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Scripting the DSM-5 Alternative Model for Personality Disorders assessment procedure: A clinically feasible multi-informant multi-method approach

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ABSTRACT
Published case studies on the DSM-5 (section III) Alternative Model for Personality Disorders (AMPD) generally utilized unstandardized assessment procedures or mono-method approaches. We present a case from clinical practice to illustrate a standardized, clinically feasible procedure for assessing personality pathology according to the full AMPD model, using a multi-method approach. We aim to present a procedure that can guide and inspire clinicians that are going to work with dimensional models as presented in DSM-5 and ICD-11. Specifically, we show how questionnaire and interview data from multiple sources (i.e. patient and family) can be combined. The clinical case also illustrates how Criterion A (i.e. functioning) and B (i.e. traits) are interrelated, suggesting that the joint assessment of both Criterion A and B is necessary for a comprehensive and clinically relevant case formulation. It also highlights how multi-method information can enhance diagnostic formulations. Finally, we show how the AMPD model can serve treatment planning and provide suggestions for how patient feedback might be delivered. © 2020 John Wiley & Sons, Ltd.

Introduction

In this paper, we will present a standardized, clinical approach to assessing personality pathology using the Alternative Model for Personality Disorders (AMPD) model. Using a multi-informant multi-method (MI–MM) approach, we aim to demonstrate how different instruments (questionnaires and interviews) from different sources (patient and family) can be combined in a semi-structured procedure. Furthermore, we aim to demonstrate how this information may be profitably shared with the patient and how it may inform treatment planning. To contextualize this procedure, we offer an elaborate case presentation to illustrate each step. Before detailing the procedure, we will provide a quick review of AMPD research findings that guided our choices in designing our AMPD assessment procedure.

The personality disorder field is currently shifting from categorical models of personality disorders (PDs) towards dimensional models. ICD-

11[1] recently introduced a dimensional model in their chapter on PDs; DSM-5 however introduced a dimensional model as an alternative approach to the assessment of personality pathology in DSM-5 section III (i.e. AMPD).[2] Because the AMPD model has already been extensively evaluated and used for clinical purposed in a number of years, the present article focuses on this approach, while underscoring that the same utility is expected to apply to the ICD-11 classification as well.[3] The DSM-5 AMPD comprises a profile of impairments in self- and interpersonal functioning along with a constellation of pathological traits.[2,4] Assessment follows a stepwise procedure, enabling subsequent diagnostic refinement. Clinicians start with assessing impairments in self- and interpersonal functioning (Criterion A), using the Level of Personality Functioning Scale (LPFS), followed by an assessment of 25 maladaptive trait facets that are organized in the five broad domains of Negative Affectivity, Detachment, Antagonism, Disinhibition and Psychoticism (Criterion B). By checking stipulated type-specific criteria, clinicians can determine whether the profile of Criterion A impairments and Criterion B trait facets matches one of six specific types of PDs, provided that patients meet Criteria C–G of the general diagnostic requirements. Additionally, a trait-specified PD diagnosis is provided for patients suffering from at least moderate impairments in personality functioning but whose presentation is not matching one of the specific types (corresponding to 'other specified' in DSM-5 Section II). Finally, the clinician may refine this global assessment by specifying the different severity scores and relevant trait facets, allowing dimensional specifiers beyond the categorical diagnosis. The AMPD model encompasses both strengths and impairments in functioning, along with resilient versus pathological features. The profile of personality functioning and traits may thus yield a balanced picture of the patient's psychological infrastructure, interpersonal dynamics and clinical prognosis and may accordingly be especially informative for treatment planning..[5,6]

The first and foremost step in the AMPD model is the assessment of personality related impairment, i.e. Criterion A, without which no PD can be present. Research into the reliability of the level of personality functioning ratings has yielded mixed results. Using a case–vignette methodology in which brief case information was selected and narratively organized by the research team, Garcia and colleagues[7] observed promising reliability of LPFS ratings. However, reliability ratings were lower when students or clinicians had to self-select the information from the clinical interviews to infer LPFS ratings.[8,9] To assess Criterion A, several interview and self-report instruments have been specifically developed.[10–17] Studies using these specific interview instruments showed superior interrater reliability compared to non-specific clinical interviews with respect to the assessment of Criterion A.[14,18] Furthermore, there is supportive evidence for internal consistency and construct validity for self-report questionnaires assessing personality functioning.[10,12,13,15,17] However, no studies have investigated the convergent validity of self-report versus clinical interview ratings.

