Ricerca Psicoanalitica | pISSN 1827-4625 | Year XXXVII, n. 1, 2026
doi:10.4081/rp.2026.1153

The *Psychodynamic Diagnostic Manual* (PDM-3): restoring subjectivity to the centre of diagnostic formulation

Laura Muzi,* *Vittorio Lingiardi***

Abstract. – This article outlines the main innovations introduced in the new edition of the *Psychodynamic Diagnostic Manual* (PDM-3), with a specific focus on its diagnostic approach in adulthood. Following an overview of the manual's history, structure, and main contents, we describe the key principles guiding the assessment of levels of personality organization and personality styles or disorders (P Axis), with a specific focus on masochistic (self-defeating) personalities. We then examine the assessment of the profile of mental functioning (M Axis), paying particular attention to the domains of bodily experiences and representations – newly included in this edition – and to the capacity to explore one's inner life. Next, we discuss symptomatic patterns and the subjective experience of symptoms (S Axis), using the updated section on eating and feeding disorders as an illustrative example of the innovations introduced. Finally, we address the subjective experience of collectively relevant phenomena, such as climate change, wars, and pandemics, as presented in the new section devoted to "psychological experiences that may require clinical attention".

Key words: *Psychodynamic Diagnostic Manual*, psychoanalytic diagnosis, personality, mental functioning, psychopathology.

The PDM diagnostic approach: an introduction

If psychoanalytic diagnosis is a long journey, its beginning may be traced to Freud (1901), who, in describing the formation of Dora's aphonia symptom, wrote: "Shall I now assert, therefore, that in every case of periodic aphonia one must diagnose the existence of a periodically absent loved person? That is certainly not my opinion" (p. 333). Conversely, he clarified that the symptom has "a psychological meaning, a sense" that is neither

*Associate Professor of Clinical Psychology, University of Perugia, Italy.
E-mail: laura.muzi@unipg.it

**Full Professor of Dynamic Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome, Italy. E-mail: vittorio.lingiardi@uniroma1.it

intrinsic nor invariable, but "may be different in each case according to the nature of the repressed thoughts struggling for expression" (*ibid*.). If diagnosis is a *mapping of psychic functioning*, Freud's lesson teaches us how essential it is to take into account multiple dimensions – conscious and unconscious, implicit and explicit, individual and relational, descriptive and functional, healthy and pathological – thus providing an accurate description of the individual's most characteristic cognitive, affective, interpersonal, and behavioural features. A necessary "torment", to use a Jaspersian expression (Lingiardi, 2018), in order not to stop at the immediate appearance of observable signs and symptoms. Rather, any diagnostic process should be able to grasp the complexity of clinical phenomena (*functional* understanding) while relying on reliable and pragmatic criteria (*descriptive* understanding). It must also be capable of integrating *idiographic* knowledge – addressing the specificity of the individual in his or her uniqueness and irreducibility (from ἴδιος, "one's own", "particular", "specific", and γράφειν, "to describe", "to represent") – with *nomothetic* knowledge, which seeks to identify general laws of functioning (from νόμος, "law", "norm", "rule", and τίθημι, "to establish", "to institute") and situates the person within a diagnostic category.

The *Psychodynamic Diagnostic Manual*, now in its third edition (PDM-3; Lingiardi & McWilliams, 2025a), pursues precisely this aim: to maintain a dialectical tension between a psychodynamic approach to diagnosis – which, particularly through case formulation, seeks to understand and articulate the characteristics of psychic functioning (defenses, resources, level of personality organization, subjective experience of symptoms, etc.), situating them within the relational matrix and the patient's history – and the psychiatric classificatory tradition, currently represented by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association, 2022), the *International Classification of Diseases* (ICD-11; World Health Organization [WHO], 2019), and the more recent *Hierarchical Taxonomy of Psychopathology* (HiTOP; Kotov *et al.*, 2017). The first edition of the *Psychodynamic Diagnostic Manual*, coordinated by Stanley Greenspan, Robert Wallerstein, and Nancy McWilliams (PDM Task Force, 2006), was published at a time when an atheoretical, descriptive, and symptom-oriented approach to mental disorders dominated the field of diagnosis. By contrast, the "PDM project" aimed to provide clinicians with a diagnostic manual grounded in both clinical literature and empirical research, one that would respect – while also disciplining – the subjectivity of both patient and therapist. The second edition (PDM-2), edited by Vittorio Lingiardi and Nancy McWilliams (2017), and the recently published third edition (PDM-3; Lingiardi & McWilliams, 2025a), despite numerous innovations, maintain the same objectives: the PDM represents the most

comprehensive nosography based on a psychodynamic diagnostic approach and, departing from descriptive and atheoretical taxonomies, seeks to provide clinicians with information useful for planning truly patient-tailored treatment (Horwitz *et al.*, 1998; Norcross & Wampold, 2018). Indeed, the *American Psychological Association Guidelines on Evidence-Based Psychological Practice in Health Care* (2021) suggest that "different clinical presentations often require different approaches". In other words, any form of psychotherapeutic treatment that aims to maximise its effectiveness should adapt to the individual's unique and specific characteristics while, at the same time, taking into account the diagnostic label assigned to their functioning, to compare one's intervention hypotheses with the information available in the clinical and empirical literature.

The PDM-3 introduces a clearly psychodynamic perspective, now vital in the assessment of psychological distress and mental disorders, enabling clinicians to describe personality patterns, social and emotional capacities, the profile of mental functioning, and the subjective experience of symptoms of the individual patient. In all its editions, the PDM has presented itself as a "*taxonomy of people*" rather than a "*taxonomy of disorders*", highlighting the importance of considering *who* the person *is*, not merely which mental disorder they manifest (Lingiardi & McWilliams, 2025a, 2025b; Westen *et al.*, 2006). From this perspective, PDM diagnoses are *dimensional* and *prototypical* – that is, they are based on the assumption that a patient's clinical presentation may show varying degrees of overall similarity or overlap with the description of a prototype or "ideal type" of a disorder. Going beyond the reorganization based on the typical age of onset of diagnostic labels in the DSM-5-TR and ICD-11, the PDM-3 also proposes a diagnostic approach attentive to the specific features of individual functioning across different stages of the life cycle. It is therefore divided into several sections, reorganized in this edition in chronological order: *Infancy and Early Childhood* (0-3 years), *Childhood* (4-11 years), *Adolescence* (12-19 years), *Adults*, and *Older Adults*. This edition also includes specific considerations regarding *transitional phases* between age groups (for example, emerging adulthood and the transition between adulthood and old age), as well as a final section entirely devoted to the assessment process using the evaluation instrument derived from the PDM, the *Psychodiagnostic Chart* (PDC-3; Gordon & Bornstein, 2025), and updated *illustrative clinical cases* assessed according to the PDM-3 approach.

In line with the previous edition, the PDM-3 offers clinicians the opportunity to understand psychopathology within the context of personality and symptoms within the individual's overall functioning; to include the subjectivity of the symptomatic experience; to consider the specific needs of different patients; to identify possible psychological resources and not only

pathological or dysfunctional elements; and to take into account the influence of the life-cycle stage (Lingiardi & Muzi, 2018; Tanzilli *et al.*, 2024a). Specifically, adopting a multi-axial and multidimensional approach requires clinicians to describe, systematically and in an age-specific manner:

- the *level of personality organization* and *personality styles/disorders* (P Axis);
- the *profile of mental functioning* (M Axis);
- *symptomatic patterns*, including the patient's subjective experience of their symptoms and the therapist's possible emotional responses (S Axis).

