A Primer for Clinicians on Alternatives to the *DSM-5*

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Abstract

Various researchers have been developing alternatives to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*). However, most clinicians are too busy to keep up with progress on these alternatives. Therefore, this article serves as a "primer" for clinicians by introducing four alternatives to the *DSM-5* that are currently garnering significant attention: *International Classification of Diseases* (*ICD-10* and *ICD-11*), *Psychodynamic Diagnostic Manual 2* (*PDM-2*), Hierarchical Taxonomy of Psychopathology (HiTOP), and Power Threat Meaning Framework (PTMF). The Research Domain Criteria (RDoC) research initiative is also briefly discussed. The basics of each alternative system are presented and their primary strengths and weaknesses identified. All four systems show promise but have significant obstacles to overcome before they can be deemed viable substitutes for the *DSM-5*.

Keywords: *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), *International Classification of Diseases* (*ICD*), *Psychodynamic Diagnostic Manual 2* (*PDM*), Hierarchical Taxonomy of Psychopathology (HiTOP), Power Threat Meaning Framework (PTMF)

Public Significance Statement

This article offers a "primer" on several systems that can serve as either alternatives or supplements to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) in the diagnosis, conceptualization, and formulation of mental health concerns. Offering an invaluable resource to clinicians, students, and the lay public, the authors summarize the strengths and weaknesses of the *International Classification of Diseases* (*ICD-10* and *ICD-11*), *Psychodynamic Diagnostic Manual 2* (*PDM-2*), Hierarchical Taxonomy of Psychopathology (HiTOP), and Power Threat Meaning Framework (PTMF), while also briefly mentioning the Research Domain Criteria (RDoC) research initiative.

A Primer for Clinicians on Alternatives to the *DSM-5*

Although the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) remains the foremost diagnostic system used by mental health professionals, dissatisfaction with it remains high. Recurring questions have arisen about the *DSM*'s reliability, validity, and high comorbidity rates (Widiger, 2016). Critics also complain that the *DSM-5* inappropriately medicalizes everyday problems (Frances, 2014; Kinderman, 2017). Consequently, numerous alternatives to the *DSM-5* have been proposed in recent years. However, although psychologists and counselors have expressed support for the development of diagnostic alternatives (Gayle & Raskin, 2017; Raskin & Gayle, 2016), most clinicians remain relatively unfamiliar with existing alternatives. To rectify this, four alternatives to the *DSM-5* are briefly described: *International Classification of Diseases* (*ICD-10* and *ICD-11*; World Health Organization [WHO], 1992, 2019a), Hierarchical Taxonomy of Psychopathology (HiTOP; Kotov et al., 2017), *Psychodynamic Diagnostic Manual 2* (*PDM-2*; Lingiardi & McWilliams, 2017), and Power Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018a, 2018b). Each of these alternative schemes faces daunting challenges that must be overcome for them to compete with, supplement, or serve as replacements for the *DSM-5*. Herein, we summarize and evaluate these diagnostic alternatives for clinicians who may be unfamiliar with them.

International Classification of Diseases (*ICD*)

Overview

The *ICD* is in the process of rolling out its 11th edition (WHO, 2019a, 2019b). Unlike the sold-for-profit *DSM*, the *ICD* is free resource and openly available online (Goodheart, 2014). It is authored by the World Health Organization (WHO), which currently has 194 different member countries (http://www.who.int/countries/en/) and is officially part of the United Nations. Thus, in contrast to the *DSM*, which is written and published by a single U.S. professional organization (the American Psychiatric Association), the *ICD* is a product of international cooperation. The *ICD* is the worldwide standard for

cataloging all diseases and health conditions, not just mental disorders (WHO, 2019a, 2019b). However, successive revisions have expanded its mental health diagnostic clout (Goodheart, 2014); *ICD* provides the world its most widely used mental health diagnostic system (Keeley et al., 2016).

Many clinicians believe they must use the *DSM*, without realizing that its diagnostic codes are imported from the *ICD* (Goodheart, 2014). Use of *ICD* codes for all billing claims was mandated in the U.S. with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Clark et al., 2017). Thus, using *ICD* codes for insurance purposes is required, but using the *DSM* is not. The *DSM* has been able to incorporate *ICD* codes because the two manuals are highly similar in structure and assumptions. Both divide presenting problems into discrete and mutually exclusive medical model diagnostic categories. They even attempt to "harmonize" these categories so that their respective diagnoses are alike or identical (Sanders, 2011). As such, the *ICD* is the diagnostic alternative most similar to the *DSM*.

For now, the *ICD-10* (https://icd.who.int/browse10/2016/en) remains the current edition implemented globally. The *ICD-11* was released in 2018 and is under review by WHO member countries, and should go into effect in 2022 (WHO, 2019b). Some countries—including the U.S.—adapt their own *clinical modifications* of the *ICD* (*ICD-10*-CM; U.S. National Center for Health Statistics, 2015). These clinical modifications follow their own revision schedules (Clark et al., 2017). This explains why the U.S. did not switch from *ICD-9* to *ICD-10* until 2015, even though *ICD-10* was approved two decades prior.

Diagnostic Model

Definition of Disorder and Diagnostic Guidelines

The *ICD-11* describes mental disorders as "syndromes characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioural functioning" (WHO, 2019a). This is consistent with the *DSM-5* (American Psychiatric Association, 2013). *ICD* provides *diagnostic guidelines*, symptom descriptors to aid in making diagnoses. They are similar to

DSM's diagnostic criteria, but less rigid—reflecting how *ICD* has traditionally given clinicians more latitude to rely on their own judgment than has the *DSM*, which emphasizes more rigid criteria (Clark et al., 2017; Paris, 2015; WHO, 1992). When diagnosing, the *ICD* typically offers greater flexibility than *DSM* (e.g., minimum symptom duration of *about two weeks,* as opposed to *two weeks*) (Clark et al., 2017).

Diagnostic Groupings

ICD-10's mental disorders section (code F) is subdivided into 10 major disorder groupings organized by syndrome similarity (Roberts & Evans, 2013; WHO, 1992). Under a somewhat different organizational scheme, *ICD-11*'s mental disorders section (code 6) is subdivided into 21 major disorder groupings (WHO, 2019a). Importantly, *ICD-11* has moved sexual dysfunctions and gender incongruence out of the mental disorders section (Reed et al., 2016). Although these issues remain diagnosable, *ICD-11* no longer considers them mental disorders. A comparable move would not be possible for the *DSM* because its scope is limited to mental disorders; it could only reclassify sexual dysfunctions and gender dysphoria as non-mental disorders by removing them from the *DSM* entirely. *ICD*'s broader scope allows it to retain these diagnoses without grouping them as mental disorders.

Comparison to *DSM-5*

As noted, efforts have been made to "harmonize" the *DSM* and *ICD* (Goodheart, 2014), with mixed results (Blashfield et al., 2014). However, several areas of divergence are worth mentioning. While the *DSM-5* combined substance use and substance dependence into *substance use disorder*, the *ICD-11* maintains the abuse-dependence distinction by continuing to differentiate *harmful use* from *dependence* (WHO, 2019a). Additionally, the *ICD-11* has added *complex PTSD* and *prolonged grief disorder* as trauma-related disorders (WHO, 2019a), even though these remain criteria sets for further study in the *DSM-5* (American Psychiatric Association, 2013). Finally, *ICD-11* has radically altered personality disorder diagnosis. To address comorbidity problems, it has eliminated all of the familiar personality disorder categories and replaced them with a single diagnosis of *personality disorder*, which

clinicians assess using five personality trait dimensions (*negative affect*, *detachment*, *dissociality*, *disinhibition*, and *anankastic features*) and a *borderline* qualifier (Bach & First, 2018; WHO, 2019a). In doing so, the *ICD-11* went further than the *DSM-5*, which retained traditional personality disorder categories despite also including a hybridized dimensional/categorical proposal for further study (Krueger et al., 2012).

