

The contribution of Sidney Blatt's two-polarities model to the Psychodynamic Diagnostic Manual

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ABSTRACT

This article reviews the theoretical and empirical contributions of Blatt's two-polarities model of personality development and psychopathology to the second edition of the Psychodynamic Diagnostic Manual (PDM-2). First, we briefly provide an overview of the manual's main features and describe the guiding principles of the revision process. We then discuss in more detail how Blatt's model, which is focused on the dialectic interaction between *anaclitic-introjective* and *relatedness vs self-definition* dimensions in both normal and disrupted personality development, increases the PDM-2's theoretical and empirical comprehensiveness and clinical utility, especially concerning the classification and assessment of personality and overall mental functioning in adult populations. Finally, we address the implications for the therapeutic process, showing how anaclitic and introjective patients may be differentially responsive to different psychodynamic techniques (e.g., supportive or expressive interventions). Taken together, these considerations demonstrate the importance of a more theory-driven and empirically informed diagnostic system that embraces, in accordance with Sidney Blatt's empirically supported and psychoanalytically-oriented ideas, the complexities of human experience (both normal and pathological) and captures the subjective and underlying dynamics of psychological symptoms and syndromes.

Key words: Relatedness; Self-definition; Two-polarities model; Psychodynamic Diagnostic Manual; Personality development.

Introduction

Both the *Psychodynamic Diagnostic Manual* (PDM) (PDM Task Force, 2006) and Blatt's (2008) two-polarities model are pertinent to an era of critical change in psychi-

atric nosology. This period began with the publication of the DSM-III [American Psychological Association (APA), 1980], which represented a shift from a dimensional, inferential system to a neo-Kraepelinian descriptive, symptom-focused, multiaxial classification relying on present-versus-absent criteria for the identification of discrete mental disorders. One of Blatt's most important contributions, which has continued to evolve over more than five decades of scholarship (see Auerbach, 2016; Luyten & Blatt, 2016; Oasi, 2015; Zuroff, Sadikaj, Kelly, & Leybman, 2016), is a comprehensive conceptual approach aimed at understanding the person and rooted in a psychodynamic, developmental, empirically grounded perspective. Paralleling to what has been noted with the PDM, Blatt moved beyond the DSM's intentionally atheoretical description of psychological syndromes to offer a unified model that include two interlocked domains: a) personality development (relating to adaptive/disrupted personality organization and psychopathological manifestation) (Luyten & Blatt, 2013) and b) psychotherapy process and outcome (Blatt & Ford, 1994; Blatt & Shahar, 2004; Blatt, Zuroff, Hawley, & Auerbach, 2010).

Similarly, both the PDM-1 and the forthcoming PDM-2 (Lingiardi & McWilliams, *in press*) are openly psychodynamic diagnostic systems that offer a systematic description of healthy and disordered personality functioning, include individual profiles of mental functioning and symptom patterns, and describe differences in individuals' personal, subjective experiences of symptoms and the related experiences of treating clinicians. Further-

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more, both the PDM and Blatt's model provide a framework for improving comprehensive treatment approaches, enabling clinicians to formulate individual cases and to plan the best possible intervention for each patient.

In this theoretical article, we provide an overview of the main features of the PDM-2. We then discuss in more detail how Blatt's anaclitic-introjective dimensions have influenced the descriptions of personality styles or disorders (P Axis) and overall mental functioning (M Axis) in adult populations. Finally, we address the clinical implications for the therapeutic process and outcome.

Toward the second edition of the *Psychodynamic Diagnostic Manual*: Blatt's contribution

The first edition of the *Psychodynamic Diagnostic Manual* (PDM-1) (PDM Task Force, 2006) represented the collaborative efforts of five sponsoring organizations: the American Psychoanalytic Association, the International Psychoanalytical Association, the Division of Psychoanalysis of the American Psychological Association, the American Academy of Psychoanalysis and Dynamic Psychiatry, and the National Membership Committee on Psychoanalysis in Clinical Social Work. The manual had three major sections: *Adult Mental Disorders*; *Child and Adolescent Mental Health Syndromes*; and *Conceptual and Empirical Foundations for a Psychodynamically Based Classification System for Mental Health Disorders*.

