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Clinical Utility of the Alternative Model of Personality Disorders: A 10th Year Anniversary Review

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The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* (*DSM–5*) alternative model of personality disorders (AMPD) has now been available for researchers and clinicians for a decade. The present article aims to provide a narrative review of literature on the AMPD framework with particular emphasis on its clinical utility, inclusive of clinicians' and patients' acceptability, ease of use, diagnostic accuracy, continuity with clinically familiar constructs, and proposed utility for treatment planning, case-formulation, and clinical management. The review specifically covers the utility of Criterion A (i.e., Level of Personality Functioning Scale) and Criterion B (i.e., maladaptive personality traits) in relation to common disorders of personality. By drawing on empirical studies, surveys, clinical cases, and recommendations, the current review points to various aspects of clinical utility as well as areas for improvement. One way of increasing the AMPD's feasibility for clinicians is to omit the transitional personality disorder (PD) hybrid types while retaining a purer diagnostic classification of PD severity and traits that also align with the *International Classification of Diseases, Eleventh Revision* (ICD-11), PD classification. This would allow for a more efficient assessment for busy practitioners working in general psychiatry and primary care while retaining the possibility of a more fine-grained elaboration of the PD diagnosis in high-resource specialist settings. Such revision could possibly be introduced in *DSM–5.1* or *DSM–6*. We also propose that future exploration of the AMPD's clinical utility may involve its potential value for allocation of clinical resources, communication between clinicians and their patients' relatives, and utility for informing different treatment modalities.

Keywords: DSM–5 alternative model of personality disorders (AMPD), clinical utility, treatment, Level of Personality Functioning Scale (LPFS), personality traits

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Approximately 10 years ago, a new diagnostic framework for personality disorders (PD) saw the light of day, primarily in terms of the Level of Personality Functioning Scale (Bender et al., 2011) and the Maladaptive Personality Trait Model[1] (Krueger et al., 2012). Within this framework, a PD diagnosis is present when the impairment of personality functioning (i.e., Criterion A) is at a moderate level or higher, whereas the trait system (i.e., Criterion B) characterizes the individual expression of the personality dysfunction (Skodol, 2012). In addition, the model allows practitioners to draw on six traditional PD types based on various configurations of Criteria A and B (i.e., hybrid PD types). Rather than dwelling on the traditional PD categories, this new approach can be said to focus on what is shared by all PDs and what it essentially means to be human while also portraying individual stylistic features (Sharp & Wall, 2021).

Despite intentions for this model to serve as the official PD classification framework in the upcoming *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM–5*), the initial proposal was met with a plethora of concerns and criticisms pertaining to the proposed model having indeterminate clinical utility (Gunderson, 2010; Shedler et al., 2010), increased complexity (Lynam & Vachon, 2012; Tyrer, 2012), and that the removal of specific PD types such as histrionic, paranoid, schizoid, and dependent types was unjustified (Kernberg, 2012). Eventually, the American Psychiatric Association's board of trustees decided to retain the familiar categorical PD approach in *DSM–5* Section II to preserve continuity with current clinical practice. Concurrently, the American Psychiatric Association fully acknowledged that this categorical approach suffered from inadequate utility and was largely problematic for clinical practice (Zachar et al., 2016). For that reason, the new model—the alternative model of personality disorders (AMPD)—was eventually included in Section III of the *DSM–5* "to address the numerous shortcomings of the current approach to personality disorders" (APA, 2013, p. 751).

A number of previous reviews and case studies have focused on the AMPD's utility for case conceptualization and treatment

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[1] Mainly operationalized using the Personality Inventory for *DSM–5* (PID-5), which exists in a self-report form (Krueger et al., 2012) and an informant report form (Markon et al., 2013).

planning (Bach & Simonsen, 2021; Hopwood, 2018; Rodriguez-Seijas et al., 2019; Torres-Soto et al., 2019; Waugh, 2019; Weekers et al., 2020), psychological assessment (Waugh et al., 2017), and forensic settings (Hopwood & Sellbom, 2013). A meta-analytic review conducted by Bornstein and Natoli (2019) suggested that dimensional models of personality pathology, including the AMPD, are generally perceived by clinicians as more useful than the categorical approach. Most recently, Milinkovic and Tiliopoulos (2020) extended upon Bornstein and Natoli's review by specifically focusing on the AMPD, establishing strong support for its clinical utility.

