### Title

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# Personality Constructs and Paradigms in the Alternative *DSM-5* Model of Personality Disorders

Abstract

The *DSM-5*, Section III Alternative Model for Personality Disorders (AMPD) is a personality disorder (PD) nosology based on severity of personality dysfunction and pathological traits. We examined the degree to which the personality constructs identified by McAdams and Pals (2006; dispositional traits, characteristic adaptations, narrative identity) and the paradigms of personality assessment described by Wiggins (2003; psychodynamic, interpersonal, personological, multivariate, empirical) are represented within the AMPD. Nine raters expert with the AMPD and personality evaluated elements of Criterion A and the 25 trait-facets of Criterion B for presence of type and degree of personality constructs and paradigms, as well as level of inference. Criterion B showed higher rater agreement compared to Criterion A. Criterion A and B reflect different configurations of construct, paradigm, and level of inference. The characteristic adaptation construct and interpersonal paradigm were strongly reflected in both Criterion A and B. The psychodynamic and personological paradigms and the narrative identity construct were highly correlated, and the multivariate, empirical, and dispositional traits variables were highly correlated. Results illustrate differential conceptual emphases as well as areas of overlap with Criterion A and B. This characterization highlights that PD nosology rests on personality theory and suggests implications for integrative PD assessment.

*Keywords*: AMPD, personality disorder, personality assessment, personality traits

# Personality Construct and Paradigm in the DSM-5 Alternative Model of Personality Disorder

Psychiatric nosology is increasingly moving towards dimensional models of mental disorder (Regier, Narrow, Kuhl, & Kupfer, 2009), and personality disorder (PD) diagnosis is leading the way (Krueger, 2013). The Alternative Model for Personality Disorders (AMPD) in Section III of the *Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition* (*DSM-5*; American Psychiatric Association [APA], 2013) provides a dimensional alternative to the categorical approach found in Section II. In fact, the APA officially recognizes the AMPD as a complement to the *DSM-5* Section II PD diagnoses (see also Waugh, Hopwood, Krueger, Morey, Pincus, & Wright, 2017; Zachar, Krueger, & Kendler, 2016). Diagnosis with the AMPD requires fulfilling seven general criteria for PD (*DSM-5*, p. 761). The focus of this article will be the first two criteria, Criterion A (level of personality functioning) and Criterion B (maladaptive personality traits). Criterion A involves clinician-rated or self report (e.g. Huprich et al., 2017; Hutsebaut, Feenstra, & Kamphuis, 2016; Morey, 2017) assessment, using the Levels of Personality Functioning Scale (LPFS; Bender, Morey, & Skodol, 2011), of disturbances in self functioning (identity and self-direction) and interpersonal functioning (empathy and intimacy). Criterion B involves clinician and/or self-rated assessment of 25 pathological personality trait-facets, which may be organized into the five trait domains of negative affectivity, detachment, antagonism, disinhibition, and psychoticism. Criteria C through G cover issues of pervasiveness, stability, emergence, discrimination from other mental disorders, effects of substances or medical conditions, and developmental stage or sociocultural environment.

There is a growing body of empirical support for the AMPD. For example, studies have examined the reliability and validity of the LPFS for assessing Criterion A (e.g., Zimmermann,

Böhnke, Eschstruth, Mathews, Wenzel, & Leising, 2015) and the Personality Inventory for *DSM-5* for assessing Criterion B (Personality Inventory for *DSM-5* [PID-5]; see Krueger, Derringer, Markon, Watson, & Skodol, 2012; Wright et al., 2015). Other research has focused on evaluating the clinical utility of the AMPD (e.g., Morey, Skodol, & Oldham, 2014) and on its associations with relevant outcomes, such as alcohol abuse (Creswell, Bachrach, Wright, Pinto, & Ansell, 2016). Research has also noted the sizeable degree of empirical overlap between Criterion A and B (Few et al., 2013; Hentschel & Pukrop, 2014; Widiger, 2015). In fact, some have questioned the incremental predictive validity of Criterion A with respect to B (Few et al., 2013; Widiger, 2015); however, other studies have also found independent contributions of Criterion A (Bastiaansen, Hopwood, Van den Broeck, Rossi, Schotte, & De Fruyt, 2016; Morey, Skodol, & Oldham, 2014; Roche, Jacobson, & Pincus, 2016; Zimmermann et al., 2015).

**Personality Science and the AMPD**

While it is clear that the AMPD has garnered significant interest, little empirical attention to date has been given to its pantheoretical approach to the assessment of PD (Pincus, 2011). In fact, its integrative nature may be a relatively underappreciated aspect of the model (Waugh et al., 2017). One of the hallmark strengths of the AMPD is that Criterion A and B are derived from different clinical and empirical traditions in personality science. Bender, Morey, and Skodol (2011) drew on concepts and methods from psychodynamic, attachment, and social-cognitive traditions to formulate the LPFS of Criterion A (e.g., Social Cognitions and Object Relations Scale [SCORS-G; Hilsenroth, Stein, & Pinsker, 2007]; Reflective Functioning Scale [RFS; Fonagy, Target, Steele, & Steele, 1998]; Object Relations Inventory [ORI; Bers, Blatt, Sayward, & Johnston, 1993]). Criterion B derives from the general lexical trait tradition in personality science (e.g., Allport & Odbert, 1936; Goldberg, 1993; McCrae & Costa, 1987) and organizes

the multivariate space of pathological personality traits into a set of five correlated dimensions (Krueger & Markon, 2014). This integration between seemingly disparate traditions in personality science offers many scientific and practical advantages (see Waugh et al., 2017). Additionally, it may facilitate learning and application by researchers and clinicians of varying theoretical orientations (Morey & Benson, 2016; Morey, Skodol, & Oldham, 2014).

