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The Psychodynamic Diagnostic Manual – 2nd edition (PDM-2)

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For decades many clinicians, especially psychodynamic and humanistic therapists, have resisted thinking about their patients in terms of categorical diagnoses. In the current era, they find themselves having to choose between reluctantly "accepting" the DSM diagnostic labels, "denying" them, or developing alternatives more consistent with the dimensional, inferential, contextual, biopsychosocial diagnostic formulations characteristic of psychoanalytic and humanistic approaches. The Psychodynamic Diagnostic Manual (PDM) (1) reflects an effort to articulate a psychodynamically oriented diagnosis that bridges the gap between clinical complexity and the need for empirical and methodological validity. It has been strongly influenced by a similar effort, the Shedler-Westen Assessment Procedure (SWAP-200) (2,3), on which it has drawn extensively. The second edition of the PDM (PDM-2) (4,5) will be published in 2016 by Guilford Press.

The first edition of the PDM, spearheaded by S. Greenspan with help from N. McWilliams and R. Wallerstein, represented the collaborative efforts of members from five sponsoring organizations: the American Psychoanalytic Association, the International Psychoanalytical Association, the Division of 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. The PDM-2 will be sponsored also by the International Association for Relational Psychoanalysis and Psychotherapy.

The PDM-1 had four major sections: Adult Mental Disorders; Child and Adolescent Mental Health Syndromes; Infant and Early Childhood Disorders; and Conceptual and Empirical Foundations for a Psychodynamically Based Classification System for Mental Health Disorders. Schematically, except when evaluating infants and pre-schoolers (assessed with a specific multiaxial system), clinicians were encouraged to assess the following in all patients: level of personality organization and prevalent personality styles or disorders (Axis P); level of overall mental functioning (Axis M); symptoms and syndromes and the patient's subjective experience of them (Axis S).

The PDM aimed to promote integration between nomothetic understanding and the idiographic knowledge that is useful for individual case formulation and the planning of patient-tailored treatment. In focusing on the full range of mental functioning, it aspired to complement DSM and ICD efforts to catalogue symptoms and syndromes. In the Pocket Guide to the DSM-5 Diagnostic Exam (6), Nussbaum notes: "ICD-10 is focused on public health, whereas the 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" (6, pp. 243-244).

Addressing the discomfort many clinicians have with categorical diagnosis (7), the PDM provided 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" (1, p. 1). The PDM explicitly describes itself as a "taxonomy of people" rather than a "taxonomy of diseases", as an effort to describe "what one is rather than what one has" (1, p. 17). According to Stepansky (8), the exposure of the first edition in the U.S. has been extensive.

In October 2013, the American Psychoanalytic Association noted: "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." (www.apsa.org). It went on to recommend the PDM for this complementary assessment.

In the aftermath of the death of S. Greenspan shortly after the 2006 publication of PDM-1, and the retirement of R. Wallerstein (who died in 2014; the PDM-2 will be

dedicated to both Greenspan and Wallerstein), the new edition required leadership representing both continuity and change, which we have attempted to provide. Several specific Task Forces were organized, each under the leadership of two editors: Adults - P Axis (N. McWilliams and J. Shedler); Adults - M Axis (V. Lingiardi and R. Bornstein); Adults - S Axis (E. Mundo and J. O'Neil); Adolescents (M. Speranza and N. Midgley); Children (N. Malberg and L. Rosenberg); Infancy and Early Childhood (A.M. Speranza and L. Mayes); Elderly (F. Del Corno and D. Plotkin); Tools (S. Waldron, F. Gazzillo and R. Gordon); Case Illustrations and PDM-2 Profiles (F. Del Corno, V. Lingiardi and N. McWilliams). The second edition will thus retain the basic multiaxial structure, but will be characterized by several important changes, including those that follow.

The Adult Personality section will be integrated and revised according to theoretical, clinical and empirical indications, especially those derived from measures such as the SWAP-200 (2,3,9) and its new versions (10,11) and applications (12,13), and from the Psychodynamic Diagnostic Prototypes (14). The section on Levels of Personality Organization will, in light of research since 2006 that indicates the clinical utility of this concept, include a psychotic level of personality organization (15).

In the M Axis, the number of mental functions 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; self-esteem regulation and quality of internal experience; 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 purpose. An assessment procedure with a Likert-style scale will be associated with each mental function.

The S Axis will enhance its integration with the DSM-5 and the ICD-10. The new edition will give a more exhaustive explanation of the rationale for the description of "affective states", "cognitive patterns", "somatic states" and "relationship patterns", and cite related clinical and empirical studies. It will more thoroughly emphasize both the subjective experience of the patient and the likely countertransference of the clinician (16-19).

Because there are significant psychological differences between young children and teenagers, an Adolescent section (age 11-18) will be separated from the Child section (4-10). The Special Section on Infancy and Early Childhood (IEC) will include a discussion of developmental lines and homotypic/heterotypic continuities of early infancy, childhood, adolescent and adult psychopathology, as these have been investigated in both clinical and empirical literatures. The PDM will give better definitions of the quality of primary relationships (child and caregivers), emphasizing the evaluation of family systems and their characteristic relational patterns, including attention to attachment patterns and their possible relationship to psychopathology and normative development.

There will be a section on Mental Health Disorders of the Elderly, absent in the first edition.

The PDM-2 will contain two special sections on Clinician-Friendly Tools (both PDM-2-derived and derived from prior studies) that are intended to help practitioners attain a better understanding of the overall approach embodied in the manual (20,21).

Finally, the PDM-2 will omit the extensive last section on supporting empirical articles, and will instead integrate more systematic references to research, especially as empirical studies inform more operationalized descriptions of the different disorders.

In summary, the PDM aims to detect and describe patients' characteristic mental experiences, thereby increasing the capability of clinicians to relieve the psychological distress of the distinctly individual patients who seek their help. It attempts to restore the connection between deep understanding and treatment, without the requirements of other diagnostic systems that they be useful for demographic studies, billing, institutional record-keeping, syndromal research, and other ancillary uses of diagnostic labels.

Without a counterpoint to the current tendency to focus more and more narrowly on discrete disorder categories, the clinical relationship may be jeopardized and even damaged. Avoiding this hazard is the main reason why the authors of both editions of the PDM have offered this complementary classification system to the mental health community.

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