A Broadened Definition of Clinical Utility

In the present article, we seek to embrace an understanding of clinical utility that is broader than that drawn upon in previous reviews. The most common criteria for the clinical utility of a diagnosis in mental health-care settings include user-friendliness, utility for communication with other professionals and with the patient, utility for describing all personality problems, and utility for formulation of effective treatment (First et al., 2004). In addition to such features, construct validity, diagnostic accuracy, and prognostic ability are also considered important aspects of clinical utility that may influence whether practitioners perceive the diagnoses as informative for clinical management in areas of risk assessment, treatment planning, and clinical decision-making (Keeley et al., 2016). Thus, if the construct validity and prognostic validity of a diagnostic framework are questionable, the clinical information derived from this framework will also be questionable, thereby compromising its clinical utility. Aspects of scientific validity can therefore be considered a precondition for the utility of a PD diagnosis in clinical practice.

Goal of the Present Review

Since its release a decade ago, research on the AMPD has exploded, with most of the findings having direct or indirect implications for its clinical utility (Zimmermann et al., 2019). The present article, therefore, sought to provide a narrative overview that synthesizes this accumulated knowledge to inspire and guide clinical practitioners and policymakers. By using various keywords synonymous with "AMPD," "Criterion A," and "Criterion B," we conducted a search of multiple databases (e.g., PsycINFO and PubMed). The search revealed 1,281 studies of interest inclusive of empirical studies, surveys, and clinical case studies, which were considered in relation to their implications for aspects of clinical utility. We excluded AMPD research in areas deemed out of the current review's focus on PDs such as addictive behaviors (Cavicchioli et al., 2020), nonsuicidal self-injury (Somma, Fossati, Ferrara, et al., 2019), trauma disorders (Møller et al., 2021), eating pathology (Solomon-Krakus et al., 2020), and schizophrenia-spectrum disorders (Bastiaens et al., 2019). The AMPD's clinical utility will be reviewed with regard to perceived utility for clinical decision-making, learnability, and patient acceptability; the model's ability to capture common features of personality pathology in a clinically informative manner, with particular focus on borderline PD, narcissism, and psychopathy, and its potential utility for informing prognosis, clinical management, and treatment. Lastly, we provide concluding recommendations and include suggestions for improvement.

Perceived Clinical Utility of the AMPD

The complete diagnostic procedure of the AMPD, including the multifaceted hybrid configurations of six defined PD types, has been referred to as "a trip into the jungle" with regard to its ease of use and learnability (Tyrer, 2012, p. 373). However, from a scientific perspective, ease of use should of course not have full priority over validity in the construction of a diagnostic tool. A major purpose of introducing the AMPD was to improve the reliability and validity of PD diagnoses, not merely the simplest, fastest, and most appealing approach (Skodol, 2012). Nevertheless, without perceived utility and ease of use, the model's scientific qualities are virtually redundant because clinicians may simply refrain from using it (Tyrer, 2012).

Routine Clinical Practice Field Trials

In the *DSM–5* routine clinical practice field trials—inclusive of 621 mental health professionals providing data for 1,269 patients—the newly proposed PD classification (i.e., the AMPD) received the most favorable clinical utility ratings along with posttraumatic stress disorder, substance use disorders, and bipolar disorders (Moscicki et al., 2013). Given this promising finding, it may seem puzzling that the American Psychiatric Association Board of Trustees decided against the model in favor of the established categorical approach.

In a subsequent evaluation drawing on the expertise of 337 doctoral-level clinical psychologists and psychiatrists, the AMPD was generally found to be more useful than the retained PD categories across different areas of comparison, regardless of professional background (Morey et al., 2014). Specifically, Criterion A was considered more useful than the extant PD categories with respect to differential treatment formulation and communication with patients (Morey et al., 2014). The Criterion B was considered more useful than the PD categories in terms of global personality description, communication with patients and relatives, professional communication, comprehensive description of personality problems, and treatment planning.

A more recent survey among 361 PD experts specifically revealed a preference for the AMPD approach over a purely categorical approach (Morey & Hopwood, 2020). In general, these findings align with the meta-analytic evidence provided by Bornstein and Natoli (2019) indicating that dimensional models, including the AMPD, are largely perceived as more clinically useful than categorical approaches. Moreover, the findings are also consistent with a previous survey among 400 PD experts, in which 80% felt that PDs are better conceptualized as dimensions or spectra along a continuum in contrast to distinct categories (Bernstein et al., 2007).

