

A Primer for Using the Alternative Model for Personality Disorders in Graduate Student Clinical Training

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Personality scientists have largely abandoned studying categorical diagnoses and instead shifted to dimensional models because of clear evidence that favors dimensions over categories. The alternative model for personality disorders is a hybrid dimensional–categorical model that includes criteria reflecting personality impairment and a hierarchical pathological trait model that includes five overarching domains and 25 narrow facets. Training students in dimensional personality assessment, including this emerging model, is consistent with the American Psychological Association training competencies, including the scientific foundation of professional practice, application of scientific method to practice, knowledge and application of evidence-based practice, diagnosis, conceptualization and recommendations, and intervention planning. However, there is little guidance available for supervisors who are not deeply embedded in this area but want to provide up-to-date training. The current article provides a brief summary of the available evidence on the alternative model for personality disorder and measures, an illustrative case example, and a description of one approach to training and supervision. This article intends to facilitate training consistent with evidence-based clinical psychological assessment and competencies expected in the training of clinicians. The [Supplemental Materials](#) include a nonexhaustive list to aid supervisors in crafting a training curriculum that fits their particular style and needs.

Public Significance Statement

Personality scientists have shifted to studying a new, dimensional model of personality disorders and have struggled to translate these advances into real-world settings. This article summarizes the model and research as well as includes a how-to guide for supervising clinicians to use the model when training future practitioners.

Keywords: personality assessment, alternative model for personality disorders, American Psychological Association competencies, personality disorders, evidence-based clinical psychological assessment

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The emergence of the alternative model for personality disorders (AMPD; American Psychiatric Association [APA], 2022) is built off decades of empirical work demonstrating that a categorical approach to personality disorder (PD) diagnosis is scientifically

unsound and does not adequately capture the complexity of patient presentation (Hopwood et al., 2018). At this stage in psychological science, it is clear that dimensions will inevitably dethrone categories as the standard of practice in diagnosis, assessment, and

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treatment (Hopwood et al., 2023). However, training in PD assessment and treatment is at a challenging juncture. Scientists are focused on identifying a parsimonious, dimensional model of personality pathology, while clinicians continue to rely on a categorical model they generally view as less useful than a dimensional or hybrid model (Hopwood et al., 2018; see Bach & Tracy, 2022).

This particular juncture reflects the AMPD's struggle to fully connect with an applied audience (e.g., Mulay et al., 2025), despite the publication of AMPD approaches to case conceptualization (see Supplemental Materials), assessment (Hopwood et al., 2019), and treatment (Hopwood, 2018; Skodol et al., 2015). However, there is no work articulating how those involved in training clinicians may incorporate the AMPD into teaching and supervision. This gap mirrors more widespread issues in clinical psychology, which has historically struggled to adopt empirical advances into regular clinical practice. It seems unlikely that the AMPD will be successfully implemented if those involved in training the next generation of clinicians are not provided with resources that facilitate the translation of scientific advances into training.

The purpose of this article is to introduce the AMPD to a training audience, discuss the benefits of training students to use this system, and outline one approach. Our guide focuses on training students to understand the AMPD conceptually, leverage multimethod assessment to characterize patient presentation, and use the AMPD in therapy. This is simply *one* approach, and we hope supervisors will find this article helpful as they consider ways to integrate the AMPD into training settings. Finally, we hope this article facilitates training consistent with evidence-based clinical psychological assessment, which indicates that decision making should use "both categorical (traditional diagnosis) and dimensional aspects of functioning" (Wright et al., 2022, p. 380), and competencies expected in the training of clinicians.

What Is the AMPD?

