Online Supplement to **Psychodynamic Diagnostic Manual, Second Edition**

PDM-2

Edited by

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Contents

Psychodiagnostic Chart–2 (PDC-2)

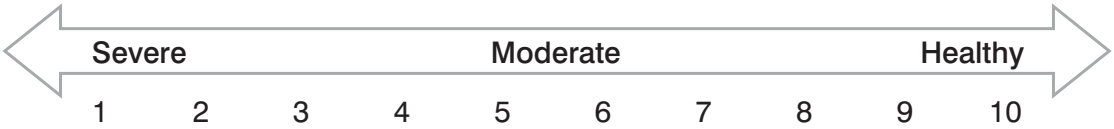
Psychodynamic Diagnostic Chart–2, Adult Version 8.1

Name: _____ Age: ___ Gender: _____ Ethnicity: _____

Date of evaluation: ___/___/___ Evaluator: _____

Section I: Level of Personality Organization

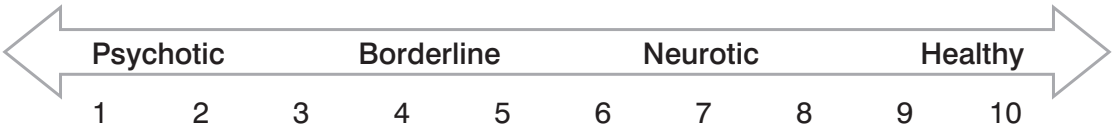
Consider your client's mental functions in determining the level of personality organization. Use these four mental functions to efficiently capture the level of personality organization. Rate each mental function on a scale from 1 (Severely impaired) to 10 (Healthy).



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.



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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.)

(There are no sharp cutoffs between categories. Use your clinical judgment.)

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 level.

Check off as many personality syndromes as apply from the list below; 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

(continued)

Level of severity

☐ **Anxious–avoidant and phobic** ___
Subtype:
- Converse manifestation: Counterphobic

☐ **Obsessive–compulsive** ___

☐ **Schizoid** ___

☐ **Somatizing** ___

☐ **Hysteric–histrionic** ___
Subtypes:
- Inhibited
- Demonstrative

☐ **Narcissistic** ___
Subtypes:
- Overt
- Covert
- Malignant

☐ **Paranoid** ___

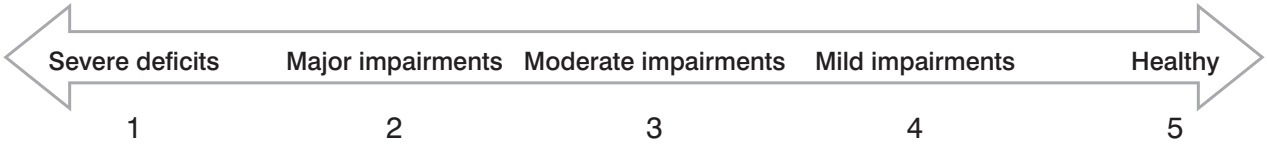
☐ **Psychopathic** ___
Subtypes:
- Passive–parasitic, "con artist"
- Aggressive

☐ **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.



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- **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 ___
- **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 ___
- **Defense and coping**
  7. Impulse control and regulation ___
  8. Defensive functioning ___
  9. Adaptation, resiliency and strength ___
- **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 ___

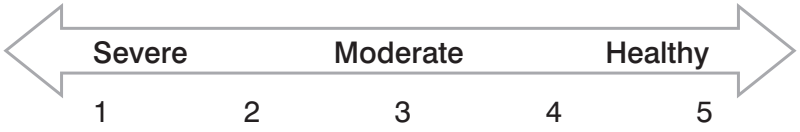
Overall level of personality severity (Sum of 12 mental functions): ___

[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-2 symptom patterns (those that are predominantly related to psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

(continued)

Section V: Cultural, Contextual, and Other Relevant Considerations

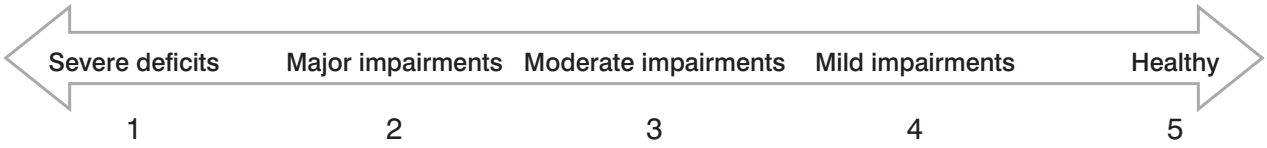
Psychodiagnostic Chart—Adolescent (PDC-A)

Name: _____ Age: ___ Gender: _____ Ethnicity: _____

Date of evaluation: ___/___/___ Evaluator: _____

Section I: Mental Functioning (MA Axis)

Rate your patient'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.



- **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 ___
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) ___
  5. Capacity for relationships and intimacy ___
  6. Capacity for self-esteem regulation and quality of internal experience ___
- **Defense and coping**
  7. Capacity for impulse control and regulation ___
  8. Capacity for defensive functioning ___
  9. Capacity for adaptation, resiliency, and strength ___
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) ___
  11. Capacity to construct and use internal standards and ideals ___
  12. Capacity for meaning and purpose ___

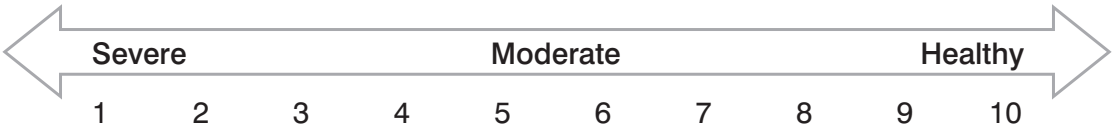
Overall level of personality severity (Sum of 12 mental functions): ___

[Healthy/optimal mental functioning 54–60; Good/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]

(continued)

Section II: Level of Personality Organization

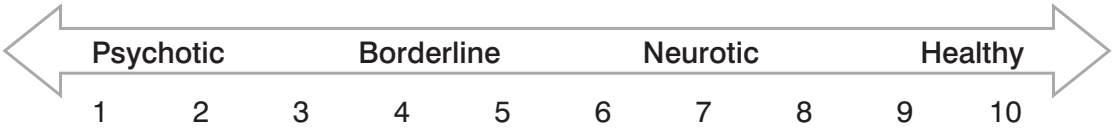
Consider your patient's mental functions in determining the level of personality organization. Use these four mental functions to efficiently capture the level of personality organization. The clinician should keep in mind the stage of adolescence presented by the patient: early adolescence (approximately 11–13 years old), middle adolescence (approximately 14–18 years old), or late adolescence (19–21 years old). 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.



"Normal" emerging personality patterns (Healthy): Characterized by mostly 9–10 scores. These adolescents demonstrate a cohesive emerging personality organization in which their biological endowments, including their temperamental vulnerabilities, are managed adaptively within developmentally appropriate relationships with families, peers, and others. In relation to their stage of adolescent development, they have an increasingly organized sense of self, comprising age-appropriate coping skills and empathic, conscientious ways of dealing with feelings about self and others.

Mildly dysfunctional emerging personality patterns (Neurotic): Characterized by mostly 6–8 scores. These adolescents demonstrate a less cohesive emerging personality

(continued)

organization in which their biological endowments, including their temperamental vulnerabilities, are managed less adaptively. Early in life, their primary caregivers may have had trouble helping them manage these constitutional dispositions. Thus relationships with families, peers, and others are more fraught with problems. Such adolescents do not navigate the various developmental levels as successfully as those with less problematic endowments and/or more responsive caregivers. However, their sense of self and their sense of reality are pretty solid. As development proceeds, their adaptive mechanisms may be apparent in moderately rigid defensive patterns, and their reactions to adversities may be somewhat dysfunctional.

Dysfunctional emerging personality patterns (Borderline): Characterized by mostly 3–5 scores. These adolescents demonstrate vulnerabilities in reality testing and sense of self. Such problems may be manifested by maladaptive ways of dealing with feelings about self and others. Their defensive operations may distort reality (e.g., their own feelings may be perceived in others, rather than in themselves; the intentions of others may be misperceived).

Severely dysfunctional emerging personality patterns (Psychotic): Characterized by mostly 1–2 scores. These adolescents demonstrate significant deficits in their capacity for reality testing and forming a sense of self, manifested by consistently maladaptive ways of dealing with feelings about self and others. Their defensive operations interfere with basic capacities to relate to others and to separate their own feelings and wishes from those of others. (Use 3 for adolescents who go between psychotic and borderline levels.)

(There are no sharp cutoffs between categories. Use your clinical judgment.)

Section III: Emerging Adolescent Personality Styles/Syndromes (PA Axis)

In addition to considering level of organization, adolescent patients begin to demonstrate an emerging personality style. Rather than thinking of these styles as categorical diagnoses, it is more useful for clinicians to think of the relative degree to which the patient might be exhibiting an emerging style.

Check off as many personality syndromes as apply from the list below; 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**	___
☐ **Anxious–avoidant**	___
☐ **Schizoid**	___

(continued)

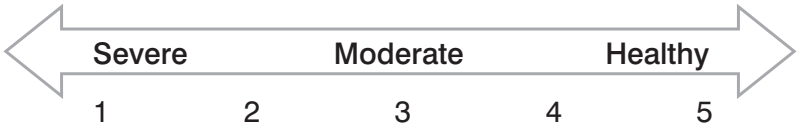
Level of severity

- ☐ **Psychopathic–antisocial** ___
- ☐ **Narcissistic** ___
- ☐ **Paranoid** ___
- ☐ **Impulsive–histrionic** ___
- ☐ **Borderline** ___
- ☐ **Dependent–victimized** ___
- ☐ **Obsessive–compulsive** ___

Section IV: Symptom Patterns (SA Axis)

List the main PDM symptom patterns (those that are related to predominantly psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

Section V: Cultural, Contextual, and Other Relevant Considerations

_____

_____

_____

_____

_____

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_____

_____

Psychodiagnostic Chart—Child (PDC-C)

Name: _____ Age: ___ Gender: _____ Ethnicity: _____

Date of evaluation: ___/___/___ Evaluator: _____

Section I: Mental Functioning (MC Axis)

Rate your patient's level of strength or weakness on each of the 11 mental functions below, on a scale from 1 to 5 (1 = Severe deficits; 5 = Healthy). Then sum the 11 ratings for a level-of-severity score.

Severe deficits	Major impairments	Moderate impairments	Mild impairments	Healthy
1	2	3	4	5

- **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 ___
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) ___
  5. Capacity for relationships and intimacy ___
  6. Capacity for self-esteem regulation and quality of internal experience ___
- **Defense and coping**
  7. Capacity for impulse control and regulation ___
  8. Capacity for defensive functioning ___
  9. Capacity for adaptation, resiliency, and strength ___
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) ___
  11. Capacity to construct and use internal standards and ideals ___

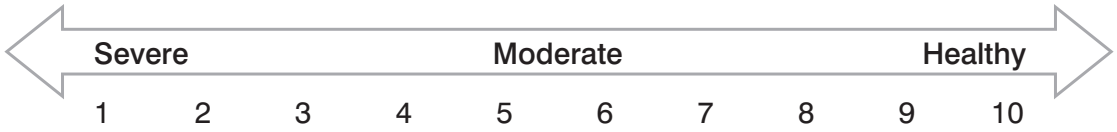
Overall level of personality severity (Sum of 11 mental functions): ___

[Healthy/optimal mental functioning, 50–55; Good/appropriate mental functioning with some areas of difficulty, 43–49; Mild impairments in mental functioning, 37–42; Moderate impairments in mental functioning, 30–36; Major impairments in mental functioning, 24–29; Significant defects in basic mental functions, 17–23; Major/severe defects in basic mental functions, 11–16]

(continued)

Section II: Emerging Level of Personality Pattern and Difficulties

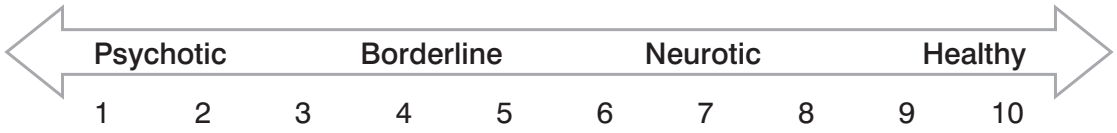
Consider your patient's mental functions in determining the level of personality organization. Use these four mental functions to efficiently capture the current personality patterns and difficulties leading to an emerging level of personality organization. Age-specific characteristics, as well as the high level of fluidity in symptomatology during this stage of development, should be considered—as should other specific external factors influencing current clinical presentation. Rate each mental function on a scale from 1 (Severely impaired) to 10 (Healthy).



1. **Identity:** Emerging ability to view self in age-appropriate, stable, and accurate ways ___
2. **Object relations:** Emerging ability to maintain intimate, stable, and satisfying relationships ___
3. **Emerging personality pattern** (using the guide below, select a single number): ___
   - 1–2: Psychotic level
   - 3–5: Borderline level
   - 6–8: Neurotic level
   - 9–10: Healthy level
4. **Reality testing:** Ability to appreciate conventional notions of what is realistic ___

Overall Emerging Personality Organization

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



"Normal" emerging personality patterns (Healthy): Characterized by mostly 9–10 scores. These children demonstrate a cohesive emerging personality organization in which their biological endowments, including their temperamental vulnerabilities, are managed adaptively within developmentally appropriate relationships with families, peers, and others. In relation to their stage of development, they have an increasingly organized sense of self, comprising age-appropriate coping skills and empathic, conscientious ways of dealing with feelings about self and others.

Mildly dysfunctional emerging personality patterns (Neurotic): Characterized by mostly 6–8 scores. These children demonstrate a less cohesive emerging personality organization in which their biological endowments, including their temperamental

(continued)

vulnerabilities, are managed less adaptively. Early in life, their primary caregivers may have had trouble helping them manage these constitutional dispositions. Thus relationships with families, peers, and others are more fraught with problems. Such children do not navigate the various developmental levels as successfully as those with less problematic endowments and/or more responsive caregivers. However, their sense of self and their sense of reality are progressing in an age-appropriate manner. As development proceeds, their adaptive mechanisms may be apparent in moderately rigid defensive patterns, and their reactions to adversities may be somewhat dysfunctional.

Dysfunctional emerging personality patterns (Borderline): Characterized by mostly 3–5 scores. These children demonstrate vulnerabilities in reality testing and sense of self. Such problems may be manifested by maladaptive ways of dealing with feelings about self and others. Their defensive operations may distort reality (e.g., their own feelings may be perceived in others, rather than in themselves; the intentions of others may be misperceived).

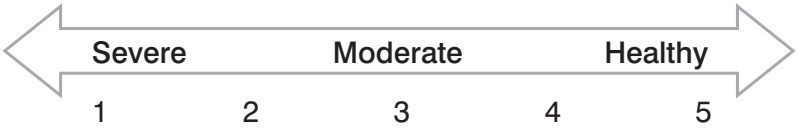
Severely dysfunctional emerging personality patterns (Psychotic): Characterized by mostly 1–2 scores. These children demonstrate significant deficits in their capacity for reality testing and forming a sense of self, manifested by consistently maladaptive ways of dealing with feelings about self and others. Their defensive operations interfere with basic capacities to relate to others and to separate their own feelings and wishes from those of others.

(There are no sharp cutoffs between categories. Use your clinical judgment.)

Section III: Symptom Patterns (SC Axis)

List the main PDM symptom patterns (those that are related to predominantly psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

(continued)

Section IV: Influencing Factors and Relevant Clinical Observations Informing Diagnosis

1. Epigenetics: _____

_____

2. Temperament: _____

_____

3. Neuropsychology: _____

_____

4. Attachment style _____

_____

5. Sociocultural influences: _____

_____

6. Countertransference–transference manifestations: _____

_____

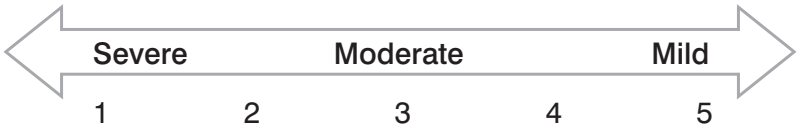
— Psychodiagnostic Chart—Infancy and Early Childhood (PDC-IEC) —

Name: _____ Age: ___ Gender: _____ Ethnicity: _____

Date of evaluation: ___/___/___ Evaluator: _____

Section I: Primary Diagnoses

List the main IEC diagnoses and rate the level of severity for each, using a 1–5 scale. If necessary, you may use the DC: 0–3R, DC: 0–5, or DSM diagnosis here.



Principal diagnosis: _____ Level: _____

Other diagnosis: _____ Level: _____

Other diagnosis: _____ Level: _____

Section II: Functional Emotional Developmental Capacities

Circle the child's level of strengths or deficits on each of the six emotional functions below, on a scale from 1 to 5 (1 = Severe deficits; 5 = Healthy).

Level	Expected emotional function	Rating scale				
1	Shared attention and regulation	5	4	3	2	1
2	Engagement and relating	5	4	3	2	1
3	Two-way purposeful emotional interactions	5	4	3	2	1
4	Shared social problem solving	5	4	3	2	1
5	Creating symbols and ideas	5	4	3	2	1
6	Building logical bridges between ideas: Logical thinking	5	4	3	2	1

Section III: Regulatory–Sensory Processing Capacities

Axis III describes the child's regulatory–sensory processing profile. There are a number of constitutional–maturational differences in the way in which infants and young children respond to and comprehend sensory experiences and then plan actions. The different observed patterns exist on a continuum from relatively normal variations to disorders.

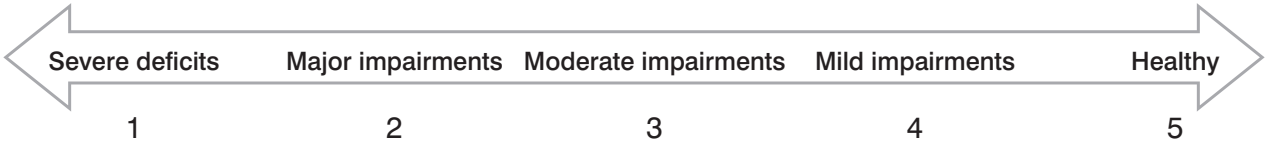
(continued)

Circle the child's level of regulatory–sensory processing capacities in each of the categories below, on a scale from 1 to 4 (1 = Severe problem; 4 = No indication).

Category	Subtype	Challenge in this area			
		No indication; never or rarely a problem	Mild problem or only occasionally a problem	Moderate problem or frequently a problem	Severe problem or almost always a problem
Sensory modulation	Sensory underresponsivity	4	3	2	1
	Sensory overresponsive	4	3	2	1
	Sensory seeking	4	3	2	1
Sensory discrimination	Tactile	4	3	2	1
	Auditory	4	3	2	1
	Visual	4	3	2	1
	Taste/smell	4	3	2	1
	Vestibular/ Propriocep.	4	3	2	1
Sensory-based motor functioning	Postural challenges	4	3	2	1
	Dyspraxis challenges	4	3	2	1

Overall Regulatory–Sensory Profile

Considering the ratings and your clinical judgment, circle the degree to which each regulatory–sensory pattern represents normal variation versus disorder. For scores 1–2, consider a regulatory–sensory processing disorder as a primary diagnosis; for scores 3–4, consider that the disordered regulatory–sensory processing can be associated with other primary diagnoses.



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Section IV: Relational Patterns and Disorders

Each child's relationship with a significant caregiver (mother or father but, if appropriate, custodial parent, grandparent, etc.) should be evaluated in this section. Rate the caregiver–child relationship on each of the eight descriptions below, on a scale from 1 to 5 (1 = Severely impaired; 5 = Healthy). Then sum the eight ratings for the degree to which the pattern represents healthy/adapted relationship versus relational disorder.

Caregiver 1: _____ (please specify)

Infant/child–caregiver relationship	***Rating scale***				
Quality and flexibility of caregiver's representation of the child	5	4	3	2	1
Quality of caregiver's reflective functioning	5	4	3	2	1
Quality of caregiver and child's nonverbal engagement	5	4	3	2	1
Quality of interactional patterns (reciprocity, synchrony, interactive repair)	5	4	3	2	1
Affective tone of the caregiver–infant relationship	5	4	3	2	1
Quality of caregiver's behavior (sensitivity vs. threatening and/or frightening behaviors)	5	4	3	2	1
Quality of caregiving patterns (comfort, stimulation, response to infant emotional signals, encouragement vs. withdrawal, overstimulation, controlling behavior, insensitivity)	5	4	3	2	1
Infant/child's ability to engage and form a significant relationship (vs. specific difficulties that impair this ability)	5	4	3	2	1
	Total score = ___				

Overall Level of Relational Pattern (Caregiver 1)

[Healthy/adapted relational patterns, 36–40; Adapted relational patterns with some areas of difficulty, 29–35; Moderate perturbation or disturbance in relational patterns, 22–28; Significant disturbance in relational patterns, 15–21; Major impairments in relational pattern or relational disorders, 8–14]

Attachment Pattern (Caregiver 1)

Rate the caregiver–child relationship as regards attachment patterns on a scale from 1 (no correspondence) to 5 (high correspondence) for each of the four prototypes.

Secure _____

Insecure–avoidant _____

Insecure–ambivalent/resistant _____

Disorganized/disoriented _____

(continued)

Caregiver 2: _____ (please specify)

Infant/child–caregiver relationship	***Rating scale***				
Quality and flexibility of caregiver's representation of the child	5	4	3	2	1
Quality of caregiver's reflective functioning	5	4	3	2	1
Quality of caregiver and child's nonverbal engagement	5	4	3	2	1
Quality of interactional patterns (reciprocity, synchrony, interactive repair)	5	4	3	2	1
Affective tone of the caregiver–infant relationship	5	4	3	2	1
Quality of caregiver's behavior (sensitivity vs. threatening and/or frightening behaviors)	5	4	3	2	1
Quality of caregiving patterns (comfort, stimulation, response to infant emotional signals, encouragement vs. withdrawal, overstimulation, controlling, insensitivity)	5	4	3	2	1
Infant/child's ability to engage and form a significant relationship (vs. specific difficulties that impair this ability)	5	4	3	2	1
	Total score = ___				

Overall Level of Relational Pattern (Caregiver 2)

[Healthy/adapted relational patterns, 36–40; Adapted relational patterns with some areas of difficulty, 29–35; Moderate perturbation or disturbance in relational patterns, 22–28; Significant disturbance in relational patterns, 15–21; Major impairments in relational pattern or relational disorders, 8–14]

Attachment Pattern (Caregiver 2)

Rate the caregiver–child relationship as regards attachment patterns on a scale from 1 (no correspondence) to 5 (high correspondence) for each of the four prototypes.

Secure _____

Insecure–avoidant _____

Insecure–ambivalent/resistant _____

Disorganized/disoriented _____

Section V: Other Medical and Neurological Diagnoses

_____

_____

_____

_____

Psychodiagnostic Chart—Elderly (PDC-E)

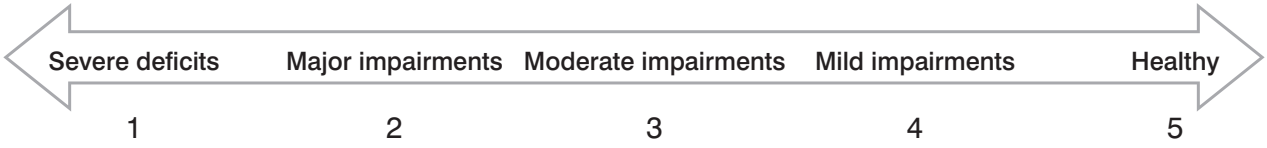
Name: _____ Age: ___ Gender: _____ Ethnicity: _____

Date of evaluation: ___/___/___ Evaluator: _____

Section I: Mental Functioning (ME Axis)

Rate your patient'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.

Although most older adults do not have significant cognitive impairment, it is important to assess for presence of cognitive impairment or neurocognitive disorders that may affect mental functioning.



- **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 ___
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) ___
  5. Capacity for relationships and intimacy ___
  6. Capacity for self-esteem regulation and quality of internal experience ___
- **Defense and coping**
  7. Capacity for impulse control and regulation ___
  8. Capacity for defensive functioning ___
  9. Capacity for adaptation, resiliency, and strength ___
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) ___
  11. Capacity to construct and use internal standards and ideals ___
  12. Capacity for meaning and purpose ___

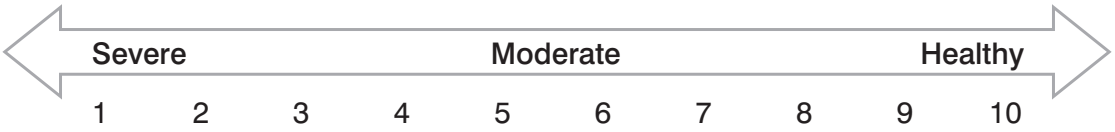
Overall level of personality severity (Sum of 12 mental functions): ___

[Healthy/optimal mental functioning, 54–60; Good/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]

(continued)

Section II: Level of Personality Organization

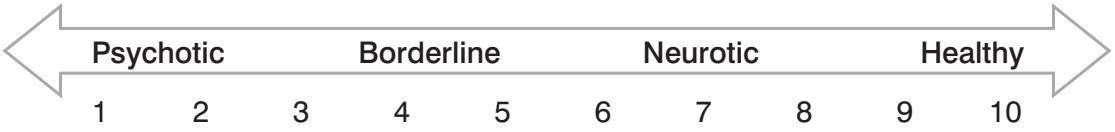
Consider your patient's mental functions in determining the level of personality organization. Use these four mental functions to efficiently capture the level of personality organization, and don't forget you are evaluating an older person who falls into one of these age groups: young-old (55–64 years of age), middle-old (65–74 years of age), old–old (75–84 years of age), and oldest–old (85 years of age or older). 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.)

