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THE *PSYCHODYNAMIC DIAGNOSTIC MANUAL VERSION 2* (*PDM-2*): *Assessing Patients for Improved Clinical Practice and Research*

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This article reviews the development of the second edition of the *Psychodynamic Diagnostic Manual*, the *PDM-2*. We begin by placing the *PDM* in historical context, describing the structure and goals of the first edition of the manual, and reviewing some initial responses to the *PDM* within the professional community. We then outline 5 guiding principles intended to maximize the clinical utility and heuristic value of *PDM-2*, and we delineate strategies for implementing these principles throughout the revision process. Following a discussion of 2 *PDM*-derived clinical tools—the Psychodiagnostic Chart and Psychodynamic Diagnostic Prototypes, we review initial research findings documenting the reliability, validity, and clinical value of these 2 measures. Finally, we discuss changes proposed for implementation in *PDM-2* and the potential for an updated version of the manual to enhance clinical practice and research during the coming years.

Keywords: PDM, *DSM*, diagnosis, personality, *PDM-2*-derived clinical tools

The first edition of the *Psychodynamic Diagnostic Manual* (*PDM* Task Force, 2006) was published during a critical era of change in mental nosology. This period began in 1980 with the publication of the *Diagnostic and Statistical Manual of Mental Disorders*

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(*DSM*)–*III*, which represented a shift from a psychoanalytically influenced, dimensional, inferential diagnostic system to a "neo-Kraepelinian" descriptive, multiaxial classification that relied on present-versus-absent criteria sets for identifying discrete mental disorders. This paradigm shift was adopted deliberately, with the aim of removing the psychoanalytic bias from the manual now that other theoretical orientations were common, including cognitive–behavioral, family systems, humanistic, and biological. The shift was also intended to make certain kinds of outcome research easier: Present-versus-absent traits could be identified by researchers with little clinical experience, whereas the previous classifications (*DSM-I* and *DSM–II*) had required significant clinical training to diagnose inferentially many of the syndromes described. Each succeeding edition of the *DSM* has included more discrete disorders (see Clegg, 2012). The publication of *DSM–IV* (American Psychiatric Association, 1994) continued the neo-Kraepelinian descriptive trend, which has been further elaborated and expanded with the recently published *DSM-5* (APA, 2013).

Although the *DSM* is considered by many as a permanent fixture in the world of mental health—a set of guidelines and diagnostic criteria that, for better or worse, will always guide our clinical work—this belief is based more on history and habit than anything else. The *DSM-I* (American Psychiatric Association, 1952) was published just over 60 years ago. The manual is not a government document (although the development of *DSM-I* was in part a government effort), nor is it in any way related to policies and procedures endorsed by the National Institute of Mental Health (see Insel, 2013). The *DSM* is not the most widely used diagnostic system today: The International Classification of Diseases (ICD-10; World Health Organization, 2004) takes that prize. Despite its aura of inevitability, the current version of the diagnostic manual, the *DSM-5* (American Psychiatric Association, 2013), is a privately published book, a product of the American Psychiatric Association, intended to guide the professional activities of mental health professionals, but also to shape the reimbursement policies of managed care organizations and to fund various activities of the association.

Although early editions of the manual were applauded for systematizing what had been, prior to World War II, a somewhat chaotic array of overlapping diagnostic systems emerging from different theoretical traditions, more recent editions of the *DSM* have been increasingly controversial (see, e.g., Cooper, 2004; Vanheule, 2012). Beginning in October of 2014, the Health Insurance Portability and Accountability Act (HIPPA) has required clinicians to provide ICD-10—not *DSM-5*—codes for reimbursement. Moreover, although advances in biological and cognitive research have tended to dominate recent discussions of diagnosis, assessment, and treatment, psychoanalytic concepts have undergone a quiet resurgence as well, not only in clinical psychology, but in myriad other subfields (e.g., cognitive, social, developmental, neuropsychological; see Protopopescu & Gerber, 2013; Wilson, 2009).

Recent critiques of the *DSM* have touched upon its problematic political and economic aspects, but they have not ended there. Clinicians and clinical researchers have also questioned the *DSM* emphasis on a disease model of psychopathology, which works better for some syndromes (e.g., schizophrenia) than others (e.g., narcissistic personality disorder). Critics have noted the expansion in the number of categories in *DSM-5* (Batstra & Frances, 2012; Frances, 2013), and have questioned the Kraepelinian nature of *DSM* diagnoses, with their continued adherence to categorical classification, even for those disorders which may be best conceptualized as reflecting continua of functioning, with no sharp cutoff between normality and pathology (see Craddock & Owen, 2010; Livesley, 2010). Beyond questions regarding the overarching framework of *DSM-5* (Good, 2012;

Zimmerman, 2012), and its choice of syndrome and symptom descriptors (Huprich, 2011), much of the current opposition to *DSM-5* may be seen as a product of the process used to create it (Bornstein, 2011).

Any classification system that is based on the work of a committee (or set of committees) will never be completely free of politics and personal preference. Nonetheless, as a number of writers have pointed out—including some who were involved in earlier *DSM* revisions (e.g., Frances, 2011; Livesley, 2010; Widiger, 2011)—the *DSM-5* revision process differed from earlier efforts in ways that have concerned many researchers and practitioners. First, the process of developing *DSM-5* lacked the transparency on which good science depends. Even though progress toward *DSM-5* was periodically updated online, giving the public some chances to submit comments and observations, it is arguable that the priceless opportunity to have a real open dialogue with the clinical and scientific communities was partially lost. Members of the *DSM-5* work groups were asked not to reveal details of their deliberations to other mental health professionals, the media, or members of the public, presumably in an effort to avoid being unduly influenced by those who might have a vested interest in the outcome of work group decisions. Although such a strategy has the advantage of minimizing the potential biasing effects of outside forces (e.g., representatives from managed care organizations and pharmaceutical companies), it may foster groupthink, increasing the possibility that decisions will be driven by interpersonal dynamics within work groups (e.g., the persuasive power of individual committee members; see Turner & Pratkanis, 1998). In the absence of a real conversation with the whole community, *faux pas* such as the proposed deletion of the narcissistic personality disorder were perhaps inevitable (about the controversy over the proposed elimination of some personality disorders in the *DSM-5*, see Shedler et al., 2010).

Second, as several critics (e.g., Bornstein, 2011; Ronningstam, 2011; Widiger, 2011) noted, the reviews of relevant literature by *DSM-5* work groups was selective: Large areas of empirical evidence were not considered. The work groups failed to give detailed rationales for their decisions about what to include and what to exclude.

