Every individual with psychological difficulties, whether suffering from a major symptom disorder such as depression or experiencing serious difficulties with self and relationship functioning, has a unique personality organization. The nature of the personality organization is most likely to influence all forms of therapeutic intervention, whether it is through medication compliance or other aspects (i.e., therapeutic alliance) of a psychotherapeutic process. This clinical reality ensures that the Psychodynamic Diagnostic Manual (PDM) is a conceptually important and clinically useful addition to the Diagnostic and Statistical Manual of Mental Disorders (DSM), as it provides the clinician with the structure and tools to assess personality and personality functioning to a greater depth than the DSM. DSM–III (American Psychiatric Association, 1980) made it clear that it was a diagnostic manual and that it was not intended to be sufficient for case formulation and treatment planning, and the DSM successors have done no better.

As Robert Michels (1984, p. xiii) stated some time ago, “The easiest way to practice psychiatry is to view all patients and problems as basically the same, and to apply one standard therapy or mix of therapies for their treatment.” Michels goes on to say that this is a flawed approach, as we “have progressed to the point where we can recognize and describe differences among patients, their disorders, and the problems they bring us” (p. xiii), and we have an array of treatments to utilize. The PDM potentially sits at the crossroads of matching each unique individual with treatments tailored to that individual. It is difficult to see how psychodynamic treatments can move forward without this approach.

The first edition of the PDM has a track record, and the committee is now preparing a revision based on prior experiences with the first edition and advances in the field. Lingiardi and McWilliams (2014) and their colleagues detail the positive public response to the PDM and describe impressive initial empirical efforts at issues of reliability and validity. I am a friendly reviewer and commentator, as I have contributed to the empirical assessment of personality pathology (Clarkin, Caligor, Stern, & Kernberg, 2004; Lenzenweger, McClough,
Clarkin, & Kernberg, 2012) and the use of psychodynamic object relations theory to treat patients with borderline personality disorder (Clarkin, Yeomans, & Kernberg, 2006). Although I am in basic agreement with the aims and goals of the PDM, I attempt in this commentary to make some comments that might enhance the effort in the future.

Lingiardi and McWilliams base the rationale for the PDM on the shortcomings of the DSM system. Indeed, the limitations of the DSM system are real and have been discussed extensively. However, before rushing to a sense of triumph regarding the PDM over the limited DSM, one should consider that any alternative diagnostic system faces the same issues and potential limitations of the DSM. After all, any diagnostic schema or system must address certain key issues. The issues that I will focus on include (a) theoretical model guiding assessment, (b) targets of assessment, and (c) reliable methods to obtain assessment information.

Theoretical Model Guiding Assessment

With hindsight, it is astonishing that the DSM system dating from DSM–III (American Psychiatric Association, 1980) to the present has not had a theory or model of personality functioning and personality dysfunction, to guide the taxonomy, assessment, and diagnosis of the personality disorders. DSM–III was atheoretical and used specific criteria to diagnose personality disorder types. Gunderson (Gunderson & Kolb, 1978), who devised the criteria for borderline personality disorder to distinguish it from schizophrenia, provided a model for this way of thinking. His criteria were to become the basis of the DSM–III diagnosis of BPD. At the same time, Kernberg (1975) was conceptualizing borderline phenomena in terms of levels of personality organization. Because DSM–III was “atheoretical,” the Gunderson criteria were adopted in DSM–III.

The use of a set of criteria for each of 10 supposedly discrete personality disorders has led to the problems that prompted a new approach to the personality disorders in DSM-5 (American Psychiatric Association, 2013). The heterogeneity among individuals within one personality disorder diagnosis and the diagnosis of multiple personality disorders for individual patients brought many to question the basis of the whole system. Two approaches to these difficulties emerged in the work group of the DSM-5: an attempt to articulate the core dysfunction central to and common across all the personality types, and the introduction of a dimensional trait system to capture the complexity of personality pathology (DSM-5, section III). Within these two elements, a certain amount of theory is being introduced.

As to the central dysfunction across the personality disorder types, a subset of the work group members (Bender, Morey, & Skodol, 2011) pointed out that many theories of personality dysfunction focus on difficulties in self and other functioning. This realization was far from new (see e.g., Kernberg, 1984), but what was new was the introduction of the theoretical positions even in a small way into the diagnostic system. The second approach to theory was the position by a number of individuals in the work group that argued for dimensional traits to describe patients suspected of personality disorder.

What does psychoanalytic theory bring to the understanding of the whole person, and how can that central organizing theory contribute to the organization of the PDM? It is important to understand more specifically how psychodynamic theory is being used to inform the gap between the patients’ description and experience of their symptoms–functioning and the psychodynamic clinician’s conception of the patients’ strengths–pathology, which is then linked to differentiated treatment. The three dominant themes in psychodynamic theories of personality organization are attachment theory (Fonagy, 2001), object relations theory (Kernberg & Caligor, 2005), and interpersonal theory (Pincus, 2005). (I am sure many would
disagree with me here and add their own favorite.) These orientations place an emphasis on the quality of the connection between individuals and the internal representations of self and others (e.g., dominant object relations, internal working models, personality signature). Each of these orientations has supporting research on the pathology, and they have stimulated and informed treatments focused on their respective foci (Bateman & Fonagy, 2004; Cain & Pincus, in press; Clarkin, Yeomans, & Kemberg, 2006). These concepts are captured in the PDM diagnostic process but will probably come into sharper focus in the PDM-2.

