

OPERATIONALIZING THE PDM

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Operationalizing the Psychodynamic Diagnostic Manual: A Preliminary Study of the Psychodiagnostic Chart (PDC) ¹

Abstract: The Psychodiagnostic Chart (PDC) operationalizes the Psychodynamic Diagnostic Manual (PDM) Adult section. We collected 104 PDC cases from 15 psychologists who are MMPI-2 experts. We found very good construct validity when compared to MMPI-2s, the Karolinska Psychodynamic Profile (KAPP) and the Operationalized Psychodynamic Diagnosis (OPD) Psychic Structure/Mental Functioning Scales. We found very good reliability for the 73 cases with a two week test-retest of the PDC. Additionally, 61 psychologists were recruited from listservs and asked to use the PDC on a recent client; 84% rated Level of Personality Organization as “helpful-very helpful” in understanding their patients. There was also similar support for the Personality Patterns or Disorders, and Mental Functioning dimensions. In comparison only 31% rated the ICD or DSM symptoms as “helpful-very helpful” in understanding

¹ Part of these findings were presented at the American Psychoanalytic Association National Meeting at New York Discussion on January 17, 2013, “Research in Psychoanalysis: Creating the Psychodynamic Diagnostic Manual, Version 2 (PDM-2): Conceptual and Empirical Issues.” The session was co-organized by the American Psychoanalytic Association and the Psychodynamic Psychoanalytic Research Society. The IRBs of Muhlenberg College and Chestnut Hill College determined that this project adequately protects the welfare, rights, and privacy of human subjects and voted unanimously to approve it.

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their patient. The PDC may be used for diagnoses, treatment formulations, progress reports, and outcome assessment, as well as for empirical research on the PDM.

Keywords: Psychodynamic Diagnostic Manual, PDM, Psychodiagnostic Chart, PDC, MMPI-2, ICD, DSM, KAPP,OPD, personality structure, personality organization.

Operationalizing the Psychodynamic Diagnostic Manual: a Preliminary Study of the Psychodiagnostic Chart (PDC)

The Psychodynamic Diagnostic Manual (PDM Task Force, 2006) is a diagnostic taxonomy designed to be especially useful for psychological treatment planning. The PDM does not look at symptom patterns in isolation, as do the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM). The PDM's overarching theoretical assumption is the placement of the whole person in a bio-psycho-social context with personality structure at the core of the taxonomy. It is organized by developmental age (Infancy and Early Childhood, Children and Adolescents, and Adults), and within each developmental period there is a classification of the person from healthy functioning to severe functioning.

Since this research is focused on operationalizing the Adult section of the PDM, we will discuss this section in a little more detail. Within the Adult section, the PDM asks us to consider three axes: P Axis-Personality Patterns or Disorders, M Axis-Profile of Mental Functioning and S Axis- Symptom Patterns. The P Axis is comprised of the following personality disorders (or, more mildly, patterns): schizoid; paranoid; psychopathic

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(subtypes- passive/parasitic and aggressive); narcissistic (subtypes- arrogant/entitled and depressed/depleted); sadistic and intermediate manifestation- sadomasochistic; masochistic (subtypes- moral masochistic and relational masochistic); depressive, (subtypes- introjective and anaclitic), converse manifestation- hypomanic; somatizing; dependent, passive-aggressive versions of dependent, converse manifestation- counterdependent; phobic (avoidant), converse manifestation- counterphobic; anxious; obsessive-compulsive, (subtypes- obsessive and compulsive); hysterical (histrionic), (subtypes- inhibited and demonstrative or flamboyant); dissociative; and mixed/other.

Once the personality disorder is determined, the PDM P axis then considers each personality disorder in terms of temperamental, thematic, affective, cognitive, and defense patterns.

