International Journal of Medical and Pharmaceutical Research

Online ISSN-2958-3683 | Print ISSN-2958-3675
Frequency: Bi-Monthly
Available online on: https://ijmpr.in/

Original Article

Beneath the facade, Beyond the labels: Comparing DSM-5- TR and Psychodynamic clinical formulation of Obsessive-Compulsive Disorder, A Thematic Analysis

Bhavyejot Singh[1], Dr. Ritu Aggarwal[2]

[1]4th year BA Psychology (HONS.), Department of Psychology, Zakir Husain Delhi College, University of Delhi, India
[2]Assistant Professor, Department of Psychology, Zakir Husain Delhi College, University of Delhi, India.

Corresponding Author:

Bhavyejot Singh
4th year BA Psychology (HONS.), Department of Psychology, Zakir Husain Delhi College, University of Delhi, India

Received: 09-03-2026
Accepted: 29-03-2026
Available online: 13-04-2026

ABSTRACT

Objective: This study is a thematic conceptual comparison of Obsessive-Compulsive disorder as its understood in Diagnostic & Statistical Manual of mental disorders 5th edition (DSM-5-TR) and Psychodynamic Diagnostic Manual 2nd edition (PDM-2) situated in historical development of Psychiatric nosology and conceptual sensitivity of both the diagnostic systems where a nomothetic-homogenous categorical approach and ideographic-heterogeneous dimensional approach to diagnosis of OCD was analyzed on their divergence & convergence to present incremental validity of clinical formulation organized in accordance with psychodynamic principles & structure. **Method**: Thematic analysis as a qualitative research method was chosen with a critical realist lens where the contemporary diagnostic system, resulting conceptual differences, varied theoretical emphasis were reviewed and themes were reported using Nvivo software. **Results**: The foundational and clinical differences of both the systems in regard to OCD could be seen in themes like descriptive symptomatology vs. psychological dynamics, categorical vs. Dimensional personality organization, symptom-reduction vs. meaning-making, behavioral manifestation vs. intrapsychic conflict, universal classification vs. singular subjectivity. **Conclusion**: The present epistemic tensions between Psychiatry versus conceptual competency based practices of Clinical Psychology & neuroscientific led studies that actively denounce the DSM-5-TR diagnostic system & it's overemphasis on reliability and apparent corruption in place of comprehensive approach towards diagnosis is explicit and this study identifies with such a person- centered movement in mental health field with future implications for process- oriented research in psychodiagonostics & psychotherapy.

Keywords*: OCD, Psychiatric diagnosis, qualitative approach, psychodynamic formulation.*

INTRODUCTION

Obsessive-Compulsive Disorder (OCD) is characterized by recurrent intrusive thoughts (obsessions) that prompt the performance of repetitive behaviours or neutralizing rituals (compulsions) performed to reduce distress (American Psychiatric Association [APA], 2022). Psychodynamic diagnosis frames itself in the contemporary classification system is the 'taxonomy of people' rather than the taxonomy of disorders, it emphasizes the therapeutic value by placing diagnosis not merely to label symptoms but to understand the underlying personality organization, personality styles, mental functioning, relational functioning and subjective experience or symptoms that other diagnostic manuals in current usage present as disorder categories.

Here, diagnosis is a complex, inferential, and clinician-guided process that rather relies exclusively on observable symptom checklists. The characterological emphasis of psychoanalytic diagnosis over phenomenological DSM/ ICD systems is a both conceptual and empirical framework that aims at truly empathic engagement, treatment planning, and qualitative

depth (McWilliams, 2011; Lingiardi & McWilliams, 2017) .While the DSM-5 dominates psychiatric diagnosis globally, critics argue that its descriptive model neglects subjective experience and personality structure (Shedler & Westen, 2010). According to Thomas Kuhn the idea of scientific progress doesn't occur through a steady, cumulative process, but rather through a series of paradigm shifts (Kuhn,1962). Here, it's proposed that sciences operate within a dominant paradigm which is a shared framework of theories, methods, and standards accepted by a scientific community. However, with passage of time anomalies accumulate that can't be explained by the existing paradigm. When these anomalies become significant enough, they can trigger a crisis, leading to the emergence of a new paradigm that replaces the old one. During such a pragmatic transition, fundamental historical issues become increasingly relevant and gain scholarly momentum (Zachar & Kendler, 2017) as new generations of scholars appear less wedded to tradition in contrast to reliance on conventional systems of the older generation of clinicians based on conformity and convenience rather than scientific evidence (Clark,2005; Livesley, 2012).

