9

Diagnosis and Assessment

Modern-day psychiatric diagnosis can trace its roots back to Hippocrates, who identified personality types based on the composition of the bodily humors (i.e., fluids). Obviously, the field has evolved quite a ways from its very earliest nomenclature, yet it remains the case that the major objective throughout the evolution of psychiatric diagnosis has been to create the most accurate description of a complex collection of cognitive, emotional, social, motivational, and behavioral symptoms that characterize a psychiatric disorder. Early efforts to do this were presented by Kretschmer (1925) and Kraepelin (1921), as were later notable taxonomies reported by Fenichel (1945), Laughlin (1956), Schneider (1958), Shapiro (1965), and Kernberg (1970). Notable was the influence of psychoanalytic theory on the development of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) system. However, as the *DSM* system evolved, there was increasing pressure to move away from its psychoanalytic origins to a more "atheoretical" system. This was precisely the intention when the *DSM*, 3rd ed. (*DSM-III*) (American Psychiatric Association, 1980) was published. A multiaxial system of diagnosis was offered, and psychiatric disorders were to be placed on either Axis I or II. The former was for clinical syndromes and problems, most of which were acute in nature, whereas the latter was reserved for personality disorders and mental retardation. However, many were unhappy with this change.

A good example of this is the creation in the *DSM-III* (American Psychiatric Association, 1980) of the diagnostic category dysthymic disorder (DD), which was to be placed on Axis I. DD was believed to be a pathological disease state, based on the findings of Akiskal, Bitar, Puzantian, Rosenthal, and Walker (1978) and Klerman, Endicott, and Spitzer (1979), both of whom noted that chronic, low-grade depression (formerly known as *depressive neurosis*) appeared to have

a biogenetic underpinning and that many patients with these symptoms could be treated with antidepressant medication. They reasoned that it was appropriate to think of chronic depressions as having a biological basis, which inherently reflects the idea that depression is a pathological, disease state.

This subsequent change in the diagnostic concept of DD invoked substantial criticism. Cooper and Michels (1981) argued that such a change did not reflect an atheoretical orientation but rather made the assumption that all depressions share a biological basis. A similar concern was raised by Frances and Cooper (1981), who noted that characterologically depressed patients are individuals who have the poorest response to medication and that just because some do respond to medication does not imply that the disorder is fundamentally a disease state.

Kernberg (1984) and Goldstein and Anthony (1988) also criticized the approach to chronic depressive disorders taken in the *DSM-III* as it related to the well-known psychoanalytic construct of depressive personality disorder. Kernberg wrote, "It should be noted that clinical descriptions arrived at by means of psychoanalytic exploration, with its eminently phenomenological characteristics, must be differentiated from the etiological, psychopathological, and psychodynamic theories of psychoanalysis. To throw out prevalent clinical syndromes because they were discovered, studied, and described by psychoanalysts is not an expression of atheoretical objectivity but may reveal a theoretical bias against psychoanalysis" (p. 82).

Many other problems have been inherent in the *DSM* system throughout its history. One of these has been the issue of comorbidity (Carson, 1997; Herzig & Licht, 2006). Despite an effort to describe disorders with greater precision and the inclusion of additional disorders with each new *DSM* edition, comorbidity has been the rule rather than the exception (e.g., National Comorbidity Survey and National Comorbidity Survey-Replication). Another problem Carson (1997) observed can be traced back to the introduction of the symptom-based, behavioral descriptions of mental disorders found in the *DSM-III* (American Psychiatric Association, 1980). This edition of the diagnostic manual sought to eliminate the subjective and unreliable diagnostic practices that were occurring at the time. These problems were attributed mainly to psychoanalysts, who were not particularly interested in the research literature and whose diagnoses and conceptualizations varied widely from person to person. With the *DSM-III*, greater precision was desired in the description of the

diagnostic categories, which placed an emphasis on the observable and the symptomatic nature of the disorders. In theory, this change was supposed to increase diagnostic reliability. However, Kirk and Kutchins (1992) tested the assumption that diagnostic accuracy and reliability improved with the *DSM-III* and found that the average diagnostic reliability of *DSM-III* disorders was $k = .70$, which is not particularly strong when accounting for change agreements.

A lack of reliability continues to be a problem today. Herzig and Licht (2006) reviewed evidence for the reliability and validity of the most common *DSM* disorders and reported wide ranges of diagnostic agreement across recent studies of mood, anxiety, attention-deficit, oppositional defiant, and conduct disorders in the *DSM*, 4th ed. (*DSM-IV*; American Psychiatric Association, 1994). Ganellen (2007) recently observed how personality disorder assessment continues to be filled with substantial levels of diagnostic unreliability. He and Huprich and Bornstein (2007) suggested that such problems are based, in part, on an excessive reliance on self-report data, whether it comes in the form of a structured or unstructured diagnostic interview or in a paper-and-pencil self-report inventory. Because of these problems in personality disorder assessment, there have been calls for reorganizing the personality disorder diagnostic system to reflect a consensus of findings in factor analytic studies of personality, which suggests that there are broad, biological underpinnings of many personality disorders (e.g., Costa & Widiger, 2002; Widiger, Simonsen, Krueger, Livesley, & Verheul, 2005). These ideas also have been extended into the conceptualization and diagnosis of Axis I disorders (Achenbach, Krukowski, Dumenci, & Ivanova, 2005; Helzer, Kraemer, & Krueger, 2006; Krueger & Markon, 2006a; Krueger & Tackett, 2006; Markon, Krueger, & Watson, 2005). Needless to say, the viability of the *DSM* system continues to remain in question.