The second PDM dimension, the M axis, or Mental Functioning, is a detailed look at the capacities that contribute to an individual's personality. These are: the capacity for regulation, attention, and learning; the capacity for relationships (including depth, range, and consistency); the quality of internal experience (level of confidence and self-regard); the capacity for affective experience, expression, and communication; the level of defensive patterns; the capacity to form internal representations; the capacity for differentiation and integration; the self-observing capacities (psychological-mindedness); and the capacity for internal standards and ideals, that is a sense of morality.

Lastly, the PDM considers the S axis, or Manifest Symptoms and Concerns. This is a list of the patient's subjective experience of the symptoms that emerge from the dynamic interactions of the above personality constructs.

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Although the PDM is based on the psychoanalytic assumption of a dynamic unconscious and personality structure, both the psychodynamic and non- psychodynamic practitioners gave the PDM favorable ratings. Ninety percent of 192 psychologists surveyed (65 Psychodynamic, 76 CBT and 51 Family Systems, Humanistic/Existential, Eclectic with no primary preference) rated the PDM as favorable to very favorable (Gordon, 2008, 2009).

However, the current version of the PDM does not have a separate axis of personality organization (i.e. healthy-neurotic, borderline or psychotic). McWilliams (2011) recommends a separate axis of personality organization and a separate axis for the type of character organization or personality disorder (e.g., schizoid, hysterical).

The DSM 5 and ICD 10 do not use personality organization as a dimension since they are taxonomies of symptom groups rather than a taxonomy based on a dynamic personality structure. However, the level of personality organization may be the most parsimonious and important factor in considering the response to and type of treatment (Koelen et al., 2012; McWilliams, 2011). Koelen et al (2012) identified 18 studies that suggest that higher initial levels of personality organization are moderately to strongly associated with better treatment outcome. Moreover, the authors found that patients with higher initial levels of personality organization may do better with interpretive versus supportive interventions in predicting treatment outcome.

In addition to a separate level of personality organization axis, Torello (2010) argued that the PDM needs a cultural-social context as part of its taxonomy, since many symptoms are better understood in a particular context.

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These two criticisms suggest a revised PDM that includes a PO (personality organization) Axis, followed by the current P Axis-Personality Patterns or Disorders, M Axis-Profile of Mental Functioning, S Axis- Symptom Patterns (i.e., ICD-10 symptoms), and finally adding a Cultural/Context Axis. Both a PO and Cultural/Context dimensions were included in the Psychodiagnostic Chart (PDC).

The Psychodiagnostic Chart (PDC): Operationalizing the Entire PDM Adult Section²

Robert F. Bornstein and I agreed that although the PDM was valued, we were concerned that it was not being used enough by practitioners or researchers. We felt that it needed a brief, user-friendly tool that would: guide the practitioner through all the dimensions of the PDM taxonomy, would be idiographic, flexible and useful for practitioners of most theoretical orientations, have the additional dimensions of personality organization and cultural/context, and integrate the PDM with the symptom classifications of the DSM or ICD. The use of ICD symptom classification is also important for insurance reimbursement requirements. With this in mind, we developed the Psychodiagnostic Chart (PDC).

The PDC has both categorical and dimensional ratings, and all the ratings are on a 1 to 10 scale, where 1 is the lowest level of functioning and 10 the highest. The PDC is purposely simplified and limited to three pages, yet it operationalizes the adult section of the PDM. The PDC may be used for diagnoses, treatment formulations, progress reports, outcome assessment, as well as for empirical research on the PDM.

² For free copies of the PDC search online for “Psychodiagnostic Chart” or email the first author at: rmgordonphd@gmail.com

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The practitioner must perform (or have access to) diagnostic interview data and psychological assessment data to derive optimal ratings. We recognize that this is not always feasible, and in many instances the clinician will code an initial impression, then re-assess as additional information accrues. If the PDC is used for progress notes, there will be opportunities to re-assess and revise the person's diagnosis as well. The validity of this chart can be enhanced with the integration of relevant psychological tests.