The AMPD is a hybrid categorical–dimensional model of personality pathology that draws from multiple clinical and empirical traditions (e.g., psychodynamic, psychometric; Waugh et al., 2017). Personality impairment (Criterion A) includes self (identity, self-direction) and interpersonal (empathy, intimacy) functioning and reflects the "core of personality psychopathology" (APA, 2022, p. 883). Criterion A delineates the presence of personality pathology in the same manner that functional impairment marks the clinical line for other diagnoses. A fear of spiders does not necessitate diagnosis if there is no impact on functioning, and the presence of maladaptive personality traits does not reach the threshold for diagnosis without impairment in self or with others. Criterion B's five-factor trait model reflects the style of pathology. Within Criterion B, there are five higher order domains (antagonism, detachment, negative affectivity, psychoticism, disinhibition) that contain 25 lower order facets (e.g., hostility, emotional lability, risk taking). The Criterion B model is, to a degree, conceptually and empirically like the five-factor model of personality, although openness to experience has no clear counterpart in the AMPD (Suzuki et al., 2015, 2017; Widiger & McCabe, 2020). Research on this topic indicates that specific aspects are connected to psychoticism, but associations can vary in strength and direction depending on the conceptualization of openness (e.g., Chmielewski et al., 2014; see Widiger & McCabe, 2020, for a review of the AMPD and five-factor model). Both Criterion A and B are conceptualized as dimensional constructs, such

that patients display *degrees* of personality functioning and personality traits.

Clinicians can use patient standing on these dimensional constructs to provide categorical diagnoses for six disorders, including antisocial, avoidant, borderline, narcissistic, obsessive–compulsive, and schizotypal PDs, or a PD: trait specified. These four additional categories were not retained due to comorbidity, limited validity, and/or arbitrary diagnostic thresholds associated with these diagnoses (Skodol et al., 2011). The dimensionality of the criteria reflects long-standing empirical evidence in support of dimensions over categories (Hopwood et al., 2018), whereas the existence of categorical diagnoses laid on top of these dimensions acknowledges the clinical reality that the field remains constrained by categories for practical purposes (e.g., billing). These categories should also serve as a helpful "bridge" between traditional and modern PD diagnosis (Zachar & First, 2015).

Measuring the AMPD

Scientists have developed and validated several instruments to assess the AMPD, although a review of all instruments is beyond the scope of this article. This research has developed standalone measures, for example, the Personality Inventory for *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5, PID-5; Krueger et al., 2012), as well as rescoring approaches of existing instruments (e.g., Personality Assessment Inventory [PAI] scores for impairment and personality facets; Busch et al., 2017). We highlight instruments that we have used due to their empirical support and feasibility. For Criterion A, we regularly ask student clinicians to use the Level of Personality Functioning Scale (LPFS; APA, 2022). The LPFS is a clinician-rated instrument printed within the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, text revision (*DSM-5-TR*) for Criterion A. Response options for this scale include "little or no impairment (i.e., healthy, adaptive functioning; Level 0) to some (Level 1), moderate (Level 2), severe (Level 3), and extreme (Level 4) impairment" (APA, 2022, p. 883). Per the *DSM-5-TR*, this instrument "is valuable in treatment planning and in predicting the course and outcome of many mental disorders in addition to personality disorders" (APA, 2022, p. 895). This tool is useful after student clinicians have completed their initial intake because it requires integrating the totality of interview and psychological testing data into a scoring system for personality functioning. Anecdotally, many of our students report that the use of the LPFS provides them with a language and structure to talk about initially confusing patient presentations. There is also evidence that students can learn and apply the LPFS relatively easily (Zimmermann et al., 2014).

There also exist well-validated self-report measures of Criterion A.¹ We typically employ the Level of Personality Functioning Scale–Brief Form 2.0 (LPFS-BF 2.0; Weekers et al., 2019) because of the brevity (12 items), clinically salient item content (e.g., "My relationships and friendships never last long"), and recently published normative data (Weekers et al., 2019, 2023). There are also structured interviews, including the Structured Clinical Interview for the *DSM-5* Alternative Model for Personality Disorders Module I (SCID-5-AMPD-I; Bender et al., 2018) and the Semi-Structured Interview for Personality Functioning *DSM-5* (STIP-5.1; Hutsebaut et al., 2017). We typically focus on self-report and clinician-rated

¹ Other measures include, but are not limited to, the Level of Personality Functioning Scale–Self Report (Morey, 2017).

personality functioning scores within our intake battery, but we would integrate interview measures when appropriate for the client (e.g., complex presentation) or for training.

