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Comparing the Clinical Utility of the Alternative Model for Personality Disorders to the Section II Personality Disorder Model: A Randomized Controlled Trial

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The alternative model for personality disorders (AMPD) has been extensively studied over the past decade, but to date there is no direct comparison of the clinical utility of the AMPD model relative to the Section II personality disorder (PD) model in an ecologically valid design. The current study examined the clinical utility of an AMPD-informed assessment procedure and Section II PD assessment procedure as assessed by both patients and clinicians in a randomized controlled trial. A sample of 119 patients were randomly assigned to either an AMPD or a Section II PD assessment procedure. At the end of the assessment, patients filled out questionnaires pertaining to clinical utility, satisfaction, motivation for treatment, and general experience of the assessment. Clinicians who subsequently started treatment with these patients also completed two clinical utility questionnaires. There were no significant differences between the AMPD and Section II PD assessment procedure on patients' reported clinical utility, motivation for treatment, satisfaction, and general experience of the assessment nor were there significant differences between the models on clinician reported clinical utility. Explorative analyses revealed that, for patients, a positive relationship with the assessor was predictive of experienced utility. This study shows no superiority of the AMPD in terms of clinical utility but suggests that the alliance with the assessor is a particularly salient factor in clinical utility.

Keywords: alternative model for personality disorders, Section II personality disorder, clinical utility, randomized controlled trial, assessment

Diagnostic and Statistical Manual of Mental Disorders, fifth edition (*DSM-5*) introduced the alternative model for personality disorders (AMPD) in its Section III ("emerging measures and models"; American Psychiatric Association, 2013). It provides a major shift in the operationalization of personality disorders (PDs) by describing PDs as a combination of (a) impairments in self- and interpersonal functioning (Criterion A) and (b) pathological personality traits (Criterion B). Since its publication, numerous studies concerning the reliability and validity of the model have been conducted (e.g., Zimmermann et al., 2019). Several self-report, informant report, and interview schedules have been constructed to reliably assess both Criterion A and B (e.g., First et al., 2018; Goth et al., 2018; Huprich et al., 2018; Hutsebaut et al., 2017; Krueger et al., 2012; Morey, 2017; Thylstrup et al., 2016; Weekers et al., 2019). Validity of the model has been demonstrated by meaningful associations with other measures of PD severity and related constructs (e.g., Zimmermann et al., 2019). Head-to-head comparisons of the AMPD model and Section II PD model are still scarce; however, they are needed to warrant such a major paradigm shift. The current study compares the AMPD and Section II PD model in terms of clinical utility as rated by both patients and clinicians.

The Section II PD model has been criticized for its lack of reliability and validity (e.g., Krueger et al., 2014; Samuel, 2015; Skodol, 2014). Although reliability and validity touch upon the conceptual soundness of a diagnostic system, in clinical practice, clinical utility may be at least as important. Clinical utility refers to the extent to which a diagnostic system assists professionals in fulfilling five core diagnostic functions (First et al., 2004): (a) conceptualizing diagnostic entities, (b) communicating clinical information to relevant others, (c) using diagnostic categories and criteria sets in clinical practice (including for diagnostic interviewing and differential diagnosis), (d) choosing effective interventions to improve clinical

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Laura C. Weekers served as lead for data curation, formal analysis, methodology, project administration, and writing–original draft. Joost Hutsebaut contributed equally to methodology. Hilde De Saeger served in a supporting role for supervision and writing–original draft. Laura C. Weekers, Joost Hutsebaut, Hilde De Saeger, and Jan H. Kamphuis contributed equally to conceptualization. Joost Hutsebaut and Jan H. Kamphuis contributed equally to writing–original draft and supervision.

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outcomes, and (e) predicting future clinical management needs. Limited clinical utility of the Section II PD model has been demonstrated by the fact that clinicians do not use the Section II PD model as intended by the manual (Keeley et al., 2013, 2015), for example, by using theoretical assumptions to weigh the importance of different PD criteria (Kim & Ahn, 2002). Furthermore, the utility of the Section II PD model for assessing adolescents and old age has been questioned, with some criteria being less suited for these age groups (Videler et al., 2019). Lastly, the Section II model has a risk of stigmatizing patients by differentiating arbitrarily between abnormal and normal categories of personality and by using concepts that have become connotative, like narcissistic and histrionic PD (Waugh, 2019).

Research on clinical utility of the AMPD model is rather limited and has almost exclusively focused on utility from a clinician perspective. An overview has been provided by Bach and Tracy (2022). A meta-analysis showed clinicians favor dimensional PD models over categorical PD models, particularly in respect to its usefulness in communicating with patients, comprehensiveness in describing the patient's personality problems, and usefulness in formulating therapeutic interventions (Bornstein & Natoli, 2019). Research on the utility of the AMPD model from a client perspective is even more scarce. One study by Lengel and Mullins-Sweatt (2017) demonstrated that computerized feedback concerning (mal) adaptive personality traits helped patients' understanding of their personality characteristics and problems in living. Several authors hypothesize that the AMPD model can improve utility of assessment for clients. For example, the use of understandable, less-jargonized language can enhance communication with clients and can potentially work to avoid stigma (Waugh, 2019). Feedback that is framed in experience near language might further promote a therapeutic working alliance from the start and enhance epistemic trust (i.e., trust in the authenticity and personal relevance of information from others; Kamphuis & Finn, 2018; Sperber et al., 2010).

