Designing DSM-6: Lessons from the PDM-3

Seven working solutions to psychiatry's core diagnostic challenges

KIMBERLY (KIMMIE) GILBERT

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Here is a sentence from a psychiatric policy document of 2026:

> "The committee aims to develop a framework for integrating transdiagnostic dimensions into the DSM nosology."

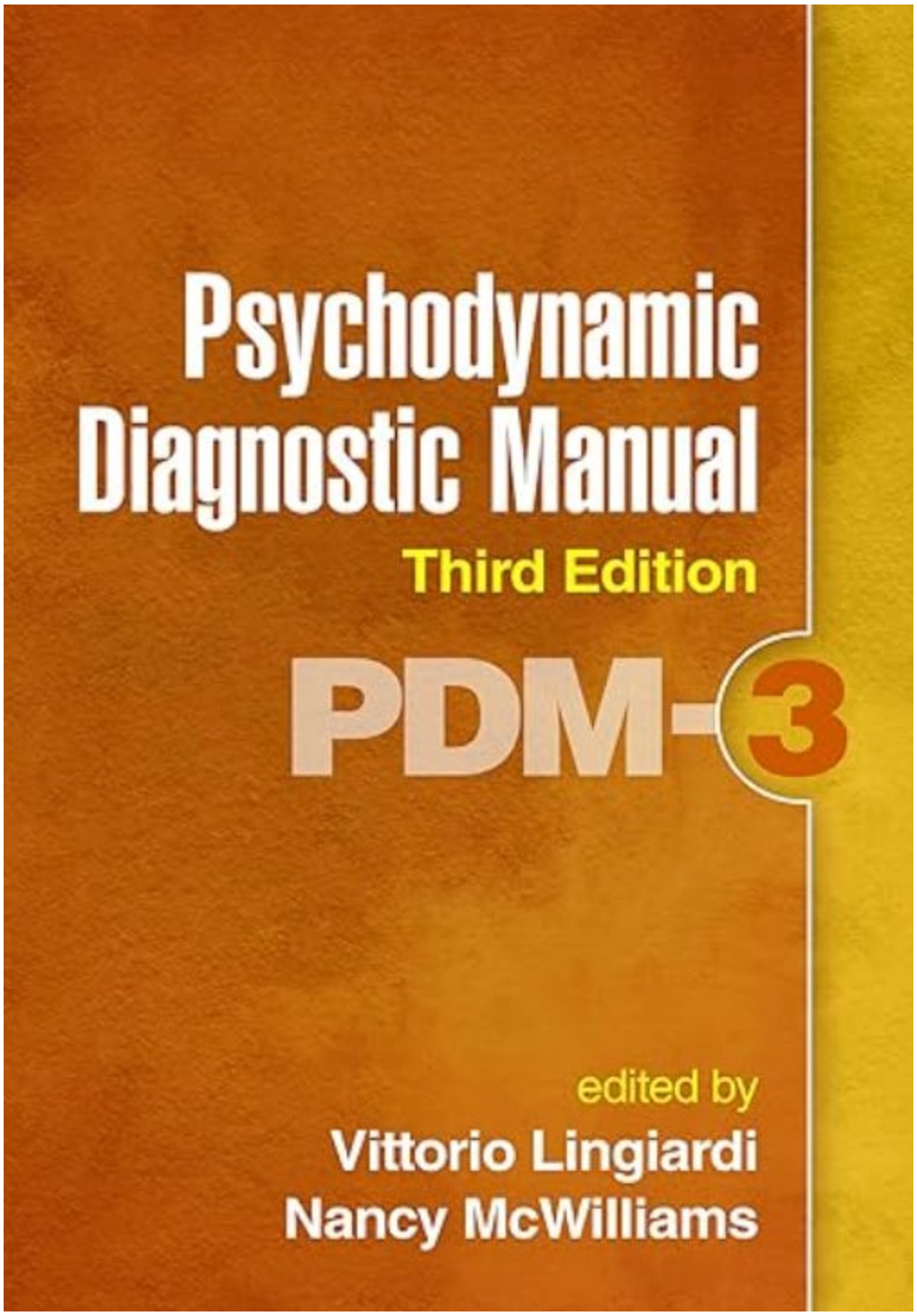
And here is a sentence from a manual published the same year, which the policy document never cites:

> "Each patient is assessed across 13 mental functioning capacities, each rated on a 5-point scale, organized into four domains, and summed to yield an overall level of mental functioning mapped to seven tiers from healthy through psychotic."