For Criterion B, most research has focused on validating the self-report PID-5 (Krueger et al., 2012) and developing abbreviated and informant forms. There exists a 25-item brief form that provides scores for each of the five domains and can serve as a useful screener (PID-5-BF; Krueger et al., 2013). The 100-item faceted brief form provides domain and facet scores (Maples et al., 2015). The informant version exists as a 218-item instrument that can be useful, but this is not something we typically do (Markon et al., 2013). The PAI Morey (1991) provides regression-based scores for facets (Busch et al., 2017) and item-based scores for domains (Ruiz et al., 2018) that are norm-referenced and included within the PAI Plus report Morey (2020). The Minnesota Multiphasic Personality Inventory–3 (MMPI-3) provides scores for five personality domains via the Personality Psychopathology Five scales that conceptually and empirically correspond with the AMPD domains (Anderson et al., 2013; Finn et al., 2014; Haugh et al., 2024). Finally, a recently published PID-5 manual summarizes the current state of the literature, includes norms and scoring materials, and provides clinical vignettes (Markon et al., 2024).

Within our clinic, we typically administer a broadband instrument—either the MMPI-3 or the PAI—as part of our intake procedure alongside any self-report measures specific to the client’s presenting problem. For these reasons, we typically avoid administering another lengthy instrument unless there is a compelling reason to do so. Typically, we employ the PID-5-BF as a screener. If the patient is presenting with notable personality pathology, then we may implement the full-length PID-5. We prefer the full-length PID-5 over the 100-item version because there is substantially more research on the original version. In addition to the self-report instruments, the SCID-5-AMPD Module II is a semistructured interview that provides ratings on each of the Criterion B facets and domain scores (Skodol et al., 2018). Our students typically complete this interview in ~45 min. We do not by default use this instrument in intakes but do so when there is some indication of personality pathology. The use of this measure is an excellent opportunity for students to practice administering a semistructured interview and to apply the constructs to their client. Usually, this instrument is administered alongside the self-report measures (e.g., PID-5, LPFS-BF 2.0, PAI, MMPI-3) and ratings of the LPFS. Even when patient personality pathology does not arise to a “diagnostic” level, understanding a patient’s strengths and weaknesses is helpful when tailoring interventions and being mindful of potential barriers to the therapeutic alliance and treatment implementation. Thus, our students are expected to integrate multiple sources of information to comprehensively characterize patient personality presentation.

Importance of AMPD Training

American Psychological Association has acknowledged a clear disconnect between the emerging body on dimensional models of personality and the traditional categorical nosology that has dominated the practice of psychological health care for decades (APA, 2022). It is important that training the next generation of psychologists serves to minimize this disconnect. Indeed, recent guidelines for best practices in assessment work include using dimensional models to characterize clients (Wright et al., 2022). In addition, we believe

training on the AMPD fits across a variety of American Psychological Association training competencies, including the scientific foundation of professional practice, application of the scientific method to practice, knowledge and application of evidence-based practice, diagnosis, conceptualization and recommendations, and intervention planning. Beyond meeting requirements set by American Psychological Association, AMPD training also offers an opportunity to train clinicians to have better assessment and conceptualization skills.

The structure of the AMPD allows for a more comprehensive and clinically useful description of personality pathology than is possible with the categorical model. A full AMPD case conceptualization requires clinicians to describe and convey additional information that is not tied to a diagnosis, including elevations and “typical” levels of other elements of personality functioning and traits. This structure addresses a long-standing issue with the categorical model in that there exists no formal way to add in presentation outside of the boundaries of a diagnosis. It also provides useful clinical information relevant to treatment planning, as individuals with the same diagnoses present with differing symptom combinations and areas of impairment.

On the surface, this model appears more difficult than the current standard of practice and training. And, it is if we limit training to differential diagnosis. Indeed, we train undergraduate students in abnormal psychology about *DSM-5* diagnoses, and we stress the importance of diagnostic criteria in graduate-level psychopathology courses. However, we also routinely ask students to think beyond diagnosis in assessment, case conceptualization, and intervention planning. Although the AMPD is certainly more complicated than a checklist of symptoms, its ties to empirical literature and its emphasis on bigger picture client conceptualization outweigh the increased complexities involved in assigning diagnoses.