(continued)

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.)

(There are no sharp cutoffs between categories. Use your clinical judgment.)

Section III: Personality Syndromes (PE 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 level. Don't forget you are evaluating an older person, so take into consideration:

- Possible age-related behavioral features that may confound the diagnosis of a personality syndrome or disorder
- Possible effects of the aging process on previous personality syndromes
- Possible effects of personality syndromes on the aging process

Check off as many personality syndromes as apply from the list below; 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 and phobic** ___

☐ **Obsessive–compulsive** ___

☐ **Schizoid** ___

(continued)

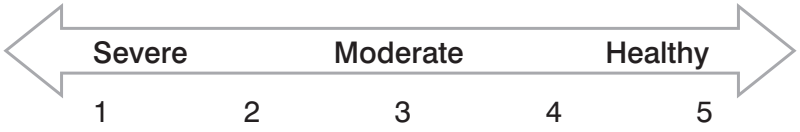
Level of severity

- ☐ **Somatizing** ___
- ☐ **Hysteric–histrionic** ___
- ☐ **Narcissistic** ___
- ☐ **Paranoid** ___
- ☐ **Psychopathic** ___
- ☐ **Sadistic** ___
- ☐ **Borderline** ___

Section IV: Symptom Patterns (SE Axis)

List the main PDM symptom patterns (those that are related to predominantly psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

Section V: Cultural, Contextual, and Other Relevant Considerations

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Additional Clinical Illustrations and PDM-2 Profiles

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Introduction

The clinical illustrations included in this portion of the online supplement to PDM-2 come from different treatment facilities and are written in different styles by the clinicians describing them. Some clients were seen very briefly; others for a long time. Some are described after only a few consultations; others after the end of therapy. Personal details in all clinical illustrations are disguised in accordance with contemporary standards for published case material. The illustrations are organized in the same way as those in Chapter 16 of the manual are (again, with some variations). To demonstrate individual variety, we have included a number of adult cases; however, we feel that one case each in the categories of adolescence, childhood, infancy/early childhood, and later life is adequate to demonstrate the PDM-2 approach to diagnosis. Blank versions of the various PDCs are available both in this online supplement to PDM-2 and in the Appendix to the manual.

Adulthood

Mary-Ann

Personal Data, Family History, and Specific Features of Relationships with Family Members

Mary-Ann is a 54-year-old female patient, the first-born of four siblings, with a significant family psychiatric history: Her paternal grandfather had bipolar I disorder and committed suicide; her father had cyclothymic disorder and obsessive personality traits; her only brother has bipolar I disorder and was once hospitalized for a manic episode with psychotic features; and a younger sister has schizotypal personality disorder.

Mary-Ann was born into an upper-middle-class family. Her childhood was characterized by normal psychosocial development, and she was a good student until high school; after 2 years at a university, however, she quit because of lack of interest. Her father, to whom she was very close, was an entrepreneur in a plastics company, described as affectionate, moody, punctilious, and controlling. Her relationship with her mother (a housewife, described as not very demonstrative, often in low spirits, and aligned with the father's decisions) was characterized in terms of Mary-Ann's feeling misunderstood and jealous of her attention to her other children, intermixed with positive emotions. Overall, the relationship with her siblings was serene, though complicated in the case of her brother and her younger sister by feelings of rivalry that she almost never expressed, on account of her parents' lack of understanding and her fear of their criticism.

Mary-Ann's adolescence was generally normal, but she felt that she was not good-looking enough; she also had a strong need to be noticed and admired by her peers, especially boys, with whom she was shy (despite considering herself interesting and often superior to her female friends). She describes herself as inclined to sadness and very sensitive to problems in interpersonal relationships, which easily generate feelings of inadequacy. She feels she has a tendency to uncritical submission, alternating with anger toward others.

Mary-Ann is heterosexual and she married at age 24 and had a son and a daughter. At the beginning of the relationship with her husband, she felt important and appreciated; then gradually she experienced a sense of rejection and emotional distance from her husband, leading her to characterize him as an "icy" man. The daughter had some eating disorders in late adolescence that developed into anorexia nervosa, which continues despite various attempts at treatment with partial results. Her son has for years had an antagonistic attitude toward her, sometimes bordering on mistreatment, even after his departure from the parental home.

For a number of years, Mary-Ann worked as a general administrative assistant in an organization for the protection of animals. Some time ago she quit this job, feeling dubious about her responsibilities and exploited on a personal level by the acquaintance who ran the office. For several years now she has managed the family-of-origin business; she alternates between self-criticism, with a sense of ineptitude in this role, and the belief that she has to handle everything on her own, with anger toward her siblings for being ungrateful and self-centered.

History of the Problem

At age 25, Mary-Ann first entered treatment, classical psychoanalysis (four sessions weekly), in which she stayed for 2 years. She described the results as "mediocre," especially with respect to her ongoing sense of unfulfilled needs.

Next, at age 40, she sought psychiatric treatment, complaining of depressive symptoms of medium severity, with anxiety, insomnia, and a tendency to ruminate that had lasted for several months. She connected these symptoms to having discovered her husband's infidelity, to which she had responded with her own extramarital relationship—eventually a disappointment, due in part to her overidealized expectations. Two years before seeking the psychiatric treatment, she had entered cognitive psychotherapy (twice weekly) on her own initiative, combined with homeopathic medicine treatment; again, she complained of meager results, attributing these alternately to her own inadequacy and to the therapist's lack of interest. Her overall condition was characterized by a perception of herself as damaged and falling apart, along with intense feelings of worthlessness, ineptitude, and deep anger toward the world. Given Mary-Ann's low tolerance for frustration and difficulty with impulse control, this anger, habitually masked by a passive–aggressive attitude, could flare up openly. She also experienced anxiety, polarized around recent episodes in her love life, along with insomnia with early awakening. She further noted excessive alcohol consumption (one bottle of wine daily and several glasses of whiskey in the evening), connected to moments of stress; however, while on she was on vacations, away from the family and everyday environment, she was able to interrupt the alcohol use without difficulty or cravings.

The psychiatrist prescribed pharmacotherapy with tricyclic antidepressants and benzodiazepines at low dosage, which she took regularly; no increase was necessary at later checkups, which showed a gradual abatement of symptoms to the point of near-complete remission over 4 months. The medication was therefore reduced to a single antidepressant in the evening for 2 months, after which the patient suspended it on her own initiative, while continuing the cognitive psychotherapy despite her skeptical outlook.

After this period, she consulted the psychiatrist on an annual basis. She experienced periodic reexacerbations of her depressive symptoms, usually in connection with such problems as difficulties with her husband, son, daughter, or other relatives. Her emotional relationships continued to be characterized by excessive submission alternating with rage, impulsiveness, and an increase in malaise and self-criticism. Her condition was always experienced with an alternation between self-disparagement and outbursts of rage, which made it difficult for the patient to accept help in a collaborative way.

About 8 years ago, Mary-Ann quit the cognitive psychotherapy, which she had long considered useless and expensive even while continuing it. Shortly thereafter, she showed a tendency to feel abandoned and to take a hyperaccommodating, manipulative attitude toward the psychiatrist—who was now her only professional connection, and whom she asked to become her therapist as well. With some difficulty, the psychiatrist suggested that they jointly examine her psychological needs and identify a figure who could be brought in to help with them. Her difficulty in modifying central problems in her personality (such as the tendency to hold herself to extremely high standards, leading to constant self-criticism in regard to mistakes or doubts, or her profound sense of being alone and misunderstood in her suffering, which nevertheless she felt to be primarily her own fault) prompted the psychiatrist to refer her to a psychologist, who agreed to avoid regularly scheduled sessions and to give the patient guidance on managing concrete problems (the family business, the economic support of her daughter, etc.). The psychologist also worked to discourage her tendency toward the intellectual control of emotions and almost magical investment in thought as a tool for change. Antidepressant treatment was continued at a low dosage, since it was believed helpful in controlling Mary-Ann's symptoms, even though her low mood was believed to be more closely connected to a personality disorder than to a depressive disorder.

Current Situation

In recent years, this therapeutic approach has allowed Mary-Ann to invest more in practical personal questions, to improve her functional capacities somewhat by shielding them from indiscriminate self-criticism, and to achieve an appreciable reduction in the intensity and frequency of her depressive and anxiety-related symptoms. There have been no more incidents of excessive alcohol consumption. Mary-Ann has also been able to avoid being seriously destabilized by the death of her father.

DSM-5/ICD-10 Diagnosis

Persistent depressive disorder (dysthymia) (ICD-10-CM code: F34.1)

Other specified personality disorder (mixed personality features) (ICD-10-CM code: F60.89)

Alcohol use disorder (mild) (ICD-10-CM code: F10.10)

PDM-2 Diagnosis

P Axis

Mary-Ann's central tension seems to involve goodness versus badness and her central affects are sadness, guilt, shame, and anger. Her main defenses are devaluation of herself and idealization of others.

Personality syndrome: Depressive personality
Level of personality organization: Borderline

M Axis

Almost all domains in mental functioning show major constrictions and alterations. There are significant limitations of experience of adequate feelings and/or thoughts in important life areas (work, relationships, etc.).

M05. Major impairments in mental functioning (range = 26–32)

S Axis

S21. Persistent depressive disorder (dysthymia)

S71.1. Substance-related disorders

PDM-2 Profile on the PDC-2

A completed PDC-2 for Mary-Ann, revealing her full PDM-2 profile, is provided in Figure S.1.

(text resumes on page 9)

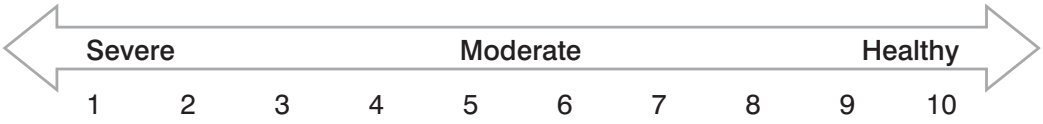
Psychodiagnostic Chart–2 (PDC-2)

Name: Mary-Ann Age: 54 Gender: Female Ethnicity: European

Date of evaluation: XX / XX / XX Evaluator: Psychologist

Section I: Level of Personality Organization

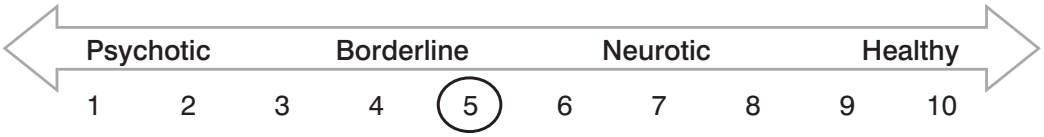
Consider your client's mental functions in determining the level of personality organization. Use these four mental functions to efficiently capture the level of personality organization. Rate each mental function on a scale from 1 (Severely impaired) to 10 (Healthy).



1. **Identity:** Ability to view self in complex, stable, and accurate ways 4
2. **Object relations:** Ability to maintain intimate, stable, and satisfying relationships 5
3. **Level of defenses** (using the guide below, select a single number): 5
   - 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 5

Overall Personality Organization

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



(continued)

FIGURE S.1. A completed PDC-2 for Mary-Ann.

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.)

(There are no sharp cutoffs between categories. Use your clinical judgment.)

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 level.

Check off as many personality syndromes as apply from the list below; 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** 2
Subtypes:
- Introjective
- Anaclitic
- Converse manifestation: Hypomanic

☐ **Dependent** ___
Subtypes:
- Passive–aggressive
- Converse manifestation: Counterdependent

(continued)

FIGURE S.1. *(continued)*

Level of severity

☐ **Anxious–avoidant and phobic** ___
Subtype:
- Converse manifestation: Counterphobic

☐ **Obsessive–compulsive** ___

☐ **Schizoid** ___

☐ **Somatizing** ___

☐ **Hysteric–histrionic** ___
Subtypes:
- Inhibited
- Demonstrative

☐ **Narcissistic** ___
Subtypes:
- Overt
- Covert
- Malignant

☐ **Paranoid** ___

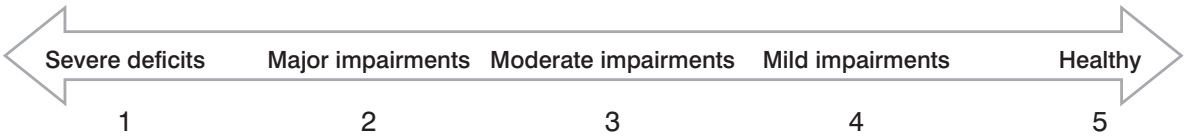
☐ **Psychopathic** ___
Subtypes:
- Passive–parasitic, "con artist"
- Aggressive

☐ **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.



(continued)

FIGURE S.1. *(continued)*

- **Cognitive and affective processes**
  1. Capacity for regulation, attention, and learning 3
  2. Capacity for affective range, communication, and understanding 4
  3. Capacity for mentalization and reflective functioning 2
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) 2
  5. Capacity for relationships and intimacy 3
  6. Self-esteem regulation and quality of internal experience 2
- **Defense and coping**
  7. Impulse control and regulation 3
  8. Defensive functioning 3
  9. Adaptation, resiliency and strength 3
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) 3
  11. Capacity to construct and use internal standards and ideals 2
  12. Meaning and purpose 2

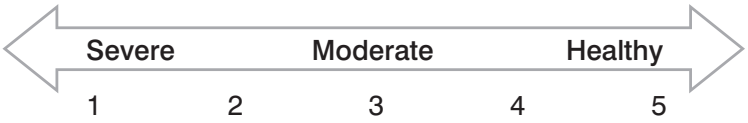
Overall level of personality severity (Sum of 12 mental functions): 32

[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-2 symptom patterns (those that are predominantly related to psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: Persistent depressive disorder (dysthymia) Level: 2

Symptom/concern: Substance-related disorders Level: 2

Symptom/concern: _____ Level: ___

(continued)

FIGURE S.1. *(continued)*

Section V: Cultural, Contextual, and Other Relevant Considerations

Mary-Ann is a 54-year-old European woman, heterosexual, born into an upper-middle-class family. Mary-Ann has familiarity with psychiatric disorders through her family's history of such disorders.

FIGURE S.1. *(continued)*

Berta

This case is drawn from the medical records of hospitals. Consequently, it lacks some information contained in other cases. We have included such a case with the intention of illustrating how the PDM-2 approach may be applied in institutional contexts.

Personal Data, Family History, and Specific Features of Relationships with Family Members

Berta is a 40-year-old self-employed photographer who grew up in an upper-class family. The mother worked as a headmistress; the father, who died 10 years ago, was director of a travel agency. She has no siblings. After graduation, she attended a specialized graphic education and research institute, and then worked as a photographer in an upper-class urban district. She has been freelancing for 9 years, with her main focus on industrial photography.

Berta is heterosexual and lives alone, but in the last 12 years she has had a male partner, a lawyer, with whom she has a very good relationship. They have no children. Berta has a large circle of friends and a good relationship with her mother, who lives nearby.

She has a small studio in a desirable district and hires an assistant for some jobs. In the past 6 months, she has worked on a very large project. Berta is ambitious, sociable, intelligent, educated, and careful to be socially correct. She is energetic to the point of workaholism. She appears neat and stylish and is of normal weight.

History of the Problem

Medical History

Berta had an appendectomy at age 12. Ten years ago, she experienced a hypomanic phase, in which she worked for 10 days with a substantially reduced need for sleep. Friends had to care for her and brought her to the hospital, from which she was discharged the same evening with some medication for sleep. After she had slept well, she felt well again and was no longer hypomanic.

Five years ago, Berta went through a depressive phase. The family physician prescribed antidepressant medication (the selective serotonin reuptake inhibitor fluoxetine), which the patient did not take. Without it, her depression remitted after a few weeks.

Now she has been severely depressed for 6 weeks. She has again been prescribed fluoxetine, and has been taking it this time. Four days ago, she attempted suicide with 40 tablets of fluoxetine. She was found by her mother, who brought her to the emergency department of the local hospital for detoxification.

Illnesses in the Family

Father: Died of pancreatic cancer

Grandfather (paternal): Died of a heart attack

Grandmother (paternal): Died after a kidney operation

Grandparents (maternal): Died of old age

Current Situation

Berta begins the conversation with the hospital psychiatrist by saying, "I come from the detoxification unit because I have swallowed 40 tablets." Berta is severely depressed, with current suicidal ideation, for which she has been taking fluoxetine. Her vegetative history as she describes it includes a general state of exhaustion, weakness, pronounced sleep disturbances, extreme constipation, dry mouth, loss of appetite, and loss of libido.

Berta moves slowly and slumps in her chair, with her hands lying limp at her sides. She looks at the ground, avoids eye contact, and speaks slowly and laboriously, as if exhausted. She occasionally responds to comments with a slight nod or speaks after a long delay, saying in a weak voice fragmentary sentences such as, "Do not know . . ." Behind all this can be felt a silent anger, as if feelings are a nuisance for her.

Further Observations

Current Thoughts and Feelings

Berta does not want to live any longer, saying that everything is empty and meaningless. She has no sense of agency and no ideas for her career; she feels empty and without energy. She often says, "This will never get better," or "Even my mother and my friend can't help me there," or "I'm feeling guilty about the helplessness," or "There is nothing that could help me."

Mental Functioning Status

- Depressive mood, with loss of interests and happiness
- Reduced energy and vitality and increased exhaustibility
- Loss of self-esteem and self-confidence
- Unfounded self-reproaches
- Recurrent suicidal ideation and thoughts of death
- Complaints of reduced mental activity
- Inability to concentrate, think, and solve problems
- Vegetative symptoms (i.e., psychomotor slowdown with concomitant inner disturbance, sleep disturbance, and loss of appetite/weight)

Relevant Affects, Defenses, Main Concerns, Pathogenic Beliefs, and Therapist's Reactions

Berta's current state is associated with strong depressive affect, somatic/vegetative symptoms, and depressed mood that clearly differs from ordinary mourning. Berta's depression has led to an affective change that is disproportionately large and seems to have occurred without a trigger. Symptom constellations such as cognitive limitations, characteristic slowdown in thoughts and language, changes in sleep architecture, drive disorders, and autonomic dysfunction are typical for clinical depression.

Because the patient has reported a hypomanic phase in the past, her depression is viewed as part of a bipolar disorder.

The therapist finds Berta a stimulating and captivating patient, even though the therapist feels overwhelmed, confused, and overstimulated after a few sessions.

Treatment Indications

The proposed therapeutic approach is based on Berta's inferred central inner dynamics. On the one hand, Berta shows a dependent (entangled) processing of the depressive conflict. She fears that the realization of her own interests (desires, etc.) or the expression of her own assertiveness will put others off and they will leave her. The therapeutic goal would be to resolve the "turning against the self" and help her to understand and contain her guilt feelings. Her presumed unconscious belief that losses occur because she is inadequate or bad should be exposed and confronted. A working alliance will be hard to establish because Berta is ambivalent, convinced that she is not "allowed" to receive therapy.

On the other hand (and this side is more overt), her avoidant object relationship style leads her to view her need for treatment as contemptible. Containment of her self-devaluation would be a primary therapeutic goal.

In summary, insight into her depressive conflict; focus on the value of containment; recognition of hidden, painful emotions and pathological patterns; and working through these issues would be the longer-term treatment objectives.

DSM-5/ICD-10 Diagnosis

Bipolar II disorder, current episode depressed, severe (ICD-10-CM code: F31.81)

PDM-2 Diagnosis

P Axis

Personality syndrome: Depressive personality, including hypomanic manifestation

Level of personality organization: Borderline

M Axis

M05. Major impairments in mental functioning (range = 26–32)

S Axis

S24. Bipolar disorder

PDM-2 Profile on the PDC-2

A completed PDC-2 for Berta, revealing her full PDM-2 profile, is provided in Figure S.2.

Kevin

Demographic Data

This is the first application for mental health services from this 20-year-old, white, single, heterosexual male patient from a middle-class Irish Catholic family. He was referred by his psychology professor at his university, where he is currently a sophomore and an English major. Kevin is the sole informant and seems reliable.

Chief Complaint

Kevin states that he is coming for help with difficulties in social relationships: "I have trouble making friends and contacts with people. I have no girlfriend, and I feel tense in the presence of people. I find it hard to adjust to school." He states that his social difficulties have been a lifelong problem, but that they are currently more painful than usual because of his feeling pressure at this age to be more socially involved, especially with women. He feels comfortable with a few male students who share his interests and speaks with relief about how his current roommate "doesn't bother him"—unlike the more athletically inclined, fraternity-oriented roommate he had in his freshman year, whose busy social life felt like a constant impingement. He says he feels chronically like a kid who is last in a line of children who are all enjoying a hike: "I'm lagging behind, talking to no one, and being periodically yelled at for slowing everybody down. When I try to catch up, I trip and fall in a mud puddle, and everybody laughs. I try to laugh with them, to pretend that I did it on purpose, but I want to crawl in a hole."

(text resumes on page 17)

Psychodiagnostic Chart–2 (PDC-2)

Name: *Berta* Age: *40* Gender: *Female* Ethnicity: *European*

Date of evaluation: *XX* / *XX* / *XX* Evaluator: *Hospital psychiatrist*

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).

Severe — Moderate — Healthy

1 2 3 4 5 6 7 8 9 10

1. **Identity:** Ability to view self in complex, stable, and accurate ways *3*
2. **Object relations:** Ability to maintain intimate, stable, and satisfying relationships *3*
3. **Level of defenses** (using the guide below, select a single number): *4*
   - 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 *4*

Overall Personality Organization

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

Psychotic — Borderline — Neurotic — Healthy

1 2 (3) 4 5 6 7 8 9 10

(continued)

FIGURE S.2. A completed PDC-2 for Berta.

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.)

(There are no sharp cutoffs between categories. Use your clinical judgment.)

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 level.

Check off as many personality syndromes as apply from the list below; 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** 2
Subtypes:
- Introjective
- Anaclitic
- ✓ Converse manifestation: Hypomanic

☐ **Dependent** ___
Subtypes:
- Passive–aggressive
- Converse manifestation: Counterdependent

(continued)

FIGURE S.2. *(continued)*

Level of severity

☐ **Anxious–avoidant and phobic** ___
Subtype:
- Converse manifestation: Counterphobic

☐ **Obsessive–compulsive** ___

☐ **Schizoid** ___

☐ **Somatizing** ___

☐ **Hysteric–histrionic** ___
Subtypes:
- Inhibited
- Demonstrative

☐ **Narcissistic** ___
Subtypes:
- Overt
- Covert
- Malignant

☐ **Paranoid** ___

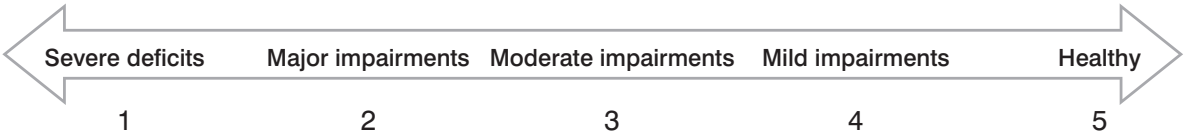
☐ **Psychopathic** ___
Subtypes:
- Passive–parasitic, "con artist"
- Aggressive

☐ **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.



(continued)

FIGURE S.2. *(continued)*

- **Cognitive and affective processes**
  1. Capacity for regulation, attention, and learning 2
  2. Capacity for affective range, communication, and understanding 3
  3. Capacity for mentalization and reflective functioning 3
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) 2
  5. Capacity for relationships and intimacy 3
  6. Self-esteem regulation and quality of internal experience 2
- **Defense and coping**
  7. Impulse control and regulation 2
  8. Defensive functioning 2
  9. Adaptation, resiliency and strength 3
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) 3
  11. Capacity to construct and use internal standards and ideals 2
  12. Meaning and purpose 2

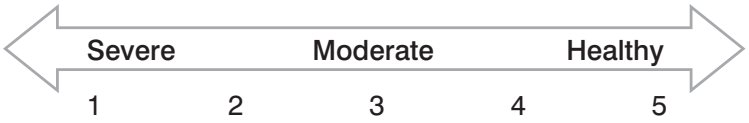
Overall level of personality severity (Sum of 12 mental functions): 29

[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-2 symptom patterns (those that are predominantly related to psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: S24. Bipolar disorder Level: 2

Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

(continued)

FIGURE S.2. *(continued)*

Section V: Cultural, Contextual, and Other Relevant Considerations

Berta is white, heterosexual, and from a privileged family. Consequently, she believes she has no basis for complaint or resentment, and she attributes all her negative feelings to internal failings. Because of the amount of suspected psychopathology in her family, it will be important that she replace depressive pathology with normal mourning for what she has missed in development, despite her family's social position.