Part I (the adult section) opened with the Personality Patterns and Disorders (P Axis), followed by the Profile of Mental Functioning (M Axis). Discussion of symptoms and syndromes and the patient's subjective experience of these (S Axis) were intended to capture the phenomenology of mental illness – the personal, private experience of suffering – from the patient's perspective.

Part II (the children and adolescent section), on the basis of the developing nature of children's psychologies, opened with the Profile of Mental Functioning (MCA Axis), followed by the Emerging Personality Patterns and Disorders (PCA Axis) and the Subjective Experiences (SCA Axis). A special section on *Infancy and Early Childhood (IEC) Mental Health Disorders* followed.

Part III contained a selection of recent and relevant empirical papers by noted scholars on psychodynamic diagnosis and psychotherapy research.

Given the success of the PDM-1 (e.g., Del Corno & Lingardi, 2012; Nussbaum, 2013; Stepansky, 2009), and in response to feedback about its strengths and weaknesses (Bornstein, 2011; McWilliams, 2011), the manual was revised to enhance its empirical rigor and clinical utility (Clarkin, 2015; Huprich et al., 2015; Lingardi & McWilliams, 2015; Lingardi, McWilliams, Bornstein, Gazzillo, & Gordon, 2015).

In order to overcome the paucity of validation data associated with the PDM-1, the second edition gives more attention to the empirical perspective. Furthermore, in

order to thoroughly cover all developmental stages, seven specific task forces were recruited to draft sections relating to: i) adults, ii) adolescents, iii) children, iv) infancy and early childhood, v) the elderly, vi) assessment tools, and vii) case illustrations and PDM-2 profiles. Similar to the previous edition, the PDM-2 guides assessment of a patient's functioning on three dimensions: personality, in terms of both level of organization and style (type), including personality disorder diagnosis, when warranted (P Axis); overall mental functioning (M Axis); and manifest symptoms and concerns (S Axis). Similarly, the order in which these axes are considered varies by section. In the section relating to adults, personality is evaluated before mental functioning; in the sections relating to children, adolescents, and the elderly, mental functioning is evaluated first.

The PDM-2 diagnoses are prototypic, offering a clinician-friendly approach and highlighting patients' internal experiences. The important changes and innovations of the second edition include, in the section relating to adults, the introduction of a psychotic level of personality organization and a description of *borderline personality* as both a type of personality and a level of organization in the P axis; an increased number (from 9 to 12) of mental functions with a Likert-style scale assessment procedure associated with each capacity in the M Axis; and a more thorough integration of the PDM approach with the DSM-5 and the ICD-10, emphasizing the subjective experience of both the patient and the clinician in the S Axis.

Several guidelines for the PDM-2 revision process were influenced by Blatt's conceptualization. Although a detailed description of the complexity of Blatt's thinking is beyond the scope of this contribution, we can briefly outline that in the two-polarities model the process of psychological development consists of a complex interaction between two fundamental psychological coordinates: i) interpersonal relatedness – that is, the capacity to establish and maintain reciprocal, meaningful, and satisfying relationships; and ii) self-definition – the capacity to establish and maintain a coherent, realistic, differentiated, and essentially positive sense of self. These two developmental processes influence each other in synergistic and dialectical transactions, wherein progress in one facilitates progress in the other (Blatt & Blass, 1990; Blatt & Luyten, 2009; Luyten & Blatt, 2011). Psychopathological conditions derive from exaggerated distortions of one developmental line at the expense of the other; such distortions are viewed as compensatory (defensive) attempts to cope with developmental disruptions (Blatt, 2008; Maffei et al., 1995). We note that this conceptualization seems to have influenced Section III's Alternative DSM-5 Model for Personality Disorder, which lists Criterion A for the diagnosis of personality disorder as a moderate or severe impairment in self and interpersonal functioning (APA, 2013; Bender, Morey, & Skodol, 2011).

