Fare diagnosi oggi:
DSM-5, PDM-2, SWAP-200

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DIPARTIMENTO
DI PSICOLOGIA
DINAMICA E CLINICA

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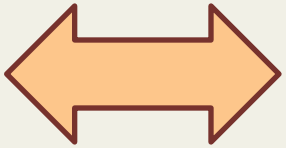
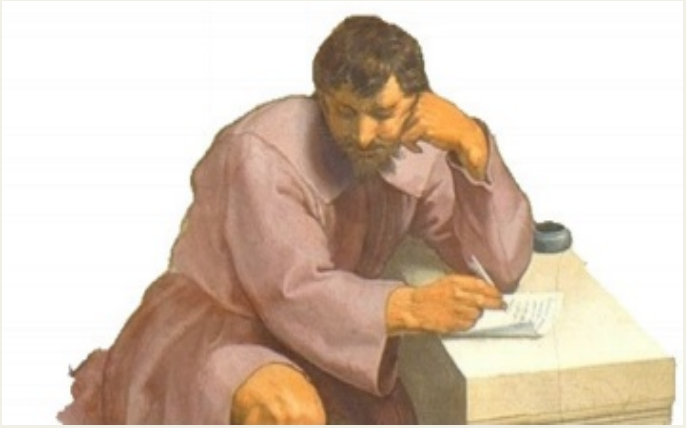
Two ways of approaching the diagnostic process

- Categorial
- Descriptive
- Medical model
- Objectivity
- Symptom oriented
- Label



- Dimensional
- Inferential-contextual
- Biopsychosocial model
- Subjectivity
- Case formulation

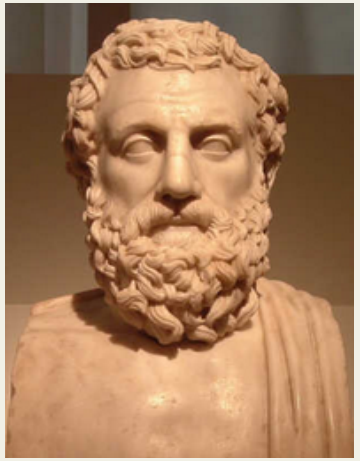
Ogni logica diagnostica presenta limiti specifici: rigidità eccessiva (la ***monotetica***), inclusività eccessiva (la ***politetica***), oggettivante (la ***nomotetica***), tipizzazione "ideale" (la ***prototipica***), soggettività eccessiva (la ***idiografica***) …



“Character is destiny.”
(Heraclitus)

“You can't sum up people.”
(Virginia Woolf)

"Don't tell me what type of disease the patient has, tell me what type of patient has the disease.”
(Sir William Osler
… and also Hippocrates)



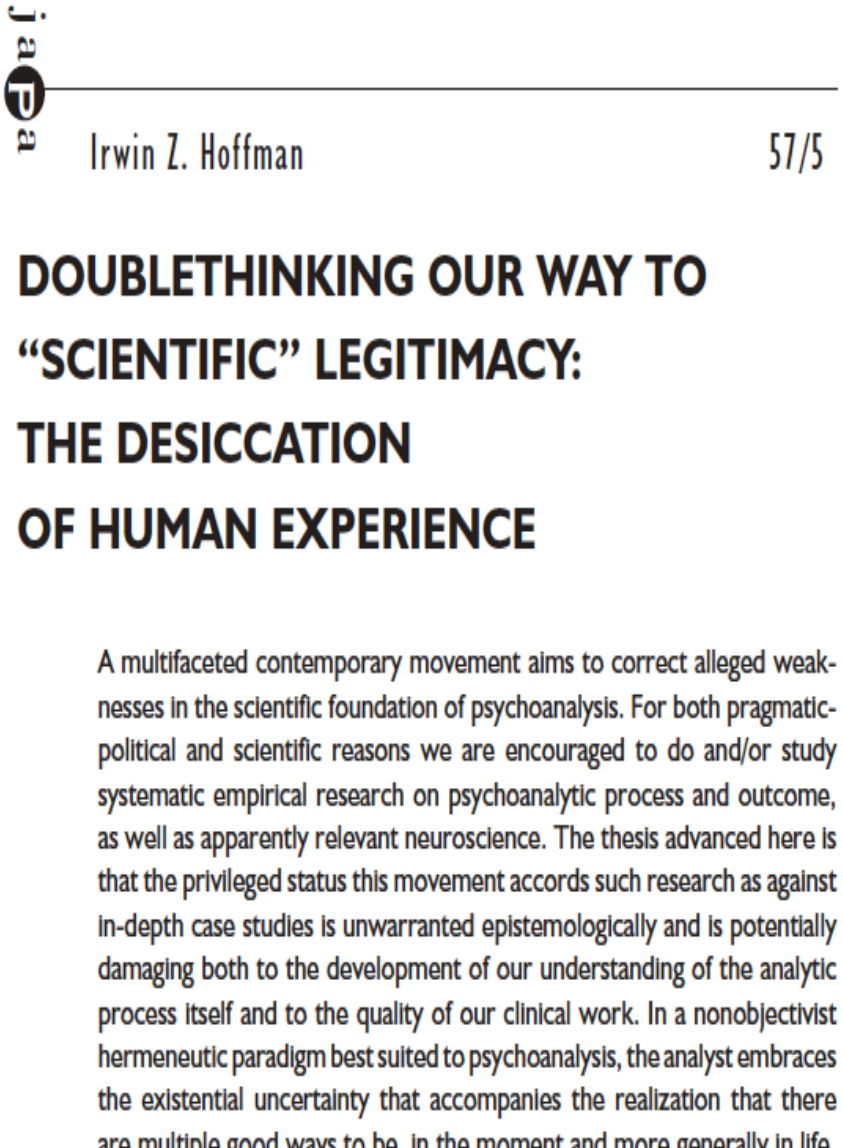
Hoffman vs Eagle & Wolitzky

Irvin Z. Hoffman
(JAPA, 2009):

"Authoritarian objectivism"

"Desiccation of human experience"

PDM: "Nod to humanistic existential respect for the uniqueness and limitless complexity of any person", but … p. 1060



J. Am. Psychoanal. Assn.

Irwin Z. Hoffman 57/5

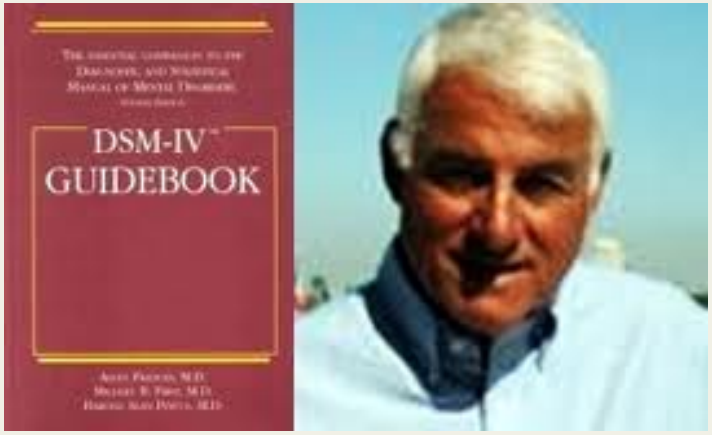
DOUBLETHINKING OUR WAY TO "SCIENTIFIC" LEGITIMACY: THE DESICCATION OF HUMAN EXPERIENCE

A multifaceted contemporary movement aims to correct alleged weaknesses in the scientific foundation of psychoanalysis. For both pragmatic-political and scientific reasons we are encouraged to do and/or study systematic empirical research on psychoanalytic process and outcome, as well as apparently relevant neuroscience. The thesis advanced here is that the privileged status this movement accords such research as against in-depth case studies is unwarranted epistemologically and is potentially damaging both to the development of our understanding of the analytic process itself and to the quality of our clinical work. In a nonobjectivist hermeneutic paradigm best suited to psychoanalysis, the analyst embraces the existential uncertainty that accompanies the realization that there are multiple good ways to be, in the moment and more generally in life

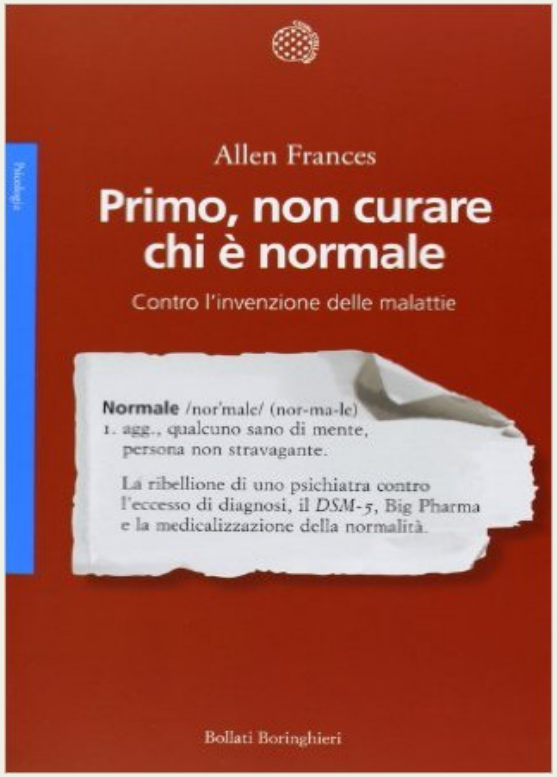
SYSTEMATIC EMPIRICAL RESEARCH VERSUS CLINICAL CASE STUDIES: A VALID ANTAGONISM?

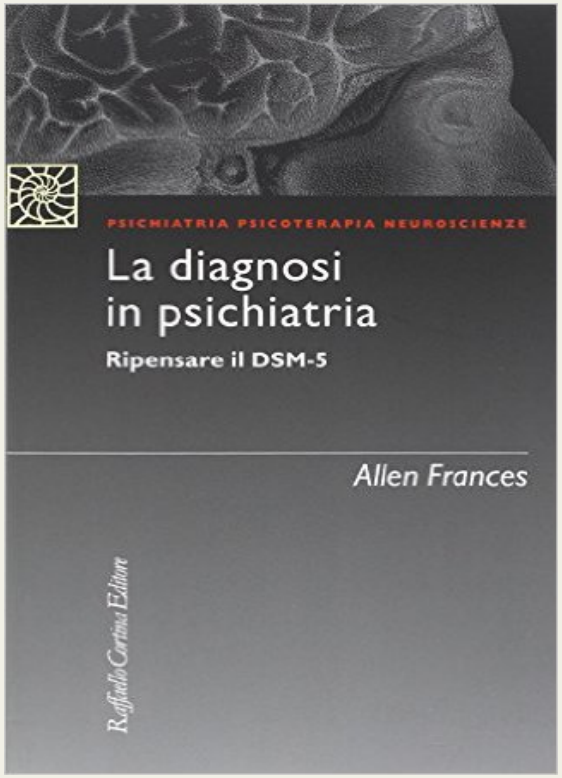
This paper considers the issue of systematic empirical research versus clinical case studies raised by Hoffman (2009). A rebuttal of Hoffman's arguments is offered, followed by an argument that each method addresses itself to different questions and that posing them in opposition is not fruitful. Finally, criteria and requirements of the case study method are proposed that, if met, would enhance its evidential value.

