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Personality, mental functioning, and symptoms: assessing suicidal risk with the Psychodynamic Diagnostic Manual, 2nd ed. (PDM-2)

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Summary

Comprehensive and careful diagnostic assessment is a crucial aspect of the clinical management of suicidal patients. The new edition of the Psychodynamic Diagnostic Manual (PDM-2; Lingiardi & McWilliams, 2017) adds a needed perspective on symptom patterns depicted in existing taxonomies, enabling clinicians to describe and categorize personality patterns, related social and emotional capacities, unique profiles of mental functioning, and subjective experiences of symptoms. This paper provides an overview of the PDM-2, focusing on its diagnostic approach to evaluating patients presenting suicidal intention and behaviors. First, the basic premises of the PDM-2, including its rationale and structure, are briefly discussed. Second, following the multiaxial organization of this diagnostic system, the features and main innovations that can guide clinicians in their assessment and clinical management of suicidal risk are examined.

Key words

Suicide • Psychodynamic Diagnostic Manual • Diagnosis • Assessment

Introduction

Clinicians routinely investigate the presence of suicidal ideation, suicidal intention, a history of such ideation and intention, and the nature and severity of any suicide attempts in all patients they encounter in their practice. Suicide is the second leading cause of death among persons aged 15 to 29, and almost 800,000 people die by suicide worldwide, each year [1]. Therefore, for many patients, the clinician's highest priority when determining the therapeutic intervention is to assess the risk of suicidal behavior. As suicidality is widely considered a transdiagnostic dimension [2 3], it can assume different meanings, functions, and clinical priorities according to the presence of other psychiatric comorbidities, as well as the cognitive, affective, and interpersonal patterns demonstrated by the patient [4 5]. Accordingly, a comprehensive, careful, and wide-ranging diagnostic assessment is a crucial aspect of the clinical management of suicidal patients [6 7].

Notwithstanding the advantages of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the *International Classification of Diseases* (ICD) systems, their classifications often fail to meet the needs of clinicians. In particular, several scholars have questioned the usefulness of such diagnostic categories in guiding clinicians to formulate a management plan and predict outcomes [8-10]. A recent global survey reported that a large sample of mental health professionals rated the ICD-10 and some editions of the DSM as having the lowest utility in "selecting a treatment" and "assessing probable prognosis"; the frameworks were deemed primarily useful for administrative purposes [11]. The limitations of these official diagnostic systems are significantly problematic in the context of the

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routine management of suicidal risk, due to the urgent requirement for the careful and accurate evaluation and assessment of patients.

The recently published 2nd edition of the *Psychodynamic Diagnostic Manual* (PDM-2) [12 13] adds a much needed new perspective on the symptom patterns depicted in existing taxonomies, enabling clinicians to describe and categorize personality patterns, related social and emotional capacities, unique profiles of mental functioning, and subjective experiences of symptoms. Specifically, the PDM-2 highlights patients' *internal experiences*, adopting a multidimensional approach to describe the intricacy and depth of patients' overall functioning in various areas (e.g., interpersonal, cognitive, emotional). This comprehensive diagnostic framework can guide clinicians in formulating individual cases and planning treatments, and hence improve the *clinical utility* of psychiatric diagnoses [14].

In this article, we provide an overview of the PDM-2, focusing on its diagnostic approach to evaluating patients presenting suicidal intention and behavior. First, we briefly describe the basic premises of the PDM-2, including its rationale, structure, and organization. Second, we review, following the multiaxial organization, its features and primary innovations that can guide clinicians in their assessment and clinical management of suicidal risk.

Rationale of the PDM-2 classification system

The PDM-2 [15] reflects an effort to articulate a diagnostic system that bridges the gap between clinical complexity and empirical and methodological validity. Taking a "prototypic" approach to diagnosis, the manual rejects the idea that a diagnostic category can be merely described as a collection of symptoms (e.g., [16 17]). Specifically, the PDM-2 diagnostic categories emphasize both individual variation (i.e., an individual's unique experience and personal history) and commonalities (i.e., patterns of intercorrelated reported experiences [symptoms] and observed behaviors [signs]), integrating nomothetic understanding and idiographic knowledge of clinical presentations.

