The Psychodynamic Diagnostic Manual: A Clinically Useful Complement to DSM


The Psychodynamic Diagnostic Manual1 (PDM) was created by a task force chaired by child psychiatrist Stanley Greenspan, MD, in cooperation with 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.

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Background
Over the past few decades, Greenspan became concerned about the gradual diminishment in professional discourse of in-depth, biopsychosocial case formulation and individual treatment planning. He noted that notwithstanding their laudable efforts to create a more reliable and less theoretically biased classification system than previous taxonomies, the creators of DSM-III and its successors had inadvertently contributed to a mental health culture in which complex, interrelated clinical problems have been reduced to a string of descriptions of behaviors and symptoms (represented ultimately as comorbid diagnoses) that make it difficult to conceptualize integrated and comprehensive therapies for many kinds of problems.

Although the authors of DSM-III, DSM-III-R, DSM-IV, and DSM-IV-TR explicitly disavowed the aim of guiding psychotherapy, the descriptive, noninferential language of those manuals (see Klerman and associates2 for the prototypical debate on the paradigm shift) has come to define the categories in which therapists think and talk, as well as the categories by which outsiders, such as third parties, construe the clinical process. Our understanding of psychotherapy has tilted toward the observable and readily quantifiable. Therapy results have come to be measured almost solely in terms of symptom relief rather than in terms of the patient's growth toward over-all mental health (as defined by such concepts as ego strength, affect tolerance, resilience, and related concepts, all of which have been subject to a long history of disciplined clinical observation and well-designed research).

In the present climate, the claim that there is no empirical evidence supporting psychoanalytical concepts and treatments has been frequently made, most stridently by insurers reluctant to support long-term care. It is true that there are very few randomized controlled trials (RCTs) of more complex and open-ended treatments compared with the number of RCTs of more short-term, symptom-focused therapies. This reflects both cost factors and the complacency of the psychoanalytical community in its long heyday. Despite the scarcity of relevant RCTs, there are abundant scientific data supporting traditional psychodynamic and humanistic treatments and their underlying assumptions about defense,7-10 personality,9,10 affect,11,12 attachment,13,14 and other areas relevant to treatment.

Contemporary neuroscientists15,16 are also weighing in on the biology of the traditional "talking" cures. Empirical studies repeatedly demonstrate that individual personality factors and the quality of the therapeutic relationship account for the lion's share of variance in psychotherapy
outcome.\textsuperscript{17-20} The strengths of the psychodynamic tradition have been its appreciation for individual differences (often framed as neurotic, borderline, and psychotic organizations interacting with defensive patterns and personality styles) and its explication of relationship factors (working alliance, resistance, transference). In other words, psychodynamic formulations and treatments have emphasized precisely the domains that empirical studies have concluded are critical to outcome.

A tradition that has stimulated, responded to, and benefited from a vast body of research in areas critical to clinical process cannot reasonably be said to be without empirical foundation. Greenspan wanted to make this point and to keep alive in the mental health disciplines the psychodynamic appreciation of individual differences, subjective experience, maturational issues, complexity, and inferences about meaning. While he acknowledged that recent editions of the DSM have greatly facilitated certain kinds of research, he felt that clinical reliance on this manual, in the absence of more inferential, dimensional, and contextual biopsychosocial assessment, has skewed our field in disturbing and even countertherapeutic ways, and he concluded that a more practitioner-oriented classification system might compensate for this effect.

Accordingly, with help from leaders of the sponsoring organizations, he established task forces on adult personality structure and pathology, adult symptom syndromes, childhood and adolescent syndromes, assessment of capacities that comprise mental health, and outcome research. He also solicited original papers from noted psychoanalytical scholars and researchers. Despite considerable theoretical diversity among task force members, Greenspan set a collaborative tone and produced the PDM in just 2 years.

**Overview of the PDM**

The text that emerged consists of sections on adults, children and adolescents, and infants and toddlers, followed by the compilation of solicited papers. The first 2 sections are divided into chapters on personality differences (level and type of personality organization), profile of mental functioning (components of mental health such as reality testing, ego strength, affect tolerance, self and object constancy, self-esteem, moral sense, authenticity, mentalization, and reflective functioning), and characteristic subjective experiences (affective, cognitive, somatic, and interperson-al) of patients with DSM-diagnosed disorders. There are 3 extensive case formulations at the end of each section and there are clinical vignettes throughout. The longer case narratives illustrate how patients with similar DSM-diagnosed conditions may require significantly different treatments depending on their unique characteristics and situations.