Early studies on the clinical utility of the AMPD model bear promise but are also limited in many ways. Most importantly, the issue of clinical utility is almost exclusively approached from the perspective of the clinician, focusing on rather formal aspects like ease of use or ease of communication. These studies did not assess an essential ingredient of clinical utility: how may an assessment help clients and professionals to come to a better understanding of the core problems, and how does this understanding inform treatment planning and enhance treatment readiness? Moreover, these studies make use of case vignettes (Garcia et al., 2018) or involve hypothetical assessments of already familiar patients (Morey et al., 2014). None of these studies represent personality assessment in daily clinical practice. In order to assess the AMPD model in terms of clinical utility, as compared to the Section II PD model, a comprehensive ecologically valid assessment procedure using established instruments and resulting in a case formulation that reflects the core aim of the classification system is needed. Also, clinical utility should be studied from the patients' and the professionals' perspective in order to establish its (assumed) clinical usefulness for both groups of stakeholders.

The current study constitutes a rigorous test of the clinical utility of the AMPD model compared to the Section II PD model in an ecologically valid randomized controlled trial (RCT). We employed well-established interview measures to assess the AMPD and Section II PD criteria. Both patient- and clinician-rated utility were assessed. Based upon our review of the literature, we hypothesized that the AMPD assessment procedure would have superior clinical utility for both patients and clinicians.

Method

Design

This study is a RCT comparing the clinical utility of the AMPD assessment to the Section II PD assessment in a parallel group design. Patients were randomly allocated to either the AMPD assessment or Section II PD assessment and outcome questionnaires were administered after the assessment was completed.

Ethics

This study was approved by the Medical Ethics Research Committee of the Academic Medical Centre, Amsterdam (NL75676.018.20).

Sample Size and Power Calculation

A priori sample size calculation was based on the clinical utility patient questionnaire, the primary outcome measure in this study. We conducted a short pilot study with 17 patients. All participants were assessed using the Section II PD assessment procedure. Internal consistency of the total clinical utility score was high ($\alpha = .88$) and mean total score was 3.71 ($SD = 0.48$). Based on a prior study by De Saeger et al. (2014), in which therapeutic assessment was compared to a short structured motivational treatment, we expected an effect size of $d = 0.50$. Based on information from the pilot study, with a sample size of at least 64 per assessment procedure, an effect size of $d = 0.50$ can be detected with two-sided testing, with $\alpha = .05$ and a power of .80 (G-power; Faul et al., 2007). We therefore aimed at a sample size of $N = 128$.

Participants and Eligibility Criteria

Participants were treatment-seeking adults who were referred to De Viersprong, a mental health care facility for the assessment and treatment of PDs. Inclusion and exclusion criteria were the same as the in- and exclusion criteria for assessment at De Viersprong. Inclusion criteria were (suspected) personality pathology. Exclusion criteria were a diagnosis of autism spectrum disorder, chronic psychotic disorder or organic brain disorder, and intellectual disability.

Procedure

Patients on the waitlist for initial assessment were contacted by one of the researchers and informed about the study. An information letter was sent after this call and a (virtual) meeting was arranged 1 week later to answer questions and sign informed consent. If patients consented, they were randomized into either the traditional Section II PD assessment or AMPD assessment. The randomization file was a block (4×2) randomization constructed by an independent statistician and managed by an employee who was not part of the research team. After randomization, participants were invited for the assessment procedure; the result of the randomization was not shared with participants. Patients who wanted to be informed about the assessment procedure were informed after the assessment and after they had filled out all questionnaires.

After the assessment procedure was complete and patients had received a written report of the assessment, they were contacted to

fill out the questionnaires. If patients were referred for subsequent treatment within the institution, the treating therapist was asked to read the written report of the assessment and to complete a clinical utility questionnaire after their first contact with the patient. All data were collected between February 2022 and May 2023.

