

The Psychodynamic Diagnostic Manual: A Review

NORMAN A. CLEMENS, MD

Long frustrated by perceived shortcomings of successive recent editions of the American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III through IV-TR)¹⁻⁴ in defining the psychic ills that plague mankind, a collaboration of psychoanalytic organizations has produced a diagnostic manual that offers a more refined way of categorizing these ills. In the view of at least some psychodynamically oriented mental health professionals, the DSMs focus exclusively on symptoms, behavior, and external appearances, but do not integrate the many individual features of the clinical picture into a coherent understanding of that patient's basic problem. All too often in the real world, signs and symptoms fall into several categories so that a patient carries multiple "comorbid" diagnoses—when in fact there is a core problem with a multifaceted presentation. While recent DSMs have facilitated certain kinds of research and recognition of a medical perspective, it is often difficult to find pure cases to assemble a series or construct a study reflecting real-life conditions.

From DSM-III on, there was an explicit effort (not entirely successful, some believe) to base the criteria on evidence and measurable or observable data, not theory. These purely descriptive DSMs do not assume any relationship between a symptomatic diagnosis and etiology or theoretical basis. However, there is an inherent bias in focusing on symptom constellations, which inclines towards targeted, so-called specific biological or psychological treatments for symptoms. Psychodynamic therapists are disposed to look for underlying psychological issues, such as internal conflicts, unconscious defenses against unacceptable impulses or affects, problems in relationships and self-image, dysfunctional responses to traumatic experiences or losses, or other issues unique to the person. Whereas DSM lumps patients into categories, psychodynamic thinking recognizes major descriptive patterns but individualizes treatment to the life history, needs, developmental stage, and distinctive psychology of each patient.

To fill this gap, an alliance of five major psychoanalytic organizations assembled a Psychodynamic Diagnostic

(PDM) Task Force* of leading scholars. This group conducted an extensive literature review and produced a monumental work, *The Psychodynamic Diagnostic Manual* (PDM).⁵ The PDM is divided into three sections: 1) adult mental health disorders, 2) child and adolescent mental health disorders, and 3) papers on conceptual and research foundations for a psychodynamically based classification system for mental health disorders. The child and adult sections both include three axes: personality patterns/disorders (P axis), profile of mental functioning (M axis), and subjective experience (S axis). The child and adolescent section is further broken down into child and adolescent disorders and mental health and developmental disorders of infancy and early childhood. Cases illustrate how to apply the diagnoses in both the adult and child/adolescent sections. When possible, the diagnostic categories are numbered parallel with the DSM, but the larger number of categories and different theoretical basis often lead down a different path. Diagnostic numbers are preceded by P, M, or S in the adult section; MCA, PCA, or SCA in the child/adolescent section; and IEC in the infancy/early childhood section. The adult section begins with personality patterns/disorders, whereas the child/adolescent section begins with mental functioning, reflecting developmental differences. Statements are frequently supported by citations; long lists of references complete each chapter. The authors frankly admit their psychodynamic bias but hope their work will also be useful to those trained in other traditions.

Classification of Adult Mental Disorders

Putting the dimension of personality (P axis) first in the adult section reflects "accumulating evidence that symptoms or problems cannot be understood, assessed, or treated in the absence of an understanding of the mental life of the person who has the symptoms" (page

*The organizations are listed as American Psychoanalytic Association, International Psychoanalytical Association, American Psychological Association Division of Psychoanalysis, American Academy of Psychoanalysis [now American Academy of Psychoanalysis and Dynamic Psychiatry], and National Membership Committee on Psychoanalysis in Clinical Social Work. The PDM Task Force was headed by Stanley I. Greenspan, MD, Chair, with Nancy McWilliams, PhD, and Robert S. Wallerstein, MD, Associate Chairs.

NORMAN A. CLEMENS, MD, is a clinical professor of psychiatry at Case Western Reserve University and training psychoanalyst in the Cleveland Psychoanalytic Center.

8). The list of personality patterns and disorders is considerably expanded from those considered to be disorders in DSM-IV-TR. There is a distinction between neurotic and psychotic level personality disorders, with the term “borderline” used more in its context of lying between the neurotic and the psychotic, rather than limited to the clinical syndrome described in DSM. Some categories, such as narcissistic and obsessive-compulsive personality disorders, are expanded into sub-categories with sub-numeric codes. Some old friends reappear—for example, depressive and passive-aggressive personality disorders. “Avoidant” becomes “phobic (avoidant)” personality disorder; this change reflects the greater attention the PDM approach gives to the psychodynamics underlying the described behavior patterns. Also returning are old standbys in psychoanalytic thought such as sadistic, sadomasochistic, and masochistic (self-defeating) personality disorders. The older term “psychopathic” also resurfaces with “antisocial” in parentheses as an alternative term.

Not so happily returning is the long-discarded term “hysterical.” This term has taken on a markedly pejorative connotation in common usage and reflects an ancient Greek view that hysteria was etiologically related to the uterus. The current term, “histrionic,” is gender-neutral and more descriptive of some of the behavior that characterizes this category, and it mystifies me why the term *hysterical* was revived in the PDM.

Rather than a checklist of prominent features for each category, several paragraphs of discussion relate observable features of the condition to psychodynamically operative factors. Each personality disorder then has a listing of six characteristic attributes:

- Contributing constitutional-maturational patterns
- Central tension/preoccupation
- Central affects
- Characteristic pathogenic beliefs about self
- Characteristic pathogenic beliefs about others
- Central ways of defending.

Subtypes sometimes include a “converse manifestation,” such as “counterphobic” for phobic. All in all, this section of the PDM provides a rich discussion of personality traits and disorders that I hope will be seriously studied by the authors preparing DSM-V.

