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By Bo Bach, Christopher J. Hopwood, Erik Simonsen, and Robert F. Krueger.
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Chapter 5

Assessment and Reporting in Clinical Practice

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To reinforce a point: level of personality functioning and trait dimensions are not exclusively intended for personality disorder assessment; they also can be useful for assessing the complete range and severity of personality and mental health problems (i.e., from psychological difficulty to severe psychopathology).[1] Consider also that personality functioning can be impaired due to complex trauma, ADHD, persistent depressive disorder, or other long-standing mental disorders. In many cases, individuals may also show accentuated traits and milder impairment of personality functioning without exceeding the diagnostic threshold for any mental disorder. Moreover, personality functioning and traits always make sense for describing individuals with subthreshold diagnostic features, including thin-skinned narcissism, anxiousness, depressivity, and psychopathic features. Accordingly, the AMPD framework is also deemed useful for practitioners working in different fields, such as forensic settings, private practice, or substance abuse rehabilitation. Under any circumstances, personality functioning and trait profiles can be informative for understanding individual vulnerability and psychological health and thereby inform clinical decision making, treatment planning, and "personalized medicine" (i.e., tailoring treatment to the client's individual characteristics).

[1]For the same reason, the AMPD trait framework delineated in the present book largely corresponds to the nosological building blocks of the emerging hierarchical taxonomy for psychopathology (HiTOP), which is a new, empirically informed framework of psychopathology.

The clinical utility of the AMPD model lies in its potential to check and focus attention on multiple relevant areas of personality variation in the individual client, which may be approached hierarchically at different levels in different steps. Instead of solely focusing attention on the identification of one optimal diagnostic label (e.g., narcissistic personality disorder), the clinical application of the AMPD model involves reviewing (1) a client's general core personality dysfunction, (2) five broad trait domains of individual features, and (3) the more specific level of unique facet descriptors within the most prominent trait domain. Depending on clinical resources, the AMPD model may be used as a "quick and dirty" tool (Step 1) if necessary or "slow and sophisticated" (Step 3) if possible.

The AMPD approach to clinical assessment is similar to the approach physicians take to evaluating a client. Imagine you are a medical practitioner examining a client, whose presenting problem may apply to a specific neurological symptom. During the initial evaluation, you would also review functioning across all relevant systems (e.g., respiratory, cardiovascular, gastrointestinal). Unless you review all these different systems, you could miss important areas of impaired functioning and the corresponding opportunity for effective treatment (American Psychiatric Association, 2013). Likewise, when using the AMPD approach, you do not assess only what appear to be depressivity and emotional dysregulation, but you also examine high and low scores (i.e., peaks and valleys) on all other dimensions, which together portray the personality structure of the client.

The AMPD diagnostic procedure may also be compared to a preflight checklist in aviation. Imagine you are a pilot sitting in the cockpit about to take off. Before taking off, your "review of systems" evaluation must first of all include a systematic check of the most general and critical issues that may arise in an aircraft, which may further guide the evaluation of more specific functions of the machine. Likewise, when using the AMPD approach, you not only assess what appears to be a severe problem, but you also determine the level of dysfunction, followed by determining where the client falls on five higher order domains of maladaptive trait expressions and 25 lower order subfacets (Waugh et al., 2017). As in the cockpit procedure, such a stepwise formula may safeguard diagnostic appraisal against common forms of human error and omission in clinical practice (i.e., overlooking significant vulnerabilities or risk factors of the client).

RECOMMENDATIONS FOR ASSESSING PERSONALITY FUNCTIONING

Like most human tendencies and features, personality functioning is best captured on a continuum. An optimally functioning person has a fully elaborated, complex, and well-integrated psychological world that

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includes a mostly positive, stable, and purpose-driven self-concept; a rich and appropriately regulated emotional life; and the capacity to be a productive and thriving member of a society. At the least functional end of the continuum, an individual with severe personality pathology has a disorganized, impoverished, and/or conflicted psychological world that includes an unclear, unstable, and ineffective self-concept; a tendency to a negative and dysregulated emotional life; and a deficient capacity for productive social engagement and behavior (American Psychiatric Association, 2013).

The assessment of personality functioning is valuable not only for clinical characterization but also for treatment planning and estimation of prognosis, including risk of violence toward oneself or others, and for identification of target groups for differential treatment (Clark et al., 2018; Crawford et al., 2011). Likewise, the client's level of personality organization, including appraisal of self and others (i.e., quality of mental models of self and others), affects the nature of interaction with friends, family, partners, and mental health professionals and can have a significant impact on treatment efficacy and outcome (Koelen et al., 2012).

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Whereas personality disorders are defined as being relatively stable over time (e.g., at least 2 years), features of personality functioning may be relatively unstable and sometimes fluctuate moment to moment (e.g., Roche, 2018); this may be particularly important to consider and evaluate in treatment settings. Accordingly, self-esteem may only be "diminished at times" (i.e., some impairment), while in several other situations the individual may show "inflated self-appraisal" (i.e., moderate impairment). This important dynamic aspect of personality functioning typically mirrors the person's situational dynamics and coping strategies. For example, under extraordinary stress or pressure, individuals who are normally well functioning may in rare moments use immature defenses and in extraordinary cases even exhibit regression-like states and psychotic-like experiences (see Chapter 2 for further explanation of such coping and defense mechanisms). In other words, under sufficient trauma or strain, any of us can have personality disorder symptoms (e.g., Caligor et al., 2018; Lingiardi & McWilliams, 2017).