Further, we would argue that this approach to diagnosis is consistent with existing training related to case conceptualization in both intervention and psychological assessment courses. For instance, broadband psychopathology instruments on which most students are trained (such as the MMPI-3 or PAI) similarly measure broad dimensional constructs that are useful beyond differential diagnosis (Mihura et al., 2017). The authors are not aware of data that dimensional models are commonly incorporated into doctoral training, but we do believe that broadband instruments could be one avenue to incorporate this content. Similarly, case conceptualization in intervention work is rarely restricted to categorical diagnosis. Training on the model may be more difficult than training categorical disorders, but this type of training aids in the broader understanding of psychopathology and helps lead students toward better conceptual thinking in clinical settings. Indeed, despite relying on a categorical diagnostic framework in our training clinic, the first and second authors routinely ask students to conceptualize clients using AMPD traits to help students see beyond their clients’ diagnosis (PD or not) and better understand the complexities of their symptoms and interpersonal presentations.

Our Training Approach

It is first important that those who are training students to use the AMPD should develop a strong working knowledge of the model. For this, we provide a list in [Supplemental Materials](#) with a fairly comprehensive (though nonexhaustive) list of important readings on the AMPD, its development, assessment, and application in clinical

settings. In training our students, we focus on a general understanding of the AMPD model, with an applied focus. We adopt a “read, discuss, practice, discuss” approach. This training is intended to instill a rich understanding of the AMPD and the “know-how” for administering and interpreting instruments, particularly the *DSM-5-TR*’s LPFS and the SCID-5-AMPD Module II. We train our students through two “reading meetings” and two “instrument meetings” in that order. We focus predominantly on clinical ratings because this is the most likely method of diagnosis in clinical practice. However, we also stress the importance of becoming familiar with the numerous self-report and informant ratings of AMPD constructs discussed above and encourage students to seek out opportunities to use these methods in clinical work. To aid this, we utilize these methods frequently in our supervision of both assessment and therapy cases in our doctoral training clinic.

Meeting 1

Students are instructed to read the *DSM-5-TR*’s section on the AMPD in preparation for the first meeting. We have found in our experience that students find the shift to dimensions and the addition of a substantial number of new terms (25 facets, five domains, four elements) initially hard to manage. However, the goal for this meeting is primarily to lay a conceptual groundwork to build upon. We specifically work with students to understand what it means to think about patients from a dimensional perspective and how the AMPD layers categorical diagnosis on top of these dimensions.

Meeting 2

Students are instructed to read “The AMPD and Three Well-Known Cases” (Hopwood & Waugh, 2019) and Bach et al.’s (2015) article on six clinical cases. The goal of this meeting is to illustrate the AMPD concepts with multiple complex cases. There are nine cases presented across both readings with varying presentations of personality pathology. We find multiple iterations of different cases strengthen familiarity with the terms and thinking about patients *comprehensively*. That is, one of the main advantages of the AMPD over the categorical model is that patient pathology that is not captured within a diagnosis is still considered in the case conceptualization and treatment planning processes.

Meetings 3 and 4

After completing the two “reading meetings,” we assign a student to complete and record the SCID-5-AMPD Module II interview and LPFS ratings with another student who acts as a patient. All of us separately view and rate the recording in preparation for a discussion on the rating process and administration of the Module II interview. Engaging in this process requires students to think deeply about the constructs and how to differentiate between them when assessing a patient. For example, poor social support might reflect any number of Criterion B traits, such as suspiciousness, intimacy avoidance, withdrawal, depressivity, or anxiousness. We work with students to properly anchor the patient’s lived experience to the correct AMPD construct. We also discuss every rating for each of the AMPD constructs and work as a group to come to a consensus. We repeat this process with a new dyad.