The profile of mental functioning (M axis) is a short but pithy chapter that describes important capacities:

- Capacity for regulation, attention, and learning,
- Capacity for relationships and intimacy (including depth, range, and consistency),
- Quality of internal experience (level of self-confidence and self-regard),

- Affective experience, expression, and communication,
- Defensive patterns and capacities,
- Capacity to form internal representations,
- Capacity for differentiation and integration,
- Self-observing capacity (psychological-mindedness),
- Capacity to construct or use internal standards and ideals: sense of morality (pp. 76–83).

It lists characteristics of the capacities and illustrates levels within the “range and adequacy of functioning.”

Obviously, considerable acquaintance with a patient and a degree of psychological sophistication are required to construct this kind of profile. The bottom line reduction to a numbered category ranges from M201, “optimal age- and phase-appropriate mental capacities with phase expected degree of flexibility and intactness,” to M208, “major defects in basic mental functions.” Therapists may find the detailed breakdown of the specific nature of a patient’s deficits more useful than the final numeric designation of severity.

The section on “symptom patterns: the subjective experience” builds more on DSM-IV-TR and often gives tables citing DSM. An important statement bears quoting: “Despite evidence of biological contributions to many mental health problems, however, we do not assume that the presence of multiple symptom expressions inevitably constitutes ‘comorbidity’ between different mental health disorders; we believe that more commonly, they are expressions of a basic complex disturbance of mental functioning” (p. 93). The chapter also stresses relating symptom patterns to developmentally relevant and age-related variables that have implications for individualized treatment. The category of psychotic disorders includes the panoply of schizophrenia and other psychotic disorders, while bipolar disorder is categorized under mood disorders as in the DSM.

The real contribution of this chapter is its thoughtful discussion of the subjective experience of patients who suffer from these conditions. The clinician will find useful descriptions of the conscious and unconscious mental states associated with these disorders and information on developmental experiences and psychodynamic patterns illuminating how they came to be. Again, the information in these elaborations may prove far more useful than the numerical designations.

Classification of Child and Adolescent Disorders

Not being a child and adolescent psychiatrist, I am not equipped to critique the sections on infants, children, and adolescents. My impression is that they provide a worthy introduction to conditions affecting these age groups that

is considerably more in-depth and relevant than the comparable chapter of DSM. The discussion of mental functioning is presented first in the child and adolescent section, giving first priority to the overall person before addressing nascent personality characteristics or presenting symptoms. As in the adult section, abundant clinical illustrations make the theoretical abstractions easier to understand. The section on infant development integrates a neuropsychological dimension with a guide to specific types of observation and assessment. Although numerical designations are given, the most clinically useful material is found in the fine points describing where an infant or child fits on the scales of functioning at particular developmental stages.

Supportive Essays

The final section of the PDM is a collection of essays by internationally known psychoanalysts and researchers. Four papers summarize historical and conceptual foundations. Wallerstein offers a fine historical account of the development of psychoanalytically based nosology. A group of French analysts, Braconnier et al., address suitability and indications for psychoanalytic psychotherapy from multiple perspectives, with an emphasis on the views of Lacan and his followers. Greenspan from the United States and Shanker from the United Kingdom present a developmental framework for depth psychology and a definition of healthy emotional functioning. Shevrin discusses how cognitive behavioral and neurophysiological frames of reference can contribute to a psychodynamic nosology.

Eight papers address international research. Wallerstein presents the historical perspective along with projections into the future. Blatt et al. discuss evaluation of efficacy, effectiveness, and mutative factors. Dahlbender et al. describe the German experience in evaluating psychotherapy. Shedler and Westen present their "SWAP" clinical assessment procedure. Herzig and Licht give an overview of the empirical support for the DSM symptom-based approach to diagnostic classification and raise questions about its validity and reliability. Westen et al. discuss the status of empirically

supported psychotherapies, covering assumptions, findings, and reports from controlled clinical trials. Fonagy from the United Kingdom describes evidence-based psychodynamic psychotherapies. Finally, Leichensening from Germany reviews meta-analyses of outcome studies of psychodynamic therapy and airs some disagreements with Fonagy. This collection of essays goes a long way to counter those who assert that the empirical basis for psychodynamic therapies is weak compared with that for other psychotherapies or medications.

This is a massive volume with 857 pages in a rather large format. In paperback it weighs 3 pounds, 5.7 ounces. Although the index is helpful, the volume is still ponderous to handle and thus unlikely to find use as a bedside manual. The papers on conceptual and research foundations strongly support the theoretical and empirical bases for the PDM. In this respect, they parallel the function of APA's *DSM-IV Sourcebooks*⁶ and *Practice Guidelines*. However, these papers more than double the size of the book. One wonders why the manual was not published in two volumes, with the supportive articles presented in a second volume. Given the evidence presented here that the psychodynamic diagnostic system has solid foundations, it is to be hoped that the Task Force will consider producing a pocket-sized abstraction of the PDM that can be used in the trenches .

References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, third edition. Washington, DC: American Psychiatric Association; 1980.
2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, third edition, revised. Washington, DC: American Psychiatric Association; 1987.
3. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, Fourth edition. Washington, DC: American Psychiatric Association; 1994.
4. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, Fourth edition (Text revision). Washington, DC: American Psychiatric Association; 2000.
5. PDM Task Force. Psychodynamic diagnostic manual. Silver Spring, MD: Alliance of Psychoanalytic Organizations; 2006.
6. Widiger TM, Frances AJ, Pincus HA, et al. DSM-IV sourcebook, volumes I–IV. Washington, DC: American Psychiatric Association; 1994–1998.