Subsequent to the assessment of the LPFS (Criterion A), the specific expression of personality dysfunction is delineated in terms of stylistic traits (i.e. Criterion B). The majority of Criterion B research draws upon a self-report instrument: the Personality Inventory for DSM-5 (Personality Inventory DSM-5 (PID-5)).[19] The PID-5 shows a stable factor structure across different samples and cultures, with good internal consistency at domain and facet levels.[20] Furthermore, Bach and colleagues[21] demonstrated that findings from non-clinical data were generalizable to clinical populations thus supporting the results of many non-clinical studies. Although the Structured Clinical Interview for DSM-5–Alternative Model of Personality Disorders Module II (SCID-AMPD)[11] provides an interview-based alternative, no studies to date have examined its reliability. Previous studies showed a wide variation in reliability scores when traits were assessed based

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upon clinical vignettes.[7] As was noted for Criterion A, no convergence studies have been conducted between questionnaire-based assessment of traits versus interview-based ratings.

Clinical application of the AMPD not only requires assessment of Criteria A and B, but also a clinical integration of the comprising elements in a way that represents the nature of a patient's problems and informs subsequent treatment. Such profitable integration relates to the issue of clinical utility, which has received rather scant attention in the AMPD research to date, but may be what matters most to clinicians. Early critics of the AMPD model have questioned the ease of use of the model in clinical practice.[22,23] Morey and colleagues[24] assessed the clinical utility of the AMPD model by asking clinicians to diagnose their own patients using the DSM-IV-TR categorical diagnosis and the AMPD model. Clinicians reported that the AMPD model was as useful or more useful than the categorical system especially with respect to communication with patients, treatment formulation, comprehensiveness and global descriptive utility. A similar survey on the ICD-11 PD classification using the same approach concluded that mental health professionals (i.e. psychologists, psychiatrist and nurses) generally preferred the ICD-11 dimensional approach over the ICD-10 categorical approach, particularly in respect to utility for treatment formulation.[25] Furthermore, some authors have illustrated the clinical value of the AMPD model by describing case studies.[26–33]Although these demonstrations of the clinical utility of the AMPD model are informative and inspiring, they also have some limitations. First, most case studies lack the standardized use of specifically tailored assessment instruments for both Criteria A and B.[28,30–33] As noted, the reliability of the Criterion A assessment appears to benefit from the use of specifically designed instruments. Second, most case studies relied on the patient as the exclusive source of information, especially with regard to Criterion B.[26,29,33] However, patients with (severe) PDs frequently have difficulty reflecting on their internal experiences and may offer an incomplete and/or biased picture of their functioning.[34] In similar vein, the wholesale reliance on a self-report inventory (e.g. PID-5) to assess traits could be questioned.[35] Finally, most case studies[29–31] were limited in their description of how the AMPD information may be used to inform treatment or how feedback could be provided to the patient. To address these issues, we developed a standardized clinical approach to assessing personality pathology using the AMPD model. Given the conceptual overlap between the AMPD and the PD chapter in ICD-11, this clinical approach may also be informative for clinicians that are going to use ICD-11.

A multi-method multi-informant Alternative Model for Personality Disorders assessment procedure

We will now describe the successive steps of the AMPD assessment procedure (Figure 1) and illustrate each step by describing the case of a 39-year-old man, henceforth called 'Adam', referred for help by his general practitioner (GP) for psychiatric assessment and evaluation for treatment. Adam gave full written consent to utilize his clinical records for the current case illustration.

Step 1: Collect relevant referral information regarding personality functioning and personality traits in social, occupational and relationship domains. At referral, some information pertinent to the patient's personality functioning may be immediately available (e.g. based upon earlier treatment or reasons for referral). Additional information may be collected from previous therapists or the GP. Relevant topics include current social network, stability of intimate and family relationships and course of academic and professional career.

Adam described a long history of prematurely terminated studies, discontinued jobs, along with enduring sleeping problems, stress complaints and low mood. The GP surmised that this pattern of problems might be rooted in his personality. At the time of the intake, Adam held no paid job but

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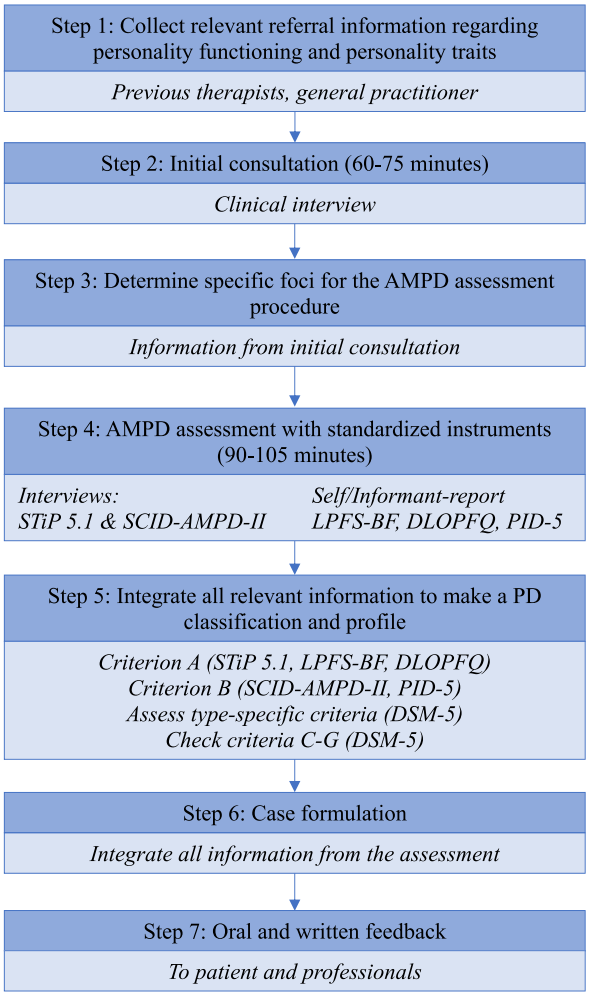

