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Do practitioners find a psychodynamic taxonomy useful?

Abstract

What do typical practitioners think of a psychodynamic taxonomy? A sample of mental health practitioners from a wide range of educational backgrounds and theoretical orientations (*N*= 438) were asked to rate the utility of the Psychodynamic Diagnostic Manual's taxonomy with a recently seen patient. Our survey indicated that the percent rated as "helpful – very helpful" in understanding their patient for each diagnostic taxon were: level of personality organization 75%, personality disorders 62%, mental functioning 67%, and cultural/contextual dimension 41%. Only 30.5% rated symptoms as "helpful-very helpful" in understanding their patient. All differences were statistically significant. These results suggest that our earlier findings with 61, mainly psychodynamic assessment experts are likely to be generalizable to most non-psychodynamic practitioners. The results suggest that a useful taxonomy should include the psychodynamic categories: personality organization (healthy, neurotic, borderline, psychotic), personality syndromes (ex: schizoid, histrionic, narcissistic, etc.), and mental functioning (ex: capacity for intimacy, defensive level, self observing capacity, etc.) in addition to manifest symptoms. Our results are also generalizable to the forth coming PDM-2, which has the same diagnostic categories as the PDM. We recommend teaching the PDM/PDM-2 along with the ICD and DSM.

Keywords: psychodynamic diagnostic manual, pdm-2, diagnoses, psychodiagnostic chart

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Introduction

The diagnoses of mental disorders helps practitioners formulate their cases for treatment, increase their understanding of the patient, set goals and justify reimbursement. However, practitioners have several diagnostic taxonomies to choose from, each having distinct advantages and disadvantages. The Diagnostic and Statistical Manual of Mental Disorders 5.[1] is based on descriptive psychiatry without a theoretical foundation and is mainly used in the United States. The DSM5 is rather precise in its descriptions but it has problems with reliability and may be biased towards the medical categorical model.[2] The International Classification of Diseases- 10[3] as is the DSM5, based primarily on overt symptoms, which make it easier to assess for clinicians of any theoretical orientation. The ICD-10 is from the World Health Organization and used worldwide. It is based on an international consensus of the description of mental disorders and is prototypic in its diagnostic criteria. But the DSM and ICD deemphasizes the ideographic, psychodynamic processes and thus have limited ability to inform therapeutic interventions.[4–6]

The Psychodynamic Diagnostic Manual[7] and the forth-coming Psychodynamic Diagnostic Manual-2[8] consider the levels of personality organization (healthy, neurotic, borderline, psychotic), personality disorders or syndromes (schizoid, histrionic, dependent, etc.), mental functioning (capacity for intimacy, defensive level, self observing capacity, etc.), as well as manifest symptoms (anxiety, depression, PTSD, etc.). The PDM considers the whole person in the biosocial context, from the healthy to severe pathological range at various stages of development (infancy, childhood, adolescence, adult, etc.) The PDM has as its over-aching goal a diagnostic taxonomy that better informs the psychological treatment of the individual. However, the PDM is not widely used and is associated with a psychodynamic theoretical orientation.

Most practitioners have a negative stereotype of psychoanalytic theory[9] and would not consider a psychodynamically based diagnostic taxonomy. The aim of this study is to survey practitioners of various educational levels and theoretical orientations to assess how they might value the PDM's diagnostic taxonomy in their clinical work.

Previously, we had asked experts in assessment to complete an online survey after using an operationalized tool for the PDM that is the Psychodiagnostic Chart (PDC) with at least one of their patients.[10,11] We will discuss the PDC in more detail in the Method section below. The survey asked how the experts valued the various PDM diagnostic taxa and the symptom-based classifications of the DSM and ICD. Sixty-one psychologists responded with completed PDCs and surveys of clinical utility. Using a seven-point scale (1 = *Not at all helpful;* 7 = *Very helpful*), psychologists rated the helpfulness of the operationalized PDM in understanding their patients.

Of the 61 practitioners surveyed, 80% held doctorates and 20% held masters degrees. Fifty-two percent of the respondents were women. Their primary theoretical orientations were: Psychodynamic (44%), Eclectic (21%), Cognitive-Behavioral (15%), Humanistic/existential (13%), and Systems (3%).

Eighty-four percent rated as "helpful-very helpful" the level of personality organization in understanding their patient, 72% personality patterns and disorders, 79% mental functioning and 50% cultural/contextual dimension. In contrast, only 31% rated the ICD

or DSM symptoms as "helpful-very helpful" in understanding their patient.

