PDM-2

Psychodynamic Diagnostic Manual, Second Edition

Personality Syndromes in Adults (P Axis)

Why is this important?

The situation

- People's psychological problems are often complexly intertwined with their personality and need to be appreciated and understood in the context of the whole person.
- Personality includes non-observable internal processes, such as motives, fantasies, patterns of thought and feeling, ways of experiencing self and others, ways of coping and defending, etc.
- Other diagnostic systems (e.g. DSM, ICD) put symptoms and attributes that people have in common into the same diagnostic compartments, without imputations of underlying mental processes or meaning.

The problem

- DSM/ICD systems focus on disorder constructs and observable behaviors or symptoms, instead of meaning and internal experience, categorizing people in arbitrary compartments without taking into account the whole person.
- The same symptoms may have different meanings for different people, warranting different conceptualizations and approaches.
- Clinicians may emphasize the treatment of "symptoms," "conditions," or "disorders" rather than the treatment of human beings in their whole complexity, resulting in short-lived results and high remission rates.

The solution

- The PDM-2 is geared toward individualized case formulation and treatment planning, for therapies that attempt to address the full range and depth of a person's psychological experience.
- The P-Axis (Personality) helps clinicians deepen the understanding of their patients and enhance their effectiveness, rather than merely describing "disorder" labels based on observable symptoms and behaviors.
- Understanding a person's overall psychological makeup and developmental trajectory allows for meaningful growth and fundamental shifts; this may be more important than classifying symptoms or mastering specific techniques.

About the PDM-2

Guiding principles

- In order to understand symptoms, we must know something about the person who hosts them; the PDM-2 aspires to be a "taxonomy of people" rather than a "taxonomy of disorders."
- Mental health is more than the absence of symptoms; the PDM-2 focuses on the full range of *mental functioning*, based on outcome research, clinical observation, and theoretical development.
- Diagnostic categories are not described as a compilation of symptoms, but focus on the *internal experience* of those conditions.
- PDM-2 attempts to capture the gestalt of human complexity by using a multidimensional approach.

Structure of the PDM-2

- Adulthood
- Adolescence
- Childhood
- Later life
- Infancy and early childhood

P Axis: Personality syndromes, organized around personality organization and personality style.

M Axis: Mental functioning along specific skills involved in psychological health and pathology.

S Axis: Subjective experience associated to DSM/ICD categories of symptom patterns.

Mental health and developmental disorders

- Assessment and clinical illustrations

The scope of this document is limited to the P Axis in Adulthood

The P Axis

Personality is more about who one is than about what disorder one has.

The P-Axis is defined along two principles

- Personality is defined by stable ways of thinking, feeling, behaving, and relating.
  - "Stability" refers to underlying psychological patterns and organizing themes, rather than specific behaviors.
- We all have a personality organization and a personality style.
- The PDM-2 does *not* focus on personality disorders – there is no hard line between "style" and "disorder."

1 Personality organization

- Organization continuum with 4 levels, from psychotic to healthy.
- Spectrum describes severity of personality disfunction.
- Levels of severity don't have clearly demarcated boundaries.
- Situational factors and trauma may cause organization fluidity.

2 Personality syndromes

- 12 styles/syndromes representing core psychological themes and organizing structure.
- Do not intrinsically imply health or pathology.
- They are **not** labels to which people do or do not "belong".
- People show mixes of personality styles, with some predominant over others.
- Some styles (e.g., depressive, narcissistic) are found across all levels of organization, others (e.g., psychopathic, sadistic) in most severe levels.

In the PDM-2, "Borderline" is both a personality style (due to extensive literature on DSM's construct) *and* a level of personality organization (consistent with the psychoanalytic historical perspective).

Personality organization

The PDM-2 defines four levels of functioning organized in a continuum

Healthy — **Neurotic** — **Borderline** — **Psychotic**

Level description

- May favor certain ways of coping, but does not display rigid defenses.
- Relative flexibility to accommodate to challenging realities

- Relatively rigid and narrow range of defenses and coping strategies.
- Suffering tends to be restricted to a specific domain (e.g., rejection, control).
- Often experience problems as inner conflict, with some insight on difficulties.
- Maladaptive defensive patterns may be limited to one area (e.g., relationship with authority vs. problems in all relationships).