Figure 1: Stepwise approach to AMPD assessment

did some voluntary work in a home for the elderly. According to the GP, Adam spent a lot of time gaming and seemed to have a very limited social network.

Step 2: Conduct a clinical intake interview. The initial consultation will usually consist of an open-ended clinical interview. The therapist explains the full assessment procedure and invites the patient to talk about his or her own reasons for seeking help. Furthermore, s/he invites information of the patient's developmental background, family of origin, current and past relational and professional context, previous treatment history and medication use.

It warrants mentioning that Adam presented at the clinical intake interview accompanied by his mother, though not upon our request. His mother explained that Adam might be inclined to 'mislead' the clinician by providing 'too positive a view of himself and his problems'. Adam in fact agreed and added he experienced difficulty in providing an overview of his current situation. Both Adam and his mother seemed highly stressed and fearful. We observed that Adam frequently behaved rather submissively; being overly polite, highly apologetic or frequently praising the clinician. Moreover, Adam tended to intellectualize when talking about his problems, using difficult and often rather vague language, without reference to specific, concrete examples of his personal issues. His mother would interrupt and then fill in for Adam during the consultation.

With regard to his family of origin, Adam described his father as a 'verbally abusive man' who would often target him for severe scolding. His parents divorced when he was 16 years old. Adam and his mother drew a picture of persistent social and emotional problems over the course of his childhood. First, starting in early adolescence, Adam had recurring depressive episodes. Moreover, Adam had always experienced difficulties in connecting with his peers. He was repeatedly and severely bullied in primary school, and he changed schools several times to escape this. His parents put him in a protective school for children with special needs. After completing primary school, he was advised to follow a lower level technical secondary school, although later testing revealed intelligence in the superior range.

After leaving secondary school, Adam initiated several studies, including Engineering, Philosophy, Law, Psychology and most recently Social Work Studies. However, he failed to complete any of these studies: Adam would begin enthusiastically, but after some time he, got increasingly stressed and then prematurely terminated his

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studies. Over the past 20 years, he accrued a study loan of 40 000 euros. During this period, he held many temporary jobs that usually ended up in conflicts with superiors. Adam then either withdrew and simply stopped showing up or got into a verbal fight and was subsequently fired. He explained his behaviour as being a response to experienced injustice from superiors.

Adam explained that he typically got very upset when feeling pressured to do something. He preferred to be alone and not feel demands from others, but he also recognized that complete withdrawal created increased feelings of loneliness and depression. Adam disclosed that he felt 'like a failure' with no future perspective, and he had become increasingly desperate. In fact, he reported feeling anxious and depressed most of the time and that he sought relief from the negative emotions by withdrawing socially. Instead, he had been seeking refuge in online gaming. At times, the stress was also causing him physical complaints including severe headaches. He had also developed a pattern of compulsions, like counting, to avoid feeling miserable.

Adam reported a history of suicidal ideation but never to the point of planning or making a suicide attempt. He had never engaged in deliberate self-injury, but his mother reported extended periods of neglected self-care. Adam seemed ambivalent about seeking help. On the one hand, he would often minimize his problems (for example saying he was 'just lazy'). On the other hand, he had grown increasingly demoralized and despondent, and indicated he did not see his way out of this situation.

Step 3: Integrate referral and intake information to determine specific foci for the Alternative Model for Personality Disorders assessment procedure. Prior to conducting the Criteria A and B interviews, the clinician integrates all available information to appraise which areas of personality functioning or trait facets may be especially relevant for subsequent exploration. Although all elements of personality functioning and trait facets will be explored in the assessment, noting specific areas of interest based on the referral and intake information helps the clinician to develop some tentative hypotheses regarding the level of personality functioning and trait elevations that can help focus the assessment.

Based on the collected information, several foci of attention could be identified. Regarding the LPFS domains, there was clear evidence of severe problems in self-direction, as reflected by Adam's longstanding inability to complete studies and hold jobs. Adam's history was also suggestive of impaired self-esteem and his social isolation and inability to collaborate in a professional context as expressed in repeated conflicts with superiors pointed to interpersonal impairment. With respect to personality traits, there were several indications of easily triggered antagonism, as exemplified by his recurring conflicts at work. Conversely, his general overly friendly and compliant demeanour suggested submissiveness. His chronic stress may point to increased dysfunctional negative emotions. Finally, several indications of detachment were evident, e.g. his extensive social withdrawal and him seeking refuge in isolated activities (e.g. gaming). In sum, Adam's history was consistent with a wide range of impairments in personality functioning along with several pronounced maladaptive traits, to be explored further in specific AMDP assessment.