Psychodynamic Diagnostic Manual

Because of these many concerns with the *DSM* system, the *Psychodynamic Diagnostic Manual* (*PDM* Task Force, 2006) was created by a joint effort of the American Psychoanalytic Association, the International Psychoanalytic Association, Division 39 (Psychoanalysis) of the American Psychological Association, the American Academy of Psychoanalysis, and the National Membership Committee on Psychoanalysis in Clinical Social Work. It represents a significant

advancement in the articulation of psychodynamic diagnosis in that it may be used to structure a common terminology among psychoanalytic and psychodynamic clinicians, along with being a common sourcebook reference, much like the *DSM*. The *PDM* uses several of the diagnostic labels that are currently in use with the *DSM*, 4th ed., text revised (*DSM-IV-TR*; American Psychiatric Association, 2001) and International Classification of Diseases-10 (ICD-10) (WHO, 1990). However, the *PDM* is explicit about what it offers that is not to be found in other diagnostic systems: "Despite the fact that mental health professionals are inevitably dealing with the elusive world of subjectivity, we require a fuller description of the patient's internal life to do justice to understanding his or her distinctive experience. We are hoping that with more elaborated depictions, we can make more progress on understanding naturally occurring patterns" (p. 5).

The *PDM* evaluates patients' functioning on three dimensions:

1. Personality patterns and disorders (P axis)
2. Mental functioning (M axis)
3. Manifest symptoms and concerns (S axis)

All assessment begins with the P axis because there is "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" (*PDM* Task Force, 2006, p. 8). Indeed, any psychoanalytic or psychodynamic clinician will report the importance of understanding persons' personality structure and organization to plan effective treatment. In the *PDM*, personality is assessed as being in the healthy level (meaning that no personality disorder is present), the neurotic level, or the borderline level. Although psychotic personality structures have been described by some, the *PDM* opted not to include this label as it could be confused with psychotic conditions such as schizophrenia. The *PDM* suggests that healthy personalities and neurotic personality disorders may be treated via conventional psychoanalysis or psychoanalytic/psychodynamic therapy; in contrast, borderline personalities require structure and support as part of the treatment, as is found in supportive psychodynamic psychotherapy. A listing of the *PDM* personality disorders is provided in Table 9.1.

The M axis allows clinicians to assess patients' overall level of psychological functioning. This scale is much more complex than the

TABLE 9.1 *Psychodynamic Diagnostic Manual* Personality Disorders

Code	Diagnosis
P101	Schizoid personality disorders
P102	Paranoid personality disorders
P103	Psychopathic (antisocial) personality disorders
P103.1	Passive/parasitic
P103.2	Aggressive
P104	Narcissistic personality disorders
P104.1	Arrogant/entitled
P104.2	Depressed/depleted
P105	Sadistic and sadomasochistic personality disorders
P105.1	Intermediate manifestation: sadomasochistic personality disorder
P106	Masochistic (self-defeating) personality disorders
P106.1	Moral masochistic
P106.2	Relational masochistic
P107	Depressive personality disorders
P107.1	Introjective
P107.2	Anaclitic
P107.3	Converse manifestation: hypomanic personality disorder
P108	Somatizing personality disorders
P109	Dependent personality disorders
P109.1	Passive aggressive versions
P109.2	Converse manifestation: counterdependent personality disorder
P110	Phobic (avoidant) personality disorders
P110.1	Converse manifestation: counterphobic personality disorder
P111	Anxious personality disorders
P112	Obsessive-compulsive personality disorders
P112.1	Obsessive
P112.2	Compulsive
P113	Hysterical (histrionic) personality disorders
P113.1	Inhibited
P113.2	Demonstrative/flamboyant
P114	Dissociative personality disorders (dissociative identity disorder/multiple personality disorder)
P115	Mixed/other

Source: *PDM* Task Force, *Psychodynamic diagnostic manual.* Silver Spring, MD: Alliance of Psychoanalytic Organizations, 2006 (with permission).

DSM-IV-TR Global Assessment of Functioning Scale. In this case, nine overall dimensions of functioning are assessed:

1. The capacity for regulation, attention, and learning
2. The capacity for relationships and intimacy
3. The quality of internal experience, which includes the level of self-confidence and self-regard
4. The capacity for affective experience, expression, and communication
5. Defensive patterns and capacities
6. The capacity to form internal representations
7. The capacity for differentiation and integration
8. Self-observing capacities, or psychological mindedness
9. The capacity to construct or use internal standards and ideals (i.e., a person's sense of morality)

Individuals are assessed across all of these dimensions, and a rating is provided. The M axis dimensions are listed in Table 9.2. The *PDM* indicates that "there is a growing body of research demonstrating that it is possible to measure these components of mental functioning" (*PDM* Task Force, 2006, p. 74). A representative sample of empirically based measures of M axis dimensions is presented in Table 9.3.

TABLE 9.2 *Psychodynamic Diagnostic Manual* Assessment of Mental Functioning (M Axis)

Code	Label
M201	Optimal age- and phase-appropriate mental capacities with expected degree of flexibility and intactness
M202	Reasonable age- and phase-appropriate mental capacities with phase expected degree of flexibility and intactness
M203	Age- and phase-appropriate mental capacities with phase-specific conflicts or transient developmental challenges
M204	Mild constrictions and inflexibility
M204.1	Encapsulated character formations
M204.2	Encapsulated symptom formations
M205	Moderate constrictions and alterations in mental functioning
M206	Major constrictions and alterations of mental functioning
M207	Defects in integration and organization or differentiation of self-representations and object representations
M208	Major defects in basic mental functions

Source: PDM Task Force, *Psychodynamic diagnostic manual.* Silver Spring, MD: Alliance of Psychoanalytic Organizations, 2006 (with permission).