The three axes must be evaluated in a different order depending on the patient's age. Only with adult patients should clinicians first consider the P Axis, followed by the M Axis, and finally the S Axis. With children, adolescents, and older adults, however, the assessment procedure begins with the M Axis, followed by the P Axis (since, for example, in childhood and adolescence, personality is an "emerging" dimension still in the process of formation), and lastly the S Axis. An innovation of the PDM-3 is that, following each S Axis in the various sections, there is now a chapter specifically devoted to "psychological experiences that may require clinical attention". This chapter includes all *non-psychopathological* conditions that may warrant specific clinical evaluation only when associated with subjective distress. Against this conceptual background, the principal innovations of the three axes will be discussed below with reference to the section devoted to adulthood (Figure 1).

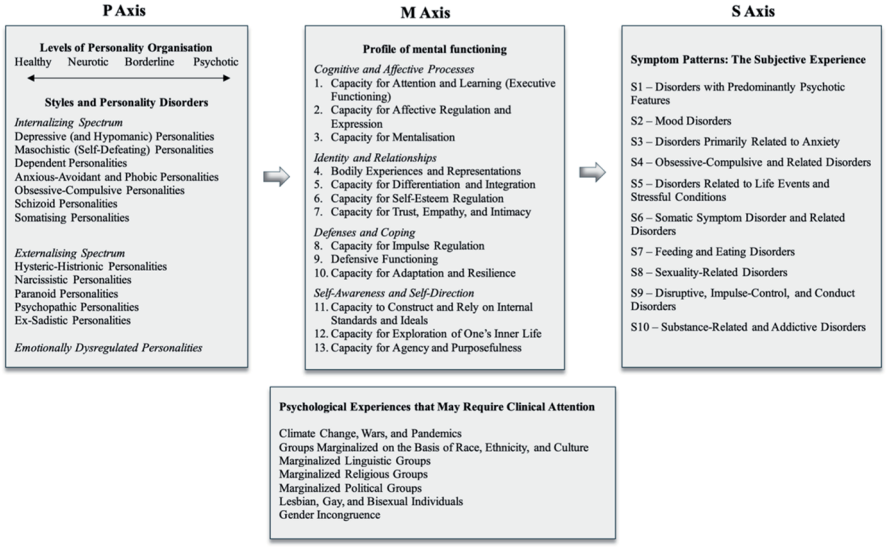

Figure 1. Structure and contents of the *Adult* section of the PDM-3.

Toward a clinically useful and empirically supported view of personality: the P Axis

As anticipated in the previous paragraph, the two organizing principles underlying the P Axis of the PDM-3 are the *level of personality organization* (a spectrum of functioning ranging from healthy to psychotic levels, passing through neurotic and borderline levels – both high- and low-functioning) and *personality style/disorder* (that is, clinically recognized personality types that may present at different levels of organization). A first innovation of the PDM-3 is the abandonment of the term personality syndrome, to avoid potentially pathologizing language that fails to take into account the various levels of personality functioning, which are not necessarily characterised by significant impairment. After situating the individual's functioning along the *continuum* of personality organization – an approach that recalls the now well-established Kernbergian structural model (Kernberg, 1984) – the P Axis requires the clinician to evaluate, from a prototypical perspective, the extent to which the patient's clinical presentation approximates the "ideal type" of a specific personality style or disorder. It is noteworthy that, in this latest edition, *empirically derived* prototypes based on research using the Shedler-Westen Assessment Procedure (SWAP; Westen & Shedler, 1999a, 1999b; Shedler *et al.*, 2014) have been included for assessment purposes. These are complemented by *clinically derived* prototypes for those personality configurations that emerge from work with real patients in clinical practice.

Thirteen personality styles/disorders are included in this section, consistent with research conducted using the Shedler-Westen Assessment Procedure (SWAP; Westen *et al.*, 2012), and organized according to two higher-order spectra: the internalizing and the externalizing spectra – with the sole exception of emotionally dysregulated personalities, often described as "stably unstable" (Schmideberg, 1959), which oscillate continuously between features characteristic of both polarities. In general, patients who fall within the *internalising spectrum* experience their suffering "internally": they tend to blame themselves for their difficulties and are chronically vulnerable to dysphoric affects, depression, and anxiety. This spectrum includes depressive (and hypomanic), masochistic (self-defeating), dependent, anxious-avoidant, phobic, obsessive-compulsive, schizoid, and somatising personalities.

Conversely, patients whose personality functioning falls within the *externalising spectrum* tend to "impose" their suffering on others (although they may also experience profound inner distress), attributing their difficulties to other people and/or elements of external reality, and displaying a greater propensity toward anger and aggression. This spectrum includes hysterical-histrionic, narcissistic, paranoid, psychopathic, and sadistic personalities.

The attentive reader will have noticed several significant innovations compared with the previous edition. Kernberg (2006) had already addressed the

problem of discrepancies in the use of the term *borderline*, proposing a distinction between borderline personality *disorder* (consistent with the DSM conception) and borderline personality *organization* (more closely aligned with the psychoanalytic understanding) – a solution that was also adopted in the previous edition of the PDM. In the PDM-3, however, to minimise potential terminological and conceptual confusion, the decision was made to refer to the condition that the DSM designates as "borderline personality disorder" using the expression *emotionally dysregulated personalities*. These are characterised by chronic and pervasive difficulties in tolerating and regulating affects, and thus by a tendency to experience emotions that readily escape regulatory control, reaching extreme levels of intensity and thereby compromising more adaptive functioning.

To this central symptomatic core must be added the characteristic instability in the perception of self and others, which gives rise to intense and chaotic relationships, as well as a propensity to act on impulses, including self-destructive ones (Westen et al., 2012). These features also recall the *borderline pattern* specifier provided in the ICD-11 (WHO, 2019), which may be applied to individuals whose personality disturbance is marked by a pervasive pattern of instability in interpersonal relationships, self-image, and affects, together with pronounced impulsivity.

Another significant innovation of the PDM-3 is the recognition of *masochistic (self-defeating) personalities* as a distinct constellation in their own right, rather than as a possible manifestation of depressive personalities. This new prototype describes individuals who seem to act unconsciously in ways that seek pain and suffering, systematically avoiding or rejecting pleasurable situations or opportunities for success and personal gratification. From this perspective, masochistic-self-defeating personality should be understood as an exaggeration or rigidification of an inner motivation and tendency – non-pathological in itself – to prioritise the well-being of others at the expense of one's own.

From a historical standpoint, this type of personality style/disorder was included in the DSM-III-R (American Psychiatric Association, 1987) under the label *self-defeating personality disorder*, which implied a tendency to become involved in situations or relationships that bring suffering, disappointment, failure, or mistreatment; the rejection or sabotage of others' attempts to offer help; negative or rejecting responses to pleasant or positive events; and a propensity for personal sacrifice. However, this diagnosis was later removed from the manual and disappeared from subsequent editions.

By contrast, the PDM-3 has highlighted theoretical and clinical contributions emphasising that masochistic and depressive dynamics reflect different underlying themes, requiring specific therapeutic approaches. Individuals with masochistic-self-defeating personalities tend to actively seek out pain rather than passively resign themselves to suffering. These patients tend to

sabotage and punish themselves, and they hold a negative self-representation as unworthy, guilty individuals who do not deserve love or appreciation unless they sacrifice themselves excessively for others.

