Personality Disorders: Theory, Research, and Treatment

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ISSN: 1949-2715

2022, Vol. 13, No. 4, 380–382
https://doi.org/10.1037/per0000578

COMMENTARY

Opportunities and Challenges of New Classification Systems for Personality Disorders: Commentary on "Clinical Utility of the AMPD: A 10th Year Anniversary Review"

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At the time of publication of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* alternative model of personality disorders, skepticism regarding the clinical utility of a dimensional conceptualization of personality disorders was high including questions about its feasibility for clinicians, its reliability, predictive value, and implications for science and treatment. Following huge research activities summarized by the article of Bach and Tracy (2022), there is meanwhile convincing evidence that a dimensional classification of personality disorders that meets with high utility for clinical decision-making is accepted by clinicians and meets with patients¨ needs because it can be easily connected with treatment planning oriented at functional impairments rather than diagnostic categories. Being close to mechanistic models of psychopathology, the alternative model of personality disorders provides a suitable framework to converge self- and interpersonal dysfunctioning indicated in Criterion A with (sub-)domains of the Research Domain Criteria and Hierarchical Taxonomy of Psychopathology systems and, thus, to inspire research to better understand the psychological and neurobiological mechanisms of change.

Keywords: dimensional classification, functional impairments, clinical decision making, patients' needs

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In May 2013, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM–5*) was published. Although the need for a revision of the section on personality disorders had been stipulated for a long time, the *DSM–5* kept to the distinct categories of specific personality disorders. However, in Section 3 of *DSM–5*, a hybrid alternative model of personality disorders (AMPD) was published with the idea to accumulate more research for this new classification of personality disorders (APA, 2013). The AMPD includes a dimensional classification of the severity of impairments in personality functioning (Criterion A) as well as the specification of predominant maladaptive personality traits (Criterion B), which could then be related to the six most common personality disorders. These distinct categories were included to smooth the transition from the traditional categorical classification to a pure dimensional classification. This seemed of particular importance because at the time of its publication, skepticism regarding the clinical utility of a dimensional conceptualization was high, including questions about its feasibility for clinicians, its reliability, predictive value, and implications for science and treatment (Tyrer, 2012). Now, almost a decade after the publication of *DSM–5* AMPD, Bach and Tracy (2022) have summarized the empirical studies investigating its clinical utility. This is of particular importance because the AMPD has been mainly introduced for reasons of reliability and validity (Skodol, 2012), while receiving major critique for its complexity including doubts about its acceptance by practitioners and patients, its learnability, and utility for clinical decision-making (Gunderson, 2010; Tyrer, 2012).

First, we would like to emphasize the sheer number of studies of interest (1,281 studies) documenting a broad interest in the evaluation of the *DSM–5* AMPD's clinical utility. Since its introduction, the AMPD has stimulated research on personality disorders and improved our understanding of personality disorders in a critical way. Reflecting more closely mechanistic models of psychopathology, such as the Research Domain Criteria (RDoC; Insel et al., 2010) or the Hierarchical Taxonomy of Psychopathology (HiTOP; Kotov et al., 2021), the dimensional approach of the AMPD may support research on underlying personality dysfunction in general and specific impairment in particular that will eventually improve therapeutic decision-making as well as the evaluation of mechanisms of change of specific therapeutic interventions (Insel et al., 2010). Furthermore, there is notable convergence in the assessment of personality functioning between *DSM–5* AMPD, *International Classification of Diseases, 11th Revision* (*ICD-11*),

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but also psychodynamic conceptualizations, such as the operationalized psychodynamic diagnosis providing common grounds for communication, classification, and treatment (Blüml & Doering, 2021).

Second, in all respects, Bach and Tracy (2022) provide strong evidence for the clinical utility of the AMPD. Across studies, AMPD has been regarded as more useful than the traditional personality disorder categories by clinicians independent of their discipline and level of training. Specifically, Criterion A (Levels of Personality Functioning) has been considered as useful for treatment formulation and communication with patients and to better reflect the dynamic course of dysfunctioning (Ronningstam, 2016) as indicated by longitudinal studies (Gunderson et al., 2011). As mentioned, there is consistent evidence for a stronger alignment of the AMPD nosology with various clinical theories but also therapeutic paradigms and target of treatment than with the traditional personality disorder categories (Bach & Bernstein, 2019). Furthermore, the AMPD was generally favored by trainees. Particularly, the trait system of Criterion B was favored because of many reasons including ease of use, understanding, treatment planning, diagnostic assessment, and therapeutic outcome (Morey et al., 2014). These data do not confirm previous criticism that the complexity of AMPD might undermine its feasibility and clinical utility. In addition, there is first evidence indicating the learnability of the AMPD with high interrater reliability even in relatively unexperienced student samples (e.g., Zimmermann et al., 2014). These results may be regarded as first evidence for the feasibility of assessing the AMPD —and in particular Criterion A (Levels of Personality Functioning) —in clinical routine and by general practitioners, where limited time might be available for extensive trainings of diagnosticians and assessment routines. Maybe most intriguingly, the AMPD has also been shown to be highly accepted and preferred by patients who found the individualized feedback more helpful and informative than the traditional personality disorder diagnoses (Lengel & Mullins-Sweatt, 2017). Finally, there is proof for high sensitivity and specificity of personality features. Moreover, the Global Severity Index has been found to be a stronger predictor of psychosocial impairments than all classical personality disorder categories together (Morey et al., 2013), and the factor structure of Criterion B has been replicated and shows meaningful convergence with existing personality frameworks speaking for its validity (Watters et al., 2019).