Although the PDM-2 differs in its diagnostic approach to the DSM and ICD, it also aspires to complement these manuals in their efforts to catalogue symptoms and syndromes. Therefore, the manual is not intended to replace the official diagnostic systems, but aims at improving the diagnostic process with the richness and complexity of psychoanalytic constructs, infant research, developmental psychopathology, attachment theory, and neuroscience.

The PDM-2 framework attempts to systematically describe *personality functioning*; individual profiles of *mental functioning* (including, e.g., patterns of relating to others, comprehending and expressing feelings, coping with stress and anxiety, regulating impulses, observing one's own emotions and behaviors, and forming moral judgments); and *symptom patterns*, including patients' personal, subjective experiences of symptoms.

The PDM-2 devotes specific sections to discrete age groups and developmental stages (adults, adolescents, children; infancy and early childhood, later life), and it structures and operationalizes diagnoses around three axes: the P Axis ("Personality Syndromes"), the M Axis ("Profile of Mental Functioning"), and the S Axis ("Symptom Patterns: The Subjective Experience"). The P Axis comprehensively describes a range of healthy to disordered personality functioning. Its major organizing principles relate to levels of personality organization (i.e., on a spectrum of personality functioning ranging from healthy to neurotic, borderline, and psychotic levels [18]) and personality styles (i.e., clinically familiar personality styles/types that intersect with levels of personality organization). The M Axis provides an assessment of overall mental functioning based on 12 specific capacities (i.e., the capacities involved in overall psychological health or pathology) grouped into four main domains: cognitive and affective processes; identity and relationships; defense and coping; and self-awareness and self-direction. Finally, the S Axis, while retaining a high degree of overlap with DSM and ICD diagnostic categories, provides a more specific description of individual experience of the patient related to any symptom pattern, and any non-pathological conditions that may require clinical assessment (relating to, e.g., demographic minorities, LGB populations, and gender incongruence). Moreover, it thoroughly emphasizes the critical role of transference and countertransference patterns relative to distinct clinical syndromes (e.g., [19-23]).

PDM-2 S Axis: the subjective experience of suicidal patients

In all S Axes of the PDM-2, the clinical importance of the proper assessment of suicidal risk is emphasized. According to most psychodynamic and neurobiological literature (e.g., [4 24]), *suicidal ideations*, *behaviors*, and *attempts* are typical "cross-sectional" symptoms, attitudes, and behaviors that may be present in many disorders at different times. From this standpoint, suicidality does not have diagnostic specificity; rather, it is a transdiagnostic dimension. According to the PDM-2, "suicidal risk should be carefully assessed for any patient, regardless of the 'primary diagnosis' or the patient's primary treatment request" ([3], p. 137). Thus, subjective experiences of suicidal thoughts and behaviors may vary widely within a single patient, over the course of life or treatment, and they should always be considered one of the main risk factors for suicide attempts. In addition, to support the assessment of the clinical complexities of suicide risk, the PDM-2 provides guidelines that can

be applied in various clinical conditions. Specifically, it is fundamental for clinicians to assess the following variables: presence of suicidal or homicidal ideation, intent, or plans; ready access to means for suicide, and the lethality of those means; presence of psychotic symptoms, especially command hallucinations; presence of suicidal or homicidal alters in dissociative identity disorder; distinction between suicidal intent and parasuicidal intent (especially regarding self-injury); presence of serious alcohol or other substance misuse; history and seriousness of previous self-harm attempts; family history of, or recent exposure to, suicide; and absence of a significant network of supportive relationships and social services.

Another key issue highlighted by the PDM-2 is the distinction between suicidal and parasuicidal behavior (e.g., SA28 Non-Suicidal Self-Injury). Most commonly, the aim of parasuicidal action is to reduce negative emotions, such as tension, anxiety, and self-reproach, and/or to resolve an interpersonal difficulty. Though these self-harming behaviors are not intended to destroy one's life, they represent a maladaptive way of expressing distress and seeking help, and their seriousness should not be minimized. Since impulsive self-harm generally stems from emotional pain, in therapeutic work it is essential to help patients improve their affective language and other communication skills in order to reduce these behaviors.