Assessment Procedures and Clinicians

Section II PD assessment consisted of a clinical interview, a structured interview session for assessing *DSM-5* PDs (SCID-5-PD), and a feedback session informing patients about their diagnoses and treatment options. The AMPD assessment procedure consisted of a clinical interview, a structured interview session for assessing *DSM-5* Section III (AMPD) PDs (semi-structured interview for personality functioning *DSM-5* and SCID AMPD Module II), and a feedback session informing patients about their (dimensional) diagnoses and treatment options. In both conditions, patients were additionally administered a structured clinical interview assessing major symptom disorders (SCID-5, clinician version) by a different clinician. This instrument was included to have an assessment of other (comorbid) mental disorders needed for treatment planning in this real-life assessment procedure. Each assessment procedure was manualized (available upon request) and reviewed by an international expert (A.E. Skodol). Prior to the start of the study, clinicians were distributed across conditions in a way to have an approximately equal level of experience in both conditions. They received a 1-day training (including video demonstrations of the administration of the interviews) to familiarize them with the manual of their respective assessment procedure. The Section II PD training was led by two of the authors (Hilde De Saeger and Jan H. Kamphuis), and the AMPD training was led by Laura C. Weekers and Joost Hutsebaut. Four clinicians were trained in the AMPD assessment procedure, and seven were trained in the Section II PD assessment procedure. All clinicians had experience in working with PD patients. Hilde De Saeger supervised the Section II PD clinicians and Joost Hutsebaut supervised the AMPD clinicians; all patients were discussed, and adherence to the models was monitored during these sessions.

Adherence

To assess adherence to the assessment procedures, 20 written reports (10 AMPD and 10 Section II PD) were rated on adherence by raters who were not involved in the present study but had experience with PD assessment. We constructed an adherence scale (available upon request) based on the manuals of the assessment procedures. Rates were asked to rate individual elements of the written report on adherence and provide an overall rating of adherence ranging from 0 (*all elements are missing, not adherent at all*) to 4 (*exceeded adherence criteria*). For the AMPD assessment, the average adherence score was 3.40 ($SD = 0.52$), and 100% of the written reports were scored as adherent or exceeding adherence criteria. For the Section II PD assessment, average adherence score was 2.80 ($SD = 0.92$), and 70% of the written reports were scored as adherent or exceeding adherence criteria.

Sample Characteristics

A total of 128 patients signed informed consent (see Figure 1). Nine participants were excluded because of varying reasons: four were excluded because later assessment revealed a total IQ score below 80, two were excluded because they never started the assessment procedure and sought treatment elsewhere, and three were excluded because they were not available on days when the research assessments took place.

The final sample consisted of 119 participants. Age ranged from 19 to 60 years old ($M = 36.16$, $SD = 11.23$), and 86 were female (72.3%). Of the 119 participants, 57 participants were randomized into the AMPD assessment procedure and 62 participants were randomized into the Section II PD assessment procedure. The average time from start to end of assessment was 26.96 days ($SD = 18.18$). There were no significant differences between the assessment procedures on age ($d = 0.24$), gender ($\varphi = .17$), or duration of assessment ($d = 0.27$). After assessment, 94 participants were eligible for treatment at De Viersprong (79.0%), and their treating clinician was contacted to fill out clinical utility questionnaires. Table 1 presents clinical characteristics of the sample.