- Difficulties with affect and impulse regulation.
- Vulnerable to overwhelming affect and maladaptive regulation attempts.
- Absence of "mature" defenses, commonly relying on splitting, projective identification, denial, and severe dissociation.
- Defenses used to distort reality globally.
- Lack of self and object constancy.
- People diagnosable with a DSM personality disorder generally operate at this level.

- Identity diffusion, poor differentiation between self- and other-representations, poor discrimination between fantasy and external reality reliance on primitive defenses, and severe deficits in reality testing.
- "Fixed ideas" are so absolute to approach delusional proportions, even in the absence of hallucinations or frank delusions.

Clinical Implications

- Greater emphasis on self-understanding and insight.
- Capacity to form therapeutic alliance improves prognosis regardless of approach.
- Transfer and countertransference tend to be milder and less dysregulating.

- Clear boundaries, limits and structure are needed, usually with a relatively active clinician stance.
- Deviations from therapy frame may lead to disorganizing regression.
- Therapist needs to tolerate strong transference and countertransference.
- Paying attention to the therapeutic relationship is crucial.

- Clinicians need to be particularly respectful, patient, conversational and down-to-earth.
- Mix of supportive and exploratory approaches.
- Identify and build up patient's strengths

Organization level is based on assessment of multiple capacities

- Regulation, attention, and learning
- Affective range, communication, and understanding
- Mentalization and reflective functioning
- Differentiation and integrity (identity)
- Relationships and intimacy
- Self-esteem regulation and quality of internal experience
- Impulse control and regulation
- Defensive functioning
- Adaptation, resiliency, and strength
- Self-observation (psychological mindedness)
- Construct and use internal standards and ideals
- Meaning and purpose

Each domain is addressed in the M Axis (Mental functioning) section of the PDM-2

Personality syndromes

These are not distinct categories to which a patient does or does not "belong." Rather, the descriptions are best understood as prototypes that an individual may approximate to a greater or lesser extent.

1 Depressive personalities

- Find little pleasure in life's activities and are vulnerable to painful affect (depression, shame, guilt, inadequacy, loneliness).
- Conflicted about experiencing pleasure, may squelch or inhibit joy, excitement, and pride.
- May be highly self-critical and self-punitive, as defenses for underlying anger and hostility.
- May fear rejection and abandonment, feeling alone in the presence of others.
- Introjective subtype: tendency to blame self for real or imaginary shortcomings or "badness."
- Anaclitic subtype: high sensitivity to loss/rejection; feels empty, lonely, incomplete, and helpless.
- *Hypomaniac* personality might be a defense against depressive affect.

2 Dependent personalities

- Define themselves predominantly in relation to others, and often seek security in interpersonal relationships through idealization or compliance.
- May feel ineffectual when left to themselves, while others are seen as powerful and effective.
- Psychological symptoms may appear with perceived issues in primary attachment relationship.
- *Passive-aggressive variant:* characterized by hostile dependency, based on anger and resentment.
- *Counterdependent variant:* inflexible independence masks dependence longing (via reaction formation).

3 Anxious-avoidant and phobic personalities

- Anxiety is the psychologically organizing experience.
- Anxieties may include separation, castration, moral, annihilation, or disintegration anxiety (sometimes all of them).
- Generally aware of their anxiety but may have difficulties in recognizing their feelings.
- May first appear to be hysterical or obsessional, depending on how they deal with fear.
- Can be shy and reserved, feel inferior, inadequate, indecisive, or inhibited.
- Results from affective dysregulation and failure to develop coping strategies that mitigate normal developmental fears.
- Found across all levels of functioning.

4 Obsessive-compulsive personalities

- Emotionally constricted and regimented, concerned with rules, procedures, order, and logic.
- See emotions as irrelevant or immature, to defend against their own threatening feelings and desires.
- Central resistance is to feel (their own impulses and urges) "out of control."
- Character tends to be harshly (self)critical, punitive, rigid, and perfectionistic.
- Seem to identify with controlling care givers who expected them to be "more grown-up" than possible.
- Some exhibit obsessional features (e.g., chronically "in their heads") with little compulsivity (e.g., chronically "doing and undoing") and vice versa.

