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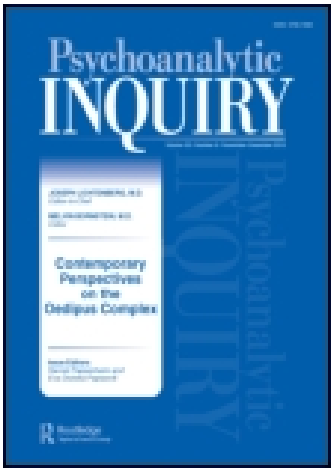

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The Psychodynamic Diagnostic Manual (PDM) and the PDM-2: Opportunities to Significantly Affect the Profession

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The *Psychodynamic Diagnostic Manual (PDM)* and the *PDM*-2: Opportunities to Significantly Affect the Profession

Steven K. Huprich, Ph.D., Nancy McWilliams, Ph.D., Vittorio Lingiardi, M.D., Robert F. Bornstein, Ph.D., Francesco Gazzillo, Ph.D., and Robert M. Gordon, Ph.D., ABPP

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In this article, we discuss the development of the *Psychodynamic Diagnostic Manual* (*PDM*) and its upcoming revision, the *PDM*-2. We describe the processes by which the *PDM*-2 is being developed and highlight important differences across both editions. At the same time, we emphasize the value of assessing internalized experience and how that can be of use toward the diagnostic assessment process.

In 2006, the *Psychodynamic Diagnostic Manual* (*PDM; PDM* Task Force, 2006) was published. The *PDM* was (and is) in many ways a revolutionary document: In contrast to extant diagnostic systems available at that time, the *PDM* was an unabashedly psychodynamic diagnostic system that embraced psychoanalytic concepts, rather than striving for theoretical neutrality, using syndrome descriptions and symptom criteria that incorporate implicit motives, conflicts, defenses, wishes, fantasies, and other dynamic processes, and drawing upon a wealth of empirical research examining psychoanalytic concepts and constructs.

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Spearheaded by Drs. Stanley Greenspan, Robert Wallerstein, and Nancy McWilliams, the *PDM* was a monumental accomplishment for psychoanalytic and psychodynamic clinicians and researchers. It was produced out of collaborative efforts of members from five professional organizations,[1] and more specifically by 36 members of the *PDM* Task Force, five consultants, and members of five working committees, most of whom were asked to participate on recommendation of the presidents of the five organizations. Now just over eight years old, the *PDM* has arguably received less attention than it rightfully deserves. Nevertheless, the *PDM* has been the focus of attention in a number of venues. For instance, the *Journal of Personality Assessment* featured a special issue on the *PDM* in March–April 2011 (Volume 93, Number 2; see Huprich and Meyer, 2011, for an overview), and a symposium on the future of the *PDM* was presented in January 2013 at the Annual Meeting of the Psychoanalytic Psychodynamic Research Society and in May at the Annual Meeting of the Division 39 of the American Psychological Association. Additionally, several published book reviews from psychoanalytically-oriented clinicians have been favorable toward the manual (Clemens, 2007; Dunn, 2008; Ekstrom, 2007; Ferrari, 2006; Michels, 2007; Migone, 2006; Silvio, 2007; Weiner, 2006; Widiger, 2006). An Italian version of the *PDM* was published in 2008 (*PDM*, 2008), and *PDM* influence has been documented also in Germany, Spain, Portugal, Turkey, France, and New Zealand (Del Corno and Lingiardi, 2012).

