Psychopathology: A Simple Twist of fate or a meaningful Distortion of Normal Development? Toward an Etiologically Based Alternative for the DSM Approach

Patricia Luyten, Ph.D.

In this comment, I focus on a central issue that spans the entirety of Sidney Blatt's research career, namely his contributions to the development of a theoretically consistent and clinically relevant classification system of psychopathology. First, I discuss empirical evidence concerning the key assumptions underlying the currently dominant classification system of mental disorders, the Diagnostic and Statistical Manual of Mental Disorders (DSM). Second, I compare these assumptions with assumptions underlying Blatt's categorization of psychopathology based on his distinction between two developmental lines, that is, self-definition and relatedness, together with a discussion of recent research on these two developmental lines in the context of the development of a more etiologically based classification system of depression and other disorders. Finally, I argue that research concerning Blatt's model of normal and pathological development—aside from direct contributions—may also inform empirically derived criteria for the development of a theoretically consistent and clinically useful way of classifying psychopathology.

In His Article "A Fundamental Polarity in Psychoanalysis: Implications for Personality Development, Psychopathology, and the Therapeutic Process," Blatt majestically summarizes three decades of theoretical, empirical, and clinical research concerning the normal and pathological development of relatedness and self-definition, two fundamental dimensions in human existence. There are many reasons it is a great honor to comment on this article. One reason is that Blatt has played a pivotal role in the establishment of a research culture within psychoanalysis and in the integration of empirical research and clinical practice in general. He already was a "scientist–practitioner," long before the term had even been invented. Another reason is Blatt, from the early 1970s on, has developed an impressive developmental psychopathology avant la lettre, originating from a continuous and continuing dialogue between psychodynamic formulations and research from cognitive, behavioral, cultural, attachment, personality, and social psychological perspectives. Not surprisingly, therefore, his theories and research have influenced many theoreticians, researchers, and clinicians alike and will undoubtedly continue to do so for many more years to come.

Taking stock of Blatt's extensive research, one is not only struck by the wide range of contributions he has made to our understanding of both normal and pathological development but also by the fact that his theoretical views continue to generate important questions that need to be addressed and elucidated by future research. One of the most crucial and pressing questions is whether Blatt's views concerning psychopathology, given the increasing dissatisfaction with the approach taken by the Diagnostic and Statistical Manual for Mental Disorders (DSM: American Psychiatric Association, 1994), may provide a more valid and clinically relevant alternative to the DSM taxonomic approach. This issue, which touches upon the essence of Blatt's contributions and in fact spans his entire research program, is the focus of this comment. First, I discuss the assumptions underlying DSM and the empirical research pertaining to these assumptions. Next, I discuss how Blatt's views can lead to the development of an etiologically based alternative to the DSM taxonomic approach. Finally, I argue that in addition to a direct contribution to the development of an etiologically based classification system of mental disorders, research concerning the anaclitic–introjective distinction may also lead to the formulation of empirically based criteria for the development of a valid classification system for psychopathology. I conclude this article by stressing that psychoanalytic formulations concerning the nature of psychopathology can and should play a decisive role in the development of DSM in the future.

What Is Wrong with DSM (and How to Mend It)?

It is well known that many clinicians are dissatisfied with the DSM approach, despite the tremendous strides that have been made in our understanding of the nature and prevalence of psychopathology since the introduction of DSM. Clinicians are mainly dissatisfied because of the wide gap between the DSM approach and actual clinical practice. For example, most clinicians do not base their diagnosis on a cumbersome counting of symptoms per the DSM and are particularly interested in the implications of diagnosis for treatment and prognosis. DSM diagnoses, however, contain little clinically relevant information. This dissatisfaction is not based on ideology, clinical intuition, or subjective preferences. To the contrary, over the past decades, empirical studies have consistently failed to validate almost all of the major assumptions underlying the DSM approach.
and have pointed to serious limitations concerning the clinical utility of the DSM. Reactions to these disappointing findings have varied widely. Some have argued that the DSM approach should be further refined; others argue that we need a fundamental change in the DSM approach. Or, as one author put it, “Dump the DSM” (Genova, 2003). Yet, such dismissive reactions to the DSM often risk our forgetting that the DSM has prompted an enormous amount of empirical research (including large epidemiological and longitudinal studies) concerning the nature, development, and prevalence of psychopathology and has undeniably led to great increases in our understanding of psychopathology. It is precisely this research that has shown that something is wrong with the basic assumptions of DSM. Hence, the fact that assumptions underlying DSM can now be evaluated based on solid empirical evidence is the result of the strong empirical orientation promoted by DSM, which can serve as an example to any attempt to validate a classification system. Hence another, more cautious, approach is to learn from experience and thus consider in detail the (implicit and explicit) assumptions of DSM, how they have fared in empirical research, and how we can develop more empirically supported assumptions. In a nutshell, the assumptions underlying DSM are