Step 4: Administer standardized measures of personality functioning and traits, involving different sources of information. Our procedure includes the collection of self- and informant report data along with clinician-ratings based on structured clinical interviews. Here, we will briefly describe the instruments used in the assessment.

The Level of Personality Functioning–Brief Form 2.0

The Level of Personality Functioning–Brief Form 2.0 (LPFS-BF 2.0) is a 12-item self-report questionnaire[17] with a 4-point Likert scale for assessing Criterion A of the AMPD. Internal consistency

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estimates for the LPFS-BF 2.0 were high in a sample of patients with PD, with $\alpha = 0.82$ for the total scale and $\alpha = 0.79$ and $\alpha = 0.71$ for the Self- and Interpersonal Functioning Scales.[17] We developed an informant version of the LPFS-BF 2.0 as an adaptation from the original LPFS-BF 2.0 for the current study.

DSM-5 Levels of Personality Functioning Scale

The DSM-5 Levels of Personality Functioning Scale (DLOPFQ) is a 66-item self-report questionnaire[12] for assessing the level of personality functioning (Criterion A) of the AMPD. Items are rated on a scale from 1 (strongly disagree) to 6 (strongly agree). The questionnaire yields scores for the four elements of the LPFS (Identity, Self-direction, Empathy and Intimacy). Internal consistency of the scales was high in a sample of in- and outpatient psychiatric patients with α's ranging from 0.72 to 0.94.[12]

Personality Inventory DSM-5 (PID-5)

The PID-5 is a 220-item self-report questionnaire for assessing the Criterion B pathological traits of the AMPD.[19] Items are rated on a scale from 0 (very false or often false) to 3 (very true or often true). The questionnaire consists of 25 facets (maladaptive personality traits), constituting five higher order domains (Negative Affectivity, Detachment, Antagonism, Disinhibition and Psychoticism). Internal consistency of the facets was high in a community sample with Cronbach's α's ranging from 0.72 to 0.96.[19] We used both the self-report as well as the informant version of the PID-5.

Semi-Structured Clinical Interview for Personality Functioning DSM-5[14]

The Semi-Structured Clinical Interview for Personality Functioning (STiP 5.1) is a semi-structured interview for assessing the 12 capacities of the LPFS; clinicians rate each capacity from level 0 (little or no impairment), level 1 (some impairment), level 2 (moderate impairment), level 3 (severe impairment) to level 4 (extreme impairment). In a previous study reporting on both a clinical and community sample,[14] internal consistency of the STiP-5.1 was high with a Cronbach's alpha of 0.97 for the total scale and 0.94 for both the self-functioning and interpersonal functioning domain. Interrater reliability was good, with ICCs ranging from 0.81 to 0.92 in the total sample, and ICC's ranging from 0.58 to 0.81 in the clinical sample.[14] Administration time is instrumental and requires between 45 and 60 min to administer and yields clinician-rated element-, domain- and total impairment scores for all 12 capacities.

Structured Clinical Interview for DSM-5 Personality Disorders–Alternative Model of Personality Disorders, Module II (specifically translated to Dutch for this study by the authors)[11]

The SCID-AMPD Module II is a semi-structured interview assessing pathological personality traits. The clinician is to evaluate the degree to which each trait facet is descriptive of the patient: 0 (not descriptive), 1 (mildly descriptive), 2 (moderately descriptive) or 3 (very descriptive). To our knowledge, no information on the psychometric properties of the interview are available yet. We omitted the 'general overview' questions of the SCID-AMPD Module II because this information (demographic variables, education and work history and current and previous psychiatric complaints) was presumably already covered in the intake interview. Administration of SCID-AMPD Module II requires another 45 min; total administration of the interview schedules thus ranges from 90 to 105 min.

Table 1 and 2 display the scores of both Adam and his mother. Scores on the LPFS-BF 2.0 range from 1 to 4, with higher scores reflecting more severe personality dysfunction. The DLOPFQ scores range from 14 to 114, again with higher scores reflecting more severe personality dysfunction. PID-5 scores range from 0 (not at all descriptive) to 3 (very descriptive). We calculated *T*-scores (in parenthesis in Tables 1 and 2) to compare Adam's scores to a normative clinical sample of

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Table 1: Criterion A results ($N = 1$)