The overarching theme of Irwin Z. Hoffman's lead article in this journal (2009), based on a plenary address given at the 2007 winter



Allen Frances



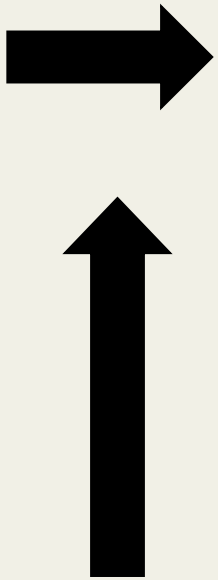


Saving Normal: An Insider's Revolt against Out of Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life (Tr.it. Boringhieri, 2013)

Essentials of Psychiatric Diagnosis: Responding to the Challenge of DSM-5 (Tr.it. Raffaello Cortina, 2014)

Il contesto

DSM-IV (1994)
DSM-IV-TR (2000)



DSM-5 (2013, 2014)

SWAP-200, SWAP-A
SWAP-II
(1999, 2003, 2012, 2014)

PDM
(2006, 2008, 2017)

DSM-IV-TR e DSM-5: cosa cambia?

Inserimento di scale di valutazione dimensionali (Sezione III) per valutare l'intensità e la gravità dei sintomi cardine dei disturbi clinici**.**
Questo nuovo sistema, definito un *modello ibrido*, **integra il sistema categoriale con quello dimensionale.**

DSM-5: CATEGORIALE + DIMENSIONALE

Diagnosi DSM-IV-TR

MULTIASSIALE

DSM-5: TRE SEZIONI

DESCRITTIVA

POLITETICA

ATEORETICA

Nella prima bozza di revisione del DSM-5, oltre ai disturbi paranoide, schizoide, istrionico e dipendente, era scomparso anche il disturbo narcisistico di personalità. Ciò ha sollevato le critiche di numerosi professionisti che hanno sottolineato come sia impossibile rinunciare a disturbi su cui si è accumulata una grande quantità di prove empiriche e cliniche. In seguito a tali critiche, la successiva proposta di revisione dei disturbi di personalità ha incluso il disturbo narcisistico. Poi, poco prima della pubblicazione del DSM-5, l'intero modello dimensionale alla diagnosi dei PDs è stato abbandonato, perché ritenuto poco maneggevole e utile clinicamente, e inserito come modello alternativo nella sezione III.

«Un agglomerato poco maneggevole di modelli disparati e male assortiti, che rischia di trovare pochi clinici disposti ad avere la pazienza e la costanza di farne effettivamente uso nella loro pratica».

Shedler, Beck, Fonagy, Gabbard, Gunderson, Kernberg, Michels & Westen, 2010

Personality Disorders in DSM-5

DSM-5 in its proposed form presents a significant shift in the approach to diagnosing personality disorders. The diagnostic criteria outlined in DSM-III and DSM-IV and the introduction of axis II were intended to focus attention on these syndromes in clinical practice and to foster research on their diagnosis, epidemiology, psychobiology, clinical course, and treatment. A diagnostic system should be clinically relevant, encompass the spectrum of personality syndromes seen in practice, facilitate their recognition, and still be simple enough to be used by busy clinicians, including those who do not specialize in the assessment and treatment of personality. At the same time, the diagnostic scheme needs to reflect and support progress in research that leads to increased understanding and better treatment of these illnesses. Regrettably, the proposed system for classifying personality disorders is too complicated, includes a trait-based approach to diagnosis without an adequate clinical rationale, and omits personality syndromes that have significant clinical utility.

The proposed DSM-5 diagnostic scheme for personality disorders is an unwieldy conglomeration of disparate models that cannot happily coexist and raises the likelihood that many clinicians will not have the patience and persistence to make use of it in their practices. The resultant draft criteria encompass 5 levels of personality functioning, 5 personality types, 6 personality trait rating scales, and 4–10 trait rating subscales or facets per trait rating scale.

"We strongly advocate that the prototype system be expanded to encompass the range of personality syndromes seen in the community and identified empirically"

A clinically useful approach should focus on types of people, not types of ratings scales. The primary unit of diagnosis should be a personality syndrome—a configuration or pattern of functionally interrelated personality processes encompassing cognition, affectivity, interpersonal functioning, behavior, coping, and defense. Mental health professionals think in terms of syndromes or patterns (as recognized by all previous versions of the DSM), *not* in terms of deconstructed subcomponents or in terms of 30-plus separate trait dimensions to be rated (as in the current DSM-5 proposal). Clinicians see coherent patterns of interrelated processes where untrained persons may see confusion. The diagnostic assessment should also acknowledge gradations of severity, as the proposed revision does (a welcome improvement over DSM-IV). A narcissistically disordered patient may be mildly socially impaired or so severely impaired as to be unable to engage effectively in any type of personal interaction.

The prototype approach proposed for DSM-5 provides descriptions of five personality disorders: antisocial/psychopathic, avoidant, borderline, obsessive-compulsive, and schizotypal. There is empirical support for the usefulness of a prototype approach to diagnosis: research in cognitive science tells us that diagnostic decision making, which is inherently a judgment about category membership, generally relies on prototype matching (1–6). Diagnosticians develop cognitive prototypes of diagnostic syndromes, and they make diagnoses by gauging the match between an individual and a particular prototype. Cognitive prototypes are syndromal constructs that capture many different but interrelated features of a personality syndrome. In this arena, the DSM-5 Personality and Personality Disorders Work Group has been attentive to the need for an approach that can work *with*, rather than against, the cognitive processes of the clinicians who will use it.

Disturbi di Personalità nel DSM-5: una «rivoluzione mancata»?

La valutazione dei disturbi di personalità è stato oggetto di numerose controversie e accesi dibattiti nel corso del processo di revisione del DSM-5

QUALCHE ESEMPIO…

«una miscela deludente di innovazione e conservazione dello status quo che è incoerente, priva di validità, impraticabile e per certi versi incompatibile con i dati empirici»
Livesley, 2010

Vivace dibattito sorto dall'iniziale proposta di eliminare il Disturbo Narcisistico di Personalità (NPD)
→ es. Ronningstam, 2011

Questo dibattito si è concluso con la decisione di mantenere inalterato il sistema di valutazione dei disturbi di personalità del DSM-IV-TR.

Modello Alternativo del DSM-5 per i Disturbi di Personalità

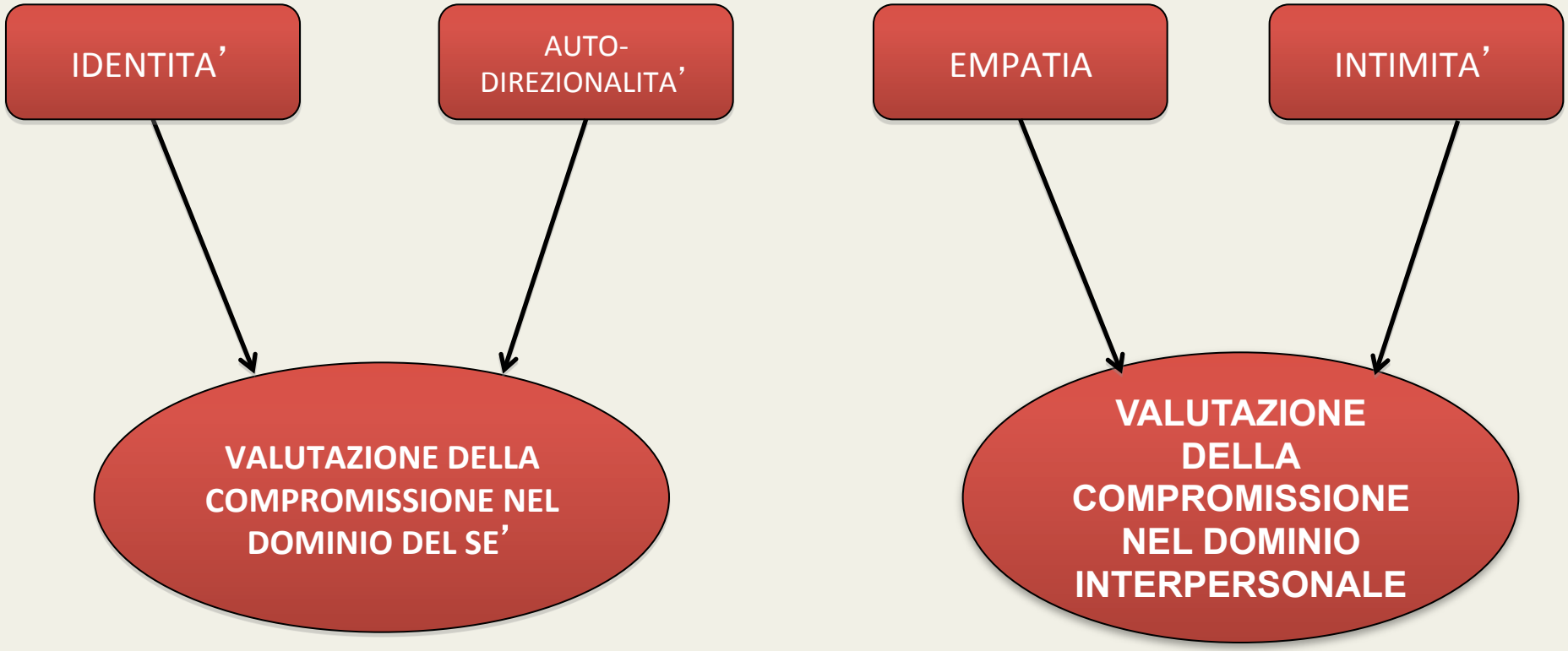
Il modello di assessment della personalità proposto in fase di revisione è stato inserito come modello alternativo alla valutazione dei PDs allo scopo di stimolare ulteriori ricerche e approfondimenti.

I Disturbi di Personalità sono caratterizzati da compromissioni nel *funzionamento* della personalità e da *tratti* di personalità patologici.

Questo modello identifica **sei specifici PDs**: antisociale, evitante, borderline, narcisistico, ossessivo-compulsivo e schizotipico.

I Disturbi Paranoide, Schizoide, Istrionico e Dipendente vengono eliminati e diagnosticati con l'etichetta di **Disturbo di Personalità tratto-specifico** (PD-TS), che sostituisce la diagnosi di PD NAS del DSM-IV-TR.

Criterio A:
Livello funzionamento personalità



Valutazione dimensionale →

Scala del livello di funzionamento della personalità (LPFS)

Identifica cinque livelli di compromissione, che variano da Nessuna o Poca Compromissione (livello «0») a Estrema Compromissione (livello «4»)

Criterio B:
Tratti patologici personalità

I tratti patologici di personalità sono organizzati in cinque grandi domini:

- **Affettività negativa (vs stabilità emotiva)**
- **Distacco (vs estroversione)**
- **Antagonismo (vs piacevolezza)**
- **Disinibizione (vs coscienziosità)**
- **Psicoticismo (vs lucidità)**

Ogni dominio è costituito da un
numero X di sfaccettature di tratto (per un totale di 25)

PER ESEMPIO…

AFFETTIVITA' NEGATIVA:

- Labilità emotiva;
- Ansia;
- Angoscia di separazione;
- Sottomissione;
- Ostilità;
- Perseverazione;
- Depressività;
- Sospettosità;
- Affettività ridotta (mancanza di)

APsaA Statement on the DSM-5

The DSM-5, published by our colleague organization the American Psychiatric Association, has been met with both praise and criticism. Like its predecessors, this fifth edition of the Diagnostic and Statistical Manual will be widely used in the mental health field to classify mental disorders according to diagnoses based on descriptive criteria. There is a place in the field for classifying patients based on descriptions of symptoms, illness course, and other objective facts. However, as psychoanalysts, we know that each patient is unique. No two people with depression, bereavement, anxiety or any other mental illness or disorder will have the same potentials, needs for treatment or responses to efforts to help.

