PSYCHODYNAMIC TREATMENT RESEARCH

A HANDBOOK FOR CLINICAL PRACTICE

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CHAPTER 7

Psychodynamic Diagnosis in the Era of the Current DSMs

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THE CREATION OF THE DSM-III SYSTEM revealed a tension between research psychiatrists and psychodynamically oriented clinicians, who represented the majority of American psychiatrists. The new DSMs served the research need for reliable diagnostic categories far better than previous diagnostic manuals and spurred a revolution in nosological and epidemiological studies. These studies have been weighted toward achieving nosological reliability, often at the cost of validity. However, the preference of DSM-III and DSM-IIIR for defining diagnostic categories by discrete, observable behaviors with minimal use of clinical theory and inference did not optimally serve the clinical need for good descriptions of patients that would lead to rational treatment decisions (Offenkrantz et al. 1982; Offenkrantz, unpublished). In contrast, although psychoanalysts have not yet developed a scientifically reliable diagnostic system, the psychoanalytic diagnostic method, properly conducted, yields a most detailed and careful clinical assessment. Analysts' diagnostic efforts have been heavily weighted toward assessing character or personality type, aspects of psychological structural integrity, and expectable treatment behaviors and transference responses. However, the absence of an empirically tested, valid, and reliable operational psychodynamic nomenclature has handicapped psychodynamic process and outcome research.

In this chapter we will present the main diagnostic systems that are, and have been, available for psychodynamic clinicians. We will suggest that the current DSM family of diagnoses is a newly sophisticated version of one portion of the traditional diagnostic system for psychoanalysis and dynamic psychotherapy, but that it does not address fully other aspects of

diagnosis significant for psychodynamic research and the clinical assessment of patients. We will review the limitations and constraints of the current DSM system, as suggested by psychoanalysis; these point to the need for both the refinement of existing DSM categories and the inclusion of supplementary measures for the psychodynamic assessment of patients for clinical care as well as research.

Complementary Diagnostic Traditions: The Descriptive and the Dynamic

Medical diagnosis from its earliest days gathered data on the presenting phenomenology of individual patients and fit that data into a classificatory system based on a theory. Where our forebears used the conception of humors, modern medicine turned to physiology and more recently to molecular genetics to explain the relationship between manifest symptoms and underlying pathology. In psychiatry and the mental health professions, the organizing diagnostic system for the past century has been a dual one. The descriptive or phenomenological system of Kraeplin, Freud, Bleuler, and others classified individuals by their shared symptom picture and course. The explanatory psychoanalytic system of Freud, like the basic science of physiology in medicine, organized psychiatric disorders according to theories of the significance of symptoms based on their underlying, core dysfunction. Using these two forms of classification—the phenomenological/descriptive and the explanatory/dynamic—a clinician or researcher can infer useful integrating diagnostic propositions (Frances and Cooper 1981).

The stated goal for the DSM-III and DSM-IIIR manuals (*Diagnostic and Statistical Manual of Mental Disorders,* 3d ed. and 3d ed. revised [American Psychiatric Association 1980, 1987]) was to develop a descriptive, behavior-based approach to diagnosis which would be as free as possible of theoretical assumptions. As much as possible, the new nomenclature was to be based on findings from the empirical research literature and was intended to encourage research. DSM-III introduced two important innovations not found in its predecessors (the first and second editions of the DSM [American Psychiatric Association 1952, 1968]). First, it operationalized diagnostic criteria, fostering enhanced reliability. Second, it introduced a multiaxial system, providing an improved conceptual framework for studying state–trait interactions and biological and social influences on psychopathology.