Given its pantheoretical approach to problematic personality functioning, we suggest that the AMPD may be usefully examined through the lens of contemporary personality theory and research. Several modern, integrative personality schemes are relevant. These include the influential Five Factor Model (FFM; McCrae & Costa, 1987), Mischel and Shoda's (1995) cognitive-affective processing (CAP) system model, Block's (2002) affect-processing system, Fleeson and Jayawickreme's (2015) Whole Trait Theory; and DeYoung's (2015) Cybernetic Big Five approach. In our study, we focus on the tripartite personality constructs offered by McAdams (1995) as systematized in McAdams and Pals (2006). In addition, we draw on the five broad paradigms of personality assessment described by Wiggins (2003). Wiggins' (2003) approach constellates personality theories, methods, and traditions within organizing heuristics termed paradigms. To the extent different personality constructs may configure the AMPD, empirical evaluation of the model may be informed by matching methods of analysis to the nature of the differing personality constructs. This follows from the logic of construct validity (Loevinger, 1957), process dissociation as a strategy for understanding the meaning of test scores (Bornstein, 2011), and multi-method assessment. Furthermore, we suggest articulation of the constructs and paradigms embedded within the AMPD may clarify advantages and limitations of the different theoretical approaches in Criterion A and B which in turn may speak to how the

model may be taught to new learners as well as issues of acceptance by the many constituents served by a PD nosology.

**Dispositional Traits, Characteristic Adaptations, and Narrative Identity**

As noted above, several general frameworks for organizing personality components, dimensions, and processes have been described (e.g., FFM, Cybernetic Big Five, CAPS, etc.). While these personality schemes share considerable overlap, they view trait, characteristic adaptations, and narrative identity somewhat differently (DeYoung, 2015). For this study, we chose to focus on the McAdams (1995) and McAdams and Pals (2006) construct types, but we note points of divergence with other conceptualizations.

McAdams (1995) and McAdams and Pals (2006) described three classes of constructs and five conceptual dimensions: (1) evolutionary theory, (2) temperament and trait, (3) modes of adaptation, and (4) narrative identity—all within a (5) cultural and social context (see also McAdams, 2015). Because they are most relevant to PD study, we focus on the constructs termed dispositional traits, characteristic adaptations, and narrative identity. For McAdams (1995), the dispositional trait dimension derives from lexical trait tradition (Allport & Odbert, 1936) as reflected in the contemporary Big 5 (Goldberg, 1993) and FFM approaches. In contrast, characteristic adaptations refer to situated motivations, the parts of personality contextualized in time, place, and social role. These involve modes of coping, schemas, motives, and personal strivings. Dispositional traits speak to the broad consistencies across situations and over time, and characteristic adaptations highlight the contextualized particularities of the person and address how those change in both predictable and unpredictable ways over time (McAdams, 1995). Traits address the question of *what kind* of person, while characteristic adaptations point to the more existential question of *who is the person*? McAdams (1995) defines narrative identity

as the integrative life story or personal narratives that people use to make meaning in the world. Narrative identity is an internalized evolving narrative of the self that integrates the reconstructed past and the imagined future into a cohesive life story to provide unity, meaning, and purpose (McAdams & Pals, 2006).

There are varying definitions of characteristic adaptation in the literature. McAdams and Pals (2006) argued that characteristic adaptations are activated in response to and ultimately shaped by the everyday demands of social life, and are not simply by-product of a trait by environment interaction. The FFM approach ascribes greater importance to the trait axis, and views characteristic adaptations as patterns organized around a given trait via interactions with the environment (McCrae & Costa, 2008). In yet another framework, DeYoung (2015) occupies a conceptual middle ground, viewing traits as descriptive, not causal; and characteristic adaptations are understood as particularized goals, strategies, and representations developed from trait dispositions. In this way, traits are viewed as universal in human behavior, and characteristic adaptations are the developed goals or representations of a person in a situation. For example, the trait of being argumentative (dominance) may develop into the characteristic adaptation of becoming a lawyer (De Young, 2015). We note these distinctions to emphasize that some investigators describe traits and characteristic adaptations differently. In our empirical analysis, however, we chose the McAdams (1995) and McAdams and Pals (2006) scheme for rating the components of the AMPD.

The McAdams and Pals (2006) integrative personality framework has been used in social psychology (e.g., Manczak, Zapata-Gietl, & McAdams, 2014) and personality research (McAdams, 2015), but has been less often extended to clinical assessment of PD. A notable exception is the work of Adler (2012) who found that patients showed changes in narrative

identity prior to manifesting symptom changes in psychotherapy. Additionally, Shiner (2009) drew on the McAdams and Pals (2006) systematization to organize trait concepts, mental representations, and identity variables in describing developmental pathways to PD. Hopwood et al. (2013) used the distinction between characteristic adaptations and traits, following McCrae and Costa (1995), to explain the longitudinally stable aspect of trait variance, compared to that of style of symptom expression, in PD. Analogizing to personality theory (McCrae & Costa, 1995), Hopwood and colleagues suggested PD symptom styles are characteristic *maladaptations*, which may remit, change, and evolve over time, as characteristic adaptations do in normal personality functioning.

**Wiggins (2003) Paradigms of Personality Assessment**

Drawing on the Kuhnian concept of *paradigm*, Wiggins (2003) compared and contrasted major schools of thought and approaches in personality assessment. According to Kuhn (1970), paradigms define what constitute accepted foci, methods, and standards of evidence in science. Importantly, paradigms are organized around exemplar methods or approaches. Using these ideas, Wiggins (2003) articulated five major traditions in personality assessment: the *psychodynamic*, *interpersonal*, *personological*, *multivariate*, and *empirical*. The psychodynamic paradigm emphasizes the role of the dynamic unconscious (e.g., inner conflict), includes contemporary developments in object relations (Greenberg, 1983) and self psychology (Kohut, 1979/2012), and emblematically uses assessment instruments such as the Rorschach Inkblot Test and the ego psychological approach of assessment across degrees of structure (Allison, Blatt, & Zimet, 1988). It should be noted that the Rorschach method is not restricted to a psychodynamic approach, and contemporary Rorschach systems emphasize its empirical basis (e.g., Comprehensive System [CS; Exner et al., 2008]; Rorschach Performance Assessment System