Strengths and Weaknesses

Goal of Enhancing Clinical Utility

The *ICD-11* attempts to enhance clinical utility without compromising diagnostic validity (First et al., 2015). Arguably, the *ICD* may suffer from the same elusive quest for validity that some critics claim plagues the *DSM* (Paris, 2015) After all, only some *DSM* and *ICD* categories have established construct validity, and even then the links between diagnosis and treatment in psychiatry are not nearly as strong as in other areas of medicine (Lilienfeld & Treadway, 2016). Steven Hyman (2010), chair of WHO's International Advisory Group for the Revision of the *ICD-10* Mental and Behavioural Disorders and a *DSM-5* Task Force member, noted that diagnostic validity cannot be achieved simply by refining disorder criteria.

Aiming for Cross-Cultural Applicability

The WHO has tried to ensure the *ICD-11*'s cross-cultural applicability (Roberts & Evans, 2013). Its *ICD-11* field testing program stressed cultural and linguistic adaptability of diagnostic constructs (Clark et al., 2017). To increase local cultural validity, individual countries may develop adaptations/clinical modifications (Roberts & Evans, 2013). This level of cultural sensitivity is something the *DSM*—with its American-centric diagnostic depictions—has been accused of lacking (Paris, 2015).

Too Much Clinical Judgment?

The *ICD-11* unshackles clinicians from unreasonably finite criteria, but giving too much credence to clinician judgment may be problematic. Precise diagnostic criteria in the *DSM* were developed to

improve reliability and accuracy of diagnosis, effectively making it less subjective (Paris, 2015). There has been some provocative research elucidating how clinicians often overestimate the accuracy of their clinical judgment (Garb et al., 2016). *ICD-11* may exacerbate this problem.

Potential Medicalization of Everyday Problems in Living

Despite aiming for cultural validity, the *ICD*—like the *DSM*—remains rooted in a medical model, which critics believe overattributes mental distress to individual afflictions at the expense of social-cultural explanations (Kinderman, 2017). By making criteria more inclusive, diagnostic manuals do risk medicalizing everyday problems (Paris, 2015). Diagnostic inflation due to oversensitive diagnostic criteria can lead to the misallocation of scarce resources (Frances, 2014). First et al. (2015) stated that including lower-limit thresholds for minimally symptomatic presentations will generally be avoided in the *ICD-11* clinical descriptions and diagnostic guidelines unless empirically established. However, the *DSM* and *ICD* have been criticized for improperly medicalizing many forms of emotional distress. With its medical model categorical approach, the *ICD* provides the most well-known and viable—but also least different—alternative to the *DSM*, one that American clinicians may or may not ultimately warm to.

Hierarchical Taxonomy of Psychopathology

Overview

HiTOP is a quantitative, dimensional classification system that organizes symptoms and traits of syndromes into cohesive, hierarchical spectra (Hengartner & Lehmann, 2017). Disorders are defined and arranged by their relationships to one another, rather than being conceptualized as discrete categorical entities. The HiTOP Consortium, a group of 70 investigators led by Dr. Roman Kotov, is conducting the seminal research behind this new diagnostic approach (Krueger et al., 2018). The taxonomy is consolidated into a representative diagram (see Figure 1), which is being continuously refined as new research becomes available. Updates to the project are periodically published on HiTOP's website (https://renaissance.stonybrookmedicine.edu/HITOP).

HiTOP is being developed by conducting exploratory and confirmatory factor analyses to empirically derive patterns of co-occurrence among recognized psychological symptoms without heeding reified *DSM* or *ICD* categories (Conway et al., 2019; Kotov et al., 2017). This seeks to capture diagnoses that fall within fuzzy boundaries between existing diagnoses (or normality), as well as heterogeneous presentations of common disorders inconsistently described using categorical diagnoses. Emphasizing a much more dimensional approach to diagnosis, HiTOP aims to address the comorbidity quandary generated by categorical *DSM* and *ICD* diagnoses, as well as remedy these manuals' overuse of catchall "unspecified" designations (Kotov et al., 2017). Although common *DSM-5* disorder names are provisionally referenced in the HiTOP system, Kotov et al. (2017) note that this is purely to facilitate communication until more research can validate HiTOP's own dimensional disorder constructs.

The hierarchy strives to capture how psychopathology is organized "in nature"; it takes complex and mixed phenotypic client presentations and intuitively identifies the empirically-established, higher-order pathology that these presentations share (Krueger et al., 2018). HiTOP eschews all-or-nothing diagnostic categories by placing its elements on continuous spectra, plotted along dimensions of severity and organized into levels indicating degrees of correlation (Kotov et al. 2017). HiTOP dimensions are hypothesized to be phenotypically correlated due to shared etiology (Lahey et al., 2017).

Diagnostic Model

Spectra Dimension Approach

From broadest to most specific, HiTOP's spectra dimensions are hierarchically organized as follows: *superspectrum*, *spectra*, *subfactors*, *approximate syndromes/disorders*, *signs/symptoms/components*, and *traits* (Conway et al., 2019; Kotov et al. 2017). Higher domains can explain the interdependence and co-occurrence of lower groups (Hengartner & Lehmann, 2017). HiTOP integrates normal personality traits into its model of psychopathology, something categorical systems fail to do (Hengartner & Lehmann, 2017). This is useful diagnostic information because personality has

been shown to influence the course of disorder; personality traits have been demonstrated to be twice as powerful as diagnoses at predicting impairment (Hengartner & Lehmann, 2017). The consortium's research into personality structure yielded something similar to the five trait domain model presented in the *DSM-5*'s pr10otifie (but not yet approved) hybrid-trait model of personality disorders (American Psychiatric Association, 2013). HiTOP's five personality traits are *negative affectivity, detachment, disinhibition, antagonism,* and *psychoticism* (Kotov et al., 2017); these traits are theorized to be directly related to five of the six spectra in the current HiTOP model (Widiger et al., 2019).

HiTOP's *spectra* are its primary innovation. These spectra constitute the taxonomy's highest descriptive class, under what is believed to be a unifying *general psychopathology superspectrum* (or *p* factor) (Kotov et al., 2017; Lahey et al., 2017). Research to define and validate the general factor is ongoing (Krueger et al., 2018). Although the *p* factor remains somewhat amorphous, it can be thought of as the mechanism that undergirds HiTOP's entire hierarchical system (Lahey et al., 2017). Every first-order dimension loads into the general factor of psychopathology: the overarching correlation uniting all mental health symptomology (Lahey et al., 2017). HiTOP's six *spectra,* their *subfactors* (the characteristic manifestations of psychopathological behaviors exhibited by each spectra), and some commonly correlated syndromes are described below.

HiTOP's Six Spectra Dimensions

Internalizing spectrum. This spectrum comprises and expands upon what many clinicians think of as emotional disorders and accounts for their frequent co-occurrence (Kotov et al., 2017; Waszczuk et al., 2017). It is characterized by the personality trait of *negative affectivity,* which refers to the tendency to experience negative emotional reactions disproportionate to the provoking stimulus (Lahey et al., 2017). Subfactors included in this spectra are *sexual problems, eating problems, fear, distress,* and *mania* (which also loads into the *thought disorder* spectrum) (Conway et al., 2019; Kotov et al., 2017). To elaborate and sort the internalizing spectrum, all symptoms of emotional disorders in the *DSM-IV-TR*

and *ICD-10* were investigated by Waszczuk et al. (2017) using a revised form of the Interview for Mood and Anxiety Symptoms (IMAS; Kotov et al., 2015). Eight dimensions were identified that closely paralleled *DSM-5* disorders: Vegetative Symptoms, Cognitive Depression, PTSD, Panic, Social Anxiety, Phobia, OCD, and Mania (Waszczuk et al., 2017).

