Introduction

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The second edition of the *Psychodynamic Diagnostic Manual* (PDM-2; Lingiardi & McWilliams, 2017) attempted to articulate clinical knowledge, promote research, and facilitate supervision and teaching. It seems to have accomplished these goals. Many students and colleagues, appreciating that the PDM since its inception (PDM Task Force, 2006) has been a work in progress, have written to us with support, advice, and criticism. The manual has been published in Chinese, Italian, Korean, Polish, Russian, and Turkish, and is currently being translated into several other languages. The emergence of an international community interested in the PDM has inspired us to develop the new edition you are now reading.

Like its predecessors, PDM-3 is organized around certain basic concepts: a dimensional approach to psychopathology and mental health diagnoses; a developmental perspective applied to diagnostic formulation; multiaxiality (converging perspectives that consider mental functioning, personality, and the subjective experience of symptoms); the relevance of cultural, social, familial, and intersectional factors; assessment of patients' strengths as well as vulnerabilities; integration of clinical experience with empirical research; and dialogue with other approaches, especially those originating in cognitive psychology and neuroscience.

Rationale for the PDM-3 Classification System

In continuity with PDM-2, PDM-3 has been influenced by formulations that include Shapiro's (1965) *Neurotic Styles*, Kernberg's (e.g., 1984) model of personality organization levels, McWilliams's (e.g., 2011) clinical-diagnostic approach, and the work

of many psychoanalytic researchers. As in previous editions, we offer a diagnostic framework that addresses a person's full range of functioning: the depth as well as the surface of cognitive, emotional, somatic, and interpersonal patterns. We try to balance nomothetic understanding with the idiographic knowledge that is useful for case formulation and treatment planning, emphasizing individual variations as well as commonalities. We hope to contribute to improvements in the evaluation and treatment of psychological problems and to a fuller understanding of the development and functioning of the human mind (Lingiardi & McWilliams, 2015, 2025; see also Frances, 2018; Kernberg, 2018).

In PDM-3, we have tried to represent mainstream psychoanalytic perspectives (ego psychology, object relations theory, self psychology, and relational psychoanalysis). We have not integrated Lacanian diagnostic concepts here, however, for three reasons: First, we are not well-schooled in Lacan's theory; second, its diagnostic classifications, which reflect the categories in which Freud originally thought, do not mesh easily with the developmental, dimensional, and inferential concepts of other evolving psychoanalytic orientations; third, the empirical literature supporting Lacanian formulations is to date still limited.

We continue to seek a balance between capturing the complexity of clinical phenomena (functional understanding) and developing criteria that can be reliably judged and employed scientifically (descriptive understanding). We advocate a stepwise approach in which complexity and clinical usefulness influence operational definitions, informing research and being informed by it. We believe a scientifically based system begins with accurate recognition and description of complex clinical phenomena and builds gradually toward empirical validation.

Favoring what is measurable over what is meaningful operates in the service of neither good science nor sound practice. A vast body of research, including process-oriented studies, has shown that essential characteristics of the psychotherapeutic relationship as conceptualized by psychodynamic models (the therapeutic alliance, transference/countertransference phenomena, real relationship, therapist subjectivity, and stable characteristics of the patient) are more predictive of outcome than any designated treatment approach (Flückiger, Del Re, Wampold, & Horvath, 2018; Gelso, Kivlighan, & Markin, 2018; Høglend, 2014; Lingiardi, Holmqvisdt, & Safran, 2016; Norcross & Lambert, 2019; Norcross & Wampold, 2019).

Until recently, the diagnostic precision and usefulness of psychodynamic approaches have been compromised by at least two problems. First, psychoanalytic accounts of mental processes have often been expressed in competing theories and metaphors, which have often inspired more disagreement and controversy than consensus (Bornstein & Becker-Materro, 2011). Second, they have sometimes conflated speculative constructs with observable/inferable phenomena. Whereas descriptive psychiatry has tended to reify "disorder" categories, psychoanalysts have tended to reify theoretical constructs.

Recently, however, psychodynamically based treatments, especially for personality disorders (see Leichsenring et al., 2024; Luyten, Campbell, Allison, & Fonagy, 2020) have been the subject of several meta-analyses attesting to their efficacy and cost-effectiveness (see Blankers et al., 2023; Leichsenring et al., 2023; Lilliengren, 2023). And because researchers have developed empirical methods to quantify and analyze complex mental phenomena, depth psychology has been able to offer clear operational criteria for a more comprehensive range of human social and emotional conditions. The current challenge is to systematize these advances with clinical experience.