The journey of Psychiatric nosology commenced when Emil Kraepelin proposed the idea of existence and scientific detectability of mental illness as "natural disease entities" (Kraepelin, 1896; Hoff, 2015). Kraepelin saw psychiatric disorders as multifactorial now where arising difficulty was due to entanglement of action and interaction of life history & personality with his established entities or personality, life experiences, and cultural effects often obscured the boundaries between putative disease entities, even though he continued to assert the existence of natural kinds in mental illness (Kraepelin, 1921). Psychoanalysis as a clinical enterprise to explore of the factors that aren't readily observed, available and socially accepted in regards to psychopathology and its thin border with daily lives of ended up operating more as a quasi-political and cultural movement that disrupted established Victorian values and medical orthodoxies, provoking resistance, institutional exclusion and personal threats toward its founder Dr. (Prof.) Sigmund Freud (Gay, 1988; Zaretsky, 2004).

The recognition of the meaning behind suffering over outward presentation drove contemporary psychodynamic engagement with diagnosis & treatment where dynamic processes within the patient are formed throughout life history that operate both consciously and unconsciously, shaping how people experience themselves and others (McWilliams, 2021).

Individuals as patients were analyzed based upon the dynamic processes that are enshrined in the Psychodynamic Diagnostic Manual 2nd edition divided along mental capacities or the M-Axis as elucidated to entail the capacity for regulation, attention, & learning refers to the ego's ability to regulate attention, impulses, affect, & to learn from experience; capacity for affective range, communication, & understanding refers to the ability to experience, understand, and communicate emotions.

These capacities reflect key psychodynamic contributions, including object relations (Melanie Klein, 1946; Fairbairn, 1952), attachment (Bowlby, 1969), mentalization (Fonagy et al., 2002), identity (Erikson, 1950), and self psychology (Kohut, 1971). Pathology is viewed dimensionally, with no strict boundary between normality and illness (Fellowes, 2025). The P-Axis conceptualizes personality along continua of severity (healthy to psychotic), influenced by Otto Kernberg, and thematic syndromes. Unlike categorical systems such as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition and International Classification of Diseases, it emphasizes person-centered formulations based on internal conflicts, object relations, and relational patterns, supporting meaningful psychotherapy planning (McWilliams, 2012). In addition to severity, the P Axis also describes personality syndromes, which are organized around underlying psychological themes, conflicts, internalized object relations, and relational patterns rather than trait dimensions alone (McWilliams, 2012; Kernberg, 1984). While trait-based models such as the Five-Factor Model and the DSM-5 Alternative Model focus on variable-centered traits like neuroticism or antagonism, the PDM-2 emphasizes person-centered formulations, focusing on recurring emotional themes, internal working models, core conflictual relationship themes, and implicit relational knowledge (Fairbairn, 1952; Bowlby, 1969; Luborsky & Crits-Cristoph, 1996). Pharmacological and neuroscientific research increasingly suggests that contemporary psychiatric diagnostic categories, such as those used in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition and the International Classification of Diseases, do not correspond to discrete, biologically distinct disease entities but instead reflect heterogeneous conditions with overlapping mechanisms and treatment responses. A large-scale network meta-analysis of 522 psychiatric disorders rather than being unique to specific diagnoses, with many disorders showing disruptions in large-scale neural networks such as the salience network, default mode network, and executive control networks, suggesting the presence of transdiagnostic neurobiological vulnerabilities (Vanes & Dolan, 2021).Supporting this, large-scale cross-disorder analyses conducted by the ENIGMA consortium have found that brain structural abnormalities across major depressive disorder, bipolar disorder, schizophrenia, and obsessive–compulsive disorder are highly correlated, with a single latent factor explaining a substantial proportion of structural variance across these disorders, indicating that much of the neurobiological variation is shared rather than disorder-specific (ENIGMA Consortium findings Opel et al.2020; Wen et al., 2025).