Given that the highest suicide rate is recorded in youth populations [25 26], the PDM-2 devotes a specific section to suicidality in both of the sections on diagnosis in childhood and adolescence, including specific diagnoses of suicidality (SC27, SA27) that are classified among those included within mood disorders. These diagnostic categories overlap that of "Suicidal Behavior Disorder," as illustrated in Section III of the DSM-5. Nevertheless, for all S Axes (as applied in adulthood to old age), the PDM-2 highlights patients' subjective experiences within cognitive, affective, somatic, and relational patterns. The essential manifestation of suicidal behavior disorder is a suicide attempt, which is defined as a behavior that the individual has undertaken with at least some intent to die. According to the DSM-5 [2], the behavior may or may not lead to injury or serious medical consequences, because several factors can influence the outcome of the attempt (e.g., poor planning, lack of knowledge about the lethality of the chosen method, low intentionality or ambivalence, or the chance intervention by others after the behavior is initiated). In addition, it can be challenging to determine the degree of intent, as this may not be clearly acknowledged by the individual involved, also because of the common presence of dissociative symptoms that may be difficult both to recognize and to express [27-29].

According to the PDM-2, suicide attempts frequently occur in adolescents and young adults with various mental disorders; but they are also observed in youth with no specific pathology, particularly in certain cultural contexts (e.g., India, China [30-32]). Consequently, particular attention should be paid to young patients reporting suicidal ideations, behaviors, or attempts of any clinical manifestation, even though these may be difficult to correctly identify. The PDM-2 can guide clinicians in this crucial evaluation, for example by listing and illustrating the main affective states and cognitive patterns described by suicidal adolescents and young adults. Specifically, in addition to feeling sadness, sorrow, despair, detachment, and anger, suicidal patients may experience negative emotions about themselves, such as a devalued sense of self or reduced self-esteem, with feelings of failure, uselessness, incompetence, and unworthiness. Their inner experience may be one of a loss of life meaning and a feeling of being trapped in a suffering present, with no possibility of a better future. The suicidal act may seem to offer them an escape from an overwhelming, unmanageable life situation and to give devastated adolescents a feeling of mastery over their bodies and the lives they feel they have lost. Likewise, self-injury, which is frequently associated with suicidal attempts, may express a similar effort to regain control. Moreover, a failed suicide attempt may be experienced as yet another demonstration of ineptitude and thus may reinforce an adolescent's negative perception of the self. The somatic states of suicidal adolescents are mainly characterized by high levels of anxiety. Anxiety can be a proximal risk factor for the suicidal act and should be monitored attentively in at-risk adolescents. The PDM-2 describes the main relational patterns of suicidal adolescents, illustrating how relational dynamics characterized by rigidity, conflict, separation, lack of trust and acceptance, and incommunicability, as well as feelings of being different or rejected, can all explain the decision to act. In essence, suicidal behavior can be considered predominantly interpersonal, concerning not only oneself, but also significant others. It can thus be interpreted as a last option when all other attempts at communication have failed.

In addition to its section on adolescents, the PDM-2 also contains a dedicated section on childhood. Many clinicians tend to underestimate suicidal risk in childhood, because the idea that a child might choose suicide to escape unbearable pain is generally considered overwhelmingly tragic and unimaginable. In addition, there is widespread belief that children lack a sufficient cognitive understanding of the biological/scientific concept of death to contemplate suicide. Although this assumption is not empirically justified, it has led to a clinical and epidemiological underestimation of suicidal behavior

