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Psychological Assessment With the DSM–5 Alternative Model for Personality Disorders: Tradition and Innovation

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The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5) Section III Alternative Model for Personality Disorders (AMPD; APA, 2013) represents an innovative system for simultaneous psychiatric classification and psychological assessment of personality disorders (PD). The AMPD combines major paradigms of personality assessment and provides an original, heuristic, flexible, and practical framework that enriches clinical thinking and practice. Origins, emerging research, and clinical application of the AMPD for diagnosis and psychological assessment are reviewed. The AMPD integrates assessment and research traditions, facilitates case conceptualization, is easy to learn and use, and assists in providing patient feedback. New as well as existing tests and psychometric methods may be used to operationalize the AMPD for clinical assessments.

Keywords: DSM–5, personality disorders, personality assessment, Level of Personality Functioning Scale, PID–5

Supplemental materials: http://dx.doi.org/10.1037/pro0000071.supp

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5) Section III Alternative Model for Personality Disorders (AMPD) provides an empirically based, pantheoretical approach to psychological assessment for the purposes of...
diagnosing personality disorders (PDs) and assessing personality-related problems in living. Severity and style of personality dysfunction are evaluated conjointly through ratings for overall level of personality impairment and specific pathological personality traits. These ratings generate hybrid categorical-dimensional PD diagnoses in addition to dimensional indices of personality psychopathology. Psychological evaluation conducted through the lens of the AMPD generates both psychiatric diagnosis and a psychometric profile of clinical data that can serve as a relatively comprehensive personality assessment.

The AMPD joins two conceptual planes of personality pathology. The first plane covers disturbances in self and interpersonal functioning. The second involves dimensions of maladaptive personality traits assessed through five broad trait domains that are partitioned into 25 narrower trait facets. A key feature of the AMPD is that these two conceptual planes are derived from major traditions in psychological assessment as well as decades of empirical research (Bender, Morey, & Skodol, 2011; Krueger & Markon, 2014). This heritage confers scientific and practical advantages. The continuity with clinical assessment traditions facilitates ease of learning and application (Morey, Skodol, & Oldham, 2014).

Importantly, the AMPD accommodates clinicians of varying backgrounds much in the same way that the psychotherapy integration movement bridges theoretical orientations. By virtue of its grounding in established practices of clinical assessment and empirical study, the AMPD rests on and benefits from the preexisting foundations of clinical assessment, and possesses an intrinsic evidence base. The concepts and variables in the AMPD will be generally familiar to any psychologist with training in personality assessment, making the system relatively easy to use and measurable via validated assessment methods.

The goals of this article are to introduce the AMPD to practitioners, highlight its roots in established paradigms of personality assessment, briefly review clinical utility and validity evidence, and demonstrate application via a case example. This review of the AMPD emphasizes two themes: its paradigmatic pluralism and kinship to established methods of psychological testing. Table 1 lists key features of the AMPD.

### Development, Description, and Conceptual-Empirical Origins

Zachar, Krueger, and Kendler (2016) provided a fascinating “oral history” of the genesis of the AMPD compiled from interviews with many of the participants involved in revising PD diagnosis for the DSM–5. The reader is referred to this article for details, but, briefly, the process of revision traces to Kupfer, First, and Reiger (2002) in A Research Agenda for DSM–5.1 Eleven conferences took place over several years in which concepts, research, and proposals were reviewed. The Personality and Personality Disorder Work Group examined complex and competing issues and proposals such as prototype versus dimensional diagnosis and the evidential value of clinical experience versus empirical data. The Work Group concluded a hybrid approach to PD diagnosis (Krueger, Skodol, Livesley, Shroft, & Huang, 2007) could enhance acceptance by striking a balance between introducing dimensional elements, which have substantial empirical support, while preserving continuity with extant DSM categories with demonstrated clinical traction. For example, in the DSM–5, Antisocial PD, a categorical concept, can be viewed as dysfunctional behavior related to a combination of dimensions including manipulativeness, callousness, deceitfulness, hostility, risk taking, impulsivity, and irresponsibility.

The AMPD was approved by the DSM–5 Task Force, but the Board of Trustees of the American Psychiatric Association (APA) retained the traditional categorical approach (essentially the DSM–IV PDs) in Section II. Zachar et al. (2016, p. 8) stated, “as an ‘official’ alternative, the hybrid model is a recognized competitor to the traditional categorical model.” Declared by the APA as an Alternative Model, the AMPD legitimately complements the DSM–5 Section II PD diagnoses and has practical relevance for clinicians. Indeed, the DSM–5 allows for formal coding of the AMPD through use of the DSM–5 code “Other Specified Personality Disorder (301.89).”