Thought disorder spectrum. Traditional constructions of psychotic disorders, cluster A personality disorders, and bipolar disorders load into the thought disorder spectrum (Kotov et al., 2017). The mania subfactor consists of three components: euphoric activation, hyperactive cognitions, and reckless overconfidence (Waszczuk et al., 2017). The *psychoticism* personality trait moderates the approximate syndromes associated with this dimension, which tend to exhibit facets of avolition, eccentricity, and reality distortion (Conway et al., 2019; Kotov et al., 2017).

Disinhibited externalizing spectrum. This spectrum explains links between *substance abuse* and *antisocial behavior* subfactors (Kotov et al., 2017). The disinhibition trait involves impulsive risk and excitement seeking, with a marked disregard for others (Conway et al., 2019; Kotov et al., 2017).

Antagonistic externalizing spectrum. This spectrum is correlated with the disinhibited externalizing spectrum, but antagonistic externalizing behaviors are directed towards others with the intention to elicit a reaction from, hurt, or control them (Krueger et al., 2018). No specific subfactors have been ide11otified that mediate this spectrum, but many cluster B personality disorders load into it.

Detachment spectrum. Data are currently limited for HiTOP's detachment dimension (Conway et al., 2019). It is tentatively included in the current version of the hierarchical system to account for remaining personality pathology reflecting disengagement from others, suspicion, and anhedonia (histrionic personality disorder has a negative loading into this spectrum) (Kotov et al., 2017).

Somatoform spectrum. This spectrum catalogs symptoms involving conversion of psychological stress into physical maladies. However, its correlation to the rest of the hierarchical model is unstable

and subject to more extensive investigation; it appears in HiTOP provisionally, but may be omitted if it cannot be further substantiated (Conway et al., 2019; Kotov et al., 2017).

Comparison to *DSM*

HiTOP embraces a much more dimensional approach than the *DSM*, which remains mostly wedded to categorical diagnosis (Kotov et al., 2017). No reliable evidence of between-disorder or within-disorder boundaries has been established for categorical diagnoses; much existing evidence suggests that psychopathology is dimensional (Hengartner & Lehmann, 2017). The correlations among *DSM-IV* diagnoses themselves resulted in people often meeting criteria for multiple diagnoses (Lahey et al., 2017). Comorbidity, poor symptom specificity, low reliability and notable heterogeneity of supposedly unique diagnoses are all categorically-created issues that impede efforts to explore etiology, underlying syndrome relationships, and even treatment responses (Clark et al., 2017; Conway et al., 2019). HiTOP attempts to resolve such issues, proclaiming an aversion to reification; syndromes that do not consistently emerge in the researchers' multivariate factor analyses will not be retained in the final system (Kotov et al., 2017). HiTOP's current model is not final; rather, it aims to spur further inquiry free from the influence of reified categorical constructs (Krueger et al., 2018). HiTOP's emphasis on dimensionality addresses the issue of arbitrary categorical diagnosis cutoffs, potentially making it an effective system to characterize *everyone*, even those with sub-threshold presentations of psychopathology (Kotov et al., 2017). HiTOP research has found that its spectra, rather than variance specific to diagnoses, best account for dysfunction (Kotov et al., 2017).

Despite HiTOP's skepticism about *DSM* categories (Hengartner & Lehmann, 2017), for now HiTOP syndromes are tied to associated *DSM-5* diagnoses for convenient communication; however, once HiTOP's empirically derived building blocks of dimensional syndromes, maladaptive traits, and homogenous components are firmly established, its developers believe that *DSM* labels will become obsolete (Kotov et al., 2017). Until then, the included diagnostic labels can facilitate cross-walking with

the *DSM* (Krueger et al., 2018). HiTOP currently harmonizes well with the *DSM*, but this may not last because the goal is to discard *DSM* categories when HITOP's dimensional model is more fully developed.

Strengths and Weaknesses

HiTOP's Parsimony

Because it can be summarized in a succinct diagram, HiTOP could quickly gain traction. There could be many benefits in utilizing a parsimonious diagnostic system that plainly conveys psychopathology using six spectra dimensions rather hundreds of categories (Kotov et al., 2017). However, this strength could also be HiTOP's fatal flaw. Navigating diagnostic constructs dimensionally poses sociopolitical obstacles (Krueger et al., 2018); HiTOP might need something similar to *ICD* diagnostic codes to streamline communication (and financial exchanges) among clinicians and insurers. Although HiTOP's authors believe it "is poised for clinical implementation" (Conway et al., 2019, p. 13), it has yet to be widely disseminated for effective application in direct care settings (Kotov et al., 2017). In addition, at this time HiTOP does not include symptoms/syndromes that account for *DSM-5* neurodevelopmental diagnoses such as autism spectrum disorder and intellectual disability disorder.

Need for "Actionable Ranges" and Clinical Measures

Clinical settings require making treatment decisions based upon initial assessments (Kotov et al., 2017). To accommodate this, "actionable ranges" on HiTOP dimensions will need to be determined so clinicians can distinguish scores that indicate clinical intervention may be warranted (Kotov et al., 2017, p. 458). These sorts of clinical decisions are usually achieved with the aid of corresponding assessment tools. The Consortium presently has a Measures Development Workgroup constructing numerous HiTOP-specific assessment instruments, which will conversely influence further structural research (Krueger et al., 2018). Until they are ready, Kotov et al. (2017) provide a detailed review of existing compatible assessment tools that harmonize with HiTOP's core concepts; amalgamations of the MMPI-2 Restructured Form (MMPI-2-RF), the Personality Assessment Inventory (PAI), and the Achenbach System

of Empirically Based Assessment (ASEBA) can be used for HiTOP assessment in clinical settings (Kotov et al., 2017).

Research Benefits

Because studies are usually conducted investigating questions pertinent to one categorical mental disorder at a time, progress has been slow in identifying causal risk factors (Lahey et al., 2017). HiTOP aims to change this. It could influence psychotherapy outcome research by measuring effect sizes across multiple HiTOP dimensions at once, yielding to more transdiagnostically effective therapy (Conway et al., 2019). HiTOP's dimensions may also be broad enough to capture neurobiological abnormalities that do not consistently appear in category-specific studies of mental disorders (Kotov et al., 2017). When performing meta-analyses of neurobiological research, it is difficult to detect statistically significant, disorder-specific effect sizes (Conway et al., 2019). Measures of brain function do not heed arbitrary disorder boundaries; some findings reflect actions of symptoms common to many categorical *DSM* diagnoses (Conway et al., 2019). Kotov et al. (2015) point out that twin studies have demonstrated genetic factors are shared within each of HiTOP's six spectra. Spectra-specific environmental risk factors have begun to be identified (Kotov et al., 2017). Most environmental stressors have non-specific influences on psychopathology, increasing the individual's *general* susceptibility to psychopathology (McLaughlin, 2016).

The current HiTOP consortium aims to continue research on spectra, clarify the relationship between personality and psychopathology, establish the utility of HiTOP constructs for research and practice, and develop a robust diagnostic model with corresponding assessment instruments (Krueger et al., 2018). HiTOP represents a new type of diagnostic system that overhauls the disjointed artifacts categorical diagnosis engenders across many domains. Kotov and his team seek to render a complete, empirically validated picture of psychopathology at once (Krueger et al., 2018)—a massive undertaking the impact of which remains to be determined.

