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Personality in PDM-2: Controversial Issues

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The Adult Personality section of the Psychodynamic Diagnostic Manual (2nd ed. [PDM-2]; Lingardi & McWilliams, 2017) reflects the best effort of theorists, researchers, and clinicians to capture clinically relevant personality constellations, from healthy personality styles to highly troubled disorders. We specify some foundational assumptions impelling this work, especially as they differ from those underlying categorical, descriptive psychiatric taxonomies such as the DSM and ICD. We describe and give the rationale for changes from PDM-1 to PDM-2, call attention to ongoing controversies and our efforts to resolve or represent them in PDM-2, and note the importance of future research on personality.

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Personality in PDM-2: Controversial Issues

Nancy McWilliams, Brin F.S. Grenyer, and Jonathan Shedler

Abstract

The Adult Personality section of the *Psychodynamic Diagnostic Manual, 2nd Ed (PDM-2)* (Lingiardi & McWilliams, 2017) reflects the best effort of theorists, researchers, and clinicians to capture clinically relevant personality constellations, from healthy personality styles to highly troubled disorders. We specify some foundational assumptions impelling this work, especially as they differ from those underlying categorical, descriptive psychiatric taxonomies such as the DSM and ICD. We describe and give the rationale for changes from PDM-1 to PDM-2, call attention to ongoing controversies and our efforts to resolve or represent them in PDM-2, and note the importance of future research on personality.

Keywords: Personality, diagnosis, assessment, Psychodynamic Diagnostic Manual, Clinical Utility

We are grateful for the opportunity to comment on the Adult Personality section—the P Axis—of the second edition of the *Psychodynamic Diagnostic Manual* (PDM-2; 2017). In this essay, we focus on issues involving personality and its formulation that have been sources of controversy in the mental health field, issues with which we grappled when revising the P Axis of the manual. First, we make explicit our basic premises, assumptions about personality which seem self-evidently reasonable to us but which are not necessarily reflected in other taxonomies. We then explore some differences between the Adult Personality sections of the first (PDM Task

Force, 2006) and second (Lingiardi & McWilliams, 2017) editions, and give the rationale for some of the changes made in the 2017 manual. Finally, we describe some disagreements and uncertainties that arose either among ourselves or among other contributors, most of which represent general controversies in the field of personality.

Guiding Assumptions

There were several basic premises underlying our delineation of personality in the adult section of PDM-2. First, we assume that everyone has a personality style—a relatively stable confluence of temperament, attachment style, developmental concerns, defenses, affect patterns, motivational tendencies, cultural influences, gender and sexual expressions and other factors—irrespective of whether that personality style can be reasonably conceptualized as “disordered.” We believe that understanding an individual’s personality structure is useful for treatment planning, irrespective of whether or not the personality itself is problematic or the direct focus of treatment. We emphasize in PDM-2 that all efforts to be either comprehensive or reductive about varieties of individuality are oversimplifications of a more complicated reality. Still, we believe that some degree of generalization about personality style or type and level of health versus dysfunction of different personality configurations is clinically useful.

Second, while we relied heavily on the findings of empirical researchers, we gave significant weight to accumulated clinical experience and a wide range of scientific investigations of issues relevant to personality and psychopathology (Hirschfeld, 1991). In contemporary academic psychology, it is common to devalue practitioner observations; in fact, some researchers want to confer the designation “evidence” only on randomized controlled trials of manualized treatments (for a discussion see Shedler, 2017). However, there are many types of scientific evidence that bear on clinical issues (e.g., empirical investigations into personality,

attachment, defense, development, affect, neuroscience). A strength of the PDM-2 is its effort to synthesize psychodynamic observations of mental functioning with additional understandings deriving from empirical studies of personality, neuroscience, and psychotherapy.