Diagnosis with the AMPD requires fulfilling seven general criteria for PD (DSM–5, p. 761). Most innovative are the first two criteria, Criterion A (level of personality functioning) and Criterion B (maladaptive personality traits). Criterion A involves assessment of disturbance in self functioning (identity and self-direction) and interpersonal functioning (empathy and intimacy). Criterion B involves assessment of pathological personality traits which are organized into five broad trait domains composed of 25 specific trait facets. Criteria C through G cover issues of pervasiveness, stability, early emergence, discrimination from other mental disorders, effects of substances, and developmental stage or sociocultural environment. Table 2 depicts a schematic of Criterion A and B; the reader is referred to Supplemental Tables S1 and S2 in the online supplemental material for detailed descriptive tables reprinted with permission from the DSM–5.

The AMPD permits diagnosis of six specific PD categories through algorithms for combining ratings of maladaptive traits and

<table>
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<th>Table 1</th>
<th>Highlights of the Alternative Model for Personality Disorders</th>
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<td></td>
<td>• Derives from major assessment traditions and empirical research</td>
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<td>• Dimensionalization of diagnosis: hybrid categorical-dimensional diagnoses + dimensional indices</td>
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<td>• Replaces Personality Disorder-Not Otherwise Specified with more useful Personality Disorder-Trait Specified</td>
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<td></td>
<td>• Simultaneously a diagnostic classification and a psychometric profile</td>
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<td>• Consistent with Empirically Supported Treatment methods</td>
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1 Dimensional representation of PD also was argued prior to and shortly after publication of the DSM–III and every edition since (see Zachar et al., 2016).

2 The diagnosis Other Specified Personality Disorder involves specification. Specification may be done with the AMPD. In this way the AMPD may be medically coded (301.89).
DSM-5 constructs are available in the online supplemental material and in the (see Krueger & Markon, 2014). Definitions and further detail on these psychopathological personality dimensions do not show simple structure. Domains may be rated globally or facets may be rated individually on a Criterion B consists of five trait domains (bolded) and 25 trait facets. This aims to correct the problem of the ambiguous and ubiquitous “PD NOS” diagnosis (e.g., PD-TS with suspiciousness, restricted affectivity, and hostility may diagnose “paranoid PD”). This includes a focus on self and other boundaries, dynamics of self-esteem regulation, and emphasis on mode of interpersonal relatedness (Hopwood, Wright, Ansell, & Pincus, 2013). Criterion B prominently reflects the Wiggins (2003) multivariate, empirical, and interpersonal paradigms. For example, the five broad, higher-order trait domains and the more narrow 25 trait facets of Criterion B parallel FFM s that derive from quantitative models of normal and abnormal personality data (Krueger & Markon, 2014). Benefitting from the cumulative wisdom of each of these great paradigms of personality assessment, the AMPD is at once both traditional and innovative.3

### Table 2

<table>
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<tr>
<th>Schematic of DSM-5 Alternative Model for Personality Disorders (AMPD) Criterion A and Criterion B</th>
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<tr>
<td><strong>AMPD Criterion A</strong></td>
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<tr>
<td>Identity</td>
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<td>Self-direction</td>
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<td>Empathy</td>
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<td>Intimacy</td>
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<tr>
<td><strong>AMPD Criterion B</strong></td>
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<tr>
<td>Personality disorder trait domains (broad) and facets (narrow)</td>
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<tr>
<td><strong>Negative affectivity:</strong> emotional lability; anxiousness; separation insecurity; submissiveness; hostility; perseveration; depressivity; suspiciousness; restricted affectivity</td>
</tr>
<tr>
<td><strong>Detachment:</strong> withdrawal; intimacy avoidance; anhedonia; depressivity; restricted affectivity; suspiciousness</td>
</tr>
<tr>
<td><strong>Antagonism:</strong> manipulativeness; deceitfulness; grandiosity; attention seeking; callousness; hostility</td>
</tr>
<tr>
<td><strong>Disinhibition:</strong> irresponsibility; impulsivity; distractibility; risk taking; rigid perfectionism</td>
</tr>
<tr>
<td><strong>Psychoticism:</strong> unusual beliefs and experiences; eccentricity; cognitive and perceptual dysregulation</td>
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**Note.** Moderate impairment is required for diagnosis of Criterion A, defined as >2 or more component ratings of >2 on a 0–4 point scale. Criterion B consists of five trait domains (bolded) and 25 trait facets. Domains may be rated globally or Facets may be rated individually on a 0–3 scale. Overlap of facets on more than one domain occurs because psychopathological personality dimensions do not show simple structure (see Krueger & Markon, 2014). Definitions and further detail on these constructs are available in the online supplemental material and in the DSM-5, Section III.

specific forms of dysfunction. These are antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal PDs (these six PDs were chosen for inclusion on the bases of empirical support and clinical relevance, and their diagnostic algorithms were calibrated with known prevalence rates of the PDs). Maladaptive personality patterns not covered by these algorithms (which also include PD syndromes such as paranoid, schizoid, histrionic, dependent, and self-defeating) are diagnosed as PD Trait-Specified (PD-TS). In a PD-TS diagnosis, the specific clinically significant traits are stated in lieu of an overarching category (e.g., PD-TS with suspiciousness, restricted affectivity, and hostility may diagnose “paranoid PD”). This aims to correct the problem of the ambiguous and ubiquitous “PD NOS” diagnosis (Verheul, 2005) by providing a scheme for characterizing the numerous patients who do not fit well into available PD categories. In a related manner, significant traits can be included with categorical diagnoses when indicated, conveniently providing the clinician with information about patient personalities that is not captured by the specific PD category.