in this age group. By contrast, suicide is currently the fourth leading cause of death among young persons aged 10 to 14; for even younger children, it is likely to be underreported [33]. In fact, more than 12% of children aged 6 to 12, across both genders, report having had suicidal thoughts [26]. The PDM-2 notes, however, that there is a developmental sequence in the manner in which children think about and discuss death. In particular, four stages of the biological/scientific concept of death have been identified [34]: *universality* (the understanding that death must happen to all living things), *irreversibility* (the recognition that the dead cannot come back to life), *non-functionality* (the understanding that death is characterized by bodily processes ceasing to function), and *causality* (the understanding that death is ultimately caused by a breakdown of bodily function). Children under the age 5 do not recognize death as final, but instead think of it as reversible. Likewise, children between the ages of 5 and 9 tend to consider death temporary, although by age 7 they are thought to be cognitively able to understand death as irreversible and permanent. These stages of cognitive development may play a pivotal role in the assessment of suicidal risk in children. Consequently, the PDM-2 provides the clinically useful suggestion to consider developmental norms in the assessment of suicidality in childhood.

The manual also describes the affective states of suicidal children, which are characterized by hopelessness, anhedonia, impulsiveness, and high emotional reactivity. In addition, suicidal children may express feelings of omnipotence, manifested in a need for power and control over others, as well as the opposite – profound feelings of hopelessness and helplessness. Their thoughts and fantasies may include obsessive ruminations about painful relationships with family members and peers, desire for retaliation and revenge, and curiosity about the death of people and/or animals; they may also ask questions about what happens after death. The somatic states of suicidal children may also relate to mood and physiological responses to trauma and abuse (if present). Finally, the PDM-2 points out the importance of the relationship context in understanding children's suicidal behavior, with particular regard to attachment style, familiarity, abuse, lack of parental warmth, bullying, and rejection by peers.

Suicidal risk and psychological experiences that may require clinical attention

The PDM-2 pays particular attention to psychological experiences that may derive from ethnic, cultural, linguistic, religious, and political factors, as well as from issues of sexual orientation and gender incongruence. All of these experiences, in themselves, are "non-pathological". Nevertheless, living in stigmatizing environments may undermine one's psychological and relational well-being by routinely subjecting them to experiences of social oppression, stereotyping, "minority stress" (i.e., psychological stress derived from belonging to a minority [35]), and internalized homophobia (i.e., the mental condition of believing same-sex sexual orientation to be wrong, sick, or inferior, while simultaneously experiencing oneself as having that orientation). It is not uncommon for patients living in minority conditions to resort to suicide as a last tragic solution to escape the overwhelming experience of minority stress [36-39]. Consequently, in the diagnostic assessment of such patients, suicidal risk should be constantly monitored. By describing minority conditions along standardized subjective experience areas (i.e., affective states, cognitive patterns, somatic states, relationship patterns, and the subjective experiences of the therapist), the PDM-2 provides a guide for clinicians to assess and manage suicidal risk in such at-risk populations.

The role of personality organization and patterns

Another innovation provided by the PDM-2 is its emphasis on the importance of personality constellations in the assessment of an individual's symptoms [40]. Such constellations are particularly important in assessments of suicide risk, which, as already mentioned, represents a cross-sectional diagnostic entity. The long-term prediction of suicide according to personality disorders represents an important challenge for clinicians [4 41], and some studies have indicated that specific personality traits can be important predictors of suicide [6 42]. Moreover, contextualizing suicidal behaviors in a personality diagnosis can promote clinical case formulation by helping clinicians understand an individual's difficulties in the broader context of his/her personality functioning. Such an understanding can inform treatment planning to better prevent suicide.

In the P Axis of the PDM-2, suicidal ideation, behaviors, and attempts represent possible symptoms of both borderline and psychotic personality organization at all ages [a]. In fact, in patients with borderline personality organization, suicidality may be explained by their typical identity diffusion, their prevalence of primitive defensive operations, and their difficulties with affect and impulse regulation. Such individuals may engage in suicidal or parasuicidal behaviors when they become unable to tol-

[a] With regard to adolescence and childhood, the PDM-2 refers to *emerging personality patterns* because the personality is still under development in these age ranges.

erate the emotional burden that arises from significant relationships. Furthermore, individuals with psychotic organization may be at risk of suicide due to significant deficits in their capacity for reality testing and forming a coherent sense of self, manifested in their consistently maladaptive ways of dealing with feelings about themselves and others.