***Psychodynamic Diagnostic Manual* (*PDM-2*)**

Overview

Compared to the atheoretical approach of *DSM* and *ICD*, and the strictly empirical emphasis of HiTOP, the *Psychodynamic Diagnostic Manual* (*PDM*) conceptualizes mental distress via a specific theoretical orientation. The *PDM* system, first published in 2006 and revised in 2017, explicitly adopts a psychodynamic orientation (American Psychoanalytic Association, 2006; Lingiardi & McWilliams, 2017). The *PDM-2* seeks to complement *ICD* and *DSM* by incorporating psychodynamic formulations that go beyond simple symptom presentation (Hilsenroth et al., 2018). It combines three-dimensional assessment axes to describe the whole person. These dimensions are *personality syndromes* (P), *mental functioning* (M), and *symptom patterns and subjective experience* (S) (Jurist, 2018). Mental disorders are considered amalgamations of personality traits, symptoms, and signs that produce distinct meanings for clients and which are essential to understand when making diagnoses (Lingiardi et al., 2015).

The *PDM-2*'s sections are organized developmentally and address adults, adolescents, children, infancy-early childhood, the elderly, assessments, and case illustrations (Huprich et al., 2015). The *PDM-2* sees personality as more relevant to clinical outcomes than traditional diagnostic categories (McWilliams et al., 2018); its developers assert that the *DSM* and *ICD* do not sufficiently assess normal personality (or more broadly, *character*) in a clinically useful way (Lingiardi & McWilliams, 2017). Instead of shying away from the supposedly incalculable complexities of personality, attachment, mentalization, insight, personalized morals, and motivations, the *PDM* plunges into the depths of subjectivity, harkening back to a pre-*DSM* era less preoccupied with observable symptoms (Frances, 2018).

Diagnostic Model

The *PDM-2*'s diagnostic complexity arises out of its signature 3 axis assessment (P axis, M axis, and S axis). Each axis is modified slightly to be developmentally appropriate when formulating diagnoses for adults, adolescents, children, infants, and the elderly (Lingiardi & McWilliams, 2017). Emphasizing

personality corroborates the assertion that the *PDM-2* is a "taxonomy of people," not just a "taxonomy of disorders"; although not everyone exhibits symptoms of psychopathology, everyone does have a personality style that the *PDM-2* maps using its 3 axes (Lingiardi & McWilliams, 2017; McWilliams et al., 2018). The *PDM-2* claims that its ability to classify personality exceeds all other contemporary diagnostic manuals (Lingiardi & McWilliams, 2017; McWilliams et al., 2018).

P Axis: Personality Syndromes

The P Axis assesses the client's level of *personality organization*—the underlying dynamic processes that determine adaptation and functioning, which are rated on a spectrum ranging from *healthy, neurotic, borderline,* to *psychotic* (Bornstein, 2018; Lingiardi & McWilliams, 2017). The clinician evaluates, using a 1 to 5 scale, the client's goodness of fit with 12 *personality syndromes*—the characteristic ways a person responds intra- and interpersonally. These personality syndromes are arranged by internalizing and externalizing spectra: *depressive*, *dependent*, *anxious-avoidant and phobic*, *obsessive-compulsive*, *schizoid*, *somaticizing*, *hysteric-histrionic*, *narcissistic*, *paranoid*, *psychopathic*, *sadistic*, and *borderline* (Bornstein, 2018; Lingiardi & McWilliams, 2017). For each personality style, the *PDM-2* provides a narrative description and then describes 6 key features: *contributing constitutional-maturational pattern*, *central tension/preoccupation*, *central affects*, *characteristic pathogenic belief about self*, *characteristic pathogenic belief about others*, and *central ways of defending* (Lingiardi & McWilliams, 2017). Importantly, the *PDM* sees no firm boundary between a personality style and disorder; people exhibit personality styles (which can be assessed on the P axis) without necessarily qualifying for a *DSM* personality disorder (Lingiardi & McWilliams, 2017).

M Axis: Profile of Mental Functioning

The M Axis aims to capture unique capacities of mental functioning present in both psychological health and pathology (Lingiardi & McWilliams, 2017). This axis assumes that even if two clients are diagnosed with the same categorical disorder, their mental functioning will not be identical

(Gordon & Bornstein, 2018). It dimensionally quantifies client functioning across 12 areas, under four domains of *cognitive and affective processing, identity and relationships, defense and coping,* and *self-awareness and self-direction* (see Table 1). Using clinical judgment and recommended assessment inventories, clinicians scale clients from 1 (low functioning) to 5 (high functioning) on each M Axis capacity and then sum the scores for an overall rating of personality functioning (Lingiardi & McWilliams, 2017). Scores between 54-60 are considered healthy; 40-53, neurotic; 19-39, borderline; and 12-18, psychotic (Lingiardi & McWilliams, 2017).

When selecting assessment tools to further quantify M Axis functioning, the most apt are measures of intelligence, working/episodic memories, neuropsychological functioning, learning capacity/disability, attention regulation, and executive function (Lingiardi & McWilliams, 2017). The M Axis specifically conceptualizes personality as emerging from the integration of nature (genetic predisposition, temperament, traits) and nurture (social-cultural context, experience, attachment style, and learning) (Lingiardi et al., 2015). M Axis assessment may predict how likely a client is to collaborate on treatment goals, the quality of the therapeutic relationship, and interpersonal dynamics (Lingiardi et al., 2018). Essentially, this axis sheds light on *what is happening in the room* while conducting therapy, as well as what may be happening elsewhere in the client's life (Jurist, 2018).

S Axis: Symptom Patterns (The Subjective Experience)

The S Axis focuses on the subjective experience of symptoms using traditional *ICD* and *DSM* diagnoses—something that allows a degree of harmonization with *ICD* and *DSM* (Hilsenroth et al., 2018). The S axis lists *DSM* disorders, but includes additional psychodynamic descriptions of what the experience of these disorders is like. The narrative descriptions of common symptom patterns overlap greatly with the *DSM-5* and include all relevant *DSM* syndromes (Lingiardi et al., 2015; Lingiardi & McWilliams, 2017). However, the S axis adds what is implicit but unstated in the *DSM-5*: the subjective experience of symptoms (Lingiardi & McWilliams, 2017). For most *DSM* disorders, it describes affective

patterns, mental content, somatic states, and associated relationship patterns—as well as the subjective experience of the therapist and clinical illustrations (Lingiardi & McWilliams, 2017). This provides the language and tools to convey that two people with the same symptoms can have entirely different subjective experiences of their disorder (Mundo et al., 2018). The S Axis also includes subjective descriptions of what it feels like to be on certain psychotropic medications (Mundo et al., 2018).

Time is a pivotal variable in *PDM-2* formulation in a more complex way than the *DSM* and *ICD*'s simplified "durations"; clinicians are encouraged to explore why a client symptom is occurring now, whether it is related to a life event, if it is historically recurrent, and its associated triggers (Mundo et al., 2018). Many syndromes on the S Axis also include information about therapists' typical reactions to clients who present with certain symptomology; this provides clinically useful information often excluded in other diagnostic approaches (Bornstein, 2018). The *PDM-2* parses out idiosyncratic countertransference reactions from relatively universal subjective responses to diagnostic syndromes (Mundo et al., 2018). Unlike the *DSM-5*, the *PDM-2* offers guidance on what therapeutic relationship dynamics might be most helpful (or risky) when working with certain pathologies (Jurist, 2018). The S Axis' appendix also offers the option to record "Psychological Experiences That May Require Clinical Attention" (such as psychological manifestations of oppression) without pathologizing them (Lingiardi & McWilliams, 2018); thus, social-cultural factors are afforded an important role in *PDM* diagnosis.