1. Disorders are categorically distinct from subclinical disorders and from normality.
2. Axis I disorders are relatively distinct from each other.
3. Symptom disorders (coded on Axis I) are independent from personality disorders (coded on Axis II) and from personality in general.
4. Disorders have their own distinct pathogenesis and etiology.
5. Disorders can and should be diagnosed based on an assessment of objective, manifest symptoms.

Despite initial optimism, these assumptions have not fared well in empirical research (Luyten and Blatt, in press: Luyten et al., in press b). First, empirical research does not support a categorical view for most disorders. Rather, most disorders appear to be situated on a continuum. Hence, DSM does not “carve nature at its joints.” Even severe psychopathology, such as schizophrenia and bipolar disorder, appears to be best situated on a continuum (Tsuang et al., 2003). The reification of DSM categories or the creation of “pseudo-entities” (Parker, 1999, p. 102) by DSM has resulted in the underestimation of the importance of “subclinical” psychopathology and has hampered research in general (e.g., most research has concentrated on the main DSM categories, such as major depression, to the neglect of “subclinical” conditions). Morrison, Bradley, and Westen (2003), for example, found that many patients treated for clinically significant personality problems could not be diagnosed by DSM criteria. Second, empirical research has shown high rates of comorbidity between Axis I disorders (e.g., between mood and anxiety disorders), suggesting that many disorders are not relatively distinct. Third, high rates of comorbidity have also been found between Axis I and Axis II disorders and between Axis II disorders (Westen et al., 2002). It is therefore extremely unlikely that Axis I and Axis II disorders are independent. In fact, Blatt’s research on dependency and self-criticism has played a key role in the realization that personality and depression are causally linked (Blatt, 2004; Luyten et al., in press b). The distinction between Axis I and Axis II also does not reflect, at least not for most disorders, a distinction between state and trait disorders or between biological and psychosocial disorders. Many Axis I disorders are highly recurrent and in a considerable number of patients even chronic (e.g., Segal, Pearson, and Thase, 2003), whereas many personality disorders show considerable fluctuations in severity over time and are not as stable as assumed by DSM (Shea and Yen, 2003). Similarly, biological factors are implied in personality disorders (e.g., borderline personality disorder, see Skodol et al., 2002), whereas psychosocial factors are clearly implied in many Axis I disorders (e.g., Blatt, 2004). Fourth, high comorbidity also makes it very unlikely that Axis I and Axis II disorders have their own distinct etiology and pathogenesis. On the contrary, research suggests that biopsychosocial processes implied in the pathogenesis and etiology of one disorder are also implied in a variety of other disorders (Luyten, Blatt, and Corveleyn, 2005). These findings are entirely congruent with the developmental psychopathological principles of equipotentiality and multifinality (i.e., that one disorder can be the outcome of various etiological pathways and that the same etiological factors may, influenced by other factors, result in different disorders, respectively). These findings, however, are not congruent with the DSM view that (implicitly) assumes that each disorder has its own relatively distinct pathogenesis and etiology. Hence, investigators and clinicians are starting to prefer the idea of spectra of disorders, which are intrinsically related by etiological and/or pathogenetic factors. Finally, one of the main limitations of the DSM is its focus on manifest symptomatology to define psychopathology. Individuals who receive the same DSM diagnosis are often very heterogeneous in terms of etiology and pathogenesis, which is detrimental for both research and clinical practice. For example, two individuals may receive the diagnosis major depression, but the etiological factors involved in these two cases, and thus the likely course and prognosis, may be completely different. This over-reliance on manifest, “objective” symptoms in an attempt to improve the reliability of diagnoses has resulted in poor validation (Blatt and Levy, 1998). The over-reliance on manifest symptoms has been particularly detrimental for the creation of a classification system for Axis II (Westen and Shedler, 2000). Empirical research suggests that accurate diagnosis of personality disorders does not so much involve the counting of manifest symptoms as rely on an assessment of personality features and dynamics based on a clinical
interview (Westen and Shedler, 2000). The reliance on manifest symptoms to diagnose personality disorders has resulted in extreme rates of comorbidity among Axis II disorders as well as poor validity, and thus little clinical utility. The almost exclusive focus on symptoms in DSM has also led to a preoccupation with symptom relief as the major expression and measure of the efficacy and effectiveness of treatment strategies. Yet it has become increasingly clear that symptom-focused treatments are insufficient for many patients. Meta-analyses show that on average about two-thirds of patients relapse after such brief, symptom-focused treatments (Westen, Novotny, and Thompson-Brenner, 2004). This has led to a growing awareness that treatments should focus on underlying vulnerability factors in order to prevent relapse (Blatt, Shahar, and Zuroff, 2002), an idea supported by recent findings of the efficacy of long-term treatments including psychodynamic treatment (e.g., Bateman and Fonagy, 2004).