The future of psychiatric diagnosis is clearly in question, given the vitriolic response that the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM*-5) has received in the professional sector (Frances, 2010, 2013; Shedler et al., 2010). In addition, beginning on October 14, 2014 in the United States, all providers who practice under the guidelines of the Health Insurance Portability and Accountability Act are required to use the *International Classification of Diseases 10* (*ICD*-10; see www.apapracticecentral.org/update/2012/02-09/transition.aspx), attenuating the influence of the *DSM* within the world of managed care. Clinicians clearly want something different, as well. For instance, in a recent survey of the World Health Organization (Evans, 2012) of 2,155 psychologists from 23 countries, 35% stated that they wanted only 10–30 diagnostic categories, and 50% wanted 31–100 diagnostic categories. The current versions of the *ICD* and *DSM* list over 300 diagnostic categories. Additionally, many researchers (First and Westen, 2007; Spitzer et al., 2008; Westen, 1997; Westen et al., 2012) have demonstrated that clinicians prefer prototype-based models over the *DSM*-IV categories themselves [2] when it comes to the current personality disorder categories. Surveys of clinicians typically demonstrate a generalized dislike of the extant diagnostic manuals (Mezzich, 2002; Spitzer et al., 2008) as well. Thus, it is an especially opportune time for psychoanalytic and psychodynamic clinicians and researchers to provide an alternative framework that attempts to "characterize an individual's full range of functioning—the depth as well as the surface of emotional, cognitive and social patterns" (*PDM* Task Force, 2006, p. 1). This is precisely what

[1]The American Psychoanalytic Association, the International Psychoanalytical Association, Division 39 (Psychoanalysis) of the American Psychological Association, the American Academy of Psychoanalysis and Dynamic Psychiatry, and the National Membership Committee on Psychoanalysis in Clinical Social Work (subsequently renamed the American Association for Psychoanalysis in Clinical Social Work).

[2]Eaton, Krueger, South, Simms, and Clark (2010) argued empirically that personality dimensions are more robust than prototypes; however, they created their prototypes from self-reported ratings of trait dimensions from mostly nonpatients, and not from ratings of patients from practicing clinicians.

the *PDM* sets out to do. The *PDM* explicitly describes itself not as a "taxonomy of diseases" but a "taxonomy of people." It is about "what one is rather than what one has" (p. 17).

In the sections to follow, we address two major issues related to the *PDM*. We first provide a brief description of the *PDM*, and we review some preliminary research on clinicians' perceptions of the manual. In the second section, we note shortcomings in the first edition of the *PDM* and describe plans underway to produce the *PDM*-2, which incorporates ways of addressing these shortcomings and strengthening the manual's empirical grounding and clinical utility.

A BRIEF DESCRIPTION OF THE *PDM* AND PRELIMINARY SUPPORT

The *PDM* was created by psychoanalytic and psychodynamic clinicians as a complement to existing diagnostic manuals. Although it utilizes a number of the diagnostic labels that are currently in use with *DSM*-5 (APA, 2013) and *ICD*-10 (World Health Organization, 1992), it is explicit about what it offers that other diagnostic systems lack:

> Despite the fact that mental health professionals are inevitably dealing with the elusive world of subjectivity, we require a fuller description of the patient's internal life to do justice to understanding his or her distinctive experience. We are hoping that with more elaborated depictions, we can make more progress on understanding naturally occurring patterns. [p. 5]

The *PDM* evaluates a patient's functioning on three dimensions: personality patterns and disorders (P-axis); mental functioning (M-axis), and manifest symptoms and concerns (S-axis). Adult assessment begins with P-axis because there is "accumulating evidence that symptoms or problems cannot be understood, assessed, or treated in the absence of an understanding of the mental life of the person who has the symptoms" (p. 8). Within this framework, the *PDM* explicitly acknowledges the necessity of understanding individuals' personality organization and patterns to effectively plan their treatment. In the *PDM*, personality is assessed as being at the healthy level (meaning that no personality disorder is present), at the neurotic level, or at the borderline level. Although psychotic personality structures have been described by some, the *PDM* opted not to include this label, as it could be confused with psychotic conditions such as schizophrenia (though a number of individuals of the Personality Disorders Task Force argued for inclusion of a psychotic level of personality organization). The personality patterns and disorders listed in the *PDM* include schizoid, paranoid, psychopathic/antisocial (passive and aggressive subtypes), narcissistic (arrogant and depressed subtypes), sadistic and sadomasochistic, masochistic/self-defeating (moral and relational subtypes), depressive (introjective, anaclitic, and mixed subtypes), somatizing, dependent (passive-aggressive and counterdependent subtyptes), phobic/avoidant, anxious, obsessive-compulsive (obsessive and compulsive subtypes), hysterical/histrionic (inhibited and demonstrative subtypes), dissociative, and mixed.