We should emphasize that many psychological conditions have not been well researched, mostly because such investigations would be particularly difficult or unethical. But they have inspired a thoughtful clinical literature that practitioners have found illuminating and clinically valuable. Notably, this writing includes in-depth commentary on clinicians' emotional experiences of working with different kinds of patients. Whereas academic critics tend to view the subjective aspects of the clinical role as contaminations of "objective" data, seasoned clinicians consistently describe relying on inference, deduction, and a disciplined subjectivity to comprehend many psychological phenomena that are not easily captured by objective measures. In PDM-2, as in PDM-1, in addition to including information from empirical studies of all kinds, we paid attention to the vast body of accreted clinical knowledge, including practitioners' descriptions of their subjective reactions to various clinical presentations.

In other words, in PDM-2, we have given the clinical literature the respect we think it deserves. This perspective is in notable contrast to the DSM, which excluded some clinically recognized personality disorders on the basis of the paucity of empirical research on them. However, people with sadistic or counterdependent personalities, for example, are living in our communities even if research funding to study them is hard to come by, and even if they are not coming for mental health treatment and thus remain harder to reach. The PDM-2 provides clinicians with the opportunity to think about these presentations, based on what has been known and developed in the clinical literature over the past 120 years.

Third, on the basis of both empirical research (American-Psychological-Association, 2012; Lambert, 2013) and reports by generations of seasoned clinicians, we think it is clear that for the majority of adults in psychotherapy, personality has vastly more relevance to outcome than the diagnostic categories of descriptive psychiatry, and that most clinicians have recognized this for a long time. Thus, except for certain specific clinical situations (e.g., ongoing acute trauma, toxic psychoses, crises of addiction), most practitioners begin a psychological evaluation by trying to understand the meaning and function of patients' difficulties in the larger context of their personality dynamics (McWilliams, 2011).

A constellation of symptoms may have different meanings in people of differing psychological make-up, much as a limp or fever or skin rash may connote different health problems depending on the circumstances. Even in medicine, "disorder" categories are not grouped by their externally observable symptoms ("limp disorders," "fever disorders," etc.) but by the pathophysiology underlying them (von Linné, 1964). Consequently, we support the conclusions drawn by most practitioners that any disorder makes sense only in the context of a person's personality and circumstances, and that approaches to symptomatic treatment should differ based on an understanding of the person suffering the symptoms (Grenyer, 2002). The decision to put the personality chapter first in the adult section reflects these clinical realities.

Fourth, we assume that the understanding of personality requires appreciation of both personality *style* and personality *level of organization*. Therapeutic experience and some empirical data (Grenyer, 2017; Sharp et al., 2015) strongly suggest that individuals differ not only in terms of *style* or *type* (as, for example, described in the DSM or ICD Personality Disorders section), but also in terms of *level* of personality organization: healthy, neurotic, borderline, or psychotic; i.e., what Kernberg (1984) has termed "level of severity."

Consequently, PDM-2 seeks to describe both personality style and level. In the following paragraph, we illustrate this position using obsessional personality to demonstrate the importance of the concept of level of organization.

A psychologically *healthy obsessional man* has routines from which he does not like to deviate. He tends to intellectualize and avoid most strong affects. But he has a satisfying life, meaningful work, and warm relationships with others. A man with *obsessional tendencies at the neurotic level* finds that rigidity and regimentation interfere with his finishing work or making important decisions. His isolation of affect diminishes the vitality in his relationships. He has some perspective on his emotional constriction and may seek therapy to address it. A man at the *borderline level of obsessional functioning* comes for treatment for raw, overwhelming dysphoric affect that hijacks his experience. Even though his extreme rigidity and problems with authority have created severe difficulties in both work and relationship, he cannot reflect on them easily. His deep feeling that his way is the only reasonable way to function makes him highly resistant to treatments that seek to examine it. An obsessional man *at the psychotic level* is consumed by his symptoms. Immersed in preoccupations that have destroyed both work and relationships, he nonetheless feels terror when his beliefs are called into question. His concerns appear delusional to others yet feel to him not only perfectly reasonable but essential for his survival.