The first sentence is an aspiration. The second is a working system. The distance between them is the subject of this essay.

In January 2026, the *American Journal of Psychiatry* published a commentary by Oquendo et al. (2026) outlining the strategic roadmap for the next DSM. The Future DSM Strategic Committee identified familiar problems: the manual is too categorical, too atheoretical, too focused on reliability over validity, too disconnected from biology, too Western, too reified, and too indifferent to the subjective experience of the people it describes.

What struck me wasn't the diagnosis of DSM's ailments. Those are well-known. It was the degree to which the proposed solutions overlap with innovations already elaborated and empirically tested in a manual the committee does not engage: the *Psychodynamic Diagnostic Manual, Third Edition* (PDM-3; Lingiardi & McWilliams, 2026).



To be fair, there are reasons the committee might have chosen not to engage. The PDM comes from a psychodynamic tradition that many in mainstream psychiatry view with skepticism. Its evidence base, while growing, does not meet the large-scale field trial standards the DSM

demands. And citing it could imply an endorsement that the committee is not prepared to make. These are understandable institutional calculations. But the question is whether they are wise ones, given the degree of overlap between the committee's stated goals and the PDM-3's working solutions.

I want to be clear upfront about four things.

First, I am not suggesting the DSM should become psychodynamic. The DSM serves purposes (insurance billing, epidemiological research, cross-disciplinary communication at massive scale) that require a different architecture than what the PDM provides.

Second, the PDM-3 has real limitations. It takes longer to learn, demands more clinical experience to use reliably, and its interrater reliability for some constructs has not been established at the level the DSM rightly requires. Its empirical base, while growing rapidly, is thinner.

Third, and most importantly: the DSM operates under structural constraints the PDM does not face. It must work for a psychiatric resident doing a 30-minute intake, a primary care physician screening for depression, an insurance coder determining reimbursement, and an epidemiologist running a population study, all simultaneously, across dozens of languages and health care systems. These are not excuses for the DSM's shortcomings; they are real engineering constraints that any proposed improvement must take seriously. Comparing the two without acknowledging this asymmetry would be intellectually dishonest.

Fourth, and this matters: the PDM-3 is not the only tradition working on these problems. The Hierarchical Taxonomy of Psychopathology (HiTOP) has developed a sophisticated dimensional taxonomy of psychopathology. The Research Domain Criteria (RDoC) has pushed for transdiagnostic, neurobiologically informed constructs. The Alternative Model for Personality Disorders (AMPD), already in Section III,

represents a genuine advance in dimensional personality assessment. The committee is almost certainly drawing on some of these streams. My argument is not that the PDM-3 is the sole source of useful ideas, but that it has worked out certain clinical problems—particularly around functional capacities, subjective experience, and developmental context—in more operational detail than these other frameworks have, and that this work deserves a seat at the table alongside them.

I should also note that the DSM has not been standing still. DSM-5 introduced dimensional measures, the AMPD, the Cultural Formulation Interview, and cross-cutting symptom assessments. The Oquendo committee's roadmap is itself evidence that mainstream psychiatry is actively grappling with many of the limitations I describe here. The question is not whether the field recognizes these problems. It clearly does. The question is whether, in developing solutions, it is drawing on the full range of available thinking.

With those caveats in place: across six developmental sections from infancy through old age, the PDM-3 has operationalized approaches to many of the problems the Future DSM Strategic Committee has identified as priorities. These approaches have not been validated at DSM scale. But they have been worked out in enough clinical and empirical detail that ignoring them because they come wrapped in psychodynamic language would be a missed opportunity.

Seven areas where this has already happened. Imperfectly, but substantively.

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1. Dimensionality: Capacities, Not Just Symptoms

The Oquendo committee identifies DSM's categorical structure as a core limitation and proposes integrating "transdiagnostic dimensions,"

building on the Cross-Cutting Dimensional Symptom measures that were introduced in DSM-5's Section III but marginalized by their placement.

The PDM-3 has operationalized this. Every patient, at every developmental stage from birth through old age, is assessed across 13 mental functioning capacities rated on a 5-point scale, organized into four domains: Cognitive and Affective Processes, Identity and Relationships, Defense and Coping, and Insight and Self-Direction. Scores are summed (range: 13–65) to yield an overall level mapped to seven tiers (Lingiardi & McWilliams, 2026, Chapter 13).