Target of Assessment: Assessment of the Whole Person

The stated intent of the PDM is to assist the clinician in arriving at a description understanding of the whole person. This is an ambitious goal indeed, and one wonders whether a clinician interviewing a person in an office under specific conditions (i.e., a person seeking help from an expert) can arrive at such a coherent and in-depth picture. Arriving at a complex and somewhat complete picture of another individual takes time. Evaluating and understanding the whole person is more of an ideal than a reality. The way the patient behaves, thinks, and reports in an evaluation with a relative stranger may be quite different than how he or she behaves in other circumstances. Nevertheless, the goal of seeing the person in his or her complexity and conceptually placing all symptoms in this context is a valid and therapeutically useful one.

This goal of arriving at an understanding of the whole person is concretized in the PDM in three major areas of evaluation: level of personality organization and dominant personality style–disorder, level of overall mental functioning, and symptom constellations. Overall level of mental functioning is captured in 12 capacities: attention, regulation, and learning; affective range, communication, and understanding; mentalization and reflective functioning; differentiation and integration; relationships and intimacy; quality of internal experience; impulse control and regulation; defensive functioning; adaptation, resiliency, and strengths; self-observation; internal standards and ideals; and meaning and purpose.

The distinctions made in the diagnostic system are only as useful as their contribution to matching treatment decisions, both at the beginning of treatment and as treatment progresses. For the PDM-2 to make the bridge to differentiated treatment planning would be a major progression.

Tools to Aid the PDM Diagnostic Process

Like the DSM-5, Section III, which has developed assessment tools (e.g., a rating scale of self and other functioning and a trait instrument), the PDM group has produced assessment tools to assist the process. This development in both DSM and PDM must reflect some ideas current in the field, concerns about shared methods of assessment that could lead to reliability, the first step to validity.

However, just like DSM-5, the PDM describes a complex taxonomy and areas of assessment without approaching a shared, reliable method of obtaining the information. Lingiardi and McWilliams mention three structured and teachable assessment interviews, including the Structured Interview of Personality Organization (STIPO; Hörz, Clarkin, Stern, & Caligor, 2012). A crucial step will be to show that clinical material gathered in a somewhat structured way with any of these approaches (modified to the task) can yield reliable diagnosis on the PDM.
Benefits of the PDM Effort

The psychoanalytic world is rich with concepts that have variable meaning and connotations to even experts in the analytic jargon and theoretical conceptualizations. One extremely important benefit of the PDM is that it could become the benchmark or standard for the definition and assessment of valued psychoanalytic concepts. We have found in our own experience with the STIPO that its use by candidates in an analytic institute was instrumental in shared meanings between candidates around key concepts (Eve Caligor, personal communication, March 2010).

Another advance fostered by the PDM is the potential emphasis on differential therapeutics; that is, the careful matching of patient pathology to differentiated treatment approaches. This is a major change from the typical psychoanalytic case presentation in which the patient’s dynamics and conflicts are matched with the creativity of the analyst reporter. Taken seriously, the PDM could lead to a clinically relevant, more refined, and possibly researchable matching of patient pathology—strengths to differentiated psychodynamic treatment approaches.

So, what would be the signs that the PDM and its effort succeeded?

- The PDM effort as a process (not just to provide a product) of focused, empirically driven efforts to integrate psychoanalytic theory to methods and foci of assessment and treatment.
- The PDM used as a guide for patient assessment in the analytic training programs, and psychology and psychiatric training programs that are friendly to psychoanalytic thinking.
- Major psychoanalytic journals featuring case reports using the PDM as a diagnostic and treatment guide.
- A demonstration that data gathered on patients can be obtained in a reliable fashion and lead to reliable PDM diagnosis.
- Diagnostic distinctions made by data from the PDM lead to differential treatment decisions by psychotherapists of all theoretical persuasions.

Conclusion

On first reflection about the PDM project, my immediate response was to think that the PDM work group was way too ambitious in its goals. The PDM group is trying to accomplish something that the American Psychiatric Association, with immense financial resources and numerous collaborators, did not totally achieve in DSM-5. Could the PDM work group have started with a more circumscribed goal, such as focus on personality—personality disorder alone, and build on that effort as time went on? However, the goal of the PDM to enrich the diagnostic process is laudable and essential. In addition, the reception of the first PDM as described by Lingiardi and McWilliams has been encouraging. And, going forward, the effort is timely. The DSM-5 effort was stimulated by an enthusiasm for emerging information on the genetics and neurobiology of the mental disorders, with a concomitant emphasis on dimensional measurement rather than categories. However, the direct relevance of genetics and neurobiology to today’s clinical practice is minimal and probably will remain so for some time. At the same time the DSM-5 process was in full gear, the National Institute of Mental Health (Insel & Gogtay, 2014) disavowed diagnostic categories to guide research and has placed total emphasis on domains of dysfunction that extend across the category boundaries. The PDM process (I
emphasize the process rather than just a product) can enliven clinical interest in placing the treatment of all patients in a context in which the clinician is curious about, aware of, and uses the personality strengths of the patient to foster hope, change, and growth.

References