TABLE 9.3 Empirically Supported Psychodynamic Measures of Personality and Psychological Functioning

Measure	Key References
Defense Mechanisms	
American Psychiatric Association: DSM-IV Defensive Functioning Scale Association	American Psychiatric Association (1994)
Cramer Defense Mechanism Manual	Cramer (1991)
Defense Mechanism Rating Scale	Perry (1988, 2001)
Defensive Style Questionnaire	Bond (2004), Bond et al. (1989)
Ego Mechanisms of Defense	Vaillant (1985, 1992, 1994)
Lerner Defense Scale	Lerner (2005)
Ego Functions	
Ego Functions Manual	Shaffer (2001)
Ego Function Assessment	Bellak and Goldsmith (1984)
Object Relations	
Attachment and Object Relations Inventory	Buelow, McClain, and McIntosh (1996)
Bell Object Relations and Reality Testing Inventory Object Relations Inventory	Bell (1995)
Child and Adolescent Object Relations Functioning	Kelly (1996, 1997)
Differentiation-Relatedness Scale of the Object Relations Inventory	Diamond, Blatt, Stayner, and Kaslow (1991)
McGill Object Relations Scale	Dymetryszyn, Bouchard, Bienvenu, de Carufel, and Gaston (1997)
Mutuality of Autonomy Scale	Urist (1977), Urist and Shill (1982)
Object Relations Inventory	Blatt, Chevron, Quinlan, Schaffer, and Wein (1988, 1992)
Percept Genetic Object Relation Test	Nilsson (1993, 1995)
Quality of Object Relations Scale	Azim, Piper, Segal, Nixon, and Duncan (1991)
Rorschach Separation-Individuation Scale	Coonerty, Diamond, Kaslow, and Blatt (1987)
Social Cognition and Object Relations Scale	Westen (1993, 1995)
Personality	
Karolinska Psychodynamic Profile	Weinryb, Rossel, and Asberg (1991)
McGlashan Semistructured Interview	Miller et al. (2003)

(*Continued*)

TABLE 9.3 (Continued)

Measure	Key References
Operationalized Psychodynamic Diagnosis	Dahlbender, Rudolf, and OPD Task Force (2006)
Scales of Psychological Capacities	DeWitt, Hartley, Rosenberg, Zilberg, and Wallerstein (1991)
Shedler-Westen Assessment of Personality–200	Shedler & Westen (2006), Westen & Shedler (1999a, 1999b)
Structured Interview of Personality Organization	Clarkin, Caligor, Stern, and Kernberg (2004)

The S axis is for symptom patterns that compose many of the Axis I disorders seen in the *DSM-IV-TR*. These include disorders of adjustment, anxiety disorders, dissociation, mood, eating, sleep, sexual and gender identity, impulse control, substance abuse and addiction, psychosis, and general medical conditions, along with somatoform and factitious disorders. In addition, *PDM* authors have attempted to provide a greater description of patients' subjective experience of the symptom patterns than what is provided in the *DSM* system. For instance, in describing the inner experience of patients with anorexia or bulimia nervosa, the *PDM* (*PDM* Task Force, 2006, p. 121) describes the following emotional states:

1. Feelings of being starved for care and affection and longings to be protected and cherished.
2. Feelings of failure, weakness, and extreme shame.
3. Feelings of being unworthy and ineffective. For example, "I would feel like I couldn't eat, and then if I did, I would feel guilty, like I did something I wasn't supposed to or took in something I didn't deserve."
4. Feelings of being abandoned by others or feelings that others will withdraw their love.
5. Feelings of anger and aggression, which feel frightening, dangerous and intolerable are denied, muted, or hated. For example, "I'm a bubbly person who never gets angry. It doesn't feel good to get angry and nobody around me feels good when I get angry. They would get hurt and you can't hurt the people you care about."
6. Fears that experiencing one's emotions leads to being out of control. For example, an anorexic woman stated that if she were to talk freely about her feelings, she would find herself "blowing in the wind."

It also is noted that "symptom patterns are not simply disorders in their own right but are, rather, overt expressions of the ways in which individual patients characteristically cope with experience" (*PDM* Task Force, 2006, p. 93). Thus, it is important to understand patients' overall personality structure and general level of functioning to best understand the symptom patterns. For many of the disorders, biological predispositions, cognitive, affective, somatic, and relational patterns are described to foster a comprehensive description of the disorder.

The *PDM* has a separate section devoted to child and adolescent disorders. This section follows the same structure as the adult section:

1. Mental functioning for children and adolescents (MCA axis)
2. Child and adolescent personality patterns and disorders (PCA axis)
3. Child and adolescent symptom patterns: the subjective experience (SCA axis)

In addition, an entire section is devoted to mental and developmental disorders in infancy and early childhood. The final section of the *PDM* is devoted to the historical and research underpinnings of a psychodynamically informed classification system. The research section alone is more than 300 pages, providing considerable empirical backing to support the development of a diagnostic manual such as this.

As interesting as the *PDM* is and the potential it shows, there are many unanswered questions about it. It is not clear yet how viable the *PDM* will become and whether it will actually be implemented in everyday clinical practice. For that matter, it is not clear whether insurance carriers will even recognize the manual. The answer to that question will rest, in part, on the empirical evidence that is produced on the diagnostic categories' reliability and validity. In particular, do clinicians make more accurate diagnoses with *PDM* diagnostic categories than with the *DSM-IV-TR* or ICD-10? Is there compelling evidence for the diagnostic categories' convergent, discriminant, and construct validity? Will comorbidity be reduced with this new manual? And, perhaps most important, will the *PDM* have evidence of incremental validity? That is, will diagnoses resulting from the use of this manual's diagnostic process and nomenclature lead to better accuracy and treatment outcomes than prior manuals? These are questions that will take years, if not decades, to answer. Yet, for

what it is worth, the *PDM* is a monumental and necessary addition to the psychoanalytic and psychodynamic nomenclature and shows much promise for what it might offer.

Assessing Patients

Outside of establishing a good therapeutic relationship from the beginning of treatment, there is probably nothing more important than conducting a thorough assessment of patients when they start treatment. All too often I have observed beginning therapists thinking that determining the diagnosis is what is required of good assessment. Regrettably, this is one of the most unfortunate myths (and mistakes) that therapists can make. Assessment is a process in which information is obtained about individuals to make informed decisions about their care. There is a focused, specific purpose to this activity, and like any good approach to patient care assessment, it is a process that does not stop. Evaluating the efficacy of patients' treatment requires ongoing information gathering. Monitoring changes that occur during and between sessions provides useful, here-and-now information about patients' responses to therapists' interventions. Thus, part of any excellent psychoanalytic or psychodynamic treatment is excellent assessment.