By the end of the training, we are looking for our students to *clearly* understand each of the AMPD constructs and to assign consistent, reasonable ratings. This training is also an excellent opportunity to reinforce why interrater reliability (i.e., consistency across evaluators) matters in applied settings and that we are all susceptible to rater drift. We emphasize using the *DSM-5-TR*’s AMPD descriptions to make ratings rather than relying on their own memory of the constructs. We stress that, even as experts in the AMPD, we rely on the construct descriptions as much as we do our own understanding of the constructs to avoid drift. We also recognize that other training approaches can also teach mastery over the AMPD. For example, there are widely used videos depicting different forms of therapy with a patient, “Gloria.” An instructor could provide students with fictitious background and testing data. Upon completion of a video, students can complete ratings on the LPFS by integrating data. Another training option could involve students recruiting a close other to complete an informant PID-5 while the students complete a self-report PID-5. Students could practice converting raw to standardized scores with the self-report PID-5 and interpreting data across both assessment sources.

The AMPD in Training: An Example Case

We will now describe a case treated by a student clinician and supervised by one of the authors.²

Case Background

Ashley (she/her) is a 47-year-old, Mexican American woman who presented to the clinic with “relationship problems, depression, and anxiety.” In the clinical interview, she reported that her marriage was in disarray and she was worried that the conflict between her and her husband was negatively impacting their 5-year-old son. Specifically, she described her husband as some days being “an excellent caregiver and spouse,” but other days as “the lowest of the low.” Ashley indicated she struggles to contain her negative affect (e.g., feeling “blue” and hopeless), which exacerbates tensions between her and her husband and causes her to feel like eventually he will leave her. She finds herself frustrated with her husband and situation more days than not. In the clinical interview, she reported that sometimes her emotions escalate quickly without her awareness. Throughout the interview, it became clear that Ashley had a genuine desire for connection to others, but struggled to maintain those connections. Over the years, she also developed a habit of lying and manipulating others. For example, when her husband approaches her about a relationship problem, she feels “vulnerable” and will manipulate him (e.g., pretend to be distraught) to regulate her feelings of vulnerability. She noted that this interpersonal approach has extended to relationships with coworkers, friends, and family members.

Testing Data

Validity

Scores on PAI validity scales suggested the client was appropriately attending to items and was not presenting herself in an overly favorable

² Please note this example case incorporates details and psychopathology presentation across multiple patients, and we have substantially altered portions of this clinical case to protect the identity of the patients.

light. However, her score on the Negative Impression Management Scale (85T) suggested she is likely exaggerating problems to a degree. We interpreted this score as likely representing a “cry for help” because of information gathered within the clinical interview (e.g., “I am desperate for any kind of relief”) and a low score on the Treatment Rejection Scale. We cautiously interpreted PAI scales with an understanding that the client’s scores are likely somewhat higher than they would be without distortion. This interpretation also influenced our understanding of her PAI AMPD scores, such that we paid particular attention to other information gathered to more accurately understand the client’s personality pathology. For example, eccentricity displayed a subclinical elevation (62T), but there was little to no evidence across the SCID-AMPD interview and the clinical interview to suggest this was part of her presentation.

Traditional PAI Scores

The patient reported elevated levels of internalizing symptoms (e.g., ANX), including excessive worry (ANX-C) and thoughts of worthlessness (DEP-C). She feels as though she does not have sufficient social support (NON) and holds grudges against people she feels have wronged her (PAR-R). Scores suggested emotional lability (BOR-A), unstable self-concept (BOR-I), and a propensity to engage in impulsive behavior without considering negative consequences (BOR-S). Moreover, there was evidence that some of her interpersonal conflict may be driven by excessive self-focus, taking advantage of others, and an unwillingness to admit fault in her own behaviors (ANT-E). These scores coupled with a dominant interpersonal style (DOM), a willingness to display anger verbally and through physical actions (AGG-V; AGG-P), and clinical interview data suggested difficulties effectively managing conflict and sustaining collaborative, healthy relationships. PAI scores are shown in Table 1.

Criterion A

LPFS

After completing the intake, the student–clinician completed the LPFS. With respect to identity, the client reported that her self-esteem was easily disrupted when she feels “not heard” or “slighted.” The student–clinician observed that she typically compensated for intense negative affect with an overly positive view of herself and disparagement of others. The student–clinician also rated the client as having severe empathy impairment because of pronounced difficulties considering and understanding others’ internal experiences. Additionally, she received a severe rating on the intimacy element because she reported substantial conflict across domains (family, work, friendships) that led to the dissolution of those relationships.