[R-PAS; Meyer, Erard, Erdberg, Mihura, & Viglione, 2011). The personological paradigm derives from the case study tradition and relies upon qualitative, narrative data and focuses on subjectivity (e.g., McAdams & West, 1997) and takes a psychobiographical approach (Alexander, 1990). The interpersonal paradigm originates from the classic work of Harry Stack Sullivan (1953/2013), and utilizes exemplar methodology such as the Interpersonal Circumplex (IPC; Leary, 1957) and the Structural Analysis of Social Behavior (SASB: Benjamin, 1996). Hopwood, Wright, Ansell, and Pincus (2013) provide a contemporary overview of developments in this paradigm. Notably, the interpersonal paradigm incorporates multi-method assessment and different classes of personality constructs. Leary (1957) delineated five “levels “ of personality accompanied by specific assessment methods, all organized within the IPC framework. The multivariate paradigm traces from the traditions of the Lexical Hypothesis (Cattell, 1943), the Big Five (Goldberg, 1993), and the FFM (McCrae & Costa, 1987). Its exemplar method is multivariate analysis (e.g., factor analysis). Wiggins (2003) construes the empirical paradigm in a specific way. This does not refer to the use of empirical methods, as all personality paradigms are amenable to empirical approaches. Rather, Wiggins (2003) defines the empirical paradigm as organized around classical Kraepelinian psychiatric diagnostic constructs. The paradigm is not restricted to diagnostic categories, although these are how they are classically organized. The exemplar assessment instrument is the Minnesota Multiphasic Personality Inventory (second edition, MMPI-2; Hathaway, McKinley, Butcher, Dahlstrom, Graham, & Tellegen, 1989), which was originally developed to assess Kraepelian diagnostic categories through the empirical-criterion keying method of test construction. Wiggins (2003) notes, however, that other assessment instruments, including empirical Rorschach indices of diagnostic constructs (e.g.,

Depression Index of the CS; Exner et al., 2008), represent assessment within the empirical paradigm.

**The Current Study**

The purpose of the current study was to evaluate the nature of personality constructs and paradigms embedded within the AMPD. PD, of course, involves *personality* and, as such, contemporary personality science may have much to contribute to PD nosology. As previously noted, very different personality theories and investigative traditions contributed to the development of Criterion A and B of the AMPD. Furthermore, clinicians are trained in one or more paradigms of personality assessment (Wiggins, 2003). To the extent these paradigms are made explicit within the AMPD, this may enable learning and applying the model as well as potential limitations. We used the personality constructs (i.e., dispositional traits, characteristic adaptations, and narrative identity) defined and systematized by McAdams (1995) and McAdams and Pals (2006), and the five paradigms of personality assessment outlined by Wiggins (2003) to characterize Criterion A, Criterion B, and the full AMPD. First, we assessed the degree to which knowledgable evaluatiors could rate elements of Criterion A and B using the aforementioned constructs and paradigms in a reliable fashion. Second, we examined mean rating differences in constructs and paradigms with respect to Criterion A compared to Criterion B. Third, we examined correlational relationships between the construct and paradigm ratings. This included depiction of the factor structure of these correlational relationships that exist in the universe of the elements of the AMPD. In addition, we evaluated the level of inference implicit in the elements of the AMPD.

## Method

### AMPD Components

The AMPD was first decomposed into component elements. The AMPD Criterion A, the LPFS, consists of a matrix of elements defined by five levels (0-4; ranging from no impairment to extreme impairment), four domains (identity, self-direction, empathy, intimacy), each of which consist of three categories of concerns or constructs (see *DSM-5* [APA, 2013], p. 775-778). For example, the domain of identity describes the constructs or concerns pertaining to self and boundaries, self-esteem regulation, and affect tolerance. Thus, the LPFS may be regarded as a 60-item scale (five levels, four domains, and three subdomains). Zimmerman et al. (2015) analyzed the LPFS in a similar manner. Criterion B consists of 25 trait-facets listed and defined in the *DSM-5* (p.797-781; APA, 2013). “Items” from the LPFS and the 25 trait-facets were pooled, randomized, and presented to raters for their evaluation.

### Rating Procedure

Raters were five clinical psychologists and four advanced clinical psychology doctoral students. The five psychologists were selected to represent several qualities. These included significant clinical experience, expertise in PD assessment and with the AMPD, and knowledge of personality theory and science. Moreover, this panel of experts pluralistically integrates a range of theoretical orientations although individually they also demonstrate expertise in particular paradigms. These raters also have familiarity with the work of McAdams and Pals (2006) and Wiggins (2003). The advanced graduate students who served as raters were versed in the AMPD and assessment psychology. But, additionally, they brought the important perspective of early career psychologists (ECP) to the project. The mean years of total clinical experience for

the nine raters was 17.28 (*SD* = 12.36). Years of clinical experience for the raters ranged from 1.5 years to 40 years.

Each rater was supplied with definitional material about the Wiggins (2003) paradigms (i.e., psychodynamic, interpersonal, personological, multivariate, and empirical; see Supplemental Table A). They were asked to work from the McAdams and Pals (2006) conceptions of dispositional traits, characteristic adaptations, and narrative identity and were given a copy of this article for reference. Raters used the following metric when rating the items/trait-facets of Criterion A and B for the constructs and paradigms: 0 = *lack of construct/paradigm*, 1 = *almost no presence of the construct/paradigm*, 2 = *limited presence of the construct/paradigm*, 3 = *moderate presence of the construct/paradigm*, 4 = *significant presence of the construct/paradigm*, and 5 = *very significant presence of the construct/paradigm*. Experts were also asked to rate the items/trait-facets of Criterion A and B according to the level of abstraction inherent within each item/trait, using the following metric: 0 = *pure behavior*, 1 = *limited level of abstraction*, 2 = *moderate level of abstraction*, and 3 = *high level of abstraction*.