The information obtained as part of the assessment comes from many avenues. First and foremost, assessment occurs during times of interaction with patients and is based on what patients say and how they say it. Careful listening, behavioral observations (e.g., movements, shifts, posture, tone of voice, nonverbal activities), and awareness of patients' subjective experience and therapists' subjective experience are *necessary ingredients* to the assessment process. Content and process are both relevant concerns here. For instance, a patient who speaks about his desire to meet a "nice woman who I can settle down with" tells the therapist something about what he desires. When the patient goes on for the next 20 minutes to engage in self-deprecating remarks about ways he has failed to meet a woman and his inadequacies in such actions and sheds a couple of tears while telling of these struggles, the therapist learns something about what the patient finds himself feeling conflicted about, his lack of defensiveness in speaking about this conflict, his representations of himself as inadequate or flawed, his threatened sense of self-esteem and agency,

his representation of woman as disappointing, his social skills, and his sense of interpreting situations accurately or in slightly distorted ways. Of course, all of this information is to be considered in the context of the patient's presenting problem. Additional information must be brought forth to come to a preliminary assessment and formulation of the patient's personality structure, ego strengths, object relations, sense of self, mastery of impulses and affect, relational capacity, characteristic defenses, and—subsequently—diagnosis.

Not only is the content itself important, but also the absence of content should be dually noted. Patients who do not shed tears for a meaningful, recent loss or who avoid talking about their sexual life provide important observable information about what they are defending against. Patients who refuse to acknowledge the therapist in socially appropriate ways (e.g., calling the therapist by her first name despite the therapist introducing herself as "Dr. Jones") or to speak about material that is directly inquired can identify important information about emotionally provocative and well-defended content, the transference, or their characteristic management of aggressive feelings (e.g., avoidance or acting out in devaluing ways), just to mention a few things.

The interpersonal dynamics of patients and therapists also are tremendously important pieces of information that add to therapists' assessment activities. In the previous example of the lonely man, the patient responded rather openly and in some detail about his failures in his dating life. Contrast this with the same situation in which the patient shared the same content, but as soon as he found himself becoming tearful, he spoke about being "such a wimp" and went on to discuss his success in his private business for the remainder of the session, even after the therapist attempted to gather other information. The process reveals not only how the patient quickly disconnected his conscious experience of sadness from thoughts that he was a weak and incapable man but also how when such threats to his masculinity arose, he defensively redirected his attention (and his experience with another person) to that of his sense of power, success, and capabilities. The process also may provide some clues into the nature of the transference that will arise, as well as information about how the patient is likely to respond to certain types of interpretations related to his sense of masculinity and efficacy. Consequently, if other signs of vulnerability arise in this patient, the therapist can become more attuned to the patient's difficulties as well as think

carefully about the type of therapy and therapeutic interventions the patient is or is not ready for at this point.

Process information also can be very helpful to therapists regarding their countertransference experience of patients. How therapists respond to certain content, interpersonal exchanges, or other therapy material and events all can prove to be fruitful in this way. For instance, Racker (1968) noted that countertransference may not only represent one's own unresolved conflicts but may also be related to a projective identification process. Knowledge of this process can be helpful for assessing patients' defenses, for understanding transference, and for planning a treatment intervention. By definition, countertransference is something therapists recognize as uniquely residing within themselves (even though particular material that arose from another person was a precipitating factor). This, then, requires that therapists be very attuned not only to the content and process as it plays out in the experience of their patients but also to their own inner world and experience. It is only when therapists are aware of and attuned to their subjective experience that they can begin to sort out the countertransference issues and assess how they are related to their patients. Thus, good assessment skills require that therapists have good inner awareness.

Within the context of assessment, it is often recognized that obtaining the report of a significant other or parent (in the case of a child) will yield fruitful information. Such ideas have been advocated in methods designed to obtain as much information as possible from multiple sources and methods of collecting such information (e.g., the Longitudinal Expert and All Data [LEADS] method; Spitzer, 1983). However, in the context of psychoanalytic and psychodynamic therapy, such practice is rarely used. This is not too hard to understand when one thinks of the effect this would have on the transference and the fostering of the therapeutic relationship. In this case, a meaningful person is being introduced into the patient–therapist dyad that has the power to influence the therapist's opinion and ideas of the patient. Unconsciously, this allies the therapist with the significant other at some level, thereby making transference phenomena difficult to interpret. For instance, consider the challenges of responding to a patient who says, "You're just thinking that because that's what you heard from my husband." In this case, the husband may be the object of his wife's paternal transference, as could the therapist. When husband and therapist (and unconsciously the father) have

met to discuss the patient, resistances can become strong and complicated to sort out. Nonetheless, some do not consider the interview of a significant other to be particularly problematic. Gabbard (2004) wrote that family members can provide important and useful information patients may have overlooked. Also, therapists may be able to educate family members about psychotherapy and what happens in the context of this type of professional relationship. Finally, Gabbard observed how cultural and social factors may be elucidated in such meetings were previously unknown.

Assessment is not just based on patient self-report and observations of the content and process. Assessment may be performed more formally with psychological testing. In the era of managed care, psychological testing is not practically feasible for some clinicians; however, the wealth of information it can provide is substantial. Meyer et al. (2001) performed a comprehensive review of the literature on psychological testing, which included data from more than 125 meta-analyses on test validity and 800 samples examining assessment with self-report and performance based measures of psychological functioning. Meyer and colleagues provided four general conclusions:

1. Psychological test validity is strong and compelling.
2. Psychological test validity is comparable to medical test validity.
3. Distinct assessment methods provide unique sources of information.
4. Clinicians who rely exclusively on interviews are prone to incomplete understandings.

These latter two points are particularly relevant to the practice of psychodynamic psychotherapy. So often, clinicians rely exclusively on patients' self-reported information, and indeed, the focus of attention is on patients' subjective experience. However, when exclusive reliance on one technique takes precedence over the search for clinical "truth," errors are prone to happen. For instance, confirmation bias can occur, in which clinicians fail to attend to information that disconfirms their previously held assumptions and assessments about their patients.