FIGURE S.2. *(continued)*

History of the Problem

Kevin says that he has lived his whole life without any close friends of either gender, and that currently he is very intimidated about the prospect of getting close to anyone of the opposite sex. He feels "weak and insignificant" when approached by anyone; all sorts of thoughts go through his mind that leave him feeling paralyzed: Will the person talk to him or ignore him? Should he open up a conversation? If so, what should he say? Asked about the basis for his sense of inadequacy, he states that he has done nothing to be proud of and that he therefore has no reason to have any self-esteem.

An exploration of his current relationships with people leads to some elaboration on his social problems as a first-year student. He immediately felt intimidated by his good-looking, athletic roommate and felt unable to relate to him. This young man was sexually experienced, or at least presented himself that way, and Kevin felt conflicted between his wish to learn from him about how to deal with women and his wish to keep from his roommate the knowledge that he has no social (let alone sexual) experience with females. Because of his sense of humiliation, he says, he found himself avoiding his roommate and making up excuses to go somewhere else when the roommate's friends came around. He was aghast at the idea of having to participate in a conversation in which people bragged about their sexual conquests.

Kevin describes one relationship with a woman who works at the college newspaper. She shares two classes with him and is also bright but very quiet. The behavior he mentions on her part, including sometimes waiting for him when they are both working late so that they can walk back to the dorms together, suggests that she would welcome at least a friendship with him. When the therapist says something to that effect, he immediately replies that she is not attractive to him; she is overweight and wears glasses. Still, even with her, "I become tongue-tied to a ridiculous degree" whenever

the conversation leaves literary or political issues and moves toward social chit-chat or personal disclosure.

Kevin has no difficulty with sleeping or eating. He is withdrawn from his environment, but this has been the pattern throughout his life. He describes more or less chronic, constant low-grade anxiety, which he refers to as feeling "tense." He takes no medication.

Family History

Kevin is the third of eight children. He was born in a city in the eastern United States and moved to a middle-class suburb when he was 11. His father is a 55-year-old college graduate in middle management at a pharmaceutical company. He is described as "a good father, an honest and devoted Catholic, a strict disciplinarian." Kevin emphasizes, however, that he does not show emotions and is not overtly affectionate. The mother is a 51-year-old homemaker with a high school education who recently began to work part time as a secretary in a law firm. Kevin describes her as "a very tense person who tends to panic in situations. She is not forceful with people and puts herself down." He added that she tries to be strict, but never carries out her threats. She is much more affectionate than her husband. Kevin speaks warmly of his mother and states that he likes to spend time with her, but that he is not close to his father.

Kevin's siblings range in age from 22 to 9 years. All live at home with the parents. Kevin says that among his siblings, he is the "oddball," the "black sheep." He reports that the others often tease him for his absent-mindedness, his naiveté, his bookishness, and his lack of physical coordination. He represents this as if it is good-natured kidding, but it appears that he is often the butt of ridicule, and that neither parent has tried to protect him from being painfully teased by his siblings or to suggest to him that there are advantages to being a sensitive, cerebral type of person. There is no diagnosed psychiatric illness in the family.

Personal History

Kevin was born by normal delivery and says that he was a wanted child. Major early milestones were normal. He was bottle-fed from infancy; his mother believed in scheduled feedings. He was sick frequently, with one childhood disease after another. Starting in kindergarten, he often wished he would be sick so that he would not have to go to school. The attacks of September 11, when he was 6 years old, upset him greatly, and he confided in no one about his reactions. Up to age 10, he was extremely fearful of darkness, bugs, and especially spiders. He had repeated nightmares, one of which he remembers distinctly, which was about his father being murdered. He described himself as a very obedient, quiet child who was shy, timid, and afraid of strangers. He never participated in sports and did not like physical activity. He was raised a Catholic and is still observant, though not as regularly as he was when younger.

Kevin's schoolwork was consistently above average. Academically, he succeeded despite his social deficits. He has done extremely well in college, too, and has been encouraged by an eminent professor to consider writing as a career. When the interviewer asks him about his literary interests, he reveals an unusual breadth of knowledge about literature and poetry.

Puberty began at age 12. Kevin noted with some embarrassment that it was his mother who provided him with sexual information. Masturbation began at age 14,

about which he felt very ashamed, since he viewed it as a mortal sin. He masturbates about twice a week now, and although he has concluded that it is not sinful, he still feels he is doing something dirty and unacceptable. When asked about his fantasies, he lowers his head and whispers that he is ashamed to describe them, but they are mostly violent and sadistic.

Medical history is unremarkable except for one long (8-week) stay in the hospital at age 7 after complications from a tonsillectomy.

Childhood memories include numerous painful incidents of being teased by his siblings (both older and younger), as noted earlier. He sees himself as the scapegoat for the aggression of the others ("There's always one of those in a large Irish Catholic family"). When he was younger, he was often the last one to be ready before the family left to go somewhere, and he frequently was the target of his father's criticism because of his lateness or hesitancy. He says that he often feels he is the only one in the family who "doesn't get the joke." He does not feel close to any of his brothers and sisters, though he has a special affection for the youngest girl. He still tends to retreat from the family and play video games alone.

The parents' marriage sounds stable but not particularly loving. The father complains loudly and frequently about money, and the mother seems always overwhelmed and irritable. Both can launch into angry tirades at the children. Kevin's interests include reading, writing, walking in the woods, and listening to music. He notes rather ruefully that these are all solitary interests.

Mental Status

Kevin is a slight, ingratiating, nervous young man who appears extremely shy and introverted. He speaks softly and slowly; at times his voice drops to a whisper. He tends to look at the floor and avoid eye contact. He wears glasses, has mild acne, and looks uncomfortable in his skin.

He speaks directly and in a goal-directed manner and appears to be of high intelligence, but it takes him a long time to come up with a sentence or description in answer to a query. By the end of the interview, the therapist finds herself feeling slightly impatient. When Kevin is asked how he is feeling talking to a woman about intimate topics, he insists that the therapist's being a professional makes it OK—almost as if he wants to reassure her that she is doing her job adequately. Along with his social backwardness, there seems to be a private sense of intellectual superiority; for example, he quizzes the therapist on her knowledge of literature and seems to be evaluating whether she is adequately educated.

There are no loose associations, blocking, hallucinations, or delusions. Kevin does seem to have some possible ideas of reference, however; he finds himself feeling that everyone is looking at him and judging him "weird" or "bizarre." Affect appears to be on the flat side. With the exception of a few somewhat apologetic smiles, Kevin shows no change in affect during the interview. His attention span is normal. Memory is intact and abstract thinking is adequate.

Kevin's mood appears to be slightly depressed. Although he complains of anxiety, he does not appear overtly anxious; anxiety seems to be more of an internal feeling. Throughout the interview, he sits in a rather frozen position in the chair furthest from the clinician's desk. He seems highly motivated to get help, and he presses for explanations about how psychotherapy may improve his life. In doing so, he conveys both a deep skepticism and a desperation to become more comfortable around people.

DSM-5/ICD-10 Diagnosis

Social anxiety disorder (social phobia) (ICD-10-CM code: F40.10)

Avoidant personality disorder (ICD-10-CM code: F60.6)

PDM-2 Diagnosis

P Axis

Personality syndrome: Anxious–avoidant and phobic personality

Level of personality organization: Neurotic

M Axis

M03. Mild impairments in mental functioning (range = 40–46)

S Axis

S31.2. Social phobia

PDM-2 Profile on the PDC-2

A completed PDC-2 for Kevin, revealing his full PDM-2 profile, is provided in Figure S.3.

Ilse

This case, like Berta's, is drawn from hospital medical records and may lack some information available in other cases.

Personal Data, Family History, and Specific Features of Relationships with Family Members

Ilse is a 38-year-old German heterosexual woman, employed in the delicatessen department of a supermarket, from which she took a sick leave 2 weeks ago. She weighs 132 pounds and appears small and roundish. She completed elementary and secondary school and a commercial apprenticeship by age 18; she then worked as a waitress in a small café, where she met her husband. She has been married for 13 years and has an 8-year-old daughter.

Ilse's mother was a social worker; her father was an army vice-lieutenant. Both parents are retired. Alcoholism was pervasive in her family. Her father beat her and her 5-years-older sister whenever they behaved badly or got poor grades at school. Her mother would beat them "unpredictably."

Ilse was a poor student, who, in a vicious cycle, often got bad marks, was beaten, and then studied badly. Ilse was afraid of both school and her parents, but did not seek solidarity with her sister, with whom she typically fought. The 8-years-younger brother was the "baby" and was not beaten; the sisters were jealous of him.

(text resumes on page 25)

Psychodiagnostic Chart–2 (PDC-2)

Name: Kevin Age: 20 Gender: Male Ethnicity: Irish American

Date of evaluation: XX / XX / XX Evaluator: Psychotherapist

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).

Severe — Moderate — Healthy

1 2 3 4 5 6 7 8 9 10

1. **Identity:** Ability to view self in complex, stable, and accurate ways 7
2. **Object relations:** Ability to maintain intimate, stable, and satisfying relationships 2
3. **Level of defenses** (using the guide below, select a single number): 6
   - 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 8

Overall Personality Organization

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

Psychotic — Borderline — Neurotic — Healthy

1 2 3 4 (5) 6 7 8 9 10

(continued)

FIGURE S.3. A completed PDC-2 for Kevin.

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.)

(There are no sharp cutoffs between categories. Use your clinical judgment.)

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 level.

Check off as many personality syndromes as apply from the list below; 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

(continued)

FIGURE S.3. *(continued)*

Level of severity

☑ **Anxious–avoidant and phobic** 2
Subtype:
- Converse manifestation: Counterphobic

☐ **Obsessive–compulsive** ___

☐ **Schizoid** ___

☐ **Somatizing** ___

☐ **Hysteric–histrionic** ___
Subtypes:
- Inhibited
- Demonstrative

☐ **Narcissistic** ___
Subtypes:
- Overt
- Covert
- Malignant

☐ **Paranoid** ___

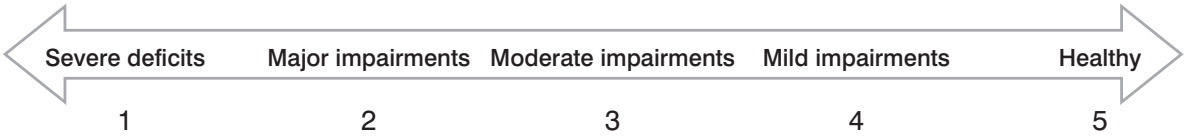
☐ **Psychopathic** ___
Subtypes:
- Passive–parasitic, "con artist"
- Aggressive

☐ **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.



(continued)

FIGURE S.3. *(continued)*

- **Cognitive and affective processes**
  1. Capacity for regulation, attention, and learning 5
  2. Capacity for affective range, communication, and understanding 4
  3. Capacity for mentalization and reflective functioning 4
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) 4
  5. Capacity for relationships and intimacy 1
  6. Self-esteem regulation and quality of internal experience 2
- **Defense and coping**
  7. Impulse control and regulation 4
  8. Defensive functioning 4
  9. Adaptation, resiliency and strength 2
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) 5
  11. Capacity to construct and use internal standards and ideals 4
  12. Meaning and purpose 3

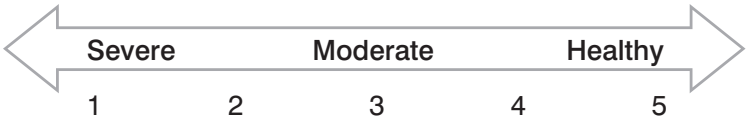
Overall level of personality severity (Sum of 12 mental functions): 42

[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-2 symptom patterns (those that are predominantly related to psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: S31.2. Social phobia Level: 2

Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

(continued)

FIGURE S.3. *(continued)*

Section V: Cultural, Contextual, and Other Relevant Considerations

Kevin was raised in a large Irish American family, by somewhat overwhelmed parents who could not relate sensitively to his introspective, highly sensitive temperament. His siblings competed for the parents' scarce attention and tended to scapegoat him. The messages of his church about sinfulness were not moderated by his parents, leaving him with harsh internal images.

FIGURE S.3. *(continued)*

With the brother, Ilse has a half-hearted relationship: "He always wants something from me. I often take care of his young son, but he never helps me." She sees him only rarely. She sees her sister, who now lives in another country, even less frequently. Currently she has a distant relationship with her parents, who are now both abstinent from alcohol, but they "do not understand" her or her life.

Ilse married her husband, an accountant who also suffers from alcoholism, 13 years ago. She had met him as a married man, whom she "wanted to wean off drinking," but this rescue effort did not succeed.

Eight years ago, her daughter was by choice born at home "so that the baby would not be interchanged in the hospital." The daughter is now in the third year of elementary school and suffers from asthma, which is very wearing for her mother. Because the child is reportedly difficult to educate both in school and at home, Ilse feels exhausted and overburdened: "Everything goes over her head." She has to help the daughter to dress in the morning, a process that she says takes almost an hour.

Ilse describes her typical day as follows: She gets up at 6:00, makes breakfast, and helps her child get to school (she accompanied her there until she got ill; now her husband takes her). Then she does housework, during which she is constantly concerned about whether her daughter will come home safely. For the last few weeks, she has not been able to leave the house because of panic attacks. Teaching the daughter, who only wants to play, often "lasts till the evening, until she does her homework." Cooking dinner and getting her daughter to bed are also very difficult. Her husband comes home very late, when the daughter is already asleep. He then sits in front of the TV, drinking beer until he falls asleep in his chair. Ilse does not watch TV, preferring to read, but since her anxiety attacks began she has been unable to concentrate.

Ever since Ilse has felt unable to leave the house because of her fear of panic attacks, her husband does the shopping (although he grumbles about it) and accompanies her to important events. She and he are reportedly very irritable with each other.

Ilse reports that several weeks ago, after the husband told her that his liver enzymes are too high, she demanded, "If you do not stop drinking, I will file for divorce." This would cause a difficult situation: Ilse currently has no job and does not dare to do anything alone, and rearing the daughter alone would be a heavy burden for her. In addition, her husband has reportedly run up huge debts from gambling and buying an expensive TV for the daughter, "so that she could watch her own TV programs" alone.

Ilse has been very anxious since childhood, when she was afraid of school, exams, and beatings from her parents. She was also phobic about taking escalators and she reports current fears of elevators, heights, narrow rooms, and underground areas.

She suffers social anxiety with unknown persons or situations, as well as in the office: "If someone speaks to me harshly, I may start crying." She cannot say no, worries about not being loved, and shows very little self-esteem.

Ilse experiences positive feelings when she reads adventure and love stories. She wrote stories in childhood and adolescence. She wants to be able to go back to work in the future, "preferably again in a little café." She enjoyed having a female boss and talking with people at her old job, when she was not full of fears. She also wants to have a bigger apartment. However, she is doing nothing now in pursuit of these desires. She continues to experience panic attacks as heart attacks. She describes spending all day worrying—not only about her daughter, but also about whether her husband (who drinks and drives) will come home safely.

History of the Problem

Medical History

The patient underwent an appendectomy in childhood.

Since her daughter's birth 8 years ago, Ilse has taken pills to alleviate headaches, but now feels that she takes too many of these. For the last few months she has taken alprazolam to reduce her fear, and to fall asleep she takes diazepam.

Her panic attacks began very suddenly about 8 weeks ago: "My heart suddenly started to rush, I had to breathe very fast, it gets me dizzy, I feel faint, which I am very afraid of; I get a lump in my throat, sweating hands, dry mouth. My heart is rushing and running so fast that I'm afraid it will explode." She had a medical checkup, with an exercise electrocardiogram that showed that her heart is healthy, but she is concerned that the attacks keep coming.

Ilse now is on sick leave, cannot leave the house, and is having panic attacks about twice a week. The family doctor has advised her to go to a mental hospital to treat her general anxiety and to reduce her dependence on drugs, especially tranquilizers (which are of particular concern, given the alcoholism of both her parents).

Current Situation

Ilse's recent complaints are about panic attacks and "fear all day long." She takes tranquilizers as noted above, plus Thomapyrin (an aspirin–acetominophen combination sold in Europe) for headaches. Her vegetative history includes dry mouth and heart palpitations.

Her posture and body language are stiff; she holds her shoulders slightly raised and is controlled in her movements.

Further Observations

Current Thoughts/Feelings and Therapist's Reactions to the Patient

Ilse says, "My head is full of thoughts, as if my thoughts gain the upper hand and I feel overwhelmed." She begins the conversation with "I can't bear my anxiety any longer."

The therapist feels under pressure, anxious, and overstimulated by Ilse's concerns and issues, and thus feels impelled to do something that will offer relief.

Risk Factors

Overprotection, encouragement of avoidance behavior, lack of emotional availability, humiliation, inconsistencies in rearing, and separation anxiety, all of which Ilse experienced in childhood, are risk factors for later anxiety disorders.

Mental Functioning

- Persistent anxious tension, nervousness
- Fear that is generalized and persistent, not restricted to specific environmental conditions
- Some specific fears, especially that the patient or a relative may soon fall ill or have an accident
- Dizziness, palpitations, trembling, muscle tension, sweating, and pain during panic attacks
- Excessive worry (personal, financial, and existential concerns) during attacks
- Awareness of the unrealistic nature of the worry, but a belief that it cannot be controlled
- Pathological concern in the area of personal life and general environment, leading to functional impairment in daily life
- Frequent lack of social competence, avoidance of social situations

DSM-5/ICD-10 Diagnosis

Agoraphobia (ICD-10-CM code: F40.00)

Generalized anxiety disorder (ICD-10-CM code: F41.1)

Panic disorder (ICD-10-CM code: F41.0)

PDM-2 Diagnosis

P Axis

Personality syndrome: Anxious–avoidant and phobic personality

Level of personality organization: Borderline

M Axis

M05. Major impairments in mental functioning (range = 26–32)

S Axis

S31.3. Agoraphobia and panic disorder

S31.4. Generalized anxiety disorder

PDM-2 Profile on the PDC-2

A completed PDC-2 for Ilse, revealing her full PDM-2 profile, is provided in Figure S.4.

Rachel

Presenting Problem

Rachel has what she describes as "very whimsical" mood swings. She is depressed for 2–3 days, during which she becomes irritable and self-reproaching. She finds herself unsatisfied with everything she does, and feels keenly that her children deserve a "better mother—one who can keep her spirits up no matter what." In her depressed state, she reportedly abandons her role as disciplinarian and finds herself happy "just not to be bothered" by her children.

In these depressive episodes, her sleeping becomes disturbed and she wakes up with no energy for life tasks. She withdraws from family members because she feels that her bad mood must be contagious. She refuses her husband's overtures for sexual contact. These episodes tend to last for several days. Then for the next few days she feels quite good. This up-and-down sequence has become particularly noticeable to her in the past 4 months. She has previously had depressive episodes, but in her earlier low periods, she could always identify a precipitant; this time, she cannot. She is reportedly seeking therapy in the hope of understanding and controlling her emotional lability.

Rachel's main concerns revolve around her general quality of life, which she sees as deteriorating dangerously. She shares the impression that her marriage, too, is failing.

History of the Problem

The first time Rachel experienced symptoms severe enough to impel her to seek therapy was at about age 25, when she became both anxious and depressed about the prospect of getting married. She saw a clinical psychologist once a week for several months and felt considerable relief from her premarital symptoms. Her next bout of depression came after the birth of her first child, when she was 28. She saw a social worker once a week for about a year to deal with this postpartum experience and felt she got considerably better; however, after the birth of her second child two years later, she again became depressed and worked with the same therapist for another 1½ years. When her third child was born, she did not have a depressive reaction. A year and a half ago, as her mother was dying, she entered group therapy and again reportedly had a good experience.

(text resumes on page 33)

Psychodiagnostic Chart–2 (PDC-2)

Name: *Ilse* Age: *38* Gender: *Female* Ethnicity: *European*

Date of evaluation: *XX* / *XX* / *XX* Evaluator: *Hospital psychiatrist*

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).

Severe — Moderate — Healthy

1 2 3 4 5 6 7 8 9 10

1. **Identity:** Ability to view self in complex, stable, and accurate ways *3*
2. **Object relations:** Ability to maintain intimate, stable, and satisfying relationships *3*
3. **Level of defenses** (using the guide below, select a single number): *6*
   - 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 *5*

Overall Personality Organization

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

Psychotic — Borderline — Neurotic — Healthy

1 2 3 4 (5) 6 7 8 9 10

(continued)

FIGURE S.4. A completed PDC-2 for Ilse.

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.)

(There are no sharp cutoffs between categories. Use your clinical judgment.)

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 level.

Check off as many personality syndromes as apply from the list below; 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

(continued)

FIGURE S.4. *(continued)*

Level of severity

☑ **Anxious–avoidant and phobic** 3
Subtype:
- Converse manifestation: Counterphobic

☐ **Obsessive–compulsive** ___

☐ **Schizoid** ___

☐ **Somatizing** ___

☐ **Hysteric–histrionic** ___
Subtypes:
- Inhibited
- Demonstrative

☐ **Narcissistic** ___
Subtypes:
- Overt
- Covert
- Malignant

☐ **Paranoid** ___

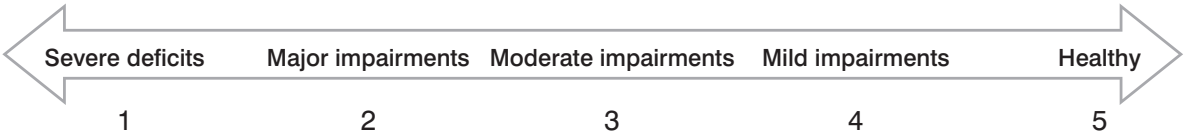
☐ **Psychopathic** ___
Subtypes:
- Passive–parasitic, "con artist"
- Aggressive

☐ **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.



(continued)

FIGURE S.4. *(continued)*

- **Cognitive and affective processes**
  1. Capacity for regulation, attention, and learning 3
  2. Capacity for affective range, communication, and understanding 3
  3. Capacity for mentalization and reflective functioning 2
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) 3
  5. Capacity for relationships and intimacy 3
  6. Self-esteem regulation and quality of internal experience 2
- **Defense and coping**
  7. Impulse control and regulation 3
  8. Defensive functioning 3
  9. Adaptation, resiliency and strength 3
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) 2
  11. Capacity to construct and use internal standards and ideals 2
  12. Meaning and purpose 3

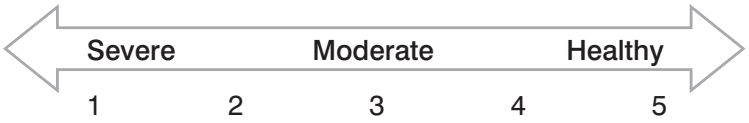
Overall level of personality severity (Sum of 12 mental functions): 32

[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-2 symptom patterns (those that are predominantly related to psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: S31.3. Agoraphobia and panic disorder Level: 2

Symptom/concern: S31.4. Generalized anxiety disorder Level: 2

Symptom/concern: _____ Level: ___

(continued)

FIGURE S.4. *(continued)*

Section V: Cultural, Contextual, and Other Relevant Considerations

Ilse is a 38-year-old German heterosexual woman. A history of alcoholism was pervasive in her family. Ilse seems to be absorbed in a stereotyped female role, given her preoccupation with household tasks and educational issues with her daughter. A feeling of loneliness and inadequacy seems to pervade her life. Some supporting figures in her life seem not to be mentioned by the patient.

FIGURE S.4. *(continued)*

Rachel has therefore experienced several previous therapies. She describes herself as a "depressed woman with some ups and downs and weak self-esteem."

Personal Data, Family History, and Specific Features of Relationships with Family Members

Rachel is a 41-year-old African American heterosexual mother of three, living with her husband and children in a middle-class suburb. She has a college education and has sometimes worked part time in clerical positions. Currently, she is not working outside the home. She has had several previous contacts with mental health professionals, as described above. She is self-referred, is the main informant, and impresses the interviewer as a reliable source of information. She is on no medications.

Rachel was born in a small Midwestern city in the United States, the second of two daughters born to a working-class family. Her father was a bus driver and part-time landscaper who died 10 years ago after a 2-year struggle with cancer. She describes him as "bright, super-controlled, tyrannical, and very frightening to a child." He would go into sudden rages followed by abject guilt, and Rachel remembers his occasionally shutting himself in the bathroom and crying when things became overwhelming for him. In the face of death, he was "very much a fighter," and she admires him for the dignity with which he died.

Her mother, a housewife who worked part time cleaning houses when the family was under financial strain, is remembered as perpetually and artificially cheerful. She never seemed depressed, always denying unpleasant realities and romanticizing whatever happened. She accepted uncomplainingly her husband's frequent derogatory comments (he would call her a "stupid housewife," a "spendthrift" who didn't contribute anything to the family). Rachel was close to her mother and remembers confiding "everything"

to her, even explicit sexual material that she now thinks it odd for a daughter to have shared with a parent. She recalls how her mother would tell her father these secrets, despite her own pleas to keep them to herself. She adds, "Maybe I really wanted him to know."