The purpose of this preliminary study is to assess the stability and construct validity of the PDC as an operationalized PDM.

Method

Participants

The first author emailed 38 psychologists from the Pennsylvania Psychological Association who frequently used the MMPI-2 in their assessment work. They were asked to rate their last 10 psychotherapy patients, disability or forensic clients. They were given a manual as to how to use the PDC and asked to rate each client using the chart without looking at their MMPI-2 scores. The psychologists were also asked to rate their clients using the Karolinska Psychodynamic Profile (KAPP) and the Operationalized Psychodynamic Diagnosis (OPD) Psychic Structure/Mental Functioning Scales. Then two weeks later, they were asked to rerate their clients using the PDC. They were advised to share no other identifying data other than the client's initials, gender, ethnicity, age and years of education. Of the 38 psychologists, 15 sent in 98 completed PDCs with MMPI-2's, and 73 included a two week test-retest of the PDC with the additional ratings

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of the KAPP and the OPD Psychic Structure/Mental Functioning Scales. Six cases had PDC, KAPP and OPD test-retest data and no MMPI-2s. This is not an usual return rate by busy experts who were asked to commit a few hours of work for this research. The overall sample of 104 clients consisted of 43 women and 61 men, 93% of whom were identified as Caucasian. The sample had a mean age of 40.65, with ages ranging from 18 to 74 years. Additionally, the sample had an average of 15.54 years of education, with a range of 6 to 22 years. The client sample included people from forensic, disability and psychotherapy evaluations, representing a wide range from psychotic to neurotic personality organizations.

We also utilized an online survey to assess the utility of the PDC. We invited psychologists who regarded themselves as expert in personality assessment, from various listservs and websites to complete an online survey regarding their attitudes toward the PDC dimensions. All survey respondents had used the PDC with a recent client prior to completing the online survey³. Of the 61 psychologists surveyed, 80% held doctorates and 20% held masters degrees. Fifty-two percent of the respondents were women. Most of the participating practitioners' primary theoretical orientations were other than psychodynamic: Psychodynamic (44%), Eclectic (21%), Cognitive-Behavioral (15%), Humanistic/existential (13%), and Systems (3%).

Instruments

³ Thanks to all the survey participants from the Pennsylvania Psychological Listserv, Florida Psychological Association Listserv, New Jersey Psychological Association website, Division 39 website, Psychology Geek website, ApsaA Psychoanalytic Candidates Website, and LinkedIn practitioners from various countries.

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The MMPI-2

The MMPI instruments are among the most widely used personality measures in the world (Butcher and Williams, 2009). The MMPI-2 is the only criteria-based (on actual cases) self-report that assesses defenses and psychopathology. It has been shown to be sensitive to changes in long-term psychoanalytic psychotherapy (Gordon, 2001).

We compared the PDC with the following MMPI-2 scales: F (acute psychopathology), Hs-Hypochondriasis, Hy-Hysteria, Pd-Psychopathic Deviate, Pa-Paranoia, Pt-Psychasthenia, Sc-Schizophrenia, Ma-Hypomania, Es-Ego Strength, Re-Responsibility, and IE-Intellectual Efficiency. We also used the MMPI-RCd, which is a general psychopathology factor.

The Karolinska Psychodynamic Profile (KAPP)

The KAPP (Weinryb, Rössel, and Asberg, 1991) is a psychoanalytically-based clinician-rated instrument used to assess character from clinical interviews.

We compared the PDC with the following KAPP scales: 1. Intimacy and reciprocity, 2. Dependency and separation, 3. Controlling personality traits, 4. Frustration tolerance, 5. Impulse control, 6. Regression in the service of the ego, 7. Coping with aggressive affects, 8. Alexithymia, 9. Normopathy, 10. Bodily appearance, 11. Bodily function, 12. Current body image, 13. Sexual functioning, 14. Sexual satisfaction, 15. Sense of belonging, 16. Feeling of being needed, 17. Access to advice and help, and 18. Personality organization.