A good example of how different modes of assessment provide useful information about individuals was presented in the last chapter. Summarized briefly, Robert Bornstein (1998) found that self-report and performence based measures of interpersonal dependency each predicted different kinds of help-seeking behavior

in a laboratary setting. More so, manipulating help-seeking instructions in the task affected individuals' behavior, but that behavior was best predicted by a performance based measure, not a self-report measure.

This kind of discrimination between self-reported qualities and real-world behaviors lies behind the implicit and explicit methodologies of personality assessment. *Implicit* measures (or methods) assess an individual's automatic, unconsciously motivated patterns of behavior, whereas *explicit* measures assess a person's self-attributed qualities and motives. McClelland, Koestner, and Weinberger (1989), who first made this distinction, noted that implicit measures are less subject to self-report bias or distortion, given that they assess attributes and motives that originated early in childhood, even prior to verbal skill development. In contrast, self-report measures can be distorted and are notoriously unreliable, as seen in the modest degree of correlation between self ratings of personality traits and those by significant others (Ganellen, 2007; Huprich & Bornstein, 2007; Meyer, 1996; Oltmanns & Turkheimer, 2006). Moderate correlations are also seen when patient ratings are correlated with clinician ratings (Huprich & Ganellen, 2006; Zimmerman, 1994). This is not to suggest that implicit measures—most often associated with performance-based (projective) measures—are free from problems. Many have criticized the validity of performance-based measures (see Hunsley & Bailey, 1999; Viglione & Hilsenroth, 2001; Wood, Nezworski, Garb, & Lilienfeld, 2001, for a discussion of this issue). Yet in the context of psychodynamic psychotherapy, it should therefore be recognized that what patients report and what they actually do should not be expected to directly correspond, and, depending on the nature of the psychopathology, the self-report may be highly biased to the point of being unreliable. Thus, psychological testing offers some useful information that may not be captured in the context of the patient–therapist relationship.

Therefore, within the context of patient interviews and observations, observation of therapists' experience of the patient, collateral interviews, and psychological testing, therapists must engage in assessing the major domains of functioning of their patients so that effective treatment can be undertaken. These domains of functioning are similar to the M axis of the *PDM* (see earlier), although I have added a few domains that I believe are just as important. These domains consist of the following:

- Biological and temperamental factors
- Life situation
- Personality organization
- Defenses
- Ego functioning (including affect and impulse regulation, communicative and expressive abilities, cognitive capacities, and reality testing)
- Object representations
- Self-representations, including one's self-esteem and sense of agency
- Capacity for insight or reflective functioning
- Sociocultural factors

The following sections discuss these areas separately.

Biological and Temperament Factors

More and more it is becoming apparent that much of personality and predispositions to psychopathology are inherited (Caspi & Moffitt, 2006; Krueger & Markon, 2006b; Plomin & Caspi, 1999; Rutter, Moffitt, & Caspi, 2006). This knowledge has much potential to identify variables that are risk factors for psychopathology, with estimates of up to 50% or more of the variance in personality traits being accounted for by the inherited factor. A multitude of medical illnesses also are known to have effects on psychological well-being (e.g., hypothyroidism and its association with depression). Patients, too, sustain illnesses or injuries that can permanently change their sense of self and psychological experience, such as the loss of a limb, a serious burn, or a head injury that alters personality and mental functioning. In all of these examples, there is an immutable relationship between biology and predispositions to psychological well-being. Subsequently, there is a need for some patients to learn to accept (and in many cases, grieve) what has been lost and to come to a new sense of understanding themselves and their sense of agency and meaning. In other cases, however, it is *not* the case that biology and genetic predispositions by default prohibit one from achieving greater psychological well-being. For instance, one patient said she felt doomed to a life of great anxiety, given how pervasively impaired her mother was by chronic agoraphobia and social phobia. It was very relieving to her to learn that no psychological research had established a causative link between her biological predisposition to these two disorders and

her subsequent development of them. Knowledge of her predisposition improved her ability to look inward, to identify potential signs of anxiety (conscious or unconscious), and to make her concerns more consciously available and mastered. Huprich and Bornstein (2007) made a similar point when discussing biological twins' vulnerability to psychopathology. With reference to a study by Tellegen et al. (1988), Huprich and Bornstein wrote, "Even in genetically similar individuals raised in the same environment, a substantial amount of variability in self-reports is affected by their unique psychological understanding of themselves and their experiences" (p. 8). In other words, it is individuals' internal, subject experience that plays a substantial role in how they understand themselves.

Life Situation

Patients enter treatment with a wide variety of events going on in their life. They are single, married, divorced, separating, cohabitating, or recently widowed. They have meaningful, high-paying jobs, jobs that could be lost, or multiple jobs or may even be changing jobs. Many patients have children, while others hope to have children. Some live in nice homes in high socioeconomic status neighborhoods. Others rent a home or apartment, are in a dangerous neighborhood, or have no home. Many patients have been subject to unfair or abusive treatment by family, friends, or society at large. Some patients may support elderly parents or find they need help from someone else to support themselves. In short, patients come with a whole host of challenges to their daily living.

Knowledge of these stressors is particularly important in the assessment process for several reasons. How patients cope with and defend against stressful or upsetting life events is particularly useful in gauging their overall level of functioning. In my own work, I have been amazed by the resiliency of some patients who have substantial trauma, abusive family members, low income, or chronic stressors from family or within the work environment. These patients may meet *DSM* criteria for posttraumatic stress disorder (PTSD) or borderline personality disorder, yet, with all that is happening in their lives, to diagnose them with these disorders may inadvertently short-circuit the recognition of their incredible defenses and ego strengths. Knowledge of patients' life situations also can foster the

therapeutic relationship by the therapist developing an increased sense of empathy and understanding that may not have been there. For instance, I once saw a patient who was inconsistent in his attendance to psychotherapy sessions. Though this could have been interpreted as a form of resistance, it was actually the case that his work schedule was inconsistent, such that he could not always get to a bus at its scheduled time. As transportation by bus was his only means of transportation and work factors were beyond his control, it was certainly not the case that this patient's inconsistency was a clear-cut manifestation of resistance. Finally, life situations are important to assess to have a sense of what kinds of changes are reasonable to expect with patients. A socially anxious patient who seeks to develop more friends and greater relationship satisfaction may have ample resources to meet others (e.g., an automobile, Internet access for dating services, money to pay for social activities); another socially anxious patient may not.