With regard to specific personality disorders, the AMPD might help to reduce heterogeneity (particularly of such broad categories as borderline personality disorder, which include a variety of internalizing and externalizing symptoms and extensive comorbidities) and may thus support the individualized treatment planning. However, as stated by Bach and Tracy (2022), the broad evidence for the validity, reliability, acceptance, and feasibility of Criteria A and B strongly suggest to drop the classical categories in the next revision of the *DSM*. We also agree that a convergence of the *DSM* and the *ICD* systems for the assessment and diagnosis of personality disorder in favor for a purely dimensional model might be the next steps. We would like to emphasize the table provided by Bach and Tracy (2022) in which they describe potential clinical implications of the different Levels of Personality Functioning in Criterion A as well as predominant traits in Criterion B for treatment. This table nicely shows that the overlap between both criteria do not undermine the validity of the classification system but serve the purpose of describing personality disorders from two different but important angles: first, by assessing the severity or quantity of impairments that inform about the need for structure and intensity of treatment and, second, by assessing the quality of impairments providing information about particular clinical needs that should be targeted by specific interventions and recognized by therapists to support the development of a reliable therapeutic relationship. Taken together, at its 10th anniversary, Bach and Tracy (2022) provide strong evidence in favor for the AMPD system.

In strong agreement with Bach and Tracy (2022), we would like to raise some challenges that should be addressed to further improve our understanding, assessment and treatment of personality disorders.

First, we would like to underline the need for convergence between different diagnostic systems, primarily the *ICD* and *DSM* with regard to personality disorders. This particularly challenges the differences in the AMDP Criterion B or *ICD-11* prominent personality traits, respectively, concerning rather fundamental conceptual differences of the psychotic spectrum between the *DSM* and *ICD* traditions. The step toward a purely dimensional model in the *ICD-11* together with the proven clinical utility of the AMPD provide strong arguments for integrating a modified version into Section II of the *DSM*. This would improve the communication and increase use of dimensional models in both research and clinical practice, the more as *ICD-11* allows different levels of depth in the diagnostic process such as restricting to the evaluation of severity and pervasiveness of functional impairment (analogue to AMPD Criterion A) in a clinical setting of nonspecialists.

Second, recommendation on further developments of standardized assessments for Criteria A and B are urgently needed, although several instruments including short self-report scales have already undergone comprehensive validation processes (for example, the Brief Self-Report Questionnaire for the Assessment of the *DSM–5* Level of Personality Functioning Scale [Hutsebaut et al., 2016] or the Personality Inventory for *DSM–5*-BF [Porcerelli et al., 2019]). This goes hand in hand with the lack of communication and the need for training of clinicians in the new dimensional models and their assessment. Specific assessment instruments may need to be developed for certain populations, such as forensic patients, adolescents, or elderly individuals. Furthermore, little is known about sex and gender differences or effects of cultures.

Third, the dimensional models provide challenges for research. Underlying psychological and neurobiological mechanisms of self- and interpersonal dysfunctions should be investigated, which may require to break down broad constructs, such as identity into aspects that can be addressed not by self-reports, but also with experimental approaches. Finding a way to converge self- and interpersonal functioning with (sub-)domains of the RDoC and HiTOP may support such a process to capture all aspects involved in personality dysfunctions (Bornstein, 2019). A particular challenge might be how to relate the existing literature that is mainly based on the comparison of one or two specific personality disorder categories with (super-) healthy controls to the new dimensional classification and aspects of self- and interpersonal dysfunctions. In breaking new grounds, the scientific community interested in the study of personality disorders needs to reorganize itself, define new inclusion and exclusion criteria and come up with new

paradigms and analyses to capture Criteria A and B in a reliable and valid way.

Fourth, the new diagnostic systems also affect treatment planning and treatment development. Diagnosing personality disorders according to severity of functional impairments and maladaptive trait profiles will provide new opportunities for individualized, modular treatments, which however require new randomized control clinical trials with complex designs and analysis strategies to arrive at targeted, evidence-based decision trees. Notably, the selection of interventions based on a dimensional, functionally oriented classification systems provides the chance of going hand in hand with the new treatment approaches of predictive psychiatry and psychotherapy (Dwyer et al., 2018).

Fifth, the advantages of the dimensional classification of personality disorders have to be communicated with patients' advocates and measures of patient-reported outcomes have to be harmonized with the new diagnostic approach. Finally, stakeholders' literacy has to be focused on to ensure that the period needed for the changeover from categorical to dimensional classification must not be at the expense of patients due to impaired access to treatment.

In sum, the dimensional approach to personality disorders inspires hope to encourage scientists' and clinicians' awareness of personality as a main predictor of mental health and illness and to broadly include interventions that target personality dysfunctioning in the treatment of mental disorders.

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