Finally, the *DSM-5* is mainly based on self-report data. A plethora of evidence from cognitive and social research confirms that people are, at best, flawed perceivers of their traits, behaviors, and internal states; our inherent introspective limitations are magnified when psychological symptoms (e.g., anxiety, personality pathology, situational variations in mood) are present (Huprich, Bornstein & Schmitt, 2011). Although, when used in combination with self-report instruments, performance-based measures have proven useful in illuminating underlying dynamics and in documenting meaningful divergences between patients' inner experience and the outward expression of that experience (see Bornstein, 2010; Ganellen, 2007), studies involving multimethod assessment strategies played virtually no role in the *DSM-5* revision process.

For all these reasons, we think that the *Psychodynamic Diagnostic Manual* (*PDM*; *PDM* Task Force, 2006) adds a needed perspective to the *DSM-5* and other mainly categorical diagnostic systems. In addition to considering symptom patterns described in existing taxonomies, it enables clinicians to describe and categorize personality patterns, related social and emotional capacities, unique mental profiles, and personal experiences of symptoms. It provides a framework for improving comprehensive treatment approaches and for understanding the biological and psychological origins of both mental health and mental illness. In focusing on the full range of mental functioning, the *PDM* complements the *DSM* and ICD efforts to catalogue symptoms and syndromes. In contrast to the *DSM*, the *PDM* has aspired to be a taxonomy of people rather than diseases, and has concep-

tualized its main purpose as helping clinicians to diagnose complex psychopathologies, formulate individual cases, and plan the best possible treatment for each patient.

The following statement by the American Psychoanalytic Association appeared on www.apsa.org in October 2013:

> The *DSM-5*, published by our colleague organization the American Psychiatric Association, has been met with both praise and criticism. Like its predecessors, this fifth edition of the *Diagnostic and Statistical Manual* will be widely used in the mental health field to classify mental disorders according to diagnoses based on descriptive criteria. There is a place in the field for classifying patients based on descriptions of symptoms, illness course, and other objective facts. However, as psychoanalysts, we know that each patient is unique. No two people with depression, bereavement, anxiety or any other mental illness or disorder will have the same potentials, needs for treatment or responses to efforts to help. Whether or not one finds great value in the descriptive diagnostic nomenclature exemplified by the *DSM-5*, psychoanalytic diagnostic assessment is an essential complementary assessment pathway which aims to provide an understanding of each person in depth as a unique and complex individual and should be part of a thorough assessment of every patient. Even for psychiatric disorders with a strong biological basis, psychological factors contribute to the onset, worsening, and expression of illness. Psychological factors also influence how every patient engages in treatment; the quality of the therapeutic alliance has been shown to be the strongest predictor of outcome for illness in all modalities. For information about a diagnostic framework that describes both the deeper and surface levels of symptom patterns, as well as of an individual's personality, emotional and social functioning, mental health professionals are referred to the *Psychodynamic Diagnostic Manual*.

The value of the *PDM* as a complement to the *DSM* has been recognized by *DSM-5*, in its *Pocket Guide to the* DSM-5 *Diagnostic Exam* (Nussbaum, 2013):

> ICD-10 is focused on public health, whereas the *Psychodynamic Diagnostic Manual* (*PDM*) focuses on the psychological health and distress of a particular person. Several psychoanalytical groups joined together to create *PDM* as a complement to the descriptive systems of *DSM-5* and ICD-10. Like *DSM-5*, *PDM* includes dimensions that cut across diagnostic categories, along with a thorough account of personality patterns and disorders. *PDM* uses the *DSM* diagnostic categories but includes accounts of the internal experience of a person presenting for treatment. (pp. 243–244)

With these observations as context, a brief description of the *PDM* structure and "philosophy" follows. The *PDM* uses a multidimensional approach to describe the intricacies of each patient's functioning and ways of engaging in the therapeutic process. In this way, it attempts to provide a comprehensive profile of an individual's mental life.

The first edition covered adults, children and adolescents, and infants, emphasizing individual variations as well as commonalities. It included four major sections: Classification of Adult Mental Disorders, Classification of Child and Adolescent Mental Health Syndromes, Classification of Infant and Early Childhood Disorders, and Conceptual and Empirical Foundations for a Psychodynamically Based Classification System for Mental Health Disorders.

Part 1—the adult section—opened with the Personality Patterns and Disorders (P) axis, followed by the Profile of Mental Functioning (M) axis. The patients' symptoms (and syndromes and their subjective experience of them; S axis) was intended to capture the phenomenology of mental illness—the personal, private experience of suffering—from the perspective of the patient. These three subsections were followed by illustrative case formulations demonstrating this more holistic, biopsychosocial kind of diagnosis. Part

2—the child and adolescent section—reordered things a bit, on the basis of respect for the developing nature of children's psychologies, and opened with the Profile of Mental Functioning axis, followed by the Emerging Personality Patterns and Disorders axis, then the Subjective Experiences axis. A special Section on Infancy and Early Childhood Mental Health Disorders followed. Part 3 contained a selection of relevant empirical papers by noted scholars on psychodynamic diagnosis and psychotherapy research.

Schematically, according to this structure, the clinician should assess the following in all patients (except infants, assessed with Infancy and Early Childhood):

- Level of personality organization and the prevalent personality styles or disorders (Axis P for adults and Emerging Personality Patterns and Disorders for adolescents and children).
- Level of overall mental functioning (Axis M for adults and Axis Profile of Mental Functioning for adolescents and children), on the basis of the evaluation of nine different but partly overlapping capacities ([a] capacity for regulation, attention, and learning; [b] capacity for relationships; [c] quality of internal experience and level of confidence and self-regard; [d] affective experience, expression, and communication; [e] defensive patterns and capacities; [f] capacity to form internal representations; [g] capacity for differentiation and integration; [h] self-observing capacity or psychological-mindedness; [i] capacity for internal standards and ideals), each assessed along a continuum with four possible levels. After having assessed the level of these capacities, the clinician has to assess on a continuum of eight possible levels the overall health/sickness of the mental functioning of the patient.
- Symptoms and syndromes and the patient's subjective experience of them (Axis S for adult and Subjective Experiences for adolescents).

PDM diagnoses are prototypic because this manual, unlike the *DSM*, is not based on the addition of symptoms within a category; that is, it is not based on polythetic diagnosis. The *PDM* considers each disorder as a constellation of signs, symptoms, or personality traits that constitute a unity of meaning. It attempts to capture the gestalt of human complexity while combining the precision of dimensional systems and the ease of categorical applications (Gazzillo, Lingiardi, & Del Corno, 2012).