Perceived Utility for Therapeutic Decision-Making

Clinicians justifiably tend to ignore the descriptive *DSM–5* diagnoses in favor of more explanatory models that are considered useful for guiding treatment planning and intervention (Hopwood & Back, 2018). Accordingly, a major concern is that the Criterion B does not capture the dynamic aspects of PDs, as these have been

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described in the clinical literature, and ultimately misses a clinically critical feature of personality pathology. Thus, Morey and Benson (2016) sought to evaluate clinicians' judgments of the AMPD's utility in relation to specific treatment models and clinical decisions. In comparison with the established PD categories, Criteria A and B of the AMPD were found to be more strongly associated with cognitive therapy, exploratory therapy, antianxiety treatment, antidepressant treatment, antipsychotic treatment, antiseizure treatment, mood-stabilizing treatment, long-term prognosis, and determination of optimal treatment level. Only supportive therapy showed a stronger association with a categorical PD diagnosis. Remarkably, the Criterion A was rated as particularly relevant for estimation of long-term prognosis and optimal treatment intensity, suggesting that this global dimension is informative for clinical management, including prediction of outcome and decision-making. These findings are somewhat consistent with studies showing that the AMPD nosology aligns with various clinical theories, therapeutic paradigms, and targets of treatment (Bach & Bernstein, 2019; Bach et al., 2016; Hopwood et al., 2013; Mulay et al., 2018). For example, within the framework of schema therapy, a maladaptive schema of "abandonment" substantially aligns with the Criterion B facet of separation insecurity, whereas the trans-diagnostic mode of "healthy adult" substantially aligns with Criterion A (Bach & Bernstein, 2019). Similar patterns of clinically informative AMPD associations have been found for psychodynamic theory in general (Granieri et al., 2017; Natoli, 2019; Roche et al., 2018) including object relations theory (Clarkin et al., 2020; Sexton et al., 2019) and theory of mentalization (Zettl et al., 2020) more specifically. In light of these findings, it seems reasonable to suggest that the AMPD framework fulfills what the *DSM–III* and *DSM-IV* Axis II was originally intended for: to encourage awareness of personality itself and its implications for treatment (Morey & Benson, 2016).

Perceived Utility and Learnability Among Trainees

A mixed qualitative and quantitative study by Nelson et al. (2017) found that trainees generally favored the clinical utility of the AMPD's trait system in comparison with three other recognized diagnostic frameworks, which included the AMPD hybrid PD types (APA, 2013), the Shedler–Westen Assessment Procedure II (Westen & Shedler, 1999), and the 15 PD prototypes of the Psychodynamic Diagnostic Manual (Lingiardi & Mcwilliams, 2017). The general preference of the Criterion B trait system was specifically attributed to ease of use, comprehensiveness, understanding of the client, conceptualization of personality pathology, usefulness for treatment planning, potential for improving diagnostic assessment, and perceived association with therapeutic outcomes, among other factors. Yet, the Criterion B trait system showed no significant superiority with respect to the perceived utility for formulating a diagnosis and for capturing impairment in interpersonal relatedness.

Based on a clinical vignette rated by advanced doctoral students in clinical psychology, Garcia et al., (2018) examined the learnability, interrater reliability, and clinical utility of the AMPD. Their findings generally showed that student clinicians can learn Criterion A of the AMPD to a high level of interrater reliability and agreement with expert ratings. In addition, the interrater reliability of Criterion B (i.e., 25 trait facets) showed overall acceptable levels of agreement. Taken together, the authors concluded that the satisfactory interrater reliability and clinical utility ratings suggest that the AMPD's learnability is promising.

With respect to the aforementioned interrater reliability and learnability, Zimmermann et al. (2014) found that even untrained and clinically inexperienced students are able to consensually assess Criterion A, on a global level, based on a single clinical interview lasting between 60 and 90 min. However, impairments in the Criterion A subdomain of empathy were less reliably assessed than the other subdomains, which suggests that clinical training courses may be particularly helpful for this specific subdomain. Morey (2018) found that 194 college students, with minimal training in PD assessment and no training in the AMPD, were able to use the Criterion A indicators to effectively and reliably discriminate between relevant levels of severity. Likewise, Preti et al. (2018) found that untrained raters can reliably assess personality pathology by rating Criterion A based on material from the Structured Interview for Personality Organization, and even open-ended, nondiagnostic life-story interviews have been found to yield promising reliability when assessing Criterion A (Cruitt et al., 2019). In general, a number of studies from various cultures and settings largely support the interrater reliability of both Criterion A (Amini et al., 2018; Buer Christensen et al., 2018; Few et al., 2013; Hutsebaut et al., 2017; Preti et al., 2018; Somma et al., 2020; Weekers et al., 2021) and Criterion B (Few et al., 2013, Somma et al., 2020). Yet, there is room for improvement such as standardized clinical training with respect to certain subdomains of personality functioning (Zimmermann et al., 2014).