**Data Analysis Plan.** Inter-rater agreement for the personality constructs, assessment paradigms, and the level of inference variable was assessed for Criterion A, B, and the full AMPD. Intraclass correlation coefficients (ICC [2-way, random effects, mean, consistency] were calculated. Because our main focus in this study was on mean differences and correlational relationships of mean ratings of constructs and paradigms within the AMPD, we used consistency ICCs to gauge rater agreement. We then conducted a one-way analysis of variance (ANOVA) to examine differences between constructs and paradigm type across Criterion A and B, followed by Pearson correlations for the Full Model. Using these data, an exploratory factor

analysis (EFA) then described the correlational relationships among the expert ratings of the AMPD for personality constructs, paradigms, and level of inference.

## Results

### Rater Agreement

See Table 1 for the results of the ICC analyses (2-way, random effects, mean, consistency) for the Full Model, Criterion A, and Criterion B. For all ICCs, we used the following interpretive guidelines put forth by Cicchetti (1994): ICCs between .75 and 1.00 were considered excellent, between .60 and .74 were considered good, .40 and .59 were considered fair, and below .40 were considered poor. Within the full AMPD, all rating dimensions showed good to excellent mean agreement. The interpersonal (mean ICC = .91), multivariate (mean ICC = .84), and empirical (mean ICC = .85) paradigms showed particularly strong agreement among raters. Within Criterion A, rater agreement was fair for dispositional traits, and good to excellent for all other domains, with the interpersonal paradigm demonstrating the highest mean ICC (.90). For Criterion B, all mean consistency ICCs were good to excellent. Again, the interpersonal paradigm showed the highest level of rater agreement (ICC .95). Transforming the ICCs to Z scores in order to compute the average agreement level with these coefficients, the full model showed an average mean ICC of .81 (range .66-.91). For Criterion A and B, the average mean ICCs were .73 (range .50-.90) and .80 (range .73-.95), respectively.

### Mean Construct and Paradigm Ratings Across the AMPD

Mean ratings of the nine participants were then calculated for each construct and paradigm, after which a one-way Analysis of Variance (ANOVA) for constructs and paradigm type across Criterion A and B was conducted. The results showed significant differences between Criterion A and B, with the exception of the construct of characteristic adaptations and the

interpersonal paradigm (see Table 2). According to Cohen's (1988) guidelines, small to large effect sizes were observed for all domains, with the exception of characteristic adaptations and the interpersonal paradigm. These relationships are displayed in Figure 1, which portrays the relative composition of construct and paradigm type in Criterion A, B, and the full AMPD. Means and standard deviations for the full model and Criterion A and B are available in Table 3. Our empirical mapping of construct and paradigm shows that Criterion A contains higher mean levels of narrative identity, psychodynamic, interpersonal, and personological paradigms, and level of inference. Criterion B is characterized by higher mean levels of dispositional traits and the multivariate and empirical paradigms.

**Correlational Analyses**

Across the full AMPD model, Pearson correlations between mean construct types, paradigm types, and level of inference are presented in Table 4. Level of inference was highly positively correlated with narrative identity, the psychodynamic and personological paradigms, and inversely associated with dispositional trait, and multivariate paradigms. The multivariate and empirical paradigms were strongly positively associated with dispositional traits. Narrative identity was strongly related to the personological and psychodynamic paradigms, and the interpersonal paradigm was strongly related to the characteristic adaptation construct, as well as the psychodynamic paradigm.

An exploratory factor analysis (EFA) described the correlational relationships among the expert ratings of the AMPD for personality constructs, paradigms, and level of inference. Examination of the kurtosis and skewness of the ratings showed that a maximum likelihood factor extraction EFA could be performed on the data (Costello & Osborne, 2005; see also

Fabrigar, Wegener, MacCaullum, Strahan, 1999).[1] Because our focus is on overlapping personality constructs and non-exclusive theoretical paradigms, there is no assumption that relationships between these variables will be orthogonal. Therefore, an oblique rotation was performed (Maximum Likelihood, Oblimin with Kaiser Normalization). This was executed for a two-factor and three-factor solution.

While both solutions demonstrated significant Chi-squares, the 3-factor solution ($X^2$ = 27.39, $df$ = 12, $p$ = .007) was retained because of its apparent interpretability. See Table 5 for the three correlated factors (67.46% of cumulative variance). Factor 1 was interpreted as Self Functioning domain; Factor 2 as Trait-Multivariate-Descriptive domain, and Factor 3 as Other-Interpersonal Functioning domain. Of note, level of inference showed the following loadings: F1 = .64; F2 = -.76; F3 = .20. Thus, the Self Functioning domain was associated with higher levels of inference, when compared to the Trait-Multivariate and Other-Interpersonal Functioning factors.

## Discussion

The AMPD features a dimensional conception of PD nosology, which is an alternative to the traditional categorical approach of the *DSM-5* (APA, 2013). Our evaluation of the AMPD nososlogy directs attention to the nature of the personality constructs and paradigms within the AMPD, rather than its advantageous dimensional versus categorical structure. The AMPD is examined in terms of content validity with respect to contemporary systemizations of personality theory and science. This point of view rests on the assumption that a PD nosology should directly

1Because our focus is wholly on the elements of the AMPD, rather than viewing elements as samples generalizable to other potential elements, use of Principal Component Analysis (PCA) is arguable. A separate PCA revealed a highly similar pattern of loadings on 3 factors, and factor scores computed on these dimensions showed F1 was significantly larger for Criterion A (ANOVA; $F$ = 142, $p$ < .0001), F2 was larger for Criterion B ($F$ = 38, $p$ <.0001, and F3 levels were not different for Criterion A and B ($F$ = .175, $p$ = n.s.). This shows construct and paradigm variance differentially obtains across Criterion A and B and that both Criterion A and B are saturated with the interpersonal dimension.

pertain to personality, not just represent improved classificatory properties. The tools of this analysis were McAdams and Pals' (2006) personality construct types of dispositional traits, characteristic adaptations, and narrative identity, as well as Wiggins' (2003) five paradigms of personality assessment (psychodynamic, interpersonal, personological, multivariate, and empirical). The analysis employed a broad and knowledgeable pool of raters who evaluated elements of the AMPD for the degree of representation of these constructs and paradigms. In addition, the level of inference implied in each element of the AMPD was assessed.