Assessment Tools

PDM-2-specific assessment tools are available at no cost (Lingiardi et al., 2015). The Psychodiagnostic Chart (PDC; Gordon & Bornstein, 2012) is included in the manual itself, providing a clinician-friendly instrument to summarize and quantify all axes' results (Gordon & Bornstein, 2018; Lingiardi & McWilliams, 2017). The PDC allows clinicians to integrate diagnostic data from the *ICD* or *DSM* into their formulations (Gordon & Bornstein, 2018). All axes' dimensions are also accompanied by lists of standard psychological assessment suggestions for measuring the theoretical constructs included

in a *PDM-2* diagnosis (Lingiardi & McWilliams, 2017). To fully formulate a client's problem, the *PDM-2* urges clinicians to combine various types of evaluations (Bornstein, 2018; Lingiardi & McWilliams, 2017). When comparing performance-based with self-report measures, the *PDM-2* encourages attention to meaningful similarities and differences; for instance, a quality evident in a performance test but absent in self-reports suggests that the client lacks insight into that characteristic (Bornstein, 2018).

Comparison to *DSM*

The *PDM-2* is more strengths-based than *DSM* and *ICD*, seeking a holistic appreciation of people, not just their symptoms (Jurist, 2018). This is important because functional and dysfunctional psychology differ by degree, not kind; most problems therapists treat are severe forms of normal human reactions (McWilliams, 2016). *PDM-2* symptoms in and of themselves do not constitute disorders; they are merely expressions of individuals attempting to cope with underlying distress (Huprich et al., 2015). *PDM-2* diagnoses tap into underlying *themes* of pathology, providing a more process-focused approach to diagnosis that does not rely exclusively on symptoms (Gordon & Bornstein, 2018). When characterizing symptoms with the *PDM-2*, the therapist scales symptom severity, which provides more information than the *DSM*'s categorical "present or absent" approach. The *PDM* does not see disorders as chronic; symptomology will be in flux throughout the individual's lifetime, and attention is given to the meanings clients make of their own distress across experiential contexts (Huprich et al., 2015).

Strengths and Weaknesses

Nuanced and Innovative

The *PDM-2* is "halfway between a diagnostic manual and a sophisticated text of psychopathology" (Kernberg, 2018, p. 295), with unparalleled attention to developmental presentations of client concerns. Chapters of the manual are organized developmentally because the authors believe it is clinically naïve to describe a 4 and 14-year-old's capacity for mental functioning in terms of the same standards (Lingiardi et al., 2015). The *PDM* section on infant psychopathology has been especially well-

received (Lingiardi et al., 2015), perhaps because the *PDM-2* is the only diagnostic manual to distinguish infants' psychopathology (Huprich et al., 2015). A targeted approach to assessing elderly clients is another innovative contribution of the *PDM-2* (Lingiardi & McWilliams, 2018).

The principle pursuit of any diagnostic manual is to promote better therapeutic outcomes—diagnosis in itself is not the end goal (Hilsenroth et al., 2018). Human behaviors are the most complex, idiosyncratic phenomena to attempt to quantify and predict; to discount their inherent subjectivity while attempting to assess them seems inappropriate (Frances, 2018). Lingiardi et al. (2015) believe that "to ignore mental complexity is to ignore the very phenomena of concern to therapists" (p. 110). Mental health clinicians treat clients, not pathologies (McWilliams, 2011). According to *PDM* editor Nancy McWilliams (2016), mental health practitioners of various theoretical orientations have expressed difficulty reconciling the activity of psychological diagnosis—which is dimensional, inferential, contextual, and integrative—with diagnostic systems that implicitly devalue the complexity of human psychology. Unlike other manuals, which explain *what* psychopathology people are exhibiting, the *PDM-2* attempts to answer questions about *why* and *how* they are experiencing it (Hilsenroth et al., 2018). This is clinically useful information that only this alternative diagnostic system can account for.

Ability to Stand Alone?

Whether the *PDM* can realistically stand alone as an independent nomenclature has yet to be determined (Lingiardi et al., 2015). Its creators intend it to function as a supplement to existing manuals. Currently, *PDM-2* diagnoses are only accepted for billing reimbursement in New Zealand (Lingiardi & McWilliams, 2017). However, the manual has been gaining popularity in Europe as an adjunct to the *ICD* and *DSM* (Gordon & Bornstein, 2018). McWilliams (2016) referred to the mental health industry's "path dependence" (when infrastructure is founded upon certain integral technologies) in conceding that the chances of adopting a new nosology besides the *DSM* or *ICD* are "remote."

Too Much Theoretical Allegiance?

Many may be deterred by the *PDM*'s blatant theoretical allegiance, despite research suggesting non-psychodynamic psychologists approve of it (Gordon, 2009). The *PDM-2* considered renaming itself the *Psychological Diagnostic Manual* to be more inclusive, but its editors were discouraged from doing so out of concern that the second edition would depart from the "brand" of the first (Huprich et al., 2015; Lingiardi & McWilliams, 2017). Of course, using a psychodynamic formulation does not necessitate a psychodynamic course of treatment; any range of eclectic therapies could be appropriate (Bornstein, 2018). However, whether non-psychodynamic clinicians will embrace *PDM* remains unclear.

Too Complex for Everyday Practice?

Otto Kernberg (2018) stated that for diagnosing mental disorder, the "PDM-2 is the most sophisticated presently available system we have" (p. 294). However, its profusion of detail is matched by its more than 1,000 page length. Allen Frances (2018) proposed an abbreviated version of the *PDM-2* for use in clinical practice (as was done for the *DSM*) because the time it takes to get acquainted with the text is a practical concern for clinicians. Therapists who work in fast-paced clinical settings with pressure to diagnose (and treat) patients quickly may struggle to incorporate the *PDM-2*; its nuance and depth may be impractical in many clinical settings (Kernberg, 2018). Ongoing promotion, exposure, and integration into clinical practice will be required for the *PDM-2* to gain traction. This is not to say the *PDM-2* has failed to make any inroads. City College of New York's Psychological Center requires *PDM-2* diagnoses to be made at intake, as well as be incorporated into the clinic's ongoing research (Jurist, 2018). Further, the *PDM* has received international attention, with various foreign language translations (Lingiardi et al., 2015). Jurist (2018) asserted that the American Psychiatric Association must be made aware of the *PDM-2*'s existence. Time will tell if the *PDM-2*'s innovative approach will help it become a more widely used diagnostic alternative.

Power Threat Meaning Framework

Overview

The Power Threat Meaning Framework (PTMF) repudiates the medical model of functional psychiatric diagnosis in favor of a new conception of mental distress that emphasizes trauma-informed, narrative case formulation (Johnstone & Boyle, 2018a). In a PTMF conceptualization, symptoms are not the result of brain dysfunction, but sensible survival strategies that insulate the individual from negative operations of power and threat in their environments (Johnstone & Boyle, 2018a). Johnstone and Boyle (2018a) deconstruct the tendency to locate pathology within individuals. Highlighting the impact of social factors on emotional wellbeing and the importance of clients' own experiential narratives, PTMF's essential message to people seeking psychosocial services is:

> You are experiencing a normal reaction to abnormal circumstances. Anyone else who had been through the same events might well have ended up reacting in the same way. However, these survival strategies may no longer be needed or useful. With the right kind of support, you may be able to leave them behind. (Johnstone & Boyle, 2018a, p. 18)

The PTMF was produced by psychologists from the British Psychological Society's Division of Clinical Psychology (DCP). These psychologists consulted with mental health service users, who shared their formative experiences in mental healthcare systems (Johnstone & Boyle, 2018a). The project was launched after the *DSM-5* was released in an attempt to address critical shortcomings of the medical model of mental illness (Johnstone & Boyle, 2018a). PTMF sees the reification of the "*DSM* mindset" as irresponsible because, despite the *DSM*'s strong advocacy of a medical model of mental illness, biological and genetic bases for diagnosing psychological dysfunction have yet to be discovered. As an alternative, the PTMF conceptualizes distress as arising from social circumstances; it is *mediated*—not caused—by biology (Johnstone & Boyle, 2018a). Rather than attributing mental distress to dysfunctions

inside people, the PTMF sees distress as the product of social forces; instead of asking "what is wrong with you," it asks "what has happened to you" (Johnstone & Boyle, 2018a).