Both Blatt's approach and the overall orientation of

the PDM-2 rely on a systematic empirical foundation for their assumptions and the development of easily usable assessment instruments that are derived from the theories that influenced them. Among the many contributions of Blatt and his colleagues to the empirical and applied practice of clinical psychology, we note the development of the *Object Relations Inventory* (ORI) (Blatt, Auerbach, & Levy, 1997; Blatt, Stayner, Auerbach, & Behrends, 1996; Huprich, Auerbach, Porcerelli, & Bupp, 2016) and the related *Differentiation-Relatedness Scale* (D-RS) (Diamond, Blatt, Stayner, & Kaslow, unpublished material; Diamond, Kaslow, Coonerty, & Blatt, 1990). Both the performance-based assessment method (the ORI) and the specific rating scale of differentiation-relatedness in descriptions of the self and others (the D-RS) have been extensively studied, and have been found to demonstrate strong clinical utility (see Huprich et al., 2016). In parallel, the PDM-2 introduces a specific Assessment section and some clinician-friendly tools derived from the PDM axes, such as the *Psychodiagnostic Chart-2* (Gordon & Bornstein, 2012; Gordon & Stoffey, 2014) and the *Psychodynamic Diagnostic Prototypes* (Gazzillo, Lingiardi, & Del Corno, 2012; Gazzillo et al., 2015; see also Lingiardi et al., 2015).

Blatt's two-polarities model promotes the integration of the psychodynamic tradition with a wide variety of disciplines, ranging from philosophy and evolutionary and cross-cultural psychology to personality and social psychology (for an extensive review, see Blatt, 2008). Similarly, although psychodynamic practitioners tend to be more familiar with PDM-2 concepts than clinicians of other orientations, the manual has been revised to be consistent with new research and contributions from other traditions, including biological, neuroscientific, cognitive-behavioral, emotion-focused, family systems, and humanistic approaches.

Finally, both models share the assumption that personality and psychological development evolve through the life span, from infancy to senescence (e.g., Blatt & Blass, 1996). Several studies have suggested the importance of Blatt's model in understanding both normal and disruptive psychological development from childhood to adolescence and adulthood (Leadbeater, Kuperminc, Blatt, & Hertzog, 1999; Luyten & Blatt, 2013). The PDM-2 provides a broader perspective on differences in personality and psychological functioning, in line with developmental issues associated with specific age periods. For example, the section relating to adolescents (aged 11-18) is separated from the section relating to children (aged 4-10), and the section on *Infancy and Early Childhood (IEC)* includes a discussion of homotypic/heterotypic continuities, as well as better definitions of the quality of primary relationships. Moreover, the manual provides a section on mental health disorders of the *Elderly*, which was lacking in the first edition and is absent in other diagnostic systems.

The anaclitic-introjective dimensions in the personality and mental axes

Blatt (1974, 2008) and colleagues (Blatt & Shichman, 1983; Blatt & Zuroff, 1992) linked the fundamental polarity of relatedness and self-definition to personality organization, using the term *anaclitic* to describe personalities that are predominantly focused on difficulties involving interpersonal relatedness and the term *introjective* to identify personality styles that are focused primarily on problems with self-definition or identity. Individuals with predominantly anaclitic personality features are preoccupied with issues relating to relationships with significant others, and seek experiences of closeness and intimacy, often at the expense of difficulties managing interpersonal boundaries. Such persons tend to have an anxious-preoccupied attachment style (Levy & Blatt, 1999) and show an intense fear of abandonment or rejection (Luthar & Blatt, 1993); they also tend to act in passive and submissive ways. They are usually emotionally naïve, distractible, easily affected by impressions, and focused on feelings (Werbart & Forsström, 2014). In contrast, individuals with predominantly introjective personality qualities are concerned with self-definition and differentiation, and strive to preserve a sense of autonomy, power, independence, and control. They tend to be assertive, perfectionistic, judgmental, and critical towards the self and others, and may be introverted, distrustful, distant, isolated, and resentful in interpersonal relationships, probably because of a fearful-avoidant attachment style (Blatt & Homann, 1992; Levy & Blatt, 1999). They tend to focus on overt behaviors and logical or rational thinking, rather than on feelings. Noteworthy, these two broad personality configurations are not presented as mutually exclusive categories, but rather as interrelated modes of maladaptation at different developmental levels that occur in response to serious disruptions of the normal dialectical development of interpersonal relatedness and self-definition (Blatt, 2008).

