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Personality Disorders (M Zimmerman, Section Editor)

The *DSM-5* Alternative Model for Personality Disorders and Clinical Treatment: a Review

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Abstract

Purpose of review The goal of the current paper is to review the *DSM-5* Alternative Model for Personality Disorders (AMPD), with particular focus on treatment of personality pathology. We briefly outline limitations of the traditional personality disorder diagnostic system, then, review differences between it and the AMPD, and how the alternative model can be applied for intervention planning.
Recent findings Criterion A of the AMPD refers to the level of self and interpersonal impairment and is required for establishing the presence of a personality disorder diagnosis. Criterion B characterizes the nature of that diagnosis by virtue of maladaptive personality traits. Both criteria have been positioned as having important treatment value, particularly when considered jointly. Several publications illustrate the utility of the AMPD for streamlining assessment, case conceptualization, and treatment.
Summary The diagnosis of personality disorder with the AMPD provides information with direct utility for case conceptualization and treatment planning. We review the clinical utility of the AMPD. In addition, we highlight limitations in the literature related to the

AMPD, with directions for future research aimed at improving understanding of the utility of the AMPD. We further situate our discussion of the AMPD within a broader scientific climate with focus on improvement of both personality and non-personality diagnosis, conceptualization, and treatment.

Introduction

In an effort to remedy limitations of the *DSM-IV-TR* conceptualization of personality pathology, the DSM-5 Task Force charged the Personality and Personality Disorders Work Group (PPDWG) with creating an empirically based personality disorder (PD) classification model [1]. However, in the main section of the *DSM-5* [2], the traditional conceptualization of personality pathology utilizing 10 putatively distinct dichotomous PD diagnoses was ultimately maintained. The model proposed by the PPDWG—thenceforth entitled the Alternative Model for Personality Disorders (AMPD)—was published in Section III of the *DSM-5*, representing a categorical-dimensional hybrid model that may be used as an alternative to the traditional Section II diagnostic approach [3••].

Empirical investigations of the utility of the AMPD have grown since its publication in the *DSM-5*. Researchers have utilized the AMPD framework to further the understanding of associations between maladaptive personality and other relevant clinical constructs. For instance, the AMPD has been explored as it relates to such psychological phenomena as spitefulness [4], childhood maltreatment [5] and adult attachment [6], and differences in neural activation patterns [7]. In addition, several contributors have outlined ways in which the AMPD might be useful for the treatment of psychopathology. Further, publications and reviews exist that entail the use of the AMPD in conceptualizing personality disorders [8, 9, 10••].

In the current article, we review the literature on the AMPD as it relates to the treatment of personality pathology and, to a lesser extent, other forms of psychopathology. We begin by presenting a brief synopsis of the nature of the development of the AMPD as it pertains to the characterization of personality pathology. Next, we outline the novelty of the AMPD alongside research findings comparing it with the traditional PD diagnostic system. We then summarize the literature on the AMPD and intervention. Finally, we conclude with a discussion of future directions for empirical and treatment considerations related to the AMPD.

Drawbacks of the traditional diagnostic system of PDs

Though an in-depth review of the history of the AMPD—from the creation of the PPDWG for *DSM-5* through the final decision to retain the *DSM-IV-TR* PD format in the *DSM-5* Section II—is beyond the scope of the current publication (interested readers might see [3••]), there are some important factors surrounding the creation of the AMPD that warrant mention. A large literature documents the myriad drawbacks of categorical conceptualizations of personality pathology—as well as psychopathology in general [11–13]. The most noteworthy problems with the extant PD nosology lie in such drawbacks as (i) significant comorbidity of diagnoses [14], (ii) heterogeneity of presentations within the same diagnosis [15–17], (iii) the use of arbitrary thresholds to distinguish normal functioning from pathology [18], and (iv) the routine diagnosis of PD-NOS [19].