Measures

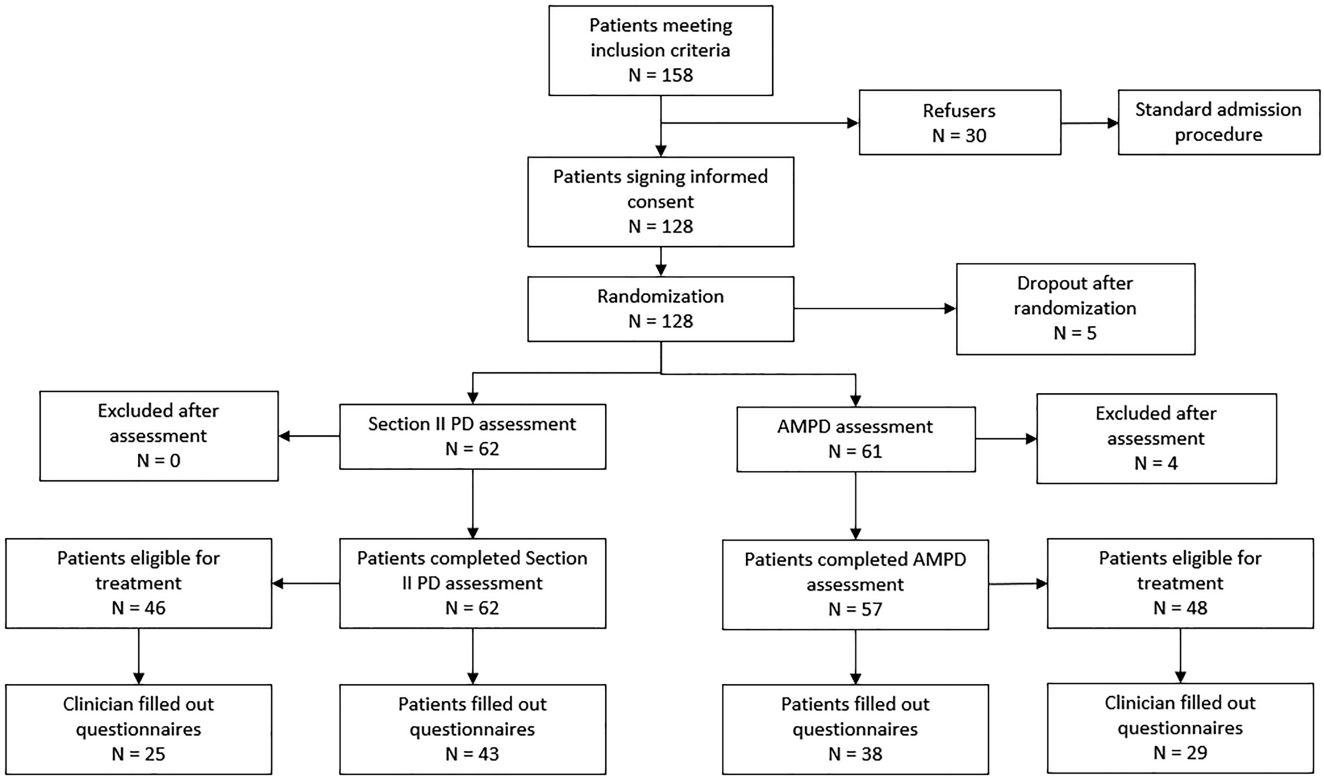
Primary Outcome Measure

Clinical Utility Questionnaire—Patient Version. A specific outcome instrument measuring clinical utility for patients was developed by our research group for the purpose of this study (Weekers et al., 2021). Given the lack of such an instrument, a focus group was organized to collect implicit patient knowledge on clinical utility of PD assessment. A group of patients was asked to brainstorm about the concept of clinical utility of assessment; this procedure was repeated with other patient groups until no new information arose (suggesting saturation). The resulting themes were described and returned to all participants in a Delphi procedure until sufficient consensus (at least 75%) was reached. Following up on consensus on the definition, specific items were formulated to assess the aspects of clinical utility that had emerged from the focus groups, until sufficient consensus was reached. We found that patients defined clinical utility of assessment as the ability of an assessment procedure to (a) be destigmatizing, (b) start a process in which the patient starts to get more insight into patterns and become hopeful and motivated to change, (c) summarize the core patterns which underly the patients' problems, (d) collaboratively work with the patient, and (e) communicate transparently with the patient about the results of the assessment. The resulting 22-item questionnaire has to be rated on a 5-point Likert scale ranging from 1 (*completely disagree*) to 5 (*completely agree*). The resulting total and domain scores range from 1 to 5. A description of the definitions of each domain, including an example question, can be found in Table 2. Internal consistency was good for the total score ($\alpha = .89$) and acceptable for the domains "destigmatizing" ($\alpha = .74$), "process enhancing" ($\alpha = .78$), "core patterns" ($\alpha = .74$), "collaborative" ($\alpha = .78$), and "transparent communication" ($\alpha = .70$).

Secondary Outcome Measures

Clinical Utility Questionnaire—Clinician Version. In a similar way as for patients, we used several focus groups and a subsequent Delphi procedure to define clinical utility of PD assessment from a clinician perspective and to formulate items to assess each of these aspects. Clinicians defined clinical utility of assessment as the ability of an assessment procedure to (a) start a process in which the patient becomes curious about the problems he is facing and gets motivated to change, (b) summarize the core patterns which underly the patients' problems, (c) give a balanced view of both

Figure 1
Flowchart of Patient Allocation and Dropout



vulnerabilities and resilience, (d) make predictions (prognostic) useful in treatment (i.e., risks, expected treatment success, expected interactional patterns, and useful treatment interventions), (e) use accessible and easy-to-understand language and paint a vivid picture of the patient, and (f) communicate transparently with the patient about the results of the assessment. The resulting 23-item questionnaire is rated on a 5-point Likert scale ranging from 1 (*completely disagree*) to 5 (*completely agree*). The resulting total and domain scores range from 1 to 5. A description of the definitions of each domain, including an example question, can be found in Table 2. Internal consistency in the present sample was good for the total score ($\alpha = .83$) and the "prognostic" domain ($\alpha = .81$) and acceptable for the domains process enhancing ($\alpha = .79$), core patterns ($\alpha = .69$), "vulnerability and resilience" ($\alpha = .71$), and transparent communication ($\alpha = .68$). The internal consistency of the domain "accessible language" was poor ($\alpha = .36$); this domain was excluded from the analyses.

Table 1
Clinical Characteristics of the Sample ($N = 119$)

	AMPD assessment ($N = 60$)		Section II assessment ($N = 59$)	
Disorders	*N*	%	*N*	%
Syndrome disorders				
Mood disorders	33	55.0	31	52.5
Anxiety disorders	24	40.0	20	33.9
Eating disorders	5	8.3	7	11.9
Somatization disorders	3	5.0	5	8.5
Substance use disorders	4	6.7	9	15.3
Any syndrome disorder	47	78.3	45	76.3
Personality disorders				
Avoidant PD	11	18.3	11	18.6
Obsessive–compulsive PD	3	5.0	3	5.1
Paranoid PD	—	—	1	1.7
Narcissistic PD	1	1.7	1	1.7
Borderline PD	20	33.3	19	32.2
Antisocial PD	0	0	2	3.4
Other/trait specified PD	25	41.7	22	37.3
Any PD	57	95.0	51	86.4

Note. AMPD = alternative model for personality disorders; PD = personality disorder.