Personality Organization

Evaluating persons' level of personality organization is one of the most fundamental elements of the assessment process. Knowledge of personality structure and pathology substantially affects the type of treatment that one provides. The *PDM* recognizes various categories of personality organization. There are *healthy* personalities, who have an absence of a personality disorder. Such individuals tend to have flexibility in how they cope with problems and accommodate well to stress. Although they may have a particular trait (e.g., introversion), this does not mean their personality is impaired to such an extent that it warrants a diagnosis. *Neurotic-level* personalities are those who tend to function relatively well at work and in relationships but who have some degree of rigidity in their ability to cope with upsetting material. Their problems often are circumscribed to a particular area (e.g., gender and sexuality for the hysterical personality). Neurotic personalities usually have some degree of insight into their problems and form a therapeutic alliance relatively well. The *PDM* lists depressive, depressive-masochistic, hysterical, and obsessive-compulsive personalities in this domain. In the context of *DSM-IV-TR*, Cluster C personality disorders are most like this group. *Borderline-level* personalities tend to have more pervasive problems. They have unstable

or very troubled relationships, difficulties in establishing intimacy, extended periods of anxiety or depression, and poor levels of coping or defending against upsetting material. The *PDM* states that splitting and projective identification are the most commonly observed defenses. A host of personality disorders fall into this category: paranoid, psychopathic, narcissistic, sadistic, sadomasochistic, hypomanic, somatizing, and dissociative. The *PDM* notes that schizoid and dependent personalities may present anywhere on the continuum of neurotic to borderline. It adds that narcissistic personalities can also function at the neurotic level, although they more often are found at the borderline level.

Patients are assessed for their level of personality functioning based on a wide range of variables, including predominant or preoccupying themes, relationship patterns (including self and other representations), defenses, ego functioning, and capacity for insight. Thus, within the context of assessing personality, other domains of psychological functioning are simultaneously assessed. In notable contrast to the *DSM* system, the *PDM* (and a psychoanalytic/psychodynamic approach in general) values the importance of assessing personality in the context of assessing persons' difficulties. Personality is not divorced from symptoms and diagnosis; as such, many view psychoanalytic and psychodynamic approaches favorably because of the comprehensiveness with which a patient may be understood.[1]

Defenses

When assessing defenses, it is important to consider two components of the defense: its maturity and its habitual use. By maturity, one is considering the psychological sophistication of the defense. *Immature defenses*, by definition, are ones that are commonly observed earlier in development, prior to the ego's maturing to the point of using more adaptive mechanisms. They involve greater blurring of the distinction between self and the outer world (McWilliams, 1994, 1999) and are commonly utilized by patients with more severe personality disorders or psychopathology (i.e., borderline level of functioning). Immature defenses include denial, projection, projective identification, and splitting. *Mature* defenses are those that involve the ego to a greater extent and involve keeping drive content or other upsetting material from consciously being experienced (Kernberg, 1984). Self–other boundaries are not often blurred in the mature defenses, and as a general principle patients who use more mature defenses tend to function better (although this does not mean that they do not experience psychopathology). Mature defenses include rationalization, intellectualization, sublimation, reaction formation, and isolation of affect.

Defenses also need to be assessed for the regularity by which they are used. Those defenses that are part of a person's personality are called *habitual or characterological* defenses, whereas those that are used in a certain situation are called *reactive* defenses. This distinction may be attributed to Reich (1933/1972), who was one of the first to describe character types and the "character armor" that was prototypical for the type. For example, an individual with an obsessive compulsive personality will very often use intellectualization and rationalization as a defense; however, when faced with the prospect of a job loss, the same person may project feelings of hostility onto his employer and believe he is being unfairly singled out when many others perform more poorly than he does. For most patients entering therapy, they are in the midst of a significant crisis or challenge for which their characteristic ways of coping have broken down (Weiner, 1998). Not only have their characterological defenses failed, but they also likely may have employed more reactive defenses as a way to cope with their difficulties. Therapists need to be attuned to the situational stressors that bring patients into treatment and how their defensive pattern manifests itself from the beginning of treatment into later stages when the stressor has been managed and the person is feeling "more like my typical self." It is very easy for patients (and beginning therapists) to assume once the crisis has passed and they have regained a sense of mastery that was threatened (via the use of their characterological defenses) that no further attention is needed toward their ways of coping with upsetting material. Such assumptions are misleading and inappropriate for most psychoanalytically or psychodynamically oriented psychotherapies, in which insight and structural change is desired.

Ego Functioning

Many psychological abilities fall under the domain of ego functioning. From a biological framework, these activities are related to the workings of the frontal and prefrontal cortex, amygdala, and limbic

system. Typically, I categorize ego functions in the broad dimensions of affect and impulse regulation, communicative and expressive abilities, cognitive capacities, and reality testing.

Affect and impulse regulation is invariably connected to the presenting problems of the patient. Patients present with all kinds of troubling emotions that are not well understood or tolerated. Sometimes, affect regulation is not at all determined by what patients say. Avoidance of, acting out, or engaging in specific behaviors are signs that some particular affect is likely intolerable. Other times, affect and impulse control problems are obvious, such as the emotional lability or promiscuous sexual activity found in more severe personality disorders. When assessing this broad dimension, it is useful to determine what kinds of resources and outlets (i.e., subliminatory channels) are available to persons. For instance, the absence of friends or romantic relationships suggests difficulties in seeking out others who can be supportive and helpful in managing one's inner world of affect and impulse.

