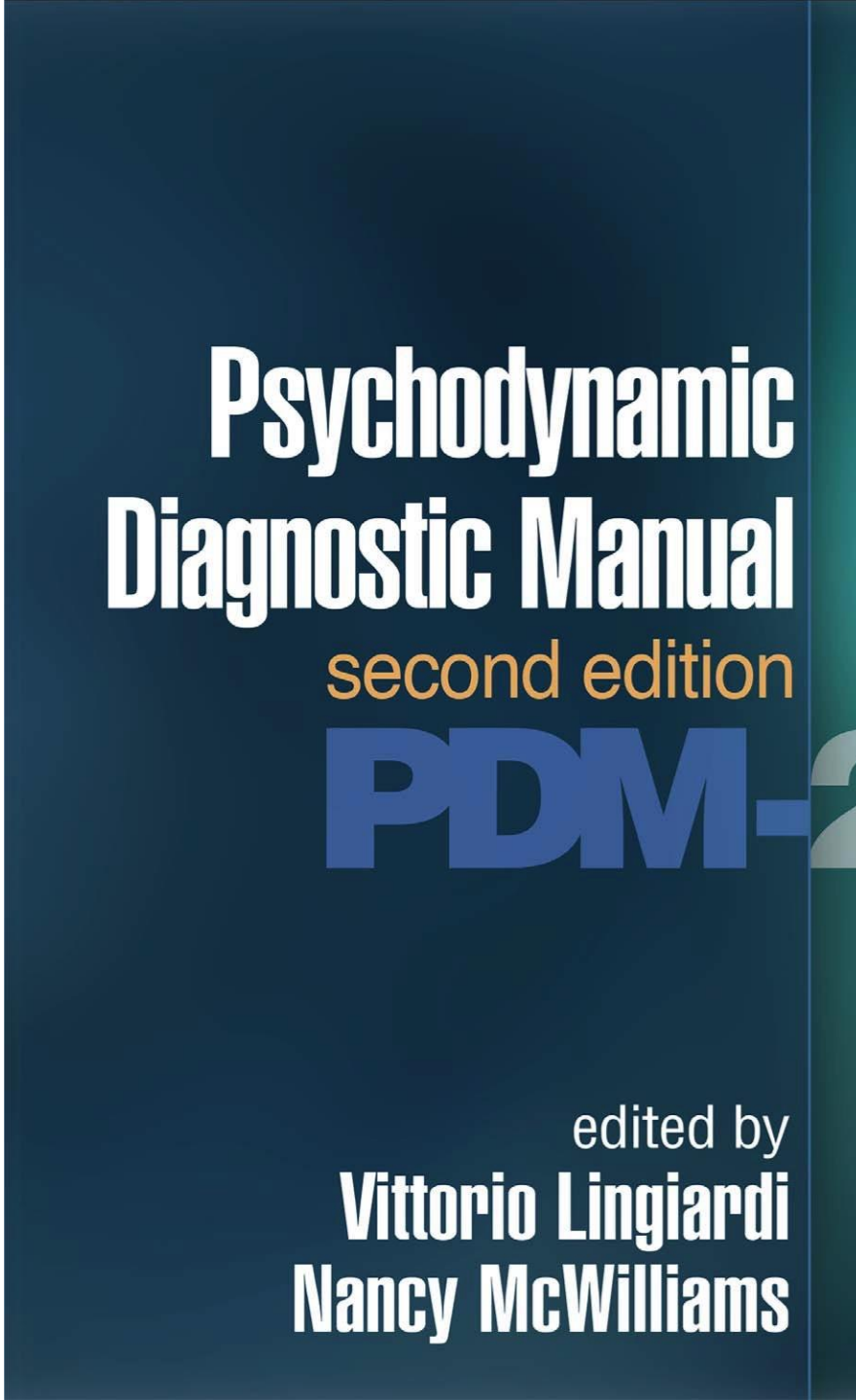
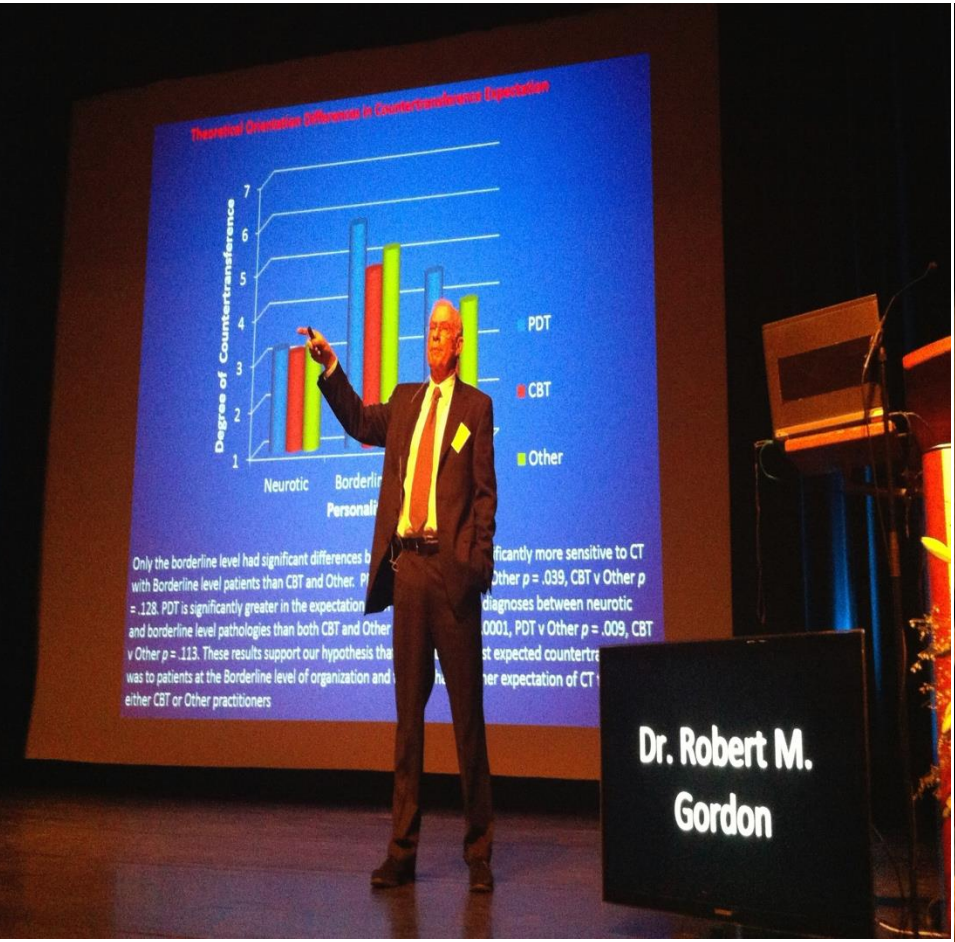
Introducing the Psychodynamic Diagnostic Manual-2

Robert M. Gordon, Ph.D.

ABPP in Clinical Psychology and in Psychoanalysis



2007-2014 Collecting PDM Data from Over 600 Practitioners



My Publications on the PDM and PDC 2007-2013

- Gordon, R. M. (2007, spring). The Powerful Combination of the MMPI-2 and the Psychodynamic Diagnostic Manual, *Independent Practitioner*, 84–85.
- Gordon, R. M. (2007, November/December). PDM valuable in identifying high-risk patients *National Psychologist, 16*, (6), November/December, pp. 4.
- Gordon, R.M. (2008). Early reactions to the PDM by Psychodynamic, CBT and Other psychologists. *Psychologist-Psychoanalyst, XXVI,* 1, Winter, p.13.
- Gordon, R.M. (2009). Reactions to the Psychodynamic Diagnostic Manual (PDM) by Psychodynamic, CBT and Other Non- Psychodynamic Psychologists. *Issues in Psychoanalytic Psychology,31,* 1,55-62.
- Gordon, R.M. (2010). The Psychodynamic Diagnostic Manual (PDM). In I. Weiner and E. Craighead, (Eds.) *Corsini's Encyclopedia of Psychology (4th ed., volume 3,* 1312-1315), Hoboken, NJ: John Wiley and Sons.
- Gordon, R.M. (2012). A Psychological Alternative to the Medically Based DSM and ICD, *The National Psychologist May/June, vol. 21, 3,* p. 19.
- Bornstein, R. F. and Gordon, R. M. (2012). What Do Practitioners Want in a Diagnostic Taxonomy? Comparing the PDM with DSM and ICD. *Division/Review: A Quarterly Psychoanalytic Forum*, Fall, 6, 35.
- Gordon, R.M. and Stoffey, R.W. and Perkins, B.L. (2013) Comparing the Sensitivity of the MMPI-2 Clinical Scales and the MMPI-RC Scales to Clients Rated as Psychotic, Borderline or Neurotic on the Psychodiagnostic Chart, *Psychology: Special issue on Criminal Investigative Psychology, 4, 9A,* 12-16. doi: 10.4236/psych.2013.49A1003.

My Publications on the PDM and PDC 2014-2016

- Gordon, R.M. and Stoffey, R.W. (2014). Operationalizing the Psychodynamic Diagnostic Manual: a Preliminary Study of the Psychodiagnostic Chart (PDC), *Bulletin of the Menninger Clinic,78,* 1, 1-15.
- Gazzillo, F., Lingiardi, V., Del Corno, F., Genova, F., Bornstein, R.F., Gordon, R.M., McWilliams, N. (2014). Clinicians' Emotional Responses and PDM P Axis Personality Disorders: A Clinically Relevant Empirical Investigation. *Psychotherapy, Special Section: Personality and Psychotherapy, 52*(2),238-246.
- Lingiardi, V., McWilliams, N., Bornstein, R.F., Gazzillo, F. and Gordon, R.M. (2015) The Psychodynamic Diagnostic Manual Version 2 (PDM-2): Assessing Patients for Improved Clinical Practice and Research, *Psychoanalytic Psychology, 32*(1), 94-115.
- Huprich, S., Lingiardi, V., McWilliams, N., Bornstein, R., Gazzillo, F., and Gordon, R.M., (2015). The *Psychodynamic Diagnostic Manual (PDM)* and the *PDM-2:* Opportunities to Significantly Affect the Profession. *Psychoanalytic Inquiry,* 35: 60-73.
- Gordon, R.M., Gazzillo, F., Blake, A., Bornstein, R.F., Etzi, J., Lingiardi, V., McWilliams, N., Rothery, C. and Tasso, A.F. (2016) The Relationship Between Theoretical Orientation and Countertransference Awareness: Implications for Ethical Dilemmas and Risk Management, *Clinical Psychology & Psychotherapy, 23, 3,*236-245; (online published 2015, DOI: 10.1002/cpp.1951)
- Spektor, V., Luu, L. & Gordon, R.M. (2015) The Relationship between Theoretical Orientation and Accuracy of Countertransference Expectations., *Journal of the American Psychoanalytic Association*, *63*(4), NP28-NP32.
- Gordon, R.M., Blake, A., Bornstein, R.F., Gazzillo, F., Etzi, J., Lingiardi, V., McWilliams, N., Rothery, C. and Tasso, A.F. (2016) What do practitioners consider the most helpful personality taxa in understanding their patients*? Division/Review: A Quarterly Psychoanalytic Forum,* 14.