Their emotional world is often dominated by feelings of anger, resentment, and grievance, which are defensively turned against the self rather than directed toward the object, which is instead idealised. Other characteristic defense mechanisms include acting out (in cases marked by a strong propensity toward self-destructiveness), moralisation (to manage their internal experiences of suffering), and denial (to disavow their own suffering, at the cost of exposing themselves to serious harm) (see also Lingiardi & Madeddu, 2023). These core features give rise to a tendency to become involved in interactions – both with significant others and with clinicians – typically characterised by alternations between submission and dominance, or between the roles of abuser and victim.

Masochism is not a unitary construct (Lingiardi, 2025; Lingiardi & McWilliams, 2025a), and masochistic dynamics can emerge in various personality styles/disorders (Huprich & Nelson, 2014). For example, while Békés and colleagues (2018) have suggested the existence of different masochistic configurations characterized by specific conflicts, defensive strategies, and unconscious motivations, Kernberg (1988) highlights distinct constellations depending on the underlying level of personality organization. Huprich and Malone (2022), in turn, have emphasized the relevance of "malignant self-regard", which links masochistic dynamics with depressive and *covert* narcissistic ones.

The PDM-3 identifies three main types of masochistic-self-defeating personality, depending on whether they present predominantly with dependent themes (Bornstein, 1993; Waska, 1997), narcissistic themes (Cooper, 1988; Glickauf-Hughes, 1997), or paranoid themes (Nydes, 1963). It further specifies that all three may include sadistic aspects that are defensively disavowed. *Relational masochism* is the more anaclitic version of masochistic dynamics and is often associated with dysfunctional forms of relational dependency. This pattern of functioning is evident in patients who tend to subordinate their own needs to those of others and who (more or less unconsciously) regard deprivation and suffering as necessary for maintaining a significant bond experienced as desperately needed. Clinically, however, it is important to note that behind this apparent submissiveness there may actually lie intense aggression, which is denied and expressed in passive-aggressive ways that, in turn, elicit mistreating behaviours from others (McWilliams, 2011).

Moral masochism is the more introjective version of masochistic dynamics and is associated with narcissistic personality features (for a general discussion of narcissistic personalities, see also Lingiardi, 2021). It describes individuals who unconsciously regard renunciation and personal suffering as moral virtues, and whose self-esteem is closely tied to deprivation: the more

pain they inflict upon themselves, the greater their sense of moral superiority. A variant of this form of masochism appears in patients who display a kind of "victim entitlement", characterised by the unconscious conviction that "the world owes them" in proportion to the suffering they have endured. This unconscious dynamic, also known as the *aggrieved pattern* (Millon & Grossman, 2007), often complicates therapy: patients who expect privileged treatment as victims may obstruct the clinician's attempts to help them through the defense of *help-rejecting complaining* – that is, they request help but reject it when it is offered (Frank *et al.*, 1952; Lingiardi & Madeddu, 2023; Perry, 1990). Moreover, this attitude frequently evokes countertransference feelings of irritation and criticism in the clinician, at times even leading to sadistic reactions.

Finally, *paranoid masochistic patterns* (characterised by *harm seeking*) represent the version most actively linked to the pursuit of harm. This derives from a (denied and projected) expectation of being attacked or harmed by others for any personal success or satisfaction achieved. Masochistic and paranoid personalities share a constant preoccupation with imminent danger (Nydes, 1963); however, the former manage this unconscious conviction by implicitly provoking the anticipated attack, preempting it, and experiencing relief when it actually occurs.

Assessing psychological strengths, not only psychopathology: the M Axis

After assessing the level of personality functioning and the degree of similarity/correspondence between the adult patient and the various styles/disorders of the P Axis, the clinician must evaluate the overall level of mental functioning. The M Axis makes it possible to describe in detail the profile of mental functioning by examining a range of capacities that define an individual's psychological health. This Axis provides articulated, treatment-oriented descriptions of mental functions that can be observed and therefore used to plan therapeutic interventions (Lingiardi *et al.*, 2018), thus integrating the assessment of personality organization and personality styles/disorders offered by the P Axis (Gori *et al.*, 2025).

Similarly, it enables clinicians to take into account and assess important psychological processes underlying both symptomatic patterns and the subjective experience of symptoms, as described later in the S Axis (Muzi *et al.*, 2021). The M Axis, therefore, constitutes a bridge and a link between the P Axis and the S Axis, and a fundamental step in assessment according to the PDM-3.

The domains of mental functioning considered are based on a broad range of concepts and observations drawn from psychodynamic, cognitive, and

developmental theoretical models, as well as on empirical research conducted within these fields. Moreover, this Axis is grounded in a conception of mental functioning as the result of the integration between nature (temperament, genetic predisposition, basic traits) and culture (learning processes, experience, and characteristics of the social and cultural context; Etzi, 2014).

Compared to the previous edition, the number of mental functions has increased from 12 to 13. Some labels have been revised and updated: what, in the PDM-2, was defined as the capacity for regulation, attention, and learning is now defined as the *capacity for attention and learning (executive functioning)*; the former capacity for relationships and intimacy has been reformulated as the *capacity for trust, empathy, and intimacy*; and what was previously defined as the capacity for self-observation (psychological mindedness) has been reformulated as the *capacity to explore one's inner life*. Moreover, in response to the growing clinical and empirical literature supporting the relevance of body-related dimensions and experiences in mental functioning, a new capacity has been introduced concerning *bodily experiences and representations*.

In addition, for each mental function, the PDM-2 included a list of the "most relevant assessment tools", which has been removed in the PDM-3 due to the frequency with which new instruments are developed and validated, the ongoing updating of their psychometric properties, and the need to make the M Axis more streamlined, practical, and user-friendly. However, a summary of the most relevant, widely used, validated, and clinically useful instruments is provided at the end of the specific chapter to enrich the assessment of all mental capacities of the M Axis (for example, the Shedler-Westen Assessment Procedure [Shedler *et al.*, 2014], the Adult Attachment Interview [George *et al.*, 1985], the Defense Mechanism Rating Scales [Perry, 1990], and the Structured Interview of Personality Organization, Revised [Clarkin *et al.*, 2016]).

The 13 mental functions included in the M Axis of the PDM-3 are as follows:

1. *Capacity for attention and learning (executive functioning)*: a multidimensional domain that includes a set of constitutional and maturational aspects, as well as higher-order cognitive processes, which enable individuals to plan and regulate goal-directed thoughts, emotions, and actions.
2. *Capacity for affect regulation and expression*: an index of overall affective functioning; it refers to the ability to identify, experience, modulate, understand, reflect upon, express, and appropriately respond to affects.
3. *Capacity for mentalization*: the ability to infer and reflect upon one's own mental states (*e.g.*, needs, desires, feelings, etc.) as well as those of others, and to use this capacity to promote interpersonal and social interactions.
4. *Bodily experiences and representations*: includes perceptions, sensations, feelings, thoughts, and attitudes – both conscious and unconscious

– regarding one's own body, as well as the implicit awareness of the body as a complex entity with defined boundaries.