In addition, and pertinent to our focus on treatment, considering PD diagnoses as qualitatively distinct entities suggests benefit of specialized

interventions tailored to each disorder. As yet, however, empirical findings suggest that interventions do not show specificity for PD [20], and even non-PD [21], diagnoses. Instead, PD diagnoses appear to share common processes that are responsible for the observed patterns of non-specific treatment effect [22, 23]. For instance, when PD diagnostic criteria are modeled simultaneously, traditional models—wherein criteria represent distinct, unrelated diagnostic entities—fit the data poorly, while a model wherein a general personality pathology factor accounts for shared variance among discrete PD criteria demonstrates superior fit [22]. The PPDWG, therefore, set out to create a diagnostic system that aligned more closely with empirical evidence about the nature of personality, and personality pathology, that might inform assessment and treatment, resulting in the AMPD.

The alternative model for personality disorders

The diagnosis of PD within the AMPD framework is based on seven diagnostic criteria (A–G). Criteria A (level of personality impairment) and B (maladaptive personality characteristics) are typically of greatest focus for both research and clinical purposes. These represent the most significant departures from the traditional PD diagnostic system and are the primary focus in this article. Criteria C through G cover issues related to environmental factors, differential diagnosis, and stability, largely congruent with the traditional diagnostic system. In addition, although the AMPD exists in a separate section from the traditional PD diagnostic system, the *DSM-5* allows for diagnosis of PD within Section II based on the AMPD through use of the "Other Specified Personality Disorder" category (F301.89). That is, it is possible for the diagnostician to utilize the AMPD for the diagnosis of PD within *DSM-5*, despite its official placement within Section III: Emerging Measures and Models. We turn to greater discussion of the first two criteria used for the diagnosis of PD within the AMPD. In addition, we highlight literature relating these AMPD criteria with traditional PD diagnoses.

Criterion A

Criterion A refers to the extent to which an individual experiences problems in self (i.e., self-direction and identity) and interpersonal (i.e., empathy and intimacy with others) functioning [24]. Five levels of impairment (little to none, some, moderate, severe, extreme) are specified for each personality functioning area. Criterion A, therefore, may be utilized to establish whether or not a PD diagnosis is appropriate. Deficits in areas of personality functioning represent the core pathology shared in common across all PDs, regardless of the specific PD diagnosis. Deficits in personality functioning, as measured by Criterion A of the AMPD, correspond with several models of personality pathology, including interpersonal, psychodynamic, and personological theories [8, 25]. The associated measurement instrument—the Level of Personality Functioning Scale (LPFS [24, 26])—is therefore positioned as informative for establishing the presence of a PD diagnosis [27, 28]. Scores on the LPFS have been found substantially related with a wide range of constructs reflective of personality pathology (e.g., maladaptive personality traits, traditional PD criteria, and

ratings of interpersonal problems [28]). Therefore, assessment of pathology in terms of self and interpersonal functioning is associated with the network of constructs related to PDs in general.

Criterion B

Criterion B characterizes the specific features of any PD diagnosis. That is, information from Criterion B articulates the personality processes that give rise to that individual's specific self and interpersonal functioning deficits. This is accomplished through specification of maladaptive personality traits. Maladaptive personality traits are arranged into five broad trait domains (negative affectivity, detachment, antagonism, disinhibition, and psychoticism) comprising 25 trait facets. Any particular PD diagnosis can be described by the specific constellation of elevated maladaptive personality traits ascribed to that person. Maladaptive personality traits assessed in the AMPD largely reflect extreme variants of normal personality. Though these maladaptive personality traits were developed independent of any specific normal personality theory, numerous studies document the close associations between maladaptive personality traits, as measured in Criterion B of the AMPD, and normative personality constructs [29–34]. Negative affectivity, detachment, antagonism, disinhibition, and psychoticism represent polar extremes of the normative personality traits of neuroticism, extraversion, agreeableness, conscientiousness, and openness to experience respectively. The AMPD, therefore, provides a tailored approach to the diagnosis of PD, which can directly inform intervention planning. PD-Trait Specified replaces the traditional PD-NOS category, the modal PD diagnosis. While the PD-NOS diagnosis itself provides relatively little specific information about any individual's pathology [10••], the inclusion of maladaptive traits in the PD diagnosis within the AMPD describes the specific features of personality problems demonstrated by that individual. Therefore, it provides immediate information pertinent to case conceptualization, which is largely absent in the PD-NOS diagnosis.

