Introduction

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The first edition of the *Psychodynamic Diagnostic Manual* (PDM; PDM Task Force, 2006) was published in an era of critical change in psychiatric nosology. This period began with the publication of the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (DSM-III; American Psychiatric Association, 1980), which embraced a shift from a psychoanalytically influenced, dimensional, inferential diagnostic system to a "neo-Kraepelinian," descriptive, symptom-focused, multiaxial classification relying on present-versus-absent criteria sets for identifying discrete mental disorders.

This change was made deliberately, in part to remove psychoanalytic bias from the manual now that other theoretical orientations (e.g., behavioral, cognitive, family systems, humanistic, biological) had arisen. It was also intended to make certain kinds of outcome research easier: Discrete traits could be identified by researchers with little clinical experience, whereas the previous classifications (DSM-I and DSM-II) had required significant clinical training to diagnose inferentially many syndromes. DSM-IV (American Psychiatric Association, 1994) continued the neo-Kraepelinian trend, which has been further elaborated and expanded with DSM-5 (American Psychiatric Association, 2013). Each succeeding edition has included more disorders.

At the same time, the psychodynamic community needed to respond to those of its members who question the usefulness of any diagnostic system and who value qualitative methodologies and clinical reports over quantitative research. The perception that analysts as a group devalue both diagnosis and systematic research has caused many

to dismiss its theories and applications on the basis of an assumed lack of empirical evidence. Among the goals of the first PDM was to call attention to how much careful research supports psychoanalytic concepts and approaches.[1]

Like its predecessor, PDM-2 has been influenced by the power and clinical utility of psychodynamic diagnostic formulations such as Shapiro's (1965) *Neurotic Styles*, Kernberg's (1984) object relations model of personality pathology, McWilliams's (e.g., 2011a) contributions on diagnosis and case formulation, and the work of many psychoanalytic researchers. As in the first edition, we offer a diagnostic framework that characterizes an individual's full range of functioning—the depth as well as the surface of emotional, cognitive, interpersonal, and social patterns. We try to promote integration between nomothetic understanding and idiographic knowledge useful for case formulation and treatment planning, emphasizing individual variations as well as commonalities. We hope that this conceptualization will bring about improvements in the diagnosis and treatment of mental problems, and will permit a fuller understanding of the development and functioning of the mind.

This diagnostic framework attempts a systematic description of healthy and disordered *personality functioning*; individual profiles of *mental functioning* (including, e.g., patterns of relating to others, comprehending and expressing feelings, coping with stress and anxiety, regulating impulses, observing one's own emotions and behaviors, and forming moral judgments); and *symptom patterns*, including differences in each individual's personal, subjective experience of symptoms and the related experience of treating clinicians.

Notwithstanding the advantages of the DSM and *International Classification of Diseases* (ICD) systems, often their classifications do not meet the needs of clinicians. Accordingly, PDM-2 adds a needed perspective on symptom patterns depicted in existing taxonomies, enabling clinicians to describe and categorize personality patterns, related social and emotional capacities, unique mental profiles, and personal experiences of symptoms. In focusing on the full range of mental functioning, PDM-2 aspires to be a "taxonomy of people" rather than a "taxonomy of disorders," and it highlights the importance of considering *who one is* rather than *what one has*. Our ability to reduce the gap between a diagnostic process and mental illness in all its complexity, and also the gap between science and practice, depends on communication and collaboration among researchers and clinicians. Hence PDM-2 is based on clinical knowledge as well as process–outcome research and other empirical work.

The rapidly advancing neuroscience field can be only as useful as our understanding of the basic patterns of mental health and pathology, and of the functional nature of disorders. Describing such patterns accurately should eventually permit a greater understanding of etiology. Research on brain development suggests that patterns of

[1]The tension between research-oriented scholars and some in the psychoanalytic community continued after the publication of the first PDM. In 2009, Irwin Hoffman critiqued the document, suggesting that the "privileged status" accorded to systematic empirical research on psychoanalytic process and outcome is "unwarranted epistemologically" and "potentially damaging," and that virtually any use of categorization in relation to patients is a "desiccation" of human experience. Hoffman viewed the PDM as merely giving lip service "to humanistic, existential respect for the uniqueness and limitless complexity of any person" (p. 1060). In response, Eagle and Wolitzky (2011) argued that human experience is not "desiccated" when researchers view it through a diagnostic lens and try to measure it; they suggested that a constructive way to bridge the gap between science and analytic work is to do better, more creative, and more ecologically valid research. Their position is shared by the authors of this document and by several psychodynamic authors involved in this discussion (for varying views, see, e.g., Aron, 2012; Fonagy, 2013; Hoffman, 2012a, 2012b; Lingiardi, Holmqvist, & Safran, 2016; Safran, 2012; Vivona, 2012).