Expectancy for Future Treatment Scale (EFTS). The EFTS is a one-item visual analog scale for patients to rate their expectancy regarding future treatment ("To what extent do you believe this intervention will benefit your future treatment?").

Client Satisfaction Questionnaire (CSQ; Larsen et al., 1979). For assessing general satisfaction with the assessment procedure, questions from the CSQ (Larsen et al., 1979) were used. The questionnaire consists of eight items rated on a 4-point Likert scale. Internal consistency in the present sample was good with $\alpha = .89$ and comparable to previous research in a Dutch sample (De Wilde & Hendriks, 2005).

Assessment Questionnaire (AQ; Finn et al., 1994). The AQ was used to assess different aspects of patient's experience of the assessment procedure. The AQ is a 48-item self-report questionnaire, with a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). It has been used in research concerning therapeutic/collaborative assessment (Allen et al., 2003; Holst et al.,

Table 2
Clinical Utility Definitions and Example Items

Clinical utility construct	Definition	Example item
Patient questionnaire		
Destigmatizing	The assessment looks beyond the diagnosis and also allows for the person behind the diagnosis to be seen. As such, the client will recognize himself/herself in the oral feedback and the written report. The assessment helps the client to not only see himself/herself as merely a diagnosis, which enhances self-acceptance and reduces shame. The client is validated for the origins of the problems.	The written report showed the person behind the diagnosis, which helps me to not just "be" the sum of my problems
Process enhancing—hope and motivation	The assessment allows the client to obtain insight into how patterns are related and strengthens the motivation and hope that treatment will help him/her to improve things. There is a focus on opportunities and potential change.	The assessment gave me hope that my current problems can change
Core problem/patterns	The assessment generates insight into the core problems and serves the client to better understand himself/herself. The assessment allows for the core problems to be discussed.	The assessment clarified recurring life patterns for me
Collaborative	In the assessment, the clinician and client work collaboratively, which instills in the client a sense of being understood and taken seriously; the clinician adjusts feedback to what the client can emotionally tolerate at that time.	During the assessment I felt I was taken seriously
Transparent communication	The clinician is sincere and transparent about the assessment findings and their conclusions and on the client's treatment prognosis.	The results of the assessment were shared in a transparent way
Clinician questionnaire		
Process enhancing	The assessment starts a process in which clients begin to see their problems in a different light and get motivated for change in subsequent psychotherapy	The assessment stimulated the client to think more about the origin and background of his/her problems
Core problem/patterns	The assessment generates information about the core of the client's problems and patterns, which allows for a coherent narrative of the client's history that integrates (often) seemingly diffuse or erratic problems and determines the focus for treatment	The assessment generated more clarity about the core of the client's problems
Vulnerability/resilience	The assessment provides a balanced view of both adaptive capacities and maladaptive characteristics of the patient	The assessment clarified the nature of the client's vulnerabilities
Prognosis	The assessment allows for predictions regarding treatment, specifically to anticipate what the patient can tolerate in treatment, which interventions and therapeutic approach are likely to be helpful, what kind of critical interactional patterns can be expected, and the probability of treatment success or failure (i.e., crisis or dropout).	The assessment clarified which therapeutic approach and interventions are likely best suited in view of the client's coping ability
Accessible language	The results of the assessment and the interaction during the assessment are communicated in an accessible, readily understandable language. The assessment paints a vivid and concrete picture of the client.	The written report paints a clear, personal, and vivid picture of the client
Transparent communication	The results of the assessment are communicated in a transparent way. The client receives all pertinent information from the assessment, and it becomes clear which parts of the diagnostic formulation are agreed upon by the client.	The results of the assessment are transparently shared

2009). The questionnaire consists of a total score and four factors: new self-awareness/understanding, positive accurate mirroring, positive relationship with the examiner, and negative feelings about the assessment. The total and domain scores range from 1 to 5. Internal consistency was good for the total AQ score ($\alpha = .88$) and ranged from acceptable ($\alpha = .74$) to good ($\alpha = .86$) for the domain scores.

Motivation for Treatment Questionnaire (MTQ-8; Van Beek & Verheul, 2008). Motivation was assessed by the MTQ-8, an eight-item self-report questionnaire composed of two factors: need for help and readiness to change. Internal consistency of the MTQ-8 is fair to good, with αs ranging from .63 to .77.

Clinical Utility Scale Clinicians. Morey et al. (2014) developed a six-item questionnaire to assess different aspects of clinical utility as rated by clinicians. Five of these items were relevant for the present study (Items 2–6) and were used as a secondary outcome to enhance comparability with other international studies. The items were rated on a visual analog scale ranging from 0 (*not useful*) to 100 (*extremely useful*).