The M-axis allows the clinician to assess a patient's overall level of psychological functioning. This scale is much more complex than the *DSM*-IV-TR Global Assessment of Functioning Scale (APA, 2000). Nine overall dimensions of functioning are assessed on the M-axis: (a) the capacity for regulation, attention, and learning; (b) the capacity for relationships and intimacy; (c) the quality of internal experience, which includes the level of self-confidence and self-regard; (d) the capacity for affective experience, expression, and communication; (e) defensive patterns and

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capacities; (f) the capacity to form internal representations; (g) the capacity for differentiation and integration; (h) self-observing capacities, or psychological mindedness; and (i) the capacity to construct or use internal standards and ideals (sense of morality). Individuals are assessed across all of these dimensions, and a single overall rating is assigned across a seven-category, dimensionalized scale. For instance, at the healthiest level of functioning, a patient is characterized as having optimal age- and phase-appropriate mental capacities with phase-expected degree of flexibility and intactness. At a mid-range level of functioning, an individual may have mild to moderate levels of alterations in functioning, which could include mild to major impairments in self-esteem regulation, limitations in the internalizations necessary for regulation of impulses, affect, mood, and thought, or alterations and limitations in a pleasure-seeking orientation. A severe level of impairment includes deficits with reality testing, perception, and regulation of affect.

The S-axis is for subjective experiences that are associated with the various symptom patterns described under the Axis I disorders in *DSM*-IV-TR. The *PDM* attempts to provide a more elaborated and clinically relevant description of the patient's subjective experience of symptoms than the *DSM* provides. For instance, in describing the inner experience of patients with Bipolar Disorder, the *PDM* (2008) says:

> intense irritability, accompanied by transient anxiety, agitation, and a hypersensitivity to, and expectation of, insult and rejection. Mania is characterized by excessive energy that may be experienced negatively, as a disruptive and distracting internal pressure, or positively, as a sense of infinite power, ability and creativity. In either case, the internal hyperarousal is often accompanied by impulsive behavior. [p. 113]

It adds that

> Individuals with mania may alternate between feeling frayed, fractured, and anxious, and feeling perfectly complete and elated. The quick fluctuations in their moods are accompanied by equally rapid fluctuations in the sense of self. One minute the individual feels sullen, useless, and agitated; the next minute, like a conquering hero. [pp. 113–114]

The *PDM* also notes more generally that, "symptom patterns are not simply disorders in their own right but are, rather, overt expressions of the ways in which individual patients characteristically cope with experience" (p. 93). Thus, it is important to understand the patient's overall personality structure and general level of functioning to best understand the symptom patterns. For many of the disorders, biological predispositions, cognitive, affective, somatic, and relational patterns are described to foster a comprehensive description of the disorder. Many of the same *DSM* groupings of disorders exist in the *PDM* (i.e., disorders of adjustment, anxiety disorders, dissociation, mood, eating, sleep, sexual and gender identity, impulse control, personality disorders, substance abuse and addiction, psychosis, and general medical conditions, along with somatoform and factitious disorders). However, the number of conditions per group is often much less than what is reported in *DSM*-5, except for the personality disorders.

The *PDM* has a separate section devoted to child and adolescent disorders. This section follows a similar structure as the adult section: There is the mental functioning for children and adolescents (MCA) axis, the child and adolescent personality patterns and disorders (PCA) axis,

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and the child and adolescent symptom patterns/subjective experience (SCA) axis. In addition, an entire section is devoted to mental and developmental disorders in infancy and early childhood.

The final section of the *PDM* is devoted to the historical and research underpinnings of a psychodynamically informed classification system. The research section is composed of eight sections and is over 300 pages, providing considerable empirical backing to support the development of a diagnostic manual such as this one. McWilliams (2011b) wrote that one of the purposes of this section was to "represent the expressly political aim of demonstrating that there is an extensive scientific basis for psychoanalytic inference and treatment" (p. 119).