Differentiation of PDM-3 from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and *International Classification of Diseases* (ICD) Systems

A clinically useful classification of mental disorders must begin with a concept of healthy psychology. Just as good cardiac functioning cannot be defined as a lack of chest pain, psychological wellness is more than the absence of observable symptoms of psychopathology (World Health Organization [WHO], 2022). Attempts to depict problems in mental health must consider deficits in many areas, including some that are not overt sources of dysfunction. For example, as frightening as panic attacks can be, an inability to perceive and respond accurately to the emotional cues of others can be a more fundamental difficulty than periodic episodes of anxiety. A deficit in reading emotional cues can pervasively compromise relationships and thinking, and may itself be a source of anxiety.

That a concept of health is foundational for defining disorder may seem self-evident, but our most widely used diagnostic formulations have not always reflected this assumption. In recent decades, psychological problems have been defined primarily on the basis of observable symptoms and behaviors, with overall personality functioning and adaptation mentioned only secondarily. But increasing research evidence supports the long-standing clinical conviction that to understand symptoms, we must know something about the person who suffers them (e.g., Luyten & Fonagy, 2022; Sharp & Wall, 2021; Sharp et al., 2015; Shedler, 2022; Westen, Gabbard, & Blagov, 2006). We need to appreciate the fact that both mental health and psychopathology involve many subtle features of human functioning (e.g., affect tolerance, regulation, and expression; coping strategies and defenses; capacities for understanding self and others; quality of relationships).

The most widely used classification systems continue to be the DSM of the American Psychiatric Association (most recently, DSM-5-TR [American Psychiatric Association, 2022], and the ICD-11 [WHO, 2019]). Notwithstanding their value to researchers, demographers, and funders of treatments, these taxonomies are insufficient to meet the needs of clinicians. Editors of the DSM have consistently acknowledged this reality; this caveat in DSM-5 (American Psychiatric Association, 2013, p. 19) is typical:

> It is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder diagnosis. [. . .] The symptoms in our diagnostic criteria are part of the relatively limited repertoire of human emotional responses to internal and external stresses that are generally maintained in a homeostatic balance without a disruption in normal functioning. It requires clinical training to recognize when the combination of predisposing, precipitating, perpetuating, and protective factors has resulted in a psychopathological condition in which physical signs and symptoms exceed normal ranges. The ultimate goal of a clinical case formulation is to use the available contextual and diagnostic information in developing a comprehensive treatment plan that is informed by the individual's cultural and social context.

We agree. We believe PDM-3 adds a needed perspective for evaluating psychological suffering, one that enables clinicians to conceptualize personality patterns, related social and emotional capacities, unique mental profiles, and personal experiences of symptoms. In focusing on the full range of mental functioning, we continue to represent a "taxonomy of people" rather than a "taxonomy of disorders," highlighting the

clinical value of considering *who one is* rather than *what one has*. We are beginning to see research that supports the reliability and validity of this kind of conceptualization (e.g., Cain, Solomo, Sowislo, & Clarkin, 2024) as well as its clinical usefulness (Polychronis & Keyes, 2022).

Our ability to reduce the gap between a diagnostic process and mental illness in all its complexity, and also the gap between science and practice, depends on communication and collaboration among researchers and clinicians. Hence, PDM-3 draws on clinical knowledge as well as process–outcome research and other empirical contributions. We aspire to bridge the distances between descriptive psychiatry, psychodynamic research, clinical experience, and the psychometric/empirical traditions that shape diagnostic reasoning.

PDM-3 offers a diagnostic framework that is symptom-oriented like DSM and ICD, while also considering individuals' idiographic characteristics and psychological functioning across different life stages. Consistent with Jaspers's (1963, p. 14) statement that "the symptomatology of every psychic disturbance will correspond with the degree of psychic development attained by the patient," we emphasize both individual variation and commonalities by retaining reliable diagnostic entities while also focusing on real-world clinical complexities, which cannot be fully captured by discrete categorial diagnoses.

We try to maintain a healthy tension between a nomothetic approach (general norms observable among individuals with common clinical characteristics) and idiographic knowledge (in-depth evaluation of individuals' uniqueness even when they share a diagnostic label with others)—because good treatment depends on this balance. A relevant case study (Tanzilli et al., 2021) suggests the value of our approach in fostering a better understanding of depression in a 16-year-old patient. When assessed by the Structured Clinical Interview for DSM-5 (SCID-5) (First, Williams, Karg, & Spitzer, 2016), this boy's complaints (irritable mood, fatigue, loss of energy, sleep problems, decreased concentration) met criteria for a recurrent major depressive disorder with no comorbid personality disorders. The PDM-oriented assessment, however, added the clinically valuable information that his symptoms were strongly associated with severe impairments in self-esteem regulation, capacity to tolerate intense dysphoric affects, and stability of relationships, in the context of an emerging narcissistic personality pattern.

