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Client and Clinical Utility of the Assessment of Personality Disorders

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Abstract: Clinical utility and client utility are important desirable properties when developing and evaluating a new classification system for mental disorders. This study reports on four focus groups followed up by a Delphi study among clinicians working with clients with personality disorders (PD) and clients with PD themselves to harness both user groups' perspectives on the utility of PD diagnosis. Our findings show that the client and clinician views of the concept of utility were closely aligned and include aspects of transparency of communication and the ability of an assessment to enhance hope, curiosity, motivation, and insight into a client's personality patterns. Unique to clinicians' appraisal was the ability of an assessment to capture both vulnerabilities and resilience of clients and to give information about the prognosis in treatment. Unique to clients' appraisal was the ability of an assessment to be destigmatizing and collaborative. These findings may serve to expand our definition and measurement of clinical utility, in that collaborative and nonstigmatizing procedures likely promote client acceptability. To capture both aspects, we offer two preliminary questionnaires (*i.e.*, item sets open to further empirical testing) based on the data derived from the Delphi procedure.

Key Words: Clinical utility, personality assessment, focus group, personality disorders

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Clinical utility has been identified as a top priority for personality disorder (PD) assessment, in both the new *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (*DSM-5*) (American Psychiatric Association, 2013) and *ICD-11* (World Health Organization, 2020) classification systems (First, 2005; Keeley et al., 2016; Reed, 2010; Skodol and Bender, 2009). First et al. (2004) defined clinical utility in terms of five core diagnostic functions of a diagnostic system: a) the way through which diagnostic entities are being conceptualized, b) the way through which clinically useful information is communicated to relevant others, c) the ease of use of the diagnostic categories and criteria, d) the extent to which the diagnostic system enables choosing effective interventions to improve clinical outcomes, and, finally, e) the capacity of the diagnostic system to predict and anticipate future clinical management needs.

DSM-5 (American Psychiatric Association, 2013) and *ICD-11* (World Health Organization, 2020) PD classifications have shifted toward dimensional models of classification. However, several authors expressed concerns with respect to the clinical utility of the proposed dimensional models in *DSM-5* and *ICD-11* (Clarkin and Huprich, 2011). In fact, these concerns were a principal consideration in relegating the *DSM-5* alternative model for personality disorders (AMPD) to Section III (Emerging Measures and Models) instead of Section II. At present, several empirical studies have documented superior clinician ratings of clinical utility of dimensional models relative to categorical models (Hansen et al., 2019; Lowe and Widiger, 2009.

Interestingly, although other aspects of the new classification systems of *DSM-5* and *ICD-11* have been studied extensively (*e.g.*, reliability and validity; see Zimmermann et al., 2019, for a comprehensive overview), only few studies have focused on clinical utility (Bornstein and Natoli, 2019; Milinkovic and Tiliopoulos, 2020). Clinical utility is comprehensively defined and measured. A six-item questionnaire, developed by Samuel and Widiger (2006), was used in several empirical studies (Hansen et al., 2019; Lowe and Widiger, 2009; Morey et al., 2014; Mullins-Sweatt and Widiger, 2011), and Kotelnikova and Clark (Kotelnikova Y, Clark LA Clinical Utility Rating Form [unpublished]) designed a 14-item questionnaire. Both instruments were developed "top-down" by expert clinical researchers based on the above-mentioned definition, which included acceptability, communication, ease of use, and value for treatment planning. Although these measures are definitely useful, it may prove beneficial to also enlist the perspective of the ultimate users of the assessment: the PD client. Therefore, we conducted two focus group procedures, followed by a Delphi study, to design an inductive definition and associated measures of utility of PD assessment based on input from professionals (*i.e.*, clinical utility) and clients (*i.e.*, client utility).

METHODS

Participants

Participants—clinicians and clients—were initially recruited at Viersprong, a mental health care facility specializing in the assessment and treatment of adolescents and adults with PDs. A second group of clinicians and a second group of clients were recruited from other mental health care institutions to retrieve additional information. As no significant new information emerged from these groups, we considered the input to be "saturated," as in sufficiently comprehensive and representative.