Whether or not one finds great value in the descriptive diagnostic nomenclature exemplified by the DSM-5, psychoanalytic diagnostic assessment is an essential complementary assessment pathway which aims to provide an understanding of each person in depth as a unique and complex individual and should be part of a thorough assessment of every patient.

Even for psychiatric disorders with a strong biological basis, psychological factors contribute to the onset, worsening, and expression of illness. Psychological factors also influence how every patient engages in treatment; the quality of the therapeutic alliance has been shown to be the strongest predictor of outcome for illness in all modalities. [1]

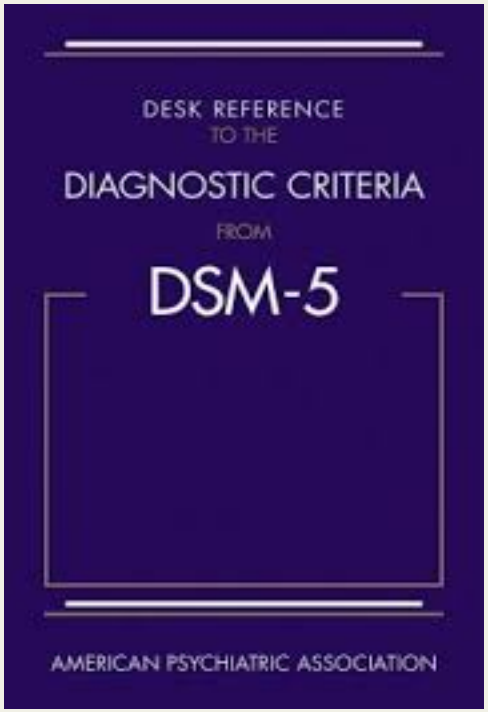
For information about a diagnostic framework that describes both the deeper and surface levels of symptom patterns, as well as of an individual's personality, emotional and social functioning, mental health professionals are referred to the *Psychodynamic Diagnostic Manual*, published conjointly by the American Psychoanalytic Association, International Psychoanalytic Association, Division of Psychoanalysis (39) of the American Psychological Association, the American Academy of Psychoanalysis and Dynamic Psychiatry, and the American Association for Psychoanalysis in Clinical Social Work.

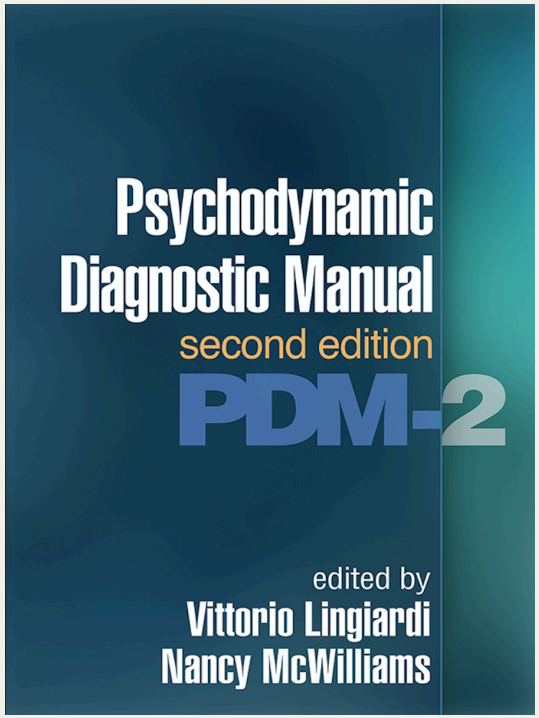
[1] Krupnick JL, Slotsky SM, Simmens S, et al The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. J. Consulti Clin Psychol 64:532-539, 1996

“C’è posto, nel campo della salute mentale, per classificare i pazienti in base alle descrizioni dei sintomi, del decorso della loro patologia, e di altri elementi obiettivi. Tuttavia, come psicoanalisti, sappiamo che ogni paziente è unico. Due individui con lo stesso disturbo, sia esso depressione, lutto complicato, ansia o ogni altro tipo di patologia mentale, non avranno mai le stesse potenzialità, necessità di trattamento o risposte agli interventi terapeutici. Che si attribuisca o meno valore alle nomenclature diagnostiche descrittive come il DSM-5, l’assessment diagnostico psicoanalitico è un percorso di valutazione complementare e necessario, che si propone di fornire una comprensione profonda della complessità e unicità di ciascun individuo, e dovrebbe far parte dell’assessment diagnostico di ogni paziente […]. Anche per quei disturbi psichiatrici con una forte base biologica, vi sono fattori psicologici che contribuiscono all’esordio, al peggioramento e al modo in cui si esprime la malattia. I fattori psicologici influenzano anche il modo in cui ogni paziente partecipa al trattamento. È ormai appurato che la qualità dell’alleanza terapeutica è il miglior predittore dell’esito terapeutico, indipendentemente dal disturbo per cui si cerca aiuto. Per un approccio diagnostico che descriva i sintomi (a un livello sia profondo sia per come appaiono), la personalità e il funzionamento emotivo e sociale, invitiamo ogni professionista della salute mentale a consultare il **PDM** ” (www.apsa.org).