From both parents, Rachel felt a strong pressure to "keep up appearances." Things were often difficult financially, but her mother would keep empty cans on the top of her refrigerator so that her neighbors would admire her ample food supply. She would nag her daughter not to wear her glasses in public, lest she be found unattractive, and she herself took great pains to keep others from finding out that she sometimes worked as a cleaning woman. Rachel's father criticized other black men for being lazy and unreliable and made a point of working hard to a fault.

She remembers that it was taboo in her family to "have problems." She was raised in a mainstream Protestant church, which she sees as having supported the values of self-reliance and not feeling sorry for oneself.

Discipline in the home was inconsistent. The children were not expected to have any responsibilities in the family, but they were sometimes made to feel guilty that they did not contribute anything. Rachel feels that she was clearly the favorite child; yet her ambivalence toward her parents, especially her father, was so great that she still bears grudges she feels are disproportionate.

Rachel's sister, Samantha, is 5½ years older. As children, they perpetually bickered and fought, but their relationship now is friendly. Samantha has become a successful attorney in California, where she lives with her husband and children. Rachel described her as "a real world-beater . . . her outlet is achieving." Samantha went to college at age 16 on a scholarship for exceptional minority students, and Rachel seems to envy her for having escaped the family early. Samantha has had extensive psychotherapy and considers it to have been deeply valuable. It was at her urging that her sister first sought help.

There is evidence of depressive illness in the family history. Rachel's father married her mother when he was 31 and she was 19. Within the first year of their marriage, both her father's mother and her mother's father committed suicide. Rachel feels that each parent's descriptions of the opposite-sex parent suggest some inappropriate boundaries. After her father's mother killed herself, he went into a severe depression.

Rachel's first memory, from about age 4, is of her father's hitting her on the rear end, in exasperation. This is her only memory of corporal punishment. Also at age 4, she hugged a puppy so hard that it died. She can remember her mother teasing, "We have a murderer in the house." Other early recollections include watching her parents get dressed to go out. Holidays are remembered as times of great unpleasantness; any unexpected event, such as a child's spilling milk, would cause a major family upset. She also remembers her father's overprotectiveness and excessive worries that she would be hurt physically. A traumatic memory from about age 9 involves her father's threat that if she and her sister did not stop fighting by a certain date, she would be sent to an orphanage. Her mother would tease both her and her sister by saying that they were really adopted and thus could be "sent back."

In school, Rachel was bright and popular. She was consistently and deliberately precocious and rebellious and began smoking marijuana and experimenting sexually at about 14. She started menstruating at 14 and was so embarrassed to be so "late" that she lied to her classmates, claiming to have gotten her period at 11. Her first intercourse was at 15 with an older boy toward whom she felt very little: "We just went about the mechanics."

Although Rachel's marriage is described as a good one, she and her husband have not developed a satisfying sexual relationship. Previously, she says, they approached sex "as a chore." She attributes this change to her therapy experiences, which reduced her defensiveness toward men. Her only complaint about her husband, a high school teacher, is that he tends to withdraw when he is upset. The couple have three children, ages 14, 12, and 7, whom she says they enjoy very much. Their son, the 12-year-old, has had some school problems in the past, for which he got effective help from a school counselor.

Further Observations

Mental Functioning

Rachel is an attractive, personable, well-dressed woman who relates in a friendly and even eager way. For example, despite her depressive affect, she smiles frequently and states that she is relieved to be talking to a therapist, emphasizing how much her previous therapies had helped her. Her affect is appropriate, her mood slightly labile, and her tone often self-deprecating. For example, she states about herself, "I guess I'm screwed up enough that I ought to be in therapy for life!" At another point, she states about her 14-year-old daughter, "I hope she has enough sense to stay out of bed with the first guy who comes along—unlike her mother!"

She has been quite introspective about her problems and seems frustrated that she cannot figure out why her current moods are unstable. At one point she comments, "I've figured a lot of things out, so I should be able to control these moods." At another point she remarks, "It's not really all about depression; I run hot and cold about sex the same way. I can never predict when I'm going to be in the mood." She contrasts this erratic pattern to that of men, about whom she generalizes, "They're always ready." She also comments that even after so much therapy, she is still not able to "keep control of my feelings."

Her speech is coherent, colorful, sometimes humorous, and very intelligent. For example, she refers to herself as a "frustrated librarian—not the 'Marian the librarian' type, but the type who wishes she could have a job surrounded by good books." When she is asked how it feels to be talking with an interviewer of another race, she responds, "I don't care if you're black, white, or green, honey; if you can help me smooth out this roller-coaster ride, I'll be grateful." When pressed about whether there are any areas she would assume the interviewer might not be familiar with, she comments, "I'll be glad to translate for you if I start 'talkin' black.' " She seems notably nondefensive in this area, and there is a positive quality in her reassurances that racial differences would not be a problem with her reversing roles and educating the interviewer.

At times, however, Rachel seems tangential. For example, when she expresses some worry about her 12-year-old son, who has had difficulty adapting to middle school, she associates this worry with her father and his wish to have had a better education; then she goes on to talk about how she wishes she had gone to a better college. Soon she is giving details about her college sorority and how strongly she feels against hazing. When reined in from tangents such as this, she reports that her thoughts occasionally race by "too fast for me to grasp" and explains that she is trying not to leave anything out. She seems to feel criticized when called back to the thread of the conversation.

Her emotional range is characterized by expressing affects of warmth, excitement, surprise, sadness, and disappointment, but there is a slightly intellectual quality to her expression of these feelings. It is as if she is giving a report on herself, rather than directly

expressing herself. Her descriptions seem notably lacking in anxiety, anger, envy, and the negative affects other than sadness. For example, when the interviewer suggests that she might feel skeptical or apprehensive about whether therapy could help her, given that her previous treatments have not protected her from the current bout of difficulty, she is very quick to state how helpful the other therapies were and how much confidence she has in mental health professionals. When it comes to difficult thoughts, such as her worry about her sex life or her son, she tends to joke and change the subject. It is hard to tell whether she is in touch with her feelings and containing them because of not yet feeling comfortable with the interviewer or whether she is out of touch with them. She has a slight quality of self-dramatization that seems to represent an attempt to convey that she does not want to be thought of as taking herself too seriously. For example, she comments, "I thought I was the first woman ever to be having a baby, I was so excited. And then I crashed so badly I felt like the village idiot!"

Eye contact is good. Capacity to reflect on her experience seems substantial, though intellectualized. There is no evidence of delusions, hallucinations, or ideas of reference. Her motivation for treatment seems to be high.

Relevant Affects

In the context of her chronic dysphoric affect, Rachel seems to believe that there is something essentially bad or incomplete about her, and that this is why people who get to know her well will reject her. She is concerned with self-definition, self-worth, and self-critical thoughts and feels at the mercy of feelings of inferiority, worthlessness, and guilt. She has a sense of having failed to live up to expectations and standards. She fears losing the approval of those whom she esteems.

Rachel feels guilty, self-critical, perfectionistic, and ashamed. Her conflicts seem to revolve around sexual intimacy, with a specific loss of sexual desire. When mistreated, rejected, or abandoned, she tends to believe that she deserves it or that it is her fault. Her central ways of defending seem to be reversal, idealization of the other, and devaluation of self. Drawing on previous experiences of therapy, Rachel has a good capacity for self-awareness and she is confident that therapy can be of help.

She has a strong connection to her sister, who seems to be a good support: Samantha has encouraged her sister through ongoing medical and mental health care relationships.

Rachel also seem to be capable of warm and stable attachments.

Therapist's Reactions to the Patient

During the first sessions, the therapist finds Rachel quite captivating, but he soon feels confused, overstimulated, irritatingly "entertained," and distanced. Sometimes he feels narcissistically infused by Rachel's idealization. She seems invested in being a "good patient," and she tends to accept the therapist's interventions without criticism.

When the therapist talks to her about these issues, she answers that he has not yet noticed how bad she really is. When Rachel is telling her story, she tends to dwell on tangential details and complaints that make the therapist feel somewhat bored and distracted.

Treatment Indications

It is vital when treating depressive patients of the introjective type to elicit their negative feelings, especially their hostility and criticism. It is also important that they see how they persist in believing that their badness is the cause of whatever difficulties and losses they encounter. Blatt's research suggests that interpretation and insight are pivotal to therapeutic progress with introjective patients.

DSM-5/ICD-10 Diagnosis

Major depressive disorder, recurrent, moderate (ICD-10-CM code: F33.1)

PDM-2 Diagnosis

P Axis

Rachel has a mild personality disorder with prominent depressive features and some hysterical and hypomanic tendencies, characterized by putting lots of energy into saying the "right things" in an intellectualized way and at the same time feeling periodically depressed and depleted. She conveys an ongoing mood of pessimism and an empty sadness just behind the "appropriate front," while denying and/or rationalizing underlying feelings of anger, competition, and disappointment. Her personality structure seems to be mainly in the neurotic range, marked by a striking tendency to use introjective mechanisms.

Personality syndrome: Depressive personality, including hypomanic manifestation
Level of personality organization: Neurotic

M Axis

M03. Mild impairments in mental functioning (range = 40–46)

S Axis

S22. Major depressive disorder

PDM-2 Profile on the PDC-2

A completed PDC-2 for Rachel, revealing her full PDM-2 profile, is provided in Figure S.5 on the next page.

(text resumes on page 42)

Psychodiagnostic Chart–2 (PDC-2)

Name: Rachel Age: 31 Gender: Female Ethnicity: African American

Date of evaluation: XX / XX / XX Evaluator: Psychotherapist

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).

Severe — Moderate — Healthy

1 2 3 4 5 6 7 8 9 10

1. **Identity:** Ability to view self in complex, stable, and accurate ways 6
2. **Object relations:** Ability to maintain intimate, stable, and satisfying relationships 7
3. **Level of defenses** (using the guide below, select a single number): 7
   - 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 7

Overall Personality Organization

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

Psychotic — Borderline — Neurotic — Healthy

1 2 3 4 5 6 (7) 8 9 10

(continued)

FIGURE S.5. A completed PDC-2 for Rachel.

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.)

(There are no sharp cutoffs between categories. Use your clinical judgment.)

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 level.

Check off as many personality syndromes as apply from the list below; 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** 3
Subtypes:
- Introjective
- Anaclitic
- Converse manifestation: Hypomanic

☐ **Dependent** ___
Subtypes:
- Passive–aggressive
- Converse manifestation: Counterdependent

(continued)

FIGURE S.5. *(continued)*

Level of severity

☐ **Anxious–avoidant and phobic** ___
Subtype:
- Converse manifestation: Counterphobic

☐ **Obsessive–compulsive** ___

☐ **Schizoid** ___

☐ **Somatizing** ___

☐ **Hysteric–histrionic** ___
Subtypes:
- Inhibited
- Demonstrative

☐ **Narcissistic** ___
Subtypes:
- Overt
- Covert
- Malignant

☐ **Paranoid** ___

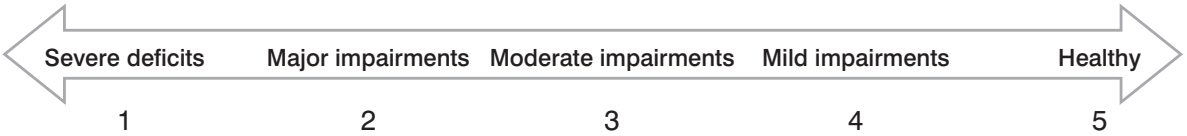
☐ **Psychopathic** ___
Subtypes:
- Passive–parasitic, "con artist"
- Aggressive

☐ **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.



(continued)

FIGURE S.5. *(continued)*

- **Cognitive and affective processes**
  1. Capacity for regulation, attention, and learning 4
  2. Capacity for affective range, communication, and understanding 4
  3. Capacity for mentalization and reflective functioning 4
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) 3
  5. Capacity for relationships and intimacy 3
  6. Self-esteem regulation and quality of internal experience 3
- **Defense and coping**
  7. Impulse control and regulation 4
  8. Defensive functioning 3
  9. Adaptation, resiliency and strength 3
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) 4
  11. Capacity to construct and use internal standards and ideals 3
  12. Meaning and purpose 3

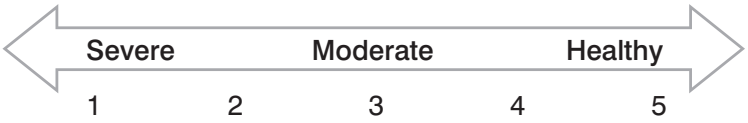
Overall level of personality severity (Sum of 12 mental functions): 41

[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-2 symptom patterns (those that are predominantly related to psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: S22. Major depressive disorder Level: 3

Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

(continued)

FIGURE S.5. *(continued)*

Section V: Cultural, Contextual, and Other Relevant Considerations

Rachel was raised in an African American family that seems to have been sensitive to racial stereotypes such as laziness, and consequently was somewhat harsh in promoting self-reliance and lack of self-pity. Eventually, it will be important to explore in therapy her deeper feelings about exposing her vulnerable aspects to a white therapist. Taking into account that Rachel was raised in a mainstream Protestant church, which she sees as having supported the values of self-reliance and not feeling sorry for oneself, is another fundamental matter for the assessment of the patient's global functioning.

FIGURE S.5. *(continued)*

Lucy

Presenting Problem

After a big fight with her boyfriend, Lucy inflicted superficial wounds on her wrists, which she immediately showed to her mother. Her mother called a psychologist asking for help for her "beloved only child," whom she described as willing to start therapy because of her fights with the boyfriend.

Lucy comes to the consultation with her mother, Linda. They enter the office together, and her mother speaks first, noting that "She's always been a normal girl, an affectionate and loving daughter. I really don't understand why in recent times she seems so vulnerable. I'm sorry, my phone is ringing. I'm organizing a party for my best friend's birthday. Could you please continue, Lucy?"

After Linda leaves the room, Lucy sighs and looks at the psychologist, exclaiming, "My mother has always been like this. How could I not hate her?"

Personal Data, Family History, and Specific Features of Relationships with Family Members

Lucy is 20 years old; she is dressed in colorful clothes for the consultation. Although she appears younger than her age, her outfit makes Lucy an older version of herself. Her t-shirt is very low-cut; she is heavily made up; and she is wearing a short skirt and high heels.

She is an only child and says she was conceived "by mistake, during Mom and Dad's honeymoon. At least that's what my mother told me. She says they wanted to wait a few years before having a child, but they made love during their honeymoon and I was born." The psychologist asks, "How do you feel about this?" Lucy shrugs her shoulders.

"Well, not particularly disturbed. Just not sure I wanted to know some intimate details that my mother used to tell me."

Lucy gestures broadly with her hands while speaking. Her voice is sufficiently loud that the psychologist worries she might be heard from outside the room. From the corridor, they can clearly hear Lucy's mother, who is organizing the party. "Anyway, I would like to have been born male. Men have more power than women; they aren't subject to the laws of pain like us; and they enjoy more rights in this life, don't you think? Look here what a man did to me, look! I hate myself, I hate myself terribly. Would you want a daughter like me? Tell the truth." Lucy shows her wounds on the wrists. The psychologist feels confused by this first exchange.

Lucy says her mother has always been "physically present, but mentally, absolutely absent." Lucy always had the impression that her mother manipulated her as a young child, to keep her closer. For example, when she would ask to go on an excursion with her class, her mother was always ill and wanted to have her at home. Lucy says that her mother revealed family secrets that she would never have wanted to know, such as the honeymoon story described above, but also the sexual infidelity of her grandfather to her grandmother (figures whom Lucy admired and toward whom she felt truly affectionate). Lucy describes an intrusive mother, often depressed and inconsolable.

Lucy's father is often unemployed. He is described as a powerful man, a "nice" and "beautiful" man, who always brings her gifts when returning from business trips. Lucy calls her father "Paul" rather than "Dad." She opines, "Paul doesn't deserve a woman like my mom. He's so busy with his work that he doesn't need a woman that gives him a lot of troubles. I try to be a perfect daughter just for him, not for my mother. I have nothing to complain about with him; in fact, he's the type of man I am attracted to."

Linda and Paul met through mutual friends. She came from a small town, and Paul was a city boy heading to a promising job. Linda is devoted to her husband, to the house, and to her daughter in a perfunctory way, but without evident emotional depth. She seems to regard her family role in terms of daily activities to be pursued. Paul is a pragmatist and realist, immersed in his work, who pressures other family members to look conventional and attain social approval.

History of the Problem

Lucy completed high school with a lot of struggle and, in deciding what to do afterward, seems to have run aground in failed projects. She has no work experience and has not attended any university. Her daily activities consist mainly of staying at home, chatting on the computer with strangers, and trying to meet new friends. Lucy maintains occasional contact with high school friends, with whom there seems to be no deep mutual affection.

When Lucy was in high school, she was twice advised to meet with the school psychologist because she had been found in the classroom in sexually explicit conduct with two classmates. She comments, "But I think they exaggerated. It's all because of the headmaster, who was jealous of me."

Lucy tells about some early sex play she had with friends when she was about 11—"erotic games in order to feel important and adult because sooner or later I would have to learn, and we might as well start early." Lucy says that she has never had full sexual intercourse, however: "I do not care, honestly. That is stuff for bored and married people." For her, sexuality appears to be a manipulatable instrument of attraction and

relationship, rather than a nourishing field of intimate and emotional exchange. Lucy says she has never had lasting love relationships, but just "relationships with friends who I sometimes saw and I liked to entertain. You know what I mean?"

At school, Lucy and her friends used to count their respective numbers of boyfriends, and Lucy says she couldn't stand the idea that some of her friends had more boyfriends than she did: "I aspired to be the first one preferred by all my boyfriends." During the session, Lucy uses graphic language to describe encounters with some of her partners: "I think I'm a good lover, even if I've never had full sexual intercourse. I really don't want that big thing inside of me, I think it would hurt me."

About her current relationship, Lucy says that she first met her boyfriend in a teenage chat room: "He was so cute that I couldn't let him escape, a really beautiful boy. So we met and, from the first moments, we immediately had a sexual feeling. Now we have been dating for a while, perhaps a few months, and yes . . . now that I'm thinking about it, maybe this is the longest relationship I've ever had in my life. He is very jealous, and this makes me feel oppressed. I want my freedom, but I don't want to hurt him. Some days ago, he told me that he had met another girl in chat, and I couldn't tolerate this defeat . . . and I cut my wrists. I hate him! And I hate that bitch! What does she have that I haven't got?"

Lucy says this is not the first episode in which she tried to attract attention through risky behavior. When she was little and was walking with her mother, she suddenly crossed the street to see whether Linda was attending to her. "What if a car had passed?" asks the psychologist. "I clearly remember I looked and saw that there was no car, but even if a car had hit me . . . well . . . at least it would do its duty!"

At age 14, a symptom appeared in Lucy's life: She would feel faint whenever she had "too many thoughts overwhelming my mind. For example, when I had an oral exam at school and I knew I didn't study, I felt faint." She continues, "When sometimes my mother left me alone at home and I saw her go out, I felt faint. I felt that my body could abandon me at any moment. I'm scared about feeling this one more time—here with you, for example."

In addition, Lucy is reportedly highly distressed by some somatic symptoms, such as dizziness, fatigue, leg pain, and some physiological accompaniments of anxiety (e.g., rapid heartbeat, blood pressure increase, and muscle tension that gives rise to pain). Lucy and her mother have consulted many doctors about these symptoms and she has undergone several diagnostic exams, none of which has ever found any medical evidence of organic disease.

Treatment Indications

Lucy says she does not have a real reason to start therapy, except for "this little episode with my boyfriend that led me to cut myself, even if I didn't really want to die, you know? I just wanted to show him and my mother how much they hurt me."

Lucy asks if the therapist will be a woman because maybe "I would have preferred a man because I feel more engaged with them, and it seems to me that I can speak to them more easily. I would prefer a man also because I think men are better workers." The psychologist, a woman, feels that authentic connection is really hard to make with Lucy, as if it is impossible for Lucy to open her inner world of shame, conflict, guilt, and fear. She herself feels demeaned and devalued by Lucy's remarks about men.

Despite Lucy's apparent lack of motivation for therapy, she seems attracted by the therapist's questions to her, and for the duration of the session, she seems to find comfort and acceptance in a place where she can bring her suffering: "I like to answer these questions. No one has been this interested in me. Maybe you are just doing your job and you don't care about me, but I don't mind! I'm used to it. I would accept it if you would disappear at any moment!" The therapeutic alliance is initially difficult, but Lucy appears at times eager to find out some things about herself.

A psychotherapy oriented to relationship may be the best means to reach Lucy. An interpretative approach, used in balance with relational aspects, may help her to explore her self-definition and her boundary issues and may lead to an increase in her capacity to mentalize.

DSM-5/ICD-10 Diagnosis

Somatic symptom disorder (ICD-10-CM code: F45.1)

Unspecified personality disorder (ICD-10-CM code: F60.9)

PDM-2 Diagnosis

P Axis

Personality syndrome: Hysteric–histrionic personality

Level of personality organization: Borderline

M Axis

M05. Major impairments in mental functioning (range = 26–32)

S Axis

S51. Somatic symptom disorder

PDM-2 Profile on the PDC-2

A completed PDC-2 for Lucy, revealing her full PDM-2 profile, is provided in Figure S.6 on the next page.

(text resumes on page 50)

Psychodiagnostic Chart–2 (PDC-2)

Name: Lucy Age: 20 Gender: Female Ethnicity: European

Date of evaluation: XX / XX / XX Evaluator: Psychologist

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).

Severe — Moderate — Healthy

1 2 3 4 5 6 7 8 9 10

1. **Identity:** Ability to view self in complex, stable, and accurate ways 3
2. **Object relations:** Ability to maintain intimate, stable, and satisfying relationships 2
3. **Level of defenses** (using the guide below, select a single number): 5
   - 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 6

Overall Personality Organization

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

Psychotic — Borderline — Neurotic — Healthy

1 2 3 4 (5) 6 7 8 9 10

(continued)

FIGURE S.6. A completed PDC-2 for Lucy.

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.)

(There are no sharp cutoffs between categories. Use your clinical judgment.)

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 level.

Check off as many personality syndromes as apply from the list below; 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** 2
Subtypes:
✓ • Passive–aggressive
- Converse manifestation: Counterdependent

(continued)

FIGURE S.6. *(continued)*

Level of severity

☐ **Anxious–avoidant and phobic** ___
Subtype:
- Converse manifestation: Counterphobic

☐ **Obsessive–compulsive** ___

☐ **Schizoid** ___

☐ **Somatizing** ___

☑ **Hysteric–histrionic** 2
Subtypes:
- Inhibited
- ✓ Demonstrative

☐ **Narcissistic** ___
Subtypes:
- Overt
- Covert
- Malignant

☐ **Paranoid** ___

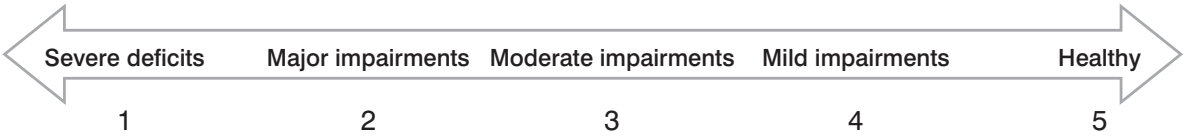
☐ **Psychopathic** ___
Subtypes:
- Passive–parasitic, "con artist"
- Aggressive

☐ **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.



(continued)

FIGURE S.6. *(continued)*

- **Cognitive and affective processes**
  1. Capacity for regulation, attention, and learning 3
  2. Capacity for affective range, communication, and understanding 3
  3. Capacity for mentalization and reflective functioning 3
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) 3
  5. Capacity for relationships and intimacy 2
  6. Self-esteem regulation and quality of internal experience 2
- **Defense and coping**
  7. Impulse control and regulation 2
  8. Defensive functioning 3
  9. Adaptation, resiliency and strength 3
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) 3
  11. Capacity to construct and use internal standards and ideals 2
  12. Meaning and purpose 3

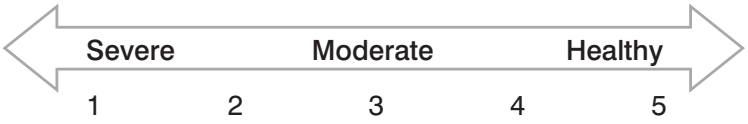
Overall level of personality severity (Sum of 12 mental functions): 32

[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-2 symptom patterns (those that are predominantly related to psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: S51. Somatic symptom disorder Level: 4

Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

(continued)

FIGURE S.6. *(continued)*

Section V: Cultural, Contextual, and Other Relevant Considerations

In addition to the dynamics in her family, Lucy may have internalized some cultural devaluation of women, which has left her with the impression that people of her gender are inherently less important than males. The opportunity to identify with a therapist of her own gender who embodies self-esteem and assumes that women are as valuable as men may be therapeutic.