The *PDM*'s Fortunes So Far

The first edition of the *PDM* in the United States and in Europe met with considerable commercial success and has influenced many practitioners and researchers. The *New York Times* reviewed the *PDM* on January 24, 2006, with the headline, "For Therapy, a New Guide With a Touch of Personality," and in the United States, the manual has received an adequate welcome also in the clinical literature, as demonstrated by the 2011 monographic issue of the *Journal of Personality Assessment* titled, "Can the *Psychodynamic Diagnostic Manual* (*PDM*) Put the Complex Person Back at the Center-Stage of Personality Assessment?"

Shortly after its publication, Nancy McWilliams (2008) wrote an article on the *PDM* for *Psychiatric Times*, outlining its background, explicating Greenspan's approach to diagnosis, and describing each section, including the one on infancy (which has received the most positive reaction from the community of practitioners). Finally, she provided a clinical example intended to demonstrate how the *PDM* can capture the entire functioning

of a patient's personality. In the monographic issue of the *Journal of Personality Assessment*, McWilliams (2011a) describes the *PDM*, whose explicit purpose is to help clinicians to become more therapeutically effective, as a worthy first effort to compensate for the limitations of descriptive psychiatric diagnosis. In Hansell and Damour's (2008) book *Abnormal Psychology*, the *PDM* is also presented as "an alternate classification system" to the *DSM*, which clinicians can use instead of, or as a supplement to, its descriptive classification. Reviewing the *PDM* in the *Journal of the American Psychoanalytic Association*, Peter Dunn (2008) states that the manual conforms with the basic framework of the *DSM* and its coding system, but adds essential content from the psychoanalytic and psychodynamic tradition.

An interesting study by Robert Gordon (2008, 2009) examined how psychologists with different training and theoretical orientations (psychodynamic, cognitive–behavioral, and other nonpsychodynamic preferences, respectively) judged the *PDM*. Results showed that the manual received a highly favorable evaluation by all psychologists, irrespective of theoretical orientation. Participants in the study emphasized the value of the *PDM*'s jargon-free language and commented on its usefulness in helping nonpsychodynamic clinicians to formulate a clinically relevant diagnosis.

According to Paul Stepansky (2009), the *PDM*'s exposure in the United States has been quite extensive. "To achieve commercial success of this order, the 'psychoanalytic' appellation must be diluted to 'psychodynamic,' and the psychodynamic 'terms' and 'concepts' offered in a user-friendly format intended to broaden rather than supplant other diagnostic frameworks. This is the very formula that has made the recently self-published *Psychodynamic Diagnostic Manual*, collectively authored by an 'Alliance of Psychoanalytic Organizations,' a stunning success, with sales, as of March 2008, of over 20,000 copies" (p. 66). Stepansky further notes that the *PDM* was not intended to replace existing diagnostic manuals, but to be integrated with them.

The *PDM* has also aroused interest in other countries, as shown by the interview with Nancy McWilliams conducted by George Halasz (2008) and published in the journal *Australasian Psychiatry*. The emphasis in the interview is on how the manual can be usefully implemented for clinical purpose and teaching.

In Europe, the *PDM*'s diffusion and reception have been investigated by Franco Del Corno and Vittorio Lingiardi (2012), who noted that (a) in the German professional literature, references to the manual are mostly linked to the *PDM*'s chapter on the operationalized psychodynamic diagnosis (OPD Task Force, 2001); (b) in Spanish and Portuguese-speaking countries (Ferrari, 2006; Ferrari, Lancelle, Pereira, Roussos, & Weinstein 2008), a group of psychoanalysts proposed a *Reportes de investigation* about the *PDM* and announced a Spanish version of the manual, while Rosenthal (2008) characterized the *PDM* as a way to reconcile the psychoanalytic therapies with scientific inquiry; (c) in Turkey, Dereboy (2013, personal communication) is striving to introduce the *PDM* to training programs for medical residents and graduate students; (d) in France, Widlocher (2007) wrote a very favorable review of the manual with the subtitle "From nosographic to psychopathologic," in which he argued that the psychoanalytic tradition is the best context for the development of new and more complex classifications of psychiatric disorders that may be complementary to the *DSM*; more recently, Widlocher and Thurin (2011) cited the *PDM* as an effort to integrate a dynamic perspective about psychopathology with a symptom-behavior-oriented diagnosis; (e) in Italy, the *PDM* was translated and published in 2008. The clinical value of the manual is mentioned in many Italian papers, research projects, books, seminars, academic courses, and training programs. Appreciation of its utility is beginning to spread in clinical settings as well.

Despite these instances of international appreciation of the *PDM*, there are many areas—both in the United States, where it was originally published, and in other countries—where the manual is virtually unknown. We believe that this unevenness of visibility is a result of the decision that Stanley Greenspan initially made to self-publish the *PDM*, so that he could keep its price as low as possible, making it affordable especially to the students he hoped it would influence. To avoid the problem of uneven impact in the future, we have decided to contract from now on with an established publishing company, whose marketing practices will ensure far greater exposure for *PDM-2* and any later versions of the manual. The new edition of the *PDM* will be published simultaneously in the United States by the Guilford Press and Italy by the publisher Raffaello Cortina, and publishers in other countries (in Europe and Asia) are already interested in translating the *PDM-2*.

Principles for the Development of the Second Edition of the *PDM* (*PDM-2*)

As members of the Steering and Scientific Committees for *PDM-2*, we have devised a preliminary set of guidelines for the *PDM* revision process that are straightforward, easy to implement, and designed to increase substantially the likelihood that the product of our efforts will be empirically rigorous, clinically useful, and viewed positively by clinicians of varying theoretical orientations. Five principles guide the work.

1. **Transparency.** All aspects of the *PDM-2* revision process will be transparent and periodically accessible to professional colleagues. New instruments for assessing *PDM-2* related constructs are available to the professional community at no cost.
2. **Inclusiveness.** We invite colleagues to contribute to the *PDM-2* revision effort by offering input and critical feedback. We invite colleagues to contact any of us if questions or concerns arise and to send us papers or works in progress that they think might be useful in shaping our discussions and debates.
3. **Flexibility.** Although members of the *PDM-2* Steering and Scientific Committees are of one mind in assuming that psychodynamic processes play a role in all forms of psychopathology, there is also a clear recognition that some symptoms and syndromes are more strongly influenced than others by psychodynamic elements. For example, certain forms of personality pathology (e.g., narcissistic, histrionic) seem to be driven primarily by psychodynamic processes; in others (e.g., schizotypal) psychodynamic processes may play a less prominent role.
4. **Empirical rigor.** In order for *PDM-2* to have a firm empirical foundation, we will conduct comprehensive surveys of the literature, including studies from outside psychoanalysis, to obtain as complete a picture as possible of what we know about normal and pathological functioning.
5. **Clinical utility.** The raison d′etre of any diagnostic system is its usefulness in clinical settings. No matter how empirically rigorous and precise they may be, diagnostic criteria and syndrome descriptions are only helpful if they enhance the work of the practicing clinician and thereby improve the lives of patients. We seek to find a better balance between empiricism and clinical utility.