The new DSM system has had a vast impact upon mental health professionals and has provided a major stimulus to psychiatric research

worldwide. The delineation of the personality disorder axis (Axis II) in the DSM[1] has led to increased diagnosis (Loranger 1990)[2] and empirical study of these disorders. Also of interest to psychodynamic clinicians is Axis V, the global assessment of functioning. This instrument, a slight modification of Luborsky's (1962; Luborsky et al., in press) Health-Sickness Rating Scale, assesses the patient's degree of impairment from symptoms and overall effectiveness of social and occupational functioning on a numeric scale. It is the first scaled, dimensional measure of the patient's life functioning to be included alongside the more usual categorical diagnoses.

Although input and cooperation from analysts was requested during the formulation of DSM-III and DSM-IIIR, for various and complex reasons very little of the psychodynamic diagnostic approach found its way into the new classificatory system. Wilson (1993) describes the professional context out of which DSM-III emerged, outlining the ideological, economic, intellectual, and scientific forces which have led in recent decades to a shift in general psychiatry away from a broadly conceived, biopsychosocial model—one informed by psychoanalysis, sociology, and biology—to a far narrower, research-based medical model. Wilson questions the wisdom of this narrowing of clinical gaze, and we do also. While participation has again been sought from the psychoanalytic community, it is also clear that the intention of the framers of DSM-IV is highly conservative (Frances et al. 1990), and they will make few changes that are not empirically based. Their position does not address the initial error of excluding psychodynamic data and inference as basic to clinical assessment. It seems unlikely that this omission will be corrected in the near future.

Limitations of Current DSM Diagnoses

The DSM-III system has many strengths. As noted previously, the multiaxial system is a great advance, the requirement for operational criteria is a transformation from the dark ages for research, and the delineation of a separate axis for personality disorders has been a boon to their study.

[1]DSM-III's preference for classifying observable rather than inferred phenomena fits with calling Axis II disorders ones of "personality" (the preferred psychiatric term) rather than "character" (the preferred psychoanalytic one). Though definitions of these terms overlap (Moore and Fine 1990; Frosch 1990), *personality* refers to an objective, observable pattern of behavior, deriving from the Greek "persona," or mask, worn in classical Greek theater. Personality refers to a social role. Character, in contrast, refers to a permanent structure which underlies this social role. Some aspects of an individual's character are not necessarily visible, but must be inferred (Auchincloss and Michels 1983; Michels as reported in Lindy 1990).

[2]Loranger (1990) notes that this finding relates in part to the different diagnostic practices of the pre- and post-DSM-III eras (in the former, parsimony of diagnosis was the rule, while the current system encourages multiple diagnoses).

However, the new DSM's preference for a behavior-based, descriptive approach that stays close to observable data and minimizes clinical inference is itself a theoretical position, although a narrow one—that of logical positivism (Faust and Miner 1986; Schwartz and Wiggins 1986; Millon 1987; Schwartz 1991). This theoretical perspective favors behavioral or biological orientations (Michels as reported in Peltz 1987; Frances et al. 1990) over other, potentially more useful, perspectives in the realm of psychopathology (Schwartz and Wiggins 1988).

Critics have questioned the value of the logical positivist perspective for psychiatric diagnosis. While the new DSM nomenclature has been widely lauded by researchers for embracing the scientific standard of operationalism, which holds that a concept has no scientific merit beyond what can be reliably measured, Millon (1987) notes that reliance on an exclusively logical positivist operationalism was questioned decades earlier by leading philosophers of science (Leahey 1980). Polanyi (1958) and Kuhn (1970), among others, demonstrated convincingly that all scientific observations must themselves be construed as representing theoretical constructs, obtaining their meaning through placement in a network of concepts. In the long term, "it is theory that provides the glue that holds a classification together and imparts to it its scientific and/or clinical relevance" (Millon 1987, 111). Moreover, systematic evidence suggests that as sciences mature, they typically progress from an observation-based stage to one characterized by abstract, higher order systems based on theoretical constructs. Millon (1987) notes that "the characteristic which distinguishes a scientific classification is its success in grouping its elements according to theoretically consonant explanatory propositions." Accordingly, "the classes comprising a scientific nosology are not mere collections of overtly similar attributes . . . but a linked or unified pattern of known or presumed relationships among them" (pp. 111–12).