As stated earlier, many early reviews of the *PDM* were favorable. From a more empirical standpoint, Gordon (2009) surveyed psychologists who attended one of two continuing education workshops that included didactics on the *PDM*. He found that 90% of those surveyed gave the *PDM* a favorable rating (averaging 5–7 on a 7-point Likert scale). Psychologists did not differ across theoretical orientation in their ratings of the following statements: "I found the levels of personality severity (healthy, neurotic, borderline) helpful," and "I better understand the value of the concept of borderline as a level of personality organization as compared to a personality disorder." However, those identifying as psychodynamic had slightly more favorable responses to the questions, "I learned how the *PDM* could help me better understand the personalities of clients/patients" and "I believe that the *PDM* can help me understand a person's full range of mental health" than those identified as cognitive-behavioral in their theoretical orientation. In a follow-up study, Bornstein and Gordon (2012) assessed 50 practitioners through online recruitment from a number of directories. They asked clinicians to rate at least one patient with *PDM* guidelines (the Psychodiagnostic Chart) and also rate the same patient with either *DSM*-IV or *ICD*-10 criteria. Using a 7-point scale (1 = *not at all helpful* and 7 = *very helpful*), they found that *PDM* personality organization, mental functioning, and dominant personality patterns were rated as *helpful-very helpful* by 68%, 58%, and 44% of the participants respectively. Comparatively speaking, 18% rated the *DSM* Global Assessment of Functioning scores as *helpful-very helpful* and 14% rated *DSM* or *ICD* symptoms as *helpful-very helpful*.

A larger study was conducted by Gazzillo, Lingiardi, and Del Corno (2012), who assessed 200 therapists and patients in mental health centers in Italy. Both the patients' therapists and one of six trained raters assessed each patient. The six raters received formal training on how to use the Clinical Diagnostic Interview (Westen and Muderrisoglu, 2003) and the Shedler-Westen Assessment Procedure-II (SWAP; Westen et al., 2012). Both the clinicians and trained raters assessed patients with three instruments—the Psychodynamic Diagnostic Prototypes (PDP), the Core Preoccupations Questionnaire (CPQ), and the Pathogenic Beliefs Questionnaire (PBQ), all of which were created by the study's authors. The first measure assessed 21 prototypical descriptions of the various *PDM* personality disorder categories, with each prototype read and evaluated by the clinician to assess the degree of fit between the patient and prototype. Ratings range between 1 (*no match-description does not apply*) and 5 (*very good match—patient exemplifies the disorder*). The second measure assessed eighteen core preoccupations proposed in the *PDM* P-axis on a seven-point rating scale. These preoccupations are associated with certain personality disorders; for example, a preoccupation with a fear of closeness, coupled with a longing for closeness (representative of schizoid personality), and a preoccupation with being attacked (representative of paranoid personality). Finally, the Pathological Beliefs Questionnaire is composed of 36, seven-point Likert items that assess pathological beliefs about oneself and others.

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Gazzillo et al. (2012) found that the clinician and research raters had moderate to excellent degrees of interrater reliability (kappa values for categorical agreement ranging between .44 [Hypomanic] and .75 [Counterdependent]; Spearman rho values for dimensional agreement ranged between .41 [Counterphobic] and .84 [Histrionic]) for the PDP ratings of personality pathology. Similar degrees of reliability were found for the CPQ (Spearman rho values ranging between .60 [lack of dependence] and .74 [fears or longings for closeness, attacking or being attacked by others, and power and sexuality in gender]) and the PBQ (Spearman rho values ranging between .53 [counterdependent beliefs] and .78 [dependent beliefs]). PDM P-axis, dimensional ratings were most highly correlated with their *DSM*-IV, Axis II dimensional ratings, with Spearman rho correlations ranging between .45 (Phobic/Avoidant with Avoidant) and .79 (Hysterical/Histrionic with Histrionic). They also reported that 14 of the 18 CBQ scales accounted for the largest proportion of variance in the corresponding PDP scales, and 27 of the 36 PBQ scales accounted for the largest proportion of variance in the corresponding PDP scores.