emotional, social, and behavioral functioning involve many areas working together rather than in isolation, with important consequences for clinical psychological models of illness and psychotherapeutic change (Buchheim et al., 2012; Kandel, 1999; Schore, 2014). Outcome studies point to the importance of dealing with the full complexity of emotional and social patterns. Numerous researchers (e.g., Høglend, 2014; Norcross, 2011; Wampold & Imel, 2015) have concluded that the nature of the therapeutic relationship, reflecting interconnected aspects of mind and brain operating together in an interpersonal context, predicts outcome more robustly than any specific treatment approach or technique per se.

Westen, Novotny, and Thompson-Brenner (2004) found that treatments focusing on isolated symptoms or behaviors (rather than on personality, emotional themes, and interpersonal patterns) are not effective in sustaining even narrowly defined changes. In recent years, several reliable ways of measuring complex patterns of personality, emotion, and interpersonal processes—the active ingredients of the therapeutic relationship—have been developed. These include, among others, the Shedler–Westen Assessment Procedure (SWAP-200, Westen & Shedler, 1999a, 1999b; SWAP-II, Westen, Waller, Shedler, & Blagov, 2014), on which we have drawn extensively; the Structured Interview of Personality Organization (STIPO), developed by Kernberg's group (Clarkin, Caligor, Stern, & Kernberg, 2004); the Operationalized Psychodynamic Diagnosis (OPD) system (OPD Task Force, 2008; Zimmermann et al., 2012); and Blatt's (2008) model of anaclitic and introjective personality configurations.

Two pertinent topics are the range of problems for which psychodynamic approaches are suitable, and the effectiveness of short- and long-term psychodynamic psychotherapies (Abbass, Town, & Driessen, 2012; Levy, Ablon, & Kächele, 2012; Norcross & Wampold, 2011). A number of recent reviews (e.g., de Maat et al., 2013; Fonagy, 2015; Leichsenring, Leweke, Klein, & Steinert, 2015) suggest that some psychodynamic treatments are more effective than short-term, manualized forms of cognitive-behavioral treatment (CBT), and that improvement after psychodynamic intervention tends to continue after the therapy ends (Shedler, 2010). In addition to alleviating symptoms, psychodynamically based therapies may improve overall emotional and social functioning.

Like its predecessor, PDM-2 has been a collaborative effort among organizations of psychoanalytically oriented mental health professionals. The manual follows the format of depicting, for each chapter, two or three Editors and a pool of Consultants (clinicians and/or researchers with expertise relevant to that domain). The task of the Chapter Editors, according to guidelines we provided on how to structure each chapter, was to plan and write their respective chapters, coordinating and integrating the texts, documents, critiques, and other materials provided by the Consultants. Final approval of chapters lay with us, the manual's overall Editors.

Rationale for the PDM-2 Classification System

A clinically useful classification of mental disorders must begin with a concept of healthy psychology. Mental health is more than simply the absence of symptoms. Just as healthy cardiac functioning cannot be defined as an absence of chest pain, healthy mental functioning is more than the absence of observable symptoms of psychopathology. Attempts to depict deficiencies in mental health must consider deficits in many different capacities, including some that are not overt sources of dysfunction. For

example, as frightening as anxiety attacks can be, an inability to perceive and respond accurately to the emotional cues of others—a far more subtle and diffuse problem—can be a more fundamental difficulty than periodic episodes of panic. A deficit in reading emotional cues can pervasively compromise relationships and thinking, and may itself be a source of anxiety.

That a concept of health is foundational for defining disorder may seem self-evident, but our diagnostic procedures have not always proceeded accordingly. In recent decades, psychological problems have been defined primarily on the basis of observable symptoms and behaviors, with overall personality functioning and adaptation mentioned only secondarily. But there is increasing evidence that to understand symptoms, we must know something about the person who hosts them (Westen, Gabbard, & Blagov, 2006), and that both mental health and psychopathology involve many subtle features of human functioning (e.g., affect tolerance, regulation, and expression; coping strategies and defenses; capacities for understanding self and others; quality of relationships).