The key innovation: these dimensions are not symptom dimensions. They are functional capacities: the ability to mentalize, regulate affect, maintain a coherent identity, use adaptive defenses, experience one's body as part of oneself. The DSM-5's Cross-Cutting measures ask whether a patient endorses depression or anxiety. The PDM-3's M Axis asks whether a patient can identify their emotions, distinguish them from bodily sensations, modulate their intensity, and communicate them appropriately. One approach counts symptoms. The other maps the psychological infrastructure that generates and maintains them. It is the difference between noting that a bridge has cracks and understanding the structural engineering that explains why.

HiTOP also moves beyond categories toward dimensions, and it does so with impressive psychometric rigor. But its dimensions describe spectra of psychopathology—what kind of problems a patient has. The PDM-3's M Axis describes functional capacities—what the patient can and cannot do psychologically. These are complementary, not competing. A comprehensive dimensional system could use HiTOP's spectra to characterize the pattern of dysfunction and PDM-style capacities to characterize the depth of it.

Does the capacity-based approach produce better outcomes? The evidence is accumulating. Muzi et al. (2021), studying patients with

eating disorders assessed with both the SCID-5 and the PDM-based Psychodiagnostic Chart, found that higher levels of mental functioning, identity integration, and mentalizing capacity predicted better outcomes, even after controlling for baseline symptoms. Critically, as the PDM-3 summarizes: “unlike DSM-5 categories, which did not have an impact on symptom change,” the PDM functional capacities did predict who improved (Lingiardi & McWilliams, 2026, p. 8). Hinrichs et al. (2019) found that PDC-assessed personality organization in 88 patients was significantly related to defensive functioning and object relations quality, and Cain et al. (2024) provided further multimethod validity evidence.

These are modest studies, not field trials, and they come mostly from psychodynamically oriented clinical settings. Whether PDM-based functional capacities would predict outcomes with the same power in primary care, community mental health, or large epidemiological samples remains an open question. But the studies point in a consistent direction: assessing functional capacities captures something that symptom checklists miss, something that predicts who gets better. The scalability question is real, but it is a reason to test these ideas more broadly, not to ignore them.

The core takeaway: Transdiagnostic dimensions worth integrating into a nosological system should describe capacities, not just symptoms. Capacities predict prognosis, guide treatment selection, and tell you what kind of therapeutic relationship a patient can tolerate.

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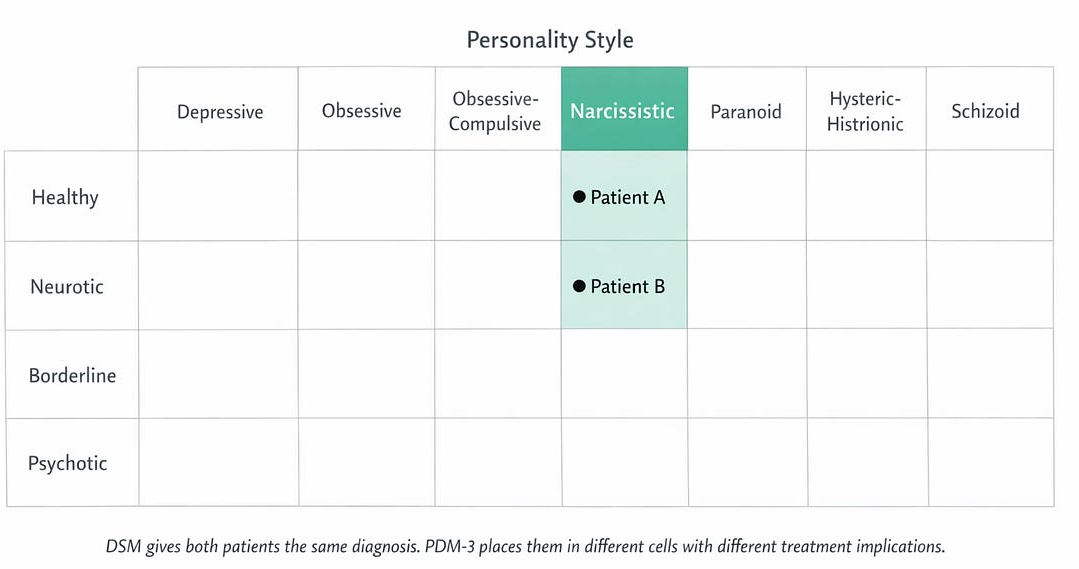
2. Severity × Style: Two Dimensions for Personality, Not One

The PDM-3 separates *level of personality organization* from *personality style*. Any style, whether narcissistic, obsessive, dependent, or paranoid,

can exist at any level: healthy, neurotic, borderline, or psychotic (Lingiardi & McWilliams, 2026, Chapter 12).