Measure	Scale	Clinician raw score	Self-report raw score (*T*-score)	Informant raw score (*T*-score)
LPFS-BF 2.0	Self-functioning		3.33 (52.1)	3.00 (46.8)
	Interpersonal functioning		2.60 (52.7)	3.00 (59.0)
	Total LPFS score		3.00 (53.4)	3.00 (53.4)
DLOPFQ	Identity		48 (53.4)	-
	Self-Direction		49 (52.3)	-
	Empathy		53 (52.6)	-
	Intimacy		76 (60.2)	-
STiP 5.1	Total severity score	3		
	Identity	3		
	Unique Self	3		
	Self-esteem	4		
	Emotions	2		
	Self-direction	3		
	Goals	3		
	Values	2		
	Self-reflection	3		
	Self-functioning	3		
	Empathy	3		
	Understanding others	2		
	Perspectives	3		
	Impact	3		
	Intimacy	3		
	Connectedness	3		
	Closeness	3		
	Reciprocity	3		
	Interpersonal Functioning	3		

DLOPFQ, DSM-5 Level of Personality Functioning Questionnaire; LPFS-BF 2.0, Level of Personality Functioning Scale Brief Form 2.0; STiP 5.1, Semi-structured interview for Personality functioning DSM-5.

treatment seeking adults (descriptions of the normative samples: LPFS-BF 2.0[17]; DLOPFQ[12]; PID-5[36]). The LPFS-BF 2.0 and DLOPFQ suggested average impairment in all domains of personality functioning as compared to clinical samples, with above average impairment in intimacy as assessed by the DLOPFQ. When comparing informant (i.e. his mother's) report with Adam's self-report, the following picture emerged. They largely agreed on the severity of his personality dysfunction (severe) and were fairly consistent in pinpointing elevated problematic personality traits (e.g. Negative Affectivity and Detachment), as well as domains that were relatively unproblematic (Disinhibition and Psychoticism). However, Adam endorsed more antagonistic traits, especially Grandiosity, than his mother recognized. On the other hand, his mother considered Adam more anxious and suspicious than Adam reported.

After completing the questionnaires, Adam was administered the (semi-) structured standardized interviews for the systematic assessment of Criteria A and B. Standardized instruments were selected because of their superior psychometric qualities as compared with regular clinical interviews. In addition to the LPFS and the assessment of maladaptive traits, the DSM-5 AMPD describes Criteria A and B for specific types of PD. We used the information as collected in these interview procedures to assess the specific Criteria A and B

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Table 2: Criterion B PID-5 and SCID-AMPD Module II results (N = 1)

Scale	Clinician raw score	Self-report raw score (*T*-score**)	Informant raw score (*T*-score**)
Negative Affectivity		1.31 (47.5)	1.74 (54.6)
Emotional Lability	2	1.86 (54.7)	2.00 (56.6)
Anxiousness	3	1.78 (50.9)	2.50 (61.1)
Separation Insecurity	1	0.29 (37.2)	0.71 (43.3)
Submissiveness*	2	1.50 (50.8)	1.25 (53.1)
Hostility*	2	1.50 (53.0)	1.60 (54.5)
Perseveration*	3	2.44 (69.7)	1.89 (60.8)
Detachment		1.44 (54.3)	1.87 (62.5)
Withdrawal	2	1.90 (57.6)	2.20 (62.4)
Intimacy Avoidance	2	0.17 (41.7)	1.17 (56.2)
Anhedonia	2	2.25 (61.4)	2.25 (61.4)
Depressivity*	3	-	2.14 (64.1)
Restricted Affectivity*	2	1.57 (60.0)	0.71 (45.4)
Suspiciousness*	2	1.43 (52.5)	2.83 (74.8)
Antagonism		1.31 (60.8)	0.33 (41.2)
Manipulativeness	1	1.00 (52.0)	0.40 (42.9)
Deceitfulness	1	1.10 (58.0)	0.10 (39.8)
Grandiosity	3	1.83 (67.5)	0.50 (45.7)
Attention Seeking*	3	1.00 (50.9)	0.25 (39.5)
Callousness*	1	0.21 (43.5)	0.21 (43.5)
Disinhibition		1.04 (50.5)	1.21 (53.7)
Irresponsibility	2	0.57 (48.5)	0.57 (48.5)
Impulsivity	0	1.00 (49.3)	1.17 (51.7)
Distractibility	2	1.56 (53.6)	1.89 (58.4)
Risk taking*	0	0.50 (36.9)	1.14 (47.9)
Rigid Perfectionism*	2	1.10 (45.0)	1.80 (56.3)
Psychoticism		0.84 (49.8)	0.93 (51.4)
Unusual Beliefs/Experiences	0	0.38 (45.3)	0.25 (43.17)
Perceptual Dysregulation	1	0.83 (52.3)	0.83 (52.3)
Eccentricity	2	1.31 (51.7)	1.69 (56.3)

PID-5, Personality Inventory for DSM-5; SCID-AMPD, Structured Clinical Interview for the DSM-5 Alternative Model for Personality Disorders

*These facets are not included in the PID-5 domain score calculation. For each PID-5 domain, only the three primary facets are included in its aggregate score

***T*-scores were computed relative to a clinical reference sample.

criteria for the different PD types (i.e. Avoidant-, Obsessive–Compulsive-, Narcissistic-, Borderline-, Antisocial- and Schizotypal PD), enabling us to omit the Module III of the SCID-AMPD (which assesses these type-specific criteria).