Strategies

To turn our vision into reality, we have inaugurated a four-step process for implementing these principles.

First, we are developing ways to collaborate across groups. By creating a mechanism through which different *PDM-2* work groups communicate with each other about their initial proposals, we hope that active exchange of information can take place as new proposals are developed and refined. Not only will this cross-communication provide a broader clinical and empirical context for each work group's discussions, but it also affords the possibility of collaborative work on syndromes that have implications for more than one part of the manual.

We believe that no theoretical framework—psychoanalysis included—can provide a complete picture of the intra- and interpersonal dynamics that characterize a particular syndrome or set of syndromes. Accordingly, we seek input from clinicians of various theoretical orientations. As a number of writers have pointed out, most disorders are best understood as reflecting a combination of factors—investigated in psychodynamic, cognitive, biological, and cultural studies—and it is only when these perspectives are integrated that a nuanced understanding of a given syndrome can emerge.

The *PDM-2* will seek feedback from researchers in other specialty areas. Although ongoing discussions with clinicians and clinical researchers of varied backgrounds and theoretical allegiances can go a long way toward ensuring that diagnostic categories and descriptors are consistent with prevailing evidence from within and outside psychoanalysis, we must also ensure that *PDM-2* is consistent with current research in neuroscience, developmental psychology, memory, social cognition, and other areas.

We aim to engage constituents and stakeholders. A decade ago, Sadler and Fulford (2004) raised the question of whether patients and their families should play a role in the *DSM-5* revision process. This is a worthwhile question for *PDM-2* as well. Beyond the advantages and disadvantages of soliciting feedback from consumers of psychological services, it raises a broader issue—the degree to which input from various stakeholders (e.g., patients, policymakers, other health care professionals) would enhance future versions of the *PDM*. To be sure, there are tradeoffs (e.g., it is important to guard against bias from powerful, economically motivated groups), but to the degree that constituents and stakeholders are engaged in the development of *PDM-2* the manual can benefit from their experience and expertise. In turn, these constituents and stakeholders may ultimately feel an increased ownership of, and commitment to, the manual.

PDM-Derived Empirical Tools

Although the *PDM* has earned respect from both psychodynamic and nonpsychodynamic practitioners (Gordon, 2008, 2009), it is in danger of being underutilized because it lacks easily usable assessment instruments. To help remedy this, we developed two user-friendly tools: the Psychodiagnostic Chart (PDC) and the Psychodynamic Diagnostic Prototypes (PDP).

The Psychodiagnostic Chart (PDC)

The two forms of the PDC (Gordon & Bornstein, 2012) would operationalize the entire adult and children/adolescent sections of the *PDM*. The chart has been developed to be idiographic, flexible, and useful for practitioners of various theoretical orientations, to have a distinct dimension of personality structure, and to integrate the *PDM* with the symptom classifications of the *DSM* or ICD. The PDC has been developed on the basis of the *PDM* (first edition) structure and will be modified according to the *PDM-2* changes.

The PDC is both a categorical and a dimensional chart. All dimensional ratings range from 1 (*most disturbed*) to 10 (*healthy*). It comprises five sections. (a) Personality organization: The PDC uses the mental capacities of the P Axis of the *PDM* (e.g., identity, object relations, affect tolerance, affect regulation, superego integration, reality testing, ego resilience) to assess level of severity. In the first step, the clinician rates each of the capacities from 1 (*severe*) to 10 (*healthy*). Then, considering all the ratings, the clinician rates the person's overall personality structure from 1 (*psychotic*) to 10 (*healthy*). (b) Personality patterns: This section reviews the personality patterns/disorders described in the P Axes. The clinician begins by checking off as many descriptors as may apply to the client. He or she then infers the most dominant personality pattern or disorder and rates the level of severity (1–10). (c) Mental functioning: The clinician rates from 1 to 10 the descriptions of a person's core mental capacities. Then he or she rates the patient's overall mental functioning using a similar scale, ranging from 1 (*severe defects*) to 10 (*optimal*). (d) Symptoms: The clinician lists as many as four symptoms or subjective complaints and rates their degree of severity from 1 (*severe*) to 10 (*mild*). (e) Cultural-contextual issues: This is a qualitative section where the practitioner may consider how cultural or contextual factors may contribute to the symptoms.

We initially assessed the utility of the PDC by surveying practitioners from various psychology listservs and Web sites who considered themselves expert in diagnostics. We asked them to complete an online survey after using the PDC with at least one client. We looked at the data when we had 50 completed surveys. Half of the respondents identified themselves as not psychodynamic. Sixty-eight percent of the practitioners rated the *PDM* Personality Organization as *helpful to very helpful*, 58% rated *PDM* Mental Functioning as *helpful to very helpful*, and 44% rated *PDM* Dominant Personality Patterns or Disorders as *helpful to very helpful*. In contrast, only 18% of the practitioners rated *DSM* GAF scores as *helpful to very helpful*, and just 14% rated ICD or *DSM* symptoms as *helpful to very helpful*. These preliminary results lend strong support for the PDC among experts (Bornstein & Gordon, 2012). After considering them, we dropped the GAF section and added a qualitative cultural/contextual dimension to the PDC. These survey results were recently replicated with a sample of 511 mental health practitioners with very similar findings, that is, personality organization rated the highest, and the ICD or *DSM* symptom classification rated the least helpful in understanding their clients (Gordon et al., 2013).

We then worked to test the test–retest reliability and construct validity of the PDC. We asked 38 psychologists who had frequently used the Minnesota Multiphasic Personality Inventory (MMPI)-2 during the last 12 months with psychotherapy patients, disability patients, or forensic clients to participate in a study on diagnoses. They were asked to rate their last 10 clients with both the PDC and MMPI. Of the 38 psychologists, 15 sent in a total of 98 PDCs and MMPI-2s. The PDC had very good 2-week retest stability. Test–retest reliability was .92 ($p < .001$) for the Overall Personality Organization scale, was .89 ($p < .001$) for Overall Severity of Personality Disorder, ranged from .77 to .89 ($p < .001$) for the nine Mental Functioning, and was .87 ($p < .001$) for Severity of Symptoms.

All the PDC constructs had good correlations with the MMPI-2 scores in the predicted direction (Gordon & Stoffey, 2014). The MMPI-2 scales of Schizophrenia (Sc), Hysteria (Hy), and Ego Strength (Es) indicated good construct validity for the distinct categorical components of psychotic, borderline, and neurotic levels of Personality Organization.