**Paradigms of Personality Assessment Within the AMPD**

The AMPD is not necessarily “new” to professional psychologists with a background in psychological assessment because it integrates several historically prominent clinical approaches to personality. To make this point, we refer to Wiggins’ (2003) articulation of five “paradigms” in personality assessment that differ in foci, scope, academic lineage, and preferred tests. The psychodynamic paradigm focuses on internal conflict and mental models (e.g., inner schema, representations) and often makes use of performance-based tests such as the Rorschach or TAT. The interpersonal paradigm focuses on dynamic social relations, and uses interpersonal circumplex based measures for assessment. The multivariate paradigm is methodologically oriented to factor analytic models, as instantiated in the Five Factor Model (FFM) instruments. Exemplar instruments of the inductive empirical paradigm in clinical settings include the Minnesota Multiphasic Personality Inventory (MMPI) and its various revisions. Through a collaborative assessment of one individual by prominent representatives of each paradigm, Wiggins (2003) shows how these five assessment paradigms overlap significantly and generate similar conclusions, but also contribute unique and nuanced insights.

The psychodynamic, interpersonal, and personological paradigms of Wiggins (2003) are embedded within Criterion A. These paradigms manifest in the focus on self and other boundaries, dynamics of self-esteem regulation, and emphasis on mode of interpersonal relatedness (Hopwood, Wright, Ansell, & Pincus, 2013). Criterion B prominently reflects the Wiggins (2003) multivariate, empirical, and interpersonal paradigms. For example, the five broad, higher-order trait domains and the more narrow 25 trait facets of Criterion B parallel FFM s that derive from quantitative models of normal and abnormal personality data (Krueger & Markon, 2014). Benefitting from the cumulative wisdom of each of these great paradigms of personality assessment, the AMPD is at once both traditional and innovative.

**Criterion A: Level of Personality Functioning and Paradigms of Personality Assessment**

Pincus (2005, p. 287) noted, “classification of personality disorders in the post DSM-III/IV era will require greater coordination of definitional theories and systems for describing variation in expression of personality pathology.” From this perspective, the AMPD Criterion A may be regarded as assessing the genus of personality pathology; it defines what PDs have in common that distinguishes them from healthy personality and other forms of psychopathology (Pincus, 2011). Criterion A, operationalized in the DSM–5 Levels of Personality Functioning Scale (LPFS; Bender et al., 2011), defines PD across two broad areas of personality dysfunction. The core components of PD are intrapersonal (self) and interpersonal (other) functioning. These domains span the constructs of identity and self-directedness, and empathy and intimacy, respectively. The LPFS, whose criteria are listed in detail in the DSM–5, orders manifestations of these constructs across level of impairment, thus defining the severity of PD for an individual patient (see Table 2).

Criterion A incorporates important structural elements, developmental processes, and personality dynamics of concern in con-

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3 The neurobiological paradigm is increasingly applied in personality and psychopathology (e.g., Depue & Collins, 1999). It should be noted that some psychobiological constructs (e.g., temperament dimensions; anhedonia, etc.) are represented in the pantheoretical AMPD.
temporary psychodynamic, attachment, interpersonal, and social–
cognitive theories of personality and psychopathology. Bender et
al. (2011) describe in detail the conceptual elements and specific
assessment approaches of the LPFS. The LPFS incorporates fa-
miliar clinical constructs such as self-esteem stability, perception
of self and others, interpersonal boundaries, identity, interpersonal
mutuality, mentalization, reflective functioning, and development-
level of personality organization. For example, Otto Kernberg’s
(2012) concept of “psycho-structural level” shows parallels with
the LPFS of the AMPD. The two overarching dimensions of the
LPFS, self and other, parallel the personality constructs of agency
and communion within the interpersonal paradigm (Pincus &
Hopwood, 2012; Hopwood, Wright, Ansell, et al., 2013). The
personological paradigm stakes its claim to key aspects of the
psychological identity (Schmeck, Schluter-Muller, Foelsch, & Do-
Hopwood, 2012; Hopwood, Wright, Ansell, et al., 2013). The
personological paradigm may be regarded as the “species” of PD.
Particular varieties of PD are profiled through the assessment of
maladaptive personality trait dimensions. It should be noted that
the term personality trait has specific meaning in the realm of
human personality. Personality traits differ from many human
traits, such as height, that are highly heritable and difficult to
modify on an individual basis. In contrast to many physical traits,
personality traits reflect similar levels of both genetic and envi-
ronmental influences, and their expressions are sensitive to envi-
ronmental contexts (South & DeYoung, 2013). Thus, a maladapt-
ive personality “trait” refers to a tendency that is relatively stable
across time and place, but also is amenable to change (Fleeson &
Jayawickreme, 2015).