So, it seems that *PDM* P-axis disorders can be reliably assessed by clinicians of different theoretical orientations, and that most of the associations between the specific P-axis disorders and the different core preoccupations and pathogenic beliefs hypothesized by the manual are empirically supported.

Outside the empirical realm, the *PDM* appears to have been generally well received in the United States. In an effort to understand the success of *PDM* scales, Stepansky (2009) wrote,

> 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]

MOVING TOWARD *PDM*-2: IMPROVING THE ORIGINAL *PDM*

Despite (or perhaps because of) the *PDM*'s success, there is already a Steering Committee in place to revise the *PDM* into a second edition (the *PDM*-2); the Steering Committee is chaired by Robert Wallerstein (Honorary Chair), Vittorio Lingiardi and Nancy McWilliams. Seven specific Task Forces have been developed to help draft the new *PDM*-2 and its corresponding sections: (1) adults, (2) adolescents, (3) children, (4) infancy and early childhood, (5) elderly, (6) assessment tools, (7) case illustrations and *PDM*-2 profiles. Most of the contributors of the first edition are involved, although new, distinguished contributors have also joined various task forces. The development of the *PDM*-2 is being sponsored by the American Psychoanalytic Association, the International Psychoanalytical Association, the Division of Psychoanalysis (39) of the American Psychological Association, the American Association for Psychoanalysis in Clinical Social Work, the American Academy of Psychoanalysis and Dynamic Psychiatry, the International Association for Relational Psychoanalysis and Psychotherapy, and the Italian Group for the Advancement of Psychodynamic Diagnosis and Research. A contract has been signed with Guilford Press to publish the *PDM*-2, which should help promote the sales and distribution of the manual.

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The Steering Committee has already begun to identify areas in which to improve the current *PDM* and to enhance its empirical standing and clinical utility (Lingiardi, McWilliams, Bornstein, Gazzillo, Gordon, in press). Some of these concerns have been articulated in the prior literature (e.g., Huprich, 2009; McWilliams, 2011b), although many of these have been shared more informally among interested parties. In the following, we describe a number of these concerns and what efforts are being made to address them in the *PDM*-2 revision.

Reliability and Validity of the Axes and Diagnoses

The *PDM* has received little empirical attention for the reliability and validity of its diagnostic categories and axes. As the *PDM*-2 is being developed, the Steering Committee and task forces will be charged with attending to the empirical literature on *DSM* and *ICD* diagnostic categories, as well as any studies on *PDM* constructs, as they articulate and refine the diagnostic categories contained therein. As was the case with the original *PDM* (and, of course, the *DSM* as well), the *PDM*-2 will be described as a manual in need of ongoing empirical study, and researchers will be encouraged to consider the reliability and validity of the *PDM* framework.

Clinical Utility

The extent to which clinicians find the *PDM* useful in clinical practice will undoubtedly affect its appeal to the mental health community. In an effort to enhance its utility, Lingiardi (2013) has noted that the *PDM*-2 Steering Committee and task forces will revise and reformulate the "illustrative descriptions of the range and adequacy of functioning" in ways that are more clinician-friendly, empirically grounded, and assessment-relevant, by introducing an assessment procedure with a Likert scale (i.e., inviting users to indicate in a quantitative way the level to which any single mental function is articulated).[3]

P-Axis Changes

There are several ways in which the P-axis will be reformulated in the *PDM*-2. First, those familiar with the P-axis have noted that in the original *PDM* there is not a psychotic level of personality organization (e.g., Kernberg, 1984 ; McWilliams, 2011a). This was intentional, as the PDM authors considered that this formulation could lead to terminological confusion with currently accepted syndrome disorders such as schizophrenia. Nevertheless, this decision has evoked