In summary, the DSM approach appears to suffer from two major limitations. First, the DSM is not based on empirical research, but on consensus. Although from a certain perspective this is unavoidable, DSM has lagged far behind empirical findings concerning the nature of psychopathology. Second, the DSM shows a marked over-reliance on a disease model in which “host” and “pathogen” are neatly distinguished. Disorders are considered relatively isolated conditions that can be diagnosed by an assessment of manifest symptoms having a relatively distinct etiology and pathogenesis. Accordingly, it is assumed that one can develop and “manualize,” analogous to the development of a drug for a disease, treatments that are specifically designed for this particular “disease.” When this treatment leads to a disappearance of symptoms, the disease has been “cured.” Hence, the disease and drug metaphor (Stiles and Shapiro, 1989) has a negative impact, not only on classification but also on current treatment research and treatment guidelines.

Assumptions Underlying the Anaclitic–Introjective Distinction

In marked contrast to the DSM approach, Blatt's assumptions concerning the nature of psychopathology and its classification are much more consistent with empirical research (see also Blatt and Levy, 1998). As summarized in his article, almost three decades of empirical research have supported his view that psychopathology should not be viewed as a series of relatively isolated diseases that result from an (often undocumented) biological vulnerability. Instead, psychopathological disorders should be seen as the result of various distortions of the normal dialectic interaction between the development of self-definition and relatedness. In addition, empirical research has also clearly supported Blatt's assumption that psychopathology should be situated on a continuum. Furthermore, congruent with empirical evidence, Blatt does not consider disorders as isolated entities distinct from normality and from other disorders. Rather, he maintains that psychopathology should be situated in a broadmodel of normal and pathological personality development and that any disorder should be seen as one disorder among other related disorders (Blatt and Levy, 1998). Anaclitic depression, for example, is part of the anaclitic cluster of psychopathology, and thus it is likely that an individual with predominantly anaclitic features, depending on other factors, is vulnerable to a number of disorders or features of disorders from the anaclitic cluster. Depression, for example, is not considered to have its own unique pathogenesis and etiology but is likely to “share” pathogenetic and etiological factors with other, related disorders (Luyten et al., in press b). It is therefore insufficient to diagnose depression based on manifest symptoms only. Underlying vulnerability factors, such as relative stablepersonality dimensions or cognitive–affective schemas associated with relatedness and self-definition should be considered in both assessment and treatment. One beautiful example, among many others, of the need to consider personality factors in psychopathology is the finding, often replicated, that introjective features negativelyaffect the outcome of brief treatments, whereas long-term treatment may lead to substantial changes in introjective pathology (see Blatt, 2004 for an overview).