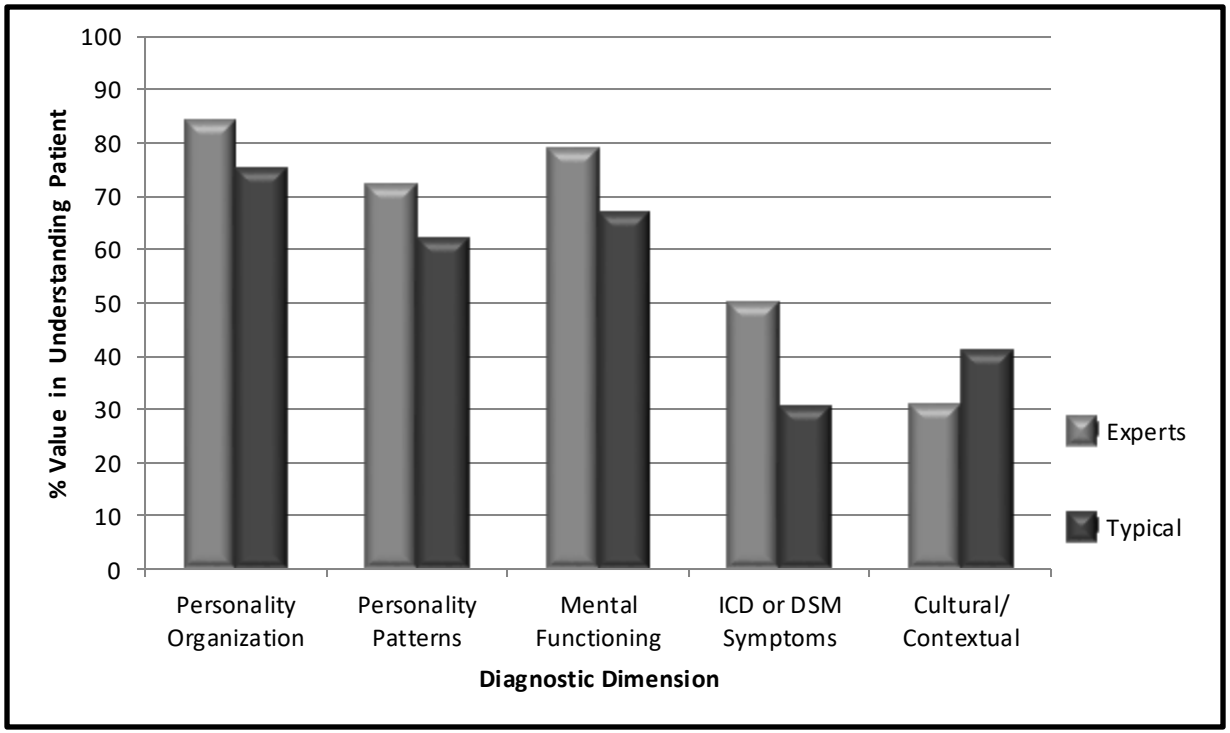
My Publications on the PDM-2 and PDC-2 2017

- Gordon, R.M. (2017). A Concurrent Validity Study of the PDM-2 Personality Syndromes. *Current Psychology,*

- Gordon, R.M. & Bornstein, R.F. (2017). Construct Validity of the Psychodiagnostic Chart: A Transdiagnostic Measure of Personality Organization, Personality Syndromes, Mental Functioning, and Symptomatology. *Psychoanalytic Psychology,*

- Gordon, R.M., Blake, A., Etzi, J., Rothery, C., & Tasso, A.F. (2017). Do Practitioners Find a Psychodynamic Taxonomy Useful? *J Psychol Clin Psychiatry 7*(5): 00452. DOI: 10.15406/jpcpy.2017.07.00452

What do practitioners consider the most helpful personality taxa in understanding their patients?

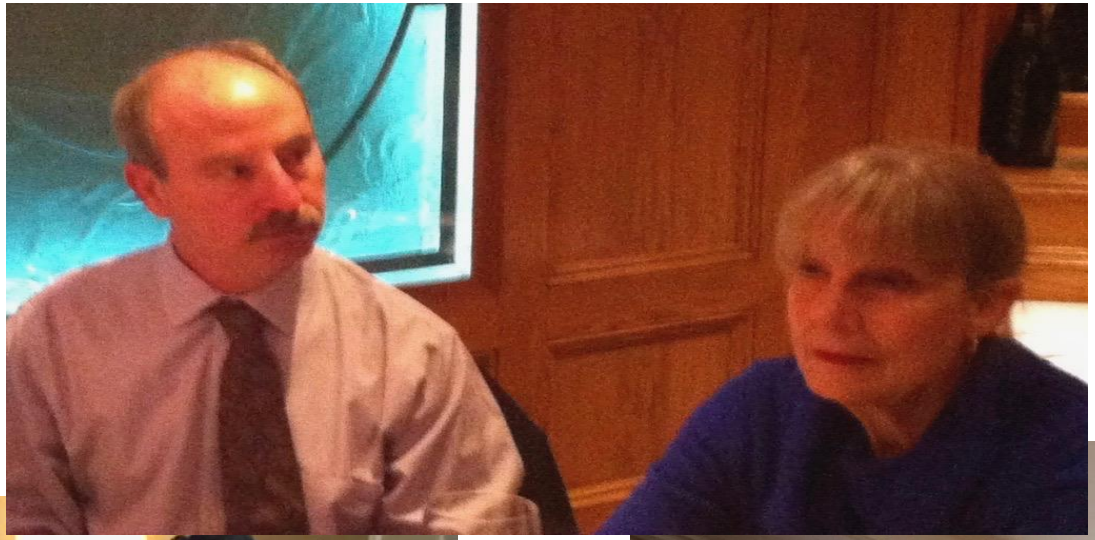


Expert diagnosticians (*N*=61, 80% had doctorates, 44% Psychodynamic, 15% CBT) and "typical" mental health practitioners (*N*=438, 46% had doctorates, 26% Psychodynamic, 33% CBT) rated each diagnostic dimension as to how helpful (1= not at all helpful, 7= very helpful) it was in understanding a patient that they diagnosed using the PDP and PDC. Scores represent the percent of practitioners who rated the dimensions in the 5-7 range (i.e. "helpful – very helpful"). All differences between the diagnostic dimensions for the current sample were statistically significant.

Gordon, R.M., Blake, A., Bornstein, R.F., Gazzillo, F., Etzi, J., Lingiardi, V., McWilliams, N., Rothery, C. and Tasso, A.F. (2016) *Division/Review: A Quarterly Psychoanalytic Forum,* 15, 70

2012-2014 The Initial PDM-2 Work Group

Vittorio Lingiardi, Nancy McWilliams, Robert Bornstein, Francesco Gazzillio and Robert Gordon



Changes in PDM-2

- Publication by Guilford Press. Implications: Better marketing, better accessibility
- Separation of Child and Adolescent sections
- Addition of Later Life section
- Psychotic level of Personality Organization
- Chapter on assessment instruments
- Addition of operationalized PDM-2 tools (PDC-2)
- Omission of separate section summarizing research
- Still using the term “Axis”

PDM-2 Sponsoring Organizations

American Academy of Psychoanalysis and Dynamic Psychiatry

American Association for Psychoanalysis in Clinical Social Work

American Psychoanalytic Association

Association Européenne de Psychopathologie de l'Enfant et de l'Adolescent

Confederation of Independent Psychoanalytic Societies

Division of Psychoanalysis (39), American Psychological Association

International Association for Relational Psychoanalysis & Psychotherapy

International Psychoanalytical Association

Chapter Editors

Robert F. Bornstein, PhD, Derner Institute of Advanced Psychological Studies, Adelphi University, Garden City, New York

Franco Del Corno, MPhyl, DPsych, President, Society for Psychotherapy Research—Italy Area Group, Italy

Francesco Gazzillo, PhD, Department of Dynamic and Clinical Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome, Rome, Italy

Robert M. Gordon, PhD, ABPP, Institute for Advanced Psychological Training, Allentown, Pennsylvania

Vittorio Lingiardi, MD, Department of Dynamic and Clinical Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome, Rome, Italy

Norka Malberg, PsyD, Yale Child Study Center, New Haven, Connecticut

Johanna C. Malone, PhD, Department of Psychiatry, Massachusetts General Hospital and Harvard Medical School, Cambridge, Massachusetts

Linda Mayes, MD, Yale Child Study Center and Office of the Dean, Yale School of Medicine, New Haven, Connecticut

Nancy McWilliams, PhD, Graduate School of Applied and Professional Psychology, Rutgers, The State University of New Jersey, Piscataway, New Jersey

Nick Midgley, PhD, Research Department of Clinical Education and Health Psychology, University College London, London, United Kingdom

Emanuela Mundo, MD, Residency Program in Clinical Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome, Rome, Italy

John Allison O'Neil, MD, Department of Psychiatry, McGill University and St. Mary's Hospital, Montréal, Québec, Canada

Daniel Plotkin, MD, Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine, University of California at Los Angeles, Los Angeles, California

Larry Rosenberg, PhD, Child Guidance Center of Southern Connecticut, Stamford, Connecticut

Jonathan Shedler, PhD, University of Colorado Denver School of Medicine, Denver, Colorado

Anna Maria Speranza, PhD, Department of Dynamic and Clinical Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome, Rome, Italy

Mario Speranza, MD, PhD, Department of Psychiatry, Versailles General Hospital, and Faculty of Medicine and Health Sciences, University of Versailles Saint Quentin en Yvelines, Versailles, France

Sherwood Waldron, MD, Psychoanalytic Research Consortium, New York, New York

Psychodynamic Diagnostic Manual-2 (PDM–2)

1 – Adulthood

Personality Syndromes- **P Axis**

Section Editors: Nancy McWilliams, Jonathan Shedler

Profile of Mental Functioning - **M Axis**

Section Editors: Vittorio Lingiardi, Robert Bornstein

Symptom Patterns: The Subjective Experience - **S Axis**

Section Editors: Emanuela Mundo, John O'Neil

2 –Adolescence

Profile of Mental Functioning - **MA Axis**

Section Editors: Mario Speranza, Nick Midgley

Emerging Personality Patterns and Syndromes- **PA Axis**

Section Editors: Norka Malberg, Johanna Malone

Symptom Patterns: The Subjective Experience - **SA Axis**

Section Editor: Mario Speranza

3 – Childhood

Profile of Mental Functioning - **MC Axis**

Section Editors: Norka Malberg, Larry Rosenberg

Emerging Personality Patterns and Difficulties - **PC Axis**

Section Editors: Norka Malberg, Larry Rosenberg, Johanna Malone

Symptom Patterns: The Subjective Experience - **SC Axis**

Section Editors: Norka Malberg, Larry Rosenberg

4 – Infancy and Early Childhood

Mental Health and Developmental Disorders in Infancy and Early Childhood (0-3)

Section Editors: Anna Maria Speranza, Linda Mayes

5 – Later Life

Profile of Mental Functioning **- ME Axis**

Section Editors: Franco Del Corno, Daniel Plotkin

Personality Patterns and Syndromes **- PE Axis**

Section Editors: Franco Del Corno, Daniel Plotkin

Symptom Patterns: The Subjective Experience **- SE Axis**

Section Editors: Franco Del Corno, Daniel Plotkin

6 – **Assessment Within the PDM-2 Framework**

Section Editors: , Sherwood Waldron, Robert M. Gordon, Francesco Gazzillo

7 – Case Illustrations and PDM-2 Profiles

Section Editors: Franco Del Corno, Vittorio Lingiardi, Nancy McWilliams

8- Appendex. Psychodiagnostic Charts (PDCs)

Psychodiagnostic Chart-2

- The PDC has good reliability and validity (Gordon & Stoffey, 2014; Gordon & Bornstein, 2017). It guides the practitioner through a PDM-2 formulation using all the axises. It is only three pages long and user friendly. It provides a "big picture" summary of the PDM-2 Adult Axis and integrates it with the ICD or DSM.