Communicative and expressive abilities refer to patients' capacity to recognize and express their inner thoughts, feelings, affects, wishes, desires, hopes, and fears to themselves and others. Some patients present clinically as individuals who have great difficulty finding words to express their inner state, a phenomenon known as alexithymia. Others may present as having the ability to verbally express themselves to the therapist but not to meaningful others, suggesting a focused kind of problem with expressive ability. In more severe cases, some may have great difficulty assembling their inner experience into a coherent, purposeful narrative, such as is often found in patients with psychotic experiences. Also included in this dimension is the person's ability to recognize, listen to, and understand the inner thoughts, feelings, affects, wishes, desires, hopes, and fears of other people. Patients who are narcissistic or particularly self-absorbed by their difficulties may show little capacity to attend to others. This may be seen in patients who do not respond to questions asked by the therapist or who respond to a different topic or issue than what was presented by the therapist.

Object Representations

Knowing how others are understood and experienced in the mental life of patients helps therapists tremendously in being empathically

attuned to patients. In seeking to discover this part of patients' inner life, therapists also will come to understand how they are represented, which helps immensely in assessing the transference that is likely to unfold. Broadly speaking, object representations vary in complexity and affective quality. At the most poorly developed level of complexity, others cannot be well separated from patients' own experience. There is a psychological fusion of self and other experience, which subsequently hinders reality testing and the capacity to fundamentally relate to others. Moving to a more advanced level, individuals may be represented in ways that are associated with how they gratify or frustrate patients. This level of representation is narcissistic and often relatively simple, since others are viewed only by way of what they provide, not who they are. At more advanced levels of representation, others are seen as separate beings with their own thoughts and feelings. With growing psychological representation, others are viewed as having a mixture of both positive and negative qualities; their experience makes them unique beings that are unlike anyone else in the world. Yet they are not considered unapproachable or incapable of being related to because of their uniqueness; rather, the shared experience of humanity allows patients to approach and experience others and to have reasonable expectations of favorable interrelatedness. An even higher level is seen in patients' capacity to establish a long-term, loving relationship with another person in which intimacy, pleasure, and happiness can be mutually experienced.

At the affective level, psychological maturity and sophistication is associated with affect and emotions toward others that are complex yet positive. At the most immature level, others are seen as hostile and having significant power to harm or control patients. There is a pervasive and powerful negative association to others, making it extremely hard for individuals to enter into any kind of relationship with other persons without considerable concern. If the cognitive complexity is very immature, patients may fear that others will invade them, with the goal of controlling or destroying. This kind of affect is seen in highly paranoid and psychotic individuals. Another less mature way of affectively experiencing others is via a naïve, childish curiosity. Here, there is a disavowal of the potential that others may have motives or desires contrary to the patients', which consequently could be hurtful or harmful. Such representations are seen in unsuspecting children, but they on occasion may be found in patients who continue to be exploited but yet cannot recognize or

understand the cause. Not far removed from these experiences are representations that have both idealized and devalued orientations toward others. Others are viewed in an overly favorable or unfavorable light, such that real elements of their personality that are contrary to the representation's emotional valence are overlooked. As emotional and affective complexity grows, others are seen as having both the potential to be gratifying and frustrating. Having various needs and desires, others are experienced in ways that are generally positive. With disappointments or frustrations in a relationship, others are experienced temporarily in a negative light, with a more generalized understanding that the problem can be resolved and that the relationship can be experienced in a more generally favorable and benign way.

Object representations may be ascertained through a number of channels. The way patients treat their therapist when first meeting, including during patients' initial contact, reveals much about the implicit way others are generally experienced. Patients' current relationships and relationship histories also provide a sense of their interest in and representation of others. Those with many short-lived relationships likely have a more need-gratifying and unrealistic expectation of others than do patients who have had a few steady, long-term relationships. The absence of relationships, particularly sexual or more intimate, also provides some clues about potential fears or anxieties that are experienced about these kinds of relationships.

Self-Representations, Esteem, and Agency

It is virtually impossible to assess object representations without learning something about self-representation. How the self is experienced and understood is very important to comprehend in the context of patients' readiness and interest in psychotherapy, as well as their orientation toward assuming responsibility for the treatment process. Overly dependent and needy individuals see themselves as inadequate or incapable of acting in self-enhancing or self-promoting ways. Those who view their needs and desires with contempt, or who disavow them, are likely to view the therapy relationship, like other relationships, as inherently problematic when the focus is turned on them. By contrast, those who view some of their wants, needs, desires, emotions, and goals with excessive attention may be protecting

themselves from feelings of powerlessness or unacceptability. Thus, therapy may initially seem highly attractive and necessary, but when upsetting feelings arise they may quickly and effectively move away with defensive prowess and skill that makes it hard for the therapist to intervene.

Like object representations, self-representations exist at various levels of complexity and self-regard. Very primitive and maldadaptive representations are those in which the self is unknown or rapidly changes. At the next level, the self is represented as being highly fragile, vulnerable, and in need of much protection. Need gratification is the central focus of one's experience of the self. Consequently, persons may seem highly narcissistic or fragile. The extent to which persons' sense of self has developed is directly related to how pathological they may appear. For instance, without having others there for protection and basic need fulfillment, individuals may feel like they will disintegrate or fall apart. Here, others are necessary to provide the psychological scaffolding that allows them to exist in their own mind. At slightly higher levels, dependency needs prevail, and individuals actively seek out others for advice and direction, something commonly observed in dependent personality disorder. At a slightly higher level, they disavow their neediness or desires, such that individual efforts and desires are of supreme importance in their mental life. In this case, persons may appear highly independent or aloof and have an exaggerated sense of esteem or agency, beyond what is reasonable. More mature levels of self-representation are composed of representations of oneself as a separate, but related, being who is interested in relatedness. The self is viewed favorably and as capable. Agency and action are seen to reside within the self, and by acting on one's agency one is able to attain satisfaction and gratification. At the same time, others are viewed favorably in their ability to help the person have his or her needs and desires met. Relationships are desired because they enrich one's life, not because they are a means to an end.