[3] In revising the *PDM*, there has been discussion about what the manual should be called. For instance, it has been questioned whether the term *Psychodynamic* should be replaced with the terms *Practitioner* or *Psychological*. The idea behind this possible change is that clinicians with alternative theoretical orientations (e.g., cognitive-behavioral, interpersonal, biological, humanistic, or family-systems) may not take an interest in a manual that is psychodynamic. Furthermore, by removing *psychodynamic* from the title, the editor would be inviting nonpsychodynamically oriented clinicians and researchers who seek a better diagnostic system. Although this latter point is fraught with potential pitfalls, it has been argued that including individuals of alternative orientations could strengthen the empirical grounding and wider clinical appeal of the manual (Bornstein, 2015; this issue). This issue continues to be discussed by the *PDM*-2 Work Group.

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a debate about whether a psychotic level of personality organization and thought-disordered psychology is appropriate and can be assessed. Members of the *PDM*-2 Steering Committee and P-Axis Task Force are considering the possibility of including a psychotic level of personality functioning that would enable clinicians to evaluate their patients on a personality organization continuum that includes healthy, neurotic, borderline, and psychotic levels. An alternative possibility would be to include what many regard as *psychotic ways of functioning* in the *Low Level of Borderline Personality Organization*.

Second, the P-axis will also be characterized by the integration and revision of the section on types of personality disorders according to theoretical, clinical, and empirical indications from the latest studies in the clinical literature and coming from the application of clinically and empirically sounded measures, such as the SWAP-200 and its new versions and applications (SWAP-II; Westen et al., 2012; SWAP-200-Adolescents; Westen et al., 2003; see also Gazzillo et al., 2013; Lingiardi, Shedler, and Gazzillo, 2006), and the psychodynamic diagnostic prototypes (Gazzillo, Lingiardi, and Del Corno, 2010). Moreover, an Emotionally-Dysregulated Personality Disorder may be added, roughly corresponding to the *DSM*-description of Borderline Personality Disorder.[4] Furthermore, other empirically derived, psychodynamic formulations of the personality disorders will be considered for how they inform the P-axis. These include formulations derived from the SWAP (SWAP-200; Westen and Shedler, 1999a, 1999b), the Inventory of Personality Organization (IPO; Kernberg and Clarkin, 1995), the Structured Interview of Personality Organization (STIPO; Clarkin et al., 2004), and the Karolinska Psychodynamic Profile (Weinryb, Rossel, and Asberg, 1991a, 1991b).

Third, Blatt's (2008) conceptualization of two key configurations of psychopathology, anaclitic and introjective, will be examined in greater depth in terms of their relationship to the personality disorders. According to Blatt (1990, 1995), *introjective* issues, centered on problems about the definition of the one's identity, seem mainly present in schizoid, schizotypal, paranoid, narcissistic, antisocial (psychopathic), and obsessive personality disorders; *anaclitic* issues, related to the need to develop more stable and mutual object relations, seem more prevalent in borderline, histrionic, and dependent personality disorders. His empirically-derived conceptualization has been demonstrated to be highly relevant to the question of which kinds of psychotherapy are more effective for which kinds of patients.

M-Axis Changes

The number of mental functions comprising the M-axis of the Adult section will be increased from nine to twelve: Capacity for regulation, attention and learning; Capacity for affective range, communication and understanding; Capacity for mentalization and reflective functioning; Capacity for differentiation and integration; Capacity for relationships and intimacy; Quality of internal experience, including level of confidence and self-regard; Impulse control and regulation; Defensive functioning; Adaptation, resiliency and strength; Self-observing capacities (psychological mindedness); Capacity to construct and use internal standards and ideals; Meaning and

[4]P-axis does not consider some traditional *DSM* personality disorders, such as Schizotypal and Borderline. This arose out of early work with the SWAP in which many patients diagnosed with Schizotypal PD actually were best classified on the Schizoid prototype, and those diagnosed with Borderline PD were on the Histrionic, Emotionally Dysregulated, Dependent, and Masochistic factors.