How to Assess Personality Functioning in Routine Clinical Practice

The AMPD descriptors of personality functioning may seem lengthy, complicated, and overly comprehensive. However, we suggest that clinicians become familiar with the concepts and then initially use the definitions as global "prototypes" to evaluate the degree to which a given client matches the description for each level of personality functioning (see Chapter 2). For example, a woman admitted for clinical evaluation and treatment discloses uncertainty about who she is or what she thinks

or feels, including a tendency to lose herself in other people and indecision about what she wants from life. Such statements indicate poor differentiation of the self, uncertainty about personal qualities, boundary problems, and low self-directedness. Having identified those symptoms, the clinician and client can explore them in more detail to delineate the client's level of personality functioning. The most basic assessment of level of personality functioning could be based on the following eight screener questions (along with the client's life history), which can be used to assign a preliminary global LPFS score based on a holistic estimation:

- In what way would you describe yourself as a person?
- How do you normally feel about yourself?
- How do you think other people would describe you?
- To what extent do you succeed at getting the things you want in life (e.g., having a satisfying relationship, close friends, a fulfilling career)?
- Who do you consider to be the most important people in your life, and how do you get along with them?
- How would you describe your relationships with other people?
- To what extent do you understand yourself?
- To what extent do you understand other people?

If there is time for a more thorough assessment, the clinician may use this preliminary assessment (and the global LPFS score) as a starting point. During such an initial clinical interview, it is important to ask follow-up questions to elicit additional details and examples in order to adequately score the level of personality functioning. Whenever necessary, scores can be changed according to new information that is gleaned in the rest of the interview. The funnel strategy illustrated in Figure 5.1 may be used as a heuristic guideline for clinicians, in which the aforementioned open questions are used to kick-start a conversation and get an idea of global levels of functioning, which may be further qualified using auxiliary questions that reformulate the questions or further investigate specific aspects. When the clinician finds it difficult to decide between two different levels of impairment for a specific capacity, a test question can be formulated in which the client will be asked to choose between two or more options. Such polarization of options may help make the possible levels of functioning clearly distinguishable from each other. Finally, when there is a more clear impression of the global level of functioning, the clinician may use check questions to confirm this level in which the collected information is summarized and reformulated for the client, eventually resulting in a definitive rating of functioning.

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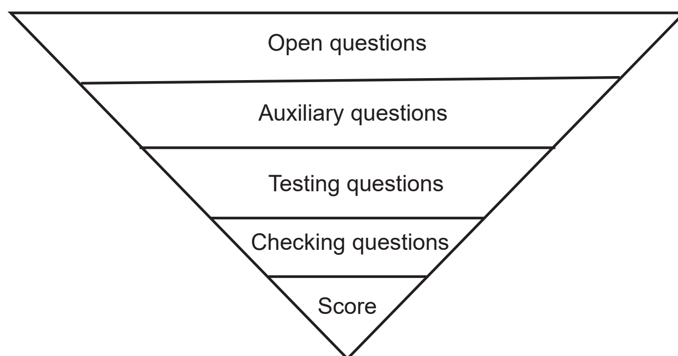

FIGURE 5.1. Funnel strategy for global assessment of personality functioning. Based on Weekers et al. (2020).

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If convenient, practitioners may particularly get familiar with and employ the information provided at Level 2 (i.e., moderate impairment in Table 1.2) as a screen for possible presence of what is traditionally referred to as a personality disorder (Skodol et al., 2014). This information can then be supplemented with a few specific questions to explore different features of the definition. For the most reliable interview-based assessment of personality functioning, we recommend using Module I of the Structured Clinical Interview for DSM-5—Alternative Model of Personality Disorders (SCID-5-AMPD; Bender et al., 2018) or the Semi-Structured Interview for Personality Functioning DSM-5 (STiP-5.1; Hutsebaut et al., 2017). Additionally, a number of client-report measures have also been developed for the LPFS, such as the 80-item Level of Personality Functioning Scale—Self-Report (LPFS-SR; Morey, 2017), the 12-item Level of Personality Functioning – Brief Form (LPFS-BF; Weekers et al., 2019), the 132-item DSM-5 Levels of Personality Functioning Questionnaire (DLOPFQ; Huprich et al., 2018), the 24-item Self- and Interpersonal Functioning Scale (SIFS; Gamache et al., 2019), the 97-item Level of Personality Functioning Questionnaire for Adolescents (LOPF–Q12–18; Goth et al., 2018).

It is important to emphasize that aspects of self-functioning and interpersonal functioning are usually intertwined and reciprocally related. For example, severe impairment of self-functioning involves poor boundary definition, which is naturally associated with a tendency to show overidentification with others (i.e., interpersonal functioning). Moreover, extreme impairment of self-functioning may involve a weak or distorted self-image, which is naturally associated with feeling easily

threatened by interactions with others (i.e., interpersonal functioning). As a final example, extreme impairment of self-functioning may involve dominant affects of hatred and aggression, which may be disavowed and attributed to others (i.e., interpersonal functioning). Aspects of the LPFS are interpenetrating, and the global score of personality functioning is unitary, integrating aspects of both self- and interpersonal functioning. It follows that the clinician must choose a level that most closely represents the client's presentation across all domains and capacities.

Assessing Self-Functioning

Poor self-functioning may be defined in terms of cognitive, emotional, and motivational impairments, in which the cognitive component is described as problems with differentiation and integration of the person's knowledge of the self, including reality testing and self-reflection. This personal knowledge is thought to accumulate during child development through interaction with the social environment (Caligor et al., 2018). During this process, the self takes structure, and a coherent identity is integrated. Poor differentiation of the self is manifested as an impoverished set of inner models or self-schemas, lack of clarity about personal attributes, a sense of emptiness, identity diffusion, and poor interpersonal boundaries, which are all reflected in the AMPD framework of personality functioning. Problems related to such poor self-integration may include lack of a sense of historicity or continuity in one's experience of the self (e.g., reflected in "unrealistic or incoherent goals"), fragmentary self-representation, and disconnected self-states (Kernberg, 1984; Livesley, 2003; Livesley & Clarkin, 2016). Accordingly, such features are important to examine in the assessment of personality dysfunction.