LPFS-BF-2.0

The client endorsed items primarily reflecting poorer interpersonal functioning (e.g., “I often find it hard to stand it when others have a different opinion”), and their total score placed them in the “moderate” impairment range according to scoring instructions (see <https://www.devidersprong.nl/over-de-viersprong/over-de-viersprong-onderzoek/onderzoekslijn-diagnostiek/onderzoekslijn-assessment-en-indicatiestelling/zelftest-vertalingen-lpfs-bf/>).

PAI AMPD

The personality functioning score (Level of Personality Functioning) was elevated (i.e., ≥ 70) and suggests some global personality impairment. AMPD scores are shown in Table 2.

Criterion B

PID-5

Within Table 2, we also include *T* scores using the PID-5 manual (Markon et al., 2024). Scores were in line with those derived from the PAI, and this has been our anecdotal experience. We have found using the PAI and MMPI-3 Personality Psychopathology Five scales provide a clear opportunity to incorporate AMPD training without adding to patient burden. However, administration of the PID-5 is a more direct integration of the AMPD into training. Supervisors should make a decision that balances training goals of students and feasibility in implementation of additional measures. The patient had elevated scores on negative affectivity and antagonism. Negative affectivity reflects a propensity for “feeling bad,” such as anxiety, worry, and anger (APA, 2022). Antagonism reflects a tendency to use others for self-serving means, a callousness toward others, and a grandiose self-concept (APA, 2022). The facet profile was also consistent with the PAI AMPD scores.

PAI AMPD Estimates

Domain elevations (i.e., *T* score ≥ 70) included negative affectivity and antagonism, which is consistent with the PID-5. Facet elevations cut across domains. These scores generally suggest a grandiose sense of self (grandiosity), unstable and frequently negative mood (e.g., emotional lability), a willingness to manipulate others for personal gain (manipulativeness), and a desire to be the center of attention (attention seeking).

SCID-5-AMPD Module II

Scores within the SCID-AMPD were largely consistent with those found from the PAI. However, important differences emerged. The student–clinician rated the client as having elevated levels of deceitfulness and hostility. With respect to deceitfulness, the client endorsed that she often exaggerates stories and misrepresents herself to manipulate her husband to attend to her emotional distress. She reported she is “an excellent liar.” A heated argument with her husband on her lying was a highly motivating factor for her to begin therapy. Additionally, the client reported that she often “snaps” at her husband and both have become exhausted with her frequent “anger outbursts” and heightened “sensitivity” to being wronged (hostility).

Diagnostic Formulation

Section II Diagnoses

From a categorical perspective, the client meets criteria for narcissistic PD and displays some symptoms of borderline and histrionic PD. For narcissistic PD, the client clearly has a “grandiose sense of self-importance,” “requires excessive admiration,” “has a sense of entitlement,” “is interpersonally exploitative,” and “lacks empathy.” For histrionic PD, she reported being “uncomfortable in situations in

Table 1
Personality Assessment Inventory Scores

Scale	T	Scale	T	Scale	T
Validity scales		Clinical scales		Treatment consideration and interpersonal scales	
Inconsistency	54	Somatic Concerns	52	Aggression	75
Infrequency	47	Anxiety	95	Suicidal Ideation	57
Negative Impression Management	85	Anxiety-Related Disorders	60	Stress	95
Positive Impression Management	52	Depression	65	Nonsupport	73
		Mania	67	Treatment Rejection	29
		Paranoia	68	Dominance	73
		Schizophrenia	63	Warmth	42
		Borderline Features	99		
		Antisocial Features	75		
		Alcohol Problems	55		
		Drug Problems	43		