Statistical Analyses

First, missing data were examined. Of the 119 patients, 37 (31.1%) did not fill out any questionnaires after the assessment. Reasons for not responding were unknown. Comparisons between the responders and nonresponders showed no significant differences on number of syndrome disorders ($d = 0.09$), PD status ($d = 0.08$), age ($d = 0.22$), or gender ($\varphi = .01$). Of the 82 patients who did fill out questionnaires, seven had partially missing data on one or more questionnaires. Of the 94 clinicians who were contacted to fill out questionnaires, 54 responded (57.4%). Of these 54 clinicians,

two had partially missing data on the questionnaires. Multiple imputation was used to create and analyze 30 multiply imputed data sets. Incomplete variables were imputed under fully conditional specification using the default settings of the mice 3.0 package (Van Buuren & Groothuis-Oudshoorn, 2011). The analyses were conducted in each imputed data set separately and combined using Rubin's rules. For comparison, we also performed the analyzing using listwise deletion and found no major differences.

Independent samples *t* tests were performed to assess differences between the assessment groups on all measures. As an exploratory part of our research question, we assessed the relationship between "positive relationship with the examiner" (AQ domain) and clients' clinical utility, satisfaction, and motivation for treatment ratings using linear regression analysis.

Transparency and Openness

Sample size calculations for the present study were reported, as well as an account of how missing data were handled. All measures and statistical analyses were reported, and Journal Article Reporting Standards were followed (Appelbaum et al., 2018). All data, analysis code, and research material are available upon request by contacting Laura C. Weekers. Data were analyzed using RStudio. This study was preregistered with trialsearch.who.int (Identifier NL9191).

Results

Primary Outcome: Clinical Utility Questionnaire Patients

There were no significant differences between the Section II PD and AMPD assessment on the total clinical utility score nor on the subscales (i.e., destigmatization, process enhancing, core patterns, collaborative, and transparent communication; see Table 3). Patients in the AMPD assessment did not rate the assessment as more useful than patients in the Section II PD assessment did.

Secondary Outcomes: Patient Questionnaires

No significant differences between the Section II PD and AMPD assessment were found for expectancy for future treatment (EFTS), satisfaction (CSQ), motivation for treatment (MTQ-8), and general experience of the assessment (AQ; Table 3).

Secondary Outcomes: Clinical Utility According to Clinicians

There were no significant differences between the Section II PD and AMPD groups on total clinical utility score as rated by clinicians nor were significant differences observed between the groups on subscales of the clinical utility questionnaire (i.e., process enhancing, core problems, vulnerability and resilience, prognostic, and transparent communication; see Table 4). Moreover, on the Morey clinical utility questions, no differences were found between the groups; however, several (nonsignificant) trends emerged in favor of the AMPD. Clinicians rated the AMPD model and Section II PD model as equally useful in terms of communicating with other professionals, communicating with the client, comprehensiveness, describing the global personality of the patient, and treatment planning (see Table 4).

Positive Relationship and Clinical Utility

Positive relationship with the examiner (AQ) was a significant predictor of the total clinical utility score, $F = 10.82$, $p = .001$, $R^2 = .12$. Patients who reported a more positive relationship with the examiner rated their assessment as more useful. Furthermore, positive relationship with the examiner was a small but significant predictor of satisfaction ratings (CSQ-8),, $F = 4.46$, $p = .04$, $R^2 = .06$. Positive relationship was not predictive of expectancy for future treatment, $F = 0.55$, $p = .554$, $R^2 = .01$, nor for motivation for treatment, $F = 0.46$, $p = .460$, $R^2 = .01$.

Discussion

The present study compared the clinical utility of the AMPD model to the Section II PD model as rated by both patients and clinicians in an ecologically valid RCT. No differences between the models were observed in terms of patient-rated clinical utility or clinician-rated clinical utility. Moreover, no differences were observed between the models for motivation for treatment, satisfaction, or expectancy for future treatment. We did find a significant relationship between positive relationship with the examiner and patient-rated clinical utility and satisfaction, with patients who reported a more positive relationship with their assessor rating the assessment as more useful and more satisfying.

Our results are partially in line with but, with regard to some aspects, also markedly different from previous research on clinician-rated clinical utility. Morey et al. (2014) compared the clinical utility of Criterion A and B of the AMPD model separately with the Section II PD model and reported superior clinical utility ratings for the Section II PD model on ease of use and communication with other professionals, while no differences were found on clinical utility ratings between the Section II PD and Criterion A for communicating with patients, comprehensiveness, treatment planning, and global descriptive ability. Criterion B was superior compared to the Section II PD model on all clinical utility ratings except professional communication. Bornstein and Natoli (2019) also demonstrated in a meta-analysis that traits (AMPD or five-factor model) were generally rated by clinicians as more useful than the Section II PD model. Although we did not find significant differences between the models, a consistent trend in favor of the AMPD model was observed for several clinical utility questions Morey et al. (2014) formulated (with effect sizes around 0.30–0.40) pertaining to communication with the patient, comprehensiveness, treatment planning, and global descriptive ability, which might suggest slight preference in terms of utility for the AMPD assessment. Of note, power analysis was based on the patient variables, which rendered our study slightly underpowered for detecting significant differences in clinicians (as not all patients were allocated for subsequent treatment).