In the P Axis of the adults section, the conceptualization of these two key configurations of personality pathology is examined in depth in connection to specific personality types. According to Blatt, introjective issues seem mainly present in schizoid, schizotypal, paranoid, narcissistic, antisocial and obsessive personality disorders, while anaclitic issues seem more prevalent in borderline, histrionic, and dependent personality disorders (Blatt & Blass, 1990, 1996). Furthermore, the manual recognizes that anaclitic conditions may be accompanied by introjective components and *vice versa*, and therefore describes both manifestations within the same personality type. For example, individuals with a *depressive personality* may be more introjective, berating themselves for real or imagined shortcomings and responding to setbacks with the conviction that they are somehow to blame or have an intrinsic badness. On the other hand, more anaclitically depressive sub-

jects tend to show distress and disorganization in the face of loss and separation, and suffer feelings of emptiness, loneliness, and weakness instead of self-criticism and guilt. It should be noted that some authors share Blatt's original conceptualization of depressive personalities as primarily characterized by anaclitic and introjective variants (Blatt, 1974; Zuroff, 1994; Zuroff & Fitzpatrick, 1995), while others empathize with a more unified perspective, through which an individual with a depressive personality structure is seen as both self-critical and dependent. For example, Westen, Shedler, Bradley, and DeFife (2012) empirically identified a depressive personality syndrome in which both introjective and anaclitic features were salient.

Similarly, several authors from different clinical perspectives have suggested a broad variation in the phenotypic expression of narcissism and the existence of two distinct subtypes of *narcissistic personalities* (Cain, Pincus, & Ansell, 2008; Gabbard & Crisp-Han, 2016; Levy, 2012). According to Blatt's (1983) perspective, the PDM-2 primarily outlines the introjective features of more *grandiose/entitled* individuals, characterized by an exaggerated sense of self-importance, a need for admiration, struggles with issues of autonomy, control, and self-worth, and a lack of empathy (see also Kernberg, 1975; Lingardi, Tanzilli & Colli, 2015; Ronningstam, 2016; Russ, Shedler, Bradley, & Westen, 2008; Tanzilli, Colli, Muzi, & Lingardi, 2015). However, the manual argues that such persons may also have anaclitic features such as a sense of emptiness and a craving for narcissistic supplies from outside the self, in line with the more *vulnerable* variants of this disorder (e.g., Blatt, 1983; Cooper, 1998; Gabbard, 1989; Kohut, 1971; Rosenfeld, 1987).

Furthermore, in the PDM-2's P Axis the anaclitic qualities of *dependent* and *hysterical-histrionic personalities* are suggested by a tendency towards object-seeking and regarding others as powerful and effective; such individuals may act in seductive or passive ways in order to ward off feelings of weakness and defectiveness (Blatt & Shichman, 1983; see also Bornstein, 2005; Cogswell & Alloy, 2006; Westen et al., 2012). At the same time, they may also be moralistic, inhibited, and preoccupied with self-definitional issues such as their sexual adequacy.

In the PDM-2's M Axis, mental functions were increased from 9 to 12, which now include: capacity for regulation, attention, and learning; capacity for affective range, communication, and understanding; capacity for mentalization and reflective functioning; capacity for differentiation and integration; capacity for relationships and intimacy; quality of internal experience, including level of confidence and self-regard; impulse control and regulation; defensive functioning; adaptation, resiliency, and strength; self-observing capacities (psychological mindedness); capacity to construct and use internal standards and ideals; and meaning and purpose. The categories of *differentiation and integration (identity)* and *relationships and intimacy* are strongly influenced by Blatt's clinical

and empirical studies with the Differentiation-Relatedness Scale (D-RS) (Blatt et al., 1996; Diamond et al., 1990) and the Object Relations Inventory assessment method (ORI) (Blatt et al., 1996, 1997; Huprich et al., 2016). In line with these contributions, the first capacity reflects the ability to construct and maintain a differentiated, realistic, coherent, and nuanced representation of the self (identity) and other people. High levels of this mental function imply that a person can appreciate the separateness and relatedness of different affect states, motives, and wishes of the self and others, even when nuanced and ambiguous, and can organize experience and socio-emotional demands over time (i.e., over the past, present, and future) and across contexts with contrasting role demands (e.g., when relating to a spouse versus a parent). Conversely, low levels imply a lack of basic differentiation between the self and others or reliance on maladaptive defenses, such as severe splitting and self-other idealization or devaluation (see also Diamond et al., 1990). The second capacity identifies the person's ability to adjust interpersonal distance and closeness in response to situational demands, including the capacity for reciprocity and mutuality. In line with Blatt's thinking, the manual argues that healthy relatedness reflects not only the degree to which an individual has stable, mutually satisfying relationships with others, but also the quality of internalized object relations and the individual's representations of them.