When trying to understand psychological upset, the PTMF's social-cultural orientation encourages people to examine causes outside themselves; "symptoms" are just embodied manifestations of meaning-based threat responses (Johnstone & Boyle, 2018a). The PTMF does not aim to be a diagnostic manual categorizing and sorting all possible meaning-based threat responses. However, it does serve as a "foundational intellectual resource" that presents seven evidence-based *Provisional General Patterns* of threat response arising from a prototypical *Foundational Pattern* (Johnstone & Boyle, 2018a). These patterns do not correspond with traditional diagnostic categories, but *DSM* diagnoses which correspond with certain patterns are listed in each pattern summary.

Diagnostic Model

The PTMF's authors do not consider it a diagnostic system, as they are opposed to traditional psychiatric diagnosis in which pathology is located inside people. Instead, the PTMF is put forward as a way to map and understand the social forces impacting clients and the ways in which clients respond and make sense of what has happened to them. Six foundational assessment questions guide the clinician's formulation of the client. Remarkably, any interpretations are co-created within the therapeutic dialogue. This is consistent with Johnstone and Boyle's (2018a) view that the act of expertly assigning a diagnosis constitutes the ultimate operation of ideological power, which can harm and traumatize the individual further. In their view, diagnosis incorrectly presupposes that clinicians have greater insight into clients' lives than do clients themselves. Throughout the course of PTMF formulation, appraisals are made as to which of a client's *core needs* (i.e. safety, secure early attachments and later relationships, autonomy, justice, meaning and purpose, etc.) have been violated over the person's lifetime and how the individual has compensated for these insults (Johnstone & Boyle, 2018a). It is worth noting that the influences of power, threat, meaning, and threat responses are

intertwined within actual narratives; these influences are distinguished from one another not because they are distinct in any absolute sense, but merely for the sake of explanation (Johnstone & Boyle, 2018a).

Power

The PTMF concept of *power* addresses "what has happened to you" by asking "how is power operating in your life?" Analyses of power are absent from mainstream psychological discourses used to name and define emotional distress (Boyle, 2020). Power can operate positively or negatively, as well as with or without the person's conscious awareness. Seven types of power that can impact people's experiences are outlined in the PTMF (Johnstone & Boyle, 2018a, pp. 206-207):

- *Biological or embodied power* (e.g., strength, physical appearance, embodied talents/abilities, physical health)
- *Coercive power or power by force* (e.g., violence, threats, intimidation)
- *Legal power* (e.g., arrest, imprisonment, hospitalization)
- *Economic and material power* (e.g., wealth, education, safety/security, privacy)
- *Social and cultural capital* (e.g., social identities, social connections, knowledge/qualifications)
- *Interpersonal power* (e.g., power to protect/help/care for others, and having choice in whether to do so)
- *Ideological power* (e.g., power to assign meanings to things, to control agendas and how issues are framed and talked about)

Adverse childhood experiences, abuse, homelessness, being able-bodied, rich, and holding political office are all conceptualized by PTMF as involving power relations.

Threat

When assessing threat, the clinician asks the client "how did it (power) affect you" and "what kind of threats does this pose?" In PTMF, *threat* is anything that impedes the core needs of the person from being met. The PTMF identifies various types of core threats. These include *relational threats* (e.g., attachments, shame, bereavement), *emotional threats* (e.g., feeling overwhelmed or unsafe), *social/community threats* (e.g., injustice, loss of roles, isolation), *economic/material threats* (e.g., poverty, lack of access to services, inability to meet physical needs), *environmental threats* (e.g., lack of safety, entrapment, displacement), *bodily threats* (e.g., chronic pain, bodily invasion, exhaustion), *knowledge and meaning construction threats* (e.g., lack of opportunity to make meaning, lack of access to information to make meaning, devaluing of one's own knowledge), *identity threats* (e.g., lack of support to develop identity or imposition of devalued identities), and *value base threats* (e.g., loss of purpose, beliefs, meanings) (Johnstone & Boyle, 2018a, p. 207).

Meaning

Assessment of *meaning* asks clients "what sense did you make of the power exerted against you" and "what is the meaning of these situations and experiences to you?" Meaning is the thread which holds all elements of the PTMF together (Johnstone & Boyle, 2018a). Client meanings are interdependent, influenced by multiple people and multiple contexts (Cromby, in press). The PTMF draws its tenets of meaning construction from an assortment of theoretical schools, including critical realism, phenomenology, process philosophy, and social constructionism (Cromby, in press; Johnstone & Boyle, 2018a). The person's position of power within society is taken into account; it is vital for the therapist to grasp clients' meanings to effectively treat their distress. The PTMF enumerates various meaning descriptors that clients may invoke—such as *afraid*, *abandoned*, *helpless*, *unworthy*, *trapped*, *inferior*, *blameworthy*, *shamed*, *dangerous*, and *abnormal* (Johnstone & Boyle, 2018a, p. 208). Any distinctive emotional or value-laden appraisal can serve as a meaning descriptor.

Threat Responses

People respond to threat with different *threat responses*. When understanding client threat responses, clinicians ask "what did you have to do to survive" and "what kinds of threat responses are you using?" Traditionally, symptoms have been deemed dysfunctional, disordered, and meaningless indicators of underlying biological abnormality; the tendency to describe them this way has been referred to as invoking "vocabularies of deficit" (Gergen, 1990; Johnstone & Boyle, 2018a). In the PTMF, threat responses are meaningful, sensible reactions to abnormally stressful circumstances that serve survival functions for the individual (Johnstone & Boyle, 2018a). Numerous behaviorist paradigms are used to conceptualize how threat responses are developed and maintained (Cromby, in press). When addressing a threat response, a pivotal question is whether it is serving a purpose in the person's current environment, or if it is outmoded. Some potential threat responses include *fight/flight/freeze*, *hypervigilance*, *learned helplessness*, *hearing voices*, *emotional dysregulation*, *intellectualization*, *bingeing*, *ritualized behaviors*, *distrust*, *substance use*, *relational strategies*, *rumination*, *impulsivity*, *self-harm*, *sleep disturbances*, and *attention/concentration problems* (Johnstone & Boyle, 2018a, pp. 211-212). The PTMF groups them by most common developmental stage or intellectual capacity.

Power Resources

When assessing a client's *power resources*, the questions asked are "what are your strengths" and "what access to power resources do you have?" This is consistent with strengths-based counseling theories. Clients are aided by helping them identify what resources they have access to that could ease their distress. Examples of power resources include *strong peer or family relationships*, *secure early attachments*, *access to educational and vocational opportunities*, *time for leisure*, *skills*, and *religion or other belief systems* (Johnstone & Boyle, 2018a, pp. 98-99).