The purpose of this study is to see if the results from the small sample of 61 expert mainly psychodynamic psychodiagnosticiansis generalizable to a much larger separate sample of "typical" mental health practitioners of varied theoretical orientations and education levels. A much larger and more representative sample would better illuminate taxonomical preferences of "everyday" practitioners.

Methods

Participants

We collected data from 510 practitioners. The first author collected most the data from 14 continuing education workshops on comparing the DSM5, ICD-10 and the PDM and the ethical implications of various diagnostic taxonomies. Most of the data was collected in the state of Pennsylvania where mental health professionals are required to have a certain amount of continuing education in ethics. Also the workshops and data collections were from 2013 to 2014, at a time when the dead line for the Untied States Federal requirement for using the ICD-10 was October 1, 2015, and the DSM5 was about to be published in 2013. This produced a usually large number and variety of practitioners of various educational levels, training and theoretical orientations. This gave us a highly representative sample of convenience to study.

Participant criteria included any mental health professional or graduate psychology student who was able to give an ICD or DSM diagnosis and had a current patient who fit our criteria. Participants were asked to "assess a patient you have recently seen (within a week or so) for at least 3 sessions, who is 18 or older, and who was not actively psychotic or neurologically impaired at the time of treatment." The workshops were about three hours long, which included instruction as to how to interpret and complete the PDC, and a survey on how they felt that each tax on helped them understand their patient.

They were not aware of the hypotheses of the investigation other than the investigators wanted help in understanding diagnostic issues. Participation was voluntary.

Of the 510 participants, 494 filled out their primary theoretical orientation (TO), and 438 completed all the surveys. It is common in surveys to have this range of participation in responding to questions that can be irrelevant or not understood by some respondents. Participants had a mean age of 43.6 (SD = 13.4), 62% were female and 47% held doctoral degrees. Practitioners' primary orientations were 33% CBT, 26% Psychodynamic, 22% Eclectic, 6% Humanistic/Existential, 6% Family Systems, .9% Behavioral, and 6% other. This sample closely reflects the general population of practitioners.[12]

Design and procedure

The Psychodiagnostic Chart (PDC)[1]

Robert M et al.,[10] developed the Psychodiagnostic Chart (PDC) as an operationalized guide to the Adult diagnostic section of the PDM. Gordon & Stoffey[11] found excellent construct validity for the PDC scales when compared with the Minnesota Multiphasic Personality Inventory-2[13] clinical scales, the scales of the Operationalized Psychodynamic Diagnosis:[14] Axis IV Psychic Structure/Mental Functioning scales: 1. Self-Perception, 2. Self-Regulation, 3. Defense, 4. Object Perception, 5. Communication, 6. Bonding/Attachment, and 7. Global Rating of Psychic Structure, and the scales of the Karolinska Psychodynamic Profile:[15] 1. Intimacy and reciprocity, 2. Dependency and separation, 3. Controlling personality traits, 4. Frustration tolerance, 5. Impulse control, 6. Regression in the service of the ego, 7. Coping with aggressiveaffects, 8. Alexithymia, 9. Normopathy, 10. Bodily appearance, 11. Bodily function, 12. Current body image, 13. Sexual functioning, 14. Sexual satisfaction, 15. Sense ofbelonging, 16. Feeling of being needed, 17. Access to advice and help, and 18. Personality organization. Gordon & Stoffey[11] also found very good two-week test-retest reliability.

The categories on the PDC are: personality organization (neurotic-healthy, borderline or psychotic), personality disorders (schizoid, histrionic, narcissistic, etc.), mental functioning (capacity for intimacy, defensive level, self observing capacity, etc.), ICD or DSM symptom diagnoses (mood disorder, anxiety disorder, etc.) and cultural/contextual dimension (immigration trauma, divorce, etc.). Recently, the PDC was updated for the forthcoming PDM-2. The PDC is scored by having the practitioner rate their patient on the various categories using Likert scales.

Participants were asked to diagnose a recent patient using the PDC categories (personality organization, personality patterns or disorders, mental functioning, and ICD or DSM diagnoses, and well as a cultural/contextual dimension). They were asked to rate how helpful each category was in understanding their patient with Likert scales. The survey scale ratings were from 1 (Not at all helpful) to 7 (Very helpful).[1] For copies of the Psychodiagnostic Chart (PDC and PDC-2) and more detailed data on scoring, validity and reliability go to: https://sites.google.com/site/psychodiagnosticchart/

Results

The percentages of participants who rated each diagnostic dimension as "helpful-very helpful" (ratings from 5-7) in understanding their patient were:

a. level of personality organization (neurotic-healthy, borderline or psychotic) 75%,

b. personality patterns and disorders (schizoid, histrionic, narcissistic, etc.) 62%,

c. mental functioning (capacity for intimacy, defensive level, self observing capacity, etc.) 67%,

d. ICD or DSM symptom diagnoses (mood disorder, anxiety disorder, etc.) 30.5%,

e. Cultural/contextual dimension (immigration trauma, divorce, etc.)41%.