From theory to clinical practice: implications for the therapeutic process and outcome

Blatt's two-polarities model has been found to discriminate between patients at all levels of psychological health and to have vital implications for the treatment of depression, personality disorders, and other psychopathologies (Blatt, 2004, 2008; Blatt & Zuroff, 1992; Fertuck, Bucci, Blatt, & Ford, 2004; Morse, Robins & Gittes-Fox, 2002; Ouimette, Klein, Anderson, Riso, & Lizardi, 1994). Moreover, a growing body of research demonstrates that patients who show primary conflicts about relatedness (anaclitic patients) and those who show primary conflicts about self-definition and autonomy (introjective patients) may respond differentially to divergent therapeutic approaches (Blatt, Besser, & Ford, 2007; see also Gabbard, 2009; McWilliams, 2004). Using data from the Menninger Psychotherapy Research Project (Wallerstein, 1989), Blatt and Shahar (2004) found that anaclitic patients seemed more responsive to supportive-expressive approaches, whereas introjective patients were more responsive to interpretive-exploratory activity (Blatt et al., 2010).

Improvements in differentiation-relatedness lines have been associated with positive changes in psychological symptoms, global functioning, attachment level, personality organization, and transference relationships during and after treatment (Calamaras, Reviere, Gallagher, & Kaslow, 2016; Diamond et al., 1999; Gruen & Blatt, 1990; Harpaz-

Rotem & Blatt, 2005; Vermote et al., 2010). Therapeutic changes in introjective individuals seem to be most evident when symptom reduction is used as an outcome measure. Anaclitic patients tend to show improvement in the quality of their interpersonal relationships (Blatt & Ford, 1994). These differential results suggest that both personality configurations change in parallel with their basic concerns and preoccupations (Blatt & Auerbach, 2003).

In line with this perspective, the PDM-2 approach promotes an understanding of an individual's full range of functioning and a consequent appreciation of specific therapeutic approaches for different psychologies (Roth & Fonagy, 2005; Westen, Novotny, & Thompson-Brenner, 2004). For example, the manual stipulates that a patient's location on the severity dimension (*i.e.*, whether the person is in the healthy, neurotic, borderline, or psychotic range of personality organization) has important implications for treatment focus, level of therapist activity, explicitness of limit setting, frequency of sessions, and other aspects of intervention. The PDM-2 pays careful attention to therapeutic recommendations for each personality type or disorder. A pertinent example is its observation that when self-critical and self-punitive (introjective) themes are prominent in depressive personalities, such patients may benefit from interpretative interventions that increase insight into the ways in which they defend against angry and critical feelings toward others and direct them against themselves. Conversely, when anaclitic preoccupations with rejection and loss are salient, patients may benefit from having their perceived inadequacies and badness accepted within a relational and supportive therapeutic context. Furthermore, narcissistic patients who have mainly grandiose or introjective features may benefit from a tactful but systematic exposure of defenses against shame, envy, and normal dependency (Kernberg, 1975), while more vulnerable and anaclitic narcissistic individuals may find an empathic attunement and exploration of the therapist's inevitable empathic failures more helpful (Kohut, 1971).

Conclusions

This brief contribution cannot do justice to the richness and complexity of Sidney Blatt's thinking. We hope, however, that it demonstrates that his comprehensive, empirically grounded theoretical framework has had a deep influence on the PDM's formulations of personality and psychological functioning. As noted in prior publications (Lingiardi & McWilliams, 2015; Lingiardi et al., 2015; McWilliams, 2011), the last two decades have seen an increasing tendency to define mental problems primarily on the basis of observable symptoms, behaviors, and traits, with overall personality functioning and adaptation levels noted only secondarily. The anaclitic-introjective distinction, rooted in the underlying interacting and interrelated dimensions of relatedness vs self-definition, has enriched

the clinical utility and heuristic value of the PDM-2 and increased its value to clinicians trying to relieve the psychological distress of the distinctly individual patients who seek their therapeutic help. This is the *raison d'être* of any clinically relevant diagnostic system.

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