Previous studies are different from the present study in several respects. In our study, the complete AMPD assessment was rated on clinical utility instead of separate elements of the model. Also, the clinicians rating the assessment model did not perform the assessment themselves but rated the utility of the assessment after reading the written report and seeing the patient for the first time. Furthermore, with our RCT design, clinicians were asked to rate only one model on experienced clinical utility and were not able to compare the assessment models relative to each other. The study by Morey et al. (2014) asked clinicians to rate already familiar patients on both models and

Table 3
Independent Samples t *Tests for the Patient Questionnaires (N = 119)*

Scale	Section II, *M* (*SD*)	AMPD, *M* (*SD*)	*t* value	*p* value	Cohen's *d*
CUQ total	3.69 (0.40)	3.66 (0.52)	−0.32	.750	0.07
CUQ destigmatizing	3.73 (0.70)	3.63 (0.78)	−0.78	.438	0.14
CUQ process enhancing	3.54 (0.67)	3.50 (0.64)	−0.38	.703	0.06
CUQ insight	3.35 (0.78)	3.48 (0.97)	0.79	.433	0.15
CUQ collaborative	4.37 (0.62)	4.29 (0.72)	−0.61	.546	0.12
CUQ transparent communication	3.69 (0.71)	3.69 (0.73)	0.05	.963	0.00
EFTS	67.70 (25.03)	68.95 (24.68)	0.27	.789	0.05
CSQ total	24.48 (4.90)	25.44 (5.28)	1.04	.302	0.19
AQ total	3.38 (0.40)	3.41 (0.36)	0.35	.725	0.08
AQ new self-awareness	3.14 (0.53)	3.10 (0.50)	−0.48	.635	0.08
AQ positive accurate mirroring	3.09 (0.58)	3.08 (0.66)	−0.03	.974	0.02
AQ positive relationship	3.64 (0.56)	3.73 (0.56)	0.75	.458	0.16
AQ negative feelings	2.29 (0.86)	2.21 (0.70)	−0.57	.572	0.10
MTQ total	50.00 (7.19)	49.70 (7.67)	−0.22	.827	0.04

Note. AMPD = alternative model for personality disorders; CUQ = Clinical Utility Questionnaire; EFTS = Expectancy for Future Treatment Scale; CSQ = Client Satisfaction Questionnaire; AQ = Assessment Questionnaire; MTQ = Motivation for Treatment Questionnaire.

compare the utility of these models. Our design constitutes a more stringent test of the clinical utility of the AMPD model.

To our knowledge, the present study is the first to compare the Section II PD and full AMPD assessment in terms of patient-rated clinical utility and experience of the assessment. Contrary to our expectations, patients rated both models as equally useful in all respects. Not the employed assessment model but the relationship with the assessor was related to experienced utility and satisfaction. We hypothesized that the AMPD model might provide the clinician with more tools to form a positive relationship with clients than the Section II PD model; however, no such differences emerged. One explanation is that we had experienced clinicians who had been working with PD patients for several years. One of the major challenges and goals in working with PD patients is forming and maintaining an alliance. It makes sense that all clinicians working in this specialized setting are skilled in building a strong alliance, independent of what "language" or model they have to use. Our results are in line with the body of research on treatment alliance and outcome in psychotherapy (i.e., Norcross & Lambert, 2018). Although therapeutic alliance is a broader concept than we assessed in the current study, forming an emotional bond (e.g., a positive relationship) is one aspect of therapeutic alliance (Bordin, 1979). Therapeutic alliance has consistently been associated with treatment outcome across a range of psychotherapies (Baier et al., 2020; Flückiger et al., 2018; Martin et al., 2000). Our results suggest that alliance in the assessment phase—often ignored in assessment research—is also related to experiencing an assessment as useful and a higher satisfaction with the assessment. Holst et al. (also using the AQ; 2009) found similar results in the context of neuropsychological assessments: a positive relationship was related to a higher level of satisfaction.

However, other reasons for a lack of superiority of the AMPD model from a patient's perspective may also be related to features of the AMPD itself. Aspects of the assessed client utility of an assessment related to, for example, the destigmatizing nature of the assessment procedures and outputs, or the increased insight into one's own core patterns. The AMPD still uses a typological approach, including potentially stigmatizing labels like borderline PD. New Criterion B concepts, including "antagonism" or "negative affectivity," are likely not less stigmatizing, while some Criterion A descriptors, like