Categorical classifications such as the DSM fail to recognize adaptive psychological resources when symptoms are less intense (e.g., good impulse regulation, mature defensive strategies, and high commitment to treatment). Accordingly, a recent narrative review (Mirabella et al., 2023) suggests that to plan patient-tailored interventions, current diagnostic frameworks for eating disorders would benefit from the addition of PDM person-centered attention not only to symptoms but also to affective, cognitive, bodily, and interpersonal patterns.

The rapidly advancing field of neuroscience can be only as useful as our understanding of the basic patterns of mental health and pathology. Describing such patterns accurately should eventually permit a greater understanding of their etiology. Research on brain development suggests that patterns of emotional, social, and behavioral functioning involve many areas working together rather than in isolation, with important consequences for clinical psychological models of illness and psychotherapeutic change (see Lane & Nadel, 2020).

In the DSM and ICD, oversimplifying psychological phenomena in the service of consistency of description (reliability) and capacity to evaluate treatment (validity)

may have compromised the goal of a more scientifically sound understanding of mental health and pathology. Ironically, given that current systems were expected to increase them, reliability and validity data for many DSM disorders are not strong (see Aggarwal, 2017, 2023; Chmielewski, Clark, Bagby, & Watson, 2015). The effort to construct an evidence-based diagnostic system may have led to a tendency to make overly narrow observations, overstep existing evidence, and undermine the critical goal of classifying states of mental health and disorder according to their naturally occurring patterns.

In our field, instead of developing empirical procedures appropriate to the complexity of the data, we seem to have uncritically and prematurely adopted methods from other sciences. As Bornstein (2015) has argued, it is time to adapt the methods to the phenomena rather than vice versa. Only an accurate description of psychological patterns can guide vital research on etiology, developmental pathways, prevention, and treatment. Under pressure for a narrow definition of evidence (in the service of rapid quantification and replication), we have attended insufficiently to this foundation of scientific knowledge and thus have tended to repeat rather than ameliorate the defects of current systems.

The inherent dimensionality of virtually all psychological phenomena has been a casualty of this process (Hopwood, Morey, & Markon, 2023). Although DSM-5-TR has reformulated some categories in more dimensional ways (e.g., recognizing an autistic spectrum, a schizophrenic spectrum, and an alternative model of personality disorders), it continues to reflect a predominantly categorical (i.e., present versus absent) approach to diagnosis. The ICD-11 offers a somewhat more dimensional conceptualization, for example, by identifying personality disorders in terms of mild, moderate, or severe, with a separate category of "personality difficulty" (not classified as a mental disorder, but included in the "Problems Associated with Interpersonal Interactions" section).

The PDM goes further by orienting to the clinical need to plan effective treatment. Its personality diagnoses are both dimensional and holistic (*prototype matching*); that is, they consider the degree to which the patient's patterns resemble a certain configuration or *gestalt*. In contrast to construing personality differences on the basis of traits, we attempt to classify them according to underlying themes (see McWilliams, 2012). And through a comprehensive appraisal of mental functions (the M Axis), we pay attention to individual strengths—an often-overlooked area in approaches grounded in medicine.

In PDM-3 we continue to apply a developmental perspective to diagnosis, addressing infancy, childhood, adolescence, adulthood, and later life. (We take pride in the fact that PDM-2 was the first general classification system to include a section on the specific needs, assets, and challenges of elderly adults.) Although DSM-5 reorganized its chapters according to developmental phases in 2013, it continues substantially to "transpose" adult conditions to children and adolescents, neglecting distinctive subjective meanings of symptoms in these age groups. In contradistinction, PDM-3 conceives psychopathology as the outcome of a dynamic process that unfolds over time, influenced by the complex transformations that mark transitions from one maturational stage to another. We assume homotypic or heterotypic continuity (for a definition of these terms, see Infancy and Early Childhood [IEC], Chapter 1, this volume, p. 27) from early childhood through adulthood and posit that knowing the complex developmental trajectories of each symptom pattern is critical to diagnosis, prevention, and intervention.