- **It is FREE!** Search "Psychodiagnostic Chart-2"

The Relationship Between Theoretical Orientation and Countertransference Awareness: Implications for Ethical Dilemmas and Risk Management

Gordon, R.M., Gazzillo, F., Blake, A., Bornstein, R.F., Etzi, J., Lingiardi, V., McWilliams, N., Rothery, C. and Tasso, A.F. (2016) The Relationship Between Theoretical Orientation and Countertransference Awareness: Implications for Ethical Dilemmas and Risk Management, *Clinical Psychology & Psychotherapy, 23, 3,*236-245; (online published 2015, DOI: 10.1002/cpp.1951)

The Relationship between Theoretical Orientation and Accuracy of Countertransference Expectations

Valeriya Spektor Lehigh University, Linh Luu Lehigh University, Robert M. Gordon, (2015). Journal of the American Psychoanalytic Association.

	CBT	Behavioral	Family	Humanistic/Exist.	PDT
Neurotic	0.019	-0.084	0.084	0.064	0.047
Borderline	-0.116*	-0.187**	0.041	0.097	0.294**
Psychotic	-0.135**	-0.201**	0.070	0.103*	0.316**

**Note.* Spearman's ρ statistic was used to compute the above correlations. **p* < .05; ***p* < .01 N=411. The correlations for psychodynamic orientation and for CBT orientation were significantly different for expected CT to patients with borderline personality structure, Fisher's Z = 5.99, *p* < .001, and psychotic personality structure, Fisher's Z = 6.61, *p* < .001. Similarly, the correlations between expected CT of the psychodynamic practitioners were significantly different from behavioral practitioners for working with clients of Borderline personality structure, Fisher's Z = 7.03, *p* < .001, and psychotic personality structure, Fisher's Z = 7.58; *p* < .001. There were no significant differences in correlations between CBT and Behavioral practitioners on expected CT to borderline personality clients, Fisher's Z = 1.04; *p* = 0.149, and psychotic personality clients, Fisher's Z = 0.97; *p* = 0.166.

Using the PDC for Treatment Formulation

We asked 497 practitioners (26% Psychodynamic, 33% CBT and 41% Other) to rate their current patient's level of personality organization using the Psychodiagnostic Chart (Gordon & Bornstein, 2012), and then asked to what extent they used clarifications of roles, tasks, boundaries, degree of supportive techniques and their degree of expected countertransference to that patient.

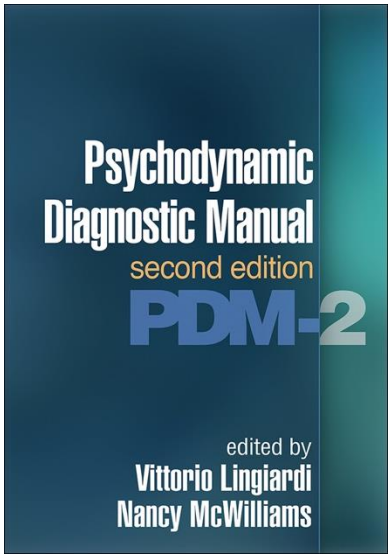
Gordon, R.M., Spektor, V., and Luu,L. (Submitted for publication)

The Relationship Between Clinicians' Attitudes About New Patients' Level of Personality Organization Traits and Use of Clarifications, Boundary Confusion, and Degree of Supportive Treatment

Table 1. Correlations Between Degree of Defensiveness, Identity Diffusion, Object Relations, Reality Testing with Countertransference and Therapeutic Interventions

Personality Organization Components	Clarifying Throughout Tx	Boundary Confusion	Counter-transference	Use of Supportive Tx
Defensiveness	-.24	-.41	-.37	-.35
Identity	-.22	-.39	-.25	-.30
Object Relations	-.25	-.39	-.25	-.27
Reality Testing	-.23	-.37	-.24	-.21

Note: N = 478 for defensiveness, N = 479 for identity, object relations and reality testing. All results are $p < .0001$. The lower the scores in the Personality Organization Components are significantly related to a higher likelihood of expected need to clarify treatment conditions, boundary issues, countertransference reactions and likely use of supportive therapeutic interventions.



Operationalizing the Psychodynamic Diagnostic Manual-2

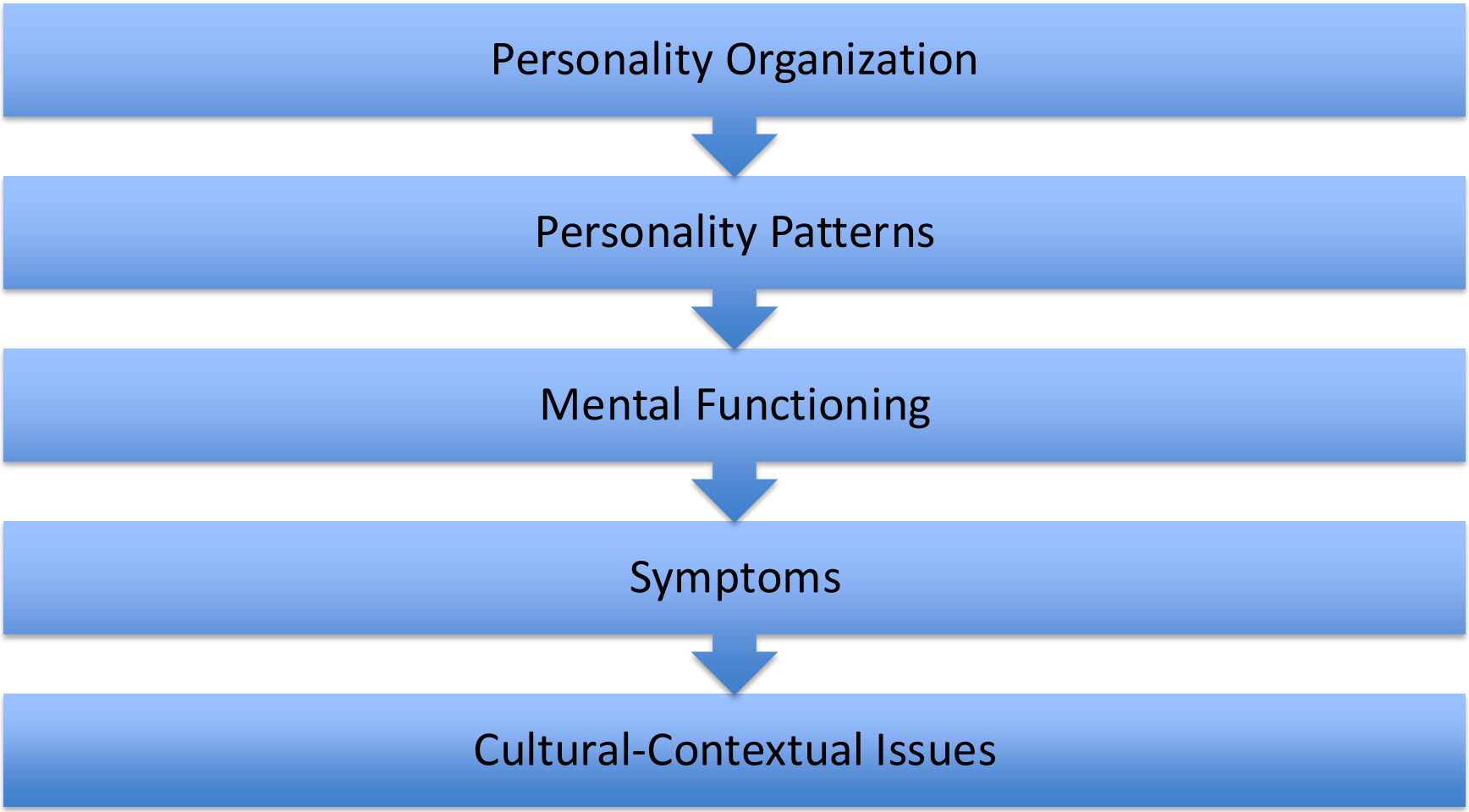
with the

Psychodiagnostic Chart-2 (PDC-2)

Psychodiagnostic Chart-2 (PDC-2)

The Operationalized PDM-2 –Adult Version

Robert M. Gordon and Robert F. Bornstein



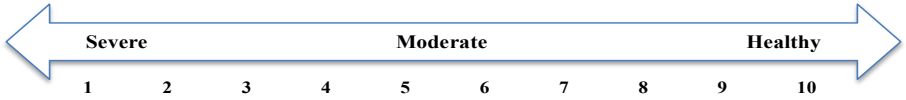
Psychodiagnostic Chart-2 (PDC-2)

Name: _____ **Age:** _____ **Gender:** _____ **Ethnicity:** _____

Date of Evaluation: _____/_____/_____ **Evaluator:** _____

Section I: Level of Personality Organization

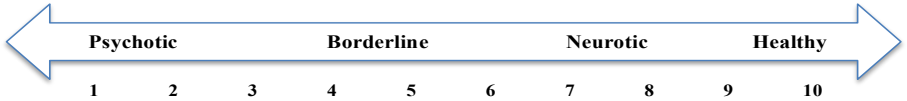
Consider your client's mental functions in determining the level of personality organization. Use these four mental functions to efficiently capture the level of personality organization. Rate each mental function on a scale from 1 (Severely impaired) to 10 (Healthy).