The categories were derived by dividing the 10-point Overall Personality Organization scale into psychotic (ratings 1–3, $n = 13$), borderline (4–6, $n = 52$), and neurotic (7–10, $n = 33$) levels. We predicted that the Sc scale mean at the psychotic level should be

significantly larger than both the Hy and Es scale means for the psychotic level. Pairwise comparisons supported that prediction: Sc was significantly larger than Es ($M = 85.77$, $SD = 19.55$ vs. $M = 34.31$, $SD = 6.78$, $p = .001$) and significantly larger than Hy ($M = 85.77$, $SD = 19.55$ vs. $M = 72.69$, $SD = 18.46$, $p = .017$).

For the borderline level, we predicted that both the Sc scale mean and the Hy scale mean should not be significantly different, but they both should be significantly larger than the Es scale mean. That prediction was supported: Sc and Hy were not significantly different, but Sc was significantly larger than Es ($M = 62.21$, $SD = 12.31$, vs. $M = 43.58$, $SD = 10.25$, $p = .001$) and Hy was also significantly larger than Es ($M = 64.21$, $SD = 12.31$ vs. $M = 43.58$, $SD = 10.25$, $p = .001$).

Finally, for the neurotic level, we predicted that the Es, Sc, and Hy scales should all be in the normal–moderate range. Hy and Sc were in the moderate range, and ego strength moved up to the average range, showing support for the prediction.

Taken together, the analyses lend strong support to the construct validity of the Overall Personality Organization scale of the PDC. They specifically support the conclusion that personality patterns can exist on a continuum from neurotic to psychotic levels (see Figure 1).

These analyses support Kernberg's (1984) and McWilliams's (2011b) positions that personality organization is an important (arguably the most important) dimension by which to understand overall psychopathology and mental suffering. This position was recently empirically supported by the review conducted by Koelen et al. (2012). We found also that expert practitioners of various theoretical orientations (most of whom were not psychodynamically oriented) felt that personality organization is a very important dimension in understanding their patients, and that personality patterns express themselves across the range of personality structure. The conviction of the members of the Personality

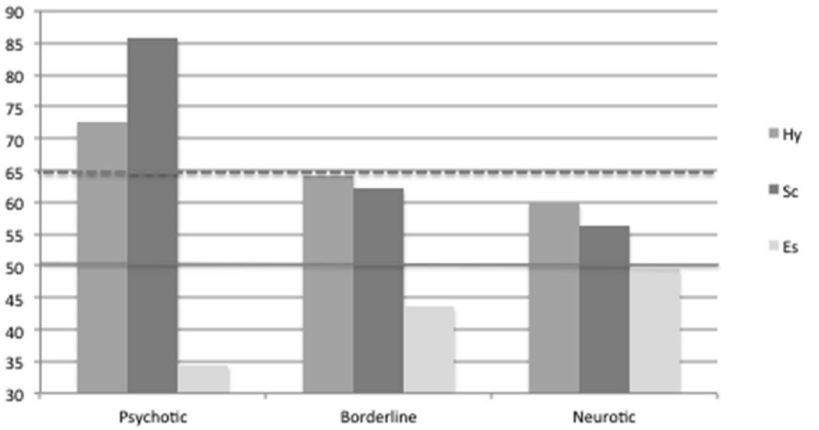

Figure 1. MMPI-2 Hysteria (Hy), Schizophrenia (Sc), and Ego Strength (Es) Scales within the Psychotic, Borderline, and Neurotic categories of the Personality Organization Scale. Solid line at MMPI-2 score of T50 is average. Dotted line at T65 indicates clinically significant scores. Psychotic (ratings 1–3, $n = 13$), Borderline (4–6, $n = 52$), and Neurotic (7–10, $n = 33$). Psychotic: Sc >> Hy > Es; Borderline: (Sc ~ Hy) > Es; Neurotic: (Sc ~ Hy) > Es all in the average to moderate range. Hy: Psychotic > Neurotic. Sc: Psychotic >> (Borderline ~ Neurotic). Es: Neurotic >> Psychotic; Neurotic > Borderline; Borderline > Psychotic. MMPI = Minnesota Multiphasic Personality Inventory; T = T- scores: standard scores with a mean of 50 and a standard deviation of 10.

Task Force of the original *PDM* that personality should be assessed as a first step in diagnoses has thus received considerable empirical support and therefore will be a primary, distinct dimension or axis in *PDM-2*.

The Psychodynamic Diagnostic Prototypes (PDP)

The PDP (Gazzillo, Lingiardi, & Del Corno, 2012), consists of 19 prototypic descriptions of personality disorders, one for each disorder included on the P Axis of the *PDM*. The aim of the PDP is to help clinicians and researchers use the P Axis even without a previous knowledge of the *PDM*. For this reason, the authors have taken the *PDM* descriptions of all the Axis P disorders, deleted the reference to articles and books presented in manual, and reformulated those parts of the *PDM* personality descriptions that were too theoretically laden or too inferential. In order to operationalize these theoretical concepts, the authors then took into account well validated dynamic assessment tools such as the Defense Mechanisms Rating Scale (Perry, 1990) and the Analytic Process Scales (Waldron et al., 2004).

The clinician/rater who uses the PDP assesses on a 1–5 rater scale the degree to which the patient resembles one or more PDP prototypes. A score of 1 means no resemblance, while a score of 5 means a complete match between the patient's clinical presentation and the prototypical description of that personality disorder; thus, with a score of 4 or 5, it is possible to make a categorical diagnosis of the disorder (see also Spitzer, First, Shedler, Westen, & Skodol, 2008).

After having completed the construction of the PDP, the authors asked seven raters, clinical psychologists who had completed a 12-hr training on the *PDM*, to assess on a 1–5 Likert scale in what measure each of the PDP prototypes resembled the description of the same disorder given in the *PDM*. In 90% of the cases, the PDP prototypes were assessed as good or very good descriptions of *PDM* Axis P disorders. The PDP, thus, seems to have good face validity.

The second step of the validation of the PDP was the assessment of interrater reliability (IRR) with respect to both dimensional (1 to 5) and categorical (diagnosis given/not given) assessment. In order to assess these IRR values, the authors collected the PDP assessments of 200 Italian patients. All were independently assessed with PDP by their treating clinicians and by one of our 7 *PDM*-trained raters. Clinicians had been following the patients assessed for an average 67.9 sessions ($SD = 86.5$; ranging from 2 to 576 sessions), while the raters assessed the personalities of these patients via the Clinical Diagnostic Interview (Westen & Muderrisoglu, 2003), a systematic interview for personality assessment. The average Cohen's kappa for the PDP prototypes categorically assessed (4 and 5 = presence of the disorder; 1, 2, or 3 = no disorder) was .61. The average intraclass correlation coefficient of the PDP prototypes dimensionally assessed was .74. Thus, the IRR of PDP ranges from good to excellent.