OBJECTIVES

This study aims to critically explore and compare by thematic analysis (Braun & Clarke, 2006) of how OCD is conceptualized within the DSM-5 and PDM-2, examining both convergence and divergence in theoretical assumptions, diagnostic methodology, and clinical implications.

1. *To examine the core concepts of contemporary psychiatric diagnostic systems*
2. *To compare symptom cluster based classifications(DSM/ ICD) with psychodynamic clinical formulation for OCD*
3. To provide a theoretical foundation *for approaches that combine categorical and phenomenological understandings of OCD for treatment planning, and future research directions in OCD.*

RESEARCH METHODOLOGY

Data Selection and Sources

The data for this study consisted of diagnostic texts, historical literature, and academic papers related to the conceptualisation of obsessive–compulsive disorder and the development of psychiatric nosology. Key sources included diagnostic descriptions and theoretical discussions from the DSM-5-TR and the Psychodynamic Diagnostic Manual, as well as historical and theoretical literature on obsessional neurosis, psychoanalytic theory, and the development of modern psychiatric classification systems. The literature consulted included works discussing the historical development of psychiatric diagnosis, including early classification approaches, psychoanalytic conceptualisations by Freud, the contributions of Kraepelin and Bleuler, the neo-Kraepelinian movement, the Research Diagnostic Criteria (RDC), and the development of DSM-III and later diagnostic systems. Articles were identified primarily through academic databases such as Google Scholar, PubMed, Academia, PsycINFO, Scopus, Web of Science and secondary data sources. and related academic sources using keywords such as "obsessive compulsive disorder," "obsessional neurosis," "DSM diagnosis," "PDM psychodynamic diagnosis," "psychiatric nosology," "neo-Kraepelinian," "Research Diagnostic Criteria," "diagnostic reliability," and "psychoanalytic formulation." The selection of texts was guided by relevance to the research question, which aimed to compare conceptualisations of OCD across diagnostic systems and historical periods rather than to conduct a fully systematic review. Therefore, the literature selection was purposive and concept-driven rather than strictly systematic, focusing on texts that contributed to understanding differences and similarities in diagnostic conceptualisation. Inclusion criteria: English-language sources, peer-reviewed journal articles, seminal texts in psychodynamic theory, and relevant clinical case studies.

Coding Process

Thematic analysis was conducted on the selected texts using a qualitative coding process. Thematic analysis as a qualitative research method was chosen with a critical realist lens where the contemporary diagnostic system, resulting conceptual differences, varied theoretical emphasis were reviewed and themes were reported using Nvivo software. After initial coding, related codes were grouped together to form broader themes that captured major conceptual differences and similarities between diagnostic systems and historical models of OCD.

RESULTS AND DISCUSSION

Theme 1: Symptom Checklist Versus Psychological Experience

In the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), OCD is classified under Obsessive-Compulsive and Related Disorders. The language is intentionally atheoretical. It avoids theorizing about underlying causes and instead prioritizes observable symptom clusters to enhance diagnostic reliability across clinicians. (APA, 2013).Cervin (2023) and Leckman et al. (2010) further clarify that DSM diagnostic evolution has focused on refining phenomenology rather than endorsing specific etiological theories. The DSM does not address symbolic meaning or intrapsychic function. However, critics argue that this neutrality risks decontextualizing symptoms from personal meaning (Shedler & Westen, 2010).

The diagnostic framework as in DSM-5-TR is defined by:-

A. Presence of obsessions, compulsions, or both

Obsessions are defined by:

Recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, and cause marked anxiety or distress.

Compulsions are defined by:

Repetitive behaviors (e.g., washing, checking, ordering) or mental acts (e.g., praying, counting, repeating words silently).

B. Time-consuming or impairment

1. Obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day)

OR

- Cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. Not due to substance/medical condition

Specify If (Differential Diagnosis Related Specifier)

DSM-5-TR also requires the clinician to specify if the obsessive-compulsive symptoms are related to another condition, although this is written as a separate diagnosis rather than a subtype of OCD.If the symptoms are better explained by another mental disorder such as body dysmorphic disorder, hoarding disorder, trichotillomania, illness anxiety disorder, generalized anxiety disorder, or psychotic disorders, then OCD should not be diagnosed. Therefore, the "specify if" component is important for differential diagnosis.