In the DSM and ICD systems, the whole person has been less visible than the disorder constructs on which researchers can find agreement. In descriptive psychiatric taxonomies, symptoms that may be etiologically or contextually interconnected are described as "comorbid," as if they coexist more or less accidentally in the one person, much as a sinus infection and a broken toe might coexist (see Borsboom, 2008). Assumptions about discrete, unrelated, comorbid conditions are rarely justified by clear genetic, biochemical, or neurophysiological distinctions between syndromes (Tyrer, Reed, & Crawford, 2015). The cutoff criteria for diagnosis are often arbitrary decisions of committees rather than conclusions drawn from the best scientific evidence.

Oversimplifying mental phenomena in the service of consistency of description (reliability) and capacity to evaluate treatment (validity) may have compromised the laudable goal of a more scientifically sound understanding of mental health and pathology. Ironically, given that current systems were expected to increase them, reliability and validity data for many DSM disorders are not strong (see Frances, 2013; Hummelen, Pedersen, Wilberg, & Karterud, 2015). The effort to construct an evidence-based diagnostic system may have led to a tendency to make overly narrow observations, overstep existing evidence, and undermine the critical goal of classifying states of mental health and disorder according to their naturally occurring patterns.

We worry that mental health professionals have uncritically and prematurely adopted methods from other sciences, instead of developing empirical procedures appropriate to the complexity of the data in our field. It is time to adapt the methods to the phenomena rather than vice versa (Bornstein, 2015). Only an accurate description of psychological patterns can guide vital research on etiology, developmental pathways, prevention, and treatment. As the history of science attests (and as the American Psychological Association stated in its 2012 guidelines), scientific evidence includes and often begins with sound descriptions—that is, naturalistic observations such as case studies. Insufficient attention to this foundation of scientific knowledge, under the pressure of a narrow definition of what constitutes evidence (in the service of rapid quantification and replication), would tend to repeat rather than ameliorate the problems of current systems.

Efforts to complement current classifications with a fuller description of mental health and illness must begin with a consensus of experts, based on disciplined clinical observations informed by accurate appraisal of existing and emerging research

(Kächele et al., 2006; Lingiardi, Gazzillo, & Waldron, 2010; Lingiardi, McWilliams, Bornstein, Gazzillo, & Gordon, 2015; Lingiardi, Shedler, & Gazzillo, 2006). Clinically experienced observers make highly reliable and valid judgments if their observations and inferences are quantified with psychometrically sophisticated instruments (Westen & Weinberger, 2004).

We attempt to maintain a healthy tension between the goals of capturing the complexity of clinical phenomena (functional understanding) and developing criteria that can be reliably judged and employed in research (descriptive understanding). It is vital to embrace this tension by pursuing a stepwise approach in which complexity and clinical usefulness influence operational definitions and inform research, and vice versa. As clinicians and researchers, we strongly believe that a scientifically based system begins with accurate recognition and description of complex clinical phenomena and builds gradually toward empirical validation.

Oversimplification, and favoring what is measurable over what is meaningful, do not operate in the service of either good science or sound practice. We are learning that when therapists apply manualized treatments to selected symptom clusters without addressing the complex person with the symptoms, and without attending to the therapeutic relationship, results are short-lived and remission rates are high. Fundamental psychological capacities involving the depth and range of relationships, feelings, and coping strategies do not show evidence of long-term change (Diener, Hilsenroth, & Weinberger, 2007; McWilliams, 2013; Westen et al., 2004). In some studies, these critical areas were not even measured—a contributing factor to "the outcome problem" (e.g., Strupp, 1963; Wampold, 2013; Westen et al., 2004).

Process-oriented research has shown that essential characteristics of the psychotherapeutic relationship as conceptualized by psychodynamic models (the therapeutic alliance, transference and countertransference phenomena, and stable characteristics of patient and therapist; see Beran, Heim, Zittel Conklin, & Westen, 2005; Bradley, Heim, & Westen, 2005; Colli, Tanzilli, Dimaggio, & Lingiardi, 2014; Fluckinger, Del Re, Wampold, Symonds, & Horvath, 2012) are more predictive of outcome than any designated treatment approach is.