The creators of the new DSM have seriously handicapped psychiatric diagnosis by omitting some of the most useful and widely affirmed concepts in modern psychiatry—unconscious mental processes, intrapsychic conflict, and defenses. Constructing a diagnostic system without the use of these inferred, theoretical concepts limits the nosology to suboptimal clinical and research usefulness. It is as if physicists were to decide that they could not discuss black holes or even electrons because these are inferences derived from theory, not themselves empirically observed.

There is considerable potential for misdiagnosis when psychodynamic considerations are excluded. Take, for example, the narcissistic personality disorder. Narcissistic pathology broadly relates to difficulties with the regulation of self-esteem and the sense of self. A variety of behavioral presentations may be used to defend against painful levels of humiliation. An overt presentation, where the patient is palpably grandiose, devaluing,

exploitative, and entitled, is one possibility, but so is a more covert presentation. A patient may be shy, charmingly dependent, unable to express anger, and easily shamed and humiliated, but covertly envious and rageful, entertaining fantasies of exhibitionistic grandiosity and denigration of supposed heroes. The difference between presentations does not define which patient is more narcissistic, but rather whether aggressive or passive masochistic defenses are being used to protect against recognition of low self-esteem and limited capacity for object relations (Cooper 1987; Cooper and Ronningstam 1992). In short, there are both "quiet" and "noisy" narcissists.

The DSM-III description of narcissistic personality disorder emphasized only the "noisy" version, and, for the most part, this trend continues in DSM-IIIR. In the latter document, a glimmer of change is evident: the description of narcissistic personality refers to a "pervasive pattern of grandiosity (in fantasy *or* behavior)" (American Psychiatric Association 1987, 349; italics added). This reference to the role of fantasy and (subtly and implicitly) to the possibility that a feature (grandiosity) might not be overtly expressed signals a covert acknowledgment of the importance and the unavoidability of psychodynamic considerations in personality disorder diagnosis.

In other current DSM diagnoses, there is some emphasis, although superficial, on conflicts, meanings, motives, object relations, and unconscious phenomena as important alongside overt behaviors. For example, in the DSM-IIIR description of avoidant personality disorder, lacking close friends is explained on the basis of needing unusually strong assurance of uncritical acceptance; avoidants yearn for relationships but cannot permit themselves to have them (Busch and Cooper, unpublished). This is in contrast, say, to DSM-IIIR schizoids, who do not want relationships at all. In DSM-IIIR, individuals with histrionic personality disorder "often act out a role such as . . . 'victim' or 'princess' *without being aware of it*" (American Psychiatric Association 1987, 348; italics added). The current DSM system is struggling under the weight of its exclusion of inferential, psychodynamic data.

Psychodynamic Diagnosis

Historically, psychoanalysis began with an interest in diagnostic specificity which was later obscured by a more narrow focus on analyzability (Bachrach 1978; Bachrach and Leaff 1978; Erle and Goldberg 1979). During the 1950s, as enthusiasm for psychoanalytic treatment expanded rapidly, notions regarding diagnostic assessment began to merge with pressures to assess and predict capacity to be treated by psychoanalysis. With diagnosis

per se in relative eclipse, analyzability became increasingly important as a means of predicting outcome in psychoanalysis. The many large-scale analyzability studies (Kernberg et al. 1972; Appelbaum 1977; Wallerstein 1986; Sashin, Eldred, and van Amerogen 1975; Erle 1979; Erle and Goldberg 1984; Weber, Solomon, and Bachrach 1985; Weber, Bachrach, and Solomon 1985a, 1985b; Bachrach, Weber, and Solomon 1985) which began to be undertaken in this era, however, failed to produce either well-defined diagnostic categories which could predict outcome reliably or clear conceptualizations of which types of patients would do well in analysis (Bachrach 1978; Bachrach and Leaff 1978; Bachrach et al. 1991).