Acceptability and Preferences From the Examinee's Perspective

Although the aforementioned body of research on perceived clinical utility of the AMPD is promising, it exclusively focuses on the clinician's point of view, without considering examinee perspectives. Accordingly, Lengel and Mullins-Sweatt (2017) specifically sought to assess the usefulness and acceptability of computerized Criterion B trait assessment (and adaptive five-factor model traits) by examining participant opinions regarding individualized feedback. Findings largely supported their hypothesis that participants would favorably rate the personalized feedback's ability to comprehensively and accurately describe the way they typically think, feel, and behave with several clinical implications. For example, examinee ratings indicated that the trait descriptions were accurate and modestly helpful in addressing their problems in daily life, that the feedback, as a whole, was "worthwhile" and helpful, and that they would recommend such an assessment to others (Lengel & Mullins-Sweatt, 2017). Nevertheless, due to its combination with adaptive five-factor model traits, these findings may only partially apply to the Criterion B maladaptive trait model, and they may suggest that the inclusion of adaptive traits is worthwhile to focus on examinees' potential resources beyond psychopathology and dysfunction.

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Utility of AMPD to Capture Clinically Informative Features of Personality Pathology

An important initial study by Morey et al. (2013) evaluated the utility of Criterion A for diagnosing the presence of a PD. They found that a score of "2" or greater (i.e., at least moderate level) identified patients meeting criteria for a specific categorical PD diagnosis with 84.6% sensitivity and 72.7% specificity. Furthermore, this global severity index was a stronger predictor of clinician-rated psychosocial impairment than the 10 PD categories combined. Based on subsequent research, it is now well established that features corresponding to Criterion A are substantially associated with mental distress, poor well-being, and relationship problems (Anderson & Sellbom, 2018; Bach & Hutsebaut, 2018; Buer Christensen et al., 2020; Hopwood et al., 2018; Huprich et al., 2018; Siefert et al., 2020; Weekers et al., 2019). Notably, the study by Anderson and Sellbom (2018) only supported the utility of Criterion A features for measuring the global level of functional impairment, whereas the PD-specific impairments proposed in the AMPD hybrid approach were not supported. Recent comparative content analyses by Zimmermann et al. (2020) and Waugh et al. (2021) suggested that the aforementioned aspects of Criterion A's utility may largely be generalized across different operationalizations of the Criterion A.

Likewise, the utility of the Criterion B trait system for capturing a range of clinically relevant features related to personality pathology has been supported in a large number of studies. Various reviews and meta-analyses of studies investigating the validity of Criterion B's formally proposed operationalization revealed a replicable factor structure and meaningful convergence with existing personality frameworks and personality constructs in an expected fashion (Al-Dajani et al., 2016; Barchi-Ferreira Bel & Osório, 2020; Dunne, 2021; Miller et al., 2018; Watters & Bagby, 2018; Watters et al., 2019).

Elucidating Heterogeneous Features of Borderline PD

Borderline PD is derived from a historically important metaphor for severe personality dysfunction and has often been referred to as a "catch-all" diagnosis because it is a heterogeneous and complex pattern that potentially includes all core features of personality dysfunction including both internalizing and externalizing expressions accompanied by high rates of comorbidity, psychosocial impairment, and distress (Sharp, 2018; Tyrer, 2013). For that reason, the AMPD hybrid proposal for borderline PD not only involves pronounced Criterion A impairments (e.g., incoherent identity and severe relationship problems) but also a complex pattern of Criterion B traits including negative affectivity (e.g., emotional lability), disinhibition (e.g., impulsivity), and antagonism (e.g., hostility). This complex composition of Criterion B trait facets has largely been supported by meta-analytic evidence (Watters et al., 2019), whereas specific findings suggest that the portrayal of borderline PD could be further improved by including features of psychoticism (e.g., perceptual dysregulation) and detachment (e.g., suspiciousness). However, this insinuates that all of the five Criterion B domains may well apply to borderline PD (Bach, Sellbom, et al., 2016; Evans & Simms, 2018; Meisner et al., 2021; Sellbom et al., 2014). Thus, although most clinicians do not treat their patients at a diagnostic level (i.e., categorical diagnosis), but rather at a symptom level (i.e., individual problems), it seems obvious to use individual trait profiles when formulating individualized treatment for patients with borderline PD. For example, one patient may primarily need to work with aspects of separation insecurity and suspiciousness, whereas another patient may need to work with manifestations of impulsivity, emotional lability, and hostility. Accordingly, a study by Gamache et al. (2021) highlights that Criterion B facets of impulsivity and depressivity, respectively, may be especially important for distinguishing subgroups of patients with borderline PD. Moreover, a composite scale derived from PID-5 scores on emotional lability, anxiousness, separation insecurity, hostility, depressivity, impulsivity, and risk-taking has been found useful for differentiating affective symptoms of borderline PD from those of bipolar disorder (Fowler et al., 2019). Thus, we propose that the AMPD may help solve some of the shortcomings of the heterogeneous "catch-all" category of borderline PD with respect to clinical utility.