DSM and ICD systems have been geared to specific goals: the reliability of their categories for research purposes; comparison of researched populations across the samples, sites, and theoretical frameworks within which researchers operate; decision making about billing and insurance reimbursement; attaining epidemiological data; and facilitating limited treatment purposes such as psychopharmacological decision making. In contrast, PDM-3 is geared toward developing a case formulation rich enough to guide effective treatment planning, especially when psychotherapy is the recommended intervention. Even though PDM-3 is based mainly on psychodynamic research and clinical experience, we intend it to be useful for case formulation in non-psychodynamically oriented practice settings. We have tried to give jargon-free descriptions, informed by neuroscience and always in dialogue with cognitive-behavioral perspectives.

The recent American Psychological Association Guidelines on Evidence-Based Psychological Practice in Health Care (2021) state that "different presentations often require different approaches" (p. 14). PDM-3 reconciles the diagnostic process with its clinical implications, supporting what practitioners have long known: that each treatment should be tailored to the individuality and unique context of each patient. In other words, each treatment must be thought of from a diagnostic hypothesis, that is, a knowledge of the patient's personality, psychic and relational functioning, and symptomatic expressions. Moreover, for each condition, we mention relevant dimensions of the therapeutic relationship, including the therapist's emotional responses.

In DSM and ICD systems, the whole person has been less visible than the disorder constructs on which researchers can find agreement. In descriptive taxonomies, symptoms that may be etiologically or contextually interconnected are described as "comorbid," as if they coexist more or less accidentally in a person, much as a sinus infection and a broken toe might coexist (see Robinaugh, Hoekstra, Toner, & Borsboom, 2020). Assumptions about discrete, unrelated, comorbid conditions are rarely justified by clear genetic, biochemical, or neurophysiological distinctions between syndromes (Tyrer, Reed, & Crawford, 2015). The cutoff criteria for diagnosis are often arbitrary decisions of committees rather than conclusions drawn from the best scientific evidence.

Comparisons of PDM-3 with Other Diagnostic Frameworks

Because of such limitations in the DSM and ICD, there have been several attempts to develop alternative classification systems (see Aftab, Banicki, Ruffalo, & Frances, 2024; Eaton et al., 2023; Raskin, 2024). We have organized the following brief depictions roughly from most to least similar to the diagnostic sensibility represented in this manual.

PDM-3-Compatible Diagnostic Approaches

Recent decades have seen several reliable ways of measuring complex patterns of personality, emotion, and interpersonal processes—the active ingredients of the therapeutic relationship. These include, among others, the Shedler–Westen Assessment Procedure (SWAP-200; see Westen, Shedler, Bradley, & DeFife, 2012; Westen, Waller, Shedler, & Blagov, 2014); the Structured Interview of Personality Organization and its revised version (STIPO-R), developed by Kernberg's group (see Caligor, Kernberg, Clarkin, & Yeomans, 2018); the Operationalized Psychodynamic Diagnosis (OPD)

system (see Ehrenthal & Beneke, 2019), and Blatt's (2008) model of anaclitic and introjective personality configurations. PDM-3 has drawn extensively on these frameworks, most of which we have incorporated within this manual.

In other scholarship, the neuropsychoanalysis movement spearheaded by Mark Solms and his colleagues has been gathering momentum for many years (e.g., Davis & Panksepp, 2018; Panksepp & Biven, 2012; Solms, 2023). Its members, now a large international group, conceptualize personality issues by reference to core motivational processes locatable in the mammalian brain and mediated by specific neurotransmitters (Panksepp's SEEKING, ANGER, FEAR, PANIC/GRIEF, PLAY, LUST, and CARE systems). They have recently begun considering the diagnostic applications of their work, seeing themselves in the early process of integrating their findings with prior clinical knowledge of personality and psychopathology. We have integrated some of their concepts in PDM-3 and look forward to their future contributions.

The Alternative DSM-5 Model for Personality Disorders (AMPD)

In academic psychology, there is a vast literature on the "five-factor model" (see John, Nauman, & Soto, 2008; Widiger & Crego, 2019), focusing on the factor-analytically derived traits of extraversion, neuroticism, openness to experience, agreeableness, and conscientiousness. The DSM's alternative diagnostic system of personality disorders is a dimensional model that relies heavily on that research (Widiger & McCabe, 2020). AMPD diagnosis involves (1) assessing the level of impairment in functioning (self-functioning and interpersonal functioning), and (2) evaluating pathological personality traits, organized into five broad domains (negative affectivity, detachment, antagonism, disinhibition, and psychoticism) with 25 trait "facets." This process permits the derivation of a personality pathology classification that includes antisocial, avoidant, borderline, narcissistic, obsessive–compulsive, and schizotypal disorders. When a personality disorder is considered present without meeting the criteria for any specific personality pathology, this framework allows a diagnosis of "personality disorder—trait specified" (PD-TS).