In practice, the clinician could begin the assessment of self-functioning by eliciting a self-description similar to the approach in the well-known Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD) interview (e.g., "How would you describe yourself as a person?"). Following are some examples:

- "Maybe we could now talk about how you view yourself?"
- "What kind of person do you consider yourself to be?"
- "How would you describe who you are?"

Such questions usually generate important diagnostic information relatively quickly. Those with a poorly differentiated self often struggle with the task and comment about being unsure about who they are. Others provide a very brief description consisting of a few very general or specific attributes. For example, "I like horses, I am good at using

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computers, I care about dogs, I live in the city. . . . I don't know what else to say." A few additional questions to elicit more information usually reveals the extent of self-related problems.

Boundaries between self and others are also important to assess because such distinction of self from others is a precondition for the definition and understanding of a self. In cases of extreme impairment, this essential problem may be characterized by LPFS in terms of boundaries with others that are confused or lacking and the experience that a unique self and sense of agency/autonomy is virtually absent. Useful questions to evaluate such problems could be:

- "Do you ever feel very exposed or vulnerable because it feels as if there is nothing to separate you from other people?"
- "Do you ever confuse other people's perceptions or opinions with your own?"
- "Are you ever worried about losing the sense of who you really are or losing yourself in others?"

The difference between extreme levels of impairment and the higher levels of personality functioning is reflected in the degree of differentiation between self and others (i.e., boundaries with others are confused or lacking). A client with a moderately severe personality disorder typically produces a self-description limited to a few concrete qualities and some uncertainties about personal properties, whereas at extreme levels of impairment the client typically defines self based on the here-and-now perceptions and expectations of others with very little information about enduring personal qualities. Likewise, with increasing severity of impairment, interpersonal boundaries vanish, leading to enmeshed relationships and a sense of losing oneself by merging with others.

Clients with such impairments of self-functioning may therefore respond to the probe questions by expressing that it is challenging to describe themselves, as their perceptions of themselves change frequently. For example, a client may express: "It is difficult to say . . . what I think or feel about myself changes all the time . . . it sometimes feels as if there are several different me's." Such responses indicate some kind of discontinuity or incoherence in the experience of the self, which can be evaluated further by asking the following questions:

- "Does your idea of who you are change from day to day?"
- "Do you have conflicting feelings about yourself and who you are?"
- "Do you sometimes have the feeling that you are several different people?"

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It should be noted that the aforementioned responses would be most typical for emotionally dysregulated clients (e.g., borderline pathology). For more detached or socially withdrawn clients (e.g., schizoid or avoidant pathology), features of the self may be experienced as a facade and the true self may be inhibited or hidden inside and never really "shown" to others.

A major differentiation between extreme impairment and higher levels of functioning is that with extreme impairment there is greater disconnection between self-states, such that experiences when in one state are poorly recalled in another state (Livesley & Clarkin, 2016). We see this at Level 4 (i.e., extreme impairment), where self-functioning (i.e., identity) may be characterized by significant distortions and confusion concerning self-appraisal, by emotions that are not congruent with context or internal experience, and by hatred and aggression that may be dominant affects although they may be disavowed and attributed to others. Moreover, extreme impairment of self-functioning (i.e., self-direction) may also be characterized by poor differentiation of thoughts from actions and inability to constructively reflect on one's own experience, and personal motivations may be unrecognized and/or experienced as external to self.

This understanding of functioning is substantially consistent with theories about self-states or ego states (Bernstein & Clercx, 2018; Bromberg, 2004; Watkins, 1978; Young & First, 2003). Self-states may be considered on a spectrum of "dissociation" (only referring to genuine dissociative identity or multiple personality disorder in the most severe and rare cases). The more dissociated or disconnected self-states are from one another, the more severe the personality disorder typically is. For example, a client with severe borderline personality disorder may feel vulnerable, lonely, and dependent on the therapist in one moment, while 10 seconds later may be enraged and abusive toward the therapist, and 20 seconds after that may be detached and feel "nothing" (Farrell & Shaw, 2012; Young et al., 2003). All self-states are thought to be there at the same time, but only one state is predominant at the moment and hijacks the entire existence of the client in that very moment. In a healthy, functioning personality, it is more common to experience a mixture of well-integrated self-states at the same time, such as a "bittersweet feeling" or going to work on a sad day, while having a productive and satisfactory time anyway.

For example, one client with an extreme level of impairment exhibited several self-states, including a more content and cheerful state, a state of intense aggression associated with the painful feeling of distrust and abandonment, and a state of empty disconnectedness. When experiencing the state of emptiness, he could hardly recall or imagine that he

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ever felt any different, even though he had been in a more positive state a short time before. This lack of access to more positive states worsened his distress because the pain of emptiness felt timeless, as if it had always been there and always would be there.

We also see aspects of disconnected self-states in terms of extremely impaired capacity for self-directedness. This capacity involves having meaningful and coherent goals in life, which contributes to the coherence of the self. Striving to attain goals further contributes to a sense of personal autonomy and agency that gives life meaning, direction, and purpose (Carver, 2011; Livesley & Clarkin, 2016). When this capacity is substantially compromised, we see poor self-efficacy in terms of being incapable of controlling oneself and one's destiny, missing purpose in life and lack of meaning, and difficulty setting and attaining long-term goals. Accordingly, this capacity may also be referred to as the motivational component of the self. Within the LPFS terminology, this may include difficulty establishing and/or achieving goals (i.e., severe impairment), or it may mean that goal-setting ability is severely compromised, with unrealistic and incoherent goals (i.e., extreme impairment).