Criterion B assesses maladaptive personality traits derived
mainly from the multivariate and empirical paradigms, particularly
as exemplified by the FFM (e.g., Thomas et al., 2013) and the
Personality Psychopathology Five (PSY-5) scales of the MMPI
(Harkness, Reynolds, & Lilienfeld, 2014). Table 2 lists the five
trait domains and 25 trait facets of the AMPD. Facets are specific
dimensional elements of personality variation subsumed by five
broad trait domains: negative affectivity, detachment, antagonism,
disinhibition, and psychoticism. These labels emphasize the mal-
adaptive extremes of these traits, but they also map relatively
specifically onto domains from the normative FFM tradition (e.g.,
Gore & Widiger, 2013; Wright & Simms, 2014). At the domain
level, negative affectivity relates to neuroticism, detachment to
trait hostility, introversion to disagreeableness, disinhibition to low
conscientiousness, and psychoticism to openness.

The DSM–5 personality traits may be assessed with the Person-
ality Inventory for DSM–5 (PID-5; Krueger et al., 2012), which
has both self-report and informant report versions, as well as
clinician ratings (in which interview, history, and other psycho-
metric data may be used). There is also a brief form of the PID-5,
which permits the assessment of domains but not facets. Reviews
of empirical research (e.g., Widiger, 2015) conclude the AMPD
Criterion B can be reliably measured with the PID-5, which shows
strong convergent validity with various well-validated measures.

Utility and Acceptability

Many investigators have noted problems with traditional cate-
gorical personality diagnosis such as extensive comorbidity, pre-
ponderance of PD-NOS diagnoses, limited convergent validity,
heterogeneity within categories, arbitrary diagnostic thresholds,
lack of treatment implications, reliance on expert consensus rather
than empirical data to develop the nosology, and the questionable
assumption that discontinuous categories reflect the nature of PD
(Widiger & Trull, 2007). A major goal of the AMPD was to
redress such fundamental problems. Bernstein, Iscan, and Maser
and the Boards of Directors of the Association for Research in
Personality Disorders and the International Society for the Study
of Personality Disorders (2007) found that an appreciable majority
(74%) of PD experts surveyed thought that the DSM–IV cat-
ergical approach to PDs should be replaced. Furthermore, 87% of
respondents believed that personality pathology was dimensional
in nature, and 70% indicated that a mixed categorical-dimensional
approach to PD diagnosis was the most desirable alternative to
DSM–IV.

Nevertheless, some feared that clinical utility would suffer from
a dimensional representation of personality problems. For example,
Shedler et al. (2010) commented “the proposed system for
classifying personality disorders is too complicated, includes a
trait-based approach to diagnosis without an adequate clinical
rationale, and omits personality syndromes that have significant
clinical utility” (p. 1026). Similarly, Clarkin and Huprich (2011)
were concerned that the AMPD “does not often meet criteria for
clinical relevance” (p. 202). However, Verheul (2005) pointed out
that actually few studies support the relative clinical utility of the
categorical model. Those that have been conducted typically com-
pared the DSM approach to the FFM, whose instruments often do
not include behaviors at the maladaptive extremes of trait dimen-
sions, resulting in mixed outcomes with some studies supporting
the DSM approach and others favoring the FFM. Summarizing,
Mullins-Sweat and Lengel (2012) noted the critical importance of
evaluating diagnostic systems with comparable methods of assess-
ment. When comparable methodologies are used, the FFM (di-
mensional approach) demonstrates equivalent or better clinical
utility than the DSM categorical model. This questions the claim
that a dimensional approach would reduce perceived acceptability
or clinical utility. It also should be noted that the increased dimen-
sionalization within the DSM–5 harmonizes with the NIMH Re-
search Domain Criteria (RDoC) (Cuthbert & Insel, 2013), an
explicitly dimensional trans-diagnostic (albeit more neurobiologi-
ical) model, connecting the AMPD with other contemporary frame-
works in psychiatric classification.

Morey, Bender, and Skodol (2013) tested this issue directly by
surveying 337 mental health clinicians (26% psychiatrists, 63%
psychologists, and 11% other professional disciplines) who evaluated one of their patients for PD features listed in DSM–IV and in the AMPD of DSM–5. After applying each diagnostic model, clinicians evaluated the clinical utility of that model with respect to communication with patients and with other professionals, comprehensiveness, descriptiveness, ease of use, and utility for treatment planning. These perceptions were compared across DSM–IV and the three components of the AMPD as well as between psychiatrists and nonpsychiatrists. The DSM–5 dimensional trait model was seen as more useful than the DSM–IV model in five of six comparisons (all but ease of use)—a perception shared by psychiatrists as well as other professionals (Morey et al., 2014).