Rater agreement measured with ICCs generally showed the full model is reliably characterized by these constructs and paradigms, with Criterion B showing slightly higher levels of rater agreement (e.g., average ICC of .73 for Criterion A and .80 for Criterion B). In Criterion A, all constructs and paradigms showed strong rater agreement, with the exception of dispositional traits, which was in the fair range. Agreement was good to excellent on all rating dimensions across the full AMPD. Overall, the interpersonal paradigm demonstrated the highest mean ICCs.

Examining mean rating levels and correlational analyses, all construct and paradigm types differed across Criterion A and B, with the exception of the characteristic adaptations construct and the interpersonal paradigm. In the full model, the psychodynamic and personological paradigms and the narrative identity constructs were strongly and positively correlated. The multivariate, empirical, and dispositional traits variables were also highly correlated. Level of inference was positively associated with the psychodynamic, personological, and narrative identity, and it was negatively associated with dispositional traits, and the multivariate and empirical paradigms. An illustrative EFA of the rating data found three underlying correlated dimensions of personality construct and paradigm within the AMPD. They

were interpreted as reflecting Self or Intrapersonal content (high loadings for narrative identity, personological, and psychodynamic), Trait-Descriptive content (high loadings for dispositional traits, multivariate, empirical), and Other or Interpersonal content (high loadings for characteristic adaptations and interpersonal). The Self Functioning domain was associated with higher levels of inference, when compared to the Trait-Multivariate and Other-Interpersonal Functioning factors.

Empirical studies and clinical experience highlight the challenges posed by our current diagnostic system. For instance, rarely does a patient fit neatly in one *DSM* diagnostic category. Instead, the *DSM*-categorical approach is plagued by the challenges of comorbidity, especially among PD diagnoses (Pincus, Tew, & First, 2004). To reflect meaningful individual differences of personality functioning in PD, a more differentiated approach such as offered in the AMPD is advantageous. Placement on the dimensions of the AMPD highlights specific aspects of an individual's problematic personality functioning, whether or not the individual meets full diagnostic criteria for a traditional DSM-categorical PD. The AMPD offers the diagnostician and the treating clinician a relatively nuanced picture of the patient's personality functioning. From this vantage point, strategic targeting of personality dysfunction and choice of treatment modalities are available. Bach, Simonsen, Markon, and Krueger (2015) illustrated how both Criterion A and B of the AMPD contribute to case conceptualization, treatment planning, and in giving patient feedback. Similarly, Clarkin, Livesley, and Cain (2015) described how specific empirically supported treatment modules for PD may be selected using a patient's location on both Criterion A and B of the AMPD.

The advantages of the AMPD are not just a matter of degree, so to speak, but are also qualitative. The AMPD is pan-theoretically inclusiveness with regard to personality constructs.

Importantly, we note that the first word in personality disorder is *personality*. Since 1980, with the advent of the DSM-III, personality theory and science have been relatively eclipsed by a focus on descriptive diagnostic criteria of PD nosology. The AMPD does not model the psychiatric syndrome in its classificatory structure. It pluralistically models PD from conceptual and empirical advances in personality science (see Waugh et al, 2017).

The emphasis on personality processes and dimensions in the AMPD contrasts with the traditional descriptive, criterion-count syndrome approach in another important way. Writing about diagnostic systems in general, Andreasen (2007) indicted the modern *DSM*s as conceptually sterile, potentially dehumanizing, and didactically misleading for new generations of clinicians, insofar as checklists of criteria do not convey the complexities of psychopathology. Similarly, we extend Andreasen's (2007) critique to traditional *DSM* PDs. To the extent the AMPD recruits multiple planes of personality theory, science, and assessment, PD nosology recovers the intrinsic complexity of its subject domain, human personality functioning. This is in turn is more humanizing (see Bach et al, 2015) and, by providing understandable diagnostic language (e.g., Criterion B traits), the AMPD may foster alliance building. Furthermore, with its user- and consumer-friendly language, the AMPD lends itself to collaborative and Therapeutic Assessment approaches (TA; Finn & Tonsanger, 1997). The practicing clinician and the trainee draw on the fruits of key personality paradigms (e.g., psychodynamic, interpersonal, personological, multivariate, and empirical; Wiggins, 2003) in assessing and applying AMPD diagnoses. Our study underscores that personality constructs and paradigms are embedded in AMPD-based PD diagnosis. Like McAdams (1995) who rhetorically asked, "what do we know when we know a person," we suggest "we know personality" when we know AMPD diagnosis.

To recap, a solution to the comorbidity problem of PD diagnosis is found within the organizational structure of the AMPD. Therein, conceptual and empirical advances from personality science are modeled into PD nosology, as opposed to chasing clarity by efforts to refine or rearrange descriptive criteria for diagnostic syndromes. The AMPD draws upon diverse theoretical orientations, which enjoy empirical support. These include the psychodynamic, attachment, and social-cognitive approaches of Criterion A (Bender, Morey, & Skodol, 2011) and the psychometric trait tradition of Criterion B (i.e., Allport & Odbert, 1936; Goldberg, 1993; McCrae & Costa, 1987). Our results not only demonstrate that the AMPD is theoretically inclusive, but this personality-focused model built upon the twin arms of Criterion A and B has breadth. This furthers content validity (Haynes, Richard, & Kubany, 1995) and expands diagnostic coverage (Blashfield and Draguns, 1976). Furthermore, we note with the AMPD the diagnostician must assess personality constructs across paradigms by virtue of the fact that both Criterion A and B, each spanning multiple domains of personality science, must be reckoned.