Utility for Capturing Features of Narcissism

The AMPD Criteria A and B were specifically intended to rectify the limitations of the narcissistic PD category, which fails to acknowledge both grandiosity and vulnerability, overt and covert presentations, and the dimensional nature of narcissism (Skodol et al., 2014). Expert reviews by Ronningstam (2016) and Schalkwijk et al. (2021), therefore, complimented the Criterion A for attending to regulatory processes in self- and interpersonal processes in a clinically informative manner. For example, the AMPD describes narcissistic pathology in terms of a vulnerable and fluctuating sense of self-worth (Criterion A), which may be regulated through approval, avoidance, or attention-seeking (Criterion B) altogether resulting in a pattern of overt or covert narcissism. Moreover, the dynamic aspect of Criterion A can be said to moderate the expression of Criterion B as per situational triggers from self-esteem injury (Ronningstam, 2016). Through the navigation of three cases of pathological narcissism varying in severity, Pincus et al. (2016) demonstrated the usefulness of the AMPD in distinguishing between narcissistic grandiosity and vulnerability and between varied presentations of narcissism more broadly.

An empirical study by Miller et al. (2013) showed that the designated Criterion B facets of narcissistic PD captured the grandiose type of narcissism rather than the vulnerable type, suggesting that the trait composition should perhaps be somewhat broadened to capture various expressions and underlying dynamics of narcissism. Moreover, a study by Fossati et al. (2017) showed that the antagonism facet of attention-seeking was associated with different established measures of narcissism, whereas grandiosity was only associated with some of these measures. One study by Garofalo et al. (2019) found narcissistic features in women to be associated with antagonism (i.e., grandiosity) along with negative affectivity (i.e., emotional lability). Similarly, a study by Wright et al. (2013) found that clinically relevant aspects of narcissism were not only captured by antagonism but also by features of negative affectivity and psychoticism. Likewise, in a study among older people, Stone et al. (2021) particularly found negative affectivity and antagonism to be associated with narcissism. Taken together, some of this evidence suggests that the AMPD trait domain of antagonism, including facets of grandiosity, attention-seeking, and callousness, could be augmented by features of negative affectivity to capture more vulnerable configurations of narcissism.

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Utility for Describing Psychopathy and Antisocial Behavior

A number of studies support the utility of the AMPD in capturing specific features of psychopathy and antisocial PD. Meta-analytical evidence supports that antisocial PD is predominantly characterized by Criterion B trait facets of callousness, deceitfulness, irresponsibility, impulsivity, risk-taking, manipulativeness, and hostility, in that order (Watters et al., 2019). This is largely consistent with the proposed AMPD hybrid-configuration for the antisocial PD type (APA, 2013). Moreover, this new alternative operationalization has been found to be more clinically useful in differentiating between borderline PD and antisocial PD in forensic settings (Anderson et al., 2018). Nevertheless, forensic practitioners usually find the traditional psychopathy construct more informative than the antisocial PD type, which is clearly mirrored in the research literature and clinical guidelines (Lynam & Vachon, 2012). For example, Strickland et al. (2013), Fossati et al. (2013), Crego and Widiger (2014), Few et al. (2015), and Wygant et al. (2020, 2016) found that a certain Criterion B trait configuration primarily composed of antagonism and disinhibition was in sound alignment with the construct of psychopathy, from which the antisocial PD diagnosis was originally derived. Moreover, Somma, Fossati, Ferraccuti, et al. (2019) specifically found the trait facets of callousness, hostility, and risk-taking to be better predictors of physical aggression in female inmates than any of the traditional PD categories, and Dunne et al. (2020) found the very same composition to predict aggression in incarcerated males. Thus, it is reasonable to propose that clinical programs should prioritize the aforementioned trait facets as primary treatment targets to reduce aggression propensity.