The AMPD innovatively organizes terminology, concepts, and techniques inherent in traditional paradigms of assessment already familiar to many professionals, and this likely will facilitate learning and applying the model. Given that clinicians in these recent studies were almost entirely unfamiliar with the AMPD at the time the studies were conducted, these findings strongly suggest, in contrast to concerns around poor acceptance and loss of clinical utility, the use of the AMPD may significantly increase the acceptance and perceived clinical utility of DSM PD diagnosis. Indeed, user acceptance and comfort should increase as training guides and materials are developed (Zachar & First, 2015) and clinical examples are made available (Bach, Markon, Simonsen, & Krueger, 2015).

Validity

The AMPD has produced a relatively large body of initial research. Both the LPFS and PID-5 instruments have exhibited acceptable reliability across a host of studies using different populations. Zimmermann et al. (2015) examined the structure of Criterion A in two samples, one of lay people and another of mental health practitioners, using informant rather than self-reports. They found that (a) the four subdomains of Criterion A generally conform to the expected structure, (b) patterns of associations among these scales support the use of a general factor (i.e., global LPFS elevation), but (c) details of the model and the measure remain to be resolved. Specifically, not all descriptors loaded most strongly on their designated domain, nor did they all achieve their hypothesized level of severity. There is also some overlap between Criterion A and B due to the use of pathological trait variants (Pincus, 2013), which leads to a “collapsing” of the structure when factored together (Zimmermann et al., 2015). Nonetheless, these results broadly support the hypothesized structure of the Model in general and of the LPFS in particular.

Several studies demonstrate the criterion validity of Criterion A. The Criterion A constructs significantly predict the presence and number of PDs in diverse samples (Few et al., 2013; Morey, Bender, et al., 2013). Morey et al. (2014) found that an LPFS score of moderate or greater demonstrated 84.6% sensitivity and 72.7% specificity for identifying patients who met criteria for at least one Section II PD diagnosis, and Criterion A significantly incremented the 10 combined Section II PD categories when predicting functional impairment, prognosis, and treatment intensity.

There has been an even more rapid accumulation of research supporting the Criterion B trait model over the past several years. The structure of the DSM–5 trait model was initially developed based on factor analyses of responses to PID-5 items in large representative population samples. Therefore, it is not surprising that the structure replicates in samples of undergraduates (Wright, Thomas, et al., 2012), U.S. community samples (Creswell, Bachrach, Wright, Pinto, & Ansell, 2016), European samples (Zimmermann, Altenstein, et al., 2014), informant reports (Markon, Quilty, Bagby, & Krueger, 2013), and clinician reports (Morey, Krueger, et al., 2013).

Importantly, the AMPD traits can account for large portions of the variance in the Section II PD constructs, whether assessed via self-report (Hopwood, Thomas, Markon, Wright, & Krueger, 2012) or interview (Few et al., 2013). Morey and Skodol (2013) provided evidence that diagnostic rules for DSM–5 PDs result in greater correspondence between DSM–IV and DSM–5 than was observed between DSM–III and DSM–III–R. In addition, the AMPD traits surpass Section II PD criterion counts and psychiatric symptoms in predicting psychosocial impairment (Simms & Calabrese, 2016). Beyond comparisons of the Section III and Section II systems, the content validity of the PID–5 has received substantial support (e.g., Anderson et al., 2013; Hopwood, Schade, Krueger, Wright, & Markon, 2013). In addition, concurrent validity for key clinical personality constructs less well conceptualized in DSM–IV also appears strong; pathological narcissism, including both more vulnerable and more grandiose aspects (Wright, Pincus, et al., 2013), and psychopathy (Fossati et al., 2013) are reasonably well captured by the DSM–5 traits. Thus, the DSM–5 trait model appears to be on solid empirical footing.

Wright et al. (2015) examined the stability of the DSM–5 traits in a sample of psychiatric outpatients, finding that the DSM–5 traits were highly stable over the course of 1.4 years in terms of mean level (average Cohen ’ s $d = -.11$ and rank order (average $r$ disattenuated $r = .67/79$). Further, the DSM–5 traits significantly predicted future dysfunction across a variety of domains (e.g., life-satisfaction, interpersonal problems, social, occupational functioning, etc.), and individual changes in traits over the course of the study were significantly associated with changes in functioning. Although additional longitudinal work is necessary, these initial results suggest that, in contrast to the traditional DSM categories and symptoms, the DSM–5 Section III traits better match the levels of consistency that are a defining feature of PD and evident in studies of longitudinal impairment (Morey & Hopwood, 2013).

Current and emerging investigation substantially advances validation of the AMPD (Morey, Benson, Busch, & Skodol, 2015), despite caveats ( Widiger & Crego, 2015). Kendler (2009) argued that a diagnostic system should be built from a bottom-up, iterative process rooted in empirical findings. This contrasts with the traditional “top-down” approach of consensus of authoritative bodies (e.g., the standard Section II categorical PDs; Markon, 2013). Generated from cumulative trends in personality assessment science, the AMPD comes closer to Kendler’s (2009) desideratum than previous classifications. This is not an academic or esoteric matter. The empirical grounding of the AMPD establishes its place within evidence-based treatment methods. This status furthermore paves the way for increased use in forensic practice.