DSM gives both patients the same diagnosis. PDM-3 places them in different cells with different treatment implications.

Two patients walk into your office. Both are narcissistic. Patient A is a successful surgeon who needs admiration and gets depressed without recognition, but maintains stable relationships, has a coherent identity, and can reflect on patterns you point out. Patient B is a 22-year-old who oscillates between grandiosity and suicidal despair, devalues every supervisor within weeks, and experiences your empathy as proof you're too stupid to see how special he is.

The DSM gives both patients the same diagnosis. The PDM-3 describes Patient A as narcissistic at a neurotic level (high-functioning/exhibitionistic subtype, per the empirically derived subtypes of Russ et al., 2008) and Patient B as narcissistic at a borderline level (grandiose/malignant subtype). This distinction immediately tells you that Patient A can benefit from interpretive, insight-oriented therapy, while Patient B needs structured treatment with explicit contracting around self-destructive behavior. Same *style*, radically different treatment *plan*.

The DSM's Alternative Model for Personality Disorders (AMPD) gestures toward this with its Level of Personality Functioning Scale, a genuine advance that deserves credit. But it remains in Section III, and it does not crosscut personality types the way the PDM-3's framework does.

A caveat: reliably rating "level of personality organization" requires clinical experience. Any DSM adoption would need tighter operationalization, probably using instruments like the Structured Interview of Personality Organization–Revised (STIPO-R; Clarkin et al., 2019), which the PDM-3 recommends for this purpose.

The core takeaway: The *type* of personality problem and the *severity* of personality dysfunction are clinically independent. Both must be assessed. The DSM could adopt this architecture without endorsing a single psychodynamic hypothesis.

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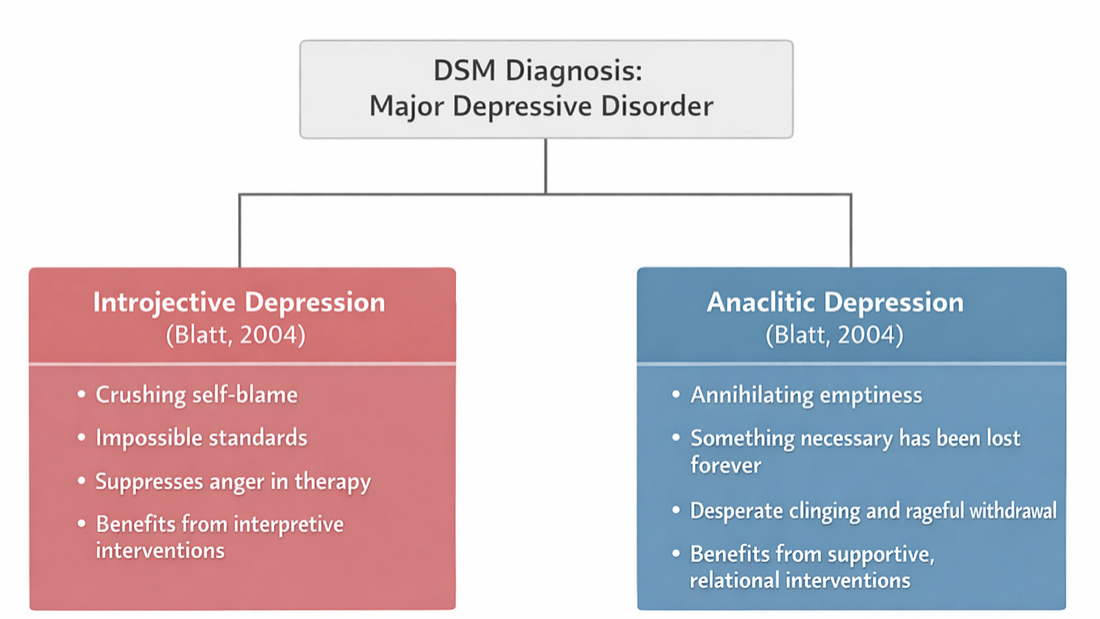
3. Subjective Experience: The Missing Axis

The Oquendo paper does not mention subjective experience. Not once.