Research has supported that the Criterion B configuration for antisocial PD may be further augmented using facets of attention-seeking and reversed withdrawal to capture social potency (e.g., dominance and boldness) as well as reversed anxiousness and reversed emotional lability to capture the fearlessness and stress immunity associated with psychopathy (Anderson et al., 2014; Dunne, 2021). Accordingly, a novel psychopathy operationalization has been developed based on an elaborated version of the Criterion B psychopathy specifier, which is referred to as the PID-5 Triarchic Scales (Drislane et al., 2019). The PID-5 Triarchic Scales covers features of boldness, disinhibition, and meanness based on elements from callousness, deceitfulness, manipulativeness, risk-taking, attention-seeking, grandiosity, irresponsibility, hostility, reversed anxiousness, reversed submissiveness, anhedonia, reversed withdrawal, restricted affectivity, reversed emotional lability, impulsivity, and suspiciousness (Drislane et al., 2019). It is assumed that this new operationalization will further strengthen the diagnostic precision and utility of the AMPD for practitioners working in forensic practice.

Utility of Criteria A and B for Clinical Management and Treatment

It is of upmost importance that clinicians understand the rationale of separating Criteria A and B to benefit fully from the AMPD framework. The distinction between Criteria A and B has stimulated some debate because of their substantial cross-sectional and conceptual overlap (Mulay et al., 2018; Sleep et al., 2019; Zimmermann et al., 2015). Nevertheless, a longitudinal study by Roche (2018) demonstrated that Criterion A impairments oscillated across days and were triggered by daily negative emotions and cognitive distortions, whereas Criterion B traits were more stable by nature. Moreover, a study by Sexton et al. (2019) suggested that Criteria A and B interact in a rich and meaningful way, which they use to highlight the dangers of simply collapsing the two concepts. Thus, the overlap between Criteria A and B should not surprise clinicians as both criteria can be said to comprise two different perspectives on the very same PD phenomenon (i.e., global and changeable aspects of PD dysfunction vs. specific and stable expressions of PD dysfunction).

From a clinical perspective, it makes sense to distinguish Criteria A and B with regard to "global dysfunction" versus "specific dysfunction," "overall severity" versus "individual styles," and "interior struggles" versus "exterior manifestations." As illustrated by Weekers et al. (2020), case formulations may essentially use Criterion A to aid understanding of the core of an individual's vulnerability from the "inside" (i.e., something has gone awry with a person's mental self-representation in relation to others), whereas Criterion B can provide a helpful description of these vulnerabilities from the "outside" (i.e., individual stylistic expressions). In other words, Criterion A is the genus of personality pathology that captures how the person manages herself and her relationships, whereas Criterion B is the specie of personality pathology that describes the person and gives flavor to the dysfunction (Pincus et al., 2020; Sharp & Wall, 2021). Moreover, based on the aforementioned research, Criterion A may dynamically be used to track clinical functioning, whereas Criterion B traits remain relatively stable due to their temperamental nature (Wright et al., 2016). Therefore, traits tend to be more or less resistant to change, whereas the functional impairment is more malleable (Bach & Simonsen, 2021; Wright et al., 2016). Clinical practice should consequently focus attention on understanding the traits (i.e., Criterion B) while changing core personality functioning (i.e., Criterion A). Nevertheless, certain expressions of Criterion B may also mirror defensive functions such as withdrawal, intimacy avoidance, and rigid perfectionism, which makes Criterion B more fluid than what has been considered in conventional trait models (Huprich, 2018). Accordingly, such Criterion B features may be altered in response to intervention focusing on related coping mechanisms. Finally, it has also been suggested that Criterion A functioning should guide the level and intensity of required care, whereas Criterion B may be more informative in determining focus and style of treatment (Bach & Presnall-Shvorin, 2020; Bach & Simonsen, 2021; Bender et al., 2011). For example, traits may provide a better understanding of individual triggers and stressors that might provoke and intensify problems (e.g., suspiciousness), and thereby also provide indications on how to interact and establish a therapeutic relationship with the patient (see examples in Tables 1 and 2).