Between December 2019 and March 2020, three live focus groups were organized: two focus groups with clinicians and one focus group with clients who had completed PD treatment. Because of the COVID-19 crisis, we had to reconsider the format of the second focus group and therefore asked them for written input. The first clinician focus group consisted of seven clinicians working at the Viersprong. Their clinical experience ranged from 3 to 32 years (mean, 14.07; SD, 9.90), and they had been trained in a variety of treatment modalities, that is, mentalization-based treatment (MBT), schema-focused therapy (SFT), cognitive-behavioral therapy, transactional analysis, psychodynamic psychotherapy, and dynamic interpersonal therapy. The second focus group consisted of five experienced clinicians working in five other mental health care facilities specialized in treating PDs. Their clinical experience ranged from 20 to 32 years (mean, 26.20; SD, 4.82). Their theoretical background was also diverse; that is, these clinicians were trained in (one or more of) psychoanalytic psychotherapy, SFT, MBT, transference-focused psychotherapy, dialectical behavioral treatment, and/or indicated an eclectic orientation. Of the 12 participants, 8 responded to the subsequent Delphi rounds.

The first client focus group consisted of three clients who had completed their treatment at Viersprong and were recruited through the client board. Their ages ranged from 29 to 63 (mean, 42.33; SD, 18.15). Two female clients were included who had been treated for borderline PD with MBT (four, respectively, 10 years before the focus group), and a male client was included who had recently completed

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SFT for avoidant PD. Two of the three participants responded to the subsequent Delphi rounds. The second client group consisted of six clients (two female and four male), all treated for cluster C PD and recruited through the expertise center for PD (Kenniscentrum persoonlijkheidsstoornissen). Because of the onset of the COVID-19 crisis, no live focus groups could be organized, and their input therefore was collected in a written format. These clients were between 29 and 57 years old (mean, 48.33; SD, 10.50), and all responded to the first and second Delphi rounds. Five clients responded to the third Delphi round.

TABLE 1. Clinical Utility Definitions and Questions: The Clinician Perspective

Construct	Definition	Items
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.	1. The assessment stimulated the client to think more about the origin and background of his/her problems
		2. The assessment stimulated client awareness of what is needed to be able to change
		3. The assessment stimulated new insights and increased awareness in the client
		4. The assessment led the client to a better understanding of the core themes and their interrelatedness with respect to his/her problems
Curiosity	The client becomes curious about the origins of his/her symptoms and gets into an inquisitive, self-observing mode ("psychotherapy" mode).	5. The assessment stimulated the client to become more curious about the origin and interrelatedness of his/her problems
Motivation	The client becomes intrinsically motivated for treatment; the willingness to change is enhanced by the assessment.	6. The assessment stimulated the client to become more willing to implement necessary changes for dealing with his/her problems
		7. The assessment stimulated the client to become more motivated to work on his/her problems in treatment
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.	8. The assessment generated more clarity about the core of the client's problems
		9. The assessment generated a clear treatment focus
		10. The assessment clarified pervasive patterns in the clients' life history
Vulnerability/resilience	The assessment provides a balanced view of both adaptive capacities and maladaptive characteristics of the patient.	
Severity of personality problems	The assessment yields information regarding the severity of personality problems, *e.g.*, defense mechanisms, ego strength, level of identity integration, presence of (self-) destructive behavior.	11. The assessment generated a clear indication of the severity of the personality problems
		12. The assessment clarified the nature of the client's vulnerabilities
Resilience	The assessment generates information on aspects of the client's adaptive or healthy functioning (*e.g.*, mentalizing abilities, motivation to change, social network/quality of interpersonal relationships).	13. The assessment clarified the client's adaptive potential and strengths
		14. The assessment clarified protective and adaptive factors in the client's environment
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, the probability of treatment success or failure (*i.e.*, crisis or dropout).	15. The assessment clarified which therapeutic approach and interventions are likely best suited in view of the client's coping ability
		16. The assessment allows for predictions regarding the probability of treatment success
		17. The assessment allows for predictions regarding possible pitfalls and risks the client may face during treatment
		18. The assessment allows for predictions regarding the nature of critical interactions between the patient and therapist, or group
		19. The assessment allows for predictions regarding which therapeutic stance and interventions are helpful to the client
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.	20. The written report paints a clear, personal, and vivid picture of the client
		21. The written report is accessibly written and easy to understand
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.	22. The results of the assessment are transparently shared
		23. It becomes clear which aspects of the clinical formulation the clinician and client agree and disagree on (if applicable)