The PDM-3 devotes its largest chapters, the S Axes at every developmental stage, to describing what each disorder *feels like*: characteristic affective states, cognitive patterns, somatic experiences, relational configurations, and expectable clinician emotional responses.

Consider two patients meeting DSM criteria for major depressive disorder. One experiences depression as crushing self-blame, holds herself to impossible standards, and in therapy idealizes the clinician while suppressing anger. The other experiences depression as annihilating emptiness, feels something necessary for survival has been permanently lost, and oscillates between desperate clinging and rageful withdrawal. Blatt (2004, 2008) distinguished these empirically as introjective and anaclitic depression. This is a distinction the PDM-3

integrates, noting that these subtypes “respond differently to different forms of treatment” (Lingiardi & McWilliams, 2026, Chapter 8, p. 485). The DSM sees one disorder. The PDM-3 sees two experiences requiring different responses.



The PDM-3 also treats the clinician’s emotional response as diagnostic data. Colli et al. (2014), in the *American Journal of Psychiatry*, found that specific personality configurations reliably elicit specific therapist responses. The manual integrates these findings throughout: clinicians working with narcissistic patients experience “boredom, detachment, distraction… and a feeling of invisibility” (Lingiardi & McWilliams, 2026, p. 689); with paranoid patients, countertransference mirrors “feelings that the paranoid patient disowns and projects, such as fear, helplessness, and anger” (p. 692); with borderline-level patients, clinicians experience “fear, confusion, helplessness, punitiveness, or rage” alongside “powerful rescue fantasies” (pp. 660–661). The Therapist Response Questionnaire (Betan et al., 2005), which the PDM-3 describes, was written without jargon so “clinicians of any theoretical orientation can use the instrument without bias” (Lingiardi & McWilliams, 2026, p. 737).

Not every DSM user can or should assess countertransference. But systematically describing the *experiential signature* of each disorder would be an enormous advance in clinical utility.

The core takeaway: Two patients with identical DSM diagnoses can have radically different subjective experiences that call for different treatments. A diagnostic manual that ignores this is leaving clinical information on the table.

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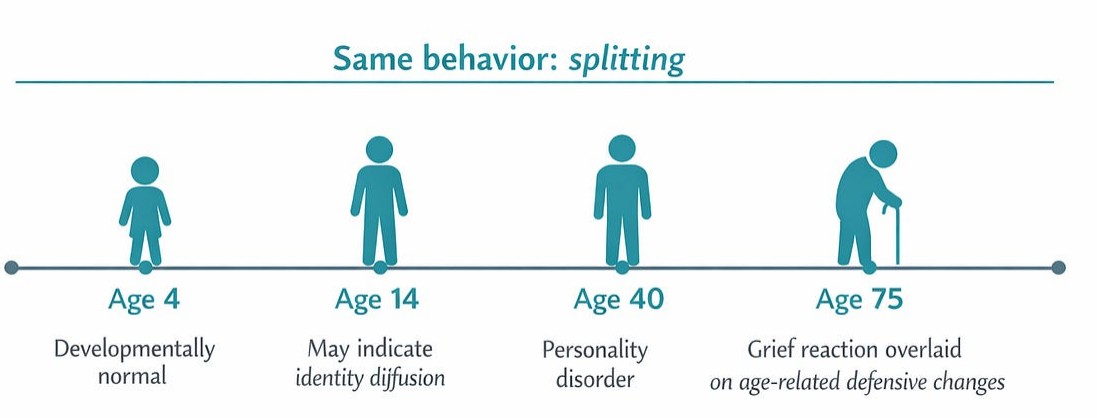
4. Development as Architecture, Not Afterthought

The Oquendo committee mentions "developmental factors" as one area to integrate. The PDM-3 makes development the *structural principle* of the entire manual: six developmental parts (Infancy 0–3, Childhood 4–11, Adolescence 12–19, Adulthood, Older Adults 70+, Assessment), each with its own M, P, and S Axes calibrated to context, with age-specific guidelines for every capacity (Lingiardi & McWilliams, 2026, Chapters 1–20).