1. **Identity**: *ability to view self in complex, stable, and accurate ways* ____
2. **Object Relations**: *ability to maintain intimate, stable, and satisfying relationships* ____
3. **Level of Defenses**: (using the guide below, select a single number) ____
   - 1-2: Psychotic level (delusional projection, psychotic denial, psychotic distortion)
   - 3-5: Borderline level (splitting, projective identification, idealization/devaluation, denial, acting out)
   - 6-8: Neurotic level (repression, reaction formation, intellectualization, displacement, undoing)
   - 9-10: Healthy level (anticipation, self-assertion, sublimation, suppression, altruism, and humor)
4. **Reality Testing**: *ability to appreciate conventional notions of what is realistic* ____

Overall Personality Organization

Considering the ratings and your clinical judgment, circle your client's overall personality organization.



Healthy Personality- characterized by mostly 9-10 scores, life problems rarely get out of hand and enough flexibility to accommodate to challenging realities. (Use "9" for people at the high functioning neurotic level.)

Neurotic Level- characterized by mostly 6-8 scores, basically a good sense of identity, good reality testing, mostly good intimacies, fair resiliency, fair affect tolerance and regulation, rigidity and limited range of defenses and coping mechanisms, favors defenses such as repression, reaction formation, intellectualization, displacement, and undoing. (Use "6" for people who go between borderline and neurotic levels.)

Borderline Level- characterized by mostly 3-5 scores, recurrent relational problems, difficulty with affect tolerance and regulation, poor impulse control, poor sense of identity, poor resiliency, favors defenses such as splitting, projective identification, idealization/devaluation, denial, omnipotent control, and acting out.)

Psychotic Level- characterized by mostly 1-2 scores, delusional thinking, poor reality testing and mood regulation, extreme difficulty functioning in work and relationships favors defenses such as delusional projection, psychotic denial, and psychotic distortion. (Use "3" for people who go between psychotic and borderline levels.)

Section II: Personality Syndromes (P-Axis)

These are relatively stable patterns of thinking, feeling, behaving and relating to others. Normal level personality patterns do not involve impairment, while personality syndromes or disorders involve impairment at the neurotic, borderline, or psychotic

Check off as many personality syndromes as apply from the list below; and then circle the one or two personality styles that are most dominant. Leave blank if none.

(For research purposes, you may also rate the level of severity for all styles, using a 1-5 scale: 1 = Severe Level; 3 = Moderate Severity; and 5 = High Functioning).

Level of Severity

! **Depressive** ___
Subtypes:
- introjective
- anaclitic
- converse manifestation: hypomanic

! **Dependent** ___
Subtypes:
- □ passive-aggressive
- □ converse manifestation: counterdependent

! **Anxious/ Avoidant/ Phobic** ___
Subtype:
- □ converse manifestation: counterphobic

! **Obsessive-Compulsive** ___

! **Schizoid** ___

! **Somatizing** ___

Level of Severity

! **Hysteric-Histrionic** ___
Subtypes:
- □ inhibited
- □ demonstrative

! **Narcissistic** ___
Subtypes:
- □ overt
- □ covert
- □ malignant

! **Paranoid** ___

! **Psychopathic** ___
Subtypes:
- □ passive-parasitic, con-artist
- □ aggressive

! **Sadistic** ___

! **Borderline** ___

Section III: Mental Functioning (M-Axis)

Rate your client's level of strength or weakness on each of the 12 mental functions below, on a scale from 1 to 5 (1 = Severe deficits; 5 = Healthy). Then sum the 12 ratings for a Level of Severity score.

Severe Defects	Major Impairments	Moderate Impairments	Mild Impairments	Healthy
1	2	3	4	5

A. Cognitive and affective processes

1. Capacity for regulation, attention, and learning ____
2. Capacity for affective range, communication, and understanding ____
3. Capacity for mentalization and reflective functioning ____

B. Identity and relationships

4. Capacity for differentiation and integration (identity) ____
5. Capacity for relationships and intimacy ____
6. Self-esteem regulation and quality of internal experience ____

C. Defense and coping

7. Impulse control and regulation ____
8. Defensive functioning ____
9. Adaptation, resiliency and strength ____

D. Self-awareness and self-direction

10. Self-observing capacities (psychological mindedness) ____
11. Capacity to construct and use internal standards and ideals ____
12. Meaning and purpose ____

Overall level of personality severity (Sum of 12 mental functions): _____

[Healthy/Optimal Mental Functioning 54-60; Appropriate Mental Functioning with Some Areas of Difficulty 47-53; Mild Impairments in Mental Functioning 40-46; Moderate Impairments in Mental Functioning 33-39; Major Impairments in Mental Functioning 26-32; Significant Defects in Basic Mental Functions 19-25; Major/Severe Defects in Basic Mental Functions 12-18]

Section IV: Symptom Patterns (S-Axis)

List the main PDM symptom patterns *(e.g., those that are related to psychotic disorders, mood disorders, anxiety disorders, event and stress disorders, specific symptom disorders, addiction and medically related disorders, etc.)* (If required, you may use the DSM or ICD symptoms and codes here.)

Severe		Moderate		Mild
1	2	3	4	5

Symptom/Concern: _____ _____ Level: ____

Symptom/Concern: _____ _____ Level: ____

Symptom/Concern: _____ _____ Level: ____

Section V: Cultural, Contextual and Other Relevant Considerations

_____

_____

Personality Syndromes Across ICD-10, DSM-5 and PDM-2

Table : Taxonomic Comparisons of Personality Syndromes/Disorders

ICD-10	DSM-5	PDM-2
Paranoid	Paranoid	Paranoid
Schizoid	Schizoid	Schizoid
Antisocial	Antisocial	Psychopathic
Borderline	Borderline	Borderline
Histrionic	Histrionic	Hysteric-Histrionic
Obsessive-compulsive	Obsessive-compulsive	Obsessive-Compulsive
Avoidant	Avoidant	Anxious/ Avoidant/ Phobic
Dependent	Dependent	Dependent
Narcissistic	Narcissistic	Narcissistic
		Depressive*
		Somatizing
		Sadistic
	Schizotypal*	

*Depressive P.D. was in DSM-IV-R in Appendix B "worthy of further study," but is not in DSM-5. In ICD-10, Schizotypal Disorder is classified in the Schizophrenic Spectrum and not as a personality disorder. In DSM-5, Schizotypal is classified as both a personality disorder and within the Schizophrenia Spectrum disorders. In PDM-2, Schizotypal is considered to be at the severe end of Schizoid P.D.

P Axis Changes Between PDM-1 and PDM-2

PDM-1	PDM Subtypes	PDM-2	PDM-2 Subtypes
Paranoid		Paranoid	
Schizoid		Schizoid	
Psychopathic	Parasitic/Aggressive	Psychopathic	Parasitic/Aggressive
Hysteric-Histrionic	Inhib/Demonstrative	Hysteric-Histrionic	Inhib/Demonstrative
Obsessive-compulsive		Obsessive-Compulsive	
Anxious		***Anxious/ Avoidant/ Phobic***	***Counter-phobic***
Phobic/Avoidant	***Counter-phobic***		
Dependent	Pass-agg; Counter-dependent	Dependent	Pass-agg; Counter-dependent
Narcissistic	***Arrogant/depleted***	Narcissistic	***Overt/Covert/Malign***
Depressive	Introjective/Anaclitic Hypomanic	Depressive	Introject/Anaclitic/ Hypomanic
Somatizing		Somatizing	
Sadistic	***Sadomasochistic***	Sadistic	
Masochistic	***Moral/Relational***		
Dissociative		***Borderline***	

Gordon, R.M. (2017). A Concurrent Validity Study of the PDM-2 Personality Syndromes. Current Psychology, DOI: 10.1007/s12144-017-9644-2

Personality Organization and PDM-2 Personality Syndromes	Component			
	1 Neurotic Level	2 Border-line Level	3 Poor Impulse Control	4 Psychotic Level
Neurotic	**.739**	.051	.049	.203
Borderline	.169	**.713**	.312	.299
Psychotic	.124	.377	.381	**.649**
Depressive	**.817**	-.041	.253	.157
Hypomanic	.088	.311	**.817**	.158
Dependent	**.790**	.405	.007	.010
Passive-agg	.363	**.738**	.388	.075
Ct-depend	.308	.517	**.606**	.077
Anxious	**.888**	-.087	.192	.065
Ct-phobic	.209	.300	**.774**	.189
Obs-compul	**.777**	.180	.133	.235
Schizoid	.419	.261	.079	**.744**
Somatizing	**.720**	.371	.096	.144
Histrionic	**.662**	.511	.066	.184
Narcissistic	.247	**.753**	.280	.263
Paranoid	.390	.367	.123	**.708**
Psychopath	-.008	**.712**	.267	.483
Sadistic	-.044	**.759**	.291	.421

N = 412, Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.

Personality Disorders
P Axis

Temperamental,

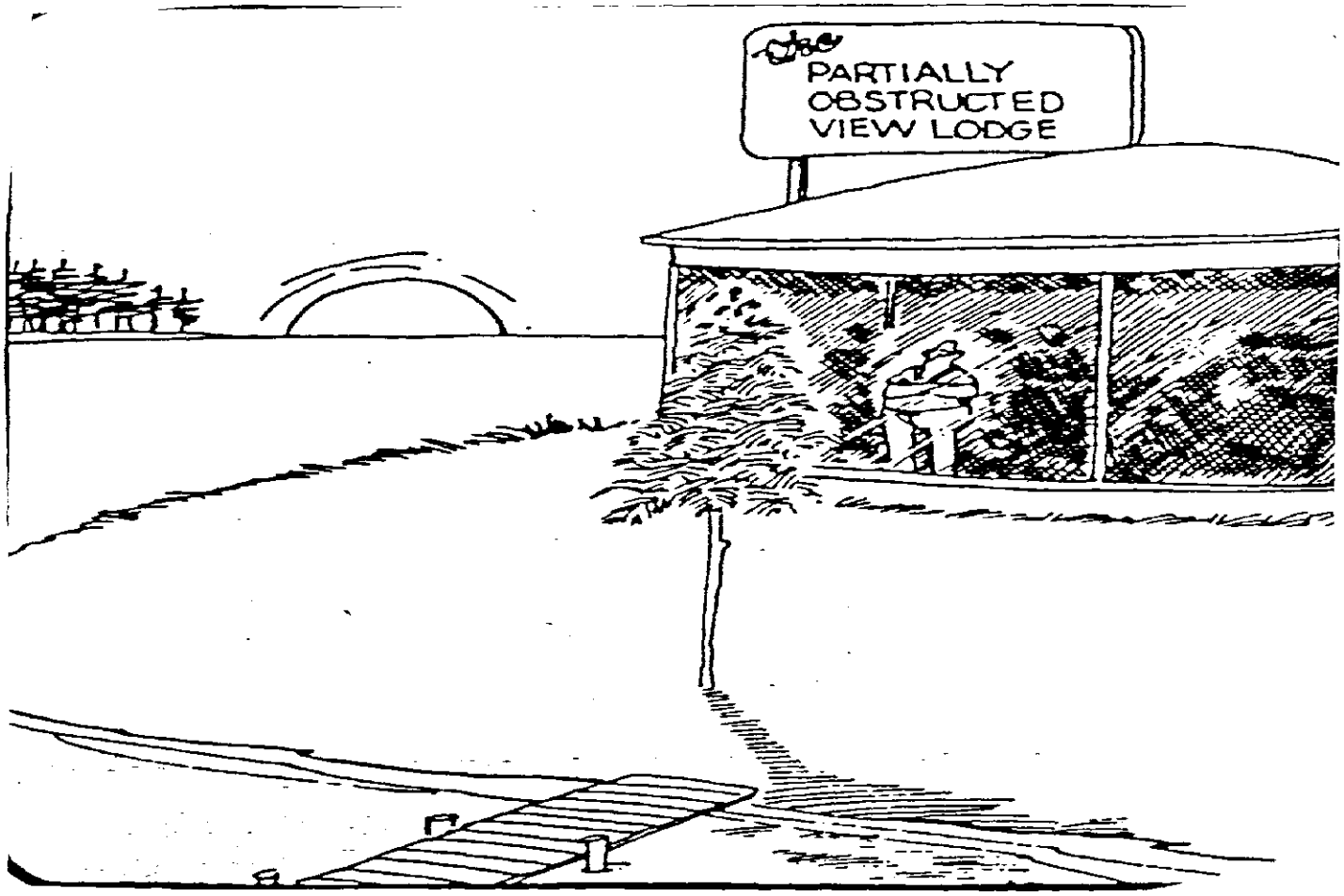
Thematic,

Affective,

Cognitive, and

Defense patterns

Depressive Personality Disorder



Lodge owner Harold Shuffle saw only the negative side of things.