Because it construes personality disorders dimensionally, we consider the AMPD a significant advance (cf. Bach & Tracy, 2022; Bach, Hopwood, Simonsen, & Krueger, 2025, Hopwood et al., 2018; Huprich, 2022). We note, however, that its focus has been relatively narrow (cf. Hopwood, 2024) and that trait models, even dimensional ones, may fail to capture *thematic* personality differences. The PDM personality groupings draw more on the clinical psychological and psychiatric traditions than on factorial assessment research; they highlight individuals' *internal psychological experience*. Because clinicians need to mentalize their patients' inner lives, we prefer personality diagnoses that are "prototypic" rather than "polythetic" (based on the idea that a diagnostic category can be accurately described as a compilation of symptoms). In this effort, we draw on more than a century of scholarship about personal narratives, including those that follow.

Personality prototypes have been variously construed by clinical writers and personality researchers (in approximate order of their emergence in the literature) as "complexes" (Jung, 1915), "internalized object relations" (Fairbairn, 1954), "repetitive structures" (French, 1958), "inner working models" (Bowlby, 1969), "nuclear conflicts" (Malan, 1976), "representations of interactions that have been generalized" (Stern, 1985), "fundamental and repetitive emotional structures" (Dahl, 1988), "internal relational models" (Aron, 1991), "nuclear scenes" (Tomkins, 1995), "emotion schemas" (Bucci, 1997), "core conflictual relationship themes" (Luborsky &

Crits-Cristoph, 1996), "implicit relational knowing" (Lyons-Ruth, 1999), "personal schemas" (Horowitz, 1998), "cyclical maladaptive patterns" (Levenson, 2003), "individual schemas" (Young, Klosko, & Weishaar, 2006), and "narrative identity" (McAdams, 2011). Such concepts privilege implicit psychological themes over discrete, variable-centered trait dimensions.

Hierarchical Taxonomy of Psychopathology

The Hierarchical Taxonomy of Psychopathology (HiTOP) was spearheaded by psychologists who sought to create an empirically based dimensional taxonomy by applying statistical methods to large data sets. They have organized their data hierarchically at the level of symptoms, then traits, then problems, then internalizing and externalizing spectra, and have concluded that psychopathology is structured along five dimensions: internalizing, thought disorder, disinhibited externalizing, antagonistic externalizing, and detachment (Kotov et al., 2017).

The HiTOP project has been an impressive collaborative application of psychological scholarship. It continues to gain momentum, and may prove to be a significant complement to categorical diagnosis (Conway, Kotov, Krueger, & Caspi, 2023). Yet we view it as having some similar limitations to the alternative DSM model of personality disorders in that it is based on measurable traits rather than inferable themes and narratives. In addition, it seems to us not readily applicable to real-world practice. An accurate assessment of HiTOP dimensions requires some fairly complex psychometric tools that may not be easily available or feasible to use in everyday clinical settings.

Research Domain Criteria (RDoC) Initiative

The Research Domain Criteria (RDoC) initiative was developed by psychiatrists at the U.S. National Institute of Mental Health around 2010, when the NIMH director concluded that the immense research done on DSM categories of mental suffering had failed to increase appreciably our understanding of brain disorders (Insel et al., 2010). He and his colleagues created a completely new system of classifying psychopathology, one of whose "seven pillars" is to assume dimensionality unless the data show otherwise (Cuthbert & Insel, 2013). In RDoC, each of the six domains reflects a brain system in which functioning is impaired, to different degrees, in different psychiatric conditions. The domains include cognitive systems, systems for social processes, arousal/regulatory systems, negative valence systems, positive valence systems, and sensorymotor systems.This system, which values flexibility and integration, focuses on brain circuitry and genetic and neurobiological data, with the aim of advancing research on serious mental illness. Its developers hope that RDoC categorizations will better reflect underlying molecular, genetic, and physiological mechanisms of disorders than do the current descriptive DSM and ICD systems (Morris et al., 2022). Because it is not oriented toward the patient's experience or the therapist's effort to conduct psychotherapy, we feel that at this point it lacks the clinical applicability of the PDM.

Network Approaches

Network approaches to psychopathology (Borsboom, 2017; Borsboom & Cramer, 2013) offer yet another alternative perspective, in which mental health conditions are seen as complex, dynamic biopsychosocial systems. The core idea is that mental

disorders can be understood as networks of interacting conditions rather than as manifestations of latent categorical disorders. In this framework, individual symptoms are viewed as *nodes* in a network, with *edges* representing the direct associations or causal interactions between symptoms. This paradigm is particularly useful for inferring interrelations of variables (e.g., symptoms). Accordingly, network approaches emphasize that comorbidity is a natural result of causal associations among mental health problems, irrespective of "artificial" diagnostic boundaries.