Procedure

The focus groups were organized as 2-hour sessions structured around a loose interview guideline and conducted by the two primary researchers (L. W. and J. H.). The main objective was to define and operationalize "clinical utility and client utility of assessment procedures for personality disordered patients." The open group discussion was focused on the broad open-ended question "What makes an assessment procedure useful/helpful for you?" and was followed by more specific questions concerning clinical utility derived from the literature. More specifically, three aspects of clinical utility were explicitly checked for relevance: ease of use, communication, and treatment planning (First et al., 2004; Mullins-Sweatt and Widiger, 2009).

The focus groups were followed by a Delphi procedure to come to an agreement upon the definition and upon specific items for a "clinical and client utility" questionnaire in both groups (clients and clinicians). Based on the focus group input, both interviewers independently identified core themes and discussed until they agreed on the relevant themes for clinicians and clients separately. Participants from both samples then received an overview of identified themes and proposed definitions by e-mail and were asked to rate the degree to which they agreed with these constructs and definitions (completely disagree, disagree, agree, or completely agree). Constructs were revised when less than 75% of the participants agreed with the definition, and new feedback rounds were held until agreement met the 75% standard. After agreement on definitions, the researchers developed items to assess each of the core themes. These items were e-mailed to the participants and revised when there was less than 75% agreement on any given item. Again, feedback rounds were repeated until there was 75% agreement on all items.

TABLE 2. Client Utility Definitions and Questions: The Patient Perspective

Construct	Definition	Items
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 him/herself in the oral feedback and the written report. The assessment helps the client to not only see him/herself as merely a diagnosis, which enhances self-acceptance and reduces shame. The client is validated for the origins of the problems.	1. The written report showed the person behind the diagnosis, which helps me to not just "be" the sum of my problems 2. The written report described my problems in a respectful way 3. The assessment helped me to better accept myself 4. The assessment helped me to be less judgmental toward myself because of my problems and diagnosis
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.	5. The assessment made me think more about the origin and background of my problems 6. The assessment made me more aware of what is needed to change 7. The assessment made me more curious about the origins of my problems as well as how they are interrelated 8. I learned things about myself during the assessment that I was not clearly aware of before 9. The assessment made the primary themes behind my problems and my patterns of behavior clearer to me 10. The assessment gave me hope that my current problems can change 11. The assessment made me more motivated to work on my problems in treatment 12. The assessment was not only focused on problems, but also on the potential to make positive changes
Insight—core problem	The assessment generates insight into the core problems and serves the client to better understand him/herself. The assessment allows for the core problems to be discussed.	13. The assessment gave me more clarity about the core of my problems 14. The assessment clarified recurring life patterns for me 15. After the assessment it was clear to me what the focus of treatment should be
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.	16. During the assessment, there was a positive collaboration between the clinician and me 17. During the assessment I felt I was taken seriously 18. During the assessment, the clinician was attuned to my level of emotional tolerance
Transparent communication	The clinician is sincere and transparent about the assessment findings and their conclusions and on the client's treatment prognosis.	19. The results of the assessment were shared in a transparent way 20. The clinician explained what the conclusions were based on 21. The clinician openly discussed with me which parts of the conclusion we agreed and (if applicable) we disagreed on 22. The clinician discussed the expected result of treatment with me

RESULTS

Part 1: Constituting of Client and Clinical Utility

Independent identification of core relevant themes from the clinicians' focus group discussion revealed a high level of convergence between the primary researchers (L. W. and J. H.). Ninety percent of themes in the first focus group and 100% of themes in the second focus group were agreed upon. Disagreement was resolved by further discussing the themes. To design an accessible definition, the researchers set out to independently organize these themes into at most six overarching categories. Although wording was slightly different, the researchers were readily in agreement about six principal categories. The agreed upon categories that were deemed to constitute the clinicians' definition of clinical utility were a) process (subdivided into motivation and curiosity), b) insight in patterns, c) vulnerability/resilience (subdivided into severity of personality problems and resilience), d) prognosis, e) accessible language, and f) transparent communication.