Recent developments in the therapeutic approach to patients with severe personality disorders (patients previously thought untreatable by analysis) has led to renewed interest in diagnostic specificity. Kohut's (1971, 1977, 1984) self-psychological approach to the preoedipal developmental and self-concept disturbances in narcissistic conditions and Kernberg's (1968, 1975, 1976, 1984) different integration of ego psychology and object relations to explain the pathological internalized object relationships of borderline and narcissistic conditions have helped with treatment conceptualization with these sicker populations. For example, Kohut believed that the narcissistic personality disorder required a different kind of participation from the analyst—one in which the analyst should allow an untouched, idealizing, regressive transference to develop during several years of the initial treatment process. Kernberg emphasizes that the analyst who has diagnosed borderline personality organization in a patient should be prepared to provide sharp limit setting and alterations within the analytic setting if necessary.

Because the psychoanalyst does not conduct a routine therapy for all patients, and because advances in psychoanalytic technique have increased the range of analyzable patients, the role of differential diagnosis has assumed renewed pragmatic significance. Clinical assessments are concerned with determining the particular psychotherapeutic mix (varying combinations of analysis or less intensive exploratory therapy, pharmacotherapy, and other psychotherapies) that is most likely to be successful with a particular patient. Thus diagnoses such as borderline personality, infantile personality, and severe narcissistic personality are important because they are believed to carry specific implications for the structure of defenses and transferences that help to determine treatment decisions. Greater knowledge of the transference responses in narcissistic and borderline patients has led to enhanced therapeutic skill. Despite the fact that a psychoanalytic nomenclature based on replicable, empirical findings has been slow to develop, on the clinical level the notion of using specific interventions for specific classes of patients is far more widely accepted today than it was years ago.

Psychodynamic diagnosis, while taking full account of descriptive

diagnostic data, attends as well to unconscious mental processes and the severity of maladaptation. It classifies core aspects of character, personality, and adaptation to life as they are revealed in different modes of relating and representing self and others, both consciously and unconsciously. A psychoanalytic assessment focuses on the nature of intrapsychic conflicts, the predominant defenses, and the nature of internalized self-other representations and their affective interaction. Psychoanalytic diagnosis is derived from the phenomenology of the interaction between analyst and patient, as well as from historical data of the life narrative.

Psychoanalytic theory posits that processes outside a person's conscious awareness, as well as those within conscious awareness, powerfully affect and motivate thinking and behavior. Adult personality will be the resultant of the person's past and present experiences; innate, constitutional givens (intellectual and physical endowment, drives, temperament); and conscious and unconscious adaptive efforts to resolve predominant conflicts and fantasies. On the basis of decades of clinical experience, psychoanalysts have identified a number of different and commonly encountered patterns of conflict, underlying affects, and defenses. The individual manages these patterns using a variety of defensive, or coping, strategies (defense mechanisms). All defensive maneuvers are employed in the service of achieving an adaptive compromise of conflict between the underlying wishes and fantasies and the needs of adaptation to outer and inner requirements and standards. Observed behavior can best be understood when the balance among these multiple determinants is taken into account. For example, in the obsessive-compulsive character disorder, powerful, unresolvable conflicts over fearful obedience and angry defiance cause ambivalent oscillations that inhibit the capacity to act (Cooper 1987). Fantasies of dreadful retribution for loss of control of rageful affects lead to tight behavioral control.

Because significant determinants of behavior may be unconscious, similar behaviors at different times, or by different people, may reflect different underlying mental content (thoughts, feelings, motives, wishes, impulses, meanings). Conversely, two different behaviors may reflect similar underlying mental content (Stricker and Gold 1988). Take a simple example of the latter: at a time of parting, some individuals may signal their thoughts and feelings with a rough pat and averted gaze, while others hug intensely and lock gaze. Characteristics that may seem to reflect severe incapacity may represent defensive masking of abilities and achievements. For example, some individuals have a need to appear stupid; pseudostupidity may be used defensively to mask competitive impulses that are perceived as dangerous, or to deny that one knows family secrets. Conversely, a person may appear well integrated outwardly, but hide considerable psychopathology.