Adam's ratings based upon STiP-5.1 (Criterion A) and SCID-AMPD Module II (Criterion B) are displayed in Tables 1 and 2. In general, the level of severity as based on the STiP-5.1 corresponded to 'Severe impairment', fully consistent with both Adam's and his mother's questionnaire-based ratings of his level of personality functioning. Self-esteem was especially impaired (extreme impairment). Based on the SCID-AMPD Module II, several trait domains were elevated. Most descriptive were the Grandiosity and Attention Seeking trait facets. Interview ratings and self/informant ratings were generally fairly consistent, with a few noteworthy discrepancies in the Antagonism domain. For instance, Attention

Seeking and Grandiosity were rated rather higher by the clinician (i.e. interview data) than both Adam and his mother had endorsed on the PID-5. Likewise, the clinician-rated Intimacy avoidance higher than Adam, and Irresponsibility higher than both Adam and his mother had. We will return to the clinical utility of discussing such patterns of convergence and divergence in the next steps.

Step 5: Develop the Alternative Model for Personality Disorders classification, and determine the profile of personality impairments and traits. Next, the clinician uses all available information to follow the different scoring and classification steps of the AMPD model. Both convergence and divergence between clinician, self- and informant report should be considered. Ultimately, the assessment is a clinician-based procedure, assigning the clinician the responsibility to weigh different sources of information and make clinical judgments based on all available information. Areas of convergence and divergence may be especially informative for structuring feedback to patients (see step 6 and 7).

The clinician first determines the severity at an element- (identity, self-direction, empathy and intimacy), domain- (self- and interpersonal functioning) and general (personality functioning) level. Although conceptually the LPFS is considered a single dimension, in our experience, some differentiation may be seen with regard to specific elements and aspects thus highlighting areas of strengths or increased vulnerability. Second, the clinician makes a profile of elevated personality trait facets. Again, it may be helpful to highlight not only (extreme) maladaptive traits, but also to note relatively intact functioning. Third, in keeping with traditional clinical practice, the clinician systematically assesses the type-specific criteria using the DSM-5 criteria for the six types.[37]Integrating all of Adam's scores (in this MI–MM procedure), the clinician concluded that the Adam's level of personality functioning was best captured by severe impairment (i.e. level 3), with an extremely impaired self-esteem aspect (i.e. level 4). Taking all measures into account, there was robust evidence for elevations in the domains of Antagonism (especially Grandiosity and Attention Seeking), Negative Affectivity (especially Anxiousness, Perseveration and Submissiveness) and Detachment (especially Intimacy Avoidance, Depressivity and Anhedonia). Conversely, on virtually all measures, Adam scored relatively low on most facets of Disinhibition and Psychoticism, suggesting that impulse control and reality testing were intact.

With regard to type-specific criteria,[2] the clinician concluded that Adam met Criteria A and B for Narcissistic and Avoidant PD. His self-esteem alternated between grandiose/inflated and deflated, and he was extremely vulnerable to experiencing criticism or slights from others (NPD, A1 Identity).[2] Personal standards were unrealistically high in order to view himself as exceptional, but he often withdrew because of fear of failure (NPD, A2 Self-direction).[2] He exhibited a pervasive inability to appraise his impact on others, leading to interpersonal problems and conflicts (NPD, A3 Empathy).[2] He was overly sensitive to criticism and rejection and quick to infer that others perceived him in a very negative way (APD, A3 Empathy).[2] Although he was sensitive to reactions of others, this appeared to be motivated by the desire to avoid criticism and negative feelings; he did not appear to be motivated by a genuine interest in the feelings and experiences of others. Mutuality was limited by either a submissive stance to avoid feeling ridiculed (APD, A4 Intimacy)[2] or an overly controlling and superior stance to protect his self-esteem (NPD, A4 Intimacy).[2] Adam reported that he considered himself destined for 'something special' and often felt slighted or misunderstood by others leading to condescension towards others (NPD, B1 Grandiosity).[2] He was inclined to withdraw socially as a way of protecting against criticism or negative feedback (APD, B2 Withdrawal).[2] Feelings of nervousness, tension and a fear of being shamed were prevalent (APD, B1 Anxiousness).[2] Although not stereotypically attention seeking, Adam was

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strongly motivated to gain the admiration of others, reflected by his high need for achievement and grandiose fantasies (NPD, B2 Attention Seeking).[2] Finally, Adam also endorsed significant Anhedonia (APD, B3),[2] which is also consistent with his escape into online gaming, and not engaging in real life experiences.

Fourth, the clinician checks whether the general Criteria C–G are met. In Adam's case this was clear: his impairment was inflexible and pervasive, relatively stable across time and not better explained by another mental disorder, nor attributable to the effects of a substance or medical condition nor normal for his developmental stage and sociocultural environment.