Scale	Subscale	T	Scale	Subscale	T	Scale	Subscale	T
Clinical subscales and additional scales								
Somatic Concerns	Conversion	51	Mania	Activity Level	53	Borderline features	Affective Instability	85
	Somatization	54		Grandiosity	75		Identity Problems	77
	Health Concerns	50		Irritability	65		Negative Relationships	68
Anxiety	Cognitive	105	Paranoia	Hypervigilance	51	Antisocial Features	Antisocial Behaviors	50
	Affective	95		Persecution	55		Egocentricity	75
	Physiological	91		Resentment	95		Stimulus Seeking	67
Anxiety-Related Disorders	Obsessive–Compulsive	55	Schizophrenia	Psychotic Experiences	47	Aggression	Aggressive Attitude	59
	Phobias	65		Social Detachment	77		Verbal Aggression	85
	Traumatic Stressors	55		Thought Disorder	57		Physical Aggression	77
Depression	Cognitive	73						
	Affective	55						
	Physiological	61						

which he or she is not the center of attention.” For borderline PD, she reported “a pattern of unstable and intense interpersonal relationships,” “affective instability,” and “inappropriate, intense anger or difficulty controlling anger.” Because only one diagnosis technically applies to the client’s presentation, the other symptoms are not as readily communicated in formal reports or other clinical documentation. For example, sole reliance on the Section II model would miss important borderline PD features because the client does not meet the required five of nine symptom threshold for a diagnostic label. This is especially problematic for this client given these symptoms, such as interpersonal dysfunction, were especially important to this client’s treatment goals (see below). In contrast, the AMPD is a comprehensive model where the clinician should be examining and communicating the entirety of the trait configuration.

Section III Diagnoses

Using the AMPD, the client continues to meet criteria for narcissistic PD (elevated grandiosity and attention seeking) but also meets criteria for borderline PD (elevated emotional lability, anxiousness, separation insecurity, depressivity, hostility). The client also has elevations on other facets (e.g., deceitfulness, manipulativeness, suspiciousness). From an AMPD framework, understanding the *trait configuration* rather than just what is elevated is paramount. Her behavior within therapy sessions indicated that often the antagonism facets (e.g., grandiosity, manipulativeness) manifested after experiencing an unpleasant emotion or discussing an emotionally challenging event.

For example, when the student–clinician challenged beliefs, the client made snarky comments about the student–clinician’s intelligence. Connecting to her interpersonal impairment, her behavior often derailed or prevented the development of close relationships, and she frequently walked away from these ruptures feeling frustrated that the other person “doesn’t care” because they were not sufficiently attending to her emotions. She then used disparagement of others to regulate this vulnerability (e.g., “they were too stupid to understand anyways”) that reflected her elevated grandiosity.

Treatment Plan

Her stated goals for therapy include “helping me feel better so I can keep my family together.” Her primary motivation included her relationship with her husband and the well-being of her son. We operationalized these skills with dialectical behavior therapy. That is, Ashley and the student–clinician agreed to build awareness of her internal states (mindfulness), improve her ability to sit with and alter difficult emotions (emotion regulation, distress tolerance), and practice effective communication (interpersonal effectiveness). This treatment plan is also more clearly aligned with her Section III diagnostic formulation. The AMPD provides a framework that enables communication about the role of emotional lability in her presentation and interpersonal problems. In contrast, the Section II diagnostic formulation emphasizes the antagonism and misses the negative affectivity. This loss of information is especially problematic because the client *specifically* wants treatment for affective instability.

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Table 2
AMPD Scores

Scale	Score	Scale	Score	Scale	Score
Self-report AMPD scores					
Negative Affectivity	92/89	Distractibility	66/55	Restricted Affectivity	43/47
Detachment	67/71	Eccentricity	62/65	Rigid Perfectionism	66/58
Antagonism	73/72	Emotional Lability	106/95	Risk Taking	61/62
Disinhibition	68/65	Grandiosity	79/74	Separation Insecurity	73/79
Psychoticism	59/52	Hostility	68/73	Submissiveness	36/42
Anhedonia	63/61	Impulsivity	78/71	Suspiciousness	72/75
Anxiousness	87/71	Intimacy Avoidance	70/78	Unusual Beliefs and Experiences	56/48
Attention-Seeking	95/72	Irresponsibility	72/69	Withdrawal	75/72
Callousness	74/71	Manipulativeness	81/75	Level of Personality Functioning	83
Deceitfulness	59/65	Perceptual Dysregulation	61/55		
Depressivity	82/73	Perseveration	68/57		
SCID-AMPD scores					
Negative Affectivity	1.625	Distractibility	2	Restricted Affectivity	0
Detachment	1.167	Eccentricity	0	Rigid Perfectionism	0
Antagonism	1.183	Emotional Lability	2	Risk Taking	0
Disinhibition	1	Grandiosity	2	Separation Insecurity	2
Psychoticism	0	Hostility	2	Submissiveness	0
Anhedonia	1	Impulsivity	1	Suspiciousness	2
Anxiousness	2	Intimacy Avoidance	1	Unusual Beliefs and Experiences	0
Attention-Seeking	2	Irresponsibility	1	Withdrawal	1
Callousness	1	Manipulativeness	3		
Deceitfulness	2	Perceptual Dysregulation	0		
Depressivity	2	Perseveration	1		