Network studies on psychopathology have grown exponentially (e.g., Eaton et al., 2023; Robinaugh et al., 2020). Network theorists have sought to understand psychopathology systems at the idiographic level, using data-driven, bottom-up approaches to investigate the degree to which psychological processes or symptoms are clustered in meaningful ways across individuals. In contrast to the HiTOP model, the network approach is not intended as an alternative framework to DSM or ICD. And it remains uncertain whether (and how) network analysis can enhance treatment efficacy by potentially offering an additional pathway for personalized assessment and intervention (McNally, 2021).

The Power Threat Meaning Perspective

A radically different approach to diagnosis has emerged in the United Kingdom among scholars who have rejected DSM and ICD on the basis of their medicalization of suffering, reifications, and focus on symptoms rather than patient experience. Developed by members of the British Psychological Society, the Power Threat Meaning framework (Johnstone & Boyle, 2018) organizes treatment by asking patients to elaborate on answers to the following questions: How is power operating in your life? How did it affect you? How did you make sense of it? What did you do to survive it? What strengths and access to power do you have?

This way of engaging with patients is thoroughly consistent with the values underlying the PDM project, but we are less willing to throw out the psychiatric baby with the bathwater of its diagnostic excesses. Still, any effort to treat patients as subjects to be respected rather than objects to be described at an emotional distance seems to us a worthy perspective.

Structure of PDM-3

Unlike previous editions, PDM-3 is organized chronologically by developmental phase: infancy and early childhood (0–3 years), childhood (4–11 years), adolescence (12–19 years), adulthood, and advanced adulthood (older adults). The respective chapters consider each diagnostic entity in the context of the clinical needs of each age group. For example, depressive disorders are discussed differently in the chapters on childhood, adolescence, adulthood, and advanced adulthood because subjective experiences and clinical manifestations of depression may vary across the lifespan in ways that a diagnostic formulation should recognize.

Evaluators should not adhere rigidly to the PDM-3's age-specified developmental groupings. The fact that a patient is in the age range assigned to "emerging adulthood" (ages 20–25) should not override a clinician's judgment that this individual is still psychologically in adolescence or, alternatively, has entered full adulthood. To highlight the nuances here, we have included two new chapters: Chapter 2 on the transition

from infancy to childhood, and Chapter 11 on the transition from adolescence to early adulthood (see Arnett, 2023). We decided not to include a dedicated chapter on the transition from childhood to adolescence. Our rationale is that the Childhood and Adolescence sections already provide detailed descriptions of age subphases, helping clinicians navigate the assessment of individuals in late childhood or early adolescence. Because the passage from adulthood to older adulthood is also variable, influenced by individual, cultural, and social factors, in PDM-2, we asked, "When does later life begin?" We have expanded and updated that chapter.

Profile of Mental Functioning—M Axis. This axis offers a detailed description of the capacities involved in overall psychological health and illness. It allows a close look at a patient's inner life, systematizing and operationalizing such capacities as affect regulation and expression, mentalization, bodily experiences and representations, impulse regulation, self-esteem regulation, coping strategies and defensive functioning, and adaptation and resilience. Clinicians can rate each capacity on a 5-point scale.

Personality Syndromes—P Axis. This axis considers both *levels* of personality structure, a spectrum of functioning that ranges from healthy to psychotic personality organization, and *styles* of personality, clinically familiar configurations that when maladaptive can be considered disorders. Our personality sections have been influenced predominantly by the SWAP-200, an instrument based on clinician report (Westen, Shedler, Bradley, & DeFife, 2012). Although PDM-3 users are not expected to use the SWAP-200, they can benefit from its empirically derived personality prototypes, which are included in the P Axis.

Symptom patterns: The Subjective Experience—S Axis. This axis considers *symptom patterns*, mostly those depicted in DSM-5-TR and ICD-11. We elaborate on individual differences in the internal experience of these syndromes (i.e., affective states, cognitive processes, somatic experiences, and relational patterns most often associated with each condition) and on the related experiences of clinicians treating patients with each constellation of symptoms.