These LPFS features can usually be evaluated when taking a personal history, because it typically becomes evident whether the client has lived a life infused with purpose and a coherent sense of self, including well-defined goals, or whether life has been less purposeful. This initial evaluation can then be followed up with some questions, such as:

- "Do you feel as if there is nothing that you can do to change your life?"
- "Do you feel as though you are not in control of your own life?"
- "Does it feel as if your life has meaning"?
- "Does it seem as if nothing that you do has any real purpose?"
- "Do you have difficulty in setting goals and deciding what you want to accomplish in life?"

In contrast to clients with severe and extreme impairment, clients with moderate impairment are typically able to set goals, but their goals often change rapidly due to a deep uncertainty about who they are, and they have a hard time sustaining the effort to achieve longer term goals.

Assessing Interpersonal Functioning

Features of interpersonal functioning are generally more straightforward to assess than self-related functioning because they manifest as observable behavior. For example, the necessary information about the capacity for intimacy is fairly easy to elicit in a clinical interview, or such

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information may be derived from clinical records in client files or by informant reports. Straightforward questions about relationships with significant others, childhood peer relationships, and adult relationships typically provide the necessary information to evaluate the client's ability to establish and maintain meaningful relationships, including the ability to sustain attachment and intimacy in a healthy manner:

- "How do you normally get along with other people?"
- "What kinds of things do you do too much with other people?"
- "What kinds of things do you wish you could do more often or better with other people?"

The clinician may also explore current circumstances in order to gain additional information about the quality, extent, and stability of relationships and friendships, which may be readily translated into a clinical assessment of the intimacy domain.

When the assessor asks the client to describe him- or herself, the clinician can also ask him or her to describe a significant other in order to evaluate the depth of differentiation and integration of their mental representation of the other. Individuals with extreme impairment in the capacity for intimacy are often characterized by an extensively compromised ability to relate to others, which involves difficulty differentiating between self and other. This typically leads either to enmeshed, parasitic relationships or severe interpersonal avoidance.

In contrast to clients with extreme impairment, clients with moderate impairment are often able to form relationships but have difficulty with sustained attachment and intimacy, which may or may not be related to conflicted or unstable relationships.

A thorough clinical assessment may also reveal whether impaired capacity for empathy (i.e., understanding others, recognizing others' viewpoints, and understanding one's own impact on others) leads to problems with prosocial and moral behavior, which can be further clarified with a few questions:

- "Do you like working with others?"
- "Do you have problems cooperating with others?"
- "Would you ever set yourself aside to help others?"
- "Do you make sure that you get what you want regardless of the consequences for others?"

Extreme impairment in empathy is typically associated with an absence of concern for others, disregard for culturally normal moral behavior, and a lack of altruism.

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RECOMMENDATIONS FOR ASSESSING PERSONALITY TRAITS

There is no mandatory instrument for or approach to evaluating the AMPD traits. To date, the trait system has been validated based on the PID-5 self-report form (Watters et al., 2019; Watters & Bagby, 2018), the PID-5 informant report form (Markon et al., 2013), and the DSM-5 Clinicians' Personality Trait Rating Form (Morey, Krueger, et al., 2013); the SCID-5-AMPD Module II structured interview has been developed for achieving reliable trait ratings (Skodol et al., 2018). The PID-5 is available in the original 220-item version (Krueger et al., 2012), an abbreviated 100-item version (Maples et al., 2015), and a brief 25-item version (Bach et al., 2016). Measures and algorithms have also been developed to capture a separate trait domain of compulsivity corresponding to the ICD-11 trait domain of anankastia (Bach, Sellbom, et al., 2017; Bach, Kerber, et al., 2020; Kerber et al., 2022; Sellbom et al., 2020). As a theoretically neutral nosology of personality pathology, the trait system may also be operationalized using various other established instruments, including the Minnesota Multiphasic Personality Inventory (MMPI; Sellbom, Anderson, & Bagby, 2013), the Personality Assessment Inventory (PAI; Hopwood, Wright, Krueger, et al., 2013), and the Dimensional Assessment of Personality Pathology (DAPP; Berghuis et al., 2019).

Apart from using such standardized approaches, practitioners may also use their clinical observations and other sources of information (e.g., medical records, conference notes, informants) to evaluate the client's prominent personality traits. For each trait facet, certain probing questions may be helpful in order to elicit the relevant information about the client (see Part III of this book). Sometimes the practitioner may be able to answer these questions on behalf of the client solely based on existing knowledge about the client or other assessment reports; at other times, it is necessary to ask the client more directly. If the practitioner sees the client for the first time and no other client information is available, it might be most helpful to employ one of the aforementioned questionnaires, supplemented by the probing questions suggested in this book.

No matter which of the aforementioned approaches practitioners are using, the same rating scale for each AMPD trait domain and facet must be used (0 = very little or not descriptive at all; 1 = mildly descriptive; 2 = moderately descriptive; 3 = very descriptive). When evaluating trait features and trying to distinguish, for example, a score of 1 from a score of 2, the clinician should consider the intensity, frequency, severity, and pervasiveness of the particular behavior or feeling being assessed. Based on this information, clinicians must use their best judgment in determining the score.