For assessing the *concurrent and discriminant validity* of the PDP, we have used as criterion measures the *DSM–IV* Axis II personality diagnoses of our patients as assessed by the raters with the *Axis II checklist*. This checklist, developed by Drew Westen (2002), is a clinician report instrument that combines a categorical and dimensional assessment of each of the Axis II criteria and disorders. For the categorical *DSM* diagnoses, we have followed the diagnostic thresholds of *DSM–IV* Axis II, and we have averaged the PDP assessment of clinicians and raters before comparing them with *DSM* diagnoses. Given that in Axis II, we have only nine disorders analogous to the *PDM* Axis P diagnoses, we have concurrent and discriminant validity data on only nine of our PDP prototypes. The

average correlation between the PDP and the analogous *DSM* disorder is .62, while the average correlation between the PDP prototype and a different *DSM* disorder is .05. On this basis as well, we can say that the concurrent and discriminant validity of our PDP is generally good.

To assess the construct validity of the PDP, we have used a stepwise model of linear regression to capture the relationships between the different *PDM* P Axis disorders and their specific core preoccupations and pathogenic beliefs. To this end, we developed two different clinician report instruments: the Core Preoccupation Questionnaire (Gazzillo & Lingiardi, 2008) and the Pathogenic Belief Questionnaire (Lingiardi & Gazzillo, 2008). These instruments ask the raters/clinicians to assess on a 1–7 Likert scale the degree to which the motivations, cognitions, emotions and behaviors of a patient reflect each of the 16 preoccupations and 36 beliefs about self and others described in the *PDM* P Axis. Our data show that 14 of the 16 core preoccupations and 21 of the 36 pathogenic beliefs are specifically connected with the disorder predicted by the *PDM*. Consequently, we have added to our PDP descriptions the core preoccupations and pathogenic beliefs described in the manual.

Finally, we have assessed the concurrent validity of the PDP with respect to some life history information collected by our raters with the Clinical Data Form (Westen & Shedler, 1999a). In this case as well, we have used a stepwise model of linear regression and we have chosen only objective data as predictors. We have found, for example, that the number of arrests and violent crimes committed by adolescents are predicted by their level of psychopathy; health problems are correlated with somatizing personality features, physical abuse in childhood correlates with masochistic personality patterns, and quality of social relationships is inversely correlated with the schizoid features.

On the basis of these data, we can say that PDP is a reliable and valid instrument for the assessment of personality with the *PDM* P Axis categories. Given that it needs no more than 30 min to be scored, we think that it is user-friendly enough to be utilized in real clinical practice, including public settings. There follows one of the PDP prototypes:

PDP Psychopathic Personality Disorder Prototype

> Psychopathic individuals manipulate others and are afraid of being manipulated by them. They tend to feel rage and envy, think they can do anything they want, and believe that everyone is selfish, manipulative, and dishonorable. For these reasons, they tend to control other people in a persistent and pervasive way and to use their power for their own sake. Psychopathic people seem to care more about themselves than other people, and tend to feel anxiety less frequently or intensely than others. In addition, they need constant stimulation. They seem to lack a moral center of gravity, but may be charming and charismatic and able to read others' emotional states with great accuracy, being hyperacute to their surroundings. However, their emotional life tends to be impoverished, and their expressed affect often is insincere and intended to manipulate other people. They lack the capacity to describe their own emotional reactions with any depth or nuance, and they frequently somatize. Their emotional connection to others is minimal, typically they lose interest in people they see as no longer useful to them, and they tend to be self-centered and manipulative. Individuals who match this prototype lack remorse and tend to devalue love and kindness, considering these feelings childish and illusory. Some are actively aggressive, explosive and predatory; others seem passive, more dependent, nonaggressive and relatively nonviolent, but in any case they are manipulative and ready to exploit others.

We are currently completing an international research project with a large sample of practitioners aimed at investigating the relationships between the PDC and the PDP

categories, defense mechanisms (with the Defensive Functioning Scale; American Psychiatric Association, 2000), and countertransference patterns (with the Countertransference Questionnaire; Betan, Heim, Zittel, & Westen, 2005; see also Colli, Tanzilli, Dimaggio & Lingiardi, 2014). Finally, in a recent study we have investigated the emotional responses of the therapists associated to the level of personality organization (assessed with the PDC) and the *PDM* personality patterns/disorders (assessed with the PDP) of the patients in treatment (Gazzillo et al., in press). We are particularly interested in the implications of each of these diagnostic elements on the structuring of the therapeutic setting.

The Construction of *PDM-2*

The *PDM-2* project would never have been achieved without its conceptual father, Stanley Greenspan (1941–2010), whom we view as "our Magellan who has given us the road map," and Nancy Greenspan, a responsive and devoted caretaker of her late husband's legacy.

The first steps toward the new edition required a steering committee representing both continuity and change. Robert Wallerstein (Honorary Chair), Nancy McWilliams, and Vittorio Lingiardi have agreed to comprise that group.

At the time of publication of this article, the sponsoring organizations for the second edition are the International Psychoanalytical Association, the International Association for Relational Psychoanalysis and Psychotherapy, the Division of Psychoanalysis (39) of the American Psychological Association, the American Academy of Psychoanalysis and Dynamic Psychiatry, the American Association for Psychoanalysis in Clinical Social Work, and the Italian Group for the Advancement of Psychodynamic Diagnosis and Research. The American Psychoanalytic Association has been contacted to renew its sponsorship as in the first edition.

For the drafting of the different sections of the manual, seven specific Task Forces have been considered: (a) Adults, (b) Adolescents, (c) Children, (d) Infancy and Early Childhood, (e) Elderly, (f) *PDM-2* Empirical Tools, (g) Case Illustrations and *PDM-2* Profiles.[1] Many contributors to the first edition are involved, with the collaboration of some new scholars.