5. *Capacity for differentiation and integration*: the ability to distinguish self from other, fantasy from reality, internal representations from external objects and circumstances, present from past and future, and to construct connections without confusing them.
6. *Capacity for self-esteem regulation*: reflects the feelings of self-worth and self-regard that characterise the individual's relationship with themselves, with others, and with the world in general, as well as the overall perception of one's personal value.
7. *Capacity for trust, empathy, and intimacy*: an indicator of overall relational and interpersonal functioning. "Basic trust" refers to the ability to explore the environment and face situations with a balance between vigilance and credulity toward others. Empathy involves understanding another's point of view and responding sensitively to their feelings; intimacy concerns the capacity to regulate interpersonal distance and closeness.
8. *Capacity for impulse regulation*: the ability to modulate and regulate one's impulses and to express needs, motivations, and desires; impairment may result in unmodulated impulse expression (impulsivity), or rigid overcontrol of impulses (inhibition).
9. *Defensive functioning*: how the individual attempts to manage motivations, affects, impulses, conflicts, memories, thoughts, and other internal experiences that may be sources of negative affect.
10. *Capacity for adaptation and resilience*: the ability to adapt to unexpected events and changing circumstances, and to cope effectively and creatively with uncertainty, loss, stress, and other adverse (even traumatic) events.
11. *Capacity to construct and use standards and ideals*: an indicator of overall moral functioning, including the beliefs, emotions, motivations, and ideals that guide personal and life choices. It also implies the ability to make decisions based on a coherent and integrated set of moral principles.
12. *Capacity to explore one's inner life*: the ability to understand and reflect upon the nature and origins of one's mental states within one's life experience. It involves recognising implicit connections among emotions, motivations, thoughts, and behaviours – past and present – as well as between one's interpretation of others' behaviours and relationships.
13. *Capacity for agency and purpose*: the ability to master one's inner impulses, feelings, and thoughts and thus to construct an inner narrative that gives coherence and meaning to personal experiences and choices. It implies an inner sense of ownership, internal control, and self-efficacy at different levels of awareness.

Of particular relevance is the introduction of the new mental function concerning *bodily experiences and representations* (see also Muzi, 2025). Clinicians intending to assess this domain must consider those perceptions, sensations, feelings, and thoughts – both conscious and unconscious – related to one's own corporeality, as well as the implicit awareness of the body as a complex entity with defined boundaries that allow the individual to distinguish themselves both from the physical environment and from the interpersonal one. This mental function also includes the perception, interpretation, monitoring, and modulation of stimuli arising from within the body (interoception) and from outside the body (exteroception), which may represent an early and pre-mentalized form of self-awareness. Bodily representations include (but are not limited to) body image and its components (*e.g.*, body satisfaction/dissatisfaction) and also result from the interaction between multisensory inputs – such as visual and tactile awareness – and internal models or expectations concerning the shape and structure of one's body.

Due to space constraints, we are unable to provide a comprehensive discussion of psychoanalytic contributions on the centrality of the body and the body-mind relationship – beginning with Sigmund Freud's well-known statement (1922) that "the ego is first and foremost a bodily ego" (p. 488); Donald Winnicott's concepts of holding and handling (1949, 1965); Didier Anzieu's Skin-Ego (1985); Joyce McDougall's "theaters of the body" (1989); James S. Grotstein's expression "mindbody" (1997); Thomas Ogden's concept of aliveness (2023); Alessandra Lemma's "under the skin" (2010); and "keeping the body in mind" within the context of mentalization theory (Shai & Belsky, 2011). All these themes are revisited in narrative form in the volume *Corpo, umano* by Vittorio Lingiardi (2024).

In addition, it is noteworthy that *the capacity to explore one's inner life* has been significantly expanded compared to the previous edition of the manual. Beyond the degree of predisposition, motivation, and curiosity to observe one's inner mental life (*i.e.*, the concept of *psychological mindedness*), this domain now includes both *insight* capacities (the ability to explore and understand the deeper dynamics underlying particular thoughts, emotions, choices, interpersonal patterns, and behavioural responses) and a more general propensity for introspection (*insightfulness*), which, in a broader sense, refers to the capacity to understand oneself in complex and sophisticated ways.

Moreover, in an assessment, clinicians are encouraged to examine a range of clinical phenomena that emerge during psychotherapy. For example, considering *free associations* may help clarify the typical ways an individual thinks, fantasises, experiences emotions, and/or behaves in relation to different internal and external circumstances. *Dream life*, and in particular the individual's capacity to become aware of and reflect upon dream

material, represents another valuable source of information, as it expresses fears, concerns, conflicts, anxieties, wishes, and representations of the self and the world – in other words, the individual's inner life (Balch *et al.*, 2025; Lingiardi, 2023; Roesler, 2023).

Beyond the symptom: the subjective experience of psychopathology in Axis S

Axis S is positioned as the third step in the formulation of the PDM-3 diagnostic profile, as symptomatic patterns can be fully understood only when situated within the context of levels of personality organization, personality styles or disorders, and the overall mental functioning that characterises a given individual. This Axis includes a taxonomy of clinical syndromes that, although generally named in accordance with the DSM-5-TR, the ICD, and the HiTOP, are entirely reformulated in prototypical terms and aligned with a psychodynamic understanding of psychopathology.

Specifically, Axis S does not provide a description of the symptoms of different psychopathological constellations; rather, it focuses on the subjective experience of the individual who manifests these symptomatic patterns. For clinical and assessment purposes, the subjective experience of symptomatology is described in terms of *affective states*, *cognitive patterns*, *somatic states*, and *relational patterns* that are most characteristic of individuals who share a particular diagnosis (Mundo *et al.*, 2018).

Axis S of the PDM-3 is particularly significant because subjective experiences have historically been neglected in traditional psychiatric classification (Eagle, 2024), which is often inadequate for capturing the complexity and vast variability of conditions, pathological or otherwise, that may warrant clinical attention and/or intervention. Individuals belonging to the same diagnostic category, even when presenting with similar symptomatology, may exhibit a wide range of subjective experiences, and these individual differences have central implications for treatment.

Taking eating and feeding disorders as an example, the manual highlights the relevance of the so-called diagnostic "shift" or "cross-over" from one diagnostic label to another over the course of the clinical trajectory. This phenomenon appears to reflect a marked temporal instability of the core symptoms of these diagnoses from a DSM/ICD perspective (Solmi *et al.*, 2024), as well as the possible existence of a broader and more unified clinical condition that evolves over time beyond its specific symptomatic manifestations (Fairburn & Cooper, 2011). For this reason, the manual does not focus rigidly on individual eating disorder labels but rather on clinical presentations characterized predominantly by restrictive symptomatology, by compensatory behaviours, or by recurrent binge-eating episodes.

More generally, Axis S of the PDM-3 underscores the importance of considering different levels of personality organization in these disorders, which may be situated along a continuum ranging from a healthy level, where individuals demonstrate overall good functioning, perhaps with some idiosyncrasies related to eating, to a more severe level of psychotic organization marked by profound impairments in overall functioning, identity diffusion (including potentially delusional qualities), loss of reality testing, and rigid, inflexible defensive mechanisms (Kernberg, 1995; Lingiardi & Zingaretti, 2019; Muzi *et al.*, 2021).

Axis S further emphasizes that individuals with predominantly anorexic symptomatology often present obsessive-compulsive and narcissistic personality traits, difficulties in managing new experiences (including relationships) and any potential psychological change, as well as ego-syntonic symptoms. By contrast, individuals with predominantly bulimic and binge-eating symptomatology appear to show a greater tendency toward emotional dysregulation and to experience feelings of emptiness and anger, which they attempt to "silence" through food intake, often within the context of traits or disorders within the borderline spectrum (Mirabella *et al.*, 2023). The manual also highlights that, across the various eating disorders, symptoms are frequently concealed for extended periods due to pervasive feelings of inadequacy and shame. In patients with predominantly anorexic/restrictive symptoms, these feelings seem to be more closely linked to body shape, whereas in patients with bulimic/binge-eating symptoms, they are more closely associated with a perceived lack of control.