The order of these axes varies by section. For adults, we recommend getting a sense of a patient's personality before evaluating the person's mental functioning, whereas in the assessment of children, adolescents, and older adults, we assume that evaluation starts with their mental functioning. Our rationale is that by adulthood, personality (P Axis) has stabilized and usually requires primary clinical focus, whereas in children and adolescents, developmental issues (M Axes) typically take precedence in clinical evaluations over emerging personality patterns; late in the life cycle, adaptation to various aspects of aging (M Axis) may again be more important to assess than personality trends. Because of the unique qualities of the first 3 years of life, the multiaxial approach for the Infancy and Early Childhood section differs. It focuses on functional emotional developmental capacities, regulatory–sensory processing capacity, relational patterns and disorders, and other medical and neurological phenomena.

Psychological experiences that may require clinical attention. Changes in the physical, social, and political environment affect people's thoughts, experiences, attitudes, and behaviors. Current environmental and geopolitical crises appear to have serious effects on mental and physical well-being at all ages (Hayes, Blashki, Wiseman,

Burke, & Reifels, 2018). In PDM-3, we include experiences of external events that we did not address in PDM-2. To emphasize the lack of connection between clinical syndromes and psychological conditions that may need specialized intervention, we separate these topics from the S Axes. We address individual responses to climate change, the recent pandemic, health and social inequalities, and actual or threatened war (Gabbard, Litowitz, & Williams, 2024). PDM-3 also considers experiences of minoritized populations, which in PDM-2 were discussed in appendices of the S Axes. These include subjective experiences of patients (and therapists) who are minoritized racially, ethnically, culturally, linguistically, politically, and by gender and sexual orientation. Of note, clinicians should recall that the subjective experience of racially, ethnically, culturally, sexually, and gender-minoritized groups, along with all other psychological experiences that may require clinical attention, should be understood in the light of a complex interweaving that considers *intersectionality*.[1]

Starting in 1994 with DSM-IV, DSM has attended to the role of culture in diagnosis by including sections on cultural formulations and culture-bound syndromes. In the early 2000s, the American Psychological Association (2002) developed guidelines for working with clients who are ethnically, linguistically, and culturally diverse, concluding from relevant outcome research (e.g., Hayes, Owen, & Bieschke, 2015) that to enhance therapy effectiveness, clinical training programs must prioritize cultural competence and multicultural education. These efforts have tended to treat culture as a dimension of experience that is relevant mainly in applying diagnoses to patients from minority backgrounds.

Contemporary psychoanalytic studies of power and diversity (e.g., Fors, 2018; Tummala-Narra, 2022) emphasize that we all have identities and social locations that carry different degrees of social power in different settings. PDM-3 assumes intersectionality of social locations such as race, ethnicity, class, gender, sexual orientation, religion, language, national origin, immigration status, and disability. The distress of individuals who have been marginalized based on more than one social location (e.g., race and sexual orientation) may be compounded across different contexts. There is evidence that demographic considerations are salient throughout the lifespan and throughout all phases of treatment, from consultation throughout the diagnostic process and into treatment planning (Aggarwal, Jarvis, Gómez-Carillo, Kirmayer, & Lewis-Fernández, 2020).

The Psychodiagnostic Chart. The final section describes the assessment using the Psychodynamic Diagnostic Chart (PDC), a PDM-derived tool (see Gordon & Bornstein, 2018). On the accompanying website (*www.guilford.com/lingiardi-materials*) we provide case descriptions intended to enhance the clinical utility of the manual. Unlike the vignettes that appear elsewhere in the manual, these seven cases are formulated comprehensively in accordance with PDM-3 dimensions. Research conducted to establish the reliability and clinical utility of the PDC has found adequate to good interrater reliability in samples of adults (Biberdzic & Grenyer, 2023; Hinrichs et al., 2019). It has also shown good sensitivity with children in discriminating between

[1]The concept of intersectionality, introduced by civil rights lawyer and activist Kimberlé Crenshaw (1989), defines the interaction and cumulative effects of various forms of discrimination, particularly in the experiences of marginalized individuals and groups. Adopting an intersectional approach allows for an understanding of how multiple dimensions of individual identity, such as race, ethnicity, social class, gender, and sexual orientation, do not simply overlap but rather interact, giving rise to unique experiences of privilege or oppression.

developmental and behavioral disorders with respect to specific mental functioning patterns, global mental functioning, and levels of personality organization (Fortunato, Tanzilli, Lingiardi, & Speranza, 2022).