Perspectives

There are two key purposes for the next edition. First, we need to enhance dialogue between *PDM* diagnosis and other diagnostic systems, in particular the *DSM* and the ICD. Like the original *PDM*, *PDM-2* is not intended to replace these descriptive nosologies, but to provide an overarching framework of personality structure and mental functioning within which the neo-Kraepelinian symptom classifications can be understood and more

[1] We are already able to list the Steering Committee (Vittorio Lingiardi, Nancy McWilliams, and Robert Wallerstein [Honorary Chair]) and the section editors of the specific sections: P Axis Adults (Nancy McWilliams and Jonathan Shedler), M Axis Adults (Robert F. Bornstein and Vittorio Lingiardi), S Axis Adults (Emanuela Mundo and John O'Neil), Adolescents (Nick Midgley and Mario Speranza), Children (Norka Malerg and Larry Rosenberg), Infancy and Early Childhood IEC (Linda Mayes and Anna Maria Speranza), Elderly (Franco Del Corno and Daniel Plotkin), Tools (Francesco Gazzillo, Robert M. Gordon, and Sherwood Waldron), and Case Illustrations and PDM-2 Profiles (Franco Del Corno, Vittorio Lingiardi, and Nancy McWilliams).

effectively treated. Furthermore, *PDM-2* will involve more systematic and empirical research than the first edition included, especially as such research informs more operationalized descriptions of the different disorders (Huprich et al., in press). Although the second edition will conserve the main structure of the first *PDM*, it will be characterized by several important changes.

P Axis

In the P Axis of the Adult section, Blatt's (2008) conceptualization of two key configurations of psychopathology, anaclitic and introjective, will be examined in greater depth with relevance to difference personality types. According to Blatt, *introjective* issues, centered on problems about the definition of one's identity, seem mainly present in schizoid, schizotypal, paranoid, narcissistic, antisocial and obsessive personality disorders, while *anaclitic* issues, related to the need to develop more stable and mutual object relations, seem more prevalent in borderline, histrionic, and dependent personality disorders (Blatt, 1990, 1995). The first *PDM* incorporated Blatt's work in noting introjective (self-definition) and anaclitic (self-in-relation) subtypes of personality types, but since its publication, more research has been done on these core polarities of personality. This conceptualization seems highly relevant to which kinds of psychotherapy may be most effective in relation to the specific difficulties of different patients.

In order to connect *PDM-2* more closely with empirical research, the section on level of personality organizations will be integrated and reformulated according to the empirical results from measures such as the Shedler-Westen Assessment Procedure (SWAP)-200 (Westen & Shedler, 1999a, 1999b), the Structured Interview of Personality Organization (Clarkin, Caligor, Stern & Kernberg, 2004), and the Karolinska Psychodynamic Profile (Weinryb, Rossel, & Asberg, 1991).

As we previously noted, in the original *PDM*, there is a significant omission. Despite some authors' arguments for the presence of a *psychotic* level of personality organization (e.g., Kernberg, 1984; McWilliams, 2011b; Wallerstein, 2006), the authors of the *PDM* considered that this formulation could lead to a terminological confusion with other syndromes, such as schizophrenia. This problem is not particular to the *PDM*; the same confusion inheres in the interesting fact that whereas the *DSM-5* characterizes schizotypal personality as a personality disorder, the ICD-10 classifies it as a psychotic disorder. Gordon and Stoffey (2014), in support of McWilliams's argument that personality organization exists along a continuum from psychotic through borderline to neurotic and healthy structures, have empirically demonstrated that even histrionic personality patterns can be expressed at the psychotic level of functioning (see Figure 1). It appears that schizophrenia and psychotic affective illnesses should not to be confused with a severe level of personality organization that can be present with any particular personality pattern. A separate axis of personality organization would also resolve the "schizotypal controversy" in that it would be classified a schizoid pattern at the psychotic level of personality organization. Such conceptualizations may demonstrate the *PDM*'s superiority to the *DSM* and ICD in the domain of personality taxonomy.

The *PDM-2* P Axis (Adults, Adolescents, Children, and Elderly) will also integrate and revise the section on types of personality disorders according to theoretical, clinical, and empirical indications from the clinical literature and according to clinically and empirically sound measures such as the SWAP-200 (Westen & Shedler, 1999a, 1999b) and its new versions and applications (SWAP-II; Blagov, Bi, Shedler, &

Westen, 2012; and SWAP-200-Adolescents; Westen, Shedler, Durrett, Glass, & Martens, 2003; see also Lingiardi, Shedler & Gazzillo, 2006; Gazzillo et al., 2013), and the PDP (Gazzillo, Lingiardi, & Del Corno, 2010). Moreover, we are considering the possibility of including an "emotionally dysregulated personality disorder," corresponding in part to the *DSM*'s description of "borderline personality disorder" (which is not included in the current list of *PDM* personality disorders, as the concept of "borderline" has been retained there in the meaning that originally arose from clinical experience: as a level rather than a type of personality organization). In other words, we may add a category that is more or less equivalent to the *DSM*'s borderline personality disorder rather than using the term strictly to denote borderline personality organization.

M Axis

The number of mental functions comprising the M Axis of the Adult section will be increased from nine to 12: (a) capacity for regulation, attention, and learning; (b) capacity for affective range, communication, and understanding; (c) capacity for mentalization and reflective functioning; (d) capacity for differentiation and integration; (e) capacity for relationships and intimacy; (f) quality of internal experience, including level of confidence and self-regard; (g) impulse control and regulation; (h) defensive functioning; (i) adaptation, resiliency, and strength; (j) self-observing capacities (psychological mindedness); (k) capacity to construct and use internal standards and ideals; and (l) meaning and purpose. Compared to the first edition of the manual, the *PDM-2* labels and descriptions of mental functioning have been revised and reformulated in a clinician-friendly, empirically grounded, and assessment-relevant way. Moreover, the M Axis will explicitly conceptualize personality and mental functioning as resulting from the integration of nature (temperament, genetic predisposition, basic underlying traits) and nurture (learning, experience, attachment style, cultural and social context). To facilitate clinically useful diagnosis and case conceptualization, it is essential that assessment of the M Axis capacities yield *practically applicable* results with utility for diagnostic formulation, and treatment planning and implementation. Given that it is also essential that clinicians across orientations are able to assess M Axis capacities in a reliable and valid manner, for each capacity we will provide a list of well validated clinical tools that can be employed to aid in assessment. These lists of tools include, among others, the SWAP-200 (Westen & Shedler, 1999a, 1999b), the Defense Mechanism Rating Scale (Perry, 1990), the Social Cognition and Object Relations Scale (Westen, 1995), the Object Relations Inventory (Blatt & Auerbach, 2001), and the Reflective Functioning Scale (Fonagy, Steele, Steele, & Target, 1997). Moreover, we will revise and reformulate the "illustrative descriptions of the range and adequacy of functioning" in a way that is more clinician-friendly, empirically grounded, and assessment-relevant, by introducing an assessment procedure with a Likert-style scale (i.e., indicating in a quantitative way the level at which any single mental function is articulated).

