part of my training, I am required to conduct a research study, and I would like to invite you to participate in this study.

The aim of my research is to explore the perceptions of clinical utility of the alternative model for diagnosing personality disorders proposed in Section III (Emerging Measures and Models) of the DSM-5 (DSM-5-AMPD) in relation to the current DSM-5 diagnostic model for personality disorders (PDs).

If you choose to participate in this research, you will be asked to provide an independent formulation of a common case file from a recent patient intake. This information will be collected through a comprehensive paper-and-pencil survey that will include the following:

1. A checklist of 79 PD criteria taken directly from the DSM-5
2. The Level of Personality Functioning Scale (LPFS): a 60-item self-report scale will be used to assess levels of self and interpersonal personality functioning
3. Specific Descriptions of Self and interpersonal Functioning Checklist: A checklist of specific diagnostic criteria proposed for the definition of the six specific DSM-5-AMPD types.
4. Personality Disorder Trait Domains and Facets Scale: A 25-item personality trait assessment scale will be used to assess 5 broad trait domains, namely: (1) negative affect, (2) detachment, (3) antagonism, (4) disinhibition, and (5) psychoticism, with each trait domain consisting of a number of trait facets.

Immediately following the completion of each of these 4 assessments, you will be asked to answer 6 questions regarding their perceived clinical utility of the information provided with regard to the patient for each of the measures, as each tap into somewhat different information. Thus, each of the 6 questions will be asked a total of 4 times. It is estimated that the entire assessment process will take approximately 60 minutes to complete. If you choose to participate in this study, you will be requested to complete this paper-and-pencil survey during your own time.

If you choose to participate in this study, please ensure that the attached assessments are completed and ready for collection by **Friday, 13 November 2015 at 9:00am**. Approximately two weeks after this process you will be invited to attend a focus group in which you will be asked to draw on this information and process, as well as your extensive clinical experience, in discussing the clinical utility of DSM-5-AMPD in relation to the DSM-5 current diagnostic model for PDs. The focus group is scheduled for **30 November 2015 at 11:00am** at Tara, and will run for approximately 120 minutes. The focus group will be audio-recorded, as well as transcribed by the researcher.

The data collected will be kept at the university for safe-keeping, and access will only be gained by consent from the researcher and supervisor. Confidentiality and anonymity will guaranteed with regard to the publication of the research report. Personal identifying information will not be provided in reporting the results, and quotations included in the report will make use of pseudonyms.

Should you wish to participate in this study, please note that you have the right to refrain from participating in any part of the discussion, and you are able to withdraw from the research at any point during the process without incurring any negative consequences. You will also be able to request the research results after a 6-month period subsequent to data collection.

If you would like to participate in this study, please sign the attached consent form prior to participation.

Many thanks for considering participating.

Kind regards,

Rivka Hadar
Phone: 072 998 2008
Email: Rivkiehadar@gmail.com

Michael Pitman
011 717 4505
Michael.Pitman@wits.ac.za

Appendix K: Participant Consent Form

Psychology
School of Human & Community Development
Private Bag 3, Wits 2050, South Africa. Telephone: +27 11-717-4500/2/3/4. Fax: +27-11-717-4559

Consent for research participation

I _____ have read and understood the information and process regarding this research, and have agreed to participate in this study. In particular, I understand and agree to the following:

1. I have read and understood the Participant Information Sheet
2. Any questions I may have with regard to participation in this study have been answered satisfactorily
3. I have been given sufficient time to consider whether I would like to participate in this study
4. I am taking part in this research study voluntarily (without coercion)
5. I agree to being interviewed in a group setting, while being either audio or video recorded
6. I understand that the research results will be reported in the form of a research report for the purpose of completing a master's degree in psychology
7. The research may be presented at a local/international conference and published in a journal and/or book chapter
8. I have received the contact details of the researcher, Rivka Hadar; and supervisor, Michael Pitman

Participant's name: _____

Professional Title: _____

(specify whether completing internship or community service)

Participant's Signature:_____

Date:_____

Appendix L: Audiotape Consent Form

Psychology
School of Human & Community Development
Private Bag 3, Wits 2050, South Africa. Telephone: +27 11-717-4500/2/3/4. Fax: +27-11-717-4559

Consent to be Audiotaped

This consent form gives Rivka Hadar permission to audio record my participation in the focus group for data analysis and transcription purposes.

I understand the following:

- My identity will be protected and I will not be required to give out my name in this recording.
- Access to these recordings will be restricted to the researcher and supervisor. No other persons will have access to these recordings.
- The recordings will be kept safe, in a private location known only to the researcher, and will be stored in password protected files.
- The recording will be destroyed after a period of 6 years is this study is not published, or after a period of 2 years if this research is published. Transcripts will be kept indefinitely, in a password protected file.
- These actual recordings will **not** be presented publicly or as a part of the study results.
- All identifying information will be removed from the transcripts and although direct quotes from the transcripts will be used in the final write-up, these will not be linked to any identifying information, as a pseudonym will be used, and information will be used in conjunction with quotes from other participants.

If I have concerns or queries regarding the audio recording of this interview I can ask the researcher before we begin the focus group so that she may clarify them for me.

I, (name) _____ give permission for my research focus group participation to be fully audio recorded with a full understanding of the above conditions.

Participant's Signature:_____ Date:_____