Fifth, we construe personality styles not in terms of dimensional traits on which a person is high or low, but in terms of *themes or conflicts* around which a person is consciously and unconsciously organized. Over decades of practice, clinicians have learned that the compulsively neat person tends also to have a mess somewhere, the withdrawing schizoid person often longs for closeness; the highly sexualized histrionic person is often sexually inhibited; the paranoid person may be naively trusting of certain individuals. Thus, it is more accurate to construe

personality differences in terms of the narcissistic *theme* of superiority versus inferiority, the obsessive-compulsive theme of defiance versus submission, the schizoid theme of closeness versus distance, the hysterical theme of conflict about sexuality, gender, and power, and so on.

Taking a Dynamic Approach

It is within this dynamic organization that the P Axis is best understood. Although we constructed this section with an effort to avoid off-putting analytic jargon, it is in essence deeply psychodynamic in its assumptions. Consistent with contemporary theories of psychopathology and personality, the axis emphasizes organizing psychological principles or themes that play out in different life domains, the psychological *meaning* of the person's experience, and the functional interrelatedness of psychological characteristics and processes. Thus, we do not construe individuals as collections of nomothetic traits which can be measured on separate dimensions.

Instead, we view the psychological characteristics by which an individual can be described as related dynamically by central internal themes and conflicts. Thus, the PDM-2 departs from the dimensional trait theory of personality currently ascendant among academic researchers in personality, which has its origins in factor analyses of items from self-report and peer-report questionnaires—the signal example being the Five Factor model (e.g., Costa & McCrae, 1985). In contrast, a dynamic understanding retains the view that within an individual, multiple motives compete for expression and vary depending on context, conflict, and anxiety. Thus, an individual with a narcissistic style is neither high nor low on the trait of “self-esteem.” Rather, it is the dynamic tension between coexisting feelings of superiority and of inadequacy that defines the narcissistic dilemma, with expressions of superiority serving to counteract painful feelings of inadequacy.

Similarly, the PDM-2 P Axis has some commonalities with other deterministic theories, such as the cognitive information processing model which emphasizes the powerful stamp of worldviews and belief systems (schemas) on a person's appraisal of events. Thus, an obsessional man sees the world in terms of dangers that would be unleashed by a lack of order and certainty. A dynamic theory extends this understanding to show how this individual is better understood in terms of a tension between submission to orderly norms and constraints, versus desires to rebel and defy (with the former linked to underlying feelings of humiliation and rage, and the latter to guilt and shame). Indeed, ongoing controversies between cognitive and dynamic models may be best understood in terms of the latter's appreciation of complexity, especially the psychoanalytic premise that opposite and conflicting tendencies can be found in everyone.

The PDM-2 thus differs from both the dimensional trait theories that currently dominate academic psychology (which influenced the "alternative" model for personality disorders in section III of DSM-5), and from the cognitive and schema-based theories of personality that emphasize cognitive beliefs. Both traits and cognitive schemas can be conceptualized within the PDM-2. Consider, for example, the schizoid person's aversion to attachment and dependency, or the paranoid person's core belief that "I am in constant danger." These can certainly be viewed in terms of cognitive schemas. But the PDM-2 goes beyond such constructs in that it alerts therapists to underlying and harder-to-reach psychological concerns, such as the schizoid person's wish for closeness and the paranoid person's need to defend against overwhelming aggression.

The DSM-5 diagnostic criteria for each of the personality disorders tend to note traits that are at one pole of a conflict rather than noting that either pole may be expressive of the same underlying theme. For example, the DSM diagnosis of Narcissistic Personality Disorder

describes the grandiose or arrogant version of narcissistic psychology, which tends to dominate when a narcissistic person's self-esteem is inflated and defenses are serving their protective functions. But it omits the depressed-depleted version of the same psychology, in which grandiose defenses fail and self-esteem is painfully *deflated* (for a history of the grandiose and vulnerable subtypes of narcissism, see Grenyer, 2013). It is truer to clinical experience to characterize narcissistic psychology according to the encompassing theme of ongoing craving for attention and affirmation, with different manifestations depending on the extent to which such "narcissistic supplies" are forthcoming.

Changes from PDM-1 to PDM-2

In the PDM-2, we tried to improve on PDM-1 while retaining its focus on the personality patterns and internal experience of individuals seeking treatment. Below, we summarize some of the significant modifications from the first to the second edition.