Imagine a physician's manual that described heart disease identically for a 5-year-old and an 80-year-old. We would never accept that in cardiology. But it is essentially what the DSM does with the mind. A 4-year-old who uses splitting is developmentally normal. A 14-year-old who uses splitting may have identity diffusion. A 40-year-old who uses splitting has a personality disorder. A 75-year-old who newly begins splitting after losing a spouse may be experiencing grief overlaid on normal age-related reduction in defensive flexibility (Lingiardi & McWilliams, 2026, Chapter 17, pp. 913–914).



This architecture is producing empirical returns. Tanzilli et al. (2024), using the PDM-based Psychodiagnostic Chart for Adolescents with 100 adolescents, identified four personality subtypes each related to distinct levels of mental functioning. The PDM-3 describes this as "the first empirical validation of Kernberg's (1967) system for personality pathology in youth" (Lingiardi & McWilliams, 2026, Chapter 21, p. 1029).

The core takeaway: The meaning of a symptom cannot be evaluated without developmental context. A manual that takes this seriously as an organizing principle produces richer formulations and opens new empirical possibilities.

Development is one kind of context that shapes diagnostic meaning. Culture is another.

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5. Culture Woven In, Not Bolted On

The Oquendo committee establishes a dedicated cultural determinants subcommittee, a welcome move, building on the genuine advance of DSM-5's Cultural Formulation Interview. But the framing still treats culture as a *factor to be added* to an existing system.

The PDM-3 weaves cultural considerations into each chapter. At every developmental stage, sections on “Psychological Experiences That May Require Clinical Attention” cover minoritized groups, gender incongruence, and contextual factors, not as appendices but as integral clinical realities (Lingiardi & McWilliams, 2026, Chapters 6, 10, 15, 20). The P-Axis chapter warns explicitly: “individuals from cultures unfamiliar to the interviewer can be misunderstood as having personality disturbance” and “the concepts of normality and pathology are not fixed and universal” (Lingiardi & McWilliams, 2026, p. 654).

The PDM-3 was itself developed primarily by Western clinicians, and its psychodynamic framework carries its own assumptions. Genuine decentering remains aspirational. But embedding cultural considerations within disorder descriptions rather than sequestering them in a separate chapter is a design principle the DSM could adopt regardless of orientation.

The core takeaway: Culture is not a modifier applied after diagnosis. It shapes what counts as pathology in the first place. The architecture of a manual should reflect this.

A third kind of context, beyond development and culture, also shapes meaning: the body itself.

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6. The Body in the Mind

The PDM-3 adds a new mental functioning capacity: “Bodily Experiences and Representations,” encompassing body schema, proprioception, interoception, body image, and the integration of somatic experience with psychological selfhood, assessed from infancy through old age (Lingiardi & McWilliams, 2026, Chapter 13, pp. 718–720).

A patient with anorexia insists she is overweight despite dangerous emaciation. The DSM records "disturbance in body image." But *what kind*? Perceptual distortion? Interoceptive failure? Fragmentation of bodily self-experience? Or a psychotic-level conviction, which the PDM-3 explicitly identifies, noting that such patients may be "usefully understood as functioning in the psychotic range" (Lingiardi & McWilliams, 2026, p. 661)? These are clinically distinct presentations requiring different interventions.

The Oquendo committee's Biomarkers Subcommittee focuses on the body viewed from outside: laboratory tests, wearable data. The PDM-3's Capacity 4 captures the body viewed from inside, as *experienced*. A patient who cannot distinguish emotional distress from physical pain has a disability no biomarker will capture.

The core takeaway: The experienced body, not just the measured body, deserves systematic assessment. The DSM has no framework for this.