The same procedure was used to infer common themes from both client focus groups. There was a high level of agreement between the researchers (five of six themes), and disagreement was resolved by further discussing the themes. The constructs deduced from the client focus groups were a) process (subdivided in to hope and motivation), b) insight in patterns, c) destigmatization, d) collaboration, and e) transparency.

Next, the appraisals of client and clinical utility, with their constituting core themes and related definitions, were sent back to both client and clinician groups separately to come to an agreement upon definitions. Both groups were asked for their agreement and for potential suggestions until sufficient consensus was reached, which required one round in both groups. The resulting definitions can be found in Tables 1 and 2.

Part 2: Preliminary Design of a Clinical Utility Questionnaire

Based on the agreed-upon definitions, the first two authors (*i.e.*, L. W. and J. H.) formulated items that were deemed to capture as closely as possible the intended meaning of the pertinent constructs. Given the overlap between clinician's and client's definitions, we tried to formulate similar items if possible and appropriate. All items were presented in a Delphi procedure until sufficient (*i.e.*, above 75%) consensus was reached for each item. For the clinician questionnaire, agreement was achieved after the first feedback round. Some items were slightly altered based on the feedback provided by the participants. For the client questionnaire, a second feedback round was necessary to obtain sufficient consensus. Items for both questionnaires can be found in Tables 1 and 2. Of course, these items are in need of psychometric testing, and we provide these here as targets for future research.

DISCUSSION

In this study, we developed two preliminary questionnaires to capture the utility of PD assessments: a client and a clinician version. The item sets were based on discussion in four focus groups with subsequent Delphi rounds among clinicians with extensive experience working with clients with PD and (former) PD clients themselves. Interestingly, clients and clinicians agreed on several utility themes, with only few themes emerging that were unique to the client or clinician samples. Both groups highlighted the importance of transparency of communication and the ability to enhance hope, curiosity, motivation, and insight into patterns. Unique to clinicians' clinical utility definition was the ability of an assessment to capture both vulnerabilities and resilience of clients with PD and to give information about the prognosis in treatment. Unique to clients' clinical utility operationalization was the ability of an assessment to be destigmatizing and collaborative.

Several themes that emerged from the focus groups were similar to the clinical utility definitions from the existing literature, such as the importance of easily understandable language and transparent communication (communication; First et al., 2004), and the importance of prognostic information that can be used to select effective intervention (treatment planning; First et al., 2004). However, there were also several aspects nominated that add to the extant clinical utility definitions. For example, both clients and clinicians emphasized the importance of engaging the client (collaboratively) and emphasized the ability of an assessment to start a process in which the client becomes curious about him/herself, hopeful, and motivated to change (see also Kamphuis and Finn, 2019, for a discussion on epistemic trust in therapeutic assessment). Furthermore, clients highlighted the role an assessment can play in destigmatizing the client. Possibly, these aspects were highlighted given the specific nature of our samples: engaging clients, enhancing motivation, decreasing negative self-images (stigma), and increasing self-understanding may be especially pivotal in clients with PD within a psychotherapeutic setting and therefore be specifically highlighted.

We believe the strength of the current definitions (and the proposed preliminary questionnaires) derives from the user-informed construction, using clients' and clinicians' appraisals of utility of assessment combined with information from the existing clinical utility literature. These client appraisals may serve to expand the more traditional definition and measurement of clinical utility in that collaborative and nonstigmatizing procedures likely promote client acceptability, which is crucial to the efficacy of any diagnostic procedure. Some caution is warranted with respect to the limits of the generalizability of our findings: all participating clients were or had been involved in psychotherapy.

DISCLOSURE

The authors declare no conflict of interest.

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