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In Chapter 4 we presented descriptive trait-by-trait definitions, including probing questions that may be used for clinical evaluation of trait facets. All individuals' trait levels fall somewhere on these dimensions, ranging from "very little or not at all descriptive" (i.e., score of 0) to "very descriptive" (i.e., score of 3). Some personality traits are easily summarized by a single label (e.g., anxiousness), whereas others are more complex (e.g., cognitive and perceptual dysregulation). Therefore, Chapter 4 provides definitions and clinical interpretations for each trait dimension to help clinicians get more familiar with them, while also providing some recommendations for clinical practice. Depending on clinical resources and the anticipated role of personality in the client's clinical problems, clinicians may rate their client's traits in several ways.

In order to be most accurate, we encourage practitioners to follow this procedure:

1. Gather information and generate initial hypotheses via an unstructured clinical interview.
2. Administer standardized self- and/or informant-report measures to quantify problems and generate more specific hypotheses.
3. Use a more structured interview and possibly other assessment methods to confirm hypotheses.

In general, we suggest that the clinician rate a client's usual personality, what she or he is like most of the time. For example, for the trait domain of detachment, the clinician must consider the extent to which the client shows (1) detachment from other people across the range of relationships from intimate to the social environment at large, (2) restricted affective experience and expression, and (3) limited hedonic capacity. If this definition describes the client very little or not at all, or is just mildly descriptive, rate a 0 or a 1, respectively. If the definition describes the client moderately or extremely well, rate a 2 or a 3, respectively (Skodol et al., 2011).

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REPORTING THE ASSESSMENT OUTCOME

The length, structure, and quality of reporting of the diagnostic impression depends a lot on clinical settings and resources. In primary care settings, the description may be very brief and succinct, exclusively for the purpose of referral to a more specialized treatment facility; whereas specialized clinical settings may report a more sophisticated and detailed

diagnostic description, including a tentative case formulation and treatment plan. In the following clinical illustration, we exemplify how client assessment may be reported in a general mental health care unit for treatment of nonpsychotic disorders. Optimally, the report is written after the feedback has been given to the client, and, ideally, some of the content is written in collaboration with the client. In that way, the report may also serve as a psychotherapy document that could foster self-knowledge and identity coherence. At the end of the report, a corresponding ICD-11 code is provided. Refer to Chapter 7 for more details about providing feedback to the client.

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Clinical Illustration of a Report of Assessment Outcome

Anna is a 23-year-old university student who was referred for mental health care by the university's student clinic due to what appeared to be treatment-resistant stress and anxiety.

Predominant Symptomatology

Our intake assessment suggests that Anna suffers from social anxiety symptomatology. There are no signs of other clinical disorders or severe psychopathology, and no previous history of mental disorders or substance abuse. Because the aforementioned anxiety symptoms seem rooted in characterological features of poor self-worth, interpersonal sensitivity, and unrelenting standards, a more comprehensive assessment of personality functioning and individual trait expressions was carried out.

Level of Personality Functioning

Anna's overall level of personality functioning is rated as moderately impaired (LPFS Level 2), corresponding to a mild personality disorder. This is particularly evident from her low self-esteem, which causes her to view herself as socially inept, inferior, and unappealing, whereas other people are perceived as judging her or thinking poorly of her. In other words, her low sense of self-worth makes her preoccupied with and sensitive to perceived criticism or rejection. For the same reason, she is often reluctant to get involved with other people, including her fellow students, unless she is certain of being liked by them. She is also afraid of expressing her true feelings and saying no to other people, including her boyfriend, because of fear of being shamed or ridiculed. Her anxiousness and low self-worth also makes her reluctant to pursue goals or take personal risks (including saying no to other people). In general, her feelings of low self-worth leave her looking around anxiously and comparing herself to others, while she feels inadequate and fearful about being looked down upon.

Finally, her internal standards for academic performances at college are overly high, apparently as overcompensation for her poor sense of self-worth, which involves much stress.

Specific Personality Trait Specifiers

The aforementioned features of moderate impairment of personality functioning are qualified by a unique configuration of personality traits. Accordingly, Anna is particularly characterized by negative affectivity in terms of anxiousness, submissiveness, and depressivity, as well as some detachment in terms of social withdrawal and some compulsivity in terms of perfectionism and risk aversion. These traits have been further discussed with and confirmed by Anna herself during feedback. In Anna's case, the depressivity is related to her poor self-esteem when around other people, which is associated with feelings of shame and pessimism. The anxiousness is related to her constant fear of being criticized, humiliated, or rejected. The withdrawal seems to have evolved as a pattern of avoiding anxiety-provoking situations, whereas the submissiveness seems to have evolved as a pattern of pleasing or complying with others, which is driven by her sense of inferiority and fear of being criticized or rejected. Likewise, her perfectionism may have evolved as an attempt to compensate for poor self-esteem by exhibiting flawlessness to her surroundings, so that no one sees the underlying defectiveness she feels. Notably, Anna also has a very low level of antagonism in terms of low callousness and low manipulativeness, which supports her overly compliant and kind-hearted but substantially self-defeating style. She rarely says no to people and never makes other people do something for her, at the cost of her own authenticity and fulfillment.

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Treatment Considerations

Against this background, Anna shows motivation to work with the problems in question with respect to becoming less anxious, inhibited, and stressed and more liberated. Based on the severity estimation, it is expected that she can benefit significantly from 1 year of weekly group therapy for milder personality disorders. This would involve working on how she can achieve a stronger and more positive sense of self-worth—including an ability to fulfill her own emotional needs as a healthy adult while also becoming more self-confident and less dominated by her anxiousness and perfectionism. This may also involve training in being more assertive in relationships; for example, being able to say no or setting appropriate limits. Simultaneously, Anna may also benefit from cognitive-behavioral strategies to confront her fear and avoidance, which compromise her ability to live an authentic and fulfilling life. Finally, it seems worthwhile to work with her self-compassion as an alternative to her rigid perfectionism, which currently seems to dominate her. However, a current dilemma for Anna is that she desires to feel more liberated in interpersonal situations and to learn to achieve and receive the emotional fulfillment she longs for, but she is

also afraid of getting rid of her self-sacrificing interpersonal style because this has become her identity when around others, something she is secretly proud of. She therefore expresses a fear of being rejected by her fellow students and her boyfriend if she stops being compliant and self-sacrificing. As a healthy compromise, Anna is willing to work on tuning down the self-sacrificing style without entirely getting rid of it.