Conceptualization of "Borderline" Syndromes

The first edition of the PDM followed Kernberg's notion that borderline personality "organization" represents the large super-cluster of personality pathology that subsumes most of the personality disorders included in the DSM. But because clinicians and researchers continue to refer to the specific personality style described in the DSM as borderline personality "disorder," its absence from the PDM-1 was confusing to therapists and perhaps unnecessarily complex for researchers unfamiliar with the psychoanalytic concept of levels of personality organization. In PDM-2, although we retained the original conception of borderline "organization" as a super-cluster, we also added the more specific and narrowly identified "borderline personality" descriptor.

The new borderline personality syndrome included in PDM-2 allows clinicians to re-think the traditional DSM diagnostic criteria using more dynamic thinking that better captures its psychological complexity. Thus, we note the tensions between identity integrity and diffusion in the "self-cohesion versus fragmentation" domain, and acknowledge the intense affect storms that necessarily result when contradictory feeling states remain compartmentalized and therefore cannot modulate one another. In addition, we highlight the sense of emptiness and unreality often expressed by people with severe versions of the disorder via the pathogenic belief descriptor "I don't know who I am" (in psychoanalytic terminology, the person may be said to inhabit dissociated self-states rather than having a sense of continuity, or to have split and unintegrated self and object representations). These descriptors help readers make useful links to some core techniques of evidence-based therapies for borderline personality, such as a focus on reconciling and integrating parts of the self that seem contradictory. They assist, for example, in conceptualizing and treating the borderline man who considers himself loving toward important others, whose love turns abruptly to rage when they disappoint him.

Addition of a Psychotic Level of Organization

Another important conceptual change from PDM-1 to PDM-2 is the addition of the psychotic level of personality organization. This modification allows greater attention to the severity of psychopathology seen at the lowest levels of personality functioning. Stern's (1938) original observations of a group of patients at the "border line" between neurosis and psychosis, which ushered in decades of theorizing, reminds us of the need to focus on psychotic parts of personality functioning even in patients without diagnosable psychotic disorders such as schizophrenia. In Kernberg's (1984) model, the psychotic level is distinguished from the borderline and neurotic levels by deficits in reality testing. Here we would locate the man with a

fixed belief that his body is permeated with the smell of rotting meat, or the anorexic teenage girl who believes she is overweight, despite being on the verge of starving to death.

Conceptualizing these more severely disturbed patients as organized at a psychotic level permits attention to needed modifications of psychotherapy technique. In general, the more fragile, primitive, and paranoid the patient, the more the therapist needs to focus on safety. We know from long clinical experience that therapists who are active, conversational, egalitarian, and respectful, while also embodying knowledge and structure, reduce a patient's need for psychotic defenses. A respectful attitude avoids the humiliation that complicates the emotional life of severely troubled patients and burdens their attitude toward their mental health problems. Similar to clinicians working therapeutically with categorical psychotic disorders such as schizophrenia, therapists working in the psychotic area of any patient's psychology should thus aim to bolster ego strengths and to recognize the psychological context in which the patient's psychotic anxieties become understandable (Garrett & Turkington, 2011).

Readers may be interested to know that among members of the Personality Task Force that created the P Axis for PDM-1, there were differences of opinion about whether to include a psychotic level of personality organization. Interestingly, this was one of the few areas in which committee members had a significant substantive disagreement. Some argued, on the basis of clinical experience, for the inclusion of a psychotic level, while others felt the term "psychotic" had become so associated with specific disorders (especially schizophrenia, schizoaffective disorders, and psychotic versions of bipolar illness) that readers would find the term confusing when applied to the domain of personality. Our resolution of this conflict at that time was to describe personality as existing on a spectrum in which the borderline part of that range extended "to the border of psychotic conditions" (PDM Task Force, 2006, p. 21).