Depressive Personalities

Introjective: self-critical, self-worth

Anaclitic: concern with attachment issues

Converse manifestation: hypomanic

- ***Contributing constitutional-maturational patterns:*** Possible genetic predisposition to depression
- ***Central tension/preoccupation:*** Self-criticism and self-punitiveness, or preoccupation with relatedness and loss (or both).
- ***Central affects:*** Sadness, guilt, shame
- ***Characteristic pathogenic belief about self:*** There is something essentially bad or inadequate about me; someone or something necessary for well-being has been irretrievably lost
- ***Characteristic pathogenic belief about others:*** People who really get to know me will reject me
- ***Central ways of defending:*** Introjection, reversal, idealization of others, devaluation of self

Implications for treatment- Depressive Personality Disorder
(Most Common type in Clinical Situations)

Introjective: self-critical, preoccupied with self-worth, guilt

Anaclitic: concerned with attachment issues, relatedness, trust, inadequacy (May combine with dependent or narcissistic personality disorder)

Depressive Personality Tx

"The *mood disorder* responds to medication, but not the *personality disorder*, which requires long-term intensive treatment.

The *introjective* type tends to respond better to interpretations and insight. These patients benefit from insight into the ways in which they defend against angry and critical feelings toward others and direct them against themselves.

The *anaclitic* type tends to respond better to the actual therapeutic relationship. These patients benefit from the experience of having their perceived inadequacies and "badness" accepted within a relational context. Where preoccupation with loss predominates, patients may need the clinician's help to mourn what has been lost, before they are able to invest emotionally in what life can offer in the present."

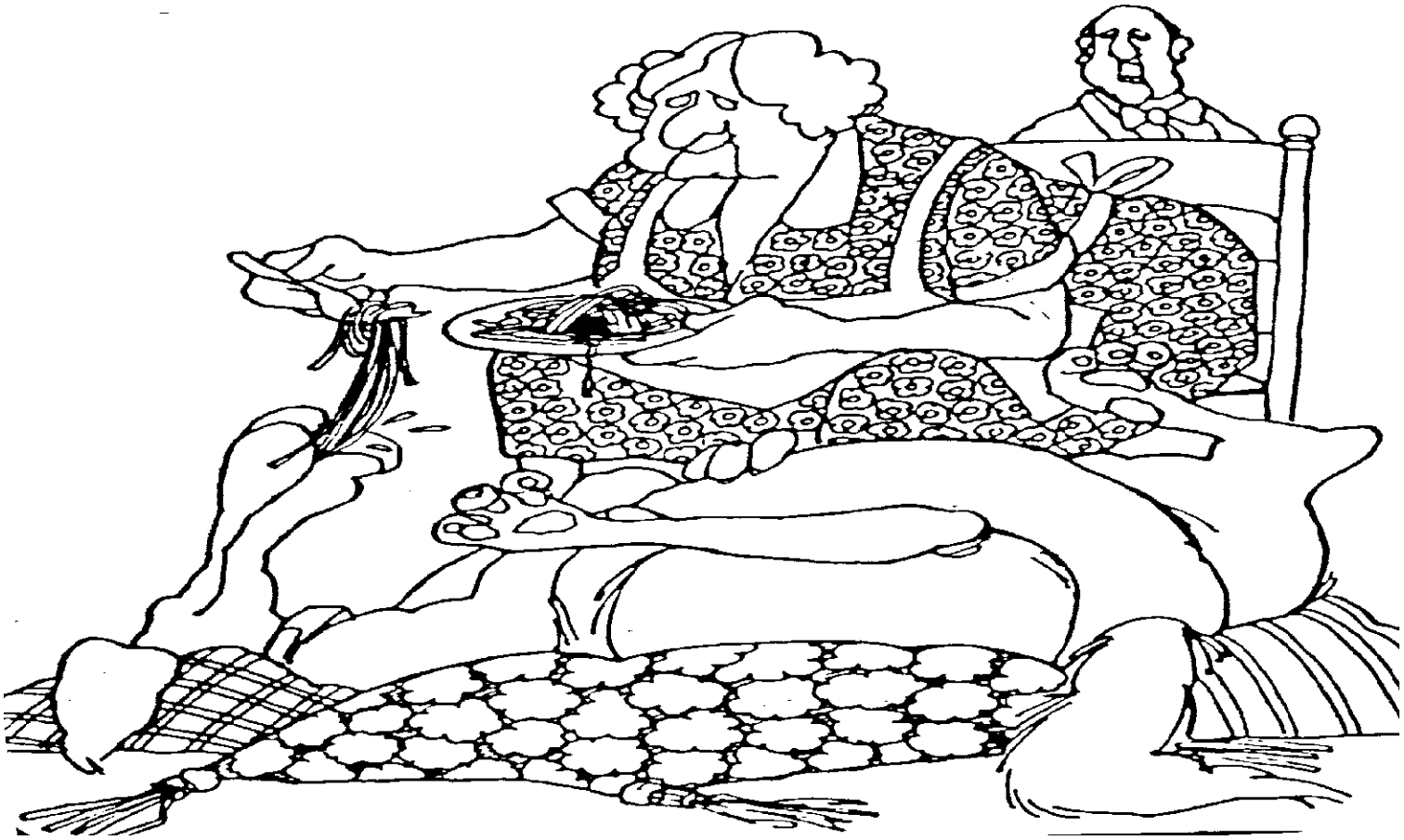
Hypomanic


© Mike Baldwin / Cornered
CARTOONSTOCK
.com
Search ID: mban754
"Lose some weight before you go flying again. Or at least get a bigger cape."

Converse Manifestation: Hypomanic Personality Disorder

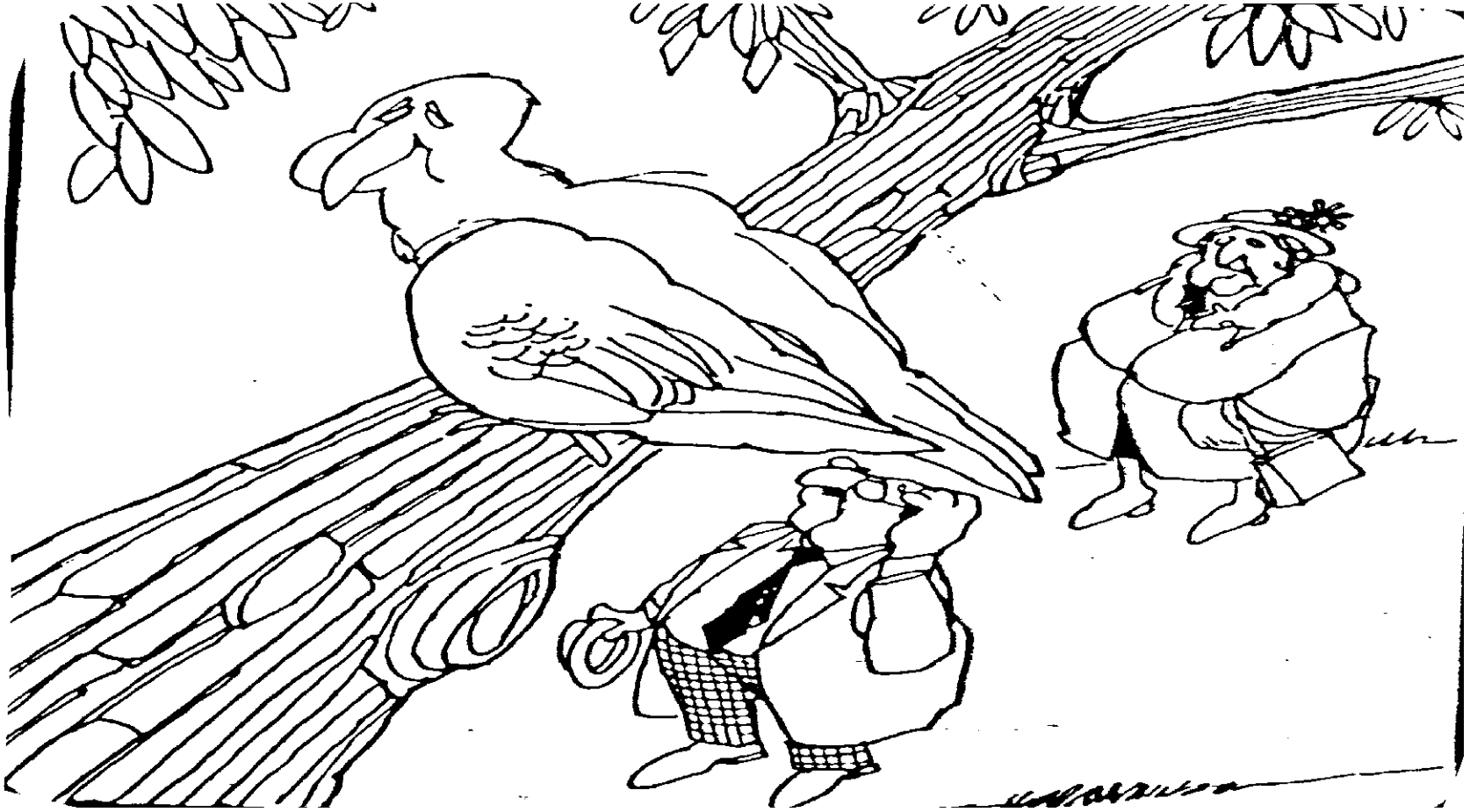
- Relatively stable state of inflated mood, high energy
- Little guilt
- Overly positive view of self
- Superficial relationships due to fear of being attached
- Highly resistant to therapy
- The mood disorder responds better to pharmacological interventions, but medication does not help the personality disorder.
- Clarify the cost of not working in treatment.