Tentative ICD-11 diagnosis

D10.0 Mild Personality Disorder
Prominent trait specifiers:
D11.0 Negative affectivity
D11.1 Detachment
D11.4 Anankastia

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CLINICAL EXAMPLE OF A MULTIMETHOD AND MULTI-INFORMANT ASSESSMENT APPROACH

In this next example of Mr. Lewis, we illustrate the essential features of a six-step protocol for clinical assessment proposed by Weekers, Hutsebaut, Bach, and Kamphuis (2020), which involves different methods and sources. In this demonstration, we use a somewhat different case example than the one presented by Weekers and colleagues. The entire procedure is summarized in Figure 5.2, at the end of the chapter.

Step 1: Collecting Relevant Referral Information

At the time of referral, certain information about the individual's personality functioning may be available straightaway (e.g., based on reasons for referral or notes from previous treatment attempts). More detailed information about impaired capacities of personality functioning may be straightforward to obtain from previous therapists, general practitioner, or the individual's previous records, including history of self-harm (e.g., emotion regulation), interpersonal violence (e.g., empathy), current social network (e.g., depth and duration of affiliation), stability of intimate and family relationships (e.g., capacity for intimacy, closeness), and course of academic and professional career (e.g., goal directedness, cooperation). In the following, we introduce the case of Mr. Lewis, which will be used to demonstrate the entire assessment approach.

Mr. Lewis is a 38-year-old single man who reports a long history of prematurely terminated studies, discontinued jobs, and conflicts with peers at work, along

with recurrent periods of dysphoria, isolation, and self-harm. Mr. Lewis was raised as the only child in an emotionally deprived home with a passive father and an emotionally abusive and highly demanding mother. In school he experienced a lot of bullying but did not meet any understanding or support from his parents other than that he should just get himself together. At the time of intake, he does not have a permanent job or any stable social network and spends most of his time streaming crime TV series and contemplating becoming a criminal investigator working for a federal bureau catching "bad guys." When probed about previous work experience, the client starts complaining about colleagues or superiors being insensitive, ignorant, sloppy, and sometimes incompetent.

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Step 2: Conducting a Clinical Intake Interview

In the initial consultation, the clinician will usually conduct a clinical interview, which is more or less structured. First, the clinician explains the full assessment procedure and invites the client to talk about his or her own reasons for seeking help. Furthermore, the clinician may dig into more details about the client's family and developmental history, current and past relational and occupational context, previous treatment history, and medication use.

For example, at the clinical intake interview, Mr. Lewis may underestimate the intensity and severity of his own problems relative to the referral information obtained in Step 1. Moreover, the clinician may observe that Mr. Lewis is being submissive and apologizing, while frequently intellectualizing and minimizing aspects of his own problems. It also turns out that Mr. Lewis has had persistent interpersonal and emotional problems over the course of his childhood and adolescence, including depressive episodes and antidepressant treatment during early adulthood. Despite good intellectual functioning, Mr. Lewis has initiated various courses of study with great enthusiasm and high ambition (e.g., graphic designer, nurse assistant, librarian) without completing any of them. Each time he had been dreaming about achieving great success and approval after completing his education. Mr. Lewis usually got increasingly stressed due to feeling incapable of doing a perfect job in his studies. This pattern was related to feelings of being unappreciated, insulted, and misunderstood, and therefore he prematurely terminated the studies. Simultaneously, Mr. Lewis had to support his finances by taking different jobs, but he regularly ended up in conflicts with superiors, leading him to withdraw or simply not show up at work again. Now, when on his own, Mr. Lewis has found refuge in TV series about criminal investigators and fantasizes about becoming a highly respected criminal investigator himself.

Step 3: Integrating Referral and Intake Information to Determine Specific Assessment Foci

Prior to conducting the semistructured interviews, the clinician may integrate relevant information to consider which areas of personality functioning or traits may be substantial for the subsequent exploration. Based on the collected information, several foci of attention might be identified.

For example, based on Step 1 and Step 2, the clinician may observe clear evidence of severe problems in self-direction, as reflected by Mr. Lewis's long-standing inability to complete education in several fields and to hold jobs due to unrelenting personal standards. Information from these prior steps may also suggest impaired self-esteem regulation and inability to collaborate in a professional context. In terms of personality traits, there were several indications of emotional lability, depressivity, suspiciousness, grandiosity, perfectionism, and easily triggered hostility across several relationships, as exemplified by his tendency to be thin-skinned and distrustful, with recurring conflicts at work. At the same time, Mr. Lewis's overly compliant style suggested the trait of submissiveness. Additionally, several indications of social withdrawal were also present (e.g., isolation at home on the couch with TV series). Taken as a whole, Mr. Lewis's history may be consistent with a wide range of impairments in personality functioning, along with several prominent traits, which may be further supported and characterized in Step 4.