Insight and Reflective Functioning

Having the capacity to step outside of one's immediate experience and to think about oneself from the perspective of an observer is a very useful ingredient for most psychoanalytic and psychodynamic

therapies. As described by Fonagy and colleagues (Fonagy & Target, 1996, 1997; Fonagy, Gergely, Jurist, & Target, 2002), *mentalization*, or *reflective capacity*, is the ability of patients to conceive of and to understand their mental states and that of others as an understandable causative mechanism of behavior and experience. Mentalization is necessary for the development of a fully developed sense of self and is acquired in the context of early attachments, specifically primary object relationships. It is typically the case that the more severe a persons' psychopathology, the more poorly developed is his/her reflective capacity (mentalization). When patients show very little awareness or recognition of their mental states or inner life, this should be a sign to therapists that more expressive interventions may not be appropriate or well received at this time and that supportive interventions are indicated. The range of interventions would involve reflection and attention by the therapist to signs of patients' mental state and their psychological symptoms. In more extreme cases of limited mentalization, patients may initially respond better to didactic interventions that teach them about the relationship of the inner life to behaviors (such as is found in cognitive therapy) or to behavioral strategies that are targeted to increase the behavioral repertoires necessary to help patients reduce their suffering. By way of contrast, patients with greater levels of mentalization are more likely to come in with some ideas about what is going on in their minds or in the behaviors of others that could be contributing to their difficulties. It is not the case that patients have to have highly well-developed mentalization capacities for psychoanalytic and psychodynamic interventions to be successful, particularly with interventions targeted toward current life situations. However, an indicator of patients' abilities to improve with psychoanalytic or psychodynamic treatment is related to mentalization.

A related concept that is important to assess early in treatment is patients' ability to have some *insight*. Insight is patients' ability to use mentalization skills in a constructive way to obtain a new understanding of their problems and difficulties that had not been consciously realized before. Sometimes, therapists may provide a relatively benign interpretive comment early in treatment to assess patients' readiness, willingness, and capacity for insight (Weiner, 1998). Although such interventions must be very carefully timed and crafted, they may allow therapists to get a sense of how likely patients will engage in obtaining new levels of understanding. In

fact, it is often the case that simply summarizing for patients what they have said in ways that draw an association between two important ideas will provide an opportunity to assess how insightful they are. For example, consider Ms. Murdock described in Chapter 1. She described her two husbands as being very different. Her first husband was someone who needed excessive support and reassurance when he was criticized, whereas her second husband worked hard to present himself as very "macho" and likeable to others. I made the observation to her that it sounded like both of her husbands found themselves feeling threatened and anxious when others did not respond to them as they would have liked. This comment provided her with some insight about these two "very different" husbands. Soon thereafter, it became clear that both husbands had rather narcissistic personalities, which provided material for us to work through as to what it was about these men that she found attractive.

Sociocultural Factors

More attention to the effect of patients' social environment and culture is needed in the psychoanalytic and psychodynamic literature (Foster, Moskowitz, & Javier, 1996). Part of this problem originates in the fact that sociocultural factors may be understood in multiple ways. One way I like to think of this dimension is to consider the social and cultural elements in my patients that are different from my own—including age, gender, gender identity, racial, cultural, regional, religious/spiritual, political, and physical differences. In thinking about how patients are different from us, I believe therapists are in a better position to really understand patients' inner world and the factors that have shaped who they are and why they are presenting to us at this time for help. It is always the case that understanding and determining patients' subjective experiences and truths is part of the assessment process and that from our understanding of their life experience, therapists can contemplate appropriate interventions. Sometimes, this is not apparent up front.

Foster (1996) provided a good example of these issues. She described working with a patient named Manash, a 29-year-old political refugee from a country in the Middle East. His family was

in a caste that was "semi-religious" and "dedicated to public and community service" (p. 12). Manash sought out treatment about 1 year after being in the United States, feeling very depressed and as if his life had lost its meaning. Given some changes that had occurred in his country, it was unlikely he could return there, where he had been hoping to enter a profession of public service. He had always seen himself in this role, which had been part of his family and caste values. Foster wrote, "As Manash eventually came to show me, the ideal of mental health in his world was not the socially autonomous, externally oriented, self-actualized individual, but rather a person centered in spiritual consciousness, the confluence of will and fate, and the emotional bonding of family and group kinship wherein one's sense of self is deeply involved, throughout life, with others" (p. 13). She used this case to illustrate that, unlike Western and European emphases on separation and independence of individuals from their family, Manash's culture taught him that his sense of self was very much related to his belonging to a community. Thinking ethnocentrically, it could have been easy to think of Manash's problems as a manifestation of psychopathology involving a poor sense of differentiation of himself from others. However, Foster suggested that such thinking would have been misguided, given that Manash's sense of self was firmly established in the context of his family and culture. Her illustration demonstrates the importance of understanding patients' subjective experience in the context of their social and cultural development prior to implementing treatment that may be insensitive to the social and cultural components of persons' psyche.

Summary

This chapter reviewed issues important in the context of diagnosis and assessment from a psychoanalytic and psychodynamic perspective. With the advent of the *PDM*, therapists now have a tool by which to communicate in a common language about their assessments and diagnoses of their patients. It also offers a much needed guide in a world that is driven by atheoretical and symptom-based descriptions of patients as is found in the *DSM-IV-TR*. In the context of assessment, the *PDM* provides an extensive listing of domains of

psychological functioning that are to be assessed in the process of coming to understand a patient.

In addition, psychological testing provides a wealth of information to the clinician that is not likely to be reported by patients or to be learned about them until several weeks or months into treatment. Already, many psychoanalytically and psychodynamically based measures have strong empirical support. Despite the challenges that exist to using these instruments, they are an often underrepresented class of assessment tools at clinicians' disposal.

Finally, to make good decisions about how to proceed with treatment, it is necessary to assess patients' psychological well-being and ways of functioning. This can be done by evaluating biological and temperamental factors, life situation, personality organization, defenses, ego functioning (e.g., affect and impulse regulation, communicative and expressive abilities, cognitive capacities, and reality testing), object representations, self-representations (e.g., one's self-esteem and sense of agency), capacity for insight or reflective functioning, and sociocultural factors. With careful review of this information, treatment can be well planned and evaluated throughout its course.

Note

1. In fact, there have been some encouraging signs that assessing personality will take on a more central role in the evolution of psychopathology research and diagnostic systems (Bornstein, 2006; Westen, Gabbard, & Blagov, 2006).