In the context of personality patterns, the meaning of suicidal intent can be understood along the *anaclitic–introjective* (or *relatedness vs self-definition*) polarity proposed by Blatt and colleagues [43-45]. According to this model, personality evolves through dialectic interaction between two fundamental psychological coordinates: *anaclitic* (or *relatedness*) and *introjective* (or *self-definition*). More specifically, relatedness and self-definition are involved in the development of the capacity to establish and maintain (respectively): reciprocal, meaningful, and satisfying relationships; and a coherent, realistic, differentiated, and positive sense of self. These two developmental processes influence each other. High-level personality organization is characterized by feelings of satisfaction and well-being on both poles of the spectrum; on the contrary, personality pathology is characterized by excessive and defensive emphasis in one of the two dimensions, at the expense of the other. Consequently, among personality syndromes that fall mainly on the anaclitic pole (e.g., dependent, borderline, or histrionic personalities), suicidal intent may have greater relational significance and may emerge in reaction to loss or rejection, accompanied by feelings of emptiness, inadequacy, and shame. On the other hand, in patients with personality syndromes that fall mainly on the introjective pole (e.g., narcissistic, antisocial, or obsessive-compulsive personalities), feelings of guilt, self-criticism, and perfectionism may increase the risk of suicidal intent through the tendency to isolate oneself and not ask for help.

Suicidality and mental functioning domains

The assessment of mental functioning (M Axis) represents an additional PDM-2 diagnostic tool to evaluate suicide risk. An understanding of patients' basic mental functioning can provide therapists with useful insight into the development of symptoms and help them capture the complexity and individuality of each patient, especially when dealing with the intricacies of suicidal behavior. By systematizing and operationalizing numerous dimensions of mental functioning, the M Axis helps clinicians flesh out – at a granular level – the mechanisms that contribute to and shape suicidal ideation, behaviors, and attempts in each patient. While the evaluation of suicidality may benefit from a complete assessment of all mental capacities, some mental functions are more directly involved in this assessment. Specifically, suicidality may be explained by dysfunctions in the following mental capacities: (2) *capacity for affective range, communication, and understanding*; (7) *capacity for impulse control and regulation;* (9) *capacity for adaptation, resiliency, and strength*; and (12) *capacity for meaning and purpose*. Thus, suicidal persons may be unable to symbolize affectively meaningful experiences (i.e., to represent such experiences mentally rather than in somatic or behavioral form) and to appropriately verbalize affective states – all difficulties that should be carefully considered by clinicians in choosing the proper treatment [46 47]. They may show unmodulated expressions of impulses (impulsivity) with a concomitant inability to tolerate frustration. This may lead to a loss of ability to adjust to unexpected events and changing circumstances and to cope effectively and creatively when confronted with uncertainty, loss, stress, and challenge. In addition, individuals with suicidal intent may have lost the ability to construct a personal narrative that gives coherence and meaning to personal choices, a sense of directedness and purpose, and a concern for succeeding generations that imbues one's life with meaning.

Conclusions

Suicidal risk is a central concern and serious challenge for clinicians assessing patients with a wide variety of psychopathological profiles. Suicidal ideation and behaviors may be predictable or unpredictable, according to several variables that require careful assessment. The PDM-2 provides a valid cross-sectional prospective on suicidality, focusing on personality patterns, related social and emotional capacities, unique mental profiles, and personal experiences of symptoms. When assessing a complex phenomenon such as suicidality, it can be more important for clinicians to consider *who one is* rather than *what one has* [12]. Accordingly, the comprehensive approach to diagnosis provided by the PDM-2 can enable clinicians to capture the subjective experiences of suicidal patients, allowing for more effective strategies to be developed for the early assessment of suicidal behavior and the preventive treatment of suicide attempts.

Conflict of interest

The Authors have no conflict of interest to declare.

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