Narrative

The PTMF emphasizes *narrative*, the ways in which clients and professionals generate stories to help explain and remedy client difficulties. Thus, in PTMF's narrative approach, clients are asked "what is your story" and "how does all this fit together?" When re-storying narratives with clients, clinicians search for more helpful meanings to alleviate anguish. This empowers clients to both make and find their own meanings independent of or in opposition to dominant discourses (Johnstone & Boyle, 2018a). However, the PTMF acknowledges the factual constraints that life circumstances impose upon the meanings that people can create (Johnstone & Boyle, 2018a). Narratives are products of social interactions (Harper, in press). By reintroducing clients' reactions back into their social contexts, the PTMF does not construe mental distress as an exclusively individual problem remedied via healthcare; instead, it shifts toward emphasizing larger societal solutions (Johnstone & Boyle, 2018a).

Provisional General Patterns

Clinicians arrange the components discussed above into narrative summaries of evidence-based patterns. Several of these patterns hone in on common and established case presentations, referred to as *Foundational Patterns*. These are not meant to diagnose clients, but rather validate their experiences and normalize common threat response strategies. Verbs are used in the titles of provisional patterns to reinforce the idea that these are things people *do,* not illnesses they *have* (i.e., surviving a threat rather than suffering from a deficit) (Johnstone & Boyle, 2018a). The PTMF includes a *Provisional General Pattern of Identity* that contains various sub-patterns. These sub-patterns include things such as identifying as or being identified by others as "mentally ill," female, male, a member of a minority group, or having an intellectual disability (Johnstone & Boyle, 2018a). Other *Provisional General Patterns* describe common strategies for surviving: rejection, entrapment, and invalidation; disrupted attachments and adversities in childhood; separation and identity confusion; defeat, entrapment,

disconnection, and loss; social exclusion, shame, and coercive power; and single threats (Johnstone & Boyle, 2018a). Clients may identify with more than one pattern (Johnstone & Boyle, 2018a).

Comparison to *DSM*

The PTMF proposes that formulation captures the nuances of client experience much better than discrete diagnostic categories do (Johnstone & Boyle, 2018a). The PTMF is skeptical of the ever-expanding list of *DSM* disorders; its authors point out that *DSM*'s tendency toward increasingly fine-grained distinctions among an expanding array of diagnostic categories has not translated into improved reliability or validity (Johnstone & Boyle, 2018a). The PTMF views the *DSM*'s ongoing efforts to divide different combinations of thoughts, feelings, and behaviors into discrete medical-model diagnostic categories as a fool's errand (Johnstone & Boyle, 2018a). Johnstone and Boyle (2018a) argue that assertions that emotional distress are biological brain diseases have been overstated; they see it as unethical that medical model explanations—such as the serotonin theory of depression—are often put forward as unassailable facts when they remain working hypotheses. From Johnstone and Boyle's (2018a) perspective, overstating the definitiveness of medical model explanations robs clients of the opportunity to develop alternative (more socially and contextually rooted) meanings that avoid portraying them as biologically defective.

In the PTMF, symptoms are emergent properties of complex interactions among biological, psychological, and social systems in response to operations of power, threat, and meaning. The framework goes deeper than traditional "biopsychosocial" or "vulnerability-stress" models of mental illness (Boyle, 2020). Perhaps due to the historical supposition that mental illness entails irrationality and a lack of insight, the *DSM* devotes little time to how the meanings people make of their experiences and symptoms mitigate distress (Johnstone & Boyle, 2018a). The *DSM* claims to be atheoretical and acultural but, according to the PTMF's authors, disowns its own role in making Western

conceptualizations of mental illness the dominant discourse—which the PTMF would likely identify as a clear instance of ideological power in action (Johnstone & Boyle, 2018a).

Strengths and Weaknesses

***Not a Replacement for* DSM**

Johnstone and Boyle (2018a) make clear that the PTMF will not replace the *DSM* or *ICD*, largely because the "*DSM* mindset" is so deeply ingrained in psychiatric discourse. Nonetheless, PTMF formulation can add depth and nuance to a standard diagnostic code. Proposing a gradual integration of PTMF principles into current mental health care, the PTMF's authors draw from numerous trauma-informed service delivery models, including ones developed by the U.S. Department of Health's Substance Abuse and Mental Health Services Administration's (SAMHSA) and Australia's Blue Knot Foundation (Johnstone & Boyle, 2018b). They point to what they see as a flaw in our current healthcare system, namely that a psychiatric diagnosis is usually a prerequisite for receiving services; the client must accept a stigmatized identity to gain the privilege of psychotherapy (Johnstone & Boyle, 2018a; Slade & Longden, 2015). However, this problem with our healthcare delivery system is not something that can easily be changed.

In many respects, the PTMF is more a continuing education resource than an alternative diagnostic manual, especially because those using the PTMF may still be required to provide diagnostic codes drawn from the *DSM* and *ICD*. Aside from offering a provocative alternative to how clinicians typically conceptualize client problems—one that tries to do justice to more socially-grounded understandings of emotional distress—the PTMF's practical usability in everyday practice remains unclear. Further, it is a brand new framework, one with which few practitioners are familiar. Research on how the PTMF performs in real-world clinical settings has yet to be compiled.

Broad Theoretical Framework or Practical Alternative to Diagnosis?

Although the PTMF will be welcomed by clinicians favoring a nonmedicalized approach to counseling and psychotherapy (Strong, 2019), some PTMF concepts appear difficult to pin down operationally. Of course, given their rejection of "clinician-as-expert" and deficit models of "pathology," it is unclear whether the PTMF's authors are trying to provide a tangible system for clinicians to assess and map client distress. Perhaps they are merely offering a theoretical framework for conceptualizing practice broadly without imposing concrete means for generating collaborative assessments. If so, this may explain why they have not provided validated assessment tools to measure or organize the variables of identity and experience the authors propose. Nonetheless, their current definitions of power, threat, and meaning would likely benefit from both theoretical refinement and a stronger research base. Meaning, in particular, seems especially vague as currently defined in the PTMF—with it mainly consisting of a series of emotion-related words that fail to delve deeply into the idiosyncratic personal ways in which people make sense events; it is unclear how clinicians are supposed to use the PTMF's list of emotion-related words to understand their clients. The PTMF might benefit by borrowing some meaning assessment methodologies from George Kelly's (1955/1991a, 1955/1991b) personal construct theory (PCP)—perhaps the original meaning-making theory in psychology. Doing so might improve the PTMF by lending it well-established methodologies for measuring personal meaning.

Emphasis on Social Underpinnings of Distress

Given that the PTMF recasts "mental health crises" as "social crises" (Pilgrim, in press), two related questions arise. First, many clinicians will disagree with PTMF's contention that *all* human suffering should be recast as socially caused; even those who think social factors are grossly underrepresented in current mental health theory and who resist overly medicalized and pathologized conceptions of human distress are likely to see a role for biological and psychological factors. Second, if we accept the premise that many of the presenting problems that other diagnostic schemes view as

mental illnesses are better understood as due to social factors, then should such problems continue to fall under the purview of healthcare providers and be paid for by insurance companies as reimbursable medical services? Further, is it reasonable to expect clients who are in acute distress to be up to the task of questioning the foundations of mainstream diagnostic practices and engage in narrative analysis of how power and threat have led them to their current situation (Harper, in press)? The PTMF offers an important social corrective to medicalized approaches to human distress. The practical utility of the PTMF can only be determined by further clarifying its theoretical premises, implementing it more thoroughly in practice, and conducting research to see how well it performs.