In the infancy section, there are detailed descriptions of early problems in different realms (eg, interactive disorders, regulatory-sensory processing disorders, sensory modulation difficulties, sensory discrimination difficulties, neurodevelopmental disorders of relating and communicating). These rich and specific depictions suggest the limitations of more reductionistic, currently popular childhood diagnoses, such as attention-deficit/hyperactivity disorder and Asperger syndrome, and have clear practical utility for clinicians treating preschoolers and their families.

So far, the clinical community’s most positive responses to the PDM concern the infancy section. Negative reactions include the complaint that this putatively developmental text lacks a section on the elderly, an omission that will be corrected in the next edition. (Remarkably, it did not occur to anyone on the steering committee—most of whom are older than 60 years—to include a section on geropsychiatry. Denial is evidently not the exclusive prerogative of our patients!)

Citations of empirical and clinical literature pervade the PDM, but the solicited papers (called "Conceptual and Research Foundations"), which make up about half the manual, provide its overall epistemological grounding. These essays are stand-alone articles—most are excellent summaries of their topic areas and are especially useful for therapists in training—that cumulatively undermine the perception that there is no science behind the psychodynamic and humanistic therapies.

**A hypothetical clinical illustration**

What does the PDM add to clinical assessment? Consider a patient complaining of long-standing episodes of severe anxiety unrelated to identifiable triggers. At presentation, she discloses a trauma history, bouts of bingeing and purging, regular marijuana use, anorgasmia, fainting spells, periods of amnesia, and recurrent physical afflictions (eg, unexplained headaches, back pain, menstrual pain,
GI bloating. Describing her condition in DSM terms would require several "comorbid" diagnoses and rule-outs, perhaps including generalized anxiety disorder, bulimia nervosa, cannabis abuse, and posttraumatic stress disorder or amnestic disorder not otherwise specified. The general impression might be of someone with somatization disorder, but the patient reports only 3 pain syndromes, not the 4 required for this diagnosis. This collection of labels captures little that a therapist needs to know to help such a patient.

Via the PDM framework, a more holistic picture might emerge. In terms of personality (P Axis), this woman would be seen as organized psychologically at the borderline level (discriminated from the DSM's borderline personality disorder), with notable problems in affect regulation, self and object constancy, and self-esteem that she has handled with compulsive and addictive behaviors, dissociation, and a characterological tendency to somatize. In the personality section, characteristics of persons in the borderline range are summarized, and therapeutic implications are discussed (eg, clear contracts, structure, here-and-now focus, weathering affect storms). Patients who somatize are described phenomenologically in a narrative and then in terms of their constitutional/maturational patterns and characteristic preoccupations, affects, pathogenic beliefs, and defenses. The manual suggests the importance of such dimensions in psychotherapy.

The patient's profile of mental functioning (M Axis) might reveal her as someone with strengths in regulation, attention, and learning, but with notable deficits in quality of internal experience; capacity for relationships and intimacy; and affective experience, expression, and communication. Such an assessment orients a therapist to certain areas of treatment emphasis.

Finally, the therapist could hone his or her empathic attunement to the patient's problems by consulting the section on the subjective experience of symptoms (S Axis) in the areas of anxiety, eating disorders, substance abuse, and trauma. For example, with respect to eating disorders, affective states noted in the PDM include feelings of being starved for care; feelings of failure, shame, and ineffectiveness; and fear of abandonment, aggression, and loss of control. Cognitive patterns include a sense of being inadequate, incompetent, and unloved, as well as a preoccupation with being young. Somatic states include numbness, confusion about bodily sensations, inability to judge the stomach's fullness, and a sense of physical emptiness that may express a more inchoate psychological emptiness. Issues of control and perfectionism, secrecy about the eating disorder, compliance, and ingratiating may affect relationships.

Conclusion
The PDM deals very little with etiology but deals extensively with the phenomenology of psychopathology. Its language is accessible; jargon is minimal. Although the authors felt they should acknowledge their collective bias by titling the manual "psychodynamic," they tried to make it readable by and useful to practitioners of other orientations, such as biological, cognitive-behavioral, and family systems perspectives.

The PDM is available online at www.pdm1.org, for $35. Through self-publishing, the steering committee was able to make it affordable for students and beginning therapists. The authors invite criticisms and suggestions from the mental health community. The manual is a work in progress that will be only as valuable as it is clinically and pedagogically useful.

References: References

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