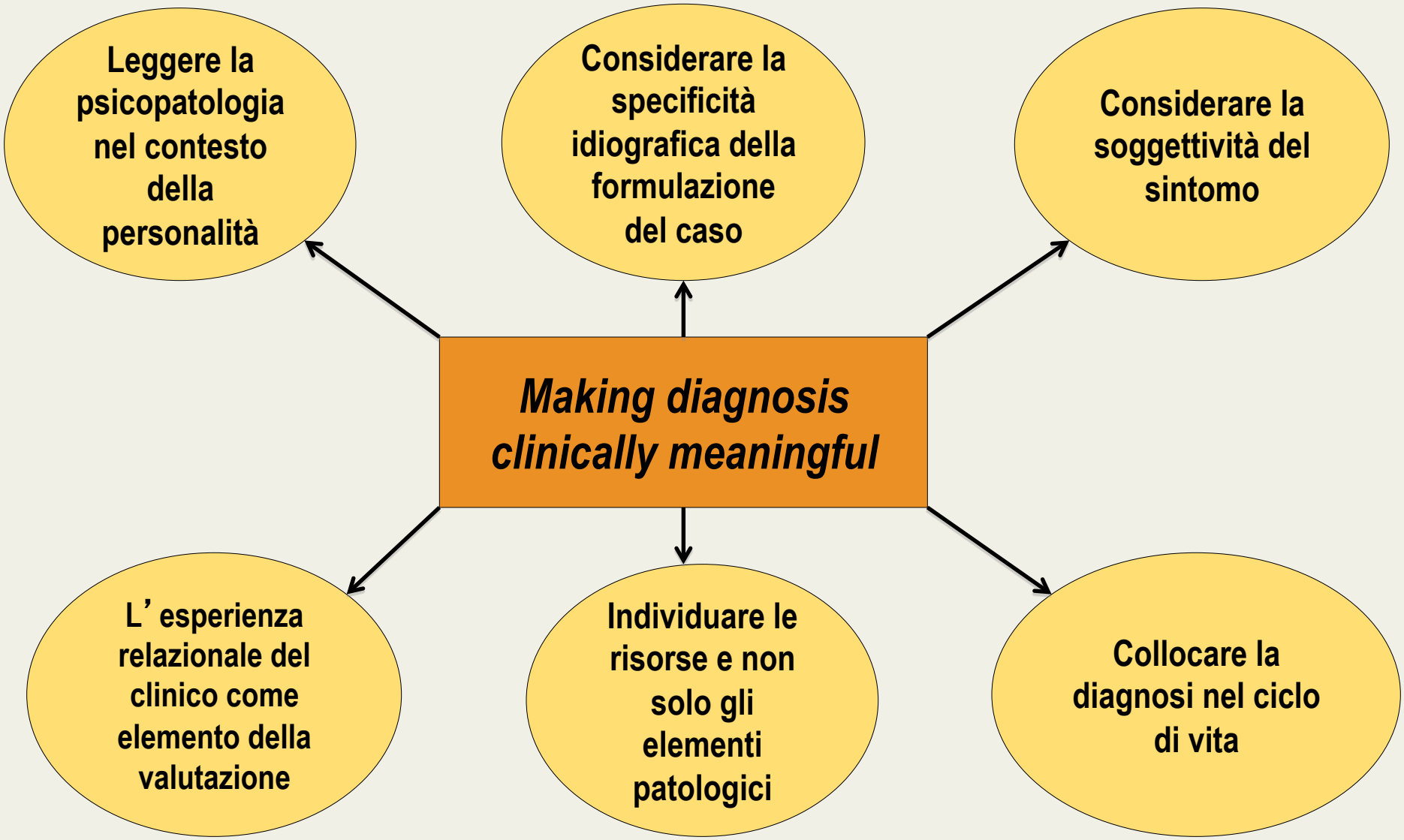
TOP-DOWN

BOTTOM-UP

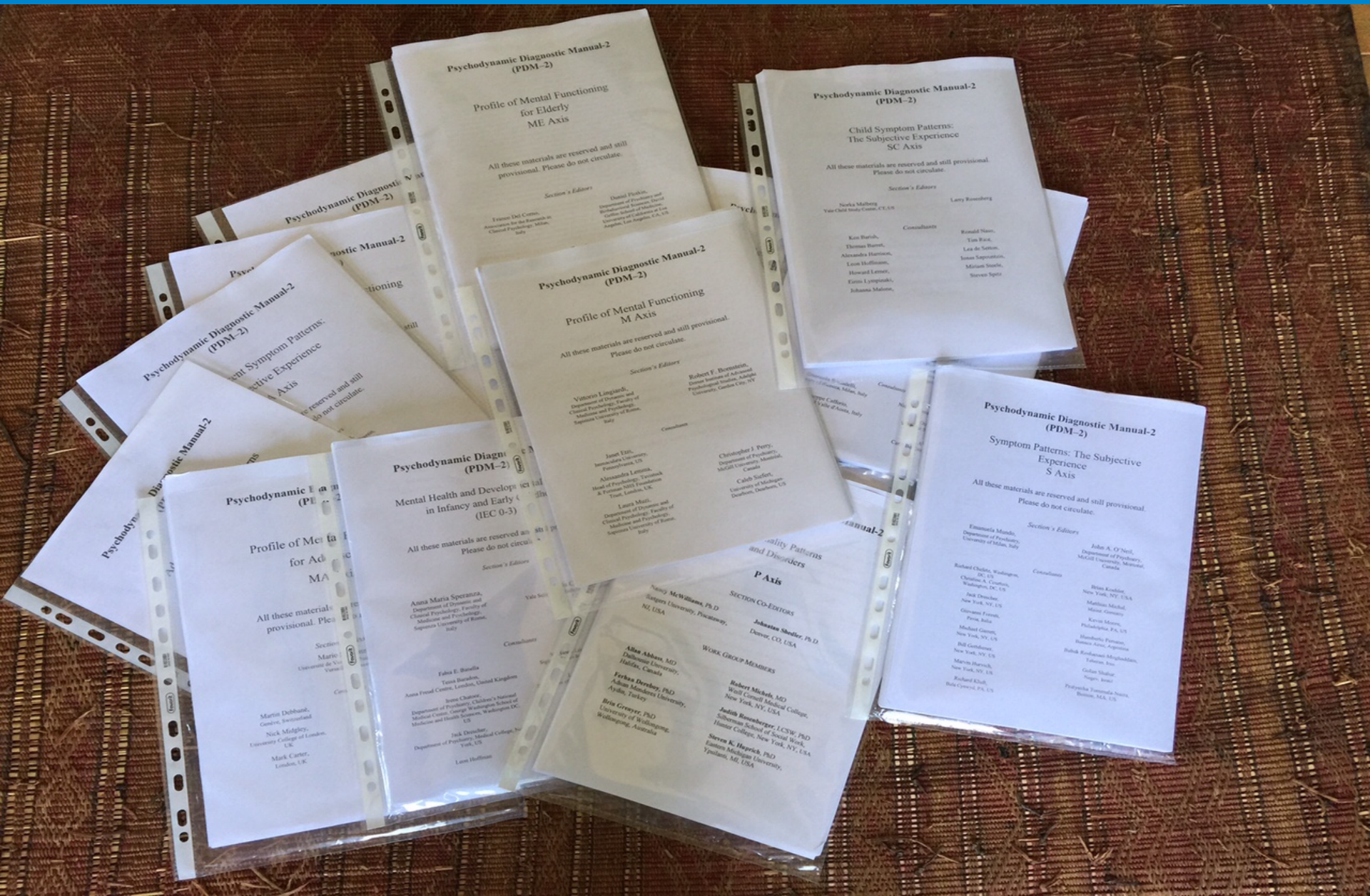




Valutazione e diagnosi al servizio del trattamento



Coming soon


Psychodynamic Diagnostic Manual-2
(PDM–2)
Profile of Mental Functioning
for Elderly
ME Axis
All these materials are reserved and still provisional. Please do not circulate.
Psychodynamic Diagnostic Manual-2
(PDM–2)
Child Symptom Patterns:
The Subjective Experience
SC Axis
All these materials are reserved and still provisional.
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Psychodynamic Diagnostic Manual-2
(PDM–2)
Profile of Mental Functioning
M Axis
All these materials are reserved and still provisional.
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Psychodynamic Diagnostic Manual-2
(PDM–2)
Symptom Patterns: The Subjective
Experience
S Axis
All these materials are reserved and still provisional.
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Psychodynamic Diagnostic Manual-2
(PDM–2)
Mental Health and Developmental Disorders
in Infancy and Early Childhood
(IEC 0-3)
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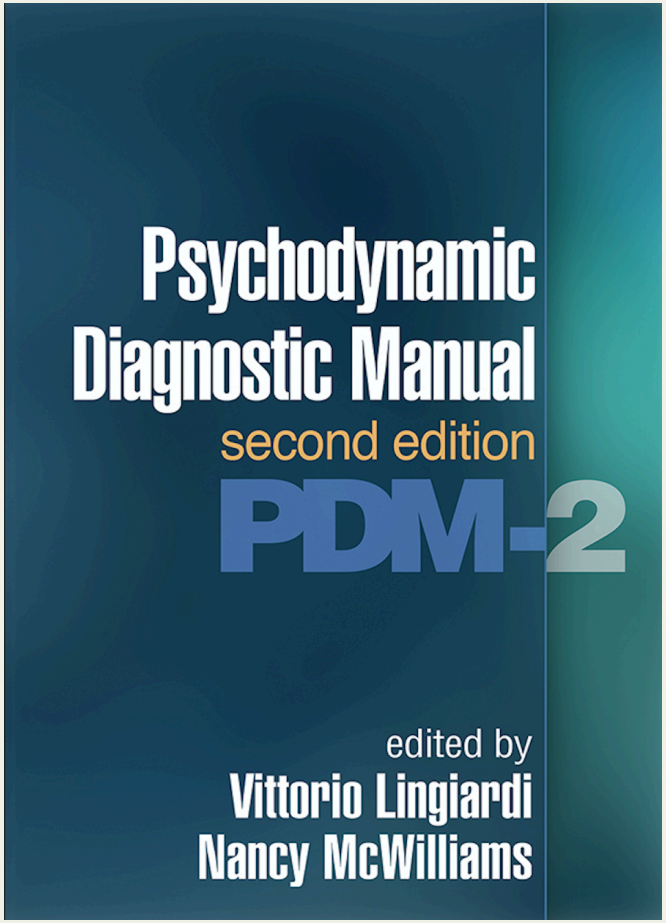
P Axis

Manuale Diagnostico Psicodinamico

"Il **DSM** si presenta come una tassonomia di patologie o di disturbi psichici, mentre il PDM come una '**tassonomia di persone**" (p. 3)

"Il **PDM** si propone di organizzare le scoperte empiriche ottenute dagli strumenti diagnostici (…), le ipotesi nate dalla pratica della psicoanalisi clinica e le suggestioni della diagnostica tradizionale in un sistema coerente e relativamente integrato che possa essere impiegato per diagnosi clinica, formulazione dei casi e la progettazione degli interventi"
(p. XXIII).

Asse P, Asse M, Asse S



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PERSPECTIVE

The Psychodynamic Diagnostic Manual – 2nd edition (PDM-2)

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For decades many clinicians, especially psychodynamic and humanistic therapists, have resisted thinking about their patients in terms of categorical diagnoses. In the current era, they find themselves having to choose between reluctantly "accepting" the DSM diagnostic labels, "denying" them, or developing alternatives more consistent with the dimensional, inferential, contextual, biopsychosocial diagnostic formulations characteristic of psychoanalytic and humanistic approaches. The Psychodynamic Diagnostic Manual (PDM) (1) reflects an effort to articulate a psychodynamically oriented diagnosis that bridges the gap between clinical complexity and the need for empirical and method-

focuses on the psychological health and distress of a particular person. Several psychoanalytical groups joined together to create PDM as a complement to the descriptive systems of DSM-5 and ICD-10. Like DSM-5, PDM includes dimensions that cut across diagnostic categories, along with a thorough account of personality patterns and disorders. PDM uses the DSM diagnostic categories but includes accounts of the internal experience of a person presenting for treatment" (6, pp. 243-244).

Addressing the discomfort many clinicians have with categorical diagnosis (7), the PDM provided an alternative frame-

Psychoanalytic Psychology, 2015

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0736-9735/15/$12.00 http://dx.doi.org/10.1037/a0038546

THE *PSYCHODYNAMIC DIAGNOSTIC MANUAL VERSION 2 (PDM-2)*: *Assessing Patients for Improved Clinical Practice and Research*

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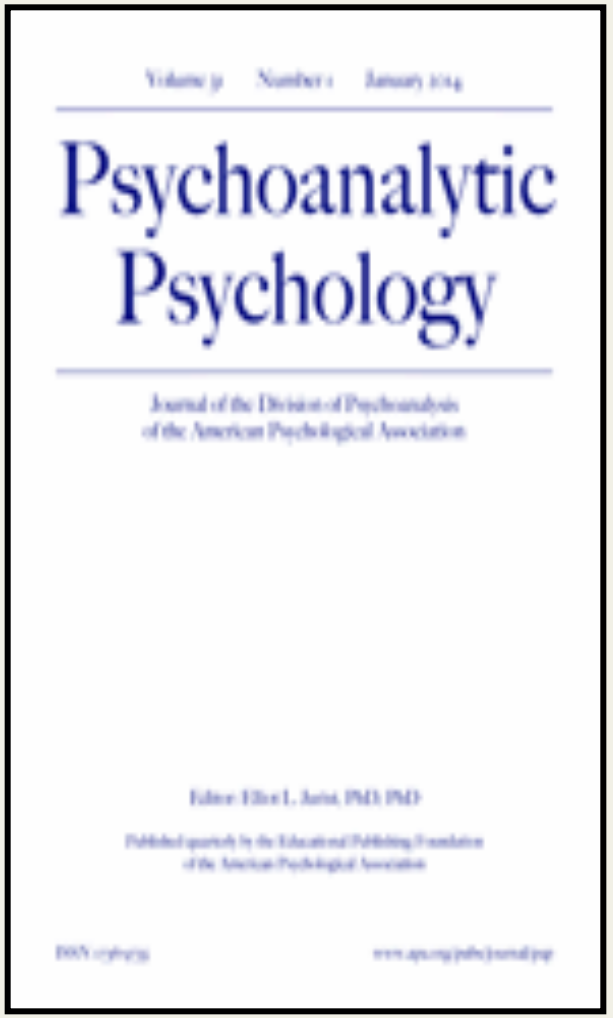
Francesco Gazzillo, PhD
Sapienza University of Rome

Robert M. Gordon, PhD
Allentown, Pennsylvania

This article reviews the development of the second edition of the *Psychodynamic Diagnostic Manual*, the *PDM-2*. We begin by placing the *PDM* in historical context, describing the structure and goals of the first edition of the manual, and reviewing some initial responses to the *PDM* within the professional community. We then outline 5 guiding principles intended to maximize the clinical utility and



Psychoanalytic Inquiry, 2015

Psychoanalytic Inquiry, 35:60–73, 2015

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Routledge
Taylor & Francis Group

The *Psychodynamic Diagnostic Manual (PDM)* and the *PDM*-2: Opportunities to Significantly Affect the Profession

Steven K. Huprich, Ph.D., Nancy McWilliams, Ph.D., Vittorio Lingiardi, M.D.,
Robert F. Bornstein, Ph.D., Francesco Gazzillo, Ph.D.,
and Robert M. Gordon, Ph.D., ABPP

In this article, we discuss the development of the *Psychodynamic Diagnostic Manual* (*PDM*) and its upcoming revision, the *PDM*-2. We describe the processes by which the *PDM*-2 is being developed and highlight important differences across both editions. At the same time, we emphasize the value of assessing internalized experience and how that can be of use toward the diagnostic assessment process.