Though variables such as the defensive masking of core conflicts and

fantasies, which occurs both consciously and unconsciously, are difficult to assess and classify reliably and validly even for experienced clinicians, these processes are part of the "physiology" of the mind as opposed to the brain (Reiser 1984, 1989). Evolving a diagnostic system that incorporates these important psychodynamic variables alongside behavioral descriptions poses a major challenge for the field.

In addition to describing predominant fantasies, conflicts, and defenses, psychodynamic diagnosis also assesses the severity of the maladaptive functioning which results from the particular mix of features in the individual case. This assessment includes noting the quality of object relations, operations of conscience, and ability to regulate inner tensions under a variety of circumstances, both stressful and relaxed. Severity assessments are critical because they strongly influence treatment technique.

A psychodynamic diagnostic hierarchy that reflects considerations of severity might range from the relatively high level adaptations found among some hysterical or obsessional personality disorders, to the mid-range of impairment found in many depressive-masochistic (Simons 1987), passive-aggressive, and narcissistic-masochistic (Cooper 1984, 1988, 1989, 1993) disorders, to the primitive-level disruptions found in severe narcissistic, borderline, antisocial, and paranoid disorders (Stricker and Gold 1988). Easser and Lesser (1965) differentiated the high-level hysteric from the low-level hysteroid, and Zetzel (1968) distinguished four subtypes on the hysterical continuum.

The psychoanalytic shorthand of "oedipal" and "preoedipal" disturbances represents another very rough severity hierarchy—one that has enjoyed considerable appeal, probably because it condenses considerations of severity with broad descriptions of conflictual content and developmental experience. Oedipal-level pathology refers to patients whose early dyadic (primary caretaker–child) relationships are believed to have been relatively undisturbed. These patients are thought to suffer from unresolved conflicts over sexuality, competition, and aggression that are reasonably well modulated in intensity of expression. Preoedipal pathology, in contrast, refers to patients who are believed to have experienced in their primary caretaking dyads early, severe distortions and disruptions which left them with structural fixations or deficits—overwhelming affects, weakness of defenses, and intense, unmodulated sexual and aggressive conflicts. The average clinical case presents a mixture of both, making these designations too broad to be useful for research. In the modern psychoanalytic view, these rough descriptions of mental organization are related not to specific developmental stages but to the quality of cumulative developmental life experience (Emde 1981, 1988; Western 1990).

Psychodynamic diagnostic assessments regarding both the type and the severity of disturbance rely heavily on assessing the quality of the

patient's relationships and styles of interacting with others, especially the therapist. The psychodynamic diagnostician assesses how the patient's particular mode of relatedness—the depth, intensity, stability, and affective tone of the relationship—crystallizes into repetitive transference patterns with the therapist in the treatment situation. In addition, the diagnostician assesses the patterns of emotional response that the patient evokes (the countertransference). Knowledge of transference and countertransference responses informs predictions about treatment course and outcome.

Despite this rich framework of attributes, no classification has yet been devised to systematize psychodynamic variables. Though psychodynamic constructs have enjoyed considerable clinical utility and appeal, the field has not yet taken the next important scientific step, that of developing operationalized psychodynamic criteria specific enough to yield diagnoses of high predictive validity. This absence of an operational, psychodynamically informed nomenclature has had implications for the ability of psychoanalysis to demonstrate efficacy in comparison with other treatments, a task that has been pressed with increasing urgency in recent years (Klerman 1990). Psychoanalysis has never claimed to be a therapy only, and its ideas have been germinal for an enormous amount of research and a variety of treatments. However, psychoanalysis is also a treatment and, as such, needs to establish its comparability with competing treatments. To be in a position to do this, analytic investigators need a system of diagnostic assessment that is more inclusive than the current DSM.