The Operationalized Psychodynamic Diagnosis (OPD)

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The OPD (Dahlbender, Rudolf, and OPD Task Force, 2006; Zimmermann, Ehrental, Cierpka, Schauenburg, Doering, and Benecke, 2012) is based on five axes: I = Experience of illness and prerequisites for treatment, II = Interpersonal relations, III = Conflict, IV = Structure, and V = Mental and Psychosomatic disorders. We compared the PDC with the OPD Axis IV Psychic Structure/Mental Functioning scales: 1. Self-Perception, 2. Self-Regulation, 3. Defense, 4. Object Perception, 5. Communication, 6. Bonding/Attachment, and 7. Global Rating of Psychic Structure.

Results⁴

Internal Consistency and Test-retest Reliability for PDC

The Overall Personality Organization Scale is made up of seven component scales: Identity, Object Relations, Affect Tolerance, Affect Regulation, Superego Integration, Reality Testing, and Ego Resilience. The test-retest reliabilities for the seven component scales ranged from .69 to .90 ($p < .001$), indicating moderate to high levels of stability across the two week interval. Test-retest reliability for the Overall Personality Organization Scale was .92 ($p < .001$), indicating high scale stability (See Table 1).

As a measure of scale internal consistency, Cronbach's coefficient alpha was calculated for the seven components of Personality Organization Scales. The coefficient alpha was .94, indicating a high degree of internal consistency among the scales. The mean inter-scale correlation was .76. The individual scale means ranged from 4.80 to 6.75, with a mean on the total scale of 5.54 ($SD = .71$).

⁴ To save space, we summarized the results for this article. However, researchers may wish to review the full version of the hypotheses and results on the "Psychodiagnostic Chart" website: <https://sites.google.com/site/psychodiagnosticchart/>

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The test-retest reliability coefficient for Overall Severity of Personality Disorder was .89, ($p < .001$), indicating high stability over a two week period.

The PDC has nine Mental Functioning scales: Capacity for Attention, Memory, Learning, and Intelligence; Capacity for Relationships and Intimacy; Quality of Internal Experience; Affective Comprehension, Expression, and Communication; Level of Defensive or Coping Patterns; Capacity to Form Internal Representations; Capacity for Differentiation and Integration; Self-Observing Capacity; and Realistic Sense of Morality. The test-retest reliabilities for the nine scales ranged from .77 to .89 ($p < .001$). The coefficient alpha for the scale was .95, indicating a high degree of internal consistency. The mean inter-scale correlation was .67. The individual scale means ranged from 4.73 to 6.63. The mean on the total scale was 5.76 ($SD = .62$). Taken together, the analyses indicated high stability and internal consistency (See Table 2).

The Severity of Symptoms test-retest reliability was .87 ($p < .001$), also indicating high stability.

Construct Validity for the PDC

We predicted significant negative correlations between PDC's Overall Personality Organization Scale (where high scores indicate a high functioning personality) with the following scales (where high scores indicate high psychopathology): MMPI-2 scales F, Hy, Sc, A, MMPI-RCd general psychopathology factor, KAPP (K-18 level of personality structure), and OPD (OPD7-Global Personality Structure Scale). As hypothesized, all correlations were significant and in the predicted direction. The correlations ranged from -.31 to -.93 ($p < .001$). We also predicted a positive correlation with Ego Strength,

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Intellectual Efficiency, and Responsibility scales on the MMPI-2 with the Overall Level of Personality Organization Scale. These correlations were significant and in the predicted direction (See Table 3).

We examined the correlations between the seven components that comprise the Overall Personality Organization Scale with hypothesized scales from the MMPI-2, KAPP, and the OPD. For all seven components, a total of 59 specific correlations were computed. Due to the high number of comparisons, we calculated the “hit” rate for each capacity. That is, if the correlation between the capacity and the hypothesized scales was significant in the predicted direction, it was considered a “hit.” Of the 59 correlations calculated, 58 (98%) were hits at $p < .05$ and 53 (90%) were hits at $p < .001$.