Dependent PD: Others are powerful and I need their care



"You're gonna spoil that dog, Annie!"

Passive-Aggressive Personality



"It's almost like they do it on purpose, isn't it, Fred?!"

Dependent Personalities

Subtypes: passive-aggressive
converse manifestation: counterdependent

- ***Central constitutional-maturational patterns:*** Unknown
- ***Central tension/preoccupation:*** Keeping/losing relationship
- ***Characteristic pathogenic belief about self:*** I am inadequate, needy, impotent (including its conscious converse in passive-aggressive and counterdependent individuals)
- ***Characteristic pathogenic belief about others:*** Others are powerful and I need (but may resent) their care
- ***Central ways of defending:*** Regression, reversal, avoidance, somatization

Dependent Personalities Tx

"…It is important that the clinician resist seduction into the role of expert authority, encourage the patient toward autonomous functioning, and contain the patient's anxieties that arise in the process…make room for the patient's anger and other more aggressive feelings, they may facilitate the patient's ultimate sense of personal agency and pride in accomplishment."

Passive-aggressive Tx

"The clinician needs a sense of humor as counterpoise to the feelings of impatience and exasperation that the patient is likely to evoke…To avoid activating their oppositionality, which may take the form of sabotaging any outcome the clinician seems to desire, clinicians should take care not to seem highly invested in their progress. Instead, clinicians need to take their provocations and inconsistencies in stride, keeping the therapy focused on the price the patient pays for passive-aggressive acts."

Counterdependent Tx

“In treatment, they need help to accept their dependent needs as a normal part of being human before they can develop a healthy balance between connectedness and separateness. Therapists who tolerate their defensive protestations about their independence long enough to develop a therapeutic alliance report that when the counterdependent defenses are given up, a period of mourning for early and unmet dependent needs then ensues, followed by more genuine autonomy.”

Anxious/Avoidant/Phobic

Anxious-Avoidant and Phobic Personalities

Subtype: converse manifestation: counterphobic

- ***Contributing constitutional-maturational patterns***: Possible anxious or timid disposition
- ***Central tension/preoccupation:*** Safety/danger
- ***Characteristic pathogenic belief about self:*** I am in constant danger that I must somehow elude
- ***Characteristic pathogenic belief about others:*** Others are sources of either unimagined dangers or magical protection
- ***Central ways of defending:*** Symbolization, displacement, avoidance, rationalization; inchoate anxieties may mask more upsetting specific anxieties – that is, anxiety itself may be defensive

Anxious-Avoidant and Phobic Personalities Tx

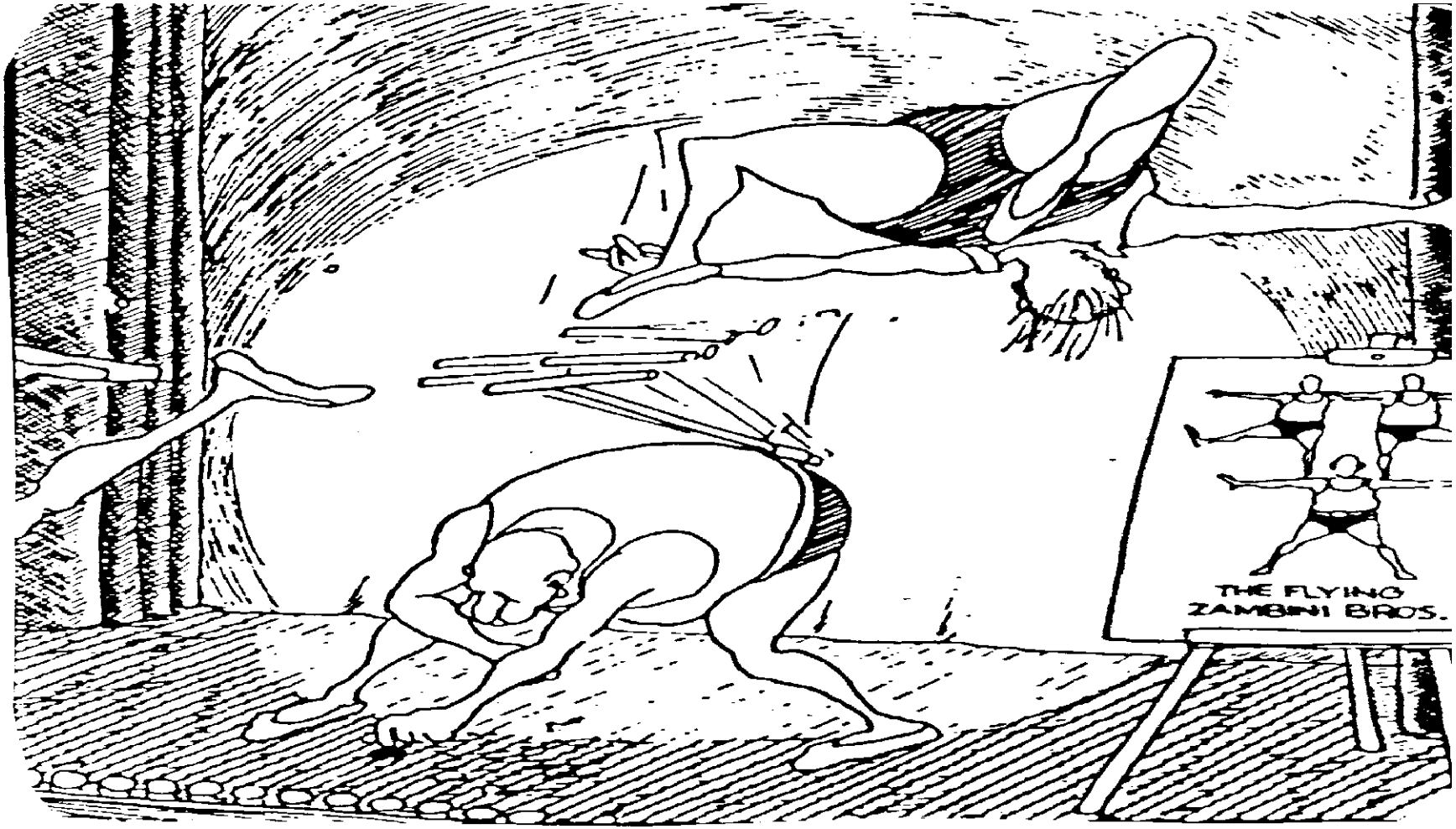
"…several different kinds of anxiety that seem universal among human beings, including separation anxiety (fear of loss of an attachment object), castration anxiety (fear of damage to the body, especially sexual mutilation), moral anxiety (dread of violating one's core values), and annihilation anxiety... require a deeper therapy response than the traditional exposure treatments…insecure attachment styles may slowly change toward more secure attachment in the context of a long, devoted relationship, particularly intensive psychotherapy…

When they make sweeping proclamations of danger, they should be pressed for details ("And then what would happen?") and asked for specific fantasies. Once there is a secure therapeutic alliance, phobic patients need to face what they fear…"

"Counterphobic…work slowly with them and to tolerate their bravado for some time before beginning to push them to acknowledge even normal fear, much less neurotic anxiety.

In all patients for whom anxiety is pervasive, there may be a period in treatment in which they suffer a depressive reaction to giving up some of the magical ideas that accompany their anxiety-driven psychology."

Obsessive-Compulsive PD: Compulsive type



Once again Elliot Zambini's tidiness ruins the act.

Obsessive-Compulsive Personalities

Contributing constitutional-maturational patterns*:* Possible aggressivity, irritability, orderliness
Central tension/preoccupation*:* Submission to/rebellion against controlling authority
Central affects*:* Anger, guilt, shame, fear
Characteristic pathogenic belief about self*:* Most feelings are dangerous and must be controlled
Characteristic pathogenic belief about others*:* Others are less precise and in control than I am, so I have to control what they do and resist being controlled by them
Central ways of defending*:* Isolation of affect, reaction formation, intellectualizing, moralizing, undoing

Obsessive-Compulsive Personalities Tx

"Obsessive patients are ruminative and cerebral; their self-esteem may depend on *thinking*. Compulsive individuals tend to be busy, meticulous, perfectionistic; their self-esteem depends on *doing*…

…As the patient insists on tendentious argument rather than emotional expression and engagement, the therapist may become impatient and exasperated. Effective therapy requires sustained and patient exploration of those aspects of personality that individuals with obsessive-compulsive personalities otherwise spend inordinate energy trying to subdue."

Schizoid

"Fred we've decided to change your job description from "outgoing and talkative" to "analytical and withdrawn."

Schizoid Personalities

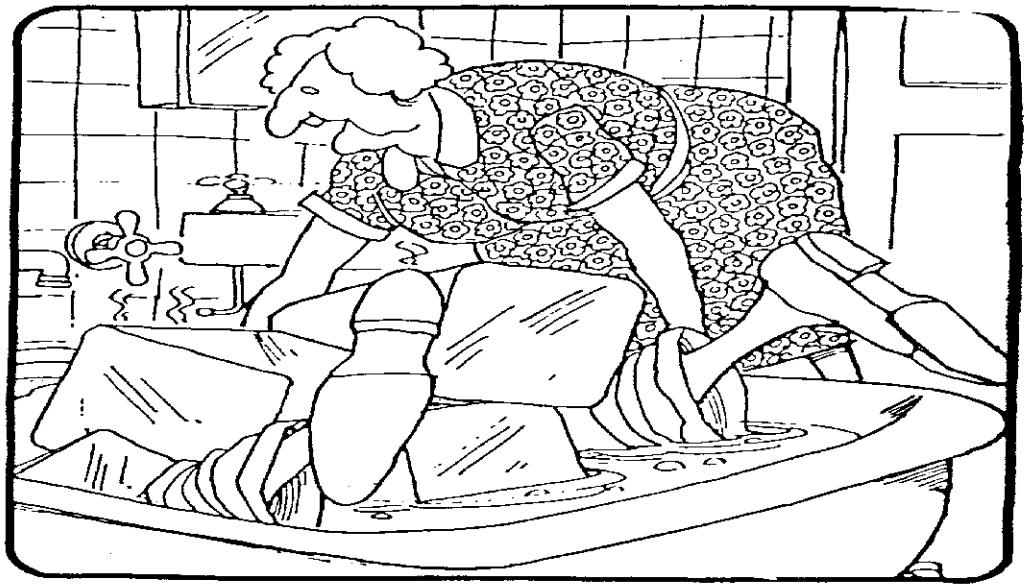
- ***Contributing constitutional-maturational patterns:*** Highly sensitive, shy, easily overstimulated, possibly vulnerability to psychosis
- ***Central tension/preoccupation:*** Fear of closeness/longing for closeness
- ***Central affects:*** General emotional pain when overstimulated, affects so powerful that they feel they must suppress them
- ***Characteristic pathogenic belief about self:*** Dependency and love are dangerous
- ***Characteristic pathogenic belief about others:*** The social world is impinging, dangerously engulfing
- ***Central ways of defending:*** Withdrawal, both physically and into fantasy and idiosyncratic preoccupations

Schizoid Personalities Tx

“Schizoid individuals may do well in therapies that both allow emotional intimacy and respect their need for sufficient interpersonal space (Khan, 1974; Ridenour, 2015).