FIGURE S.6. *(continued)*

Athena

Presenting Problem

Athena was a 40-year-old American employee of a communications corporation and mother of two young sons when she came to treatment to deal with both depression and obesity. "I want help with growth," she stated. "I want to be alive. I think I've spent most of my life in a fog." Although married to a man, she experienced herself privately as lesbian. She belonged to a small fundamentalist Christian sect whose members regarded homosexuality as sinful, and although she acknowledged her sexual orientation to the therapist and stated that she did not think it could be changed, she believed that God intended heterosexuality for everyone. She wanted the therapist to help her adapt better to her marriage with a very difficult and sometimes abusive man. She had had some previous therapy, which had helped her to set effective limits on his physical abuse of her ("That ended 3 years ago as I got good at setting boundaries"); however, even as he was behaving better and limiting his outbursts to emotional attacks, she found herself less patient with him. Athena was not particularly self-critical, but she had depressive periods in which she felt extremely lonely, empty, and hopeless.

History of the Problem

Athena's weight had been a problem since early childhood. She remembered her mother's relentlessly urging her to eat and then attacking her for being fat. She was frequently shamed by her mother and her maternal aunt, and she would retreat to her room, cry, and eat food that she had secreted there. She had gained weight steadily from early childhood on and was morbidly obese when she came to treatment. Her current eating patterns involved "grazing" all day on junk food and binge eating whenever she was

under stress. She had tried numerous programs to lose weight and had twice succeeded in taking off a considerable amount—but each time the weight had crept back, especially when people began commenting on her body and how good it was beginning to look.

At age 20, she married a man in the small Christian sect that she had joined when she went to college and found herself overwhelmed. She had never had any prior sexual encounters and had never experienced orgasm. When the couple married, both were virgins. Athena learned to masturbate to climax about 8 years after her wedding, and it took several years after that for her to be able to reach orgasm in sexual relations with her husband. She had a long history of desiring women—an orientation that became conscious when she was a teenager in a small, all-female Catholic school run by some warm and caring nuns, about whom she had many fantasies that involved both comforting holding and sexual arousal. She was also attracted to a classmate. "I don't even like men much," she commented, "much less desire them."

Personal Data, Family History, and Specific Features of Relationships with Family Members

Athena was an only child, born to an anxious mother and an unfaithful father. She was delivered by C-section and was not breast-fed. Her father was away at the time, allegedly having an affair. It is likely that she was unwanted, or at best was regarded by her resentful mother as a cross to bear. Her earliest memories concerned her parents' angry fights. They divorced when she was 7, but her father had left 2 years earlier. Her mother, the daughter of immigrants from Greece, was enmeshed in a large family: "brash, bossy, controlling people." She had married late, at 38, and later learned that her husband had had at least two prior marriages that ended because of his infidelities. She confided much of this to her daughter, with whom she apparently had a hostile but merged relationship. Significantly, when Athena entered puberty, her mother insisted that from that time on they should share a bedroom.

Athena was reared in her mother's extended family. Her mother recognized her remarkable intelligence and began exhorting her to become a doctor. She pushed her daughter ahead in school, with the result that Athena was always socially and developmentally 2 or more years behind her classmates. When she went to a prestigious, newly coeducational (formerly all-male) college at age 15, she felt completely out of her depth. Her social misery prompted her to seek out the small community of religious students that became her social network. Her not fitting in at college and in other environments where she was too young or too overweight seemed related to her recurrent nightmares of being trapped and of "not fitting" (e.g., the house was on fire and she could not fit through the door to get to safety).

As a preschooler, Athena was frightened by her father. Her parents' arguments, which were loud and physically threatening, terrified her. She recalled in particular one fight when she was about 5, in which her father threatened her mother with a knife, and her mother yelled for her to call for help while her father yelled, "Don't you dare!" She remembered some positive excursions with her father after the divorce, but after she asked him (at her mother's urging) why he was not sending child support payments, he stopped calling her and spending time with her. She never saw him again.

Her father died a few years later of a heart condition. Her mother did not let her know at the time, and so she was not able to attend the funeral. A few months later, however, when she made some adolescent threat to leave her mother's control and live with her father, her mother responded, "Good luck with that. He's dead." Her mother

lived until the third year of Athena's treatment, when she became terminally ill with cancer for which she had refused proper medical treatment; her last words to Athena were angry and critical.

Athena's husband was a rigid, explosive man, diagnosed with bipolar II disorder and attention-deficit/hyperactivity disorder (ADHD), who had difficulties holding jobs and frequently talked of suicide. Her therapist grew to wonder whether he was also on the autism spectrum, as he seemed incapable of grasping social cues and unable to mentalize the subjective states of other people. He would attack Athena verbally during rage reactions. Despite their poor relationship and his ADHD, he worked hard to try to be a conscientious father, and the couple seemed to be doing reasonably well in raising their two sons (ages 5 and 8 when she began treatment). The boys were doing well in school and seemed to have secure attachments to both parents.

Therapist's Reactions to the Patient

The therapist liked Athena, finding her intelligent, thoughtful, and warm. She was aware, however, of feeling oddly trapped herself, in that she was being asked to relieve the depression and self-comforting behaviors of a person who insisted that, for religious reasons, she could not consider any other life but a heterosexual marriage. It was hard for the therapist to imagine how Athena could recover from a tendency toward depression while living a sexually inauthentic life. She stated to the patient that although she respected the strength of her religious beliefs, she was not sure that it is possible to ameliorate either depression or overeating when life must be lived in a straitjacket.

Treatment

Athena remained in psychoanalytic treatment for almost 10 years. The therapy was characterized by recurrent wishes that the therapist should somehow make life easier for her or make the stresses and disappointments go away. In depressed states, she felt helpless and resentful. Whenever she complained about something that the therapist could fix (e.g., the light was in her eyes or the room was too hot) and the therapist responded by fixing the problem, she expressed surprise. In her family, she noted, they would simply have bemoaned the bad quality of the light bulbs or the intensity of the heat. Any sense of agency seemed alien to her. It became clear that the prototype for intimacy in her family of origin was for people to get together to complain about what they saw as inevitable suffering. The idea that Athena could do something herself to improve her situation thus seemed originally quite alien to her, but gained strength over time.

As Athena struggled to express her sense of shame over being obese and her resentments about her marriage, she began thinking that her options might not be as limited as she thought. When her church treated a suicidal gay parishioner with cruel rejection, she became outraged and began the slow process of withdrawal from her religious community, which had previously been her entire social circle. She told her husband, and later her now-adolescent sons, about her sexual orientation and found them more accepting than she had anticipated. Nonetheless, her husband's erratic and often destructive behavior continued to be a problem.

Eventually, with substantial help from members of groups for abused women, she left her husband and moved away, taking care not to set off his potential for destructive rages or to let him know where she was going (one of her friends had been killed by an enraged, moralistic husband shortly after she left him). She began no-fault divorce proceedings.

After some months, she met a woman through their shared interest in a Christian life that was not predicated on rejecting homosexuality, and they dated and eventually married. Her sons, who are now grown and self-supporting, have accepted her wife.

Athena's depression waxed and waned through the phase of her more actively facing her difficulties—including one short period of her feeling suicidal as her grief over the disappointments in her life, and her difficulty controlling her eating, seemed to overwhelm her. She went through a long and intense regressive transference in which she felt desperate to be held and reassured by the therapist, and she expressed considerable anger at the therapist's professional limits. This access to her more active negative emotions seems to have turned around her tendency to be helplessly depressed. Currently, she has been depression-free for many years. She stays in touch with the therapist occasionally and reports that her life is good.

Her problems with compulsive eating remain, however. Athena lost a significant amount of weight at one point and then gained most of it back after she had a reaction of traumatic disappointment to the news that her prediabetic blood sugar levels seemed unaffected by the weight loss. Still, she has made progress in eating much healthier food and less junk and in exercising regularly. She no longer binges. She and her wife seem to help each other with their respective problems with food regulation. Athena weighs less than she did when she first consulted the therapist, but she continues to struggle.

DSM-5/ICD-10 Diagnosis

Persistent depressive disorder (dysthymia) (ICD-10-CM code: F34.1)

Binge-eating disorder (ICD-10-CM code: F50.8)

PDM-2 Diagnosis

P Axis

Personality syndrome: Depressive personality

Level of personality organization: Neurotic

M Axis

M04. Moderate impairments in mental functioning (range = 33–39)

S Axis

S21. Persistent depressive disorder (dysthymia)

S61. Feeding and eating disorders

SApp2. Internalized homophobia and related stress from living in opposition to sexual orientation

PDM-2 Profile on the PDC-2

A completed PDC-2 for Athena, revealing her full PDM-2 profile, is provided in Figure S.7 on the next page.

(text resumes on page 58)

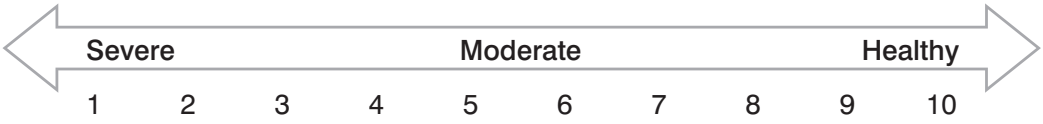
Psychodiagnostic Chart–2 (PDC-2)

Name: Athena Age: 40 Gender: Female Ethnicity: White North American

Date of evaluation: XX / XX / XX Evaluator: Psychotherapist

Section I: Level of Personality Organization

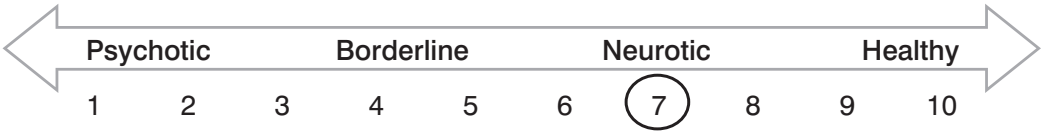
Consider your client's mental functions in determining the level of personality organization. Use these four mental functions to efficiently capture the level of personality organization. Rate each mental function on a scale from 1 (Severely impaired) to 10 (Healthy).



1. **Identity:** Ability to view self in complex, stable, and accurate ways 5
2. **Object relations:** Ability to maintain intimate, stable, and satisfying relationships 5
3. **Level of defenses** (using the guide below, select a single number): 6
   - 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 7

Overall Personality Organization

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



(continued)

FIGURE S.7. A completed PDC-2 for Athena.

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.)

(There are no sharp cutoffs between categories. Use your clinical judgment.)

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 level.

Check off as many personality syndromes as apply from the list below; 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** 3
Subtypes:
- Introjective
- ✓ Anaclitic
- Converse manifestation: Hypomanic

☐ **Dependent** ___
Subtypes:
- Passive–aggressive
- Converse manifestation: Counterdependent

(continued)

FIGURE S.7. *(continued)*

Level of severity

☐ **Anxious–avoidant and phobic** ___
Subtype:
- Converse manifestation: Counterphobic

☐ **Obsessive–compulsive** ___

☐ **Schizoid** ___

☐ **Somatizing** ___

☐ **Hysteric–histrionic** ___
Subtypes:
- Inhibited
- Demonstrative

☐ **Narcissistic** ___
Subtypes:
- Overt
- Covert
- Malignant

☐ **Paranoid** ___

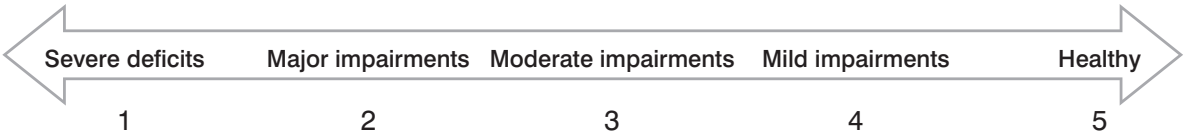
☐ **Psychopathic** ___
Subtypes:
- Passive–parasitic, "con artist"
- Aggressive

☐ **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.



(continued)

FIGURE S.7. *(continued)*

- **Cognitive and affective processes**
  1. Capacity for regulation, attention, and learning 4
  2. Capacity for affective range, communication, and understanding 4
  3. Capacity for mentalization and reflective functioning 3
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) 3
  5. Capacity for relationships and intimacy 2
  6. Self-esteem regulation and quality of internal experience 3
- **Defense and coping**
  7. Impulse control and regulation 2
  8. Defensive functioning 3
  9. Adaptation, resiliency and strength 4
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) 3
  11. Capacity to construct and use internal standards and ideals 4
  12. Meaning and purpose 4

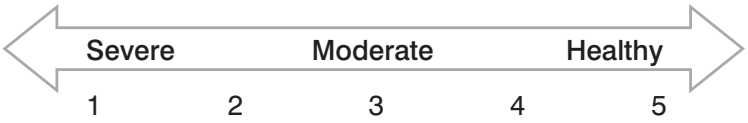
Overall level of personality severity (Sum of 12 mental functions): 39

[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-2 symptom patterns (those that are predominantly related to psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: S21. Persistent depressive disorder (dysthymia) Level: 2

Symptom/concern: S61. Feeding and eating disorders Level: 2

Symptom/concern: Internalized homophobia Level: 2

(continued)

FIGURE S.7. *(continued)*

Section V: Cultural, Contextual, and Other Relevant Considerations

Athena was raised in her mother's somewhat enmeshed Greek family, where the autonomy of young women was not supported, but nevertheless high achievement was expected. Growing up, she knew her sexual orientation would be completely unacceptable to her family of origin; thus, despite knowing from a young age that she was lesbian, she tried very hard to live as a heterosexual. Because she was pushed ahead in school, she was frequently in the context of classmates 2 or more years older, and she felt unknown, immature, and out of place.

FIGURE S.7. *(continued)*

John

Personal Data

John was a 25-year-old man from a devout Catholic family who was born in a small town. After his father's death 2 years earlier, he was forced to move to a big city to find work and provide for the economic needs of his socially disadvantaged family.

Treatment Background

John came to his first appointment on the advice of a cousin, who urged him to see a psychologist after he had a serious car accident. He had sought treatment himself once before; at age 18, he had consulted a psychiatrist for anxiety. The doctor prescribed benzodiazepines, which he was continuing to take ("just to feel better when I'm anxious"). He remembered as well having been sent to a neuropsychiatrist for nonspecific behavioral problems during childhood. When pressed for details, he explained, "When I was a child, I climbed on the ledge at school, so I think that's why they brought me for a consultation."

Chief Complaint and Current Situation

When the clinician opened her office door, she saw a boyish young man with two broken arms. John explained that he had been driving too fast and had had a serious accident. He also complained about job problems, his lack of a girlfriend, and his recurrent "ugly thoughts." In response to the clinician's query about the thoughts, he replied, "I don't want to speak about them. I come from a very religious family, and when I think about

the ugly thoughts, I get afraid that someone will punish me. Sorry." John moved his leg repeatedly, swallowed hard, and seemed to be sweating.

John reported that he worked in a bookshop, from which he was waiting to be fired because his boss had discovered him stealing a book to give his mother. "It's true I stole the book. But at the bookshop, other employees steal things. I wasn't doing such a serious thing! And I think I had the right: They use me and I use them. Why the big deal? It was just for my mother's birthday!" When asked to say more about the episode, he responded, "Sometimes I feel I don't care about anything; sometimes I feel scared they could fire me. If I lose my job, it's a mess: I'd have to return to my hometown, and my mother needs the money I make at work. When my boss called me into his office to tell me he could fire me, I left, and instead of coming home, I drove away and had the accident." John said he did not remember anything about the car crash. He denied any suicidal aim. The incident felt like a dream from which he woke up afterward.

John said about this period of his life that he had the impression that "the sky was falling" and that he could "go crazy at any moment."

Personal History and History of the Problem

John was born by vaginal delivery, was breast-fed, and reportedly reached all developmental milestones normally. About his earliest years, he remarked, "I can remember just a few things, not so much. I remember family fights during lunchtime and friends who bullied me when I was at primary school because I was fat and wore glasses. Also, my mother punished me for reacting, saying that if someone had hit me, I had obviously been bad." He added, "I remember being scared of everything: darkness, monsters, devils, and every situation where I could potentially be alone. But now I'm strong about all those things. Now I'm different."

In adolescence, he began hanging out with a group of bullies—"the same guys who would beat me up when I was a kid." At 18, John started to smoke crack occasionally in groups of friends, and then also when he was alone. "Even sometimes cocaine, but please don't give me that judgmental look!" John noted that he lacked memories of adolescence, except for the times he went to discos, used cocaine and alcohol heavily, and involved himself in risky sexual behaviors.

He is heterosexual, but reported no significant love relationship. He was attracted to "two opposite kinds of girls. Girls like Julia—the typical good girlfriend, devoted to me, quiet and very calm." He hesitated at this point and had to be encouraged to elaborate on what he thought and felt. "Maybe it's brutal to say, but I didn't feel drawn to that kind of girl. I get attracted to girls who are troubled or a bit crazy. Very attracted. Like my relationship with Pamela, who committed suicide. She was a roller-coaster woman, but I loved her so much I still remember her." Asked how he felt when with these contrasting kinds of women, he stated, "With Julia, I felt comfortable and cuddled. With Pamela, I felt excited and powerful. It's been a long time since I've had any long-lasting relationship with a girl; maybe I've never had a solid relationship. I just meet girls at the disco, where they are drunk, and I have sex with them. I'm not good-looking, so sometimes I think that only drunk girls are interested in me. Other girls will never be attracted to me because there's nothing lovable or valuable about me." When his relationships would start to get more intimate, John described a deep fear of being rejected and abandoned. He described past separations with girlfriends: "Either they left me or I left them. I think

it was better that way because they just wanted to use me." Referring to the clinician, he added, "I think you are using me, too. You just want money from me, right?"

When he moved to the city, he started to work up to 14 hours a day: "My bosses don't ask me to do that much overtime, but I think it's better to do my best." Immediately after this statement, he complained, "They exploit and abuse me because they know I'm weak and can't object. But I'll make them pay." Working such long hours had interfered with his social relationships, and he stated he was distressed not to have friends: "I'm dedicating too much time and effort to the work, and I don't have time to go out. My colleagues go out and sometimes ask me to go with them, but I don't." When asked why not, he responded, "Because I don't feel I can give them anything. I'm not nice and pleasant. Why should they be interested in me?"

At the time of the intake, John had no close friends. He described his routine as follows: "I spend most of my time at work, and when I'm not at work, I'm at home. I go out, but no one finds me appealing. On weekends, I used to go to discos with my only friend and I would drink a lot of alcohol and use cocaine. This is my only fun in life. Sometimes when I feel down or really furious, I find relief driving my car. It's true I go too fast, but I don't care!" John went on to say that he had felt a lot of shame in different situations with different people: "Sometimes I act like a baby, I'm an idiot, I'm stupid, I hate myself." At work, on occasions when his colleagues expressed admiration for his work, he would find himself feeling like the best worker his company could hire; at other times, he experienced immense anxiety about being judged ("When my boss is around, I get confused and make a lot of mistakes"). When someone would criticize him, he would feel a deep, uncontrolled anger and associated paranoid thoughts: "Two weeks ago, my boss told me I had put some books in the wrong section, and I felt so much anger that I had to shut myself into the storage room. I was afraid I'd kill someone. I punched the door so hard that I hurt my hand. I left the store early and took the car out to get some relief in driving fast. That mistake wasn't my fault, but they teased me at work about it anyway."

John described hiding in a fantasy world when his moods would become intense: "Sometimes I feel down and I lie in bed imagining I'm a famous DJ in Ibiza and could have all the girls and drugs I want." Once, during an early session while he was speaking about an episode of extreme fear, John entered into a dissociated, trance-like state in which, after a brief silence, he started to speak in gibberish; then, after a long silence, he fell asleep.

Family History and Specific Features of Relationships with Family Members

John was the youngest of five brothers. The oldest had committed suicide 5 years ago after accumulating many gambling debts. The second was reportedly addicted to drugs (principally heroin) and was in a drug rehab program. The third and fourth brothers seemed to have "normal lives"; they were both married with sons, but had both moved to another country. He rarely heard from them, but was occasionally in touch by phone. After the death of his oldest brother, he found himself feeling closer to the next one because "I know how it feels to be the problem child." John said he had had a very good relationship with the brother who died because "I saw him as powerful and unaffected

by anything. He seemed to me always calm and quiet, as if nothing could touch him emotionally." He added that he remembered feeling understood by that brother: "He was always silent and listened to me. He never judged me. I always wanted to be like him, but I failed; I was a stupid, fragile kid."

John's father was a clerk and his mother a housewife. He reported that his parents' relationship was characterized by violent fighting, which often occurred at mealtimes: "As soon as I came home from school and sat down to eat lunch, they began to quarrel. I just wanted to finish my meal as quickly as possible. I would leave to do my homework. I don't remember anything about my afternoons, or what I thought, or how I felt. At dinner, the quarrels would start again." He reiterated that he had few childhood memories, but noted, "I do remember thinking something I still think: that if I was a bad child, Jesus or someone acting for him could punish me for my bad thoughts or my bad acts."

John mentioned no other relatives who had played an important part in his family history. The main sentence by which he was able to refer to his childhood experience was an idea that continued to preoccupy his mind: "Children don't understand anything."

"I don't know why I have to come to a psychologist. I do feel relieved, but it's frustrating to pay someone to be listened to. I think no one has ever listened to me. I haven't known who to confide in. My mother always told me not to cry, not to be a baby; babies cry and adults don't." Then a memory occurred to him: "Once my parents forgot me at the supermarket. I was playing in the aisles, and they forgot me! I thought they'd never come back, that they had found a way to get rid of me because I was such a burden to them."

John said he had to meet a standard of perfection for the sake of both his father and mother; he believed that because of the failures of his older brothers, he was the only one who could realize their dreams.

Currently, his widowed mother lived alone at home. He was feeling a great deal of responsibility for her. She would call him to complain that he was her only hope of survival and that he was not bringing in enough money. When he was not feeling a crushing sense of guilt about this, he seemed able to put the issue out of his mind, along with any realistic commitment or challenge he faced: "Sometimes I would just run away or disappear. Or destroy everything."

Further Observations

Relevant Affects

When experiencing intense affects, John had problems with impulse regulation, as shown by his need to take refuge in exciting and highly dangerous situations (e.g., speeding in his car) and in his tendency to abuse substances. Twice in adolescence he had cut himself during intense fights with his parents, who would not let him be involved with the athletic kids at his school. "They started to scream. I started to scream. Everyone was screaming. Everything was chaotic. No one was listening to anyone else. I was so angry!" John seemed to have a desperate need to be contained and soothed when intolerable feelings led him to self-destructive acts.

He looked and sounded deeply ashamed of his needy and weak aspects, as evidenced by these remarks:

"I've never cried; dumb babies do it!"
"I look too ugly; no girl could be interested in me."
"Sometimes bad thoughts come into my mind, but I don't want to say them; they have nothing to do with therapy."
"I was wrong to put the books on that shelf; what a numbskull I am!"

Deep, primitive rage and paranoid fears were John's most obvious characteristic affects, but his underlying feelings of shame and humiliation were also extensive. The rage and fears seemed to defend him against helpless mortification, as in his sensitivity to feeling judged, looking like a baby, or expecting retaliation from Jesus for his failings.

During their first summer separation, John asked the clinician, "Will you ever come back?" and revealed fantasies that she could leave him abandoned for the rest of his life. But he added, "Even if you don't come back, it would be OK; I would save some money."

Defenses

John seemed to struggle internally in a battle of good against bad. His splitting prevented the integration of disparate aspects of his identity into a coherent whole. It was evident in his tendency to view certain people as either "wonderful" or "disgusting," without any capacity to find a continuity in contradictory perceptions of the same person. Julia and Pamela, for example, seemed to be external representatives of two internal compartmentalized tendencies. John perceived himself and others as unstable and changing: "Sometimes I feel I'm two different people with the same girl. It astonishes me. Will I always be this way?" and "If someone could see me in some situations, they wouldn't recognize me."

Another defense John depended on was denial: He ignored the damage that speeding in the car or using substances could cause him. Via various rationalizations in the service of this denial, he minimized the harmful effects of some of his behaviors and tended not to see aspects of situations that could bring him closer to disturbing affects he did not want to feel.

John also used projective identification. Disturbing aspects of his own personality went unrecognized and were attributed to others, evoking from them the feelings and attitudes that he had projected. For example, after 6 months of therapy, one day John appeared at the therapist's door, despite the fact that no session had been scheduled for that day. He said, "I've come today because I wanted to tell you something, and I thought you would be interested to hear it and wouldn't want to wait to listen to me." The clinician felt confused by this behavior, torn between wanting to welcome John's needs and being irritated by his intrusiveness.

Dissociative defenses were also evident in John's psychology and were particularly notable during his one trance-like episode early in treatment. On hearing his disorganized speech during that instance, the therapist had worried about the possibility of a prodromal psychotic mental state, but John's subsequent behavior in treatment failed to support this hypothesis.

Therapist Reactions and Treatment Indications

John's behavior evoked intense feelings in the clinician, who found herself struggling to contain and manage her affective responses. She felt tempted to try to satisfy his needy requests, to which she responded with deep preoccupation, painful helplessness, and strong rescue fantasies. When John talked about his dangerous behaviors, she tended to feel overwhelmed and extremely anxious. He was also exasperating in his self-destructiveness, sense of entitlement, and assumptions that the clinician would want to exploit him; these transference responses provoked her countertransference fantasies of getting rid of him.