In 2006, the *Psychodynamic Diagnostic Manual* (*PDM; PDM* Task Force, 2006) was published. The *PDM* was (and is) in many ways a revolutionary document: In contrast to extant diagnostic systems available at that time, the *PDM* was an unabashedly psychodynamic diagnostic system that embraced psychoanalytic concepts, rather than striving for theoretical neutrality, using syndrome descriptions and symptom criteria that incorporate implicit motives, conflicts, defenses, wishes, fantasies, and other dynamic processes, and drawing upon a wealth of empirical research

PDM-2

Steering Committee

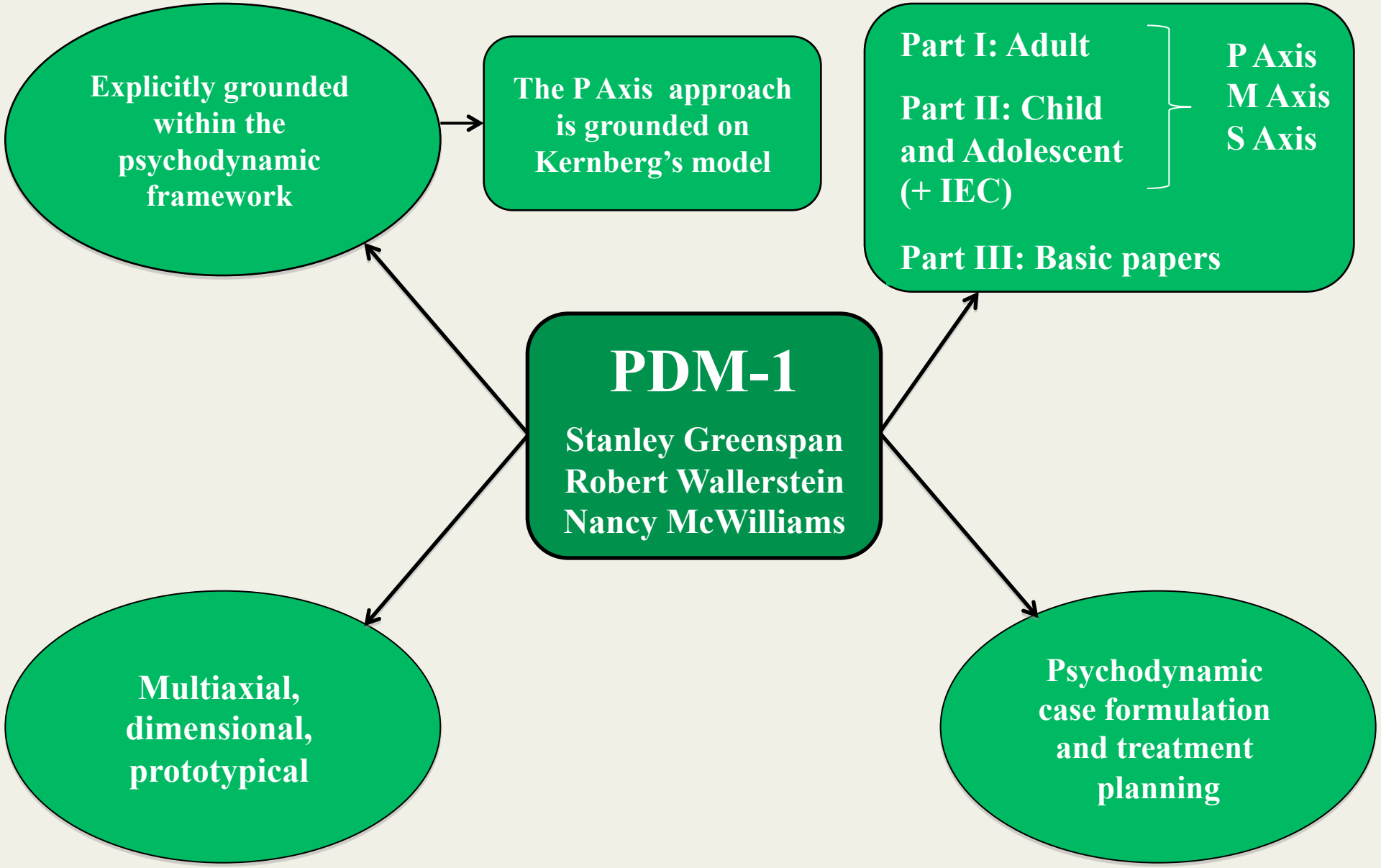
Vittorio Lingiardi
Nancy McWilliams

Sponsoring Organizations

International Psychoanalytical Association
American Psychoanalytic Association
International Association of Relational Psychoanalysis and Psychotherapy
Division of Psychoanalysis (39), American Psychological Association
American Academy of Psychoanalysis and Dynamic Psychiatry
American Association for Psychoanalysis in Clinical Social Work
Association Européenne de Psychopathologie de l'Enfant et de l'Adolescent
Italian Group for the Advancement in Psychodynamic Diagnosis

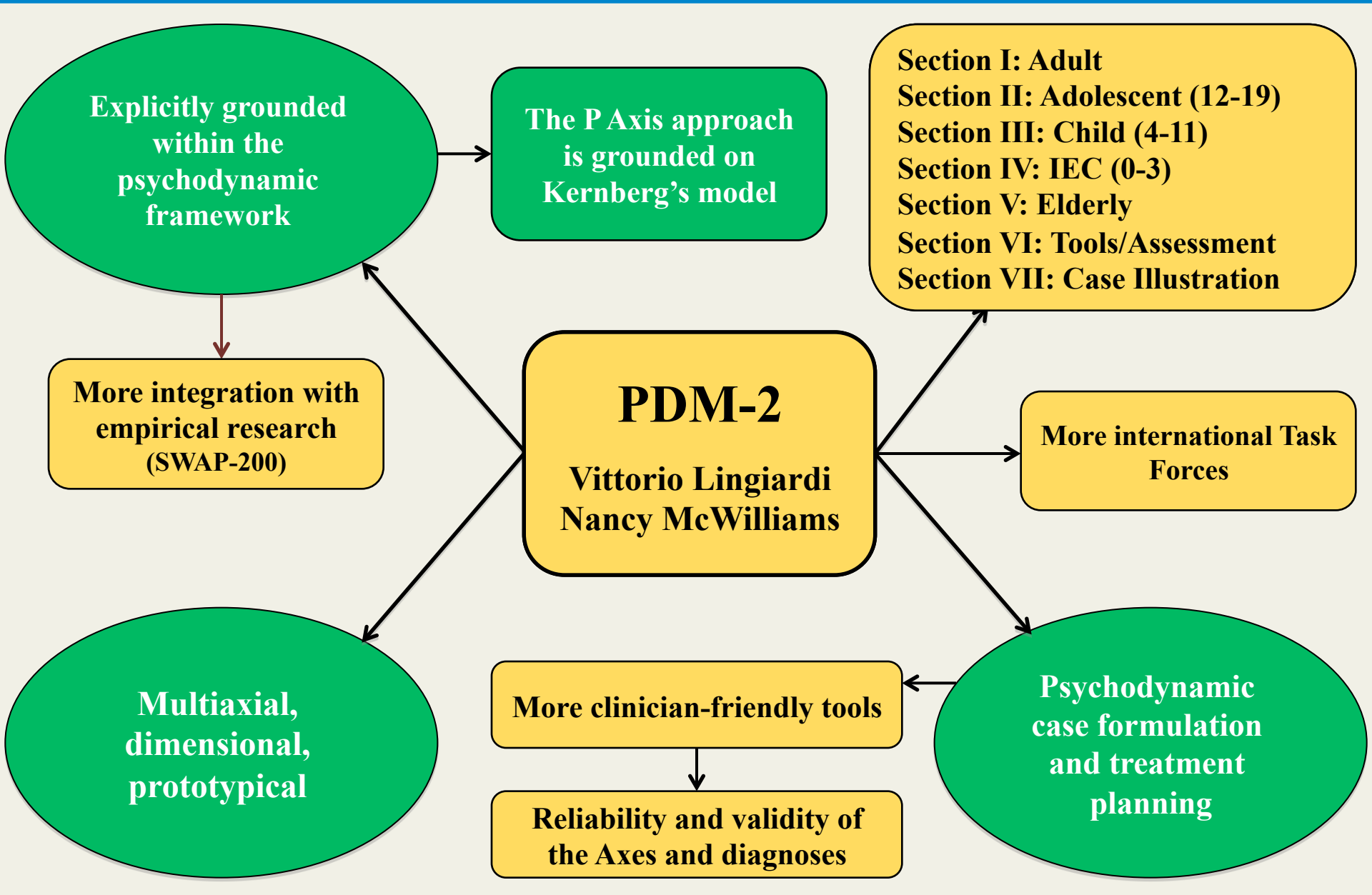
The PDM-1

"The DSM is a taxonomy of diseases or disorders of function. Ours is a taxonomy of people"
(PDM Task Force, 2006, p. 13)



From the PDM-1 to the PDM-2

"The DSM is a taxonomy of diseases or disorders of function. Ours is a taxonomy of people"
(PDM Task Force, 2006, p. 13)



"PDM finally has given clinicians -- as well as researchers and theorists -- an alternative to DSM, which is largely based on symptom counting. As the editors state, PDM provides a 'taxonomy of people' rather than a 'taxonomy of disorders.' While the first edition was a monumental achievement, the second edition is even more impressive. It is an invaluable resource not only for diagnostic purposes, but also for teaching and research. I recommend this book to anyone -- psychologist, psychiatrist, psychoanalyst, social worker, or educator -- interested in an ecologically valid way of assessing personality and mental functioning."

—Morris N. Eagle, PhD, ABPP, Distinguished Educator-in-Residence, School of Graduate Psychology, California Lutheran University

"It is quite difficult to achieve agreement on psychiatric diagnosis, and almost impossible to achieve agreement on psychodynamic concepts. The most interesting aspects of human nature are inherently the very hardest to agree upon, because they are also the most idiosyncratic, complicated, buried, and inferential. This heroically ambitious book is a startlingly successful synthesis of the confusing babel of different psychoanalytic tongues. It will improve the daily practice of psychodynamic clinicians, enliven teaching in the field, and contribute to the infant field of psychodynamic research. A labor of love and erudition."

—Allen Frances, MD, Department of Psychiatry and Behavioral Sciences (Emeritus), Duke University

"People are more than their diagnoses. Diagnostic formulations rooted in the diversity and humanity of the people we aim to help and, at the same time, rooted in carefully evaluated empirical evidence represent the real gold standard in our field. This synthesis is precisely what PDM-2 aims for. The book will be of value both to practicing clinicians and to those teaching the next generation to think in ways that combine rigor with empathy for the client's experience."

—Paul L. Wachtel, PhD, Distinguished Professor, Doctoral Program in Clinical Psychology, City College and the Graduate Center of the City University of New York

"A masterful work that fills a gap in the clinical literature. This 21st-century psychodynamic manual not only covers diagnostic formulations, but also presents validated research tools that can be used in assessment of patients. The editors have recruited leaders in the field from across the globe to contribute to this major, far-reaching resource. PDM-2 takes a lifespan approach, covering infancy, childhood, adolescence, adulthood, and old age. Crucially, it takes seriously the need to integrate research and practice, with clear comparisons between the PDM-2 and DSM and ICD diagnostic systems. The inclusion of extensive case material helps the editors achieve their goal of addressing the complexities rather than just the symptoms of patients."