They may communicate their concerns most intimately and comfortably via metaphor and emotionally meaningful references to literature, the arts, and areas in which they have a passionate solo interest, whether in abstract realms such as theology or in more prosaic pursuits such as video games.”

Somatizing Personality Disorder



"My brother, Tilford, had trouble with hemorrhoids and he never did anything like this!"

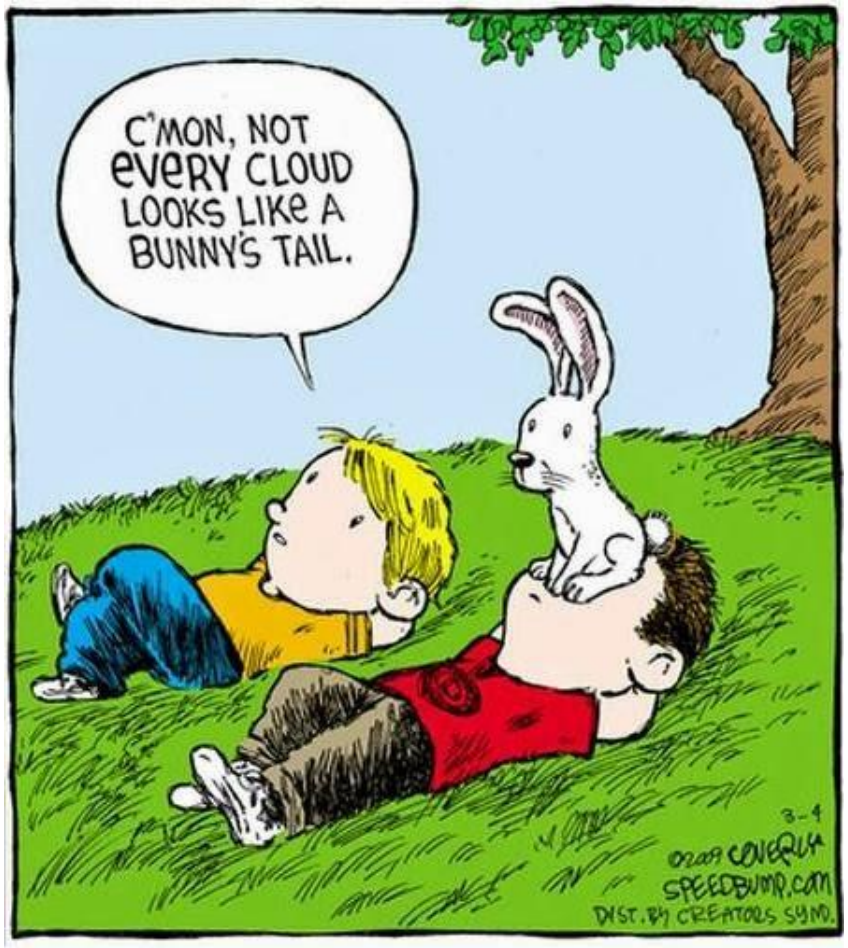
Somatizing Personalities

- ***Contributing constitutional-maturational patterns****:* Possible physical fragility, early sickliness, some clinical reports of early physical and/or sexual abuse
- ***Central tension/preoccupation****:* Integrity/fragmentation of bodily self
- ***Central affects****:* Global distress; inferred rage; alexithymia prevents acknowledgment of emotion
- ***Characteristic pathogenic belief about self****:* I am fragile, vulnerable, in danger of dying
- ***Characteristic pathogenic belief about others****:* Others are powerful, healthy, and indifferent
- ***Central ways of defending****:* Somatization, regression

Somatizing Personalities Tx

“Presumably, early caregivers of somatizing patients failed to foster a capacity to represent feelings, leaving their bodies to convey what their minds could not…Treatment of individuals with somatizing tendencies is difficult and requires patience with their inarticulateness and negativity. Empathic acknowledgment that their suffering is real is critical; otherwise, they may feel accused of malingering. Because any movement toward emotional expression is stressful for them, they frequently become ill and cancel appointments just when a therapist begins to see progress. Central to their improvement is the therapist’s tactful encouragement to feel, name, and accept their emotional states.”

Hysteric naïveté



Histrionic


BEING SEXY, CONFIDENT, BITCHY, AND WELL-DRESSED DOES NOT MEAN I LACK EMOTIONAL DEPTH.

Hysteric-Histrionic Personalities

Subtypes:

inhibited

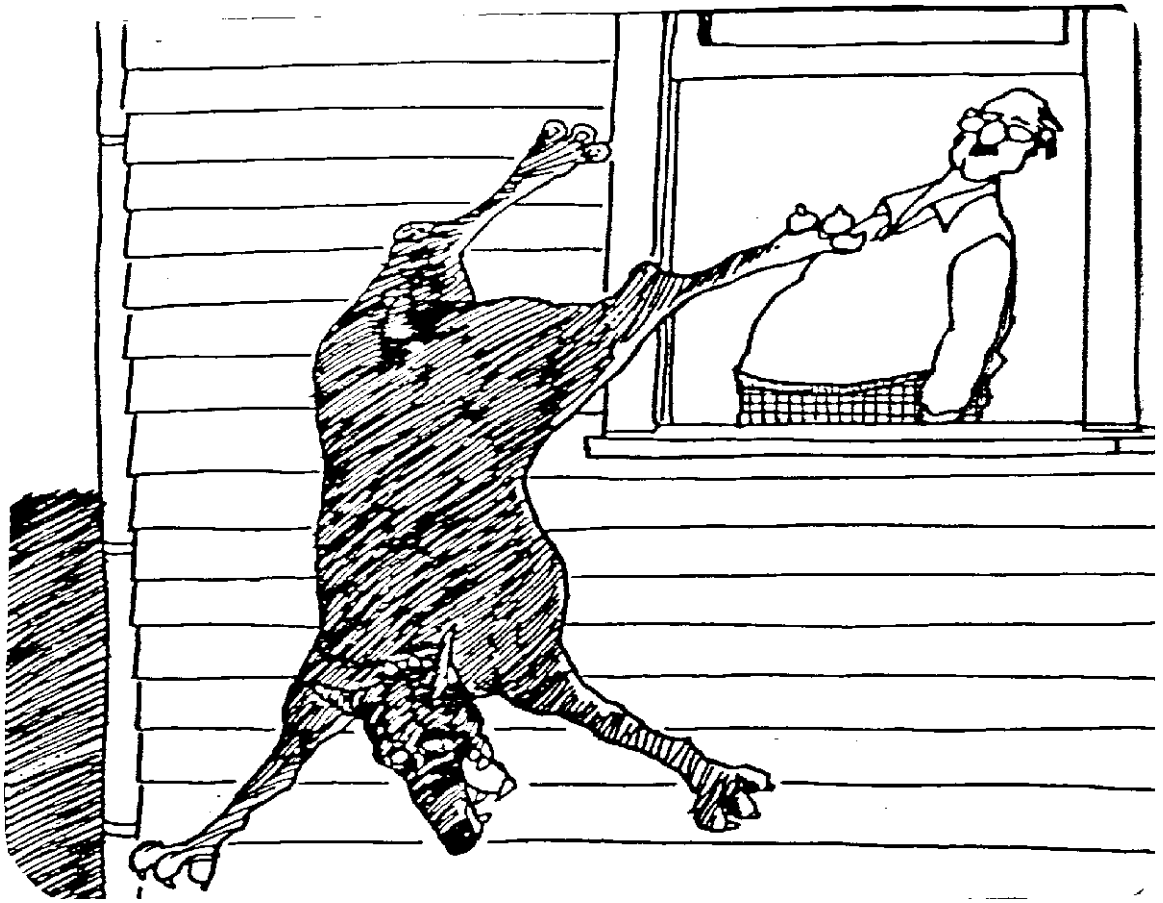
demonstrative

- ***Contributing constitutional-maturational patterns:*** Possible sensitivity, sociophilia
- ***Central tension/preoccupation:*** Gender and power; unconscious devaluation of own gender/envy and fear of opposite gender
- ***Central affects:*** Fear, shame, guilt (over competition)
- ***Characteristic pathogenic belief about self:*** There is something problematic with my gender and its meaning
- ***Characteristic pathogenic belief about others:*** The world is best understood in terms of gender binaries and gender conflicts
- ***Central ways of defending:*** Repression, regression, conversion, sexualization, acting out

Hysteric-Histrionic Personalities Tx

"Patients with hysteric-histrionic personalities benefit from both the relational and interpretive (exploratory) aspects of psychotherapy. The therapy relationship constitutes a new and different kind of relationship, one in which a therapist of the overvalued gender is neither seducing nor seducible, and a therapist of the undervalued gender is neither competitive with the patient nor powerless and ineffectual. The dependability and emotional availability of the therapist, and the safety and stability of the therapeutic frame, provide a context for self-examination and interpretation in which the patient can gain insight into conflicts around gender, power, and sexuality. Neurotically-organized patients with hysteric-histrionic personality styles respond well to the interpretive or insight-oriented aspects of therapy; treatment of patients organized at the at the borderline level may require more deliberate handling of boundary issues, confrontation about destructive enactments, and explicit psychoeducation."

Narcissistic PD: Narcissistic Injury



The Doberman threw himself out the second-story window after he realized the family had indeed named him "Binky."

Narcissistic Personalities

Subtypes: overt, covert
malignant

Contributing constitutional-maturational patterns: No clear data

Central tension/preoccupation: Inflation/deflation of self-esteem

Central affects: Shame, humiliation, contempt, envy

Characteristic pathogenic belief about self: I need to be perfect to feel okay

Characteristic pathogenic belief about others: Others enjoy riches, beauty, power, and fame; the more of those I have, the better I will feel

Central ways of defending: Idealization, devaluation

Malignant Narcissism

Kernberg (1984) characterizes the most problematic type of narcissistic individual as suffused with “malignant narcissism” (that is, narcissism blended with sadistic aggression), a condition that he places on a continuum with the frankly psychopathic personality

Narcissistic Personalities Tx

"Kohut (1971, 1977) emphasized empathic attunement and exploration of the therapist's inevitable empathic failures, and described periods in treatment when the patient would idealize the analyst, treating him or her as a perfect and all-powerful parent figure (the "idealizing transference"). He felt that during these times, the primary challenge for the therapist is to resist the temptation to confront this pattern too quickly. Kernberg (1975, 1984), on the other hand, has recommended the tactful but systematic exposure of defenses against shame, envy, and normal dependency. Contemporary practitioners are more likely to adopt an integrated approach to working with narcissistic individuals, confronting defenses when they are salient, and empathically attuning to underlying hurt and vulnerability when that is accessible.