This treatment would need to be structured with clear limits and a consistent frame; therapy should generally focus on the here-and-now. John would need long-term therapy, and the clinician should consider getting periodic consultation and support to cope with the strains that might be expected in her ongoing work with John.

DSM-5/ICD-10 Diagnosis

Stimulant use disorder, cocaine, mild (ICD-10-CM code: F14.10)

Alcohol use disorder, moderate (ICD-10-CM code: F10.20)

Borderline personality disorder (ICD-10-CM code: F60.3)

PDM-2 Diagnosis

P Axis

Personality syndrome: Borderline personality

Level of personality organization: Borderline

M Axis

M06. Significant defects in basic mental functions (range = 19–25)

S Axis

S71.1. Substance-related disorders

PDM-2 Profile on the PDC-2

A completed PDC-2 for John, revealing his full PDM-2 profile, is provided in Figure S.8 on the next page.

(text resumes on page 68)

Psychodiagnostic Chart–2 (PDC-2)

Name: John Age: 25 Gender: Male Ethnicity: European

Date of evaluation: XX / XX / XX Evaluator: Psychotherapist

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).

Severe — Moderate — Healthy

1 2 3 4 5 6 7 8 9 10

1. **Identity:** Ability to view self in complex, stable, and accurate ways 3
2. **Object relations:** Ability to maintain intimate, stable, and satisfying relationships 3
3. **Level of defenses** (using the guide below, select a single number): 3
   - 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 4

Overall Personality Organization

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

Psychotic — Borderline — Neurotic — Healthy

1 2 3 (4) 5 6 7 8 9 10

(continued)

FIGURE S.8. A completed PDC-2 for John.

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.)

(There are no sharp cutoffs between categories. Use your clinical judgment.)

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 level.

Check off as many personality syndromes as apply from the list below; 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

(continued)

FIGURE S.8. *(continued)*

Level of severity

☐ **Anxious–avoidant and phobic** ___
Subtype:
- Converse manifestation: Counterphobic

☐ **Obsessive–compulsive** ___

☐ **Schizoid** ___

☐ **Somatizing** ___

☐ **Hysteric–histrionic** ___
Subtypes:
- Inhibited
- Demonstrative

☐ **Narcissistic** ___
Subtypes:
- Overt
- Covert
- Malignant

☐ **Paranoid** ___

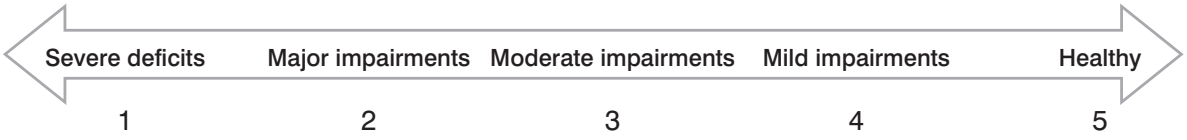
☐ **Psychopathic** ___
Subtypes:
- Passive–parasitic, "con artist"
- Aggressive

☐ **Sadistic** ___

☑ **Borderline** 3

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.



(continued)

FIGURE S.8. *(continued)*

- **Cognitive and affective processes**
  1. Capacity for regulation, attention, and learning 2
  2. Capacity for affective range, communication, and understanding 2
  3. Capacity for mentalization and reflective functioning 2
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) 2
  5. Capacity for relationships and intimacy 2
  6. Self-esteem regulation and quality of internal experience 2
- **Defense and coping**
  7. Impulse control and regulation 1
  8. Defensive functioning 2
  9. Adaptation, resiliency and strength 2
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) 2
  11. Capacity to construct and use internal standards and ideals 2
  12. Meaning and purpose 3

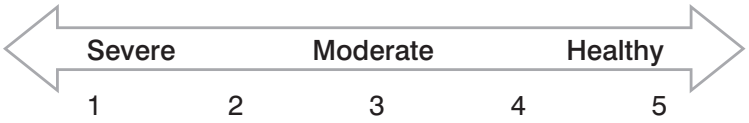
Overall level of personality severity (Sum of 12 mental functions): 24

[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-2 symptom patterns (those that are predominantly related to psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: S71.1. Substance-related disorders Level: 3

Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

(continued)

FIGURE S.8. *(continued)*

Section V: Cultural, Contextual, and Other Relevant Considerations

John comes from a Catholic family and themes centering around religion are often part of his fantasies and feelings. He has moved from a small town to a big city. The death of his father, who was the only wage earner in the home, threw his family into socioeconomic disadvantage. John manifests some resources in his cognitive capacities for learning a new job.

FIGURE S.8. *(continued)*

Adolescence

Richard

Presenting Problem

Richard was 15 when his mother brought him to therapy, as a result of concerns from school and her own worries about his sudden changes in behavior during the year prior to the referral. According to Richard's mother, Richard stole cell phones and sold them to get pocket money; he had become rude and dismissive of the rules at home; and he had moved away from his friends and begun hanging out with an older peer group known for drug dealing and vandalism in the neighborhood. The event that precipitated the referral was a reported incident where Richard had become excessively aggressive toward another young man during the traditional "birthday beat" tradition in his peer group by kicking him nonstop until two adults had to interfere. At the time of referral, Richard was on his last warning from school in response to his current defiant behavior toward teachers. He had particular difficulties with a male math teacher and was accused of being rude and vulgar toward his female French teacher.

Richard was a tall and slightly overweight 15-year-old. He was very concerned with his appearance and his reputation as a well-dressed and "clean-cut" kind of guy. Initially, he presented as very anxious and spoke nonstop; however, as the assessment sessions (five in all) progressed, he was able to stop and think about his helpless feelings regarding his need to be defiant and aggressive toward adults. At times he became boisterous and dramatic in his recollection of events, and there was an evident lack of genuine affect in some of his stories. He displayed a certain bravado and feeling of entitlement quite characteristic of a young adolescent, but displayed an obvious difficulty in the areas of frustration tolerance and empathy, as illustrated by his stories about "the stupid and

ineffective teachers" at his school. However, there was another side of Richard—one who felt lonely and very much deprived. Richard defended against this part of himself by staying active all the time and avoiding thinking, as manifested in the sessions by his nonstop talking and his constant checking of the time.

Brief Developmental History

No major delays or complications were reported by Richard's mother or father. The parents attended social history meetings separately, due to their inability to be in the same room without screaming at each other. According to his parents, Richard achieved all developmental tasks on time except sleeping. He did not sleep through the night until age 6. He was described as a difficult-to-soothe infant who wanted to wake up and play at all times of the night. His mother felt that he had been very talkative and demanding since he was little. No major illnesses were reported, and his overall cognitive development and school achievement seemed developmentally appropriate. His grades had begun to suffer due to his "lazy and procrastinating attitude," according to his mother.

History of the Problem

Richard's parents divorced when he was 7 years old. He remembered having had a good family life until that point and reported feeling loved and happy as a small child. However, once Mrs. W asked for a divorce, things seemed to have become difficult, with Mr. W losing his temper and the parental relationship becoming quite volatile—including custody disputes over the three boys, as well as scenes of domestic violence (e.g., hitting and breaking doors). Mr. W spoke of Mrs. W as being the only person who could make him lose his temper like that; he said that he was in a new relationship now and had never had any such problems with his new partner.

Mrs. W had recently remarried; her new husband was a boyfriend she had been seeing for 3½ years. The couple flew to Las Vegas and married there, leaving the children out of the event. Richard seemed to have been particularly offended by this gesture. His relationship with his stepfather seemed quite distant; he resented this fact and seemed envious of his stepfather's children, to whom the stepfather was very close. Mr. W lived with his oldest son, JJ; they shared a love for racing cars and spent quite a lot of financial resources and time on this interest. Richard felt quite resentful of this, particularly because he felt JJ was beneath him and he did not understand why his father preferred JJ. He expressed a significant amount of jealousy toward both JJ and his other brother.

Richard attended what both he and his father described as an expensive and exclusive private school. Mr. W complained about the school fees constantly and demanded good behavior from Richard in order to continue paying for the school. Richard felt manipulated and shortchanged and expressed his sense of shame regarding being "the poor boy of the school." Both parents were highly overprotective of Richard; they did not allow him to take the bus because they feared he would be mugged, and Mrs. W and Richard communicated constantly by text messages while he was in school. Although Richard expressed in his sessions how intrusive this practice was, he also enjoyed knowing where his mother was and what she was doing. Both Mr. and Mrs. W felt that Richard had always been the child through whom they communicated with each other. They displayed contradictory behavior toward their son, wanting to be "cool" and friends at times and wanting to impose harsh standards of discipline at other times.

Personal Data, Family History, and Specific Features of Relationships

Richard spoke of himself as being a "friendly and popular kind of guy" and seemed to rely on this image of himself to offset his feelings of inadequacy and confusion. This tendency was illustrated during the last assessment session, where he spoke of his experience as a "fat boy" in seventh grade in a rather intellectual manner. When asked to reflect about the painful nature of his story, he managed to turn the story around and speak of how it would be much easier if he could have more money to get help from bigger boys to fight back the attacks of the other children. However, he did manage to speak of his belief that people, like money, are transient, and that real friends are hard to come by. It was the therapist's impression that Richard's feelings of loss over his parents' divorce had never been thought of and verbalized in terms of affects; it seemed that his defiant behavior at school was the only outlet he had in relationships to express his sense of grievance over having been handed "a bad hand."

Relationship with His Mother

Richard's mother had been raised in a very traditional and strict fashion. As a result, she desperately wanted to see herself as a progressive and fair parent. During the initial assessment meeting, Richard made sure to tell the therapist about the closeness of his relationship with his mother. Since his older brother had chosen to move in with his father and his younger brother was too young at the time of the divorce, Richard seemed to have assumed the role of confidant and close friend to his mother. However, the appearance of Stuart, the mom's new husband, seemed to have left Richard in confusion about his role in the family. This became clear during later assessment sessions, during which he brought up twice an incident in which his mother had asked him to move from one room to another when her husband wanted to use the room. He expressed his sense of rage at being displaced. The assessing clinician observed what she understood as the mother's ambivalent attitude and unpredictable response toward Richard's behavior. For instance, when they arrived 20 minutes late for an appointment, she excused herself and openly spoke of forgetting the meeting. The mother and son seemed to share at that moment a sense of complicity that seemed intrinsic in the relationship. However, when the mother seemed to be breaking this implicit pact, Richard reacted with enormous narcissistic rage, and his mom would become in his mind a depriving and abandoning object. This was illustrated by his attitude after he had been sent home from school and his mom grounded him in what he thought was a severe and unfair fashion. However, his complaints focused on the fact that his mother tended to go away with her friends and husband and leave him alone with his father and brothers. In general, Richard seemed to serve as an extension of his mother's self-esteem: She seemed to identify with him and with aspects of his behavior that perhaps she wished she could have displayed herself earlier in her life.

Relationship with His Father

Richard's relationship with his father seemed to have been a close and positive one earlier in his life. However, faced with the father's aggressive and violent behavior during the period of separation and thereafter, Richard seemed conflicted and ambivalent regarding his identification with his father. Richard's sense of shame regarding his father's

somewhat antisocial stance toward life was at the core of his conflict. Both he and his father seemed to struggle with feelings of inadequacy and lack of self-esteem, which were masked behind a facade of grandiosity and narcissism, displayed in his capacity for manipulation and social charm. In general, Richard found himself struggling with his identification with this father, who seemed to get everything through what Richard described as "fake charm" and promises that he never kept. Having been on the receiving end of that style of functioning, Richard struggled with deciding what kind of a man he would choose to be in relation to others. Would he become a strong and aggressive rival or a subdued and compliant but manipulative ally, like his brother JJ?

Relationships with Siblings

Richard's relationships with his brothers seemed to consist of continuous rivalry and competition. At times, in the absence of his father and the passive role of his stepfather, Richard found himself taking over the role of father to his younger brother, whom he described as "getting away with murder" around his mother. Richard's recollection of an event in which his brother was being rude to his mother illustrated this; he recalled telling his brother off and pushing him. His brother, in return, called his father, who screamed at Richard and told him he would break his face if he touched his brother again. Richard's identification with the punitive and aggressive aspects of his father was also present in this story.

Relationships with Peers

Richard spoke of having two best friends who, he felt, would always be loyal to him. Loyalty seemed to be a central preoccupation for him in the context of peers and family. He had become especially close to an older peer who had introduced him to ways of cheating at school without being caught. He seemed both embarrassed and proud when telling the therapist this story, perhaps indicative of the strong sense of guilt he felt. When asked whether he felt guilty, he smiled and said he "sort of" did—but he also believed that he had been a "good guy" for a long time and that this had not served him well, so he felt that for once in his life he had "the upper hand" over those with power. In response, the therapist wondered who were "those with power." Richard smiled and said, "Those that get in the way of me feeling happy and not like a piece of shit!" This exchange, which took place during the third of the five assessment sessions, illustrated Richard's defensive use of oppositional behavior to deal with his feelings of worthlessness and sadness. His new older friend, Tim, had become a new person to claim him and offer him a new way of being. Richard spoke of his other friends as being "like babies, holding on to their mothers' skirts." He expressed his desire to "be a man, one that everyone respects." However, when asked how he imagined his mom felt about the change in his attitude, he became visibly sad and troubled.

Relevant Affects

Richard's affects were difficult to access, as he defended against his feelings of helplessness and loneliness either by becoming grandiose and dismissive or by becoming extremely chatty, intellectualizing, and providing his hearers (the therapist and others)

with what Richard thought they needed. For instance, when missing a session, he spent quite a bit of time speaking highly of how he could use therapy and how therapy could be a great way of understanding oneself. However, when asked to reflect about the fact that he seemed worried about the therapist's losing interest and becoming bored, he was able to stop and think about his concern regarding this matter and how it related to his behavior with peers. In this way, when the therapist engaged him and satisfied his need to feel himself in relationship with another, he was able to "lower the wall" and accept the therapist's comment.

Richard's concerns with sexual identity were age-appropriate. He seemed to consider himself an eligible boyfriend, a "good catch" (in his words). He acknowledged the past impact of having been an overweight child, but ignored any comment regarding its possible impact on his current self-esteem. However, he did seem to experience a good deal of envy and shame over his family situation, and often spoke of not wanting ever to put his children through what his parents put him through.

Defenses

Richard spoke of having problems with concentration at school; he had a hectic schedule and felt tired in general because of so much schoolwork. However, once he was invited to think about the role of all the parties and constant activities, he reflected on how much he hated being alone and how he avoided thinking. In general, Richard's defensive structure seemed to be economical and in the service of his ego, as he seemed to get along with peers, showed interest in sports, and wanted to do well for himself. But he was increasingly struggling with the strength of his repressed aggression, which seemed to be emerging as a result of his mother's remarriage, and with it the reemergence of oedipal conflicts typical of puberty (e.g., moving away from the closeness with his mom). Because of this, he had found school a safer environment where he could explore his feelings of anger and his need for defensive omnipotence. It was the therapist's impression that Richard's aggression had different meanings in the context of his relationship with his parents and that he was aware of this; he appeared to be struggling to find a safe space where he could explore these feelings without fear of retaliation or loss of the loved parent. Richard seemed painfully aware of his rage over feeling abandoned and excluded, but he was also aware of the fragility of his relationships with his parents, whom he feared losing to the new people in their lives. Confronted and preoccupied with these states of affairs, he made use of defenses such as projection by blaming the world and convincing himself that people were out to get him.

Main Concerns and Pathogenic Beliefs

As mentioned earlier, it was difficult to get a sense of how Richard really saw himself, as he displayed a highly defended style of interaction based on intellectualization, a certain degree of charm, and verbal flooding. For example, when asked about his behavior at school, he began to speak about the difficulties teachers have understanding the adolescent brain and his belief that he was often treated unfairly. However, as the therapist began to know Richard better during the assessment period, she sensed a sadness and a sense of loneliness behind the facade of what he described as being a "spoiled brat." It was the therapist's impression that Richard felt confused about his identity as

a young man. He avoided his sense of loss in relation to his parents by adhering to his father's set of values about money and self-worth. This was illustrated by his comments regarding the cost of the assessment and his belief that the process of psychotherapy was futile. However, as the therapist challenged his rationalizations regarding his behavior at school and conveyed some of the reality regarding the possibility of his expulsion from school, there was evidence that he was openly conflicted and felt helpless in light of his current impulse to become defiant at school; he even expressed his wish to understand why he acted this way. In general, when challenged, Richard expressed his sense of confusion and helplessness quite openly, once he became less anxious and more at ease with the therapist and the setting.

Therapist's Reactions to the Patient

The therapist reported liking Richard, regardless of his efforts to present as difficult and distant at times. She reported sometimes feeling slightly manipulated, but not feeling bothered by it. She did report feeling a bit confused by Richard's sudden affective shifts from being quiet and defensive to becoming overly verbal and seemingly open to the reflections and links she offered. In general, she felt that Richard was a young man who seemed desperate for connection and the experience of feeling understood. She based this impression on her recurrent maternal feelings toward him and her concern at the end of the assessment sessions regarding the impact of these sessions on Richard, when nobody at home seemed ready to offer consistent and predictable support.

Treatment Indications

A recommendation was made for twice-weekly psychotherapy, with the view of supporting Richard to develop a strong alliance with his therapist, which might help lessen his need for ineffective defenses such as projection and omnipotence. Richard expressed interest in attending therapy and was able to express openly his concerns and fears that psychotherapy would make him "weak" (i.e., too sensitive). It was the assessing therapist's belief that Richard would be able to develop a greater degree of reflective functioning, once he was able to verbalize his affects without needing his omnipotent and often manic style of interaction. Richard faced many challenges common to his stage of development, but he seemed at particular risk of developing further antisocial and self-destructive behaviors as a result of his conflicts relating to identification with his father's aggressive and controlling personality. On the other hand, his mother's overprotective and sometimes submissive approach in relation to Richard contributed further to his confusion and his often omnipotent and impulsive style of interaction. Work with both parents was recommended in order to foster more appropriate and realistic ways of parenting a young adolescent and to free Richard from his role as mediator in his family.

DSM-5/ICD-10 Diagnosis

Oppositional defiant disorder, moderate (ICD-10-CM code: F91.3)

Parent–child relational problem (ICD-10-CM code: Z62.820)

Disruption of family by separation or divorce (ICD-10-CM code: Z63.5)

PDM-2 Diagnosis

MA Axis

M04. Mild impairments in mental functioning (range = 40–46)

PA Axis

Emerging personality style: Narcissistic

Level of functioning: Neurotic

SA Axis

SA92. Oppositional defiant disorder

PDM-2 Profile on the PDC-A

A completed PDC-A for Richard, revealing his full PDM-2 profile, is provided in Figure S.9.

Childhood

Alex

Presenting Problem

Alex, age 9, was referred by a child psychiatrist who had diagnosed him with trichotillomania and requested further psychological evaluation. According to his parents, Alex used to suck his thumb and caress his hair, and then pull bits of hair out. He felt no pain and seemed to have no awareness of doing it. Whenever one of the parents drew attention to the behavior, he would stop and report feeling pain. The hair pulling had begun when Alex was 2½ years old, after he started nursery school. The symptom would appear for some weeks or a month, then stop; his hair would grow back normally; and then the hair pulling would resume periodically. At the time of referral, Alex's symptom had persisted for 6 months, and the hairless spot on his head was large and conspicuous. Alex's parents described him as "a child always in motion," explaining that he liked only activities involving movement, such as soccer, bicycling, and skating. Sometimes he engaged in risky behaviors, trying to imitate his older brother's tricks, but he was not accident-prone.

Brief Developmental History

Alex was the second child of the family. His brother was 5 years older. Both his mother and father were highly educated people with successful professional careers. They reported that Alex was a planned and wished-for baby. However, the mother's demanding job, with trips and long stays away from home, made her feel exhausted near the delivery date. Alex was delivered by C-section. He was breast-fed for 2½ months and then weaned because of his mom's return to full-time work. The mother then resumed

(text resumes on page 79)

Psychodiagnostic Chart—Adolescent (PDC-A)

Name: *Richard* Age: *15* Gender: *Male* Ethnicity: *White North American*

Date of evaluation: *XX* / *XX* / *XX* Evaluator: *Psychotherapist*

Section I: Mental Functioning (MA Axis)

Rate your patient'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 deficits	Major impairments	Moderate impairments	Mild impairments	Healthy
1	2	3	4	5

- **Cognitive and affective processes**
  1. Capacity for regulation, attention, and learning — *3*
  2. Capacity for affective range, communication, and understanding — *4*
  3. Capacity for mentalization and reflective functioning — *4*
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) — *3*
  5. Capacity for relationships and intimacy — *3*
  6. Capacity for self-esteem regulation and quality of internal experience — *3*
- **Defense and coping**
  7. Capacity for impulse control and regulation — *3*
  8. Capacity for defensive functioning — *4*
  9. Capacity for adaptation, resiliency, and strength — *4*
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) — *3*
  11. Capacity to construct and use internal standards and ideals — *3*
  12. Capacity for meaning and purpose — *4*

Overall level of personality severity (Sum of 12 mental functions): *41*

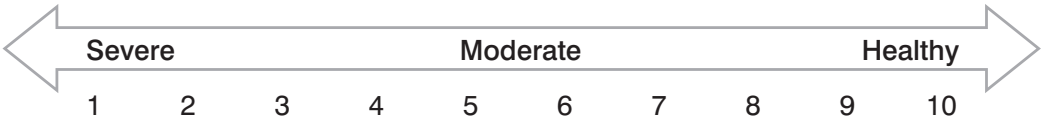
[Healthy/optimal mental functioning 54–60; Good/appropriate mental functioning with some areas of difficulty, 47–53; Mild impairments in mental functioning, 40–46; Moderate impairments in mental functioning, 33–39; Major impairments in mental functioning, 26–32; Significant defects in basic mental functions, 19–25; Major/severe defects in basic mental functions, 12–18]

(continued)

FIGURE S.9. A completed PDC-A for Richard.

Section II: Level of Personality Organization

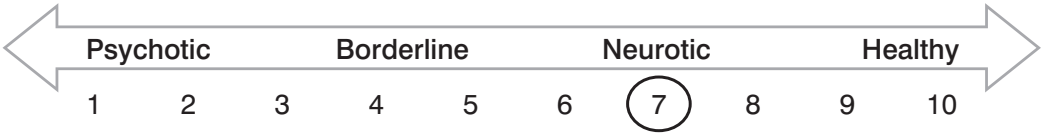
Consider your patient's mental functions in determining the level of personality organization. Use these four mental functions to efficiently capture the level of personality organization. The clinician should keep in mind the stage of adolescence presented by the patient: early adolescence (approximately 11–13 years old), middle adolescence (approximately 14–18 years old), or late adolescence (19–21 years old). 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 4
2. **Object relations:** Ability to maintain intimate, stable, and satisfying relationships 3
3. **Level of defenses** (using the guide below, select a single number): 7
   - 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 7

Overall Personality Organization

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



"Normal" emerging personality patterns (Healthy): Characterized by mostly 9–10 scores. These adolescents demonstrate a cohesive emerging personality organization in which their biological endowments, including their temperamental vulnerabilities, are managed adaptively within developmentally appropriate relationships with families, peers, and others. In relation to their stage of adolescent development, they have an increasingly organized sense of self, comprising age-appropriate coping skills and empathic, conscientious ways of dealing with feelings about self and others.

Mildly dysfunctional emerging personality patterns (Neurotic): Characterized by mostly 6–8 scores. These adolescents demonstrate a less cohesive emerging personality

(continued)

FIGURE S.9. *(continued)*

organization in which their biological endowments, including their temperamental vulnerabilities, are managed less adaptively. Early in life, their primary caregivers may have had trouble helping them manage these constitutional dispositions. Thus relationships with families, peers, and others are more fraught with problems. Such adolescents do not navigate the various developmental levels as successfully as those with less problematic endowments and/or more responsive caregivers. However, their sense of self and their sense of reality are pretty solid. As development proceeds, their adaptive mechanisms may be apparent in moderately rigid defensive patterns, and their reactions to adversities may be somewhat dysfunctional.

Dysfunctional emerging personality patterns (Borderline): Characterized by mostly 3–5 scores. These adolescents demonstrate vulnerabilities in reality testing and sense of self. Such problems may be manifested by maladaptive ways of dealing with feelings about self and others. Their defensive operations may distort reality (e.g., their own feelings may be perceived in others, rather than in themselves; the intentions of others may be misperceived).

Severely dysfunctional emerging personality patterns (Psychotic): Characterized by mostly 1–2 scores. These adolescents demonstrate significant deficits in their capacity for reality testing and forming a sense of self, manifested by consistently maladaptive ways of dealing with feelings about self and others. Their defensive operations interfere with basic capacities to relate to others and to separate their own feelings and wishes from those of others. (Use 3 for adolescents who go between psychotic and borderline levels.)

(There are no sharp cutoffs between categories. Use your clinical judgment.)