Although depth psychologies have a long history of examining human functioning in a searching and comprehensive way, the diagnostic precision and usefulness of psychodynamic approaches have been compromised by at least two problems. First, in attempts to capture the range and subtlety of human experience, psychoanalytic accounts of mental processes have often been expressed in competing theories and metaphors, which have at times inspired more disagreement and controversy than consensus (Bornstein & Becker-Materro, 2011). Second, there has been difficulty distinguishing between speculative constructs on the one hand, and phenomena that can be observed or reasonably inferred on the other. Whereas the tradition of descriptive psychiatry has had a tendency to reify "disorder" categories, the psychoanalytic tradition has tended to reify theoretical constructs.

Recently, however, psychodynamically based treatments, especially for personality disorders (e.g., Bateman & Fonagy, 2009; Clarkin, Levy, Lenzenweger, & Kernberg, 2007), have been the subject of several meta-analyses attesting to their efficacy (see Fonagy, 2015; Leichsenring et al., 2015; Shedler, 2010). Moreover, since several empirical methods to quantify and analyze complex mental phenomena have been developed, depth psychology has been able to offer clear operational criteria for a more comprehensive range of human social and emotional conditions. The current challenge is to systematize these advances with clinical experience.

PDM-2 diagnoses are "prototypic"; that is, they are not based on the idea that a diagnostic category can be accurately described as a compilation of symptoms ("polythetic" diagnosis). Some PDM-2 sections refer to categories of psychopathology used in currently prevailing taxonomies. But unlike the DSM and ICD systems, the PDM-2 system highlights patients' *internal experience* of those conditions. Because mental health professionals deal daily with individuals' subjectivity, they need a fuller description of their patients' internal lives to do justice to understanding their distinctive experiences. Evidence suggests that when making diagnoses, clinicians tend to think in terms of prototypes, even as they speak in terms of categories (Bornstein, 2015). This manual attempts to capture the gestalt of human complexity by combining the precision of dimensional systems with the ease of categorical applications. It uses a multidimensional approach, as follows, to describe the intricacies of the patient's overall functioning and ways of engaging in the therapeutic process.

- *Personality Syndromes—P Axis.* The major organizing principles of the P Axis are the level of personality *organization* (i.e., a spectrum of personality functioning from healthy, through neurotic and borderline, to psychotic levels) and personality *style* or pattern (i.e., clinically familiar types that cross-cut levels of personality organization). In the Adulthood section (Part I), because symptoms or problems often cannot be understood, assessed, or treated without an understanding of the personality patterns of the individual who has them, we have placed this dimension first. A person who fears relationships and avoids feelings will experience depression in markedly different ways from one who is fully engaged in relationships and emotions.

- *Profile of Mental Functioning—M Axis.* The second dimension offers a detailed description of overall mental functioning (i.e., the capacities involved in overall psychological health or pathology). It takes a more microscopic look at inner mental life, systematizing and operationalizing such capacities as information processing; impulse regulation; reflecting on one's own and others' mental states; forming and maintaining relationships; experiencing, expressing, and understanding different emotions; regulating self-esteem; using coping strategies and defenses; adaptation and resiliency; forming internal standards; and giving coherence and meaning to personal experience.

- *Symptom Patterns: The Subjective Experience—S Axis.* The third dimension takes as its starting point the DSM and ICD categories and depicts the affective states, cognitive processes, somatic experiences, and relational patterns most often associated with each. The S Axis presents symptom patterns in terms of patients' most common personal experiences of their difficulties, and also in terms of clinicians' typical subjective responses to them. In addition, this axis includes descriptions of psychological experiences (e.g., conditions related to gender identity, sexual orientation, and minority status) that may require clinical attention.

The order of these axes varies by section. In adults, personality is evaluated before mental functioning, whereas the assessment of children, adolescents, and the elderly starts with their mental functioning. Our rationale for this inconsistency is that by adulthood, personality (Axis P) has become quite stable and usually requires primary clinical focus, whereas in children and adolescents, developmental issues (Axis M) typically take precedence in clinical evaluations over emerging personality patterns. Late in the life cycle, adaptation to various aspects of aging (Axis M) may again be more important to assess than personality trends. The multiaxial approach for the

Infancy and Early Childhood section (Part IV/Chapter 10) differs from the others because of the unique qualities of the first 3 years. It focuses on functional emotional developmental capacities, regulatory–sensory processing capacity, relational patterns and disorders, and other medical and neurological diagnoses.