Clinical Use of the AMPD

The AMPD can be learned and used reliably with minimal specific training (Few et al., 2013; Morey et al., 2015; Zimmer-
mannot, Benecke, et al., 2014). Its integration of major assessment paradigms confers transferability to well-known tests, common constructs, and widely used interpretive frameworks. Clinicians can use several available resources to familiarize themselves with the model, starting with review of the DSM–5 Section III chapter. Particularly useful are tables in DSM–5 (pp.775–781) specifying indicators forthe LPFS and defining the five trait domains and 25 trait facets of Criterion B (versions of which are Table S1 and S2 in the online supplemental material). Current reviews of the literaturesuch asMorey et al. (2015); Krueger and Markon (2014), and Widiger (2015) provide key background.

Morey and Stagner (2012) used the AMPD to inform psychotherapy with a severely disturbed patient with narcissistic pathology. In this case report, they showed how psychotherapeutic postures informed by the AMPD (i.e., adopting “mirroring” and transference-based strategies) produced treatment gains greater than had been achieved in previous therapy conducted from DSM–IV formulations. Rommingstam (2014) showed how AMPD constructs related to dynamics of self-esteem management help in formulating subjective data that otherwise would appear discrepant with overt behavior. Examining the construct of identity in two complex clinical cases, Schmeck et al. (2013) showed how the AMPD increments traditional PD diagnosis and guides treatment planning. Bach, Markon, et al. (2015) provided six detailed patient case reports using the AMPD. They showed how the AMPD differentially guides diagnosis, treatment, and patient feedback strategies.

In practice, a global rating of 2 or more (moderate impairment) on two of the four dimensions (identity, self-direction, empathy, and intimacy) of the LPFS is required for a diagnosis of PD. LPFS ratings may be formulated from observation, history, interview, and psychological test data. Bender et al. (2011) detailed many test and interview approaches from which the LPFS was developed; these measures may be used in practice to inform ratings on the LPFS. Because Criterion A addresses overall level of personality impairment, severity or profile elevation indices from tests such as the MMPI-2 or Personality Assessment Inventory (PAI) are relevant. Performance based assessment methods such as the Rorschach or Thematic Apperception Test (TAT) also provide measures of overall level of personality functioning. For example, well-validated measures from the R-PAS systematization of the Rorschach procedures (Viglione, Perry, Giromini, & Meyer, 2011), and the Social Cognition and Object Relations Scale (SCORS; Westen, Lohr, Silk, Gold, & Kerber, 1990) of the TAT provide indices of level of personality functioning.

Regarding Criterion B, the AMPD does not specify how to determine significance with traits or facets. Rational decision and convention (Samuel, Hopwood, Krueger, Thomas, & Ruggero, 2013) suggest ratings of 2 (sometimes true) or 3 (very true) on the 25 single-item facet scales reflect clinical significance. Clinicians may use the PID-5 norms (Krueger, Derringer, Markon, Watson, & Skodol, 2012) to compute standard scores, and define “high scores” with a conventional cut-off (e.g., 65 or 70T) with either PID-5 self-report or informant forms. One may also apply clinical ratings to the five trait domains, or use values of the (significant) facets that constitute respective trait domains to calculate overall scores (Samuel et al., 2013). These data can then be used to determine the hybrid categorical-dimensional diagnoses (e.g., avoidant, borderline, etc.) following the algorithms provided in the DSM–5.

Research provides strong support for the PID-5 in the assessment of Criterion B traits. Maples et al. (2015) showed that a short form of the PID-5 (100 items) was capable of assessing both the facets and domains reliably and validly. This short form may be useful when time is limited. Samuel (2015) comprehensively reviewed clinician diagnostic agreement in the domain of PDs, comparing interview, self-report, and informant-report formats. He concluded levels of agreement are fairly robust, albeit minor to moderate method differences exist (see also Markon, Quilty, Bagby, & Krueger, 2013). Samuel (2015) opined self-report and informant-report assessment compares favorably with interview-based assessment, and recommended the PID-5 as a promising approach to PD diagnosis.

Popular psychometric instruments can also inform clinical ratings of traits and facets. For example, the MMPI-2 PSY-5 scales correspond to the AMPD maladaptive traits (Anderson et al., 2013). PAI scales can reliably indicate and discriminate Criterion B maladaptive traits (Hopwood, Wright, Krueger, et al., 2013). The Millon Multiaxial Clinical Inventory (MCMI-III; Craig, 2005), Dimensional Assessment of Personality Pathology (Livesley, Jackson, & Schroeder, 1989), Schedule for Nonadaptive and Adaptive Personality (SNAP; Clark, 1993), and the Computerized Adaptive Assessment of Personality Disorder (CAT-PD; Simms et al., 2011) are other inventories directly relevant to PD assessment. From the cognitive–behavioral therapy (CBT) perspective, the Beck and Beck (1991) Personality Beliefs Questionnaire and CBT-based measures from Schema Therapy closely map onto the AMPD (Hopwood, Schade, Krueger, Wright, & Markon, 2013; Bach, Lee, Mortensen, & Simonsen, 2015). The Shedler-Westen Assessment Procedure (SWAP; Shedler & Westen, 2007), involving Q-sort clinician ratings of clinical observations, provides quantitative indicators of PD syndromes. Performance-based (aka “projective”) testing similarly can assist trait and facet determinations. Weiner’s (2015) review of “explicit” (i.e., structured, self-report) and “implicit” (i.e., unstructured, performance) assessment of PDs, and Bornstein’s (2015) “process assessment” model, integrating structured and unstructured methods, summarize how performance-based methods inform PD evaluation.