In 2006, we could not locate empirical investigations of the utility to clinicians of thinking in terms of a psychotic level of personality functioning. We thus could not turn to the research literature to resolve the issue, and we consequently decided to err in the conservative direction of not introducing a possibly confusing construct. But since then, colleagues have conducted studies (e.g. Gordon, 2009; Gordon & Bornstein, 2017) demonstrating that for practicing therapists – and not exclusively psychoanalytic therapists, as samples included clinicians of all major theoretical orientations – the idea of some patients being organized at a psychotic level is highly resonant and clinically useful. With this additional information, we made the conceptual change in the 2017 edition.

Organization via Internalizing and Externalizing Spectra

Another innovation in the personality chapters is the introduction of the concepts of "internalizing" and "externalizing" spectra. In the new edition, based on the recurrent appearance of the concepts of internalizing and externalizing pathology in both clinical and empirical writing, we ordered the personality styles in conformance with these superordinate themes. People with internalizing personality pathology are prone to self-criticism and self-blame, as found commonly in depressive, dependent, anxious-avoidant and phobic, obsessive-compulsive, somatizing, and schizoid personalities. In contrast, people with externalizing pathology are prone to blaming others, directing anger, aggression, and criticism toward other people, as found commonly in narcissistic, histrionic, paranoid, psychopathic, and sadistic personalities.

Some Controversies

There are many issues reflected within the PDM-2 about which scholars differ and on which more work needs to be done. There were several areas, for example, in which we were not sure whether to conceptualize a given process as a personality style in its own right, or as a

personality trait or process observable across multiple personality styles. Although the following list is not comprehensive, it should give a sense of our general struggle to organize, for clinical purposes and with scholarly support, the confusing arrays of individual uniqueness that can be conceptualized as personality levels and styles.

Depressive Personality Patterns

The PDM-2 follows the first edition of the PDM in including a depressive personality style or type. Ever since the 1980 revisions of the DSM (DSM-III), such diagnoses have not appeared in its Personality Disorders section. This omission results from an explicit decision by the DSM-III editors in 1980 to eliminate Depressive Personality Disorder as a personality diagnosis. The framers of the DSM-III sought to create a classification of psychiatric disorders based exclusively on manifest, or readily observable, signs and symptoms. Personality was an afterthought (R. Spitzer, personal communication to Jonathan Shedler). Whether by coincidence or design, conceptualizing depressive phenomena solely in terms of “mood disorder” also dovetailed with the interests of pharmaceutical companies, and most contributors to the Mood Disorders section of the DSM have had financial ties to the pharmaceutical industry.

Nevertheless, there is strong clinical and empirical support for the concept of a depressive personality style and disorder. Empirical studies show that it is the most common personality syndrome encountered in psychotherapy practice (Westen & Shedler, 1999; Westen, Shedler, Bradley, & DeFife, 2012), a finding that dovetails with the experience of clinical practitioners. It also appears to be the most common personality style among therapists themselves (Hyde, 2009). Despite the tendency to suffer depressive episodes, it is possible to have a depressive personality style without suffering serious clinical depression. Depressive personality style describes individuals who are self-critical and self-punitive, inclined toward feeling of inadequacy, guilt,

and shame, and organized around themes of loss. In response to life's inevitable hardships and losses, individuals with depressive style believe, consciously or unconsciously, that they are to blame.

In PDM-2, we again drew upon Blatt's (2008) observations about two subtypes of depressive experience, which he termed introjective and anaclitic. People with the more introjective version of a depressive personality style tend toward self-attack and associated feelings of guilt; those with the more anaclitic version are highly reactive to separation, loss, and associated feelings of shame. When alone, they may feel bereft and empty.

Masochistic (Self-Defeating) Patterns

Masochistic or self-defeating personality dynamics have often been construed as variants of depressive personality, an assumption with some empirical support (e.g., Huprich, 2014). Masochistic patterns resemble depressive ones, but masochistic individuals seem highly invested in their own suffering, as if suffering had some great value that must not be relinquished. The masochistic individual appears to have learned that inflicting suffering on oneself, or tolerating mistreatment from others, is the best route to some valued goal (e.g., keeping a relationship, achieving self-esteem, avoiding criticism). In PDM-1, we characterized self-defeating patterns as constituting a separate personality syndrome, but in PDM-2, we instead offer a summary of various conceptualizations that have been discussed in the clinical literature, and a brief discussion of ways it is similar to, and different from, depressive personality per se.