A Useful Diagnosis Says Something About Prognosis, Risk, and Outcome

A useful diagnosis can be said to provide nontrivial information about prognosis, risk factors, and likely treatment outcomes, which also includes the prediction of future management needs and preventive care (First et al., 2004). First, the patient's ability to remain in treatment is of high importance to treatment outcomes. Busmann et al. (2019) found the AMPD Criterion A to be significantly predictive of premature treatment discontinuation in PD

Table 1
Tentative Recommendations for Clinical Management and Treatment According to Criterion A: Level of Personality Functioning

Severity	Prognosis	Structure	Risk	Therapy alliance
Level 1	Excellent	Less need for a structured contract.	Little to no risk of acting out.	Clarity about seeking help from a therapist; open to establishing an alliance (i.e., epistemic trust).
Level 2	Good	Explicitly agreed-upon treatment contract.	Risk of low-level acting out (e.g., increased risk of dropout).	Ambivalence about seeking help and depending on the therapist complicates the initial alliance. Early alliance is unstable or superficial.
Level 3	Fair	Treatment contract must be carefully constructed.	Some risk of dangerous acting out (e.g., suicide gestures or attempts, substance misuse).	Alliance is compromised by mistrust with fear of critical attack or exploitation by the therapist.
Level 4	Very guarded	Contracting must be extensive with a focus on secondary gain and safety of patient and therapist.	Potentially lethal acting out (e.g., threats of violence to therapist, lethal suicide attempts).	A rigid or relatively fixed view of a therapist as arrogant, corrupt, and exploitative, which limits capacity to form an alliance.

Note. Criterion A recommendations are adapted from proposals by Clarkin et al. (2020) and Bach and Simonsen (2021). The continuum from "Level 1" (some impairment) to "Level 4" (extreme impairment) indicates expected intensity of clinical management and support. "Level 0" (healthy functioning) is not included in this table. Patients at the milder levels can be said to benefit from a more interpretive approach whereas patients at the severe levels benefit from a more supportive approach.

patients, which particularly applied to self-functioning. Interestingly, this study also indicated that general measures of psychosocial impairment did not predict this outcome, which underscores the distinct utility of Criterion A for this purpose. Research has also demonstrated the utility of the Criterion B trait domains and facets for predicting the likelihood of premature termination. Using a large sample of psychiatric patients in treatment, Rodriguez-Seijas et al. (2020) found that patients who terminated treatment prematurely particularly reported higher levels of disinhibition and psychoticism domains. More specifically, Berghuis et al. (2021) investigated the utility of Criterion B trait facets in predicting dropout in an intensive outpatient setting for PD patients. They mainly found the facets of perceptual dysregulation, unusual belief and experiences, suspiciousness, rigid perfectionism, and low scores on restricted affectivity to be significant predictors of dropout from treatment.

The AMPD has also been linked to other important clinical and psychosocial outcomes, which may help inform the intensity of intervention and prevention. With respect to Criterion A, Kampe et al. (2018) found impairment of personality functioning to be associated with suicidal attempts and frequency of psychiatric hospitalization. This finding is generally consistent with other studies showing that Criterion A predicts psychosocial impairment in psychiatric patients, and even more than categorical PD criteria (Buer Christensen et al.,

Table 2
Tentative Recommendations for Clinical Management and Treatment According to Criterion B: Maladaptive Personality Trait Domains

Trait domains	Examples
Negative affectivity	Treatment focusing more globally on emotion regulation, anxiety, and sadness in terms of building up distress tolerance, self-compassion, mentalization, acceptance of negative emotions, and implementation of stress management skills. In cases of self-harm, distraction techniques and alternative coping strategies are helpful.
Detachment	Therapy may deal with lack of interest in or avoidance of relationships, mistrust, withdrawal, independence, emotional inhibition, and interpersonal ambivalence by means of behavioral activation along with social skills and assertiveness training. In some cases, it may be best to help the patient manage own innate need for withdrawal in an adaptive manner while shielding from too much social stimuli.
Antagonism	Therapy may include empathic confrontation while using rational and utilitarian arguments that focus on the benefits of prosocial behavior. Coping behaviors of self-aggrandizement and dominance can be gradually exchanged with healthy adult behavior while gaining access to underlying vulnerability.
Disinhibition	In behavior-focused therapy, the therapist identifies what is rewarding or punishing for the patient, which must be strong enough to effectively change the likelihood that problematic disinhibition takes place. May benefit from learning certain skills for everyday life as if they had ADHD. Regulation skills are particularly relevant in cases of potential harm to self or others.
Psychoticism	Improving reality-testing skills including emotion recognition and separating facts from beliefs. Helping the patient make good decisions about communicating with others about their unusual thinking, which may include social cognition training. In cases of derealization, depersonalization, and PTSD symptoms, a trauma-focused approach might be relevant. Antipsychotic drugs may be considered in cases of severe manifestations.