Criteria A, B, and traditional PDs

The creation of the AMPD represents a data-driven endeavor, aimed at delineating a classification system that aligns with the empirical evidence on the nature of personality, and personality pathology. Research has further examined the associations between AMPD criteria and traditional PD diagnoses. Largely, these findings suggest that AMPD constructs not only recapture information from the traditional conceptualization of PDs and arrange that information empirically to improve upon some of the limitations of the traditional nosology. For instance, empirical evidence supports the idea that Criterion A features are associated with traditional PD diagnoses [35, 36]. For example, among clinicians, LPFS ratings predict the diagnosis of a traditional PD [35]. Additionally, LPFS ratings are associated with traditional PD criteria. These findings are consistent with previous evidence that Criterion A of the AMPD represents an assessment of dysfunction common across personality pathology.

Research further suggests that information provided by the AMPD for characterizing PDs supplements that which is available using traditional PD diagnoses. Several studies have examined the associations between AMPD maladaptive personality traits and traditional PD diagnoses. Results suggest that

information provided by AMPD Criterion B corresponds with specific maladaptive personality characteristics attributed to specific traditional PD diagnoses [36–48]. For instance, the maladaptive personality traits associated with narcissistic PD (i.e., antagonism) explained a significant proportion of the variance in the diagnosis of narcissistic PD in one study [36]. Indeed, the AMPD specifies maladaptive personality traits that may be used for the diagnosis of six of the 10 traditional PD diagnoses (i.e., antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal). Based on particular trait constellations, the translation of these traditional PD diagnoses by virtue of maladaptive personality traits was calibrated in such a way to correspond with Section II PD prevalence rates. While the AMPD might be used to provide some traditional PD diagnoses, the ability to modify any singular diagnosis by the inclusion of important individual-specific maladaptive personality traits is one clear advantage of the AMPD.

Traditional PD diagnoses are limited in their inability to account for heterogeneity within diagnostic categories. Empirical evidence demonstrates the additional utility of the AMPD for characterizing personality pathology beyond that implied by any specific PD diagnosis. For instance, the inclusion of traits that were not proposed in the AMPD as related to the six retained diagnoses explained additional variance associated with those PDs in one study [37]. Inclusion of specific facets of antagonism—not specified as associated with the narcissistic PD diagnosis—explained an additional 12% of the variance than inclusion of only the specific facets considered hallmarks of that diagnosis (i.e., grandiosity and attention seeking). Criterion B, therefore, provides additional information specific to an individual's presentation beyond that of the prototypical diagnostic presentation, which directly increases utility of PD diagnoses made within the AMPD.

Clinical utility of the alternative model for personality disorders

Clinical utility—of any framework for conceptualizing psychopathology—pertains to the ease with which that construct might be used in practice, for communication purposes, for treatment selection, and for predicting outcomes [49]. Previous research highlights the fact that clinicians fail to adhere to traditional PD criteria when providing a PD diagnosis [50–53]. This suggests that there is limited feasibility in the usage of the traditional PD diagnostic framework. Diagnostic thresholds further fail to capture clinically important psychopathology, thereby limiting their communication effectiveness [54]. As has been mentioned previously, interventions and PD diagnoses do not bear one-to-one correspondence; traditional PD diagnoses fail to provide adequate information to inform individual-specific treatment planning [20]. Finally, the use of arbitrary thresholds in the diagnosis of PDs also neglects important associations between sub-threshold dysfunctions and clinical outcomes [55]. The emerging literature on the clinical utility of the AMPD, however, is promising. Several articles outline the ways in which the AMPD can be used to inform conceptualization and subsequent treatment planning; evidence suggests that the information in the AMPD is considered more useful by clinicians and corresponds with actual treatment decision-making; and data suggest that maladaptive personality constructs might provide information about differential treatment response.