Supplementary Measures to Specify Psychodynamic Diagnosis in Research

The limitations of the DSM system that are suggested by psychoanalytic theory point to the need both for the refinement of existing DSM categories[3] and for the inclusion of additional information relevant to the psychodynamic assessment of patients for clinical work, teaching, and research. Relevant supplementary remedies include specification of defensive operations, assessment of core intrapsychic and interpersonal conflicts, and assessment of internal psychological resources and psychiatric severity. Used in conjunction with current DSM categories, research studies that include

[3]Particularly for the personality disorders, major revisions may be needed. Consensus does not yet exist as to the number or validity of current Axis II syndromes (Hirschfeld 1993). In addition, there is active debate in the nosological literature regarding the diagnostic format that would best represent these entities (Gunderson 1992). Many investigators feel that alternative models (dimensional, prototypical) would be preferable to the current polythetic categorical model (see chapter 8).

these diagnostic measures are likely to yield important findings in their own right, as well as ones that could influence future editions of the DSM.

DEFENSE MECHANISMS

As has been noted, current DSM diagnoses do not help the clinician or researcher to distinguish more superficial defenses from the painful conflicts, object relations, or self-representations against which defenses are constructed. They also do not take severity into account. To help remedy this situation, investigators and practitioners have urged the incorporation of an axis of defense mechanisms in the DSM system. This axis would specify and quantify the psychological defense mechanisms from the pathological and immature to the healthy, adaptive, and mature. The pioneering work of Vaillant (1986, 1987; Vaillant and Drake 1985), Perry and Cooper (1986), Horowitz et al. (1984), and others has established significant evidence that the ego mechanisms of defense can be studied in empirically rigorous, clinically relevant fashion. These variables have been shown to be powerful predictors of morbidity and mortality when longitudinally assessed (Vaillant 1977; Vaillant and Perry 1980, 1985; Perry and Vaillant 1989). Ironically, a more solid empirical basis exists for including assessment of defense mechanisms than for many current Axis II disorders themselves (Vaillant 1987; Skodol and Perry 1993). A provisional axis of defensive operations is undergoing international field trials. Although it is unlikely that this psychodynamically based axis will be included in the forthcoming DSM-IV, nevertheless a number of well-developed, valid, and reliable indices for the assessment of defensive strategems are available for immediate use (see chapter 15 for an extensive review).

CORE CONFLICTS

As noted, current DSM diagnoses yield minimal information about the patient's intrapsychic conflicts or about how such conflicts typically are expressed in maladaptive interpersonal relationships. One feasible approach to taking this missing data into account systematically is to add the Core Conflictual Relationship Theme (CCRT) method to the diagnostic assessment (Luborsky and Crits-Christoph 1990; chapter 17). Numerous studies have demonstrated that the CCRT can be applied flexibly to clinical data derived from standardized diagnostic interviews, underscoring the utility of the method in assisting the clinician to formulate validly the patient's most pervasive area(s) of conflict. Core conflictual relationship themes are expressed repeatedly in the patient's conscious and unconscious wishes, in expectations regarding the reactions of others to these wishes, and in consequent self-responses to these anticipated reactions. Stable self

and object representations have been demonstrated reliably to be pervasive across relationships with different types of people and have been shown to manifest the same consistency in dreams as in waking narratives. By supplementing DSM diagnoses with the CCRT, new insights regarding the covariance of two important orthogonal classes of information can be derived.

A considerable number of newer measures of conflictual patterns have been developed (see Luborsky and Crits-Christoph 1990, table 17-1). Though some are complicated to use and others need additional psychometric development, as a group these measures are well worth reviewing in preparation for clinical studies.