With respect to specific domains of subjective experience, at the level of *affective states*, these disorders are characterized by feelings of failure, weakness, embarrassment, guilt, and shame; low self-esteem, along with feelings of worthlessness and ineffectiveness; anger and hostility, sometimes expressed through the body; and feelings of emptiness and loss of control, which may lead to extreme states of anxiety, sadness, and despair. At the level of *cognitive patterns*, there is often cognitive rigidity, a tendency toward body image distortion, high levels of perfectionism, and excessive reliance on continuous body monitoring (*body checking*).

Regarding *somatic states*, there is a general difficulty in distinguishing between mental and bodily states, with both interoceptive and enterocetive impairments, as well as an inability to detect or appropriately respond to signals indicating hunger or satiety. Finally, at the level of *relational patterns*, there is generalised insecurity in interpersonal relationships, an "interpersonal paradox" characterised by simultaneous dependency needs and fear of abandonment, and the presence of shame and embarrassment during social interactions due to fear of negative evaluation by others.

A further central aspect of Axis S in the PDM-3 is the importance attributed to the *therapist's subjective experience*, described in terms of the clin-

ician's emotional responses or countertransference patterns, which appear to be closely linked to the patient's level of personality functioning and the presence of any personality disorders (Colli & Ferri, 2015; Colli *et al.*, 2014; Tanzilli *et al.*, 2024b; Tanzilli & Lingiardi, 2022). Again, taking feeding and eating disorders as an example, the manual underscores that the countertransference reactions evoked by these patients are often intense and negative (Thompson-Brenner *et al.*, 2012), including feelings of anger, despair, pain, or detachment, as well as a strong desire to provide care and protection, particularly in patients with bulimic symptomatology (Colli *et al.*, 2015).

When personality is also taken into account, studies by Satir and colleagues (2009) and Colli and colleagues (2015) highlight that this variable more comprehensively explains the complex countertransference responses of clinicians than eating symptomatology alone. For example, patients with a more emotionally dysregulated personality profile tend to elicit not only negative feelings but also experiences of disorganization, anxiety, and a sense of being despised, mistreated, or criticised.

Such countertransference patterns tend to influence the clinician's performance, the functioning of the treatment team, the therapeutic process, and treatment outcomes. In line with this perspective, some clinicians have suggested that shifting the focus from the patient's responses to those of the therapist may be particularly helpful in clinical work with these patients (Zeeck *et al.*, 2025).

"Saving normal": psychological experiences that may require clinical attention

"First, do not treat those who are normal" is the recommendation, and the title, of a well-known contribution by Allen Frances (2013), chair of the DSM-IV Task Force and a prominent critic of the more recent editions of the manual, whose tendency toward overdiagnosis and the medicalization of conditions widely regarded as normative and expectable he has strongly emphasized (Lingiardi, 2018). Building on these reflections, all sections of the PDM-3 include a dedicated chapter describing psychological experiences associated with broader societal changes, groups, or communities whose members may seek mental health services or psychotherapy due to difficulties related to specific contextual or individual circumstances that are not, in themselves, pathological.

With specific reference to the section on adults, the chapter on *psychological experiences that may require clinical attention* (PERCA) includes the subjective experience of phenomena of collective relevance, such as climate change, wars, and pandemics, as well as the experiences of various

marginalized groups defined along ethnic, cultural, linguistic, religious, and political lines, and individuals with diverse sexual identities (lesbian, gay, and bisexual) or gender incongruence. Although space constraints prevent a detailed description, it is worth noting that the corresponding chapter in the *Childhood* section has also been expanded to include descriptions of the subjective experiences associated with abuse, as well as those of adopted children, children conceived through medically assisted reproduction, and gifted children – topics that were absent in the previous edition.

Newly introduced in the PDM-3, the section devoted to *climate change, wars, and pandemics* describes the subjective experience of living in a world that is no longer perceived as predictable and reliable, but rather as unstable and threatening, disrupted by catastrophic events and/or characterised by a prolonged state of emergency. First, the subjective effects of the current climate crisis are considered, which have led to the emergence of concepts such as "eco-anxiety", introduced by the American Psychological Association (2017) to denote the affective response, often characterised by stress and anxiety, to environmental circumstances (Clayton & Crandon, 2025). More specifically, eco-anxiety manifests as a sense of anticipation of an imminent environmental catastrophe and may include depressive responses, excessive worry, ruminative thoughts, feelings of helplessness and despair, or a passive stance toward the future (Lawrance *et al.*, 2022; Niedzwiedz *et al.*, 2025). Other concepts describing specific affective responses to climate change include eco-guilt (Mallett *et al.*, 2012), eco-anger (Stanley *et al.*, 2021), and eco-grief (Cunsolo & Ellis, 2018).

Another central domain concerns the subjective experience of wars and conflicts, which entail clear and significant negative repercussions for mental health – particularly in terms of anxiety, depression, post-traumatic stress, and psychotic disorders (Mesa-Vieira *et al.*, 2022). Notably, a study promoted by the WHO found that, as of 2018, approximately 22% of individuals residing in conflict-affected areas met criteria for at least one mental disorder, and about 5% of this population presented with severe symptomatology (Charlson *et al.*, 2019). These data, now somewhat dated, likely underestimate the current magnitude of these phenomena in terms of their impact on mental health, given the conflicts that have emerged in subsequent years.

For example, in examining the mental health consequences of the Russo-Ukrainian War (RUW-22), several studies have documented devastating effects on the Ukrainian population, including high prevalence rates of post-traumatic stress disorder and complex post-traumatic stress disorder, as well as anxiety and depressive disorders (Lushchak *et al.*, 2023; Wang *et al.*, 2024). Other research has focused on the more specific, yet nonetheless significant, phenomenon of *nuclear anxiety* – that is, fear of the

use of nuclear weapons (Riad *et al.*, 2023).

Finally, the COVID-19 pandemic – an event in itself sufficient to disrupt the sense of continuity in everyday experience – has generated an extensive body of empirical research and theoretical-clinical contributions, which converge in highlighting the traumatic impact of containment measures and, more broadly, the pervasive feelings of uncertainty and threat on global mental health. Although the public health emergency can now be considered formally concluded, it has influenced the prevalence rates of anxiety, depressive, eating, sleep, and post-traumatic stress symptoms and disorders (Nochaiwong *et al.*, 2021), and has intensified several risk factors relevant to mental health, including maltreatment, domestic violence, and illness among family members (Fegert *et al.*, 2020).

With regard to the domains of subjective experience related to climate change, wars, and pandemics, the PDM-3 emphasises that *affective states* may include anxiety, depression, melancholy, guilt, shame, annihilation anxiety, helplessness, indifference, anger, frustration, disorientation, and despair. In individuals directly affected by catastrophes that threaten their physical and psychological integrity, states of shock and difficulties in adaptation may also be present.

Concerning the most characteristic *cognitive patterns*, the manual describes obsessive strategies aimed at keeping anxiety under control, including intrusive and recurrent rumination; defensive strategies based on denial or minimisation of distressing events; and forms of *learned helplessness*. *Somatic states* may include sleep disturbances, fatigue, heightened arousal, and other physiological symptoms. Finally, the most characteristic *relational patterns* may involve social withdrawal or, conversely, a drive toward aggregation through adherence to groups or organizations characterised by rigid and extremist ideologies.