S Axis

Regarding the S Axis of the Adult section, we will enhance its integration with the more symptom–syndrome-oriented diagnostic manuals such as the *DSM* and the ICD. We will try not to exclude any relevant syndrome or psychopathological condition (e.g., panic disorder or hypochondriasis, which are not included in the *PDM* current list of symptom's patterns). Finally, we will give a more exhaustive explanation of the rationale for the

description of "affective states," "cognitive patterns," "somatic states," and "relationship patterns," and we will reference related clinical and empirical studies. Greater attention will be also paid to the subjective experiences of the clinician (countertransference).

The section dedicated to the Classification of Child and Adolescent Mental Health Disorders will also be subject to some changes. First of all, we intend to separate the Adolescent section (age 11–18) from the Child section (4–10), because it seems clinically naive to use the same levels and patterns for describing the mental functioning of, say, a 4-year-old child and a 14-year-old adolescent. The idea of assessing, in adolescence, first Mental Functioning (M Axis) Axis) and then Personality (P Axis) patterns will be maintained.

Regarding the Special Section on Infancy and Early Childhood Mental Health Disorders, we will add a specific section on developmental lines and homotypic/heterotypic continuities of early infancy, childhood, adolescent and adult psychopathology, which are objects of investigation in the clinical and empirical literature (see, e.g., Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Speranza & Fortunato, 2012). We will give better definitions of the quality of primary relationships (between the child and his or her caregivers), adding contributions from theoretical, clinical and empirical investigations into infant research and attachment theory (see Cassidy & Shaver, 2008), and we will make references to empirically grounded instruments useful for their assessment.

Starting from this perspective, we will also emphasize more strongly the evaluation of family systems and their characteristic relational patterns, including a paragraph about attachment patterns and their possible relationship to psychopathology and normative development.

An important change in the incoming new version of the manual will be the inclusion of a section on Mental Health Disorders of the Elderly, which was not in the first edition. As McWilliams (2011a) pointed out,

> One of the first serious criticisms of the *PDM* embarrassed us: Daniel Plotkin (personal communication, December 2006) at UCLA Medical Center wondered why, in this avowedly developmental document, we included sections on infancy, childhood, and adulthood, but none on the elderly. In view of the average age of the steering committee members (late 60s and early 70s, by my calculation), one can only infer massive denial: Including a section on elderly patients never occurred to us! (p. 120)

Moreover, in the *PDM-2* we have decided to eliminate the section Conceptual and Empirical Foundations for a Psychodynamically Based Classification System for Mental Health Disorders and to include a new section on assessment tools. Within this section we will include (a) the *PDM* derived instruments, such as the PDP and PDC, with their manuals; (b) the description, strengths, limitations and main references of empirical instruments that shaped the *PDM* categories (such as SWAP, Structured Interview of Personality Organization, Karolinska Psychodynamic Profile, and Social Cognition and Object Relations Scale); (c) the description, strengths, limitations, and main references of widely utilized tools, both self-report and performance-based (e.g., MMPI, Thematic Apperception Test, Rorschach Inkblot Measure), that can be a useful aid in the assessment of some of the *PDM* dimensions; (d) the description, strengths, limitations, and main references of empirical tools useful for the assessment of patient and therapist contributions to psychotherapy process (e.g., the Analytic Process Scales, the Psychotherapy Process Q-Set; Ablon & Levy, 2009; Jones, 2000; the Comparative Psychotherapy Process Scale; Hilsenroth, Blagys, Ackerman, Bonge, &

Blais, 2005). The aims of this section are to improve the dialogue between clinical practice and research, to guide the practitioners in the selection of empirical tools that can help them to refine and support *PDM* assessment, both for clinical and research purposes, and to help to bridge the gap between research on personality and research on psychotherapy process and outcome.

Finally, *PDM-2* will contain a special section dedicated to clinical exemplifications, which will help the reader to have a better and deeper understanding of the manual's contents. Our aim is to provide clinical illustrations that exemplify how the *PDM* assessment procedures can help therapists to understand and describe the mental functioning of real patients, both their positive resources and their pathological dimensions. Together with the *PDM* (P Axis, M Axis, and S Axis) and the ICD and *DSM-5* diagnoses, *PDM-2* clinical presentations should articulate what are the more relevant affects, defense mechanisms, and conflicts of the patients, their specific core preoccupations and pathogenic beliefs, and the affective reactions experienced by the assessor while interacting with them. Emphasis will be on patients' resources and strengths, not just limitations and pathology. Case presentations deriving from *PDM-2* will specify the more and less compromised mental processes of the patient and in what circumstances the person functions at higher and lower levels, respectively.

Conclusion: A Historic Opportunity

As McWilliams (2011a) has noted, the primary goals for the *PDM* were to create a diagnostic system that embraced the complexities of human experience (both normal and pathological) and to conceptualize the major psychological disorders in ways that went beyond external description to capture the subjective phenomenology and underlying dynamics that shape psychological symptoms and syndromes.

As we have noted, in the last 2 decades, there has been an increasing tendency to define mental problems primarily on the basis of observable symptoms, behaviors, and traits, with overall personality functioning and levels of adaptation noted only secondarily. There is increasing evidence, however, that both mental health and psychopathology involve many subtle features of human functioning, including affect tolerance, regulation, and expression; coping strategies and defenses; capacities for understanding self and others; and quality of relationships. Mounting evidence from neuroscience and developmental studies supports the position that mental functioning, whether optimal or compromised, is highly complex. To ignore mental complexity is to ignore the very phenomena of concern to therapists and students of human psychology. After all, our mental complexity defines our most human qualities.

Greenspan thought that the *PDM* could serve as a holistic diagnostic tool. He believed it could help not only psychodynamically oriented clinicians, but also behavioral, cognitive, humanistic, emotion-focused, family, systems, and biologically oriented therapists "understand their patients more fully . [. . .] We've seen interest from people in anthropology, sociology, educators, legal scholars and people in the justice system," he noted. "It's broadened the purview of psychology to reach into all the related disciplines that deal with human beings" (Packard, 2007, p. 30).

The *PDM* has a historic opportunity to expand beyond the doctor's office and the symptom checklist into the deeper complexities of the human being. To be trapped between the anonymity of rating scales and the challenges of self-referential jargon not only mortifies the clinician's professional identity, but also dims or distorts

practitioners' abilities to detect and describe their patients' characteristic mental experiences—and, therefore, the capacity to relieve their psychological distress. Without a counterpoint to the current tendency to focus more and more narrowly and discretely on disorder categories, the clinical relationship may be jeopardized and even damaged beyond repair.

This danger is the main reason we feel we need a biopsychosocial classification system such as the *PDM*. It also is the main reason we are committed to improving its clinical value with a new edition. With it, we hope to fulfill Robert Wallerstein's (personal communication, 2012) wish "that *PDM* will have an enduring life."

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