Research Domain Criteria (RDoC)

A fifth initiative, the Research Domain Criteria (RDoC), is not summarized in depth because it presently remains a research initiative rather than a ready-to-use *DSM* diagnostic alternative. RDoC is being developed by the National Institute of Health (NIMH, n.d.-a). Its aim is to conduct basic research on biological and psychological processes with an ultimate goal of eventually yielding a new diagnostic system in which diagnoses can be made using observable biomarkers (Cuthbert, 2014; Sanislow et al., 2019). RDoC research has produced an evolving matrix (revised as data comes in), which currently consists of six domains: *negative valence systems* (things like fear, anxiety, threat, loss, and frustration), *positive valence systems* (response to rewards, learning, and habit creation), *cognitive systems* (attention, perception, memory, and language skills), *systems for social processes* (emphasizing development of attachment, social communication skills, and understandings of self and others), *arousal and regulatory systems* (concerned with arousal, emotional regulation, and sleep-wake cycles), and *sensorimotor systems* (motor action, the sense of agency/ownership, habits, and innate motor patterns) (NIMH, n.d.-b; Sanislow et al., 2019). Whether RDoC's goal—a biomarker-based diagnostic system that defines disorders in mainly terms of presumed underlying and measurable etiologies—is something clinicians can realistically expect to achieve in the short- or long-term remains to be seen.

Concluding Comment: Obstacles Facing Diagnostic Alternatives

ICD, *PDM*, HiTOP, and PTMF are readily available diagnostic systems that clinicians can currently utilize. The question is whether any of them pose a significant threat to the authority, influence, and preeminence of the *DSM*. It seems that the main obstacles they must overcome are (a) the lack of familiarity with them by most practicing clinicians, (b) their tendency to avoid using traditional diagnostic categories (with the exception of *ICD*), (c) questions about their ease of use, (d) the need for research evidence (especially for the newest alternative, PTMF), and (e) current inability to use these systems for most insurance billing purposes (again, with the exception of *ICD*). Only time will tell whether any of the alternatives will be successful in overcoming these barriers and, in so doing, be able to challenge the longstanding hegemony of the *DSM*.

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Figure 1

The Hierarchical Taxonomy of Psychopathology (HiTOP)

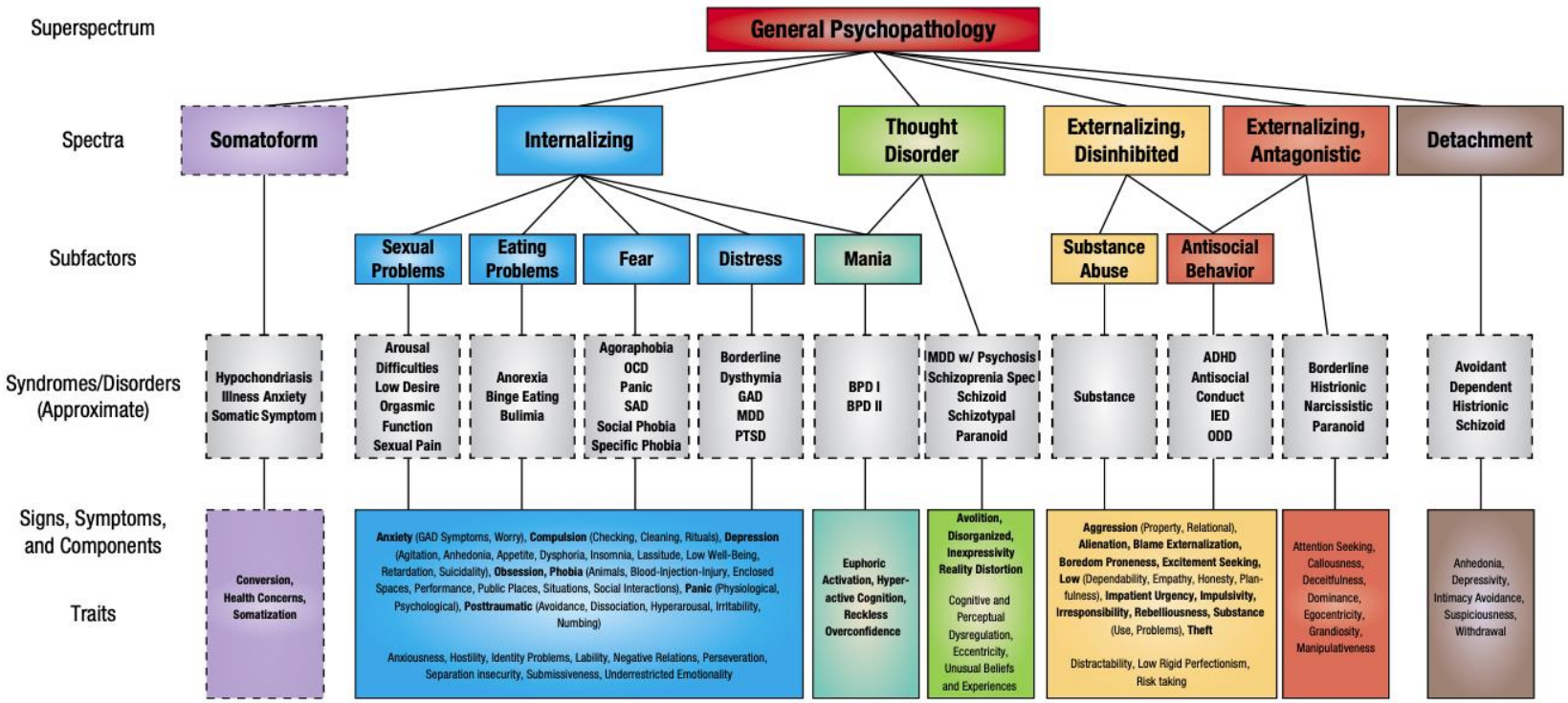

Fig. 1. HiTOP consortium working model. Constructs higher in the figure are broader and more general, whereas constructs lower in the figure are narrower and more specific. Dashed lines denote provisional elements requiring further study. At the lowest level of the hierarchy (i.e., traits and symptom components), conceptually related signs and symptoms (e.g., phobia) are indicated in bold for heuristic purposes, with specific manifestations indicated in parentheses. ADHD = attention-deficit/hyperactivity disorder; BPD = bipolar disorder; GAD = generalized anxiety disorder; HiTOP = Hierarchical Taxonomy of Psychopathology; IED = intermittent explosive disorder; MDD = major depressive disorder; OCD = obsessive-compulsive disorder; ODD = oppositional defiant disorder; SAD = separation anxiety disorder; PD = personality disorder; PTSD = posttraumatic stress disorder.

Note: From "A Hierarchical Taxonomy of Psychopathology can Transform Mental Health Research," by C. C. Conway et al., 2019, *Perspectives on Psychological Science*, *14*(3), p. 422 (https://doi.org/10.1177/1745691618810696).

Table 1

M-Axis Functioning in PDM-2

M-Axis capacities	Rating scale
1. Capacity for regulation, attention, and learning	5 4 3 2 1
2. Capacity for affective range, communication, and understanding	5 4 3 2 1
3. Capacity for mentalization and reflective function	5 4 3 2 1
4. Capacity for differentiation and integration	5 4 3 2 1
5. Capacity for relationships and intimacy	5 4 3 2 1
6. Capacity for self-esteem regulation and quality of internal experience	5 4 3 2 1
7. Capacity for impulse control and regulation	5 4 3 2 1
8. Capacity for defensive functioning	5 4 3 2 1
9. Capacity for adaptation, resiliency, and strength	5 4 3 2 1
10. Self-observing capacities (psychological mindedness)	5 4 3 2 1
11. Capacity to construct and use internal standards and ideals	5 4 3 2 1
12. Capacity for meaning and purpose	5 4 3 2 1
	Total score = ____

Note: From *Psychodynamic Diagnostic Manual* (2nd ed.), 2017, by V. Lingiardi and N. McWilliams (Eds.), The Guilford Press, p. 118.