We remain uncertain about how best to locate masochistic/self-defeating patterns. Although masochism is widely understood as an unconscious investment in suffering, and has sometimes been construed as a personality type itself—for example, in Millon's (1996) system or in the DSM-III-R provisional diagnosis of "Self-Defeating Personality Disorder—it can

appear in a wide range of other personality styles, including sadistic, dependent (Bornstein, 2005), narcissistic (Cooper, 1988), and paranoid (Nydes, 1963). In some cases it appears passive-aggressive, in some dependent, and in others it can be more self-preoccupied, as in the "moral masochism" (Reik, 1941) of putting others' needs first while ignoring or renouncing one's own. Because masochism appears as a process within a number of personality styles, it could possibly be formulated as a psychological manifestation that cross-cuts a range of personality styles.

Passive-Aggressive Patterns

Both DSM-I and DSM-II described a "passive-aggressive personality" whose characteristics were, not surprisingly, both passively dependent and provocatively hostile. At the same time, passive aggression has been formulated as a consequence of developmental exigencies in which direct expressions of hostility or antagonism – or even differences of opinion – would be highly maladaptive (as in a family with an authoritarian parent who is punitive toward argumentative children). Both editions of the PDM have conceptualized passive-aggressive patterns, as Millon (1996) did, as a possible subtype of a dependent personality style.

Schizotypal patterns

Broad-ranging controversy exists with respect to the schizotypal style: Is it best understood as a personality syndrome or as a psychotic illness? DSM 5-includes it in both the schizophrenia and personality disorder sections. ICD-9 had allowed it as a personality disorder until September 2015, then moved it to the ICD-10 Schizophrenia section. The ICD-11 will remove all psychotic and schizotypal features from the personality disorders classification (Grenyer, 2017). Historically, schizotypal presentations were labeled "simple schizophrenia" (impoverished affect, speech, and thought) and viewed as being on a psychotic spectrum.

PDM-2 reflects these controversies, conceptualizing schizotypy as both a personality trait (P axis) and a symptom disorder (S axis). Within the P axis, schizotypal features are seen as one possible aspect of schizoid personality, especially toward the psychotic end of the personality continuum (cf. Westen, Shedler, & Bradley, 2012). Schizoid mechanisms are well described in the psychoanalytic literature (Klein, 1946). Schizoid personality includes both schizotypal impoverishments and the relational avoidance, sensitivities, or eccentricities that can be burdensome to therapy but also an opportunity for treatment, if the therapist's style is adapted to respect these acute sensitivities and deficits (McWilliams, 2006). Thus, the troubled loner who is acutely wary may, over time, come to tolerate limited connection to others without becoming overwhelmed.

Hypomanic Patterns

Yet another controversy involves how to understand “hypomanic” phenomena. The issue here is whether a persistent but relatively mild manic pattern that falls short of being diagnosable as bipolar illness is better understood as a personality type or as a subclinical mood disorder. We suspect that, rather than an either-or question, both phenomena exist, making diagnosis and treatment challenging, both medically and psychologically. Medically, if a person's hypomania expresses an underlying mood disorder, a mood-stabilizing drug may be helpful. Some patients with hypomanic patterns do report improvement from such medication, and perhaps that responsiveness alone is adequate basis for inferring that a hypomanic pattern evidences a sub-clinical mood disorder. In other patients, such medications do not seem to help; their hypomanic patterns may be less biologically driven.

Prior to DSM-III, hypomanic syndromes were conceptualized as personality disorders: “hypomanic” in DSM-I and “cyclothymic” in DSM-II. Professional thinking at the time was that

denial and reaction formation (against underlying depressive affect) can be organizing personality defenses that creates a stable or recurrent hypomanic state not indicative of a biologically based mood disorder. More recently, consonant with the general trend in psychiatry toward assumed biological etiologies, psychiatric bias in accounting for hypomanic patterns favors construing them as sub-clinical mood disorders.