…Narcissistic people may be easier to help in therapy in mid-life or later, when their investments in beauty, fame, wealth, and power have been disappointed and when they have run into realistic limits on their grandiosity."

Paranoid
“Now Who’s Paranoid?”

Paranoid Personalities

- ***Contributing constitutional-maturational patterns:*** Possibly irritable/aggressive
- ***Central tension/preoccupation:*** Attacking/being attacked by humiliating others
- ***Central affects:*** Fear, rage, shame, contempt
- ***Characteristic pathogenic belief about self:*** I am in constant danger
- ***Characteristic pathogenic belief about others:*** The world is full of potential attackers and users
- ***Central ways of defending:*** Projection, projective identification, denial, reaction formation

Paranoid Personalities Tx

"…importance of maintaining a patient, matter-of-factly respectful attitude, the communication of a sense of strength (lest paranoid patients worry unconsciously that their negative affects could destroy the therapist), a willingness to respond with factual information when the patient raises questions (lest the patient feel evaded or toyed with), and attending to the patient's private conviction that aggression, dependency, and sexual desire – and the verbal expressions of any of these strivings – are inherently dangerous. It is best not to be too warm and solicitous, as such attitudes may stimulate a terror of regression and consequent elaborate suspicions about why the therapist is "really" being so nice."

Psychopathic

"I'm not anti-social…I'm just not user friendly"

Psychopathic Personalities

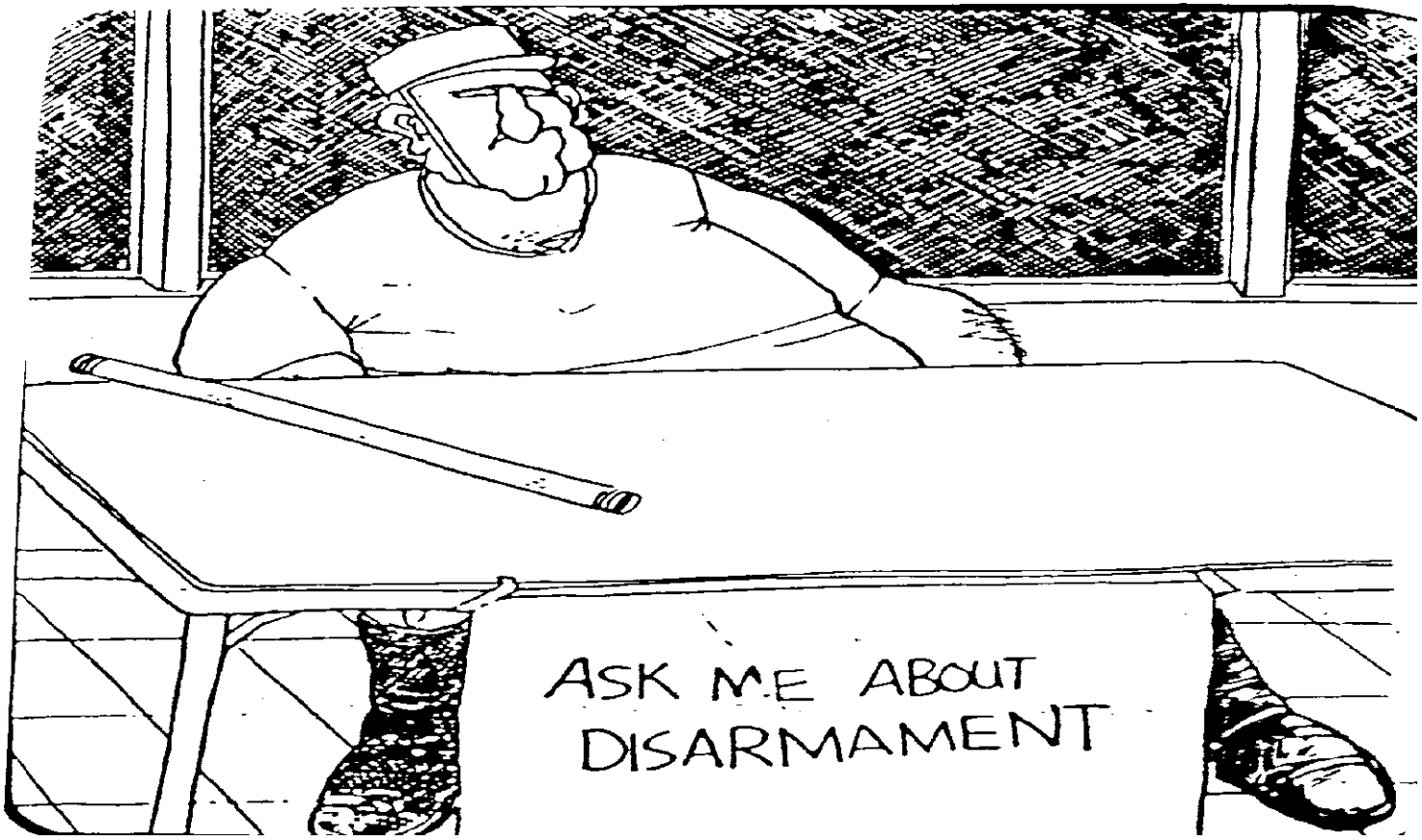
Subtypes: passive-parasitic, con artist
aggressive

- ***Contributing constitutional-maturational patterns:*** Possible congenital aggressiveness, high threshold for emotional stimulation
- ***Central tension/preoccupation:*** Manipulating/fear of being manipulated
- ***Central affects:*** Rage, envy
- ***Characteristic pathogenic belief about self:*** I can do whatever I want
- ***Characteristic pathogenic belief about others:*** Everyone is selfish, manipulative, dishonorable and/or weak
- ***Central ways of defending:*** Reaching for omnipotent control

Psychopathic Personalities Tx

"Treatment in which the therapist persistently tries to reach out sympathetically may come to grief with psychopathic patients, who regard love and kindness as signs of weakness. It is possible, however, to have a therapeutic influence on many psychopathic individuals if the clinician conveys a powerful presence, behaves with scrupulous integrity, and accepts that the patient's motivations revolve primarily around the desire for power…group and community treatments can be more effective than individual therapy. The prospects for any therapeutic influence are better if the psychopathic individual has reached mid-life or later and has thus felt a decline in physical power and encountered limits to omnipotent strivings."

Sadistic PD: I am entitled to hurt others



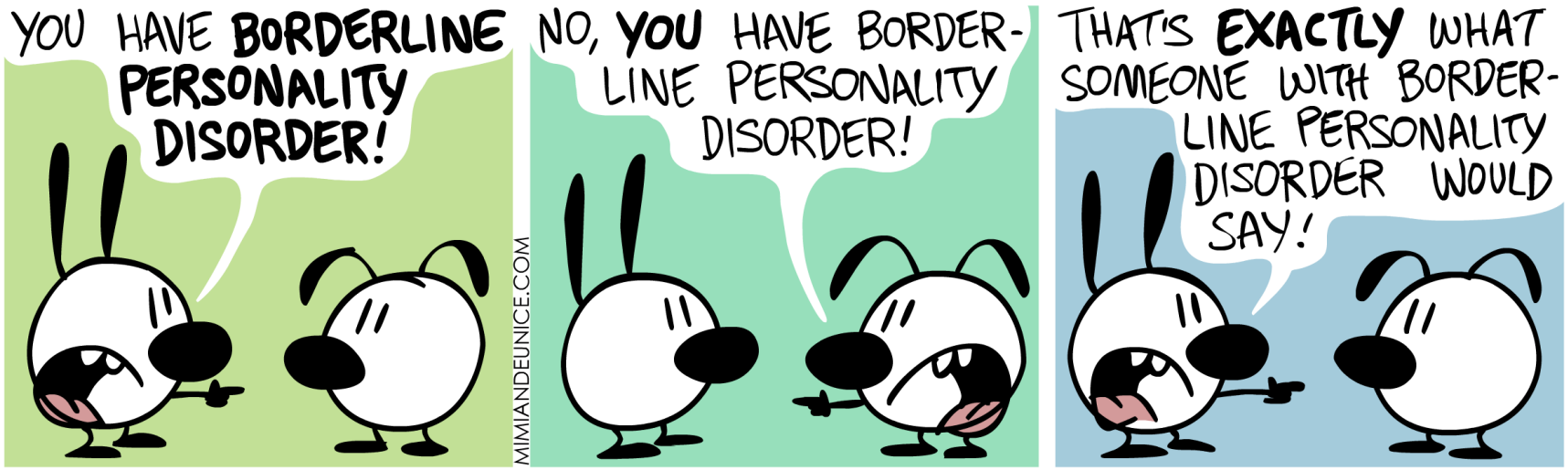
Sadistic Personalities

- ***Contributing constitutional-maturational pattern:*** Unknown
- ***Central tension/preoccupation:*** Suffering indignity/inflicting such suffering
- ***Central affects:*** Cold hatred, contempt, pleasure (sadistic glee)
- ***Characteristic pathogenic belief about self:*** I am entitled to hurt and humiliate others
- ***Characteristic pathogenic*** belief about others: Others exist as objects for my domination
- ***Central ways of defending***: Detachment, omnipotent control, reversal, enactment

Sadistic Personalities Tx

"We know of no reports of successful psychotherapy for characterological sadism."

Borderline Personality



Borderline Personalities

Contributing constitutional-maturational patterns: Congenital difficulties with affect regulation, intensity, aggression, capacity to be soothed

Central tension/preoccupation: Self-cohesion vs. fragmentation; engulfing attachment vs. abandonment despair

Central affects: Intense affects generally, especially rage, shame, and fear

Characteristic pathogenic belief about self: I don't know who I am; I inhabit dissociated self-states rather than having a sense of continuity

Characteristic pathogenic belief about others: Others are one-dimensional and defined by their effect on me rather than by a sense of their complex individual psychology

Central ways of defending: Splitting, projective identification, denial, dissociation, acting out, and other primitive defenses

Borderline Personalities Tx

"…working with individuals in the borderline range of severity apply to those with a diagnosable borderline personality disorder… emphasize the centrality of the working alliance and the importance of repairing it when it is damaged, the critical role of boundaries and the therapist's willingness to tolerate rage and hurt when boundaries are maintained, the discouragement of regression, the expectation of intensity, the inevitability of either-or dilemmas, the importance of the patient's sense of the therapist as an affectively genuine person, and the development of capacities for self-reflection, metalization, or mindfulness. They also emphasize the need for ongoing clinical supervision and consultation."

Take Home Message:

These generalizations are not to be used in a “manualized” fashion. Each person is unique, but we can start with a helpful road map in our therapeutic relationship journey.

Use the PDM-2 to better understand your patients and to fine tune your therapeutic interventions for better results.