—Miriam Steele, PhD, Department of Psychology, The New School for Social Research

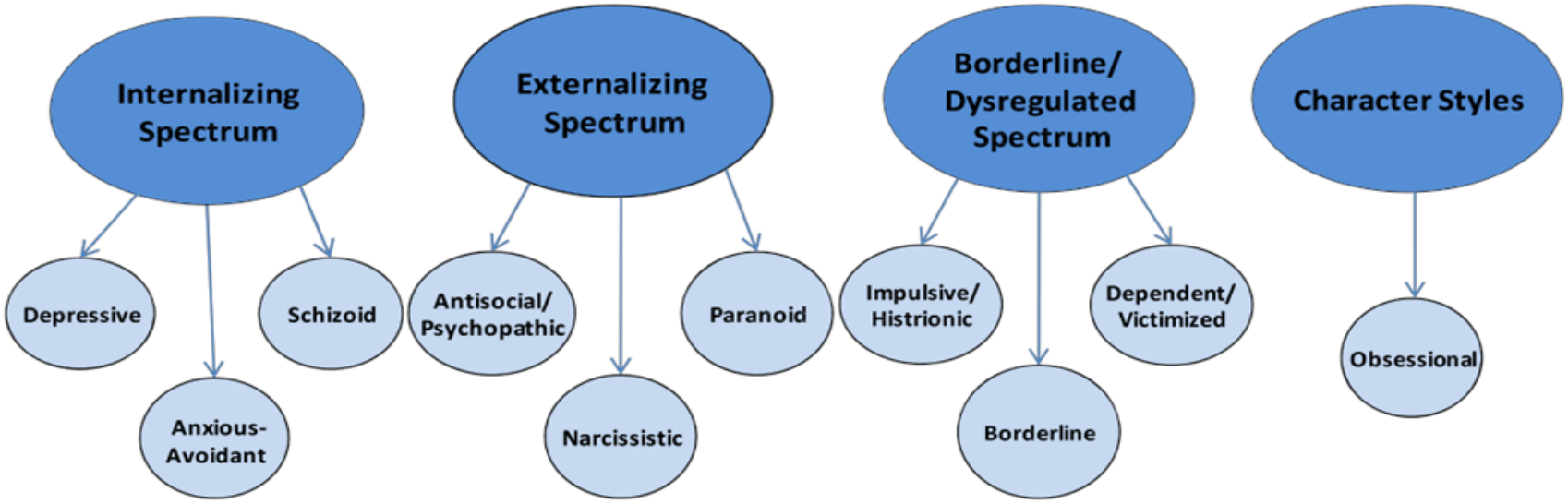
P Axis Diagnostic Approach

- Two-step process of first considering severity through level of personality organization and then assessing personality style.

- Levels of personality organization: healthy, neurotic, borderline, and psychotic.

- ***Personality Styles:***

Figure 1. Empirically Derived Personality Spectra and Styles in adolescents (Westen et al., 2014)

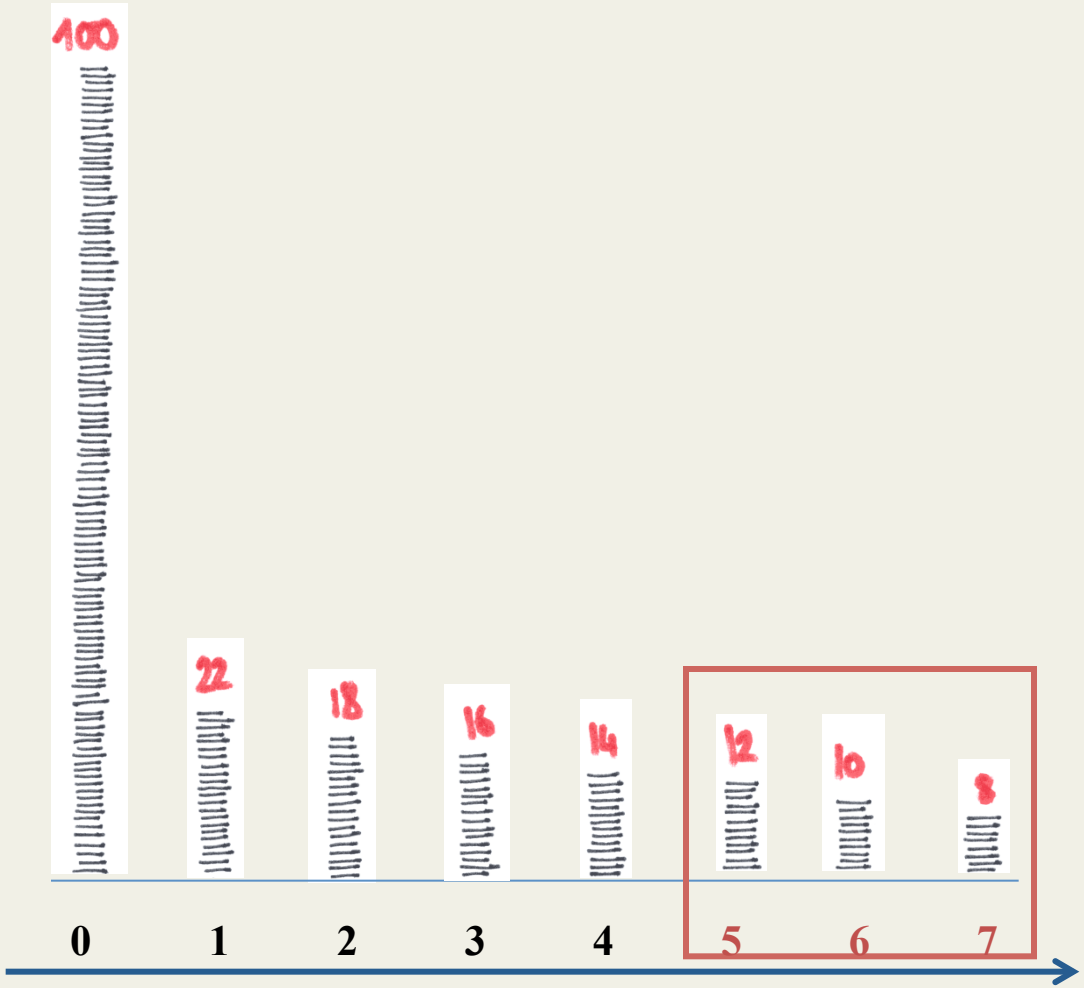


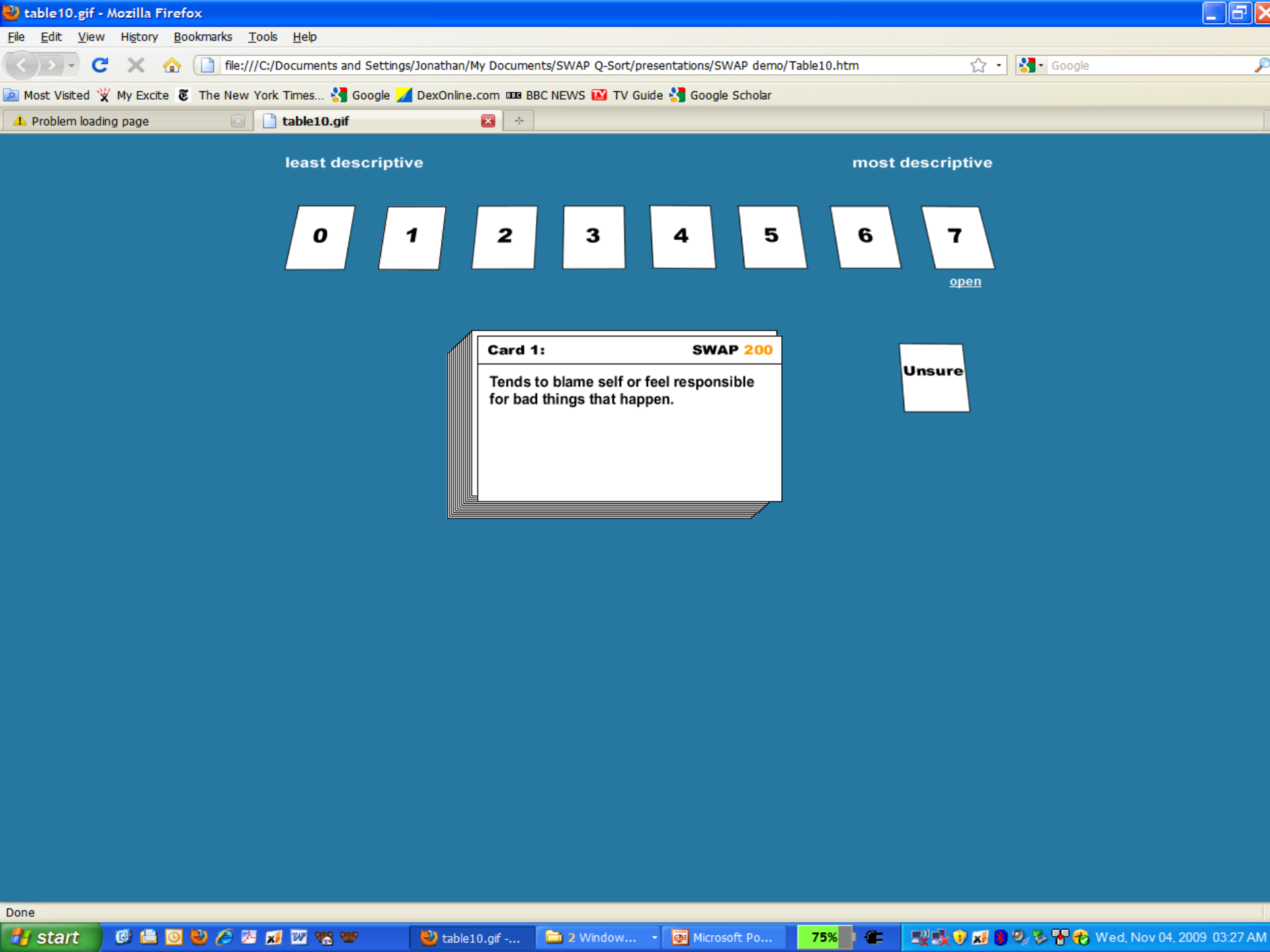
Shedler Westen Assessment Procedure (SWAP)

"Lasciamo che i clinici facciano ciò che sanno fare meglio, cioè osservare, ascoltare e fare inferenze; e lasciamo che la statistica faccia ciò che sa fare meglio, cioè aggregare i dati in modo attendibile" .

Il metodo Q-sort su cui si basa la SWAP implica una valutazione gerarchica organizzata secondo una distribuzione fissa.

A ciascuna delle 8 pile a disposizione va assegnato un numero prestabilito di item:

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SWAP-200 / SWAP-A

- A cosa serve la SWAP? A trasformare le noiose ma necessarie tabelle della ricerca empirica, nell'oro della clinica…

- Assessment del paziente
- Case formulation (ma anche label)
- Psicopatologia *e* risorse
- Sottotipizzazioni (NPD, EDs, …)
- Ricerca in psicoterapia (process-outcome-follow-up)
- Contesti forensi
- Supervisioni
- Patient in the mind

Insegnare la psicopatologia attraverso la valutazione

ITEM 14: TENDE AD INCOLPARE GLI ALTRI DEI PROPRI FALLIMENTI DIFETTI; TENDE A CREDERE CHE I SUOI PROBLEMI SIANO CAUSATI DA FATTORI ESTERNI.

ITEM 29: HA DIFFICOLTA' NEL COMPRENDERE IL SENSO DEL COMPORTAMENTO ALTRUI; SPESSO LO FRAINTENDE, LO INTERPRETA IN MODO SCORRETTO O È CONFUSO/A DALLE AZIONI O DALLE REAZIONI DEGLI ALTRI.

ITEM 59: È EMPATICO/A, SENSIBILE E RESPONSIVO/A VERSO I BISOGNI E I SENTIMENTI DEGLI ALTRI.