Psychological assessment with the AMPD parallels the “Review of Systems” diagnostic approach used in clinical medicine, as noted in the DSM–5 (APA, 2013, p. 774; see also Harkness et al., 2014). In other words, all relevant spheres of diagnostic concern are systematically surveyed. Practically speaking, this means that following a determination of moderate or greater elevation on the LPFS, all five trait domains and 25 facets are reviewed. Psychodiagnostically, this “review of systems” helps to ensure important data are not overlooked. This is a crucial point because diagnostic impressions can be colored by urgent or dramatic signs and symptoms. Although clinicians, like people in general, tend to make quite accurate impressionistic assessments (e.g., Ambady’s [2010] program of research demonstrating the accuracy of “thin-slicing” in person perception), inferences are subject to error unless deliberate, systematic analysis is also employed. Much like a pilot with a preflight checklist prior to take off, “review of systems” with the five traits and 25 facets safeguards diagnostic appraisal from common forms of error and omission.
Structured interview formats for the AMPD are currently in development (Zachar & First, 2015). Waugh (2014) offers a clinician-friendly template (PDLT-C) for organizing data within the AMPD framework similar to Gordon and Bornstein’s (2015) Psychodiagnostic Chart-2 (PDC-C). However, typically, the clinician simply synthesizes observations and inferences into AMPD ratings.

Albeit a new PD system, inclusion in the DSM–5 confers legitimacy in forensic settings as well (Zachar et al., 2016). It’s growing clinical and research record brings scientific credibility sufficient for supplemental use in the forensic arena. In point of fact, one author (Mark H. Waugh) has used the AMPD in administrative law settings in which the diagnosis of PD was disputed.

**Case Example**

We present a case with a profile of AMPD results that will look familiar to most clinicians. This case example not only illustrates use of AMPD ratings, but demonstrates the ease and consistency with which clinicians can apply the AMPD. A convenience sample of clinicians (n = 25) evaluated a case vignette abstracted from Kohut’s (1979) classic article, “The two analyses of Mr. Z” (vignette available from Mark H. Waugh). Kohut (1979) described a patient in an orthodox psychoanalysis, followed by a subsequent analysis informed by self-psychology. The 263-word case vignette was composed from Kohut’s (1979) depiction of Mr. Z’s history, presentation, and behavior (i.e., anxious, retreating, intellectualizing, thin-skinned, lonely, and rejection-sensitive) in the early phase of analysis. This case reflects aspects of “vulnerable” narcissism, a presentation which may be more difficult to capture in common diagnostic systems (Pincus & Lukowitsky, 2010). Raters were blind to the identity of the case (except for MHW); they included 12 clinicians and 13 academic clinical psychologists (theoretical orientations included psychodynamic, interpersonal, cognitive–behavioral, and integrative), with a median of 20 years clinical experience, and many with expertise in personality assessment and/or PDs. Raters were not formally trained. They were simply asked to provide an AMPD diagnosis for the case vignette and refer to the text of the DSM–5, Section III, as needed. In this way, the clinicians’ ratings likely resembled routine clinical practice as opposed to judgments made under the controlled conditions of research settings. Thus, agreement among raters may reflect typical rather than maximal diagnostic concordance—offering a more realistic assessment of clinician agreement with the AMPD. Clinicians varied from very little to extensive familiarity with the AMPD. Interrater reliability results yielded an intraclass correlation (ICC [2,1]) for the LPFS and 25 trait facets combined of 0.53 for a single rater; across the group of 25 raters, the ICC was 0.97. Thus, there was strong agreement across raters in applying the AMPD to a short case vignette. Also, 24 of 25 clinicians (96%) rated Mr. Z positive on Criterion A, establishing a PD diagnosis (see Figure 1). The profile of the 25 trait facets shows elevations on anhedonia, anxiousness, depression, emotional lability, grandiosity, hostility, restricted affectivity, submissiveness, separation insecurity, and peak elevations on intimacy avoidance and withdrawal. Applying AMPD diagnostic algorithms (DSM–5, pp. 764–770) to these data yields hybrid categorical-dimensional diagnoses of avoidant and borderline PD.