Sound diagnoses for sensitive clinicians: some concluding remarks

Any diagnostic formulation requires both specific technical competencies (such as a thorough knowledge of the major international classifications of mental disorders) and relational sensitivity and skills (such as the ability to listen respectfully and without judgment to what is communicated – consciously and unconsciously – by the patient; Nissim Momigliano, 2001). A sound diagnosis is constructed through a balance among all these positions. Yet many colleagues, especially those in training, still find themselves grappling with a traditionally predominant *symptom- and behaviour-oriented* approach, grounded in a medical paradigm that is often insufficiently attuned to clinical reality. In order to restore meaning and sensitivity to diagnosis, it is necessary, as Huprich and Meyer (2011) emphasise, for

the diagnostic process to once again place the intrinsic complexity of the person at the "*centre of the stage*".

The PDM-3, therefore, seeks to promote and underscore the dynamic, relational, and intersubjective dimensions of diagnosis, while providing therapists in training with an appropriate explanatory framework – one that also includes their own contribution to the experience of the therapeutic relationship – so as to support them in the challenging task of organizing the complex clinical material they encounter in their daily practice.

Moreover, a diagnostic approach that takes into account the complexity of individual functioning constitutes a central element in clinical supervision (McWilliams, 2021). Without attention to these aspects, the diagnostic process risks becoming a mere application of a *checklist* of criteria (Lingiardi & McWilliams, 2025b). This risk not only undermines clinicians' professional identity but also weakens their capacity to describe and grasp the most salient features of a patient's psychic functioning, thereby endangering the therapeutic relationship itself, which, as we well know, is one of the primary factors influencing the outcome of any form of treatment, including those of a psychoanalytic orientation.

REFERENCES

American Psychiatric Association. (1987). *Manuale diagnostico e statistico dei disturbi mentali*, *DSM-III-R*. Trad. it. Milano: Masson, 1988.

American Psychiatric Association. (2022). *Manuale Diagnostico e Statistico dei Disturbi Mentali, DSM-5-TR*. Trad. it. Milano: Raffaello Cortina, 2024.

American Psychological Association. (2017). *Mental health and our changing climate: Impacts, implications, and guidance*. Available from: https://www.apa.org/news/press/releases/2017/03/mental-health-climate.pdf

American Psychological Association. (2021). *Professional practice guidelines for evidence-based psychological practice in health care*. Available from: https://www.apa.org/about/policy/psychological-practice-health-care.pdf

Anzieu, D. (1985). *L'Io-pelle*. Milano: Raffaello Cortina, 2017.

Balch, J., Raider, R., Reed, C., & McNamara, P. (2025). Relationship and personality factors predict longitudinal changes in dream content. *Scientific Reports*, *15*(1), 15531.

Békés, V., Perry, J., & Robertson, B. (2018). Psychological masochism: A systematic review of the literature on conflicts, defenses, and motives. *Psychotherapy Research*, *28*, 470-483.

Bornstein, R. F. (1993). *The dependent personality*. New York: Guilford Press

Charlson, F., Van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., & Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *Lancet*, *394*, 240-248.

Clarkin, J. F., Caligor, E., Stern, B., & Kernberg, O. F. (2016). *The Structured Interview for Personality Organization-Revised (STIPO-R)*. Unpublished manuscript, Department of Psychiatry, Weill Cornell Medical College, NY, New York.

Clayton, S., & Crandon, T. (2025). Climate Change and Mental Health. *Annual Review Clinical Psychology*, *21*, 61-83.

Colli, A., & Ferri, M. (2015). Patient personality and therapist countertransference. *Current Opinion in Psychiatry*, *28*(1), 46-56.

Colli, A., Speranza, A. M., Lingiardi, V., Gentile, D., Nassisi, V., & Hilsenroth, M. J. (2015). Eating Disorders and Therapist Emotional Responses. *The Journal of Nervous and Mental Disease*, *203*(11), 843-849.

Colli, A., Tanzilli, A., Dimaggio, G., & Lingiardi, V. (2014). Patient personality and therapist response: An empirical investigation. *American Journal of Psychiatry*, *171*, 102-108.

Cooper, A. M. (1988). The narcissistic-masochistic character. In R.A. Glick, D.I. Meyers (a cura di), *Masochism: Current psychological perspectives* (pp. 189-204). Hillsdale, NJ: Analytic Press.

Cunsolo, A., & Ellis, N. R. (2018). Ecological grief as a mental health response to climate change-related loss. *Nature Climate Change*, *8*(3), 275-281.

Eagle, M. J. (2024). *Subjective Experience: Its Fate in Psychology, Psychoanalysis, and Philosophy of Mind*. Oxfordshire: Routledge.

Etzi, J. (2014). The *Psychodynamic Diagnostic Manual* M Axis: Toward an articulation of what it can assess. *Psychoanalytic Psychology*, *31*(1), 119-133.

Fairburn, C. G., & Cooper, Z. (2011). Eating disorders, DSM-5 and clinical reality. *The British Journal of Psychiatry*, *198*(1), 8-10.

Fegert, J., Vitiello, B., Plener, P., & Clemens, V. (2020). Challenges and burden of the Coronavirus 2019 (COVID-19) pandemic for child and adolescent mental health: a narrative review to highlight clinical and research needs in the acute phase and the long return to normality. *Child and Adolescent Psychiatry and Mental Health*, *14*(20).

Frances, A. (2013). *Primo, non curare chi è normale*. Trad. it. Torino: Bollati Boringhieri.

Frank, J. D., Margolin, J., Nash, H. T., Stone, A. R., Varon, E., & Ascher, E. (1952). Two behavior patterns in therapeutic groups and their apparent motivation. *Human Relations*, *5*, 289-317.

Freud, S. (1901). *Frammento di un'analisi d'isteria (caso clinico di Dora)*. In Opere di Sigmund Freud (Vol. 4). Torino: Bollati Boringhieri.

Freud, S. (1922/1977). *L'Io e l'Es*. In Opere di Sigmund Freud (Vol. 9). Torino: Bollati Boringhieri.

George, C., Kaplan, N., & Main, M. (1985). *The Adult Attachment Interview*. Unpublished manuscript, University of California at Berkeley, Department of Psychology.

Glickauf-Hughes, C. (1997). Etiology of the masochistic and narcissistic personality. *American Journal of Psychoanalysis*, *57*, 141-148.

Gordon, R. M., & Bornstein, R. F. (2025). *Psychodiagnostic Chart-3 (PDC-3)*. Unpublished manual.

Gori, A., Topino, E., Muzi, L., Lingiardi, V., & Stanghellini, G. (2025). A Multimethod Psychometric Approach to Analyse the Profile of Mental Functioning – M Axis of the Psychodynamic Diagnostic Manual, 2nd Edition (Pdm-2): A Focus on Cluster B Personality Disorders. *Clinical Neuropsychiatry*, *22*(1), 53-65.

Grotstein, J. S. (1997). Mens sana in corpore sano. The mind and the body as an 'odd couple' and as an odd coupled unity. *Psychoanalytic Inquiry*, *17*, 204-222.