Step 4: Administering Self- and Informant Report Inventories and Semistructured Interviews

In this step of the protocol, the clinician may use more standardized approaches to collecting personality data by means of self-reports, informant reports, and clinician ratings based on structured clinical interviews. For example, Mr. Lewis may be administered the 12-item LPFS-BF (Weekers et al., 2019) as a self-report screener for overall functioning, whereas the 220-item PID-5 (Krueger et al., 2012) may be employed to characterize specific trait expressions. Additionally, Mr. Lewis may be encouraged to ask his older cousin, who has known him well since his birth, to complete the informant forms of the LPFS-BF and the PID-5 (Markon et al., 2013). The possible alignments and discrepancies between self- and informant-reported patterns of functioning and traits would be of particular interest. For example, Mr. Lewis's LPFS-BF ratings may overall support a moderate to severe level of personality dysfunction across self- and interpersonal capacities, whereas his PID-5 profile may support the presence of negative affectivity (e.g., emotional

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lability, submissiveness, depressivity), compulsivity (e.g., rigid perfectionism), some detachment (e.g., withdrawal, suspiciousness), and some antagonism (e.g., hostility, perhaps grandiosity).

After completing the self- and informant-report inventories, Mr. Lewis may be administered a semistructured interview for personality functioning and traits to establish a clinical diagnosis.[2] This could involve the SCID-5-AMPD Modules I and II (Bender et al., 2018; Skodol et al., 2018). Module I covers impairment in capacities of personality functioning (i.e., self- and interpersonal functioning), whereas Module II covers maladaptive expressions of stylistic trait facets and domains.

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Step 5: Determination of Severity of Personality Impairment and Unique Traits

In this step, the clinician uses all available information to operationalize the different scoring and classification steps of the AMPD model. Both convergences and divergences between clinician, self-, and informant ratings should be considered. Ultimately, the diagnostic assessment is a clinician-based procedure, assigning the clinician the responsibility to weigh different sources of information and exert clinical judgments based on all available information. Areas of convergence and divergence may also be especially informative when providing feedback to clients (see Steps 6 and 7). Accordingly, the clinician first determines the severity within each of the 12 capacities and 4 domains of personality functioning and eventually on a global level of functioning. In this procedure, it may be informative not only to highlight impairments but also to note relatively intact capacities. Subsequently, the clinician makes a profile of elevated personality trait facets. Again, it may be useful not only to highlight (extreme) maladaptive trait expression but also to note relatively adaptive expressions of traits.

For example, after integrating all scores, the clinician may conclude that Mr. Lewis's overall level of personality functioning is best captured by severe impairment (i.e., Level 3), whereas some areas of self-functioning may be extremely impaired. Taking all sources and methods into account, there was robust evidence for elevated traits of negative affectivity (i.e., emotional lability, submissiveness), compulsivity (i.e., rigid perfectionism), detachment (i.e., withdrawal), and some antagonism (i.e., hostility). However, the identified features of submissiveness and grandiosity were not rated as prominent features by Mr. Lewis himself, although they were identified as such by the clinician, as well as by Mr. Lewis's older cousin.

[2]Depending on the individual client and presenting complaints, the clinician may also use appropriate structured interviews for other mental disorders.

Next, the clinician must check whether the general AMPD criteria C–G are met. In the case of Mr. Lewis, the diagnostic requirements seemed clear, as the 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 Mr. Lewis's developmental stage and sociocultural environment.

Step 6: Case Formulation of the Dynamic Interaction among Impaired Personality Functioning and Maladaptive Personality Traits

As highlighted by Weekers et al. (2020), the depth and clinical utility of the AMPD model resides not so much in the specific diagnostic classification it provides as in the information the AMPD yields for the development of a comprehensive case formulation, including a narrative clinical integration of all information that specifies the interplay among overall level of personality functioning, impairment of specific capacities, and unique maladaptive trait expressions. Based on all the information collected, the following case formulation was made for Mr. Lewis:

> Mr. Lewis is a 38-year-old man referred by his general practitioner for assessment and treatment of enduring and recurring problems. He presented with several persistent social and emotional problems and has been unable to successfully complete an education or hold a job, which has left him with longstanding feelings of shame, insult, grudge, and fear of not being sufficiently approved by other people. Mr. Lewis argues that former superiors, peers, and colleagues did not understand his unique abilities, which has therefore caused roadblocks on his way to success. To avoid feelings of shame and to protect himself against potential failure and hopelessness, he had adopted a socially withdrawn and daydreaming lifestyle, primarily seeking refuge in streaming TV series about criminal investigator heroes.

The AMPD assessment suggests that Mr. Lewis's problems are rooted in a severely compromised capacity for self-esteem regulation. Indeed, Mr. Lewis held a vulnerable self-concept, alternating between grandiose self-aggrandizing and severe self-defeating and overly compliant tendencies. On the one hand, he stated a deep conviction of being destined for "something special." Consequently, he endorsed such high perfectionistic standards in the various fields of education that they were impossible to live up to, and it was also impossible for him to collaborate with peers on such terms. On the other hand, the anticipated failure triggered strong negative feelings in him that he was unable to confront, which led to escape into TV series and grandiose fantasies reinforced by extensive social withdrawal.

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Interpersonally, Mr. Lewis was extremely sensitive to slights and disapproval (especially with superiors), and therefore he was heavily invested in pleasing others and meeting their expectations by taking on a submissive and overly compliant stance. However, this submissive relational position also caused frustration and anger inside because of his unmet needs for recognition and admiration. This realization triggered strong aversive feelings and suspiciousness in Mr. Lewis, leading him to either withdraw or to have emotional and often hostile outbursts that interfered with cooperating with others. His understanding of this interpersonal pattern was quite limited, which left him confused and vulnerable.