Section III: Emerging Adolescent Personality Styles/Syndromes (PA Axis)

In addition to considering level of organization, adolescent patients begin to demonstrate an emerging personality style. Rather than thinking of these styles as categorical diagnoses, it is more useful for clinicians to think of the relative degree to which the patient might be exhibiting an emerging style.

Check off as many personality syndromes as apply from the list below; 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**	___
☐ **Anxious–avoidant**	___
☐ **Schizoid**	___

(continued)

FIGURE S.9. *(continued)*

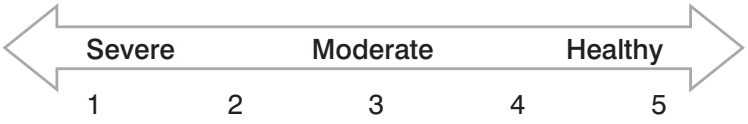
Level of severity

☐ **Psychopathic–antisocial**	___
☑ **Narcissistic**	4
☐ **Paranoid**	___
☐ **Impulsive–histrionic**	___
☐ **Borderline**	___
☐ **Dependent–victimized**	___
☐ **Obsessive–compulsive**	___

Section IV: Symptom Patterns (SA Axis)

List the main PDM symptom patterns (those that are related to predominantly psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: Defiant and oppositional behavior Level: 3

Symptom/concern: Antisocial behavior Level: 5

Symptom/concern: Level:

Section V: Cultural, Contextual, and Other Relevant Considerations

Richard's family presents as fragmented and unpredictable. At a time in his development when he needs guidance and strong role models for identification, he feels forgotten and replaced by others; his feelings of exclusion manifest themselves in aggressive behavior. Aggression seems to be the way in which his parents defend against feelings of loss, and he has begun to manifest such behavior at school toward a male and a female teacher in displacement. The moral values espoused by his father have set the ground for his identification with an older peer with strong antisocial tendencies. This places Richard at risk of further disruptive behavior, which could lead to further disorganization and an emerging sense of self as someone damaged and at the fringes of society. He does not want to be a proper private school boy anymore; he wants to be a strong, delinquent man whom his father can both fear and admire.

FIGURE S.9. *(continued)*

her trips and long stays away from home. His father was quite busy with work as well. Alex's care was assigned to a nanny and his maternal grandmother. He would cry longingly for his mother during her absences. The maternal grandmother was the most stable and consistent of Alex's caregivers during his first 5 years of life.

Alex had started walking and talking in his first year. He was toilet-trained at the ages of 2½ years (morning) and 4 years (night). At the time of referral, his parents noted occasional bedwetting. He also had difficulties with sleep that began during infancy; he needed his father to be close at bedtime. Sometimes he woke up from nightmares in the middle of the night, looking for his parents. There had been two surgeries: a tonsillectomy at age 4 years and a procedure at age 6 to remove a Baker's cyst from his knee. The parents described Alex as terrified during the second surgery.

He had started nursery school at age 2½, as noted earlier. Although he showed no separation anxiety, this was when his compulsive hair pulling started while he was at home. Within 6 months, the family moved to another area, and Alex had to change schools and be separated from his maternal grandmother. His symptom intensified and his parents blamed his school, calling it a "weird" environment. They removed Alex from that school, and he stayed at home for 4 months with his mother. He was then sent to a new school and the symptom did not reappear. When he started primary school, he was highly motivated to do his homework, enjoyed studying with his mother or grandmother (who had relocated to be close to him), and was one of the best students in his class. It was during this period that he began pulling his hair out at home again, however.

Personal Data, Family History, and Specific Features of Relationships

During diagnostic sessions, Alex reported incidents of fighting with his brother and other kids; in contrast, his parents said that he was very friendly to everyone and almost never fought. They also said that Alex was never shy and would approach other children to play with in various settings (playgrounds, school). They noted, however, that if he had a best friend, he stayed just with that friend and became very possessive. They also reported significant difficulty in convincing Alex to come to the first diagnostic session; he had cried and shouted in protest. The parents were surprised by his reaction, since Alex was a child who almost never objected to doing what was asked of him. They postponed the diagnostician's first meeting with Alex because of his intense reaction. His father finally convinced him to attend the first session by promising to buy him a video game. After the first session, the parents reported that Alex agreed to return, but then he began telling them that he was feeling bored in the sessions because he disliked talking and found "nothing interesting" in the room to play with.

When the diagnostician asked Alex's parents to describe their relationships with him, they did not refer to anything emotional, but only to the kinds of things they did together (e.g., taking walks or playing soccer). Their communication about him was intellectualized, concrete, and superficial. The absence of any reporting of emotions, or of making gestures conveying an emotional state, reminded the evaluator a lot of their son. Although both parents seemed to be warm and friendly, their emotional detachment made the psychologist feel as if they were talking about a child they had once met, not their own son. They could not generate any thoughts or hypotheses about Alex's symptom, apart from its having first appeared when he attended the "weird" school at age 3. In regard to their relationship as a couple, they said that they would disagree

a lot and fight, but not loudly and not in front of their children. Their major source of conflict was that they both wanted to have the final word about everything in the house. At the end of the interview, they stated their belief that Alex was a "normal" child and that everything was "smooth" in their relationships with him. As a result, they expressed genuine shock about their child's recurrent symptomatology.

Relationships with Parents and Siblings

Alex had aggressive outbursts, erupting suddenly when he was feeling angry or irritated; these occurred mainly with his brother and sometimes with children to whom he was not feeling very close (see below). He appeared to feel somewhat close to his father, but given their somewhat emotionless presentation, it was difficult to gauge the level of intimacy between him and either of his parents.

When asked about his relationships with his parents, Alex said that he enjoyed going out with his father, but only with him. According to him, his mother usually ruined their walks because she always wanted to go shopping. He also said that sometimes his parents went out at night and he stayed with his brother alone in the house. He enjoyed these nights because they could stay up until very late. The psychologist asked him if he ever played with his parents and he laughed, saying that his parents never played. Then she asked him if he enjoyed playing. He said, "I like playing video games, soccer, and basketball with my friends. I don't like playing with castles and things like that." He looked around the room, pointing at the toys. The diagnostician said, "So you wouldn't like to play with these toys alone or with me, would you?" He agreed.

Relationships with Peers

Alex seemed to engage easily in play with peers in various settings. In the clinical interview, he reported having a close friend, but gave no information about the quality and depth of the relationship. Projective tests revealed a superficial way of relating in general.

When asked about his friends, Alex replied, "I have just one friend at school because the rest of my classmates are mean." He stopped. The psychologist asked him to tell her more about this. He replied, "Well, for example, today a kid stole my friend's ball at school because we didn't want to play with him. I can hit, too, sometimes, you know. Today I hit this kid because what he did was not good." She asked him how he felt when he was doing that, and he said, "Good." She went on to say, "So you hit others sometimes." He said, smiling, "Yes, I fight with my brother a lot." "What do you fight about?" she asked. He replied, "I don't know . . . sometimes he plays tricks on me and he scares me, appearing suddenly in front of me from the dark! I hit him then, and we fight. I used to be scared of the dark some years ago. Now I'm not." Then she asked, "So how do you feel when your brother plays these tricks on you?" Alex answered, "I hit him. Once I used his password and got into his computer, and I ruined the video game he was playing. [He smiled with pleasure.] When he came back, he started hitting me, yelling, 'What have you done?' He'd done this to me, too, in the past, you know! I usually don't tell him anything when he does something to me. Yesterday morning he threw bacon in my milk. And then I put him down on the floor and started hitting him!" He smiled again. The diagnostician remarked that there seemed to be a frequent state of conflict with his brother, and he nodded in agreement. She asked him how he felt about it and he said, "I don't know . . . bad? I don't know!" He laughed, saying, "No!" And then he

added, "If a friend of mine asks me to play with toys like that, I might do it to be nice, but I don't like it . . . I get bored!"

During the second evaluation session, Alex came in more relaxed and started talking about an incident that had happened earlier that day at school. He was playing soccer with his classmates and one of them was trying to steal the ball from him. He stated that this guy "broke his nerves," so Alex kicked him in his genitals. He went on to say that the school principal called him to his office and told him off. He added that the principal did not tell his teacher about this incident, so everything was "fine," and the issue ended there. As he described it, he was calm, with the same frozen smile he had displayed during the first session. He could understand that what he did was serious, and he seemed to wish to report it, but he showed no remorse or guilt over his actions—only relief at having escaped punishment. In general, there was a noticeable lack of empathy in Alex's responses, and he showed very little concern over the impact of his thoughts and feelings on others.

Relevant Affects

Although Alex talked about himself, he needed questions and prompts to elaborate. His references to affects was restricted ("I felt good," "I felt bad") and occurred only after he was asked directly about them. He did not use symbolic means (e.g., symbolic play) to express his emotions or inner experience. He seemed to use his body to express affective states, especially anxiety. His intense motility during the clinical interview, his complaining of pains when tests were administered, and his description of nervous movements of his hands and legs when anxious in class were all examples. In addition, his symptom of compulsive, unconscious hair pulling could be understood as an indication of this lack of ownership of his body functions. From his stories and his overall demeanor during diagnostic sessions, it seemed that when Alex encountered issues of aggression or intimacy, his regulation capacities lapsed, inducing emotional discharge in actions. His aggression had a "raw," violent quality and was connected with both destructiveness and pleasure.

Therapist's Reactions

In the diagnostic meetings, the therapist had the feeling that Alex was a child who could connect easily, but in a rather superficial manner lacking real emotional contact. He talked easily about events, but had significant difficulty in expressing mental representations of himself in the context of relationships. He seemed more a child of "action" than of "thought."

He seemed to experience dysphoric feelings that were not expressed but internalized. The outcomes of stress from this internalization seemed to take the form of physical tension and somatic pains. Alex's self-representation seemed marked by a negative image of himself when compared to others, and he seemed to experience fears of failure and inadequacy. In his relationships to others, he tended to form superficial relationships and to avoid taking responsibility for his decisions.

Defensive Functioning

Alex's main defenses—isolation of affect and warding-off of impulses—seemed to be ineffective when his feelings were intense, and he would then lapse into acting out and/or

somatization. More generally, his use of obsessional defenses to avoid emotional stimuli seemed to restrict exchanges that might promote emotional development, such as the establishment of close relationships and the development of self-observing capacities. Alex also used projection to defend against his aggressive impulses (e.g., as he did with his brother and friends when he said that they would like to attack him as well). In addition, there was some evidence of sublimation. Sports were used as a way of mastering aggression, and his studying resulted in good school performance. In this context, sublimation had become a functional way of mastering the anxiety stemming from the conflict between his need for competence and his fear of failure and inadequacy.

Main Concerns and Pathogenic Beliefs

Alex's hair pulling was a maladaptive way of confronting stressful internal and external experiences. There seemed to be a split between the body and the mental apparatus, with the use of the former for impulse discharge and regulation. Although his dysphoric feelings showed that the latter did not remain intact, the greater cost of this form of adaptation burdened his bodily functions. Alex's self-observing capacities were seriously restricted. He seemed disinclined to engage in thinking about himself or his feelings, or to try to understand and express his experiences. There was also no evidence of symbolic representation through play or drawing. His capacity for mental representations seemed to be poor. He could differentiate right from wrong in social circumstances, and his demands upon himself were neither harsh nor loose. He failed to feel guilt or remorse when he attacked others in anger, however, and he felt happy when he could escape punishment from adults. Overall, Alex showed major constrictions and alterations in mental functioning. He had great difficulties in controlling impulse and affect and used his body as a means for regulation. His self-observing capacities and abilities to express emotions verbally were poor and his capacity for mentalization was limited.

Treatment Plan

Alex's symptoms suggested a systemic difficulty in his family's functioning. His parents seemed to have difficulties connecting inner experiences with actions and communicating them in affectively appropriate terms. The violent outbursts of their two children suggested that the older brother might also have problems with impulse control. Therefore, it was decided that the initial treatment plan should concentrate not only on Alex's problems and symptoms, but also on promoting the overall mentalizing capacity of his family system. In the beginning of treatment, a therapist should focus on how to help the parents understand each family member's behaviors and emotions in the context of their relationships and family interactions, thus increasing their ability for reflective functioning. To help deepen family bonds and make interactions more meaningful, family sessions should focus on how the thoughts, feelings, and actions of each member influenced the others. When Alex and his parents were able to communicate at a representational level about each other's thoughts, wishes, and feelings, it would become easier for him to establish a treatment alliance with a therapist and work through the conflicts over his impulses. Given Alex's age and the rigid nature of his defenses, the diagnostician felt that a twice-weekly individual psychotherapy approach with a focus on mentalizing would maximize the development of a more genuine and deeper relationship with a therapist.

DSM-5/ICD-10 Diagnosis

Trichotillomania (hair-pulling disorder) (ICD-10-CM code: F63.3)

Parent–child relational problem (ICD-10-CM code: Z62.820)

PDM-2 Diagnosis

MC Axis

M04. Major impairments in mental functioning (26; range = 24–29)

PC Axis

Emerging personality style: Neurotic

Level of functioning: Moderate

SC Axis

SC51. Somatic symptom disorder (with a rule-out of SC32.1, obsessive–compulsive disorder)

PDM-2 Profile on the PDC-A

A completed PDC-C for Alex, revealing his full PDM-2 profile, is provided in Figure S.10 on the next page.

Infancy and Early Childhood

Steven

Steven is a 3-year-old boy brought for consultation because his parents, recently separated, cannot agree about how to bring him up. Steven is an only child, attends preschool, and lives with his mother; he sees his father on Wednesdays and on alternate weekends, with overnight visitation. The parents believe that he is afraid of being abandoned because since they separated 6 months ago, he is anxious during moments of greeting and parting.

After two meetings with the parents, three family observations are made: one including Steven and his parents, another with Steven and his mother, and the third with Steven and his father. After these assessments, a meeting is scheduled for recommendations to the family.

(text resumes on page 87)

Psychodiagnostic Chart—Child (PDC-C)

Name: Alex Age: 9 Gender: Male Ethnicity: Hispanic

Date of evaluation: XX / XX / XX Evaluator: Psychologist

Section I: Mental Functioning (MC Axis)

Rate your patient's level of strength or weakness on each of the 11 mental functions below, on a scale from 1 to 5 (1 = Severe deficits; 5 = Healthy). Then sum the 11 ratings for a level-of-severity score.

Severe deficits	Major impairments	Moderate impairments	Mild impairments	Healthy
1	2	3	4	5

- **Cognitive and affective processes**
  1. Capacity for regulation, attention, and learning — 3
  2. Capacity for affective range, communication, and understanding — 2
  3. Capacity for mentalization and reflective functioning — 2
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) — 4
  5. Capacity for relationships and intimacy — 3
  6. Capacity for self-esteem regulation and quality of internal experience — 3
- **Defense and coping**
  7. Capacity for impulse control and regulation — 1
  8. Capacity for defensive functioning — 3
  9. Capacity for adaptation, resiliency, and strength — 1
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) — 1
  11. Capacity to construct and use internal standards and ideals — 3

Overall level of personality severity (Sum of 11 mental functions): 26

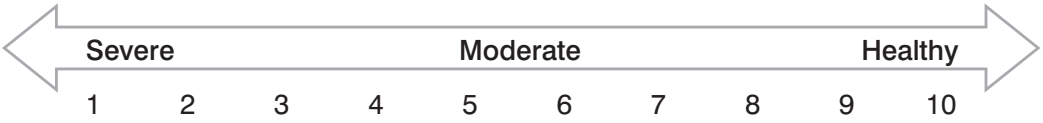
[Healthy/optimal mental functioning, 50–55; Good/appropriate mental functioning with some areas of difficulty, 43–49; Mild impairments in mental functioning, 37–42; Moderate impairments in mental functioning, 30–36; Major impairments in mental functioning, 24–29; Significant defects in basic mental functions, 17–23; Major/severe defects in basic mental functions, 11–16]

(continued)

FIGURE S.10. A completed PDC-C for Alex.

Section II: Emerging Level of Personality Pattern and Difficulties

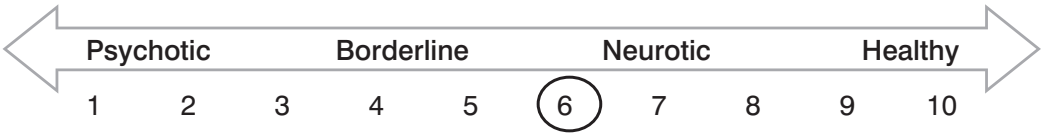
Consider your patient's mental functions in determining the level of personality organization. Use these four mental functions to efficiently capture the current personality patterns and difficulties leading to an emerging level of personality organization. Age-specific characteristics, as well as the high level of fluidity in symptomatology during this stage of development, should be considered—as should other specific external factors influencing current clinical presentation. Rate each mental function on a scale from 1 (Severely impaired) to 10 (Healthy).



1. **Identity:** Emerging ability to view self in age-appropriate, stable, and accurate ways 6
2. **Object relations:** Emerging ability to maintain intimate, stable, and satisfying relationships 6
3. **Emerging personality pattern** (using the guide below, select a single number): 6
   - 1–2: Psychotic level
   - 3–5: Borderline level
   - 6–8: Neurotic level
   - 9–10: Healthy level
4. **Reality testing:** Ability to appreciate conventional notions of what is realistic 6

Overall Emerging Personality Organization

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



"Normal" emerging personality patterns (Healthy): Characterized by mostly 9–10 scores. These children demonstrate a cohesive emerging personality organization in which their biological endowments, including their temperamental vulnerabilities, are managed adaptively within developmentally appropriate relationships with families, peers, and others. In relation to their stage of development, they have an increasingly organized sense of self, comprising age-appropriate coping skills and empathic, conscientious ways of dealing with feelings about self and others.

Mildly dysfunctional emerging personality patterns (Neurotic): Characterized by mostly 6–8 scores. These children demonstrate a less cohesive emerging personality organization in which their biological endowments, including their temperamental

(continued)

FIGURE S.10. *(continued)*

vulnerabilities, are managed less adaptively. Early in life, their primary caregivers may have had trouble helping them manage these constitutional dispositions. Thus relationships with families, peers, and others are more fraught with problems. Such children do not navigate the various developmental levels as successfully as those with less problematic endowments and/or more responsive caregivers. However, their sense of self and their sense of reality are progressing in an age-appropriate manner. As development proceeds, their adaptive mechanisms may be apparent in moderately rigid defensive patterns, and their reactions to adversities may be somewhat dysfunctional.

Dysfunctional emerging personality patterns (Borderline): Characterized by mostly 3–5 scores. These children demonstrate vulnerabilities in reality testing and sense of self. Such problems may be manifested by maladaptive ways of dealing with feelings about self and others. Their defensive operations may distort reality (e.g., their own feelings may be perceived in others, rather than in themselves; the intentions of others may be misperceived).

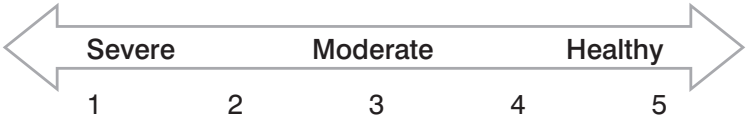
Severely dysfunctional emerging personality patterns (Psychotic): Characterized by mostly 1–2 scores. These children demonstrate significant deficits in their capacity for reality testing and forming a sense of self, manifested by consistently maladaptive ways of dealing with feelings about self and others. Their defensive operations interfere with basic capacities to relate to others and to separate their own feelings and wishes from those of others.

(There are no sharp cutoffs between categories. Use your clinical judgment.)

Section III: Symptom Patterns (SC Axis)

List the main PDM symptom patterns (those that are related to predominantly psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: SC51. Somatic symptom disorder Level: 2

Symptom/concern: _____ Level: ___

Symptom/concern: _____ Level: ___

(continued)

FIGURE S.10. *(continued)*

Section IV: Influencing Factors and Relevant Clinical Observations Informing Diagnosis

1. Epigenetics: *Family history of depression*

2. Temperament: *Influence of Alex's innate difficulties with impulsivity and affect regulation.*

3. Neuropsychology: *No evidence to support biological basis for affect dysregulation.*

4. Attachment style *Early relational bonding difficulties have influenced Alex's mentalization capacities and difficulties in affect regulation*

5. Sociocultural influences: *Family isolation as a result of parents' overwhelming work demands.*

6. Countertransference–transference manifestations: *Evaluator spoke of difficulties in making emotional contact with parents and of feeling drawn by the child's need for attention and emotional attunement.*

FIGURE S.10. *(continued)*

Personal Data, Family History, and Specific Features of Relationships with Family Members

The two meetings with Steven's parents are held for the purpose of gathering information about pregnancy, childbirth, and the first stages of his development. These sessions are tiring because in the absence of their son, the parents resume their conflict, which completely saturates the space of the joint interview. Steven seems to disappear from their minds. Information is eventually obtained that his birth was induced but normal and that he was born at term, in 10 minutes, "as precise as a Swiss watch," weighing 6.3 pounds.

Steven was breast-fed for 3 months. Whereas the mother describes these first months as "peaceful," the father says that at that time she had some hysterical crises that he did not know how to handle. He remembers that period as "a moment of panic." Steven is

still using a pacifier. About sleep–wake rhythms, the father describes Steven as sleeping often and for a long time. Normally, when Steven is at his home, he does not wake up during the night, after falling asleep with fairy tales or cartoons. The mother reports that in her home, Steven falls out of bed; the father says that this does not happen at his house.

The mother says that Steven has different dietary habits according to where he is. Steven eats milk and cereal and chooses what else to eat. He finds it hard to accept meat. The father admits that on Wednesdays, when Steven is at his home, he spoils him a bit and lets him eat whatever he wants, wherever he wants. Steven eats by himself at his father's place, while the mother has to feed him, telling him stories; the latter process takes an hour.

Steven took his first steps when he was about a year old. His parents describe him as lazy but agile and well coordinated. His first word, "Mom," was spoken when he was about a year and a half. Steven has been speaking well for 1 year, and now his verbalization is clear. Both parents complain that Steven is beginning to swear, however. No one gets upset, but they explain to him the meaning of these words and tell him that it makes no sense to say them.

Sphincter control has not been achieved yet because Steven does not want to be alone when using the bathroom, despite the fact that his parents stopped diapering him last summer. Steven also wants someone to help him to urinate and does not like to wash his hands.

With other children, Steven plays and talks. He has a strong will. If he does not like being with some friend, Steven stays by himself. He insists on getting what he wants; if he does not have it and cannot get it, he prefers remaining alone.

Functional Emotional Developmental Capacities

During the family observation, Steven shows age-appropriate expertise on every level (emotional, relational, motor, language, cognitive). His development appears harmonious.

Steven proves to be an extravert, a lively and curious child. He is able to interact with all those present (parents or psychologists). He shows his skills and freely involves himself in different activities. When he is tired, he makes it clear that he wants to go home. He is even more at ease when he comes to the observation with his father; when he is with his mother, he tends to stay close to her and to involve her in his games. Steven generally appears serene during the observations, while his parents are more nervous and strained.

He is a resourceful and skilled boy, with good access to symbolic communication. His graphic production is adequate. Furthermore, he has a good ability to activate defensive strategies appropriate to his developmental stage. Both parents are for him important, affectively significant landmarks.

Steven appears to have vitality and personal resources and already shows signs of a structured personality. He evokes in the therapist both warmth and enjoyment. He asks his parents for help if he is in difficulty, but if they cannot help him, he turns to the psychologist. The atmosphere is relaxed, as Steven evokes sympathy and attention from everyone.

Regulatory–Sensory Processing Capacities

Steven's regulatory–sensory processing capacities appear adequate and appropriate to his age, within a range of normal variation.

His sensory modulation and discrimination rarely show problematic features; indeed, he shows attentional and observational capacities that are more developed than would ordinarily be expected for his age.

Steven is able to use his own regulatory patterns to reach goals, to plan actions, and to maintain relationships. He is also able to modulate the timing of entering into contact with others and with his parents.

Although Steven's sleep–wake rhythms are dependent upon where and with whom he is sleeping, he does not seem to have any problems in this area.

The only times when Steven cries or is sad are when he must leave or reunite with his mother or father. At his mother's home, he has more difficulties in falling asleep, and he often falls out of bed because of restless sleep.

Relational Patterns and Disorders

It is evident that the father has made a genuine and substantial emotional investment in his child, and that he "really likes," esteems, and appreciates Steven. He seems to be able to identify with his son; he is impressively attuned to his wants, needs, and desires.

Steven's mother handles the practical and organizational aspects of his growth. She is not very present emotionally, though not completely absent. Although she seems a good observer of her son's internal and external worlds, she suffers heavy interference from an uncontrollable, unmanageable anxiety, which propels her into actions that do not respect the child's needs or the context.

During the family observation, Steven's parents show a capacity to keep their child in mind and take care of him together. There is a harmonious relationship with Steven, since the parents' behaviors are balanced: The mother is much more explosive and unpredictable; the father leaves space, but is participatory and involved, although more discreet. The result is a joint appropriate and practical management of their son.

Steven appears to be a friendly and sociable child who relates well to others. He easily makes a connection with the therapist; he shows confidence but does not exaggerate the closeness, thus conveying a secure pattern of attachment and an overall sense of security and confidence in self and others.