We predicted that a step-wise regression of the seven components from the Personality Organization Scale should indicate the most economical diagnostic model. The most economical regression model was significant, $F(4, 96) = 200.40$ ($p < .001$). All of the four components entering this model were significant: Affect Regulation (or level of defensive functioning) ($\beta = .35$, $t(93) = 6.01$, $p < .001$), Reality testing ($\beta = .32$, $t(93) = 5.02$, $p < .001$), Object Relations ($\beta = .20$, $t(93) = 3.76$, $p < .001$) and Identity ($\beta = .19$, $t(93) = 2.69$, $p < .001$). The regression produced an $R^2 = .89$, indicating that the four components accounted for 89% of the variance in the Overall Personality Organization Scale.

We predicted significant negative correlations between the Degree of Impairment from the Dominant Personality Pattern or Disorder Scale and the specific scales from the MMPI-2, KAPP, and OPD scales. As predicted all correlations were significant ($p =$

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.001) and in the predicted direction: MMPI-2 scales F (-.45), Sc (-.47); KAPP K3 (-.73), K4 (-.72), K5 (-.69), K7 (-.70); OPD 7 (-.87). The correlations ranged from -.45 to -.87.

We next examined the correlations between the nine components of the Mental Functioning scale with specifically hypothesized scales from the MMPI-2, the KAPP, the OPD scales, and years of education. As in previous analyses, due to the large number of correlations we calculated the “hit” rate for each of the nine capacities. Of the 79 correlations calculated, 75 (95%) were hits at $p < .05$ and 64 (81%) were hits at $p < .001$.

We predicted significant negative correlations between the Severity of Symptoms scale and scales from the MMPI-2 A scale (severity of symptoms), and KAPP-18, OPD-7, and a significant positive correlation with the current GAF. As hypothesized, all correlations were significant ($p = .001$) and in the predicted direction: MMPI-2 A (-.46), K18 (-.80), OPD-7 (-.90) and GAF (.75).

We predicted that the practitioners would find the PDC useful in terms of understanding their patients and in treatment planning. We predicted that the dimensions of Personality Organization, Personality Patterns or Disorders and Mental Functions Dimensions would be perceived as more useful in understanding their patients than the ICD or the DSM symptom classification. Finally, we predicted that the practitioners would find the Culture-Contextual Dimension useful.

Using seven-point scales (1 = *Not at all helpful*; 7 = *Very helpful*), practitioners rated the helpfulness of the PDC for improving their understanding of their patients and aiding in treatment planning beyond their ICD and DSM diagnosis. Practitioners were also asked to rate how helpful specific scales of the PDC were in understanding their patients.

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Seventy-nine percent of the practitioners rated the PDC as “helpful-very helpful” in improving their understanding of their patient beyond their ICD or DSM diagnosis, 67% rated the PDC as “helpful-very helpful” in the treatment planning of their patient beyond their ICD or DSM diagnosis, 84% rated the PDC’s level of Personality Organization Scale as “helpful-very helpful” in understanding their patient, 72% rated Dominant Personality Patterns and Disorders Scale as “helpful-very helpful” in understanding their patient, 79% rated the Mental Functioning Scale as “helpful-very helpful” in understanding their patient, and 50% rated the Cultural/Contextual Dimension as “helpful-very helpful” in understanding their patient. In comparison to the above PDC scales, only 31% rated the ICD or DSM symptoms as “helpful-very helpful” in understanding their patient (See Figure 1).

Taken together, the results supported our predictions and extend Bornstein and Gordon’s (2012) preliminary findings supporting the PDM’s taxonomy and the utility of the PDC in aiding practitioners in understanding their patients and in treatment planning beyond their ICD or DSM diagnosis.

