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A PSYCHODYNAMIC APPROACH TO THE DIAGNOSIS OF PSYCHOPATHOLOGY

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The purpose of diagnosis is straightforward: to understand better the dynamics and circumstances that result in people being in emotional distress and how best to treat them. Although the purpose of diagnosis is important and direct, the "how to" of diagnosis remains controversial and elusive. Despite considerable misgivings (e.g., Carson, 1991; Millon, 1991a; Widiger, 1992) about the various editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) developed by the American Psychiatric Association (APA), this diagnostic taxonomy continues to dominate the mental health field (Jampala, Zimmerman, Sierles, & Taylor, 1992; Maser, Kaelber, & Weise, 1991; Setterberge et al., 1991). Most insurance companies structure their reimbursements according to this diagnostic taxonomy, the *DSM* provides the basic taxonomic structure used in most clinical centers, most scientific journals require that distinctions in clinical research be made according to this diagnostic system, and many funding agencies, especially the National Institute of Mental Health, require that this diagnostic system be an integral part of most clinical research designs. These funding agencies not only often insist that this categorical taxonomic sys-

tem be an inherent part of the research design, but they also actively encourage the inclusion of one or more of the structured clinical interviews that have been derived from the *DSM* system. Given the central role that the *DSM* has come to have in clinical practice, research, and teaching, it is essential that researchers systematically examine its basic assumptions as well as some criticisms that have been directed at this nosological system.

In this chapter we consider several criticisms that have been made of the *DSM* model, particularly as they pertain to the diagnosis of Axis II personality disorders. We then propose an alternative diagnostic structure that we believe has greater potential validity than the fourth edition of the *DSM* (*DSM–IV*; APA, 1994) as well as clearer etiological and therapeutic implications.

THE DEVELOPMENT OF THE *DSM*

Beginning around 1970, clinical investigators in academic psychiatry and psychology in the United States began to feel increasing dissatisfaction with the imprecision of psychiatric diagnostic criteria. This renewed interest in diagnosis, nosology, and classification culminated in the publication of the third edition of the *DSM* (*DSM–III*; APA, 1980). The *DSM–III* was an immediate bestseller and was used by virtually every mental health professional in the United States to guide diagnosis, justify third-party reimbursement, or both. The manual received considerable praise in academic psychology and clinical psychiatry for providing a detailed lexicon, or taxonomy, that established common definitions of various psychopathological states that enabled investigators and clinicians to have greater consistency (reliability) in their diagnoses. The *DSM* system, however, also has engendered considerable controversy. Although the various editions of the *DSM* have brought a degree of reliability to the diagnosis of mental illness, they also illustrate many of the problems inherent in contemporary clinical practice and clinical research.

Several clinicians and clinical investigators have expressed serious reservations about the *DSM* approach to the diagnosis of mental disorders (e.g., Blatt, 1991a; Carson, 1991, 1994; Chodoff, 1986; Kaplan, 1983; Millon, 1981, 1991a; Persons, 1986; Vaillant, 1984; Wakefield, 1992). These problems include the following: (a) lack of a cohesive theory; (b) the forced demarcation between normal and abnormal; (c) excessive concern with signs and symptoms; (d) the use of categorical rather than dimensional distinctions; (e) arbitrary threshold or cutoff points for establishing categorical diagnoses; (f) a lack of dimension of intensity in considering the presence of many of the symptoms; (g) a high degree of overlap or comorbidity between seemingly distinct disorders; (h) viewing the diagnostic categories as separate and independent entities and failing to consider the