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purpose. There are empirically sound instruments that assess many of these functions, such as the Defense Mechanism Rating Scale (Perry, 1990), the SWAP-200 (Westen and Shedler, 1999a, 1999b), the Social Cognition and Object Relations Scale (Westen, 1995; Stein et al., 2012), the STIPO (Clarkin et al., 2004; Stern et al., 2010), the Object Relations Inventory (Blatt et al., 1988).[5] Additionally, the *PDM*-2 Work Group will consider the assessment of executive functioning, as these processes are similar to many M-axis processes, but include more specific cognitive elements, such as short- and long-term attention, sequencing, and analogical reasoning (Bornstein, 2005, Slipp, 2000; Zabarenko, 2004). By including attention to executive functioning, the *PDM*-2 would become better integrated with related research that has not to date been extensively associated with the psychodynamic literature.[6]

S-Axis Changes

Regarding the S-axis of the Adult section, the *PDM*-2 will be integrated more closely with the *DSM* and the *ICD* systems. For instance, the *PDM*-2 will include a number of well-recognized clinical syndromes, such as panic disorder and hypochondriasis, which are not in the current *PDM*'s list of symptom patterns. More precise descriptions of the affective states, cognitive patterns, somatic states, and relationship patterns associated with these diagnoses will be provided, and greater attention will be paid to the empirical investigation and clinical description of these disorders, including the subjective experiences of clinician (countertransference; see Colli et al., 2014). In addition, the authors of *PDM*-2 are considering more attention to the heterogeneity of symptom presentations and significance across patients within the same diagnostic category and within the same patient throughout time. Such consideration might make it easier to conceptualize the different symptoms and syndromes as dimensions and prototypes, rather than categories, thus reifying the well-established dynamic continuum between health and illness. Along those lines, they may stress the need to specify the precipitants of symptoms and syndromes and the particular interpretations made about these factors by patients. For example, in Blatt's (2008) research, clinically significant depressive episodes tend to arise after a person loses a job. However, how an individual interprets this job loss and its personal, subjective meaning has a considerable effect on how to treat the patient. *PDM*-2 will also include the possible genetic and environmental contributors to the different syndromes when known, and may be useful for creating and validating assessment instruments specific to the subjective experience of psychopathological symptoms. This change would be of potential value for both clinical and research purposes (Mundo, 2012). Eventually, the writers of *PDM*-2 will relate their concepts to the *ICD* codes, given that the 10th edition of the *ICD* will be the reference manual for the National Institutes of Mental Health for many countries.

Child and Family Section

The first edition of the *PDM* presented itself as an organic diagnostic system with two important sections dedicated to childhood: Classification of Mental Health and Developmental Disorders in Infancy and Early Childhood (IEC axis) and Classification of Child and Adolescent Mental

[5]Huprich (2009) has provided a comprehensive list of instruments relevant to M-axis assessment.

[6]However, the field of neuropsychoanalysis is quickly growing—see http://www.neuropsa.org.uk/.

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Health Disorders (the MCA, PCA, and SCA axes). The section on Child and Adolescent Mental Health Disorders will be subject to relevant changes in *PDM*-2 because it seems inappropriate to use the same levels and patterns for describing the mental functioning of a child (for example) who is 4 years old compared to one who is 14 years old. Thus, Adolescent section (age 11–18) will be separated from the Child section (4–10),

Regarding the Special Section on Infancy and Early Childhood (IEC) Mental Health Disorders, it should be noted that one of the merits of the *PDM* is that it was conceived as a unified system which, while paying specific attention to the various age groups with dedicated sections, emphasizes continuity and an internal coherence from infancy to adulthood. *PDM* is the only extant diagnostic system that has explicitly aimed to contain these diverse sections, moving away from the priority given to the adult by other systems that finish by simplistically adapting their criteria to the preceding ages. This choice arose from psychodynamic theoretical assumptions about the links between early adjustment and later disorders, underscoring the continuity of subjective experience and relational patterns individuals experience over their lifetimes. In fact, following the epigenetic principle of developmental psychology, it is possible to view developmental processes, like any biological process, as the product of genes and environment, previous developmental history, and current challenges posted by growth in the various spheres of development: physiological, neuropsychological, cognitive, social, emotional, and representational (Cicchettti and Cohen, 1995; Sroufe, 1996). In each phase, adjustment assumes a specific form that reflects both the history of the proceeding forms of adaptive organization and the developmental task characteristic of that phase.