Discussion

This preliminary study showed very good reliability and construct validity for the operationalized PDM guide, the PDC.

We found high internal consistency, reliability, and construct validity for the Overall Severity of Personality Organization scale (neurotic, borderline, psychotic). The PDC’s scale of Overall Severity of Personality Organization measures a very similar construct to

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the KAPP's Level of Personality Organization scale and the OPD's Global Personality Organization Scale.

We found empirical support for all seven capacities as contributing to personality organization. Kernberg (1984) theorized that domains in differentiating degree of psychotic, borderline and neurotic organizations could be determined by three main capacities: identity consolidation, use of primitive defenses, and degree of reality testing. The step-wise regression of the seven capacities showed that Affect Regulation (or level of defensive functioning), Reality testing, Object Relations, and Identity accounted for 89% of the variance of the Overall Personality Organization scale. This shows strong theoretical support for the construct validity of the Overall Personality Organization scale.

This finding is very similar to that of Ellison and Levy (2012) whose factor analysis of the Inventory of Personality Organization (an assessment based on Kernberg's structural theory) found that the first factor related most strongly to self-concept clarity, defenses, and affect.

We found good reliability and construct validity for the Personality Disorder Severity scale when measured against scales of global psychopathology. In this study we did not test the validity of the specific personality patterns. This research is now underway in a study to compare the Psychodynamic Diagnostic Prototypes based on the PDM's P Axis (Gazzillo, Lingardi, and Del Corno, 2012) with the PDC's personality patterns-disorders dimension.

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We found good internal consistency, reliability and construct validity for the nine Mental Functioning scales. For example, as predicted, the mental capacity for Attention, Memory, Learning, and Intelligence was significantly correlated with the number of years of education, MMPI-2- Intellectual Efficiency scale, and Ego-strength scale.

We found high reliability and construct validity for the Manifest Symptoms Severity scale as predicted with the MMPI-2-Anxiety scale, the global KAPP and OPD scales, and the DSM-IV's Current GAF scale.

Finally, a psychological nosology should be useful to the majority of practitioners. We found that of the practitioners surveyed, 79% rated the PDC as “helpful-very helpful” in improving their understanding of their patient beyond their ICD or DSM diagnosis, 67% rated the PDC as “helpful-very helpful” in the treatment planning of their patient beyond their ICD or DSM diagnosis. Practitioners rated Personality Organization as “helpful-very helpful” in understanding their patient more than any other diagnostic dimension.

This data was not collected from a large random survey, but a survey of 15 assessment experts. Therefore, the sample for the current study is similar to that of other limited surveys of experts. The study demanded a high level of diagnostic skill and a large time commitment on the part of the psychologists. However, this data will be compared in future research with the data that we are currently collecting on about 500 non-expert practitioners.

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Table 1

Summary of Test-retest Correlations, Means, and Standard Deviations
for the 7 Components of Personality Organization Scale and Over-all
Personality Organization Scale

Components	<i>r</i>	<i>M</i>	<i>SD</i>
1. Identity	.84*	5.50	1.68
2. Object Relations	.83*	4.85	1.75
3. Affect Tolerance	.85*	5.40	1.59
4. Affect Regulation	.86*	4.91	1.63
5. Superego Integration	.80*	6.22	2.00
6. Reality Testing	.90*	6.84	1.93
7. Ego Resilience	.69*	5.83	1.87
8. Over-all Scale	.92*	5.50	1.68