Finally, the clinician summarizes all information and makes a classification, using additional specifiers. In Adam's case: Narcissistic and Avoidant PD with Submissiveness, Perseveration, Hostility, Suspiciousness, Distractibility and Rigid Perfectionism.

Step 6: Develop a case formulation on the dynamic interaction of maladaptive personality traits and impaired personality functioning. Arguably, the depth and clinical utility of the AMPD model resides not as much in the specific diagnostic notation it provides but is especially evident in the information the AMPD yields for the construction of a comprehensive case formulation: a narrative clinical integration of all information, detailing the specific interplay between traits and level of personality functioning.

Based on all the information collected, the following case formulation was made.

Adam was a 39-year-old man, referred by his GP for assessment and treatment evaluation. He presented with several persistent social and emotional problems. For his entire adult life, he had been unable to successfully complete an education or hold a job, which led to longstanding feelings of depression and anxiety (demoralization). To avoid feelings of failure, helplessness and hopelessness, he had adopted a socially withdrawn lifestyle, primarily seeking refuge in online gaming. The present AMPD assessment suggested to us that these problems were rooted in severe self-esteem issues. Indeed, Adam held an extremely vulnerable self-concept, alternating between grandiose self-expectations and severe self-defeating tendencies. On the one hand, he stated a deep conviction of being destined for something special and endorsed high standards. On the other hand, the anticipated failure triggered strong negative feelings in him that he was unable to confront, which led to flight in phantasy and extensive social withdrawal. Interpersonally, he was extremely sensitive to rejection and slights (especially with superiors) and therefore was heavily invested in pleasing others, meeting their expectations as best he could, by taking on a submissive and overly friendly stance. However, this relational position had built up frustration and anger because of unmet needs for recognition and admiration. He did not appear to understand his impact upon other persons and felt like he 'was getting a raw deal from others'. This realization triggered strong aversive feelings in him, leading him to either withdraw or to have emotional outbursts that interfered with cooperating with others. His understanding of his pattern of interpersonal involvement was quite limited, which left him confused and highly arousable.

Step 7: Provide oral and written feedback to patient and professionals. The final step of this procedure is to share the case formulation and diagnostic information with the patient and with colleagues involved in the follow-up care. Focus should be on the interplay between traits and impaired functioning and to collaboratively building a narrative description that will help the patient make sense of his personality functioning. In our experience, elements of Therapeutic Assessment[38,39] are compatible with the AMPD model and can be used to structure the feedback session. Patients are more inclined to accept and integrate assessment information when the assessor starts with information that matches or is close to their self-concept.[38,39] Both the convergences and discrepancies across

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self-, informant- and clinician-rated instruments can inform us on the (expected) optimal sequence in which to present the results from the AMPD assessment. If the case formulation allows for it, it is best practice to start with issues on which self-report, informant report and clinical ratings converge.

In Adam's case, we started with his self-reported reason for referral and history of presenting problems. His primary concerns were his inability to complete studies or hold jobs, and the associated feelings of failure, chronic stress and demoralization. We discussed how his inability to attain his goals was linked to his vulnerable self-esteem and suggested to him how his withdrawal and emotional avoidance served to protect him from being emotionally overwhelmed by failure. Next, we linked this withdrawal to his feelings of self-loathing and how it also contributed to his anhedonia. We then introduced a finding that was a bit more discrepant from Adam's self-concept: underneath his feelings of self-loathing, he also seemed to harbour very high (grandiose) expectations for himself, which seemed to feed his fear of failure. A more tentative, not-knowing stance would be appropriate for discussing the findings that are most difficult to integrate for the client (in Adam's case how his pleasing and submissive stance was a way to control others, his 'blind spot' for the impact of his behaviour on others). Empathy and ample validation are important inputs for fostering acceptance of these highly personal (and in part novel and discrepant) findings. For example, we helped Adam to an initial understanding of how aspects of his developmental history (most notably his father's verbal abuse, and the severe bullying in primary school) had rendered him extra vulnerable to impaired self-esteem, and we validated how he had tried to solve these emotional issues as best he could by adopting high internal standards and by pleasing and controlling others; but also how this strategy had left him demoralized and depleted.

Next, specific areas of attention for treatment were discussed. We explained that treatment might help Adam confront his fear of failure and enhance his ability to tolerate the associated emotions. With the support of therapy, Adam might process his emotional injuries instead of his current coping strategy of extensive social withdrawal.