Table 4
Independent Samples t *Tests for the Clinician Questionnaires (N = 94)*

Scale	Section II, *M* (*SD*)	AMPD, *M* (*SD*)	*t* value	*p* value	Cohen's *d*
CUQ total	3.62 (0.40)	3.55 (0.36)	−0.80	.426	0.19
CUQ process enhancing	3.48 (0.52)	3.27 (0.61)	−1.84	.071	0.37
CUQ core patterns	3.62 (0.85)	3.66 (0.93)	0.25	.802	0.05
CUQ vulnerability and resilience	3.68 (0.81)	3.51 (0.80)	−1.02	.314	0.21
CUQ prognostic	3.41 (0.72)	3.59 (0.64)	1.25	.216	0.27
CUQ transparent communication	3.92 (1.02)	3.73 (1.08)	−0.80	.429	0.18
How useful do you feel this PD model is for communicating information about this individual with other mental health professionals?	78.36 (16.78)	78.11 (16.78)	−0.08	.935	0.02
How useful are these concepts for comprehensively describing all the important personality problems the individual has?	76.18 (19.31)	83.57 (18.83)	1.78	.084	0.39
How useful do you feel this PD model is for communicating information about the individual to himself or herself?	73.81 (18.69)	79.95 (17.85)	1.65	.106	0.34
How useful is this PD model for helping you to formulate an effective intervention for this individual?	68.22 (21.12)	75.53 (21.85)	1.59	.119	0.34
How useful is this PD model for describing the individual's global personality?	66.37 (24.81)	72.91 (20.22)	1.39	.172	0.29

Note. CUQ = Clinical Utility Questionnaire; AMPD = alternative model for personality disorders; PD = personality disorder.

"experience of a unique self… organized around perceived external persecution," may be complex and in need for "translation" to be fully useful for patients. Therefore, from a patient's perspective, the AMPD may benefit from rewording and simplification.

We did not find the expected superiority of the AMPD model with respect to clinician-rated clinical utility. However, when taken into account that the (end user) clinicians were very familiar with the Section II PD model and less so with the AMPD model, these results are encouraging. Clinicians (again, not involved in the assessment) rated the models as equally useful for communicating with other professionals and all other aspects of clinical utility, even though the AMPD constitutes a whole set of new constructs with which professionals were not familiar yet. Familiarizing clinicians with the AMPD model will conceivably aid experienced utility of the model in the future. Furthermore, most clinicians conducting the AMPD assessment had to familiarize themselves with a new model, while the clinicians conducting the Section II assessment had been working with this model for years. That both groups provide equally useful assessments according to the end users, despite the differences in familiarity between the models, is at least reassuring. Of note, there was a slight difference in adherence between the models, the Section II PD assessors were less adherent to the model than the AMPD assessors, although still 70% of our random sample was rated as adherent. One explanation could be that the Section II PD assessors were previously used to incorporating different theories (schema, psychodynamic, etc.) into their case formulations, which may have made it harder to be adherent to the (a-theoretical) Section II PD model. Lastly, our results are in line with many treatment intervention studies in which two well-described and protocolized interventions generally perform equally well, independent of their theoretical background (Cristea et al., 2017).

Our study has several strengths and limitations. First, a major strength is the RCT design which randomized patients over the assessment models and made direct comparisons possible. Second, the study was integrated into routine clinical practice, which aids ecological validity. Third, we conducted both assessment procedures according to detailed protocols and carefully trained the clinicians in their respective models. Most limitations of the current study pertain to the clinician variables. We included only four assessment clinicians in the AMPD assessment procedure and seven in the Section II assessment procedure, which may well have impacted the respective results of both assessment models. Accordingly, we were not able to meaningfully assess (differences in) experienced utility as rated by the assessment clinicians working with the AMPD or Section II PD models. Moreover, assessment clinicians were not randomized over the assessment models. Furthermore, most clinicians had years of experience working with the Section II PD model, while the experience of the clinicians in the AMPD assessment with the model ranged from none to only few years. A replication of our study with a larger number of assessment clinicians is warranted. Furthermore, we selected the semi-structured interview for personality functioning *DSM-5* to assess level of personality functioning in the AMPD condition. It bears mentioning that the SCID AMPD module I would have been a valid alternative that is highly compatible with the choice of the SCID AMPD module 2. Our selection was guided by conceptual fit, availability, and favorable psychometric properties in similar (Dutch) samples. Also, the current study may have been a too stringent test of clinical utility, as we compared the AMPD assessment to a Section II PD assessment conducted in a highly specialized center with clinicians with years of experience in working with PD patients. Future studies may compare the utility of the AMPD model to "assessment as usual" in a more general psychiatric unit. Furthermore, a substantial percentage of data was missing, although to mitigate this concern, we handled missing data with multiple imputation, which is regarded as a state-of-the-art, flexible technique in which the imputations stay close to the data. Lastly, this study used the AMPD assessment approach. Though highly similar to the AMPD, a replication of this study using the *International Classification of Diseases*, 11th revision framework would be timely and helpful for World Health Organization member states that are about to implement a new dimensional classification of PDs.

In conclusion, from a clinical utility perspective, the AMPD assessment was not superior to the Section II PD assessment, in terms of clinician- or patient-rated utility. There are, of course, many other reasons to choose one classification system over the other, such as general acceptability of the model in clinical practice and validity.

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