Some research argues that Criterion B carries the lion's share of the predictive variance within the AMPD (e.g., Few et al., 2013; Widiger, 2015). Predictive variance, however, is not the sole criterion on which to evaluate nosologies. Clinical utility, which involves ease of use, communicative value, and treatment planning, is vital (Mullins-Sweatt & Widiger, 2007). Our results establish the presence of diverse personality constructs and paradigms within the AMPD. This furthermore suggests clinicians of different theoretical backgrounds and assessment traditions should find the AMPD learnable and useful in part because of their familiarity with aspects of the AMPD (see Waugh et al, 2017). Emerging research shows the AMPD enjoys clinical utility (Morey et al, 2014) and that both Criterion A and B are quite learnable (Garcia, Skadberg, Schmidt, Bierma, Shorter, & Waugh, 2018).

Given the range of personality constructs and paradigms represented within AMPD, our results provide implications for assessment of Criterion A and B. The AMPD may be assessed by a variety of methods, such as self-report (e.g., PID-5, LPFS-Self Report; Morey, 2017; Hopwood, Good, & Morey, 2018), as well as clinician ratings from the *DSM-5*, Section III (APA, 2013). Yet, the assessment strategy of multi-method assessment may be particularly germane. Consider the line of research on multi-method assessment of the personality processes in dependency. From this research, Bornstein (2011) articulated the process dissociation model of understanding the meaning of test scores. This strategy uses different methods of assessment to illuminate the nature of personality constructs. The AMPD, incorporating different kinds of personality constructs, thus may lend itself to assessment with various methods such as self-report, informant report, experimental results, and performance assessment. We are reminded of Leary's (1957) interpersonal diagnosis of personality system, which relied on multiple assessment methods to organize and represent personality constructs assessed by different methods. Furthermore, we harken to the basis of construct validity. Loevinger (1993, p. 1) compared rigorous personality assessment to the "white whale" of psychometrics. The pursuit of this goal is not furthered by a single-minded search strategy (i.e., one method of assessment). A primary assumption of construct validity is that the method of assessment should mirror the nature of the construct (Loevinger, 1957).

As in personality research and assessment, much current research with the AMPD relies on self-report data. It is known that self-report assessment has great utility as well as limitations, and the latter concern may be particularly relevant with some forms of PD, including externalizing disorders (see Klonsky & Oltmanns, 2002). Thus, on the basis of psychometrics (Loevinger, 1957) and the strategy of multi-method clinical assessment, we suggest the AMPD

may benefit from assessment with a variety of approaches. The self-report approach has been empirically successful (e.g., PID-5; LPFS-SR) with the AMPD, but the repertoire of empirically supported psychological assessment (Bornstein, 2017) spans self-report, other-report, and performance methods. In fact, the conceptual heritage of the LPFS draws on performance assessment methodology such as the SCORS-G, ORI, and RF (see Bender et al, 2011). It is possible that certain methods of measurement may be differentially suited to some components of the AMPD. This notion is suggested in Zimmerman et al ‘s (2015) observation from factor analytic study of the elements of the AMPD that Criterion A may capture *how* PD is expressed, and Criterion B reflect *what* is expressed. A similar distinction is made of the dynamic interplay of personality processes and traits in Mischel and Schoda’s (1995) Cognitive Affective Personality System (CAPS).

An area in which this distinction between Criterion A and B may be particularly relevant for the AMPD is assessment of psychoticism. Psychoticism can be assessed by interview, observation, and self-report. But, the use of personality performance measures, including Rorschach indices of perceptual accuracy and thinking disorder, is very effective (Mihura, Meyer, Dumitrascu, & Bombel, 2013). The LPF of Criterion A is conceptually related to Kernberg’s (1989) dimension of psychostrucutral level of personality functioning. Acklin (1992; 1993; 1994) has shown how performance personality tests contribute to assessment of different levels of personality organization (e.g., neurotic, borderline, and psychotic). Performance personality assessment attends to issues of response process (Mihura, Dumatriscu, Roy, & Meyer, 2017). This refers to the psychological processes, as opposed to response content, implicit in responding to test stimuli. Response process addresses the *how* of responding, to return to Zimmermann et al ‘s (2015) idea with respect to Criterion A. The response process of

reality testing is tapped by Rorschach indices of perceptual inaccuracy, a key method for assessing psychoticism. And, response process in expressions of level of personality organization, as discussed by Acklin (1993), applies to multi-method assessment of the LPF. (seeThis  This subject of differential construct and method relations in PD assessment is an important area for further development and empirical study.

Our results also provide guidance on learning and applying the AMPD. First, Criterion A and B recruit different levels of inference. Criterion B, drawing on descriptive trait constructs, may be more easily learned and reliably rated. In a study of different models of PDs, Nelson, Huprich, Shankar, Sohnleitner, and Paggeot (2017) found that clinicians-in-training preferred dimensional trait approaches, such as Criterion B of the AMPD. However, Garcia et al. (2018) reviewed rater reliability studies of the AMPD and studied the learnability of the LPFS of Criterion A. The authors found that, with moderate degree of training, graduate student raters could achieve robust levels of rater agreement and concordance with expert ratings with the LPFS.

Our results reinforce a general point about PD. We note that across Criterion A and B, the interpersonal paradigm and characteristic adaptations seem to be the common ground. This is another way of saying PD is fundamentally interpersonal (Hopwood et al., 2013), the product of an individual’s agentic navigation of life experiences given one’s constitutional heritage and socio-cultural surround (Berrios & Markova, 2015; McAdams & Pals, 2006).