Recent research with different clinical populations supports the relevance of PDM-related dimensions for planning personalized clinical interventions and assessing therapeutic outcomes. For example, a naturalistic study of patients with eating-disorders evaluated with both the Structured Clinical Interview for DSM-5—Clinical Version (SCID-5-CV) and the PDC (Muzi, Tieghi, Rugo, & Lingiardi, 2021) found that higher levels of personality organization and lower severity of personality pathology predicted lower eating disorder-specific psychopathology at treatment termination, even when researchers controlled for baseline symptoms. Unlike DSM-5 categories, which did not have an impact on symptom change, higher levels of overall mental functioning, identity integration, mentalizing capacity, and self-coherence were related to better therapeutic outcomes. Single-case reports have exemplified the clinical utility of the in-depth assessment of personality style and level of organization, mental functions, and subjective experience of symptoms in children, adolescents, and adults with diverse mental health conditions (Bizzi, Locati, Parolin, Yael, & Brusadelli, 2022; Malone, Piacentini, & Speranza, 2018; Tanzilli et al., 2021), echoing the findings of prior empirical studies attesting to the superior utility and inclusiveness of the PDM in clinical practice (Gordon, 2009; Nelson, Huprich, Shankar, Sohnleitner, & Paggeot, 2017).

Principal Changes in PDM-3

Although this manual preserves the main structure of the PDM-2, we have made several innovations, some of which we have mentioned. We summarize them here:

- We take up the various age groups in developmental order, from infancy to old age.
- In the P Axis, we have retained the term "borderline" only for the borderline level of personality organization; we have replaced the prior diagnosis of borderline personalities (analogous to the DSM's borderline personality disorder) with "emotionally dysregulated personalities."
- In the M Axis, we have reformulated the mental functions (with more attention to bodily experiences and representations, capacity for trust and empathy, and ability to explore one's inner life) and increased the number from 12 to 13.
- In the M Axis, we have omitted the prior detailed list of assessment measures for each mental capacity, replacing it with a concise depiction of well-known, widely used, empirically validated, and clinically useful tools that may enhance the assessment of all mental capacities.
- We have added chapters that explore psychodynamic diagnostic assessment in the transitions from infancy to childhood and from adolescence to early adulthood (i.e., emerging adulthood).
- We have updated and expanded the sections on "psychological experiences that may require clinical attention" and have made them into separate chapters.
- We have eliminated the lengthy chapter on assessment instruments.
- We have created additional clinical illustrations (available online at *www.guilford/lingiardi-materials*) showing vivid applications of the PDM-3 and the PDC forms.

A Comment on Terminology

We have used abbreviations minimally, as we feel that describing individuals as "having" an initialized disorder (obsessive–compulsive disorder [OCD], antisocial personality disorder [ASPD], dissociative personality disorder [DID], etc.) contributes to objectification that runs counter to our emphasis on each patient as a unique, complex subject. Where initialisms have become ubiquitous, however (e.g., posttraumatic stress disorder [PTSD], attention-deficit/hyperactivity disorder [ADHD]), we have followed popular usage. We have tended to use terms like "male," "female," "man," and "woman" rather than consistently noting whether the person is cisgender or whether the gender was assigned at birth. Although we appreciate the arbitrariness and insufficiency of conventional gender categories, such locutions contribute to excessive wordiness, which we have tried to avoid along with jargon. Notably, research findings on gender differences (e.g., depression in male vs. female respondents) have almost always been stated in terms of binary gender identities, and we lack knowledge of whether these were always cisgender or assigned at birth.

Debts and Hopes

Every edition of the PDM has been a labor of love, made possible by generous colleagues who believed in the value of the project. In accordance with Stanley Greenspan's original vision, royalties go not to editors and writers but to a fund supporting clinical research. We thank all those who have contacted us with suggestions and corrections; we hope we will be forgiven for not implementing every good idea they offered. We remember here Jeremy Safran, whose friendship we will miss and whose contributions to PDM-2 were helpful. We acknowledge again our indebtedness to the late Robert Wallerstein and the late Sidney Blatt, whose wisdom and guidance we miss. We extend our deepest gratitude to Nancy Greenspan and Jeff Guenzel of the Interdisciplinary Council on Developmental and Learning Disorders for keeping the PDM alive.

We express again our hope to be helpful to younger colleagues who have found that a biomedically oriented diagnostic world leaves them insufficiently equipped to improve the lives of their patients. We think we have made some useful improvements in this edition of the PDM, which continues to represent the dynamic, relational, intersubjective aspects of diagnosis, without which we merely catalogue pathologies rather than identify with deep human dilemmas.

Note

To enhance readability and textual clarity, some chapters of this manual include only the most essential and representative references within the main text. An extended and thematically organized bibliography is provided at the end of the chapters concerned to offer readers a more comprehensive overview of the relevant literature.

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