Updating and Refining the Original PDM

The first edition of the PDM had three sections: (I) Adult Mental Health Disorders; (II) Child and Adolescent Mental Health Disorders (which included Infancy and Early Childhood Disorders); and (III) Conceptual and Research Foundations. Except with infants and preschoolers, clinicians were asked to assess each patient's level of personality organization and prevalent personality styles or disorders (P Axis); level of overall mental functioning (M Axis); and subjective experience of symptoms (S Axis).

The original PDM met with considerable success in the United States and Europe. On January 24, 2006, *The New York Times* reported positively on it. The manual also received some welcome in the clinical literature, as in a 2011 special issue of the *Journal of Personality Assessment* (see Bornstein, 2011; Huprich & Meyer, 2011; McWilliams, 2011b) and several favorable book reviews (e.g., Michels, 2007). In 2009, Paul Stepansky called the first PDM a "stunning success." In the decade after its publication, several national symposia were held on the manual. An Italian translation was published in 2008. PDM's influence has also been documented in Germany, Spain, Portugal, Turkey, France, and New Zealand (Del Corno & Lingiardi, 2012). In some countries (e.g., New Zealand), PDM diagnosis is accepted by governmental authorities who fund treatment. Gordon (2009) found that diverse psychotherapists evaluated the first PDM favorably, regardless of theoretical orientation. Participants in his study emphasized the value of its jargon-free language and usefulness in helping nonpsychodynamic clinicians to formulate a clinically relevant diagnosis.

In *The Pocket Guide to the DSM-5 Diagnostic Exam*, Nussbaum (2013) states:

> ICD-10 is focused on public health, whereas the *Psychodynamic Diagnostic Manual* (PDM) focuses on the psychological health and distress of a particular person. Several psychoanalytical groups joined together to create PDM as a complement to the descriptive systems of DSM-5 and ICD-10. Like DSM-5, PDM includes dimensions that cut across diagnostic categories, along with a thorough account of personality patterns and disorders. PDM uses the DSM diagnostic categories but includes accounts of the internal experience of a person presenting for treatment. (pp. 243–244)

In October 2013, the American Psychoanalytic Association noted:

> No two people with depression, bereavement, anxiety or any other mental illness or disorder will have the same potentials, needs for treatment or responses to efforts to help. Whether or not one finds great value in the descriptive diagnostic nomenclature exemplified by the DSM-5, psychoanalytic diagnostic assessment is an essential complementary assessment pathway which aims to provide an understanding of each person in depth as a unique and complex individual and should be part of a thorough assessment of every patient. Even for psychiatric disorders with a strong biological basis, psychological factors contribute to the onset, worsening, and expression of illness. Psychological factors also influence how every patient engages in treatment; the quality of the therapeutic alliance has been shown to be the strongest predictor of outcome for illness in all modalities. For

> information about a diagnostic framework that describes both the deeper and surface levels of symptom patterns, as well as an individual's personality and emotional and social functioning, mental health professionals are referred to the *Psychodynamic Diagnostic Manual*. (apsa.org, October 2013, quoted in Lingiardi & McWilliams, 2015, p. 238)

Given the success of the first edition, and in response to feedback about its strengths and weaknesses, we decided to revise the original PDM to enhance its empirical rigor and clinical utility (see Clarkin, 2015; Gazzillo et al., 2015; Huprich et al., 2015; Lingiardi et al., 2015; Lingiardi & McWilliams, 2015). The PDM-2 project would never have been achieved without Stanley Greenspan (1941–2010), our Magellan who showed us the way; Nancy Greenspan, a devoted caretaker of her late husband's legacy, who gave the project her unfailingly helpful support; and Robert S. Wallerstein (1921–2014), our Honorary Chair until his death. One of his last letters mentioned his hopes for this manual: "I am happy that PDM will have an enduring life. . . . I do give you my very best wishes for a really successful job in continuing the legacy of PDM."

PDM-2 is based on more systematic and empirical research than that which informed the first edition, especially as such research influences more operationalized descriptions of the different disorders. (Each chapter of the manual includes a Bibliography, which provides not only the references specifically cited in the chapter text, but additional references on the topics covered in that chapter.) Seven task forces have helped to draft its six sections: (I) Adulthood, (II) Adolescence, (III) Childhood, (IV) Infancy and Early Childhood, (V) Later Life, and (VI) Assessment and Clinical Illustrations. Although this second edition preserves the main structure of the first PDM, it is characterized by several important changes and innovations.