5 Schizoid personalities

- Feel in danger of being engulfed, enmeshed, intruded upon, controlled, traumatized by others.
- May appear detached or socially appropriate, but attending mostly to their inner world (including fantasy).
- Detachment can be defense against intense emotions and aimed at setting tolerable distance from others.
- Tend to be more comfortable by themselves, yet feel yearning and fantasies for closeness and intimacy.
- Not only the result of developmental deficits, but also of the conflict between closeness and distance needs.
- May experience deficits making sense of own and other people's behaviors.

6 Somatizing personalities

- May present hypochondriacal preoccupations, stress-related physical illness, and bodily symptoms.
- Problems and painful experiences are chronically expressed in bodily difficulties.
- Frequently unable to express emotions verbally.
- Sense of self tends to be fragile, feeling unentitled, powerless, and unheard by others.
- May feel they need to be ill as a condition for being cared for.
- Hard to differentiate personality style from psychological consequences of chronic physical discomfort.

7 Hysteric-histrionic personalities

- Preoccupied with gender, sexuality, and power; unconsciously see their own sex as weak, defective, or inferior (vs a powerful, exciting, frightening "other").
- May come across as flamboyant, attention-seeking, and seductive, but some as naïve and inhibited.
- Tend to seek power via seductiveness, as a defense against feelings of weakness, fearfulness, or shame.
- May compete for attention in the realm of sexuality and gender that reassures them of their value.
- Their own feelings and desires evoke anxiety and dread; self-dramatizing may play a defensive role.

8 Narcissistic personalities

- Preoccupied with grandiose fantasies, spend much time comparing their status to others.
- Have an internal sense of *empirical* and meaning-lessness, requiring external affirmations of value.
- If received, they behave with grandiosity and arrogance. If not, they feel depressed, shy, ashamed, envious, avoidant, and "fragile."
- Tend to defend wounded self-esteem through idealizing and degrading others.
- Insecure attachment stemming from confusing/unpredictable early relationships.
- Found across all levels of functioning.
- Range from relatively adjusted (with some difficulty for intimacy) to suffering from identity diffusion and lacking inner-directed morality.

9 Paranoid personalities

- Hold unbearable ideas, affects, and impulses that are disavowed and attributed to others, and then viewed with fear or outrage.
- Projected feelings may include hostility, dependency, and attraction, along with hatred, envy, shame, contempt, and disgust.
- Complex subjective experience is organized around terror and trust, as their histories tend to be marked by felt shame and humiliation.
- Personality is defensively organized, as they expect to be mistreated.
- May have trouble conceiving that thoughts are different from actions.
- May experience conflict between panic of being alone and anxious in relationships.

10 Psychopathic personalities

- Oriented to seeking power for its own sake, taking pleasure in manipulating others.
- Act and think in self-referential and egoistic ways, lacking empathy, remorse, and a moral center of gravity.
- May read others' emotions accurately, but their affective connection to others is minimal: may lose interest in people not seen as useful.
- Experience impoverished emotional life, unable to describe own emotions with depth or nuance.
- Not necessarily "antisocial": they can be charming, charismatic, and pursue their agendas with approval and admiration.
- More commonly found in borderline and psychotic levels of functioning.

11 Sadistic personalities

- May experience internal deadness or affective sterility, relieved by inflicting pain and humiliation (in fantasy and/or in reality)
- Overriding motivation involves controlling, subjugating, and forcing pain and humiliation.
- Domination and control pursued with emotional detachment or guiltless enthusiasm.
- Detachment has the effect (and perhaps the intention) of dehumanizing the other.
- Abusing others or having sadistic sexual fantasies or behaviors does not imply characterological sadism.
- More commonly found in borderline and psychotic levels of functioning.

12 Borderline personalities

- Characterized by chronic, long-term difficulties tolerating and regulating affect.
- Emotions easily spiral out of control and become extremely intense, compromising capacity to adapt and function.
- Difficulty mentalizing and experiencing continuity of self and others; attachment figures are objects of fear and safety.
- Need others to regulate, but in close relationships they feel controlled and engulfed, as well as afraid of rejection and abandonment.
- Tend to feel an inner void, using self-harm to soothe or enliven themselves.
- Rely on splitting, projective identification, and other *cruder* defenses.

Source for all content:

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