Horwitz, L., Gabbard, G. O., Allen, J. G., Frieswyk, S. H., Colson, D. B., Newsom, G. E., & Coyne, L. (1998). *Borderline personality disorder: Tailoring the psychotherapy to the patient.* Washington, DC: American Psychiatric Association.

Huprich, S. K., & Malone, B. C. (2022). Malignant self-regard: Overview and future directions. *Harvard Review of Psychiatry*, *30*(4), 226-237.

Huprich, S. K., & Meyer, G. J. (2011). Introduction to the JPA special issue: Can the Psychodynamic Diagnostic Manual put the complex person back at the center-stage of personality assessment? *Journal of Personality Assessment*, *93*(2), 109-111.

Huprich, S. K., & Nelson, S. M. (2014). Malignant self-regard: accounting for commonalities

in vulnerably narcissistic, depressive, self-defeating, and masochistic personality disorders. *Comprehensive Psychiatry*, *55*(4), 989-998.

Kernberg, O. F. (1988). Clinical Dimensions of Masochism. *Journal of the American Psychoanalytic Association*, *36*, 1005-1029.

Kernberg, O. F. (1984). *Disturbi gravi della personalità*. Torino: Bollati Boringhieri, 2000.

Kernberg, O. F. (1995). Technical approach to eating disorders in patients with borderline personality organization. *The Annual of Psychoanalysis*, 23, 33-48.

Kernberg, O. F. (2006). Identity: Recent findings and clinical implications. *Psychoanalytic Quarterly*, *75*(4), 969-1003.

Kotov, R., Krueger, R. F., Watson, D., Achenbach, T. M., Althoff, R. R., Bagby, R. M., Brown, T. A., Carpenter, W. T., Caspi, A., Clark, L. A., Eaton, N. R., Forbes, M. K., Forbush, K. T., Goldberg, D., Hasin, D., Hyman, S. E., Ivanova, M. Y., Lynam, D. R., Markon, K., Miller, J. D., & Zimmerman, M. (2017). The Hierarchical Taxonomy of Psychopathology (HiTOP): A dimensional alternative to traditional nosologies. *Journal of Abnormal Psychology*, *126*(4), 454-477.

Lawrance, E. L., Thompson, R., Newberry, Le Vay, J., Page, L., & Jennings, N. (2022). The Impact of Climate Change on Mental Health and Emotional Wellbeing: A Narrative Review of Current Evidence, and its Implications. *International Review of Psychiatry*, *34*(5), 443-498.

Lemma, A. (2010). *Sotto la pelle. Psicoanalisi delle modificazioni corporee*. Milano: Raffaello Cortina, 2011.

Lingiardi, V. (2018). *Diagnosi e destino*. Torino: Einaudi.

Lingiardi, V. (2021). *Arcipelago N. Variazioni sul narcisismo*. Torino: Einaudi.

Lingiardi, V. (2023). *L'ombelico del sogno*. Torino: Einaudi.

Lingiardi, V. (2024). *Corpo, umano*. Torino: Einaudi.

Lingiardi, V. (2025). *Farsi male. Variazioni sul masochismo*. Torino: Einaudi.

Lingiardi, V., & McWilliams, N. (2017). *Manuale Diagnostico Psicodinamico, seconda edizione (PDM-2)*. Trad. it. Milano: Raffaello Cortina, 2018.

Lingiardi, V., & Muzi, L. (2018). Il *Manuale Diagnostico Psicodinamico* (PDM-2): Un'occasione di dialogo interdisciplinare. *Giornale Italiano di Psicologia*, *45*(4), 781-804.

Lingiardi, V., Colli, A., & Muzi, L. (2018). A clinically useful assessment of patients' (and therapists') mental functioning: M-axis implications for the therapeutic alliance. *Psychoanalytic Psychology*, *35*, 306-314.

Lingiardi, V., & Madeddu, F. (2023). *I meccanismi di difesa: Teoria, valutazione, clinica (3ª ed.)*. Milano: Raffaello Cortina.

Lingiardi, V., & McWilliams, N. (2025a). *Manuale Diagnostico Psicodinamico, terza edizione (PDM-3)*. Milano: Raffaello Cortina.

Lingiardi, V., & McWilliams, N. (2025b). The Psychodynamic Diagnostic Manual, 3rd edition (PDM-3). *World Psychiatry*, *24*, 442-443.

Lingiardi, V., & Zingaretti, P. (2019). La personalità e i disturbi della nutrizione e dell'alimentazione. In Spitoni, G.F., Aragona, M. (a cura di), *Manuale dei Disturbi Alimentari*. Roma: Carocci, pp. 85-94.

Lushchak, O., Velykodna, M., Bolman, S., Strilbytska, O., Berezovskyi, V., & Storey, K. B. (2023). Prevalence of stress, anxiety, and symptoms of post-traumatic stress disorder among Ukrainians after the first year of Russian invasion: a nationwide cross-sectional study. *The Lancet regional health. Europe*, *36*, 100773.

Mallett, R. K. (2012). Eco-guilt motivates eco-friendly behavior. *Ecopsychology*, *4*(4), 223-231.

McDougall, J. (1989). *Teatri del corpo. Un approccio psicoanalitico ai disturbi psicosomatici.* Milano: Raffaello Cortina, 1990.

McWilliams, N. (2011). *La diagnosi psicoanalitica.* Trad. it. Roma: Astrolabio, 2012.

McWilliams, N. (2021). *La supervisione*. Milano: Raffaello Cortina, 2022.

Mesa-Vieira, C., Haas, A., Buitrago-García, D., Roa-Diaz, Z., Minder, B., Gamba, M., Salvador, D., Gomez, D., Lewis, M., Gonzalez-Jaramillo, W., De Mortanges, A., Buttia, C., Muka, T., Trujillo, N., & Franco, O. (2022). Mental health of migrants with pre-migration exposure to armed conflict: a systematic review and meta-analysis. *The Lancet Public health*, 7(5), e469-e481.

Millon, T., & Grossman, S. (2007). *Moderating severe personality disorders: A personalized psychotherapy approach.* Hoboken, NJ: Wiley.

Mirabella, M., Muzi, L., Franco, A., Urgese, A., Rugo, M. A., Mazzeschi, C., Speranza, A. M., McWilliams, N., & Lingiardi, V. (2023). From symptoms to subjective and bodily experiences: the contribution of the Psychodynamic Diagnostic Manual (PDM-2) to diagnosis and treatment monitoring in eating disorders. *Eating and Weight Disorders*, *28*(1), 35.

Mundo, E., Persano, H., & Moore, K. (2018). The S Axis in PDM-2. Symptom patterns: The subjective experience. *Psychoanalytic Psychology*, *35*(3), 315-319.

Muzi, L. (2025). «When the body speaks». Il contributo del Manuale Diagnostico Psicodinamico (PDM-3) alla valutazione psicodinamica dei disturbi alimentari in età adulta. *Rivista di Psicoanalisi*, *LXXI*(4), 1039-1055.

Muzi, L., Tieghi, L., Rugo, M., & Lingiardi, V. (2021). Eating pathology and *Psychodynamic Diagnostic Manual* (PDM-2) diagnostic assessment: Implications for treatment outcomes in a psychodynamic-oriented residential setting. *Psychoanalytic Psychology*, *38*(4), 300-310.

Niedzwiedz, C. L., Kankawale, S. M. & Katikireddi, S. V. (2025). A systematic review of social, political and geographic factors associated with eco-anxiety in children and young people. *Nature Mental Health*, *3*, 1579–1615.