Discussion

This case study illustrated how different methods and different sources of information collection may serve to yield a comprehensive picture of the nature and degree of the patient's personality pathology. In some domains, Adam's self-reported personality problems aligned with informant reports and clinical ratings based on structured interviews. These are the topics for which feedback is most readily integrated. However, notable areas of discrepancy also emerged, most likely because of Adam's limited introspective ability. More specifically, Adam did not fully grasp how his relational (submissive) stance actually invited the sort of interpersonal injuries he felt unable to cope with. This observation may highlight a clinically important issue regarding the assessment of Criterion B, which in research is predominantly questionnaire-based. It may well be that certain maladaptive areas remain unidentified when relying on self-report only. Our hypothesis is that especially in severe personality pathology, meaningful discrepancies may occur between self-report and clinical ratings. In fact, as argued many years ago by Grove and Tellegen,[40] sometimes, the discrepancies may be the most informative pieces of evidence. Evaluating the correspondence between self- and informant report ratings is an interesting topic for future research. Marked discrepancies may point to potentially diagnostic limitations in self perception and, as such, serve to identify targets for treatment interventions.[41] The interplay between Criteria A and B in conducting clinical AMPD model evaluations warrants discussion from the perspective of clinical utility. Some have argued that the conceptual distinction is blurry and that

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Criteria A and B have poor incremental validity relative to one another.[5,42,43] These observations call into question whether the model might be further reduced. However, these discussions tend to ignore aspects of clinical utility. Our case analysis illustrated how Criteria A and B are intertwined and how information derived from both criteria added to a comprehensive clinical understanding of this patient's pathology. In this particular case, Criterion A information was essential to capture the severity of Adam's level of functioning; i.e. the severity of impairment of his self-esteem and his pervasive inability to constructively connect to other people. It explained his strong tendency to avoid and withdraw from interpersonal contact, in order not to be overwhelmed by self-esteem injury and the associated uncontrollable aggression. Without Criterion A, it would be difficult to fully describe the severity of these impairments. Criterion B on the other hand, detailed in what ways his emotion regulation fell short (e.g. Emotional Lability and Hostility) and how he dealt with it interpersonally (e.g. Grandiosity, Attention Seeking, Submissiveness and Withdrawal). Along these lines, Huprich[44] hypothesized that traits may ultimately be thought of as defences against unpleasant ideas and motives rooted in Criterion A. From a different perspective, Criterion B can alert the clinician to the patient's relational style in therapy, while Criterion A captures the pervasiveness and rigidity with which this relational style will be expressed. Our patient may withdraw when he feels anxious or injured in personal interactions, but reflecting the severity of his personality dysfunction, this withdrawal may not only be emotional, but also concrete: he may simply no longer show up. A case formulation like this, in which different aspects of personality functioning and traits are logically related and explained, is potentially more informative for treatment planning (than a summary of behavioural symptoms) and can offer patients a narrative understanding of their personality problems. Likewise, the AMPD model lends itself for giving feedback to patients in understandable, non-stigmatizing language, facilitating empathy in clinicians and fostering alliance early on.

The AMPD assessment can provide important clues for treatment planning. The specific areas and severity of dysfunction direct us to relevant interventions, in line with the integrated approach to treatment of PDs from Clarkin and colleagues.[45] For example, in the case of Adam, Criterion A points to his extreme sensitivity and inability to tolerate even minor injury. It alerts us that therapists will have to approach him with great sensitivity and be extremely supportive and validating, continuously monitoring for any, even very small ruptures within the therapeutic relationship. Confrontations should be deferred for quite some time and subsequently be done with great caution. Criterion B informs us on how Adam may approach the therapeutic relationship: he may initially defer and present himself rather submissively, while trying to control negative feelings that may be stirred up in the therapy sessions. His affect may be initially somewhat detached, and he may be quite reluctant to disclose vulnerable emotions. However, establishing alliance with him is fraught with danger, as his increased self-revelations also increase the probability of feeling misunderstood or slighted, which in turn may lead to anger, displays of superiority or even withdrawing completely. Building alliance will be an important goal in treatment and will probably take a considerable amount of time. For Adam, the therapeutic relationship may over time serve to help him better understand how he affects others (AMPD; Impact).

Finally, we want to highlight an interesting issue regarding the classification of narcissistic personality disorder. The section II PD criteria for NPD have been criticized for capturing only the grandiose types of narcissism.[46,47] In this respect, it is worth noting that Adam met criteria for NPD according to the AMPD, but did not according to the traditional section II PD criteria. Adam's narcissistic disturbance may be best conceptualized as a form of 'vulnerable' or 'covert'

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narcissism.[48,49] A hallmark of this type of narcissistic pathology is that the patient holds latent grandiose ideas but initially expresses predominantly an avoidant personality style. Over time, the grandiose ideas become more overt as the therapeutic relationship deepens. The case of Adam thus illustrates that the AMPD assessment can detect covert narcissism as well.

Conclusion

As illustrated in this case analysis, we presented what we deem to be a clinically feasible multimethod, multi-informant procedure for assessing personality pathology according to the AMPD model. Within the scope of 3 h of face-to-face assessment time, using readily available standardized instruments, the clinician can integrate the MI–MM data into a comprehensive case formulation that can readily serve both shared decision making with the patient and treatment planning. We anticipate that substantial aspects of this clinical procedure may be generalized to the ICD-11 classification of PDs, which soon awaits all World Health Organization member countries.

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