There are, however, significant limitations of the IEC-axis in the present *PDM*, most notably the lack of empirical, theoretical, and clinical considerations related to the continuity among the different developmental phases (Speranza and Fortunato, 2012). The *PDM*-2 will underline the aspect of continuity in relation to the specific developmental tasks of different ages and phases, and may include a section on the developmental pathways of homotypic and heterotypic continuity (Costello and Angold, 1995; Costello et al., 2003). Homotypic continuity defines conditions of substantial uniformity of pathological disorders in the course of development to adulthood (e.g., bipolar disorder which, once diagnosed in childhood, tends to remain stable at later ages). Heterotypic continuity, by contrast, manifests itself when different pathological presentations positively correlate when measured at temporally distant moments (Kagan, 1989). That is, to one pathology that appears in childhood there corresponds a different one in adulthood, and continuity is identified in the underlying dynamics, notwithstanding the differences between the respective psychopathological manifestations. Anxiety disorders are examples of heterotypic continuity: a diagnosis of separation anxiety or social phobia in childhood, for instance, may correspond to different types of diagnoses at later ages, such as depressive disorder, social phobia, or panic disorder (Costello et al., 2003).

In addition, there may be a specific section of the *PDM*-2 dedicated to the assessment of the quality of primary relationships (between child and caregiver), which incorporates the theoretical, clinical, and empirical contributions of infant research and attachment theory (see Cassidy and Shaver, 2008). The acquisitions that accompany child development certainly broaden the characteristics of relationships that children build with their caregivers; nevertheless, the dimension of attachment helps illuminate two crucial aspects in the diagnostic assessment of the child; the sense of security (which may be observed initially in the attachment relationship and assessed progressively through representational measurements of the internal working

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models), and the quality of affect regulation (Speranza and Fortunato, 2012). By including this perspective, *PDM*-2 will allow better evaluation of family systems and their relational patterns.

New Additions

A number of additions will introduce some clinician-friendly tools derived from *PDM* axes, replacing the original *PDM*'s lengthy section on Conceptual and Research Foundations of a Psychodynamically Based Classification System for Mental Health Disorders. These tools will include the Psychodiagnostic Chart-2 (Gordon and Bornstein, 2012; Gordon and Stoffey, 2014) and the Psychodynamic Diagnostic Prototypes (Gazzillo et al., 2010), As Bornstein (2011) noted, in contrast to the *DSM* model wherein assessment data sometimes (but not always) play a supporting role in refining and corroborating diagnoses, in the *PDM* psychological assessment data play a central role in the diagnostic process, because they are the only measures designed to quantify the underlying psychodynamic factors that are central to *PDM* symptom and syndrome descriptions.

Finally, an important change in the incoming new version of the manual—one not included in other widely used diagnostic systems—is the inclusion of a specific section tentatively entitled, "Mental Health Challenges and Disorders of the Elderly" (McWilliams, 2011b; Cafforio, Brusadelli, and Francavilla, 2012). There also will be a special section tentatively entitled, "Case illustrations and *PDM*-2 Profiles," which will help the reader to have a better and deeper understanding of the manual's contents.

CONCLUDING THOUGHTS

Although work on the *PDM*-2 is well underway, it is important to keep in mind that it is still a work in progress; the final product will evolve as work groups debate possible changes, and data regarding the strengths and limitations of the first edition of the manual continue to accumulate. Whatever form the *PDM*-2 ultimately takes, it will represent an important counterweight to the symptom focused emphasis of *DSM*-5 and *ICD*-10, providing a more nuanced, patient-centered framework for conceptualizing normal and pathological functioning.

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