ITEM 74: ESPRIME LE PROPRIE EMOZIONI IN MODI ESAGERATI E TEATRALI.

Insegnare la psicopatologia attraverso la valutazione (segue)

ITEM 89: SEMBRA ESSERE RIUSCITO/A A SCENDERE A PATTI CON ESPERIENZE DOLOROSE DEL PASSATO, AVERVI TROVATO UN SIGNIFICATO ED ESSERE CRESCIUTO/A GRAZIE AD ESSE.

ITEM 100: TENDE A PENSARE IN TERMINI ASTRATTI E INTELLETTUALIZZATI, ANCHE SU ARGOMENTI DI RILIEVO PERSONALE.

ITEM 108: TENDE A LIMITARE L'ASSUNZIONE DI CIBO FINO AL PUNTO DI DIVENTARE SOTTOPESO E MALNUTRITO/A.

ITEM 173: TENDE A INTERESSARSI ECCESSIVAMENTE AI DETTAGLI SINO A PERDERE DI VISTA CIO' CHE E' DAVVERO SIGNIFICATIVO IN UNA DATA SITUAZIONE.

Psychoanalytic Psychology
2010, Vol. 27, No. 2, 190–218

0736-9735/10/$12.00 DOI: 10.1037/a0019418

AN EMPIRICALLY SUPPORTED PSYCHOANALYSIS

The Case of Giovanna

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Sherwood Waldron Jr., MD
New York Psychoanalytic Institute and
Mt. Sinai School of Medicine

Psychoanalysts have long relied on the case study method to support the validity of their theoretical hypotheses and clinical techniques and the efficacy of their treatments. However, limitations of the case study method have become increasingly salient as the medical-scientific community and policymakers have increasingly emphasized the need for empirical data. This article describes the progression of an analysis from the perspective of both the treating analyst and an independent research team using empirical methods to study verbatim session transcripts. Empirical measures include the *Shedler-Westen Assessment Procedure-200* (Westen & Shedler, 1999a, b; Shedler & Westen, 2006), the *Defense Mechanism Rating Scale* (Perry, 1990a) and the *Analytic Process Scales* (Waldron, Scharf, Crouse, Firestein, & Burton, 2004, and Waldron, Scharf, Hurst, et al., 2004). The article illustrates one way in which clinical and empirical methods can complement each other synergistically and lead to a deeper and more precise understanding of analytic process and psychological change.

Keywords: case study, personality assessment, psychoanalytic process, defense mechanisms, therapeutic factors

JOURNAL OF PERSONALITY ASSESSMENT, *86*(1), 23–32

CLINICAL CASE APPLICATIONS

Assessing Personality Change in Psychotherapy With the SWAP–200: A Case Study

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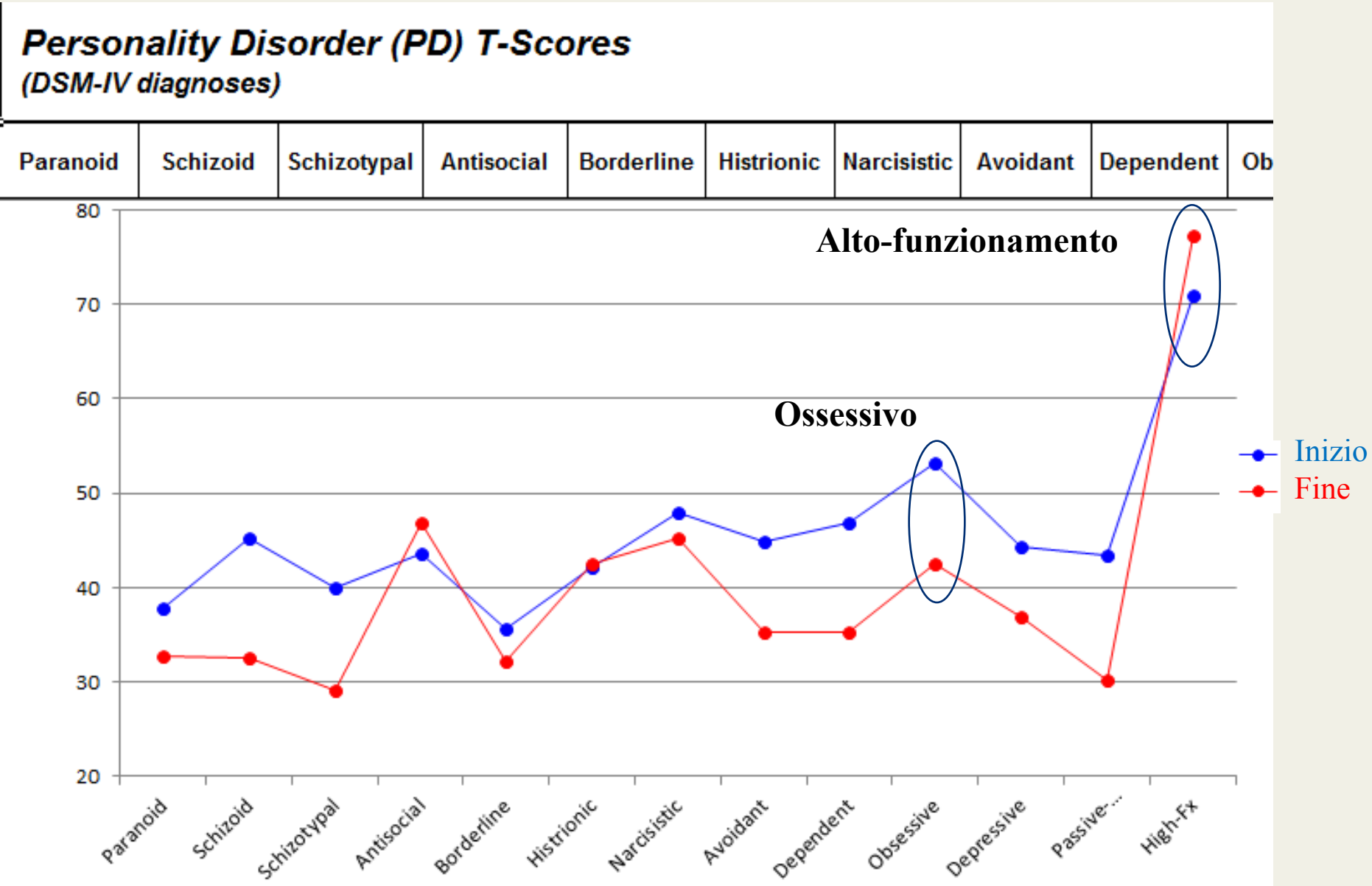
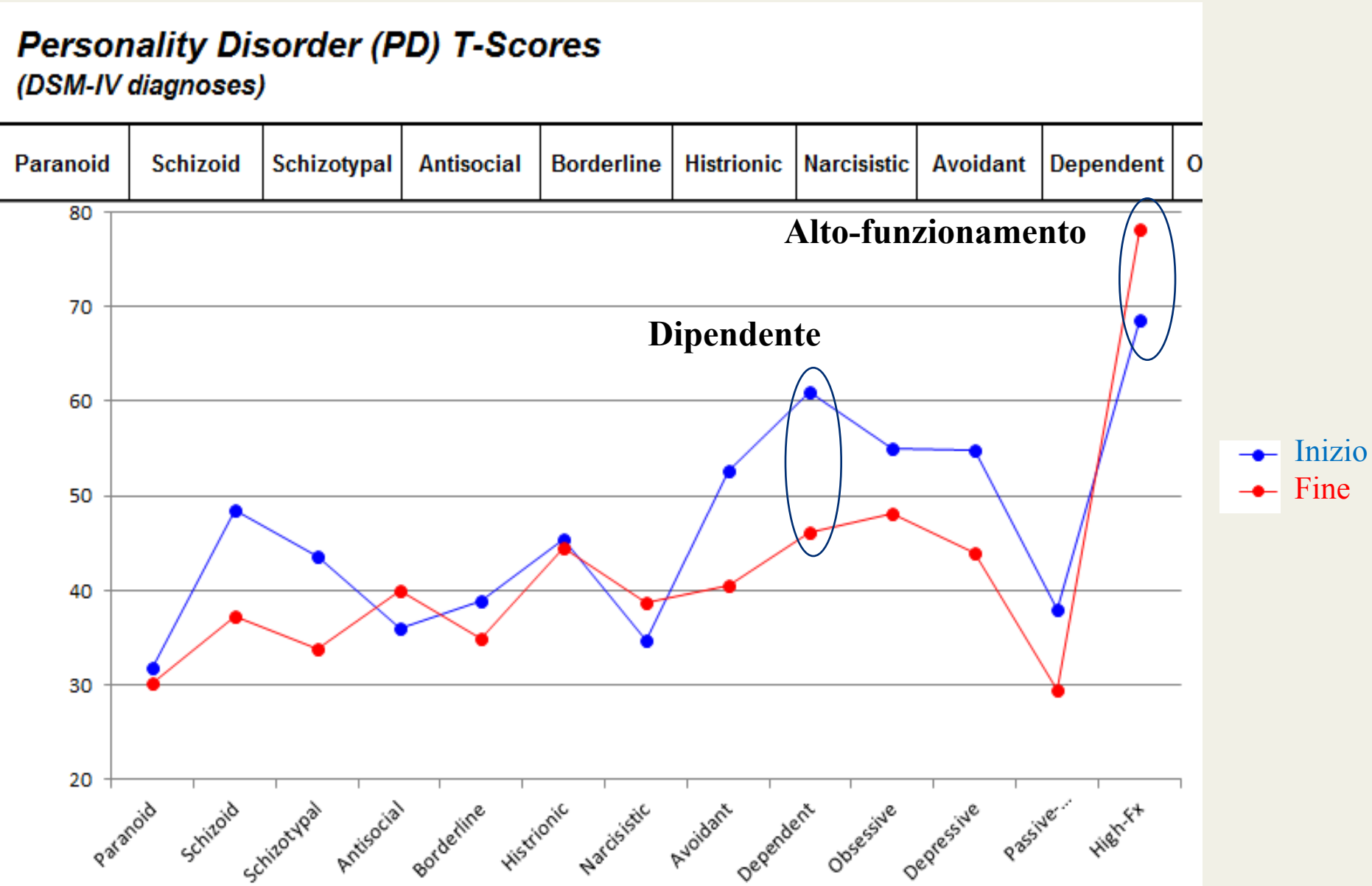
Many studies document the efficacy of psychotherapy for acute syndromes such as depression, but less is known about personality change in patients treated for personality pathology. The Shedler–Westen Assessment Procedure (SWAP–200; Westen & Shedler, 1999a, 1999b) is an assessment tool that measures a broad spectrum of personality constructs and is designed to bridge the gap between the clinical and empirical traditions in personality assessment. In this article, we demonstrate the use of the SWAP–200 as a measure of change in a case study of a patient diagnosed with borderline personality disorder. We collected assessment data at the start of treatment and after 2 years of psychotherapy. The findings illustrate the personality processes targeted in intensive psychotherapy for borderline personality.

Personalità a inizio e fine trattamento: Profili SWAP di N9 (good outcome) (2)



Personalità a inizio e fine trattamento: Profili SWAP di F4 (good outcome) (4)



Colli, Tanzilli, Dimaggio & Lingiardi (2014)

Article

Patient Personality and Therapist Response: An Empirical Investigation

Antonello Colli, Ph.D.