To summarize, Blatt's approach of psychopathology, which can be described as a person- rather than a disorder- or symptom-focused approach, is much more consistent with empirical findings on the nature of psychopathology than the DSM approach. Influenced by the DSM, researchers have investigated disorders andsymptoms, and clinicians are treating these disorders and symptoms. Blatt's approach teaches us that we should start (again) to investigate and treat individuals who, as a result of a complex interaction among a variety of biopsychosocial factors, are vulnerable to a set of interrelated problems and disorders. Take, for example, the case of a girl who has grown up with severely disturbed parents who have emotionally and physically abused her as a child. Although she was somewhat shy and fearful as a child, in early adolescence she starts to experience severe problems with authority, becomes involved in delinquent acts, and starts to experiment with drugs. Very quickly, she becomes addicted to soft drugs and alcohol, has frequent encounters with the police, shows promiscuous behavior, and has several severe bouts of depression andaxiety. She also starts to suffer from serious eating problems and tends to dissociate in stressful circumstances. To describe this “case,” a clinical picture frequently encountered in clinical practice, from a DSM perspective, one needs a pile of diagnoses (e.g., substance abuse disorder, major depression, anxiety disorder, borderline personality disorder, antisocial personality disorder, eating disorder, impulse control disorder; see also Genova, 2003). It would be
clearly incorrect to assume that each of these various conditions reflects a specific disease with its own distinct etiology and pathogenesis. To the contrary, it would be more correct to assume that this girl's problems are expressed in different moments of life, depending on a variety of circumstances, in various ways. For instance, her symptoms might represent various ways to experience, express, and/or defend against underlying feelings of emptiness, shame, and anger.

Toward an Etiologically Based Alternative?

Although Blatt's views are consistent with empirical research concerning the nature of psychopathology, at the same time it must be clear that much remains to be done on our way to establish an etiologically based alternative to the DSM. But investigators are increasingly responding to this call for further research. We will comment here on only two recent exciting developments, illustrating the potential of Blatt's theoretical views and psychodynamic formulations in general to contribute to the development of an alternative to the current DSM. First, as noted, DSM assumes that individuals are passive recipients both of intrapersonal (biological and psychological) factors and of their environment, much as, from a disease perspective, certain "pathogens" are expected to influence their "hosts." Recent research, consistent with Blatt's views, increasingly shows that individuals, in part, generate their own internal and external stressors. For example, studies have shown that anacritic and introjective individuals are not only particularly sensitive to life events that match their personal vulnerability (loss vs. failure) but that they also generate, in part, such congruent events, mainly as a result of a so-called dysfunctional interpersonal style (Blatt and Zuroff, 1992). Because of exaggerated fears of rejection and abandonment, anacritic individuals typically have a clinging, claiming relational style, which leads to resentment and irritation in others and eventually in abandonment, confirming these individuals' fear of rejection. Introjective individuals, in contrast, have a cold and ambivalent relational style, leading to distant, ambivalent relationships with others, which eventually confirm these individuals in their underlying fear of disapproval. These findings are entirely congruent with recent research on person— (and gene—) environment correlations and interactions, that is, that personality factors (or genes) may affect the exposure to certain stressors (or vice versa) or that certain personality factors (or genes) may increase the sensitivity for stress (Rutter, 2002; Luyten et al., in press b; Zuroff, Mongrain, and Santor, 2004). Thus, there appears to be no neat distinction between "hosts" and "pathogens" in the realm of psychopathology.

Second, any etiologically based alternative to the DSM should integrate empirical findings from various theoretical and methodological perspectives. We must avoid competition among various theoretical and/or methodological approaches in establishing a meaningful classification system. Such competition would most probably result in a return to the formation of task forces, with experts trying to reach a consensus on which etiological or pathogenetic theories should be included in an atheoretical classification system. What are needed are new, truly integrative theories: theoretical models that have meaningfully integrated findings from various perspectives. In this respect, it is interesting to note that Blatt's model has recently evolved into an encompassing dynamic interactionism model that integrates research from various theoretical strands—including psychiatric genetics, neurobiological research, cognitive—behavioral, personality, attachment, and social psychological perspectives—with psychodynamic theory (see Zuroff et al., 2004; Luyten et al., 2005: Luyten et al., in press b). This dynamic interactionism model assumes that genes, neurological factors, relatively stable personality dimensions, or cognitive—affective schemas concerning relatedness and self-definition, early and later life stress, and other environmental factors (such as parental style and social support) are in constant reciprocal interaction. Further research concerning this dynamic interactionism promises to give a new impetus to the development of an integrative, etiologically based alternative for the DSM approach.