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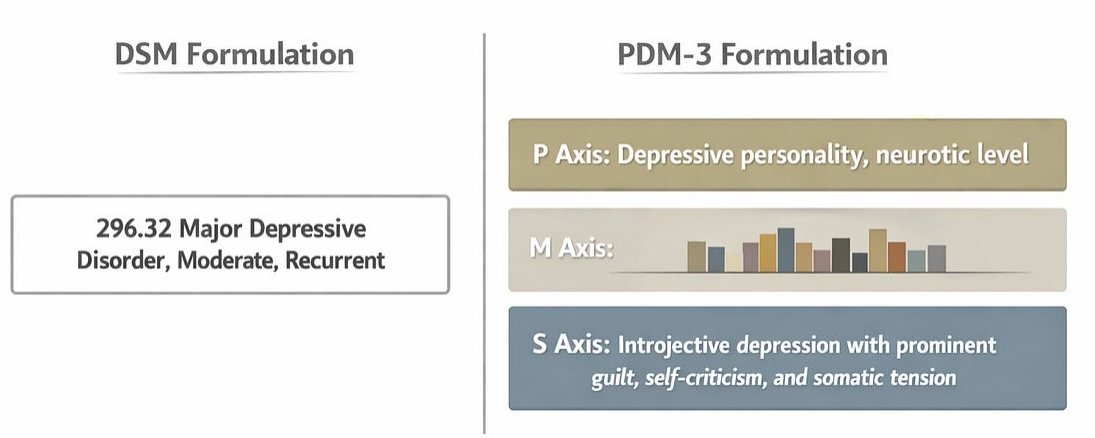
7. Anti-Reification by Design

The Oquendo committee identifies reification as a risk and proposes transdiagnostic dimensions as a partial remedy. The PDM-3 addresses reification not as a communication problem but as an *architectural* one.

By assessing every patient on three independent axes (personality style and level, mental functioning across 13 capacities, and subjective experience of symptoms) the PDM-3 makes it structurally impossible to reduce a person to a single label. Two patients with the same symptom pattern will have different M-Axis profiles and different P-Axis configurations. The formulation is necessarily individualized.



The PDM-3 calls itself a "taxonomy of people" rather than a "taxonomy of diseases" (Lingiardi & McWilliams, 2026, Chapter 21, p. 1030). Clinicians across orientations have endorsed this. Bornstein and Gordon (2012) and Gordon et al. (2017) found that diverse psychotherapists evaluated the PDM favorably regardless of theoretical orientation, and further studies found that both experienced and trainee clinicians rated it as "the easiest and most useful for assessing personality functioning, as compared to other diagnostic systems" (Gordon et al., 2016; Huprich et al., 2015; Nelson et al., 2017).

A system that gives you one label for one patient produces reification no matter how many disclaimers you attach. A system that gives you a multidimensional profile makes reification difficult by design.

The core takeaway: Reification is not solved by education. It is solved by architecture. The PDM-3 demonstrates what anti-reification architecture looks like in practice.

The Hard Problem: Can One System Do Both?

Everything I have described raises an obvious objection: can a single diagnostic system realistically serve both the administrative needs of

health care systems and the clinical depth these ideas require?

Probably not in a single layer. But the DSM already has a layered architecture. It has Section II (the categorical diagnoses everyone uses) and Section III (dimensional models, emerging measures, the AMPD). The problem is not that layers don't exist. The problem is that Section III is treated as optional, under-taught, and effectively invisible in clinical practice.

What the PDM-3 demonstrates is what a well-developed "deeper layer" could look like. Not every clinician would use it. A primary care physician screening for depression does not need to assess 13 functional capacities. But a psychiatrist formulating a treatment plan for a complex patient does, and the current DSM gives that psychiatrist almost nothing to work with beyond symptom checklists.

But I want to push myself here, because the scalability objection deserves more than a concession followed by a pivot. The gap between "this works in a psychodynamically-oriented residential setting with experienced clinicians" and "this works for a psychiatric resident doing a 30-minute intake" is not just a matter of running larger studies. It is a design problem. The PDM-3's richness is partly a function of the fact that it does not have to work at scale. It can assume a clinician with years of training, time for extended assessment, and fluency in concepts like mentalization and defensive organization. The DSM cannot assume any of that, and any proposal that requires it will fail the same way Section III has failed: by being theoretically admirable and practically ignored.

So what would a PDM-informed deeper layer actually look like if it had to survive contact with real-world clinical settings?

Here is one possibility. Section II stays roughly as it is: categorical diagnoses, organized for administrative efficiency, used for billing and epidemiology and primary care screening. No one is pretending these

categories carve nature at its joints, but they serve real purposes and replacing them wholesale is neither feasible nor necessary.