Steven's mother is focused on the "rules" of a situation and reacts too much to her own anxiety. She impinges on his spaces of thought and silence. The father is amused and fascinated by his child and seems to understand his needs and emotions. Both parents enjoy Steven and admire his ability to be amusing. The mother, however, is excessively present with her own interests and purposes. Steven needs to spend more time with his father.

Steven's parents believe that he is afraid of being abandoned because he is anxious during moments of greeting and parting. Specifically, the mother is afraid that the father could take away the son, and the father believes that the mother engages in strange behaviors that harm the child. They believe that Steven's difficulties depend on their effort to implement parenting strategies in common. They do not realize that their conflicts often lead them to focus their attention more on themselves than on their son, who is then forgotten.

The critical issues turn out to be the fragility and precariousness of the individual psychologies of both parents, which have a relevant impact on the relationship with Steven and threaten to jeopardize his development. If the parents fail to strengthen their individual structures and stabilize the relationship with their child, it will be difficult for them to develop the parenting skills that, although limited and incomplete, are currently available.

Treatment Indications

Given Steven's young age and the current high level of parental conflict, it seems important for his parents to get psychological help aimed at improving their shared parenting. By relying on the parents' deep feelings of love for their child, a professional could help them find solutions to the educational, relational, and affective challenges that meet Steven's developmental needs more effectively.

PDM-2 Diagnosis

Primary Diagnoses

IEC09. Adjustment disorder (level 4)

IEC01. Sleep disorder (level 5)

PDM-2 Profile on the PDC-IEC

A completed PDC-IEC for Steven, revealing his full PDM-2 profile, is provided in Figure S.11.

Later Life

Giovanna

Presenting Problem

Giovanna shows signs of great weariness combined with anger, impatience, and strong resentment toward her husband, who has Alzheimer's disease; she takes care of him daily. Giovanna complains of being left alone with the heavy task of her husband's care.

Personal Data, Family History, and Specific Features of Relationships with Family Members

Giovanna is 78 years old. She is retired and is married to Aldo, a former bank employee, who is 85 and has been suffering from Alzheimer's for about 6 years. They have two daughters, Sonia and Teresa. Seven years ago, Giovanna and her husband moved from their town to a mountain village where both their daughters have been living with their families for some years. The daughters had urged them to move because they were

(text resumes on page 95)

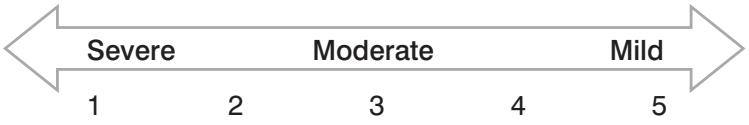
— Psychodiagnostic Chart—Infancy and Early Childhood (PDC-IEC) —

Name: *Steven* Age: *3* Gender: *Male* Ethnicity: *European*

Date of evaluation: *XX* / *XX* / *XX* Evaluator: *Psychologist*

Section I: Primary Diagnoses

List the main IEC diagnoses and rate the level of severity for each, using a 1–5 scale. If necessary, you may use the DC: 0–3R, DC: 0–5, or DSM diagnosis here.



Principal diagnosis: *IEC90. Adjustment disorder* Level: *4*

Other diagnosis: *IEC01. Sleep disorder* Level: *5*

Other diagnosis: _____ Level: _____

Section II: Functional Emotional Developmental Capacities

Circle the child's level of strengths or deficits on each of the six emotional functions below, on a scale from 1 to 5 (1 = Severe deficits; 5 = Healthy).

Level	Expected emotional function	Rating scale				
1	Shared attention and regulation	(5)	4	3	2	1
2	Engagement and relating	(5)	4	3	2	1
3	Two-way purposeful emotional interactions	(5)	4	3	2	1
4	Shared social problem solving	(5)	4	3	2	1
5	Creating symbols and ideas	(5)	4	3	2	1
6	Building logical bridges between ideas: Logical thinking	5	(4)	3	2	1

Section III: Regulatory–Sensory Processing Capacities

Axis III describes the child's regulatory–sensory processing profile. There are a number of constitutional–maturational differences in the way in which infants and young children respond to and comprehend sensory experiences and then plan actions. The different observed patterns exist on a continuum from relatively normal variations to disorders.

(continued)

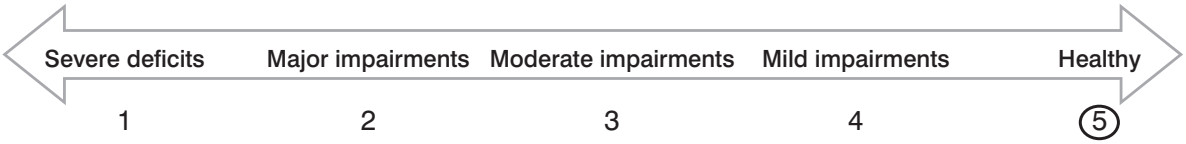
FIGURE S.11. A completed PDC-IEC for Steven.

Circle the child's level of regulatory–sensory processing capacities in each of the categories below, on a scale from 1 to 4 (1 = Severe problem; 4 = No indication).

Category	Subtype	Challenge in this area			
		No indication; never or rarely a problem	Mild problem or only occasionally a problem	Moderate problem or frequently a problem	Severe problem or almost always a problem
Sensory modulation	Sensory underresponsivity	(4)	3	2	1
	Sensory overresponsive	(4)	3	2	1
	Sensory seeking	(4)	3	2	1
Sensory discrimination	Tactile	(4)	3	2	1
	Auditory	(4)	3	2	1
	Visual	(4)	3	2	1
	Taste/smell	(4)	3	2	1
	Vestibular/ Propriocep.	(4)	3	2	1
Sensory-based motor functioning	Postural challenges	(4)	3	2	1
	Dyspraxis challenges	(4)	3	2	1

Overall Regulatory–Sensory Profile

Considering the ratings and your clinical judgment, circle the degree to which each regulatory–sensory pattern represents normal variation versus disorder. For scores 1–2, consider a regulatory–sensory processing disorder as a primary diagnosis; for scores 3–4, consider that the disordered regulatory–sensory processing can be associated with other primary diagnoses.



(continued)

FIGURE S.11. *(continued)*

Section IV: Relational Patterns and Disorders

Each child's relationship with a significant caregiver (mother or father but, if appropriate, custodial parent, grandparent, etc.) should be evaluated in this section. Rate the caregiver–child relationship on each of the eight descriptions below, on a scale from 1 to 5 (1 = Severely impaired; 5 = Healthy). Then sum the eight ratings for the degree to which the pattern represents healthy/adapted relationship versus relational disorder.

Caregiver 1: Mother (please specify)

Infant/child–caregiver relationship	***Rating scale***				
Quality and flexibility of caregiver's representation of the child	5	(4)	3	2	1
Quality of caregiver's reflective functioning	5	(4)	3	2	1
Quality of caregiver and child's nonverbal engagement	5	(4)	3	2	1
Quality of interactional patterns (reciprocity, synchrony, interactive repair)	5	4	(3)	2	1
Affective tone of the caregiver–infant relationship	5	4	(3)	2	1
Quality of caregiver's behavior (sensitivity vs. threatening and/or frightening behaviors)	5	(4)	3	2	1
Quality of caregiving patterns (comfort, stimulation, response to infant emotional signals, encouragement vs. withdrawal, overstimulation, controlling behavior, insensitivity)	5	4	(3)	2	1
Infant/child's ability to engage and form a significant relationship (vs. specific difficulties that impair this ability)	(5)	4	3	2	1
	Total score = 30				

Overall Level of Relational Pattern (Caregiver 1)

[Healthy/adapted relational patterns, 36–40; Adapted relational patterns with some areas of difficulty, 29–35; Moderate perturbation or disturbance in relational patterns, 22–28; Significant disturbance in relational patterns, 15–21; Major impairments in relational pattern or relational disorders, 8–14]

Attachment Pattern (Caregiver 1)

Rate the caregiver–child relationship as regards attachment patterns on a scale from 1 (no correspondence) to 5 (high correspondence) for each of the four prototypes.

Secure	4
Insecure–avoidant	1
Insecure–ambivalent/resistant	3
Disorganized/disoriented	1

(continued)

FIGURE S.11. *(continued)*

Caregiver 2: *Father* (please specify)

Infant/child–caregiver relationship	***Rating scale***				
Quality and flexibility of caregiver's representation of the child	(5)	4	3	2	1
Quality of caregiver's reflective functioning	5	(4)	3	2	1
Quality of caregiver and child's nonverbal engagement	(5)	4	3	2	1
Quality of interactional patterns (reciprocity, synchrony, interactive repair)	5	(4)	3	2	1
Affective tone of the caregiver–infant relationship	(5)	4	3	2	1
Quality of caregiver's behavior (sensitivity vs. threatening and/or frightening behaviors)	5	(4)	3	2	1
Quality of caregiving patterns (comfort, stimulation, response to infant emotional signals, encouragement vs. withdrawal, overstimulation, controlling, insensitivity)	5	(4)	3	2	1
Infant/child's ability to engage and form a significant relationship (vs. specific difficulties that impair this ability)	(5)	4	3	2	1
	Total score = *36*				

Overall Level of Relational Pattern (Caregiver 2)

[Healthy/adapted relational patterns, 36–40; Adapted relational patterns with some areas of difficulty, 29–35; Moderate perturbation or disturbance in relational patterns, 22–28; Significant disturbance in relational patterns, 15–21; Major impairments in relational pattern or relational disorders, 8–14]

Attachment Pattern (Caregiver 2)

Rate the caregiver–child relationship as regards attachment patterns on a scale from 1 (no correspondence) to 5 (high correspondence) for each of the four prototypes.

Secure	*4*
Insecure–avoidant	*1*
Insecure–ambivalent/resistant	*1*
Disorganized/disoriented	*1*

Section V: Other Medical and Neurological Diagnoses

FIGURE S.11. *(continued)*

worried about the health problems that old age might bring. Because of their other commitments, however, Sonia and Teresa cannot help Giovanna enough with their father's care.

Although she understands and respects the necessity of the move, Giovanna misses the city. She feels lonely, uprooted, and deprived of her friends. She is especially uncomfortable with the villagers, whom she regards as closed-minded, suspicious, and hostile to those who, like her, are not natives or long-term residents.

The eldest daughter, Sonia, 55 years old, was born after 2 years of marriage when Giovanna was 23. Sonia is in a second marriage to a hotelier and works with him in the management of the business. Sonia's first marriage was turbulent; she separated from her husband with great pain. The current marriage is surviving, but not without difficulties. Giovanna is worried about Sonia's emotional life, but partly justifies her daughter's condition by laying most of the blame on her first husband, who cheated on her many times. Despite the fact that Giovanna says nothing about it, the psychologist knows that Sonia has been hospitalized twice in a psychiatric unit for suicide attempts. Giovanna seems to rely heavily on Sonia's help in her sick husband's care.

The second daughter, Teresa, is 51 and was born when Giovanna was 27. She is married, has two teenage boys, and is a secondary school teacher. Giovanna says that Teresa gave her more satisfaction than Sonia. Teresa was always a good girl and now she is a good wife and the mother of two well-mannered and hard-working students. In addition, Teresa sometimes helps her mother with the father's care.

Giovanna was born into a middle-class family in a big city. Her family consisted of the parents; the first-born, Antonio; herself; and her younger sister, Amelia. Her father, who died at the age of 84, was a respected bank accountant. Thanks to his position, he helped two of his three children to find jobs in the bank. Giovanna has always admired her father, both as a parent and as a worker. Even now, she remembers him with much pleasure for the attention he showed to his wife and children; she particularly remembers Sunday strolls with him at the local park.

Her brother, Antonio, was 5 years older than Giovanna. Like his father, he was a respected bank accountant. He died at age 78 from cancer, shortly before the death of Giovanna's mother. Giovanna had a consistently positive relationship with him. She recalls their games and describes him as "nice" and "generous."

Her sister, Amelia, is 6 years younger than Giovanna. From childhood on, there were always many conflicts between them; they broke off their relationship altogether several years ago. Giovanna was the "wise daughter" who respected the family rules, whereas Amelia was a real worry for her parents. She was always unruly and hostile, especially toward Giovanna. Amelia may have been jealous of Giovanna, who was reportedly their father's favorite (Giovanna says, "I was his darling"). Amelia was also a bank accountant, but unlike her father and brother, she was never a model employee. Moreover, Giovanna blames her sister for the failure of Amelia's two marriages, as well as for having completely broken off her relationship with her only son. Today Giovanna envies Amelia because she lives in their native city, away from the mountain village that she now hates, but which was once the happy place where the family spent their holidays.

Giovanna's mother died at age 99 after a long period in a nursing home. She was a housewife who took care of the family, particularly of her three children, and was more severe with Giovanna than her father was. She would demand that Giovanna come home early when she went out with friends, especially if they were boys. Giovanna says ironically that her mother's strict rules failed to change the unruly nature of Amelia, whose arrogance made her relations with everyone difficult ("Amelia has a bad nature. She made life impossible for herself").

Giovanna's family did not have many economic or health difficulties, not even during World War II.

When she was 21, Giovanna married Aldo, a bank employee like her father, brother, and sister. Although Giovanna is also a qualified accountant, she found ("by chance," according to her) a job in a lawyer's office instead of a bank. Giovanna was always happy with her work because her employers appreciated her skills and also because there she formed lasting friendships. However, Giovanna was never able to confide openly in her friends about her disappointment with her marriage—not even in Maria, her best friend, who had lent her some money to cover Aldo's wild extravagance. Giovanna paid the money back, but she was too ashamed to tell Maria about her marital unhappiness. At her best, Giovanna managed to hold together the roles of mother and employee. These two roles have given meaning and satisfaction to her life. She has been a good mother to her daughters, and she worked until she retired. But she is disappointed with her marriage.

Aldo is the only man with whom Giovanna has ever had a relationship. Their engagement lasted 3 years. Today, Giovanna is aware that at the time she did not know Aldo sufficiently. If, on the one hand, Giovanna's mother did not allow her to go out a lot with Aldo, on the other hand, the couple did not insist much on seeing each other. In fact, sometimes Aldo phoned and said that an unexpected commitment would keep him from seeing Giovanna. Giovanna never asked why. Only later, Giovanna realized that behind those sudden changes of plan, Aldo was hiding his habit of binge drinking with friends. Giovanna would discover in time that she had married a man who drank too much and who was to develop alcoholism in several years. Although during the week Aldo's behavior was socially appropriate, he often got drunk on weekends. Sometimes he disappeared on Friday after work, or on Saturday, and then he came back home on Sunday evening in a horrible state of inebriation.

Aldo did not look after his daughters much. He was reportedly aggressive and disparaging, though never physically violent. Giovanna rarely entrusted their daughters to him. Now she recalls with pain the long days spent with "my two little girls."

Giovanna, who discovered in the early years of marriage that Aldo had been unfaithful, wanted a separation, but her mother stopped her "for the sake of the family." Giovanna took revenge on him by denying him sexual intercourse ("We didn't have sexual relations for more than 30 years"), but she has never been unfaithful to him. Giovanna has long had a silent contempt for her husband, as both a man and a father; now that his illness is getting worse, Giovanna is able to express her anger in words. The major issue of her marriage is the lack of pleasure and love, only partly compensated for by her relationships with her two daughters (whom she still calls "little girls").

Further Observations

First Sessions with the Therapist

This is the first time Giovanna has turned to a local psychological service. After consulting her doctor, she made her decision autonomously. After nearly a 2-month wait, Giovanna travels 2 hours by bus to reach the psychological service for her first meeting.

The therapist welcomes Giovanna into the waiting room. Her slow gait and her posture suggest physical weakness. During the conversation, Giovanna demonstrates good explanatory skills and adequate, appropriate use of language. Her speech is slow, and the tone of her voice is low. Her thought is logical and linear and seems to express some

energy and hope. Despite her subdued voice and her evident impatience and weariness, Giovanna appears to be highly motivated. While she is sitting, her posture is slightly bent toward the desk. Sometimes she smiles and thanks the therapist for his help.

Giovanna asks for advice on how to behave with her husband, since she is tired of him and his illness. She also has sleeping problems. At first her doctor prescribed a mild antidepressant, but this was later abandoned because she did not tolerate it well. Despite the physical limitations of old age, Giovanna is having to take care of Aldo largely by herself. Her limited economic resources do not allow her to rely on an external source of help, such as a hired caregiver. With the approval of her daughters, she tried to put Aldo in a nursing home, but as he was rapidly getting worse, after 3 weeks she decided to take him back home. Giovanna takes care of Aldo, but she says that it is impossible for her to love him. She maintains that she often desires his death, without feeling guilty for doing so. She thinks that what she must do for her sick husband is unfair. It is his dependence that annoys Giovanna; she must meet her husband's continuous, trivial, and illogical demands, which she considers excessively entitled, and which remind her of painful interactions she suffered with him in the past.

Despite everything, Giovanna looks after Aldo; she gives him his medications, walks with him daily, washes his clothes, tidies up the house, cooks, and keeps him company. The only things Giovanna categorically refuses to do are to wash his body and dress him ("I tell him to wash himself and I give him clothes, but I don't care how he washes himself or how he dresses"). Giovanna says that at the beginning of the disease, her husband asked her suddenly and aggressively to have sex with him after more than 30 years of abstinence. Giovanna got scared, and her daughters dialed the emergency number. That happened only once, though, and it was probably related to the drugs he was taking. Since that incident, Giovanna has been sleeping in another room and locking the door.

Her daughters urge Giovanna to be patient with their father. She strives and even manages for quite long periods to control her anger, but after some time she becomes rude and aggressive. Sometimes she feels bad for not being patient; at other times she justifies herself. Giovanna realizes that her husband is ill, but she also believes that she has the right to take care of herself. The memories of Aldo's infidelities and of the suffering he caused her for many years drive away any feeling of compassion for his condition.

Giovanna rarely asks for her daughters' help ("I do not want to bother them"), despite their concern, Teresa's in particular. Giovanna says that her daughters' jobs are more important than her difficulties. However, her statements mask an ill-concealed expectation of greater assistance. Giovanna indirectly blames her daughters for her having to live in the hateful countryside, which keeps her away from old friends and colleagues.

The therapist addresses Giovanna's sleeping problems, and in a few weeks, her mood and sleep patterns improve slightly. During the fourth session, Giovanna notes that Maria, her closest friend and former colleague, died some days earlier. Giovanna is very sad. She does not understand how Maria could have died so suddenly, since she had been a guest at Giovanna's home only 3 months previously, and the two had spoken on the phone only a few days before, when Maria seemed fine. Giovanna asked Teresa to take her to town to say a final goodbye to her friend. But on the weekend, her daughters preferred to celebrate her 79th birthday. She was not in the right mood and would have preferred to give up the birthday party, but her daughters insisted that she should not disappoint her grandchildren. With the therapist, Giovanna reflects on mourning and on how to come out of it. Eventually she says, smiling softly, that Maria's death has induced

her to think about her own. She accepts the therapist's proposal to deal with this issue in the next meeting, and she also asks for more meetings "because I need them."

DSM-5/ICD-10 Diagnosis

Persistent depressive disorder (dysthymia), with anxious distress (ICD-10-CM code: F34.1)

Insomnia disorder (ICD-10-CM code: G47.00)

Relationship distress with spouse or intimate partner (ICD-10-CM code: Z63.0)

PDM-2 Diagnosis

ME Axis

Giovanna seems to have well-preserved cognitive skills. She has a good level of education and has continued to nourish her intellect by reading. She shows a considerable capacity for insight. However, Giovanna also shows mild constrictions and rigidities in areas such as self-esteem regulation, defensive functioning, and identity.

M03. Mild impairments in mental functioning (range = 40–46)

PE Axis

At present, Giovanna's relevant feelings are anger, contempt, sadness, guilt, and shame, which she addresses through the use of defense mechanisms such as denial, repression, and passive aggression. Giovanna's central tension is about goodness versus badness. She thinks that there is something inherently bad or inadequate about her and that she must be good to be accepted.

Personality syndrome: Depressive personality
Level of personality organization: Neurotic

SE Axis

SE22. Depressive disorders

SE62. Sleep–wake disorders

PDM-2 Profile on the PDC-E

A completed PDC-E for Giovanna, revealing her full PDM-2 profile, is provided in Figure S.12.

Psychodiagnostic Chart—Elderly (PDC-E)

Name: *Giovanna* Age: *78* Gender: *Female* Ethnicity: *European*

Date of evaluation: *XX* / *XX* / *XX* Evaluator: *Psychotherapist*

Section I: Mental Functioning (ME Axis)

Rate your patient'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.

Although most older adults do not have significant cognitive impairment, it is important to assess for presence of cognitive impairment or neurocognitive disorders that may affect mental functioning.

Severe deficits	Major impairments	Moderate impairments	Mild impairments	Healthy
1	2	3	4	5

- **Cognitive and affective processes**
  1. Capacity for regulation, attention, and learning *4*
  2. Capacity for affective range, communication, and understanding *4*
  3. Capacity for mentalization and reflective functioning *4*
- **Identity and relationships**
  4. Capacity for differentiation and integration (identity) *3*
  5. Capacity for relationships and intimacy *3*
  6. Capacity for self-esteem regulation and quality of internal experience *3*
- **Defense and coping**
  7. Capacity for impulse control and regulation *4*
  8. Capacity for defensive functioning *3*
  9. Capacity for adaptation, resiliency, and strength *3*
- **Self-awareness and self-direction**
  10. Self-observing capacities (psychological mindedness) *4*
  11. Capacity to construct and use internal standards and ideals *3*
  12. Capacity for meaning and purpose *3*

Overall level of personality severity (Sum of 12 mental functions): *41*

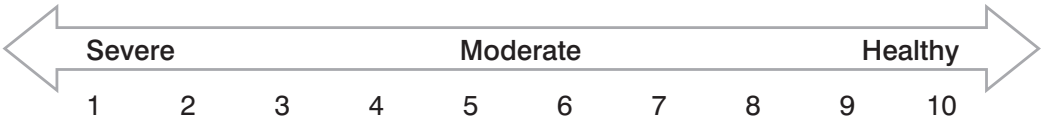
[Healthy/optimal mental functioning, 54–60; Good/appropriate mental functioning with some areas of difficulty, 47–53; Mild impairments in mental functioning, 40–46; Moderate impairments in mental functioning, 33–39; Major Impairments in mental functioning, 26–32; Significant defects in basic mental functions, 19–25; Major/severe defects in basic mental functions, 12–18]

(continued)

FIGURE S.12. A completed PDC-E for Giovanna.

Section II: Level of Personality Organization

Consider your patient's mental functions in determining the level of personality organization. Use these four mental functions to efficiently capture the level of personality organization, and don't forget you are evaluating an older person who falls into one of these age groups: young-old (55–64 years of age), middle-old (65–74 years of age), old–old (75–84 years of age), and oldest–old (85 years of age or older). 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 6
2. **Object relations**: Ability to maintain intimate, stable, and satisfying relationships 6
3. **Level of defenses** (using the guide below, select a single number): 7
   - 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 7

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.)

(continued)

FIGURE S.12. *(continued)*

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.)

(There are no sharp cutoffs between categories. Use your clinical judgment.)

Section III: Personality Syndromes (PE 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 level. Don't forget you are evaluating an older person, so take into consideration:

- Possible age-related behavioral features that may confound the diagnosis of a personality syndrome or disorder
- Possible effects of the aging process on previous personality syndromes
- Possible effects of personality syndromes on the aging process

Check off as many personality syndromes as apply from the list below; 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	3
☐ **Dependent** Subtypes: • Passive–aggressive • Converse manifestation: Counterdependent	___
☐ **Anxious–avoidant and phobic**	___
☐ **Obsessive–compulsive**	___
☐ **Schizoid**	___

(continued)

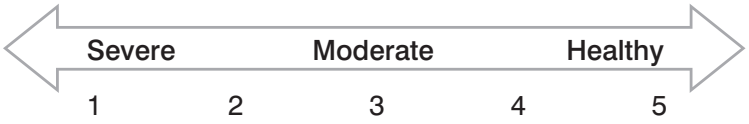
FIGURE S.12. *(continued)*

	Level of severity
☐ **Somatizing**	___
☐ **Hysteric–histrionic**	___
☐ **Narcissistic**	___
☐ **Paranoid**	___
☐ **Psychopathic**	___
☐ **Sadistic**	___
☐ **Borderline**	___

Section IV: Symptom Patterns (SE Axis)

List the main PDM symptom patterns (those that are related to predominantly psychotic disorders, mood disorders, disorders related primarily to anxiety, event- and stressor-related disorders, etc.).

(If required, you may use the DSM or ICD symptoms and codes here.)



Symptom/concern: SE22. Depressive disorders Level: 2

Symptom/concern: SE62. Sleep–wake disorders Level: 3

Symptom/concern: _____ Level: ___

Section V: Cultural, Contextual, and Other Relevant Considerations

Giovanna was born into a middle-class family in a big city. In her current situation, she has moved from a town to a mountain village, so she is experiencing adaptation difficulties in this new context. She is also having difficulty with issues related to her husband's Alzheimer's disease. Despite these stresses, it seems that she can count on the support provided by her daughters.

FIGURE S.12. *(continued)*