* $p < .001$

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Table 2

Summary of Test-retest Correlations, means, and Standard Deviations

For the 9 Mental Functioning Scales

Mental Functioning	<i>r</i>	<i>M</i>	<i>SD</i>
1. Capacity for Attention, Memory, Learning, and Intelligence	.89*	6.63	1.92
2. Capacity for Relationships and Intimacy	.80*	4.73	1.75
3. Quality of Internal Experience	.84*	5.26	1.63
4. Affective Comprehension, Expression and Communication	.77*	5.88	1.70
5. Level of Defensive or Coping Pattern	.83*	5.31	1.69
6. Capacity to Form Internal Representation	.82*	5.48	1.58
7. Capacity for Differentiation and Integration	.87*	6.03	1.90
8. Self-Observing Capacity	.89*	5.94	2.12
9. Realistic Sense of Morality	.83*	6.53	2.10

*p<.001

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Table 3

Summary of PDC's Over-all Personality Organization Scale
with the MMPI-2 scales, MMPI-RCd,
KAPP (*K-18 level of personality structure*), and
OPD (*OPD-7 Global Personality Structure Scale*)

<i>Scales</i>	Over-all Scale <i>r</i>	<i>M</i>	<i>SD</i>
F	-.60**	61.10	16.52
Hy	-.31*	63.62	14.42
Sc	-.56**	63.44	15.59
A	-.55**	57.39	13.75
RCd	-.41**	56.65	11.71
K-18	-.88**	1.58	.64
OPD-7	-.93**	2.36	.67
Ego Strength	.47**	44.50	10.98
Intellectual Efficiency	.52**	45.03	10.20
Responsibility	.32**	47.08	11.72

**P < .001

* P = .002

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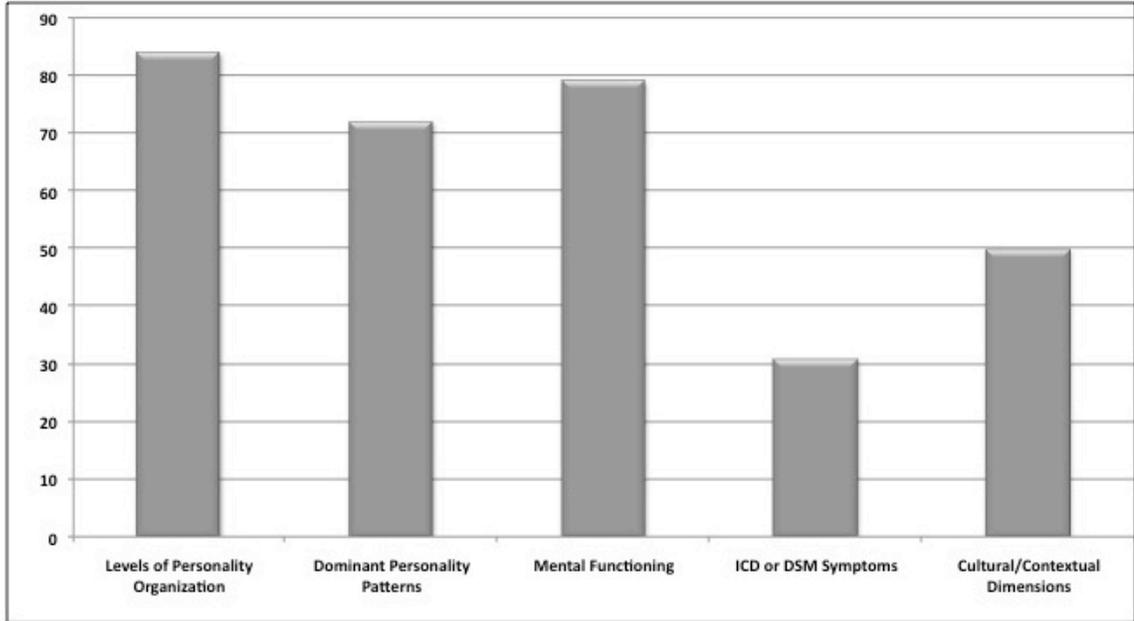


Figure 1: Percent of Practitioners Rating the PDC Dimensions as “Helpful—Very Helpful” in understanding their patient in Comparison to the ICD and DSM.

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