The AMPD for case conceptualization

Literature outlining the ways in which the AMPD might be incorporated into clinical practice typically utilizes clinical case examples to demonstrate case conceptualization, differential diagnosis, and treatment planning [8, 10••, 27, 56–58]. For instance, Bach and colleagues [27] illustrated the ways in which the AMPD provides simultaneous diagnostic and case conceptualization information. By virtue of six clinical vignettes, the authors showed how information garnered from Criteria A and B assessments of the AMPD can assist in situating other clinically relevant background information into a coherent diagnostic picture. Similarly, Skodol and colleagues [57] presented one comprehensive case example in which they delineated how adoption of an AMPD framework can (i) aid in discerning personality pathology from a general presenting complaint of depressed mood, (ii) provide individual-specific information to supplement the dichotomous PD diagnoses, and (iii) inform intervention planning.

Hopwood [59••] outlined a comprehensive framework for the assessment and treatment of PDs based on the AMPD, grounded in empirical evidence on the malleability of personality in response to interventions [60–63]. Based upon an understanding of how maladaptive personality domains are associated with affective versus interpersonal dimensions of dysfunction [64], treatment approaches for elevations in different Criterion B domains are outlined. For instance, behavioral approaches—like exposure and response prevention—are considered favorable for PDs whose primary characteristic profile involves high negative affectivity. Treatment focus on skills related to interpersonal effectiveness is warranted for PDs where elevations in antagonism and detachment are primary. Treatment for PDs defined by elevations in traits related to the disinhibition domain involves focusing on contingency management and techniques designed to increase motivation for changing maladaptive ways of interacting with various types of socioemotional stimuli. For presentations characterized by high psychoticism, clinical focus involves confrontation of active perceptual dysregulation and development of skills aimed at increasing rational understanding of the self and one's impact on their own environment.

Pincus and colleagues [58] illustrated how the AMPD can be used for creation of fine-grained understanding of important clinical distinctions among individuals who meet criteria for the same diagnosis: narcissistic PD. By its ability to accommodate both vulnerable and grandiose NPD presentations [65, 66] within its framework, the authors demonstrated how the use of the AMPD provides important treatment information associated with the heterogeneity of individuals assigned to the same PD diagnosis. For instance, the authors noted how relatively low scores on the detachment domain, as exhibited in one of their three case presentations, might have been associated with that case's more favorable treatment adherence/response. In addition, they pointed out how initial case conceptualizations that overlook AMPD-based constructs—as a result of a principal focus on mood, anxiety, and substance use disorder diagnoses—resulted in a less effective treatment approach. Taken together, this literature demonstrates the potential clinical utility of the AMPD in terms of case conceptualization and treatment planning.

The AMPD and clinical decision-making

While proponents of the AMPD outline its clinical utility, one criticism of the AMPD has been an assumed lack of fidelity between the model and actual clinical decision-making. Detractors initially cited as insurmountable the level of complexity inherent to the model. The AMPD was criticized for lacking a rational clinical basis, thereby limiting the feasibility of its adoption in routine clinical practice [67, 68]. Rebuttal of these claims involved highlighting the disconnection between traditional PD diagnoses and clinical utility similar to the claim levied against the AMPD. There is little evidence suggesting the use of traditional PD diagnoses aids treatment decision-making [69, 70]. However, emerging evidence paints a positive picture on the extent to which information from the AMPD can be incorporated into clinical treatment; clinicians, treating both personality and non-personality psychopathology, perceive the AMPD as clinically useful [71–73].