Annalisa Tanzilli, Ph.D.

Giancarlo Dimaggio, M.D.

Vittorio Lingiardi, M.D.

Objective: The aim of this study was to examine the relationship between therapists' emotional responses and patients' personality disorders and level of psychological functioning.

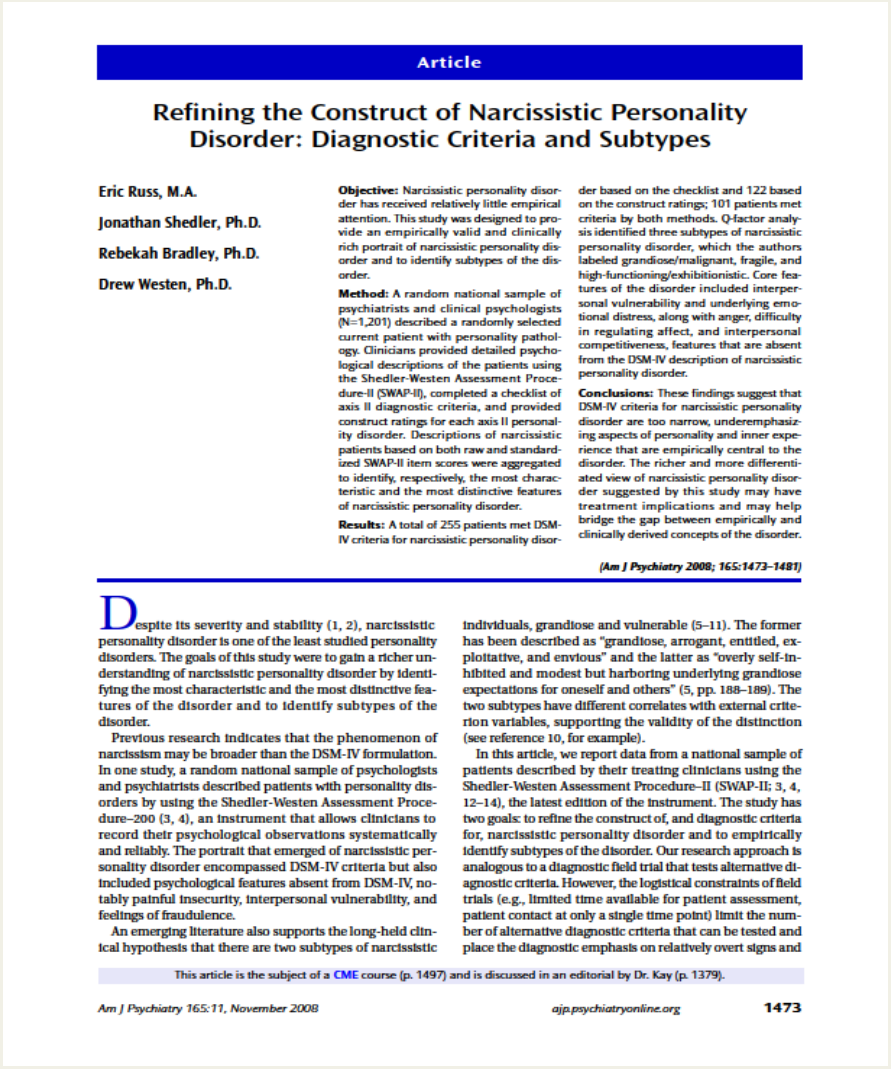
Method: A random national sample of psychiatrists and clinical psychologists (N=203) completed the Therapist Response Questionnaire to identify patterns of therapists' emotional response, and the Shedler-Westen Assessment Procedure–200 to assess personality disorders and level of psychological functioning in a randomly selected patient currently in their care and with whom they had worked for a minimum of eight sessions and a maximum of 6 months (one session per week).

Results: There were several significant relationships between therapists' responses and patients' personality pathology. Paranoid and antisocial personality disorders were associated with criticized/mistreated countertransference, and borderline personality disorder was related to helpless/inadequate, overwhelmed/disorganized, and special/overinvolved countertransference. Disengaged countertransference was associated with schizotypal and narcissistic personality disorders and negatively associated with dependent and histrionic personality disorders. Schizoid personality disorder was associated with helpless/inadequate responses. Positive countertransference was associated with avoidant personality disorder, which was also related to both parental/protective and special/overinvolved therapist responses. Obsessive-compulsive personality disorder was negatively associated with therapist special/overinvolved responses. In general, therapists' responses were characterized by stronger negative feelings when working with lower-functioning patients.

Conclusions: Patients' specific personality pathologies are associated with consistent emotional responses, which suggests that clinicians can make diagnostic and therapeutic use of their responses to patients.

(Am J Psychiatry 2013; 00:1–7)

Perfezionamento del costrutto di disturbo narcisistico di personalità con la SWAP: criteri e sottotipi



Article

Refining the Construct of Narcissistic Personality Disorder: Diagnostic Criteria and Subtypes

Eric Russ, M.A.
Jonathan Shedler, Ph.D.
Rebekah Bradley, Ph.D.
Drew Westen, Ph.D.

Objective: Narcissistic personality disorder has received relatively little empirical attention. This study was designed to provide an empirically valid and clinically rich portrait of narcissistic personality disorder and to identify subtypes of the disorder.

Method: A random national sample of psychiatrists and clinical psychologists (N=1,201) described a randomly selected current patient with personality pathology. Clinicians provided detailed psychological descriptions of the patients using the Shedler-Westen Assessment Procedure-II (SWAP-II), completed a checklist of axis II diagnostic criteria, and provided construct ratings for each axis II personality disorder. Descriptions of narcissistic patients based on both raw and standardized SWAP-II item scores were aggregated to identify, respectively, the most characteristic and the most distinctive features of narcissistic personality disorder.

Results: A total of 255 patients met DSM-IV criteria for narcissistic personality disorder based on the checklist and 122 based on the construct ratings; 101 patients met criteria by both methods. Q-factor analysis identified three subtypes of narcissistic personality disorder, which the authors labeled grandiose/malignant, fragile, and high-functioning/exhibitionistic. Core features of the disorder included interpersonal vulnerability and underlying emotional distress, along with anger, difficulty in regulating affect, and interpersonal competitiveness, features that are absent from the DSM-IV description of narcissistic personality disorder.

Conclusions: These findings suggest that DSM-IV criteria for narcissistic personality disorder are too narrow, underemphasizing aspects of personality and inner experience that are empirically central to the disorder. The richer and more differentiated view of narcissistic personality disorder suggested by this study may have treatment implications and may help bridge the gap between empirically and clinically derived concepts of the disorder.

(Am J Psychiatry 2008; 165:1473–1481)

Despite its severity and stability (1, 2), narcissistic personality disorder is one of the least studied personality disorders. The goals of this study were to gain a richer understanding of narcissistic personality disorder by identifying the most characteristic and the most distinctive features of the disorder and to identify subtypes of the disorder.

Previous research indicates that the phenomenon of narcissism may be broader than the DSM-IV formulation. In one study, a random national sample of psychologists and psychiatrists described patients with personality disorders by using the Shedler-Westen Assessment Procedure–200 (3, 4), an instrument that allows clinicians to record their psychological observations systematically and reliably. The portrait that emerged of narcissistic personality disorder encompassed DSM-IV criteria but also included psychological features absent from DSM-IV, notably painful insecurity, interpersonal vulnerability, and feelings of fraudulence.

An emerging literature also supports the long-held clinical hypothesis that there are two subtypes of narcissistic individuals, grandiose and vulnerable (5–11). The former has been described as "grandiose, arrogant, entitled, exploitative, and envious" and the latter as "overly self-inhibited and modest but harboring underlying grandiose expectations for oneself and others" (5, pp. 188–189). The two subtypes have different correlates with external criterion variables, supporting the validity of the distinction (see reference 10, for example).

In this article, we report data from a national sample of patients described by their treating clinicians using the Shedler-Westen Assessment Procedure–II (SWAP-II; 3, 4, 12–14), the latest edition of the instrument. The study has two goals: to refine the construct of, and diagnostic criteria for, narcissistic personality disorder and to empirically identify subtypes of the disorder. Our research approach is analogous to a diagnostic field trial that tests alternative diagnostic criteria. However, the logistical constraints of field trials (e.g., limited time available for patient assessment, patient contact at only a single time point) limit the number of alternative diagnostic criteria that can be tested and place the diagnostic emphasis on relatively overt signs and

This article is the subject of a CME course (p. 1497) and is discussed in an editorial by Dr. Kay (p. 1379).

Narcisista grandioso-maligno

Narcisista fragile

Narcisista esibizionistico-di alto funzionamento

(Russ, Shedler, Bradley, Westen, 2008).

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COMPREHENSIVE PSYCHIATRY

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Personality subtypes in adolescents with anorexia nervosa

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[b]*University of Turin*
[c]*Bambino Gesù Children Hospital, Rome*

Abstract

The aims of this study are to (1) empirically identify the personality subtypes of adolescents with anorexic disorders and (2) investigate the personality disorders, identity disturbances, and affective features associated with the different subtypes. We assessed 102 adolescent patients with Eating Disorders (anorexia nervosa and eating disorder not otherwise specified) using three clinical instruments: the Shedler-Westen Assessment Procedure for Adolescents (SWAP-200-A) (Westen D, Shedler J, Durrett C, Glass S, Martens A. Personality diagnoses in adolescence: DSM-IV Axis II diagnoses and an empirically derived alternative. Am J Psychiatry 2003;160:952–966), the Affective Regulation and Experience Questionnaire (AREQ) (Zittel Conklin C, Bradley R, Westen D. Affect regulation in borderline personality disorder. J Nerv Ment Dis 2006;194:69–77), and the Identity Disorder Questionnaire (IDQ) (Wilkinson-Ryan T, Westen D. Identity disturbance in borderline personality disorder: An empirical investigation. Am J Psychiatry 2000;157:528–541). We performed a Q factor analysis of the SWAP-200-A descriptions of our sample to identify personality subtypes. We correlated these personality styles with AREQ and IDQ factors and explored the personality differences among individuals with the different types of ED. The Q factor analysis identified three personality subtypes: high-functioning/perfectionist, emotionally dysregulated, and overcontrolled/constricted. Each subtype showed specific identity and affective features, comorbidities with different personality disorders, and clinical implications. These results contribute to the understanding of adolescents with ED and seem to be relevant for treatment planning.

Patient Personality and Therapist Response: An Empirical Investigation

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Conclusions: Patients' specific personality pathologies are associated with consistent emotional responses, which suggests that clinicians can make diagnostic and therapeutic use of their responses to patients.

(Am J Psychiatry 2013; 00:1–7)

- Sta a noi, dunque, **dare un senso alla diagnosi**.

- L'*assessment procedure* di Westen e Shedler e il *Manuale Diagnostico Psicodinamico* sono due compagni di viaggio capaci di dare **senso** alla diagnosi e dunque alla nostra **sensibilità** clinica.

- Restituiscono il tormento, ma anche la sfida e il piacere conoscitivo e relazionale del processo diagnostico.

- La diagnosi va sottratta alla compilazione burocratica e riconsegnata al clinico e alla sua identità.