Nissim Momigliano, L. (2001). L'ascolto rispettoso: scritti psicoanalitici. Milano: Raffaello Cortina.

Nochaiwong, S., Ruengorn, C., Thavorn, K., Hutton, B., Awiphan, R., Phosuya, C., Ruanta, Y., Wongpakaran, N., & Wongpakaran, T. (2021). Global prevalence of mental health issues among the general population during the coronavirus disease-2019 pandemic: a systematic review and meta-analysis. *Scientific Reports*, *11*.

Norcross, J. C., & Wampold, B. E. (2018). A new therapy for each patient: Evidence-based relationships and responsiveness. *Journal of Clinical Psychology*, *74*(11), 1889-1906.

Nydes, J. (1963). The paranoid-masochistic character. *Psychoanalytic Review*, *50*, 215-251.

Ogden, T. H. (2023). Like the belly of a bird breathing: On Winnicott's 'Mind and its relation to the psyche-soma'. *The International Journal of Psychoanalysis*, *104*(1), 7-22.

PDM Task Force. (2006). *Manuale Diagnostico Psicodinamico* (PDM). Trad. it. Milano: Raffaello Cortina, 2008.

Perry, J. C. (1990). *The Defense Mechanism Rating Scale manual* (5th ed.). Cambridge, MA: Author.

Riad, A., Drobov, A., Alkasaby, M. A., Peřina, A., & Koščík, M. (2023). Nuclear Anxiety Amid the Russian-Ukrainian War 2022 (RUW-22): Descriptive Cross-Sectional Study. *International Journal of Environmental Research and Public Health*, *20*(4), 3551.

Roesler, C. (2023). Dream interpretation and empirical dream research – an overview of research findings and their connections with psychoanalytic dream theories. *The International Journal of Psychoanalysis*, *104*(2), 301-330.

Satir, D. A., Thompson-Brenner, H., Boisseau, C. L., & Crisafulli, M. A. (2009). Countertransference reactions to adolescents with eating disorders: relationships to clinician and patient factors. *The International Journal of Eating Disorders*, *42*(6), 511-521.

Schmideberg, M. (1959). The borderline patient. In S. Arieti (a cura di), *American Handbook of Psychiatry* (Vol. 1, pp. 398-416). New York: Basic Books.

Shai, D., & Belsky, J. (2011). Parental embodied mentalizing: Let's be explicit about what we mean by implicit. *Child Development Perspectives*, *5*(3), 187-188.

Shedler, J., Westen, D., & Lingiardi, V. (2014). *La valutazione della personalità con la SWAP-200*, *nuova edizione*. Milano: Raffaello Cortina.

Solmi, M., Monaco, F., Højlund, M., Monteleone, A. M., Trott, M., Firth, J., & Correll, C. U. (2024). Outcomes in people with eating disorders: a transdiagnostic and disorder-specific systematic review, meta-analysis and multivariable meta-regression analysis. *World Psychiatry*, *23*, 124-138.

Stanley, S. K., Hogg, T. L., Leviston, Z., & Walker, I. (2021). From anger to action: Differential impacts of eco-anxiety, eco-depression, and eco-anger on climate action and wellbeing. *The Journal of Climate Change and Health*, *1*, 100003.

Tanzilli, A., Muzi, L., & Lingiardi, V. (2024a). Manuali e procedure diagnostiche. In Lingiardi, V., *La personalità e i suoi disturbi. Nuova edizione*. Milano: Raffaello Cortina, (pp. 327-388).

Tanzilli, A., & Lingiardi, V. (2022). The diagnostic use of countertransference in psychodynamic practice. In: Biondi, M., Picardi, A., Pallagrosi, M., Fonzi, L. (Eds.), *The clinician in the psychiatric diagnostic process* (151-163). Switzerland AG: Springer Nature.

Tanzilli, A., Fiorentino, F., Liotti, M., Lo Buglio, G., Gualco, I., Lingiardi, V., Sharp, C., & Williams, R. (2024b). Patient personality and therapist responses in the psychotherapy of adolescents with depressive disorders: toward the *Psychodynamic Diagnostic Manual* - third edition. *Research in psychotherapy: Psychopathology, Process and Outcome*, *27*(1), 752.

Thompson-Brenner, H., Satir, D. A., Franko, D. L., & Herzog, D. B. (2012). Clinician reactions to patients with eating disorders: a review of the literature. *Psychiatric Services*, *63*(1), 73-78.

Wang, S., Barrett, E., Hicks, M., Martsenkovskyi, D., Holovanova, I., Marchak, O., Ishchenko, L., Haque, U., & Fiedler, N. (2024). Associations between mental health symptoms, trauma, quality of life and coping in adults living in Ukraine: A cross-sectional study a year after the 2022 Russian invasion. *Psychiatry Research*, 339.

Waska, R. T. (1997). Precursors to masochistic and dependent character development. *American Journal of Psychoanalysis*, *57*, 253-267.

Westen, D., & Shedler, J. (1999a). Revisione e valutazione dell'Asse II: Parte I. Lo sviluppo di un metodo clinicamente ed empiricamente valido. Trad. it. in J. Shedler, D. Westen, V. Lingiardi (a cura di), *La valutazione della personalità con la SWAP-200* (pp. 67–100). Milano: Raffaello Cortina, 2014.

Westen, D., & Shedler, J. (1999b). Revisione e valutazione dell'Asse II: Parte II. Verso una classificazione dei disturbi di personalità empiricamente fondata e clinicamente utile. Trad. it. In J. Shedler, D. Westen, V. Lingiardi (a cura di), *La valutazione della personalità con la SWAP-200* (pp. 101–130). Milano: Raffaello Cortina, 2014.

Westen, D., Gabbard, G. O., & Blagov, P. (2006). Back to the Future: Personality Structure as a Context for Psychopathology. In: Krueger, R.F., Tackett, J.L. (Eds.), *Personality and Psychopathology* (335-384). New York: Guilford Press.

Westen, D., Shedler, J., Bradley, B., & DeFife, J. A. (2012). Una tassonomia delle diagnosi di personalità derivata empiricamente. Colmare il divario tra scienza e clinica nella concettualizzazione della personalità. Trad. it. in J. Shedler, D. Westen, V. Lingiardi (a cura di), *La valutazione della personalità con la SWAP-200. Nuova edizione* (pp. 131-145). Milano: Raffaello Cortina, 2014.

Winnicott, D. W. (1949). La mente e il suo rapporto con lo psiche-soma. In: *Dalla Pediatria alla Psicoanalisi*. Firenze: Martinelli, 1975.

Winnicott, D. W. (1965). *Sviluppo affettivo e ambiente*. Roma: Armando, 1973.
World Health Organization. (2019). *Descrizioni Cliniche e Requisiti Diagnostici per i Disturbi Mentali, Comportamentali e del Neurosviluppo ICD-11*. Milano: Raffaello Cortina, 2025.
Zeeck, A., Gruteser, V., Lau, I., Egenolf, M., Klose, C., Lienhart, S., & Hartmann, A. (2025). Countertransference in the treatment of patients with eating disorders. *Journal of Eating Disorders*, *13*(1), 240.

Conflict of interests: the authors declare no potential conflict of interests.

Ethics approval and consent to participate: not required.

Received: 3 February 2026.
Accepted: 17 February 2026.

Licensee PAGEPress, Italy
Ricerca Psicoanalitica 2026; XXXVII:1153
doi:10.4081/rp.2026.1153