Three studies, to our knowledge, have examined the clinical utility of the AMPD among practicing clinicians. In two studies, utilizing a sample of clinicians ($N = 337$) treating clients with a PD diagnosis, the AMPD was rated as superior when compared with the traditional PD classification system. Specifically, clinicians rated the maladaptive personality traits of the AMPD (Criterion B) as having greater clinical utility across several domains (ease of application, communication with patients, application to cases, comprehensiveness, case formulation, and description) than traditional PD diagnoses. In contrast, information on the level of personality functioning (Criterion A) was considered less easily applicable and less useful for communication with other professionals than traditional PD diagnoses; there were no other differences across domains [72]. Clinicians' ratings on AMPD dimensions were also more closely associated with actual clinical decision-making than PD diagnostic information. AMPD constructs showed larger effect size–related decisions about implementation of specific forms of psychotherapy (e.g., cognitive and exploratory therapy) and pharmacotherapy (e.g., the use of antidepressants, anxiolytics, antipsychotics, etc.) than traditional PD diagnoses [71]. Together, these studies suggest benefit in the AMPD by virtue of the advantageous associations with treatment decision-making compared with traditional PD diagnosis.

Fewer empirical investigations have examined the utility of the AMPD among non-PD populations in the context of treatment outcome. In one study examining clinician-patient agreement, Samuel and colleagues [73] examined the convergence of ratings of pathological personality among clinicians and their patients, in a sample of non-PD psychotherapy patients. With the exception of the psychoticism domain, correlations between clinician and patient ratings of maladaptive personality were in the moderate-to-strong range ($r = 0.40–0.61$). Though nascent, these findings suggest that the information gained using the AMPD is (i) more clinically useful to clinicians, (ii) aligns with clinical practice, and (iii) corresponds with patients' perceptions of their own dysfunctions.

Maladaptive personality and differential treatment response

To our knowledge, there have been no studies that have empirically examined the extent to which AMPD constructs specifically predict differential treatment outcome. However, previous research findings on normal personality suggest

that the use of AMPD-related constructs can increase prediction of response to specific interventions. In one study, high neuroticism scores—associated with the AMPD maladaptive trait domain of negative affectivity—were associated with more positive treatment response to pharmacotherapy compared with psychotherapy [74]. Similarly, in a machine learning paradigm, high neuroticism was identified as one of the predictors of treatment response to sertraline [75]. These findings provide evidence that (maladaptive) personality constructs hold some benefit for treatment-matching, representing an exciting opportunity for future research. These findings are also consistent with other calls for increased attention to be paid to the ways in which personality assessment can inform intervention planning [76]. This conglomerate of findings on the AMPD and other related constructs demonstrate the wealth of clinically useful information that is provided from the diagnosis and conceptualization of PDs from an AMPD framework.

The alternative model for personality disorders: into the future

The extant literature has largely been focused on examining the potential benefits of the AMPD relative to the traditional PD diagnostic system. The AMPD is effective in distinguishing the presence of PD from non-PD, provides additional contextual information absent in traditional PD diagnosis, and inherently permits greater case conceptualization and treatment planning potential. It is positioned as a means of streamlining assessment, diagnosis, and treatment. The use of the AMPD for the assessment of the presence of PD provides important individual-specific information that can inform actual clinical practice beyond that which can be achieved from the use of traditional PD diagnoses. Still, there exist additional avenues for improvement of the model. We end by identifying future directions for research on the AMPD, and limitations associated with its implementation in routine clinical practice.

Relative importance of criterion A versus B

Questions remain about the relative distinctiveness of information provided by Criterion A compared with that of Criterion B of the AMPD. Empirical evidence supports conclusions that therapist ratings of self/interpersonal impairment might be both informative beyond ratings of maladaptive personality traits, as well as representative of redundant information. Level of personality functioning explains additional variance not accounted for by the measurement of maladaptive personality traits [77]. However, other data suggest redundancy between the variance related to the information from the two Criteria [36]. The distinctiveness of Criterion A and B might lie in their relative utility for treatment planning. A treatment focus on fundamental psychotherapy principles—like fostering treatment alliance—is suggested for attending to impairment in self/interpersonal functioning (Criterion A). Focus on specific modular interventions, however, has been positioned as useful for targeting maladaptive personality constructs (Criterion B), provided appropriate alliance has been achieved [66, 78, 79]. Nonetheless, the relative importance and distinctiveness of impairment in self/interpersonal functioning compared with maladaptive personality traits remain open for future adjudication [70, 80, 81].