Note. Before / = PAI AMPD scores. After / = PID-5 AMPD scores. AMPD = Alternative Model for Personality Disorders; SCID-AMPD = Structured Clinical Interview for the *DSM-5* Alternative Model for Personality Disorders Module; PAI = Personality Assessment Inventory; PID-5 = Personality Inventory for *DSM-5*; *DSM-5* = *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition.

Client Feedback

A major goal with feedback is to make sure the client feels “seen” in the data we present. Additionally, it was important that we delivered information that was not overly technical. The student–clinician and supervisor worked through the model to highlight major takeaways about specific elevations, the diagnostic labels, and the interplay of these personality features. We linked the interplay component to some of the stories Ashley told within the intake and some of the behavioral observations. We were also able to highlight her strengths. For example, Ashley was not overly rigid (e.g., low perseveration) nor impulsive (e.g., low risk taking), and she was clearly interested in close relationships (e.g., low detachment). In this way, we were able to capitalize on these scores to frame Ashley’s prognosis as relatively positive. We conveyed that we had challenging goals ahead of us but were confident that Ashley could likely build healthy relationships by changing behavioral patterns. Anecdotally, the student clinician not only found the AMPD strengthened her understanding of the client but felt inclusion of the AMPD provided for a useful feedback session. The client agreed with our conceptualization and commented on the disconnect she felt between her antagonism and detachment. She felt torn because she recognized that her propensity to manipulate others when she felt vulnerable conflicted with her desire for relationships. She felt hopeful that her desire for attachment would help her reduce maladaptive interpersonal behaviors. She commented that the “interplay” component resonated with comments her husband made over the years and clarified a pattern she could not “figure out”. Finally, we were concerned about the provision of a narcissistic PD diagnosis. We contextualized this label within the AMPD discussion,

her treatment goals, and connected both models to interview data. For example, we connected her Section III antagonism facets (e.g., manipulateness) to her Section II narcissistic PD symptoms (e.g., interpersonal exploitation) as well as her reporting within the clinical interview that she uses her distress to accomplish interpersonal goals with her husband. We then discussed the ways our treatment plan addressed this combination of issues. For example, our goal for her by the end of treatment was to integrate dialectical behavior therapy skills across modules, such as emotion regulation and interpersonal effectiveness, to better manage her distress during difficult conversations with her partner and incorporate healthier interpersonal strategies. Our perception was that the label of narcissistic PD was experienced as stigmatizing, but folding this diagnosis into the other components discussed above increased the client’s flexibility and optimism for our intended treatment.

Supervision

It was important to talk through the student–clinician’s frustration and connect how this dynamic partially mirrors the interpersonal conflict outside of the therapy room. Additionally, we actively discussed AMPD constructs using clips of difficult moments to help the student–clinician identify intervention opportunities and reduce personalizing the client’s reactions. For example, the student–clinician gently pointed out the interplay of the client’s negative affectivity and antagonism, and over time, they were able to engage in mindfulness exercises to sit with the emotional vulnerability. We have also used brief, freely available AMPD measures for treatment monitoring. For example, weekly administration of the 25-item PID-5-BF and

LPFS-BF 2.0 enables tracking of changes in the five pathological trait domains and personality functioning, respectively. Both instruments are quick with clinically salient item content (e.g., PID-5-BF: “I get emotional easily, often for very little reason”), making it a simple way for supervisors to fold the AMPD into clinical training in a meaningful way.

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