Note. Criterion B recommendations are adapted from Hopwood (2018) and Bach and Presnall-Shvorin (2020). An overall goal of treatment is to help the patient find more adaptive expressions of their maladaptive traits. ADHD = attention-deficit hyperactivity disorder; PTSD = posttraumatic stress disorder.

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2020). With respect to Criterion B, the trait domain of negative affectivity has been identified as a significant predictor of nonsuicidal self-injury in a sample of adolescent inpatients (Somma, Fossati, Ferrara, et al., 2019), and trait facets of hostility, callousness, and risk-taking have been found to explain physical aggression in personality disordered psychotherapy patients (Somma, Krueger, et al., 2019). These findings are also somewhat consistent with a prospective study by Wright et al. (2015), which found that Criterion B traits measured at baseline significantly predicted psychosocial functioning and life satisfaction approximately 1.5 years later.

Taken together, Criteria A and B can provide clinically useful information about the risk of treatment dropout, risk of harm to self- and others, as well as prognostic information about psychosocial impairments. For more specific details, see Bach and Simonsen (2021).

Concluding Comments With Future Recommendations

Shortly after the official release of the AMPD, the Personality and Personality Disorders Work group members declared that if "the Section III model continues to perform as early studies suggest, the possibility exists for it to migrate in its existing or some revised form into Section II of a planned *DSM–5*.1" (Skodol et al., 2013, p. 348). Now, after 10 years of accumulated research with compelling support for the clinical utility of the AMPD, the aforementioned migration seems even more plausible.

In the years before the *DSM–5* was released, renowned experts shared their concerns pertaining to the new model lacking clinical utility (Shedler et al., 2010) and the removal of PD categories being unjustified (Kernberg, 2012). The present review suggests that these concerns were largely premature. Nevertheless, as is usually the case for any diagnostic system, there is room for improvement.

As indicated by the aforementioned research on Criteria A and B versus PD categories, it now seems timely to leave behind the "hybrid" PD types while of course remaining recognizant of their immense historical importance. A major reason for including the six "hybrid" PD types in the AMPD was to ensure a smooth transition from categories to dimensions (Zachar & First, 2015). Now, after 10 years of research and clinical testing of the AMPD, it may no longer be necessary to adopt such a transitional approach. The cumbersome matching of specified Criteria A and B features with distinct configurations of PD types may indeed be experienced as a trip into the jungle by busy clinicians (Tyrer, 2012). Across virtually all reviewed studies, the AMPD outperformed the PD types with respect to perceived clinical utility, prognostic utility, prediction of psychosocial impairment, and ability to inform clinical management. With regard to the Criterion A, the utility of the global level of functioning has received the most empirical support, whereas the PD-specified impairment configurations received the least (Anderson & Sellbom, 2018). With regard to Criterion B, research suggests that eliminating the trait-specified PD types and exclusively having an individual trait profile as the only diagnosis has been deemed more parsimonious and clinically useful (Clark et al., 2015). In any case, if the proposed "hybrid" PD types are retained in a future *DSM–5*.1 or *DSM–6*, they must at least be revised according to accumulated research, which is particularly relevant for borderline PD, antisocial PD and psychopathy, and narcissistic PD.

All World Health Organization member countries, including the United States, must soon get accustomed to the *International Classification of Diseases, Eleventh RevisionI* (ICD-11), classification of PDs, which overlaps substantially with the AMPD (Tracy et al., 2021). Thus, a strong argument can be made for improving the AMPD's harmonization with the ICD-11, classification. This could be accomplished by omitting the hybrid PD types while keeping a more pure diagnostic classification of PD severity and traits along with the option of specifying a borderline pattern. Such revision would also allow for a more efficient assessment for busy practitioners working in general psychiatry and primary care while retaining the possibility of a more fine-grained elaboration of the PD diagnosis in specialist settings. We recommend that future research highlight the AMPD's potential value for optimal allocation of clinical resources, communication between clinicians and their patients' relatives, and utility for informing different treatment modalities. Finally, we recommend future literature reviews to cover the AMPD's clinical utility in relation to other clinical problems such as addictive behaviors, trauma disorders, eating pathology, and schizophrenia spectrum disorders, which were beyond the scope of the present article.

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