The following were the means and standard deviations for each diagnostic category. The ratings were from 1 (Not at all helpful) to 7 (Very helpful).

Level of personality organization (M= 5.3, SD = 1.40), personality disorders (M= 4.9, SD = 1.49), mental functioning (M=5.0, SD= 1.40), ICD or DSM symptoms (M= 4.2, SD=1.47), and cultural/contextual (M= 4.7, SD= 1.54), were assessed with Wilcoxon Nonparametric Paired Tests due to the skewed distributions. The paired sign test does not rely on symmetry. We used paired tests to assess that these mean differences between the diagnostic categories were in fact statistically different. All of the diagnostic categories were significantly different at p<.0001, except the differences between personality disorders and cultural/contextual which was p=.004.

The results support our hypothesis that our earlier finding with a small sample of largely psychodynamic assessment experts is

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generalizable, and that the PDM's taxonomy would also appeal to most practitioners of various educational levels and theoretical orientations (Figure 1).

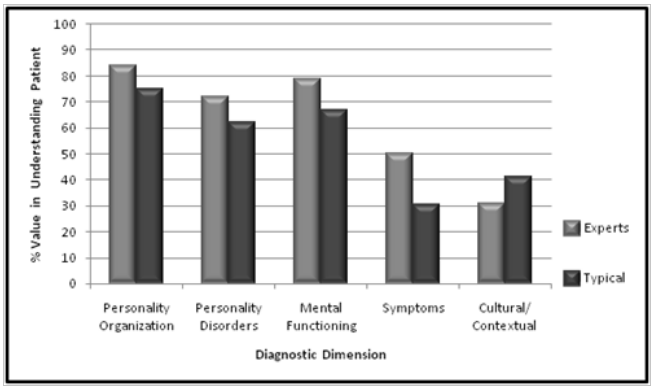

Figure 1 Taxonomic Preferences of "Expert Diagnosticians" and "Typical Practitioners".

Expert diagnosticians (*N*=61, 80% had doctorates, 44% Psychodynamic, 15% CBT) and "typical" mental health practitioners (*N*=438, 47% had doctorates, 26% Psychodynamic, 33% CBT) rated each diagnostic dimension as to how helpful (1= not at all helpful, 7= very helpful) it was in understanding a patient that they diagnosed using the PDP and PDC. Scores represent the percent of practitioners who rated the dimensions in the 5-7 range (i.e. "helpful – very helpful"). All differences between the diagnostic dimensions for the current sample were statistically significant.

Discussion

The aim of our study was to assess if the "typical" practitioner would find the Psychodynamic Diagnostic Manual's (PDM) classification system useful in understanding their patients. Given the negative stereotype that many practitioners have of psychoanalytic theory, it was likely that without an introduction to the PDM, many practitioners would not be likely to consider a psychoanalytic classification system.

Our sample of 438 mental health practitioners, who attended workshops reviewing the DSM5, ICD-10 and PDM and completed all the survey questions, indicated that the Psychodynamic Diagnostic Manual'staxa (e.g. level of personality organization, personality disorders, and mental functioning) were predominant over the taxon of manifest symptoms (the basis of the DSM and ICD taxonomies) despite the fact that the majority of participants were non-psychodynamic in orientation. This strongly suggests that the clinical utility of the PDM transcends one's preferred theoretical orientation.

This finding is similar to an earlier study in which 80% of the participants were doctoral-level assessment experts who were mostly psychodynamic.[11] These results use the same taxa and are generalizable to the forthcoming PDM-2, which is scheduled to be published in 2017.[8,16]

Our sample was not created by random sampling, though it approximates the general population of psychotherapy practitioners in the United States where most practitioners have a CBT orientation.[12] These finding do need to be replicated with other samples. This study did not look at how practitioners of various theoretical orientations and demographic factors differed in their valuing of the various taxa. This is a matter for future research. However, previous research[17] did find that CBT practitioners prefer more concrete diagnostic taxa to more inferential taxa. We accepted face valid responses to the participants' level of education and self-described theoretical orientation. Some might question this assumption however. We recommend further research into this issue as well.

Since, the PDM/PDM-2 can offer valuable information to help practitioners of all theoretical orientations understand their patients; we recommend PDM/PDM-2 education along with the instruction on the ICD and DSM.

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Conflicts of interest

Author declares there are no conflicts of interest.

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