An additional instrument to consider is the Structural Analysis of Social Behavior (SASB), developed by Benjamin (1974, 1982, 1987), which is one of the oldest, richest, most reliable, and most sophisticated of these methods. The SASB can be used to yield dynamic formulations about conflicts manifested interpersonally. Calling upon an impressive body of empirical data, Benjamin (in press) describes the interpersonal and intrapsychic patterns characteristic of each of the Axis II disorders according to DSM-IIIR criteria. Because symptoms of personality disorder are dynamically interpreted in an interpersonal context, Benjamin has demonstrated that multiple diagnoses are far less likely to occur with her method. Theoretically and empirically based, the SASB method yields data regarding probable developmental experiences, typical transference patterns, and helpful therapeutic strategies for each DSM disorder.

INTERNAL PSYCHOLOGICAL RESOURCES AND PSYCHIATRIC SEVERITY

A large body of research literature suggests that an assessment of the severity of psychiatric illness has considerably more predictive power than any DSM-IIIR diagnostic category alone. In large part this is because high severity interferes with the patient's capacity to internalize the benefits, and tolerate the inevitable frustrations, of treatment. A number of psychotherapy outcome studies suggest that overall adequacy of personality functioning is a far more potent predictor of favorable outcome than is individual diagnostic category (Luborsky 1984; Luborsky et al. 1988; Luborsky and Crits-Christoph 1990; Bachrach and Leaff 1978; Diguer, Barber, and Luborsky 1993).

As already noted, the importance of this finding is underscored by the inclusion of a revised Axis V (Global Assessment Scale) in DSM-IIIR. This measure assesses both the extent of impairment from symptoms and the overall efficacy of social and occupational functioning. However, good adaptation in these different realms is often, but not necessarily, correlated. For example, reasonably effective occupational or social functioning not

infrequently masks significant psychological morbidity and dysfunction. Accordingly, while Axis V serves as a potent predictor psychometrically, it is not specific enough in the individual case.

Devising a scale consisting of more purely internal measures remains an area of inquiry ripe for potential investigation. (See, for example, Bellak, Hurvich, and Gediman [1973] and Bellak and Goldsmith [1984] on ego function assessment, and Karush et al. [1984] and Cooper et al. [1966] on the adaptive balance profile.) Patients should benefit substantially from the development of experience-based measures which can attend with far greater precision to psychodynamically relevant variables, particularly severity measures.

In summary, with the current availability of psychometrically sophisticated measures, assessing psychodynamic variables such as defense mechanisms, intrapsychic and interpersonal conflict, and internal psychological resources should enhance significantly standard psychiatric approaches to diagnosis. Refined specification of the type and quantity of disturbance would compensate for many of the deficiencies of current DSM diagnoses. For instance, it should be possible to diagnose reliably how much and how primitive the projection used by a given patient is at baseline, and then to study systematically how such a variable relates prospectively to the selection and course of treatment, therapeutic change, and outcome over time.

Conclusion

There is a need for a more psychodynamically informed nosology. Psychoanalysis began with an interest in diagnostic specificity which was obscured by a narrower focus on responsiveness to treatment. With recent analytic theoretical advances, psychoanalysis has regained an interest in diagnostic specificity. The DSM-III family of diagnoses is a newly sophisticated descriptive portion of the traditional diagnostic system for psychoanalysis; its general clinical utility and research usefulness would be greatly enhanced by the inclusion of inferential psychodynamic data and observations. Current descriptions suffer from reliance on too narrow a theoretical base, and hence lack optimal research and clinical usefulness. In addition, present categories are insufficiently attentive to markers of severity.

There is now a great need to define the clinical questions, operationalize relevant variables, and collect the data upon which future classifications will be based. Those who are frustrated by the shortcomings of the current nomenclature may find it helpful to remember that it is a system in evolution, but one that holds out hope for achieving a nosology that is reliable, valid, and clinically relevant. Indeed, the system is at a relatively

early stage of development. An important opportunity now exists for expanded collaborative work to devise a more theoretically based, psychometrically sound, and clinically relevant diagnostic classification. Optimal diagnostic criteria have yet to be determined. Patients will benefit from a more sophisticated and inclusive diagnostic effort.

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