The AMPD and the nature of psychopathology

Questions also remain to be answered about the extent to which personality pathology differs from non-personality psychopathology, and the extent to which the AMPD is helpful in this decision-making. To what extent can AMPD constructs be utilized for differential diagnosis of personality and non-personality psychopathology? Level of self/interpersonal functioning is positioned as the hallmark of PD [35, 36]. In contrast, Criterion B is positioned as an omnibus measure of psychopathology [82, 83]. Therefore, is it possible to conclude that self/interpersonal deficits are the defining feature of personality pathology when compared with non-personality pathology? In this vein, would elevations in maladaptive personality traits with normative self/interpersonal functioning be associated with an absence of personality pathology? Further efforts at disentangling the relative contribution of AMPD criteria to the assessment/diagnosis of PD are warranted. These sorts of questions transcend discussions of traditional PD versus AMPD diagnosis of PD and are related to a broader contemporary focus on the validity of any nosology of psychopathology.

The AMPD may be situated within a current context of seeking to use data-driven techniques to improve understanding of the fundamental nature of psychopathology. The creation of the AMPD corresponds with contemporaneous efforts aimed at improving the conceptualization of psychiatric disorders based upon empirical information. Such endeavors have resulted in the exposition of a hierarchical meta-structure of psychopathology entitled the Hierarchical Taxonomy of Psychopathology (HiTOP [84••, 85]). The HiTOP model characterizes the interrelatedness of traditional dichotomous psychiatric diagnoses with dimensional transdiagnostic factors of psychopathology. A wealth of literature documents the favorable properties of these dimensional structures, and how they can be utilized for intervention planning [12, 13, 86].

The hierarchical structure of the HiTOP model is strikingly similar to that underlying maladaptive personality domains [87, 88]. Furthermore, level of personality functioning (Criterion A) has been shown associated with many HiTOP-related constructs [89]. These findings highlight the importance of determining the extent to which Criteria A and B offer distinctive information for the conceptualization and treatment of PD [90••], particularly as this model becomes increasingly integrated within the intervention literature [86]. Further, understanding the ways in which personality pathology—in terms of level of self/interpersonal functioning and elevations in maladaptive personality traits—relates to non-personality psychopathology aligns with the epistemological questions about the nature, and treatment, of personality and non-personality psychopathology.

From empirical evidence to actual clinical practice

Criterion B constructs can inform decisions about specific interventions [68, 74, 75, 78]. Three measures of Criterion B maladaptive personality traits exist with varying numbers of items associated with each (220 items in the original Personality Inventory for *DSM-5* [PID-5] [33]; 100 in the short form [PID-5 SF] [91]; and 25 in the brief form [PID-5 BF] [92]). However, empirical findings are typically based on the use of the original 220-item PID-5. While the use of the PID-5 might be feasible in research settings, and even in outpatient clinical

settings to some degree, the length of the original PID-5 measure is restrictive in other acute clinical settings. Studies have demonstrated acceptable psychometric properties of these abridged versions [93, 94] when compared with the original PID-5. Understanding the clinical utility of these shorter, less burdensome versions—potentially more compatible with measurement-based care [95]—is paramount.