However, this will necessitate the collaboration between both researchers and clinicians from various theoretical perspectives, an exciting but also daunting task for the future, particularly given the unfounded optimism that characterizes much of the current literature concerning the role of the neurosciences in the development of a new classification system. Many appear to expect that the crucial and, according to some, even "final" breakthroughs in the development of a classification system will come from new findings in the neurosciences. Although neurobiological findings (e.g., concerning the hypothalamic—pituitary—adrenal [HPA] axis) have undeniably led to great advances in our insight in psychopathology and have even revolutionized our ways of thinking about several disorders, neurobiological findings alone can never be the basis of a classification system. Recent studies, for example, suggest that the effects of genes are expressed both through "within-the-skin" physiological effects (direct effects of genes on neurobiological processes) and "outside-the-skin" behavioral effects (the effects of genes on the social environment via temperament, personality, etc.; Kendler, 2001). These findings are congruent with the more general finding that biological and psychological factors reciprocally interact (e.g., Gold and Chrousos, 2002). To quote Rose (2001): "organisms select environments just as environments select organisms. Like organisms, environments evolve and are homeodynamic rather than homeostatic; both 'genome' and 'envirome' are abstractions from this continuous dialectic" (p. 3). Therefore,
any theory that starts from an obsolete “nature versus nurture” distinction, or that does not take into account subjectivity (“psychic reality” is insufficient (see also Fonagy, 2003).

Criteria for the Development of a Valid Classification System

One major impediment to the development of an etiologically based classification of mental disorders, and to any classification of psychopathology as such, is the absence of an objective standard. There is no known set of “naturally occurring categories” against which we can validate a given classification system (Westen and Shedler, 2000). One approach toward this issue is empirical, that is, to delineate the criteria for a classification of psychopathology based on empirical research. Regardless of the direct contribution of Blatt’s views to the development of an etiologically based classification system, almost three decades of empirical research concerning the anaclitic–introjective distinction suggest the following criteria:

1. Any categorization system must be based on empirical research. Although this might seem self-evident, as noted earlier, DSM is fundamentally based on consensus, not on empirical research.

2. Congruent with other findings, research concerning Blatt’s views clearly suggests that a classification system should not be solely based on an assessment of manifest symptoms but should include etiological and pathogenetic factors. Ideally, research concerning these etiological and pathogenetic processes should be driven by an encompassing theory concerning the nature of psychopathology. Currently, we lack such integrative theories, but, as already noted, the first steps toward such theories are currently being made and appear promising. Yet, it must also be clear that we are closer to such theories for some disorders than for others. Blatt’s view also demonstrates that any integrative theory should see disorders not as isolated entities but as related disorders that share a number of characteristics, including etiological and pathogenetic factors. Hence, high comorbidity between disorders may not be a problem that needs to be solved but may in fact reflect common etiological and pathogenetic processes.

For instance, as noted by Blatt, empirical evidence indicates that the anaclitic/introjective distinction may explain the high comorbidity between various Axis I and Axis II disorders in terms of clusters of disorders that belong to the anaclitic versus introjective configuration (Blatt and Levy, 1998). Such a view may not only explain high comorbidity but may also explain why progression (e.g., as a result of psychotherapy) or regression (e.g., as a result of stressful circumstances) in patients is often observed between a related series of disorders (e.g., between obsessive–compulsive disorder, guilt-ridden depression, and paranoid traits). Finally, research concerning Blatt’s views clearly suggests that the disease metaphor is inadequate for most, if not all, mental disorders. Individuals should not be seen as “hosts” to certain “pathogens,” but they actively contribute to the creation and persistence of (internal and external) stressors. Again, there may be important differences here between disorders, but this can be systematically investigated.