Results depict an individual with “moderate” personality impairment (global rating of 2 on LPFS) and particular liability in intimacy aspects of the interpersonal domain. In terms of dispositional traits, the profile shows an anxious individual who is interpersonally detached and reserved, yet also emotionally reactive, irritable or angry, as well as self-focused and sensitive to slights. The AMPD data are consistent with “narcissistic vulnerability” (Pincus, Cain, & Wright, 2014). Raters gave diagnostic impressions prior to the AMPD. Avoidant and narcissistic PD or traits were frequently listed, followed by diagnoses ranging from dysthymia, social anxiety disorder, other depressive and anxiety disorders, to borderline traits. The AMPD ratings appeared to capture many constructs reflected in the clinicians’ diverse diagnostic impressions while providing a psychometric profile of meaningful data. This example illustrates how the AMPD provides data for both diagnosis and psychological assessment; this dual benefit aids clinical practice (e.g., Bach, Markon, et al., 2015; Schmeck et al., 2013).

**Whither the AMPD?**

The AMPD is listed as an emerging model and measure in DSM–5 Section III. A limitation of the AMPD approach is that it is not the official Section II PD diagnostic system. The AMPD also has seen critiques. Proponents of a prototype-based diagnostic model (involving ratings of exemplar descriptions of syndromes, as in DSM-I and -II), argue prototype diagnosis provides more clinical utility (Shedler et al., 2010). Some have noted coauthor academic commonality within the P&PD Work Group and speculated that other views may have received less attention (e.g., Blashfield & Reynolds, 2012; Widiger & Crego, 2015). Crego, Sleep, and Widiger (2016) suggested the clinical utility of some AMPD PD algorithms are not optimal and that other FFM approaches may offer improved clinical utility in trait ratings.

Research on incremental validity of Criterion A (LPFS) over Criterion B’s pathological personality traits has shown mixed results. A cross-sectional study (Few et al., 2013) found little support for incremental validity of Criterion A over Criterion B; however, a study examining prediction of longitudinal criteria (Roche, Jacobson, & Pincus, 2015) found evidence supporting the incremental validity of Criterion A above and beyond Criterion B. The issue of incremental validity and Criterion A and B convergence are subject to further empirical and conceptual explanation. From a construct validity point of view (Loevinger, 1957), Criterion A and B require nuanced analysis beyond incremental or predictive validity. Relatedly, Morey (1991) pointed out that diagnostic classifications carry surplus meanings beyond operationalized criteria.

Operationalization of the AMPD certainly requires further study. This includes refinement of thresholds and cut points for ratings, optimal algorithms for hybrid categorical-dimensional diagnoses (Crego et al., 2016), and improved norms for ratings and instruments. The AMPD will receive additional scrutiny of its clinical utility, reliability, and validity. Importantly, traditional

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6 Current scholarship reveals that “Mr. Z” is Heinz Kohut himself, a fictive-autobiographical statement of his experience in psychoanalysis (Strozier, 2001). Using Mr. Z as a target for AMPD ratings offers historical, heuristic, and clinical relevance.
psychometric principles (Nelson-Gray, 1991) can be used to evaluate the AMPD diagnostic system and measures. In this regard, a major advantage of the AMPD is that the comparison of a diagnostic system to a psychological test (Blashfield & Livesley, 1991) no longer is “metaphoric.” The assessment paradigms and psychometric specification of the AMPD establish direct connections to psychological testing. Training in the use of the AMPD as well as development of standardized research interviews are receiving attention (Zachar & First, 2015). As more training programs teach the AMPD, future psychologists will be familiar with the approach and its application.7

Summary

Using concepts and assessment techniques familiar to practitioners (e.g., dysfunctional interpersonal boundaries; MMPI-2 PSY-5 Scales; FFM approaches), the AMPD is pluralistic theoretically and methodologically. This pantheoretical approach integrates the nomological nets of major personality assessment paradigms. This heritage confers clinical fidelity and compatibility with many clinical orientations. Practitioners of different orientations and disciplinary background will find many aspects of the AMPD familiar. Furthermore, the AMPD directly connects to instruments commonly used to assess personality and offers AMPD-specific instruments that are in the public domain.

Hybrid categorical-dimensional diagnosis from assessment of severity and style of personality dysfunction rectifies many limitations of traditional PD diagnosis. Through dimensionalization, the AMPD conforms to contemporary conceptualization of PDs and aligns with broader trends in the DSM–5 and with the NIMH RDoC. Emerging validity studies are strong. The central characteristics of the AMPD (dimensionalization, integration of assessment paradigms, and ties to psychological testing) establish its place at the forefront of PD diagnosis (Krueger, Hopwood, Wright, & Markon, 2014; Rodriguez-Seijas, Eaton, & Krueger, 2015). In short, the AMPD is an innovative approach to PD diagnosis that synthesizes assessment traditions while alleviating many shortcomings of past diagnostic systems. Not only is this a scientific advance, but the needs of the practicing clinician are met through the twin functions of psychiatric classification and psychological assessment that the AMPD provides.

7 All of the current authors, representing six clinical psychology doctoral programs, instruct students in the AMPD; numerous other programs also teach the AMPD.

References


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