In light of research since 2006 supporting the clinical utility of this concept, the P Axis now includes a psychotic level of personality organization. This axis has been integrated and reformulated according to theoretical, clinical, and research indications, including empirically sound measures such as the SWAP-200, SWAP-II, and SWAP-200—Adolescents. A borderline personality typological description has been added, while a dissociative personality type is no longer included (instead, the section on dissociative symptoms has been expanded). In the M Axis for Adulthood, we have increased the number of mental functions from 9 to 12. An assessment procedure with a Likert-style scale is associated with each mental function. The S Axis is integrated more closely with the DSM-5 and ICD-10 systems. In addition, we give a fuller explanation of the rationale for the description of "affective states," "cognitive patterns," "somatic states," and "relationship patterns." This chapter more thoroughly depicts both the common subjective experiences of the patient and the likely countertransference reactions of the clinician.

In PDM-2, we have separated the section on Adolescence (ages 12–19) from the section on Childhood (ages 4–11) because it seems clinically naive to use the same levels and patterns for describing the respective mental functioning of, say, a 4-year-old and a 14-year-old. We have retained the recommendation to assess first on the M Axis, thus guiding the application of the P and S Axes. The section on Infancy and Early Childhood includes more detailed discussion of developmental lines and homotypic–heterotypic continuities of early infancy, childhood, adolescent, and adult psychopathology. We improve the definitions of the quality of primary relationships, emphasizing the evaluation of family systems and their characteristic relational patterns, including attachment patterns and their possible connections to both psychopathology and normative development.

An innovation in PDM-2 is the section on Later Life—the first time such a focus has appeared in any major diagnostic manual. Given the paucity of psychodynamic studies on this life stage and its implications for psychological treatments, much of this section is based on clinical observation.

Finally, PDM-2 contains an Assessment and Clinical Illustrations section. The Psychodiagnostic Chart–2 (PDC-2) and the Psychodynamic Diagnostic Prototypes were derived from the original PDM; other measures were derived from prior studies. (The PDC-2 and versions of the PDC for different age groups are included in the Appendix to this manual.) The chapter within this section on Clinical Illustrations and PDM-2 Profiles is intended to help readers improve their formulations. Illustrative clinical vignettes appear elsewhere, but this final chapter includes five clinical cases illustrated according to the PDM-2 approach.

A substantial part of the first PDM involved articles solicited from leading psychodynamic scholars. In PDM-2, we have chosen instead to integrate the voluminous empirical literature that supports psychodynamic therapy into the sections to which the respective studies apply.

Although psychodynamic practitioners will be more familiar with PDM-2 concepts than clinicians of other orientations will be, we hope that this volume will be of interest to therapists trained in other traditions, including biological, CBT, emotion-focused, family systems, and humanistic approaches. Future clinical practice is likely to be characterized by both diversity and integration of approaches. Consequently, we considered retitling PDM as the *Psychological Diagnostic Manual*, the *Practitioner's Diagnostic Manual*, or the *Psychotherapist's Diagnostic Manual*—but our publisher felt that because the title *Psychodynamic Diagnostic Manual* is already a "brand," we would be confusing our readers. This may be, but we nevertheless emphasize both our respect for alternative terminologies and conceptualizations, and our effort to be helpful to therapists of diverse conceptual systems and therapeutic traditions. We believe that a more thorough diagnostic formulation can inform any treatment plan seeking to take the whole person into account. And we think that even fondly held ideas must be subject to potential disconfirmation. Hence we hope that this manual will be tested and improved in the years to come, as empirical researchers continue to investigate our assumptions, and clinicians continue to report on their applicability.

As teachers and supervisors, we realize every day how many young colleagues feel lost in a biomedical diagnostic world, and how keenly they feel the lack of a more psychologically articulated system. Without the dynamic, relational, and intersubjective aspects of diagnosing, the process stops making sense and becomes routinized and boring. It not only stresses clinicians' professional identities, but also dims or distorts their abilities to detect and describe patients' clinically salient characteristics and mental functioning, resulting in jeopardizing the clinical relationship. One of our prime motives is thus to be useful to beginning therapists.

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