Step 7: Providing Written and Oral Feedback to Client and Professionals

In this final step of the protocol, the clinician shares the case formulation and diagnostic information with the client and with colleagues involved in follow-up care. The clinician should focus on the interplay between traits and impaired functioning and, through dialogue with the client, should build a narrative description that will help the client make sense of his personality functioning. Weekers, Hutsebaut, and Kamphuis (2021) propose that elements of therapeutic assessment are particularly compatible with the AMPD model and can be used to structure the feedback session. As a general rule, clients are more inclined to accept and integrate assessment information when the assessor starts with information that matches or is close to their self-concept (Kamphuis & Finn, 2019). Both the convergences and discrepancies across 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 it, it is most appropriate to start with issues on which self-report, informant report, and clinical ratings converge.

In Mr. Lewis's case, the clinician may begin with his self-reported reason for referral and history of presenting complaints. His primary concerns were the experienced dysphoria, the inability to complete studies or hold jobs, and the associated feelings of shame, failure, and stress. The clinician may discuss how Mr. Lewis's inability to attain his goals might be linked to his vulnerable self-esteem: withdrawing and avoiding (emotionally and socially) as a way to protect himself from being emotionally overwhelmed by failures and disappointments over not meeting his own perfectionistic standards. Next, the clinician may link the withdrawal to Mr. Lewis's feelings of suspiciousness and depressivity. Next, the clinician may cautiously introduce a finding that is a bit more discrepant from Mr. Lewis's self-concept. Underneath his feelings

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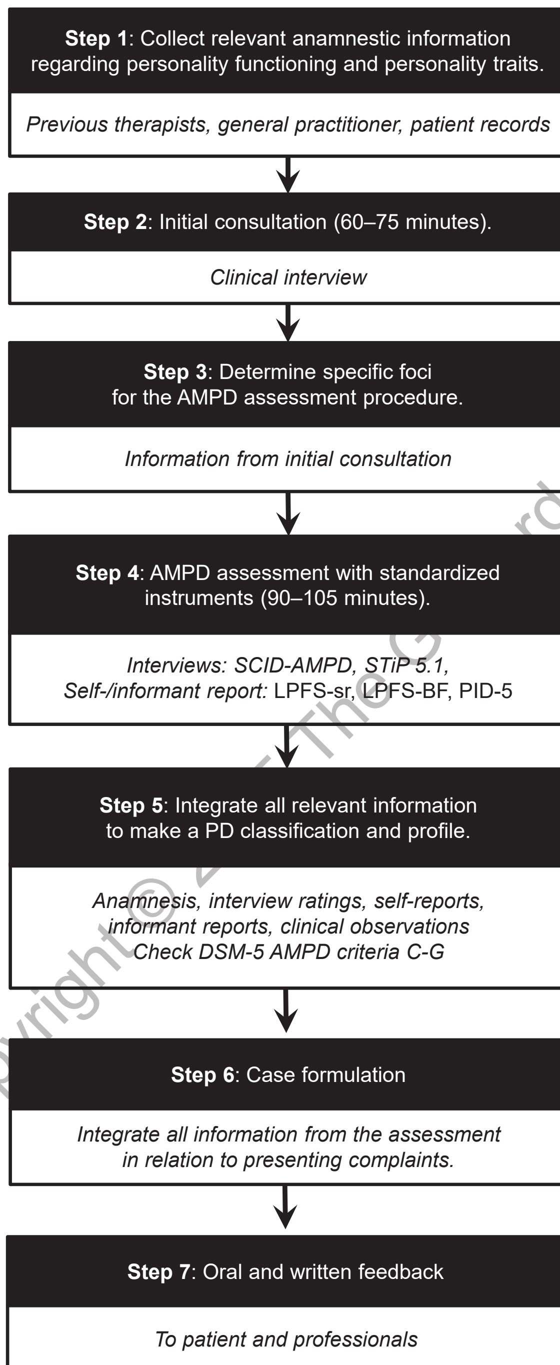

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FIGURE 5.2. Protocol for AMPD assessment. Based on Weekers et al. (2020).

of shame and failure, he also seemed to harbor high (grandiose) expectations for himself, which seemed to nurture his fear of failure. A more tentative, open-minded, and humble stance would be appropriate for discussing the findings that are most difficult to integrate for the client. In Mr. Lewis's case, the client may be guided to an understanding of how his pleasing and submissive stance serves as a means to control others—his "blind spot" about the impact of his behavior on others. When communicating this information, empathy and warm validation are important inputs for fostering acceptance of these highly personal (and in part novel and discrepant) findings. For example, the clinician may help Mr. Lewis to an initial understanding of how aspects of his developmental history (most notably his mother's verbal abuse and the severe bullying in primary school) had rendered him extra vulnerable to impaired self-esteem regulation. Additionally, the clinician may validate how Mr. Lewis has tried to solve these emotional issues the best he could by adopting perfectionistic internal standards and by pleasing and controlling others but also how this life strategy had left him demoralized and emotionally exhausted.

Finally, the clinician may discuss specific areas of attention for treatment and support motivation for engaging in this. Accordingly, the clinician may explain that treatment might help Mr. Lewis confront his fear of failure and enhance his capacity to tolerate the related emotions. With the help of psychological treatment, Mr. Lewis might process his emotional injuries instead of using his current coping strategies of extensive withdrawal, along with perfectionistic overcontrol and hidden self-aggrandizing overcompensation. Chapter 7 further elaborates on the clinical utility of providing feedback on AMPD assessment.

CONCLUDING COMMENTS

This chapter provided an overview of how to perform the AMPD assessment in clinical practice and subsequently reporting it for clinical purposes. The procedure involved a stepwise method based on different sources of information, including anamnesis, clinical interview, self- and informant reports, determination of severity, case formulation, and providing the written and oral feedback to client and colleagues. The theme of providing feedback is further addressed in the next chapter, which also links the psychoeducational feedback to the natural establishment of a treatment alliance.

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