In balancing the need to reduce client burden with the need for comprehensive assessment, we offer one potential way in which AMPD constructs might be used in clinical practice. Shorter PID-5 (e.g., the PID-5 BF) measures might be incorporated as broad screeners of psychopathology. Lengthier trait modules can be strategically utilized for a more fine-grained analysis of facet-level elevations, following more general domain-level assessment. For clinical interests in formal PD diagnosis, one might consider the use of the Level of Personality Functioning Scale (FPS [26]) in conjunction with measures of maladaptive personality. While this represents one way in which the information from the AMPD can be routinely incorporated into practice, future research must determine the extent to which clinically relevant information is lost by the adoption of these shorter versions of the PID-5 measure. For instance, the PID-5 BF does not measure maladaptive trait facet-level information, only providing assessment of broad domains. Future research must also ascertain the extent to which adoption of an AMPD framework in the diagnosis of PD, and its subsequent treatment, is associated with favorable treatment outcomes.

Relatedly, despite several publications that demonstrate the potential utility of the AMPD for clinical decision-making, there is still little empirical evidence validating the ways in which maladaptive personality can inform intervention planning. Traditional PD diagnoses fail to demonstrate diagnosis-specific intervention effects [20]. Though empirical investigations of the associations between AMPD constructs and traditional PD diagnosis have been undertaken, the results of these studies have largely demonstrated the overlap between—and additional information provided by—the AMPD and traditional PD diagnoses in the assessment of PD. Perhaps the next step in understanding the utility of AMPD might involve the exploration of AMPD-related evidence-supported treatments. Hopwood and colleagues [64] already identify potential treatment options based on the defining features of various AMPD domains (i.e., Criteria A and B). Further, at least one text exists with direction for clinicians in using the AMPD in routine clinical practice [10••]. Empirical evidence is needed to validate the use of these intervention techniques within this AMPD paradigm.

AMPD dimensionality and PD diagnosis

Traditional PDs have been criticized for possessing arbitrary thresholds [18]. With the introduction of more dimensional models of psychopathology, like the AMPD, questions about the demarcation of function versus dysfunction remain pertinent [96, 97]. That the AMPD provides a single PD diagnosis, the examination of epidemiological trends is not hampered through its adoption. Questions arise, however, about finding the appropriate cutoff scores for providing PD diagnoses. Utilizing a rational decision of a score of 2—on a 0–3 point scale—to indicate elevation in maladaptive personality traits [98], prevalence rates of the six retained PD diagnoses within the AMPD were consistent with those of PDs diagnosed via the traditional PD nosology. However, this

remains an important issue that is not specific to the AMPD. Finding data-driven cutoffs with associations to important clinical outcomes is also important in further understanding the clinical utility of the AMPD. For instance, information about appropriate cutoffs can provide insight into how individual scores on AMPD constructs be utilized to inform selection into treatment studies. Reconciling the dimensional nature of personality pathology with the need for clinical cutoffs, therefore, represents a continued focus for both PD and general psychopathology.

Conclusion

The AMPD was developed in an effort to provide a diagnostic system for PDs that corresponds with empirical evidence about the nature of normal and maladaptive personality. The diagnosis of PD using the AMPD provides comprehensiveness of information about the individual's presenting pathology, which can easily be incorporated in clinical practice, and aligns with actual clinical decision-making. Further, numerous publications have demonstrated how information from the AMPD can be incorporated for the purpose of clinical assessment, diagnosis, and treatment planning. Indeed, the constructs within the AMPD provide a comprehensive means of assessing personality pathology and conceptualizing the appropriate treatment approach. In addition, the literature further suggests that information from the AMPD is not solely relegated to personality pathology, but can be useful for the conceptualization and treatment of non-personality psychopathology as well.

Compliance with Ethical Standards

Conflict of Interest

Craig Rodriguez-Seijas declares that he has no conflict of interest. Camilo Ruggero declares that he has no conflict of interest. Nicholas R. Eaton declares that he has no conflict of interest.

Robert F. Krueger is a coauthor of the PID-5 and provides consulting services to aid users of the PID-5 in the interpretation of test scores. PID-5 is the intellectual property of the American Psychiatric Association, and Dr. Krueger does not receive royalties or any other compensation from publication or administration of the inventory.

Human and Animal Rights and Informed Consent

This article does not contain any studies with human or animal subjects performed by any of the authors.

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