Our study is not without limitations. Our number of raters might be viewed as relatively small (9). However, rather than using raters of a broad range and large number (e.g., Morey et al. 2014), our study used a team of raters, which represents an integrative cross-section of theoretical orientations, years of clinical experience, and considerable expertise in personality

assessment. Furthermore, another potential weakness of this study is our psychometric comparison between elements of A and B is not strictly parallel. For Criterion A, we decomposed all elements of the LPFS into 60 items. In effect, each anchor point of the five-level metric for the four domains of the LPFS was defined and rated. In contrast, for Criterion B, the trait-facet dimension was evaluated rather than rating each anchor point of the trait-facets. A strictly comparable evaluation of A and B would require the dimensions of Criterion A (the three sub-domains of each of the four domains of the LPFS) to be compared to Criterion B. Criterion B as depicted in the *DSM-5* (APA, 2013) does not include descriptions of each anchor point of the 4 levels of the trait-facets (when rated 0-3). However, in the interests of making use of the full specification of the AMPD as presented in the *DSM-5*, we used all the information in the LPFS via the "60-items." We also note that the LPFS was not originally designed to be used as a 60-item scale. However, others have examined it in this fashion (Zimmermann et al 2015), and a multi-item self-report version shows strong psychometric properties (Hopwood et al, 2018; Morey, 2017).

In closing, we offer an analogy to the psychotherapy movement. Psychotherapy integration seeks to incorporate multiple schools of psychotherapy (Norcross & Goldfried, 2005; Stricker & Gold, 2013). Norcross and Goldfried (2005) and Stricker and Gold (2013) described four approaches to psychotherapy integration. These are (1) focus on *common factors*, (2) a strategic combining of approaches (*technical eclecticism*), (3) framing of schools of therapy via a preferred paradigm (*assimilative integration*), and (4) a comprehensive synthesis of psychotherapies (*theoretical integration*). Our study shows that the AMPD draws on multiple personality constructs and paradigms. The AMPD particularly brings the psychodynamic, interpersonal, multivariate, and empirical paradigms to PD nosology. By requiring both Criterion

A and B for PD diagnosis, the AMPD is reasonably theoretically comprehensive in the manner of technical eclecticism. A given clinician, however, is free to operate from the point of view of assimilative or theoretical integration. The model itself requires only that a broad spectrum of constructs and paradigms be considered—and no paradigm is favored. Analogizing to the common factors approach, ratings for severity of PD functioning, either through the LPFS or the highly correlated dimension of the mean trait-facet elevation, captures that which is common in PD. Yet, this is insufficient empirically or conceptually. We suggest that in understanding PD, a broad and pluralistic perspective is important. The AMPD, with its pantheoretical focus, integrates major systems of personality constructs (McAdams & Pals, 2006) and personality paradigms (Wiggins, 2003). This is an underappreciated advance within PD nosology, in addition to the dimensionalization of diagnosis found in the AMPD

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Table 1

*ICCs of four raters for full model, Criterion A, and Criterion B*

| | ICC consistency, average |
|---|---|
| Full Model | |
| Dispositional Traits | **.72** |
| Characteristic Adaptations | **.66** |
| Narrative Identity | **.80** |
| Psychodynamic | **.79** |
| Interpersonal | **.91** |
| Personological | **.78** |
| Multivariate | **.84** |
| Empirical | **.85** |
| Level of Inference | **.82** |
| Criterion A | |
| Dispositional Traits | .50 |
| Characteristic Adaptations | **.70** |
| Narrative Identity | **.72** |
| Psychodynamic | **.80** |
| Interpersonal | **.90** |
| Personological | **.70** |
| Multivariate | **.72** |
| Empirical | **.64** |
| Level of Inference | **.66** |
| Criterion B | |
| Dispositional Traits | **.76** |
| Characteristic Adaptations | **.72** |
| Narrative Identity | **.83** |
| Psychodynamic | **.73** |
| Interpersonal | **.95** |
| Personological | **.73** |
| Multivariate | **.74** |
| Empirical | **.76** |
| Level of Inference | **.79** |

Table 2

*One-way ANOVA between Criterion A and Criterion B*

| | *df* | *F* | $\eta^2$ | *p* |
|---|---|---|---|---|
| Dispositional Traits | 1 | 65.39 | .44 | .000 |
| Characteristic Adaptations | 1 | .01 | 0 | .92 |
| Narrative Identity | 1 | 39.86 | .32 | .000 |
| Psychodynamic | 1 | 10.37 | .11 | .002 |
| Interpersonal | 1 | .58 | .01 | .449 |
| Personological | 1 | 31.03 | .27 | .000 |
| Multivariate | 1 | 76.57 | .48 | .000 |
| Empirical | 1 | 124.14 | .60 | .000 |
| Level of Inference | 1 | 61.33 | .42 | .000 |

Table 3

*Means and standard deviations of nine raters*

| | *N* | *M* | *SD* |
|---|---|---|---|
| Full Model | | | |
| Dispositional Traits | 85 | 2.80 | .64 |
| Characteristic Adaptations | 85 | 3.63 | .49 |
| Narrative Identity | 85 | 2.79 | .69 |
| Psychodynamic | 85 | 3.82 | .61 |
| Interpersonal | 85 | 3.33 | 1.02 |
| Personological | 85 | 3.09 | .59 |
| Multivariate | 85 | 2.50 | .73 |
| Empirical | 85 | 3.07 | .77 |
| Level of Inference | 85 | 2.06 | .50 |
| Criterion A | | | |
| Dispositional Traits | 60 | 2.53 | .44 |
| Characteristic Adaptations | 60 | 3.62 | .48 |
| Narrative Identity | 60 | 3.04 | .59 |
| Psychodynamic | 60 | 3.95 | .55 |
| Interpersonal | 60 | 3.39 | .92 |
| Personological | 60 | 3.30 | .53 |
| Multivariate | 60 | 2.17 | .52 |
| Empirical | 60 | 2.69 | .47 |
| Level of Inference | 60 | 2.27 | .34 |
| Criterion B | | | |
| Dispositional Traits | 25 | 3.46 | .56 |
| Characteristic Adaptations | 25 | 3.64 | .51 |
| Narrative Identity | 25 | 2.18 | .51 |
| Psychodynamic | 25 | 3.51 | .64 |
| Interpersonal | 25 | 3.20 | 1.23 |
| Personological | 25 | 2.62 | .45 |
| Multivariate | 25 | 3.27 | .54 |
| Empirical | 25 | 3.99 | .52 |
| Level of Inference | 25 | 1.56 | .47 |