Section III becomes something more ambitious than its current grab bag of emerging measures. It becomes a structured formulation layer with three components:

First, a functional capacity profile. Not all 13 PDM capacities—that is too many for routine use. But a core set, perhaps five or six, selected for their demonstrated predictive validity: affect regulation, mentalization, identity coherence, defensive functioning, and relational capacity. Each rated on a brief, anchored scale with behavioral descriptors clear enough that a second-year resident could use them with reasonable reliability after a training module. Instruments like the STIPO-R and the Operationalized Psychodynamic Diagnosis-3 (OPD-3) already provide models for how to operationalize these constructs. The question is whether briefer versions can maintain adequate psychometric properties—a question that can only be answered by actually testing them, which means someone has to build and fund the field trials.

Second, a severity dimension that crosscuts personality style. The AMPD's Level of Personality Functioning Scale already does a version of this. The PDM-3's contribution is showing what it looks like when severity is systematically crossed with style across the full range of personality configurations, not just the handful the AMPD currently covers. A merged framework could use the AMPD's operationalization of severity (which has stronger reliability data) with the PDM-3's broader typology of styles (which has stronger clinical utility data).

Third, experiential descriptors. For each major diagnostic category in Section II, a brief, structured description of common subjective presentations—not as an exhaustive phenomenology, but as a clinical orientation. What does this disorder typically feel like? What relational patterns does it tend to produce? What should the clinician expect to

feel? These could be written in accessible language, without psychodynamic jargon, and formatted as brief reference material rather than extended narrative. The PDM-3's S-Axis chapters provide the raw material; the task would be distilling them into something a busy clinician would actually read.

This is not the PDM-3. It is a translation of the PDM-3's most empirically grounded and clinically useful innovations into a format compatible with the DSM's institutional constraints. It would require investment: developing brief assessment tools, testing their reliability across settings, training clinicians to use them, and—critically—integrating them into residency curricula and clinical workflows rather than parking them in an appendix.

Would this be expensive and difficult? Yes. But the committee is already proposing to restructure the DSM around transdiagnostic dimensions, integrate biomarkers, develop culturally informed assessment tools, and rename the manual. None of that is cheap or easy either. The question is not whether ambitious changes are feasible. It is which ambitious changes are most likely to improve clinical care.

The realistic proposal is not to replace DSM categories with PDM formulations, but to build a more robust version of what Section III was always supposed to be: a clinically rich, dimensionally organized, developmentally informed layer that experienced clinicians can use for formulation, treatment planning, and outcome tracking. The PDM-3's architecture offers a working model for what that layer could contain. Whether the specific constructs survive large-scale reliability testing is an empirical question that deserves to be asked rather than preemptively dismissed.

What This Means for the Person in the Chair

A 16-year-old girl with a history of sexual abuse, chaotic attachment, self-harm, emotional volatility, and chronic emptiness walks into an emergency room. The DSM gives her one of a handful of labels, probably borderline personality disorder if the clinician will diagnose it in an adolescent, or major depressive disorder with "behavioral disturbance" if they won't. Either way, the label tells the next clinician almost nothing about who she is, what she needs, or what kind of therapeutic relationship she can tolerate.

The PDM-3 would describe her as having an emotionally dysregulated personality at a borderline level of organization, with specific impairments in mentalization, affect regulation, identity integration, and bodily experience. It would note complex posttraumatic features with dissociative elements. It would describe her subjective experience: terror of abandonment, inner emptiness, desperate need for someone to help regulate states she cannot manage alone. It would predict that her clinician will feel overwhelmed, rescue-driven, and eventually depleted. And it would tell her that recognizing this is not a clinical failure but a diagnostic data point, consistent with the findings of Betan et al. (2005) and Colli et al. (2014).

That formulation doesn't just describe a patient. It *is* a treatment plan. It tells you what to target, what to expect, what will go wrong, and why. The DSM formulation tells you what billing code to use.

The committee's proposed name change, from "Diagnostic and Statistical Manual" to "Diagnostic and Scientific Manual," signals an aspiration toward scientific credibility. Science means following evidence wherever it leads, including into the consulting rooms of clinicians whose theoretical tradition you may not share.

The question isn't whether the DSM should become the PDM. It shouldn't. The question is whether the patients who depend on the DSM deserve a manual that has drawn on the best available thinking about human suffering, regardless of where that thinking originated.

Whether the committee has chosen not to engage with the PDM-3, or simply hasn't encountered it, the result is the same: a set of working solutions sitting unused while the problems they address are being treated as unsolved.

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