3. Although discrete, categorical disorders may exist, a dimensional view of psychopathology appears to better fit the data for most disorders. Yet, some disorders might represent true “taxons,” and clinicians and insurance companies will continue to find it more convenient to think and speak in terms of categories (e.g., this patient “has” PTSD). The challenge for the future then will be to develop a classification system that capitalizes on the advantages of both a dimensional and categorical view (e.g., see Westen and Shedler, 2000).

4. One important criterion, that seems to have slipped into the background in the process of developing and refining DSM, is the clinical utility and clinical relevance of a classification system. A classification system should be “nature friendly but also user friendly” (Westen et al., 2002, p. 222). As noted by Blatt, the anaclitic–introjective distinction is relatively easy and reliable to make, provides a theoretical rationale for the high comorbidity among Axis I and Axis II disorders, and has immediate implications for assessment and treatment. DSM, in contrast, includes distinctions that are not only to some extent arbitrary (e.g., why two and not three weeks of depressive complaints?) but also often difficult to make (e.g., when is perfectionism in obsessive–compulsive individuals maladaptive?) and cumbersome (as anyone who has ever administered a structured clinical interview for DSM will endorse). Its clinical utility is also quite limited in that most diagnoses give little information concerning treatment and prognosis.

5. A final issue concerns methodological pluralism. Blatt’s research, combining theory, empirical research, and clinical experience, is a clear illustration of the fact that research on the nature of psychopathology cannot be restricted to any particular methodological point of view. For example, although diagnoses may be made with high reliability by trained raters in epidemiological studies,
this does not mean that clinicians in daily clinical practice may reach the same level of reliability or that it helps them to make valid diagnoses. Similarly, the delineation of several depressive disorders on pathophysiological principles should, as a minimum requirement, have clinical relevance. Hence, we need a wide variety of methodological approaches, ranging from N = 1 designs, experimental and naturalistic studies in both animals and humans, to epidemiological studies in community samples. Also, process–outcome studies should be included in the development of a classification system because these studies, as Blatt's contributions demonstrate, have considerably changed our ways of thinking concerning the nature of psychopathology and the therapeutic process and will likely continue to do so. And, finally, no nomothetic findings should also be immediately tested at the idiographic level, and vice versa (Luyten, Blatt, and Corveleyn, in press a). For example, in clinical practice, many patients present with mixed depressed–anxious complaints, yet DSM does not include such a category. Likewise, clinicians often encounter patients with depressive–personality disorders, but researchers have experienced considerable trouble operationalizing and replicating this condition (Westen and Shedler, 2000). Careful consideration of the possible causes of such divergences between diagnosis of actual cases in clinical practice and research could lead to considerable advances in the development of a valid classification system; yet because of the dissociation between clinical practice and research in the development of the DSM, this has been neglected.

**Conclusions**

This article illustrates that psychoanalysis can and should provide an important contribution to the future development of DSM. Historically, DSM evolved into an atheoretical (and even antipsychanalytic according to some) classification system in part as a reaction against the dominance of orthodox psychoanalytic theory in psychiatry. It seems that, by doing this, the DSM might have thrown out the proverbial baby with the bathwater. By its exemplary emphasis on systematic, replicable empirical research, DSM has led to tremendous new insights in mental disorders. Yet, it has also become clear, precisely by the research it has prompted, that many of its core assumptions are invalid. Now that researchers and clinicians involved in the development of DSM-V are increasingly realizing this (e.g., Kupfer, First, and Regier, 2002), the time has come to reconsider psychoanalytic formulations and research concerning the nature and classification of psychopathology in the context of the further development of DSM.

Blatt's work in particular has indisputably led to great progress in our understanding of the nature of psychopathology. Perhaps one of his most important contributions is that psychopathology should not be seen as a “simple twist of fate”—the result of (undocumented) genetic/biological disturbances that are present in some individuals but not in others—but as the outcome of a complex interaction between vulnerability and resilience throughout life associated with two fundamental dimensions of human existence, self-definition, and relatedness and thus a possibility that resides in us all. Hence, mental disorders are not relatively isolated diseases but can be seen as the other side of the human capacity to assert oneself and to achieve and to care for and relate to others. As important, Blatt's views continue to pose important questions concerning the nature of psychopathology, its development, and its classification. Much remains to be learned, but it is a comforting thought to have such an experienced guide in this terra incognita.

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**References**