Table 4

*Correlations of mean ratings between the domains for the full model*

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| 1. Dispositional Traits | | | | | | | | |
| 2. Characteristic Adaptations | .03 | | | | | | | |
| 3. Narrative Identity | -.44** | .08 | | | | | | |
| 4. Psychodynamic | -.19 | .00 | .40** | | | | | |
| 5. Interpersonal | -.06 | .47** | .03 | .32** | | | | |
| 6. Personological | -.39** | .20 | .90** | .45** | .17 | | | |
| 7. Multivariate | .82** | .08 | -.46** | -.28** | -.05 | -.43** | | |
| 8. Empirical | .60** | -.17 | -.53** | -.14 | -.17 | -.50** | .67** | |
| 9. Level of Inference | -.64** | .10 | .64** | .45** | .14 | .59** | -.70** | -.61** |

*Note*. $N = 85$. $^{**}p < .01$.

Table 5

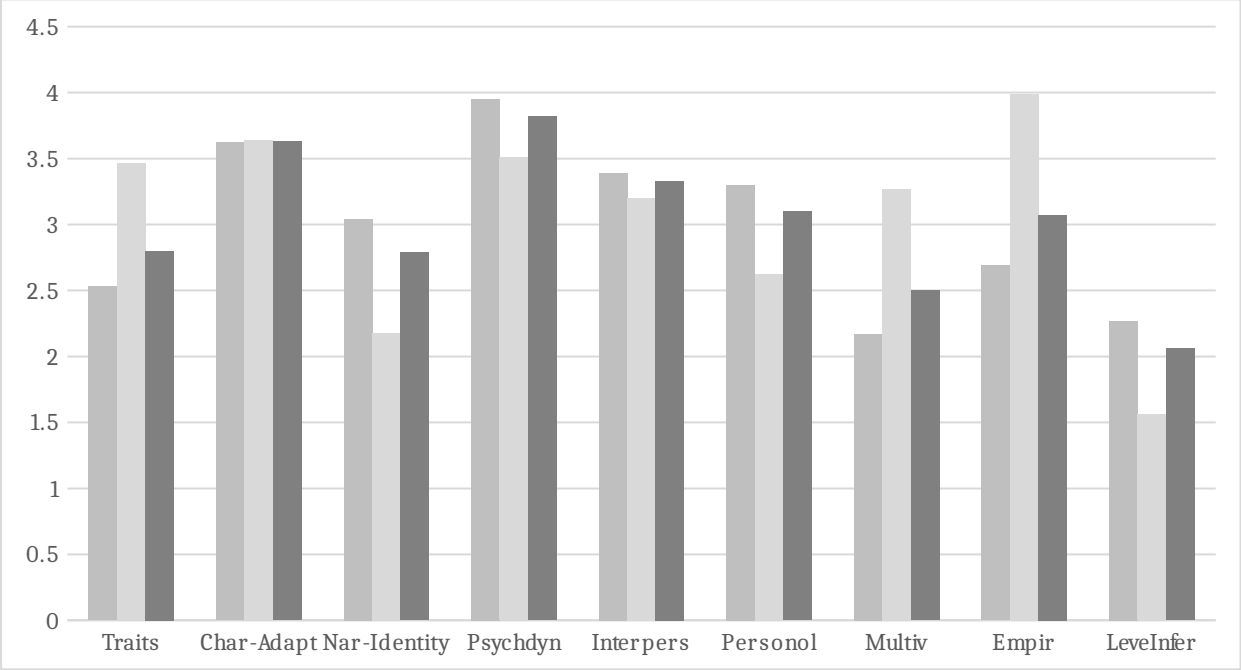
*Exploratory factor analysis of the Constructs and Paradigms*

| | Factor 1 | Factor 2 | Factor 3 |
|---|---|---|---|
| Factor 1-Self Functioning Domain | | | |
| Narrative Identity | **.99** | -.55 | .14 |
| Personological | **.92** | -.52 | .30 |
| Psychodynamic | **.43** | -.33 | .36 |
| Factor 2 – Trait-Multivariate Domain | | | |
| Multivariate | -.43 | **.97** | -.03 |
| Dispositional Traits | -.42 | **.84** | -.04 |
| Empirical | -.54 | **.72** | -.20 |
| Factor 3 - Other-Interpersonal Functioning Domain | | | |
| Interpersonal | .13 | -.11 | **.87** |
| Characteristic Adaptation | .15 | .02 | **.56** |

*Note*. Items in bold are considered high loaders.

Figure 1

*Mean ratings of constructs and paradigms in the AMPD*




*Note*. Traits = Dispositional Traits; Char-Adapt = Characteristic Adaptations; Nar-Identity = Narrative Identity, Psychdyn = Psychodynamic; Interpers = Interpersonal; Personol = Personological; Multiv = Multivariate; Empir = Empirical; LevelInfer = Level of Inference

Supplemental Table A

**Wiggins' (2003) Paradigms of Personality Assessment**

**Psychodynamic**: intrapsychic processes; unconscious; pathological object representations/relations; often clinical inference and/or performance assessment - process data; subjective experience important; uses S, O, & T data); Rorschach/Performance measures

**Interpersonal**: interpersonal field, social interaction processes (may be internalized), relationship patterns (especially S and O data), represented in circumplex, SASB models

**Personological**: subjective and self-system experiential processes; life history/case study; life themes; narrative data; S, T, O, L data relevant; T data can be TAT, Ems [per McAdams]

**Multivariate**: descriptive constructs, often traits; multivariate model (factor analysis-dimensions, predictive validity emphasized); FFM heritage, but also a descriptive vocabulary; S & O data (as seen or observed by self or by other)

**Empirical**: classification by diagnostic category, construct, or dimension; Kraepelinian tradition; prototypically MMPI, but PAI and MCMI relevant; diagnostic groups/dimensions/empirical correlates