This issue has important clinical implications. Hypomanic presentations can be in the service of avoiding situational depressive feelings, as in the behavior of some young people who apply to countless universities in an effort to ward off anxieties that they will be accepted into none. Such patients can be treated by interpretation of their defenses and exploration of the feelings that the manic activity counteracts. Presumably, people with a hypomanic personality style would benefit from a similar interpretive emphasis. In contrast, when a hypomanic presentation expresses a bipolar illness, such interpretive interventions would accomplish little. Pharmacological treatment is likely in order, and the therapist would be wise to shift the initial focus of therapy from interpreting defenses to helping the person to avoid risky behaviors.

High-functioning people with hypomanic defenses rarely seek psychotherapy, and so we have scant clinical experience with versions of the personality type that may be stable and adaptive. Usually, individuals that therapists have construed as characterologically hypomanic come to treatment when their defenses have failed and they have been overwhelmed, at least briefly, with intense dysphoric affect. Because they have a tendency to bolt from treatment as soon as their hypomanic adaptations are reestablished, they may be difficult to keep in therapy long enough to help with their personality issues. It is thus critical for therapists to have some psychodynamic understanding of the defenses involved and their function.

Our way of dealing with these complicated issues in PDM-2 was similar to our approach in PDM-1. We retained the notion of a hypomanic style as expressing one version of the operation of denial, i.e., as a persistent defense interwoven in stable dynamics that express themselves in a pattern of personality notable for charm, quick wit, impulsivity, distractibility, hypersexuality, and general sped-up-ness. At the same time, in other sections of the manual we acknowledged hypomanic states as a part of both mild and serious mood disorders.

Anxious Patterns

Another area of debate concerns anxiety, again because it can have both symptom features and longer-term personality characteristics. For example, there is disagreement as to whether “generalized anxiety disorder,” typically a symptom on the S axis (as in DSM-5 and ICD-10), can in many patients be better understood as a pervasive personality pattern affecting most everyday activities. The PDM-2 has included anxiety in both sections and acknowledged the variety of presentations in terms of severity and intention. The free-floating anxious personality can range from psychotic levels of functioning that might include paranoid delusions and annihilation fears, through to neurotic worries expressed in forms such as hysterical to obsessional traits or moral preoccupations. Similarly, anxieties may be directed at avoidance of specific objects or phobic worries about particular situations.

Anxiety has always had a special place in psychoanalysis. It was recognized early as central to many forms of psychopathology, not only in its role as signaling threat and symbolizing conflict, but also because of its triggering mental defenses to ward off or isolate parts of the self from those threats and conflicts (Freud, 1926). There is good empirical data showing how core anxiety preoccupations, including separation or abandonment fears, can

become an ongoing personality feature that requires deeper and longer psychotherapy processing (Kirsten, Grenyer, Wagner, & Manicavasagar, 2008).

Concluding Comments

The move from the PDM-1 to PDM-2 has provided a timely opportunity to clarify our thinking around how different manifestations of personality can be understood dynamically, developmentally, dimensionally, by level of severity, and by the organization of underlying conflictual themes. What sets the *Psychodynamic Diagnostic Manual* apart from the DSM and ICD models is the effort to describe underlying psychological processes that give rise to manifest symptoms and presenting problems. The PDM helps clinicians understand conflictual tensions between underlying tendencies.

The PDM-2 attempts to help practitioners, especially newer clinicians, to make sense of their patients' personality styles and possible disorders. It provides a general exposure to the psychoanalytic concept of levels of healthy, neurotic, borderline, and psychotic personality structure, but it also can now more precisely assist in the understanding of individuals who fit within a narrower definition of borderline personality disorder. The PDM-2 has expanded to allow further description of the more psychotic aspects of personality and has called attention to broader internalizing and externalizing spectra that emerge consistently in efforts to map both personality and symptom syndromes. There remain a number of controversies that have not yet been resolved by either research or clinical consensus. We hope that PDM-2 will inspire further work that will shed more light on unresolved conceptual issues.

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