In the Psychodynamic Diagnostic Manual, Second Edition (PDM-2), OCD is understood not merely as a cluster of symptoms but as a manifestation of underlying psychological conflict, personality organization, and subjective experience. The core psychopathology consists of obsessions and compulsions, where obsessions are intrusive, recurrent thoughts, impulses, or images that disrupt mental functioning, and compulsions are repetitive behaviors or mental acts performed in rigid, often ritualized sequences that significantly impair functioning. These symptoms are conceptualized as compromise formations, emerging from unconscious conflicts typically involving opposing forces such as desire and prohibition, impulse and guilt, aggression and conscience, or autonomy and fear of punishment (Lingiardi & McWilliams, 2017).Cognitively, OCD is marked by intrusive thoughts, rumination, magical thinking, and rigid, repetitive patterns of thinking. Insight exists along a continuum, ranging from ego-dystonic awareness of symptoms as irrational to ego-syntonic acceptance and, in more severe cases, quasi-delusional or fully delusional conviction. Somatically, individuals often present with hyperarousal, fatigue, restlessness, and physical consequences of compulsions, such as skin damage due to excessive washing, along with possible co-occurring motor tics. Chlebowski and Gregory (2009) argue that symptom meaning is central to psychodynamic clinical management. Interpersonally, OCD can lead to significant relational impairment, including social withdrawal, dependency on reassurance, controlling behaviors in relationships, and involvement of significant others in compulsive rituals (Lingiardi & McWilliams, 2017).

From a psychodynamic perspective, OCD symptoms are rooted in unconscious conflicts and are maintained through characteristic defense mechanisms. The PDM-2 further emphasizes that OCD symptoms can occur across different levels of personality organization (P Axis), including neurotic, borderline, and psychotic levels. At the neurotic level, individuals typically retain good reality testing and experience symptoms as ego-dystonic. At the borderline level, there may be greater affective instability and impaired impulse control. At the psychotic level, obsessions may take on delusional qualities, with severely impaired insight and reality testing. Finally, the PDM-2 highlights the transdiagnostic nature of obsessive and compulsive phenomena, noting that such symptoms may appear across a wide range of disorders, including depressive disorders, personality disorders, trauma-related conditions, and even psychotic structures, where they may function as a "pseudoneurotic façade" masking deeper disturbances. Developmentally, OCD is often understood in relation to early experiences and maturation processes. Ritualistic behaviors and magical thinking are common in childhood, particularly between the ages of 6 and 9, and are typically transient. However, in pathological OCD, these patterns persist and become rigid and maladaptive. The onset of clinically significant OCD most commonly occurs in adolescence or early adulthood, with earlier onset often associated with tic disorders.

Thus, rather than focusing solely on symptom presence, the PDM-2 approach situates OCD within a broader framework of personality, developmental history, defensive functioning, and subjective meaning, offering a more comprehensive and depth-oriented understanding of the disorder (Lingiardi & McWilliams, 2017).

Theme 2: Categorical Static Versus Dimensional Dynamic Personality Organization

The emphasis on personality has central to dimensional diagnostic framework in PDM-2 which is the quintessential for diagnostic validity & psychotherapy plan though the foundation of personality in DSM-5-TR begins from personality disorders which are conceptualized as fundamentally different from other mental disorders because they represent enduring, pervasive patterns of inner experience and behavior that deviate from cultural expectations, begin in adolescence or early adulthood, and are stable across time and situations, rather than discrete episodes of illness with a clear onset and course, as seen in many mood, anxiety, or psychotic disorders (American Psychiatric Association, 2022).

The DSM-5-TR introduction to personality disorders also emphasizes that one of the major challenges in personality disorder diagnosis is the high level of comorbidity, both among personality disorders themselves and between personality disorders and other clinical disorders, which often makes categorical diagnosis difficult and clinically confusing. This extensive overlap has led researchers to question whether personality disorders are truly separate categories or whether they represent maladaptive variants of normal personality traits. Even with the use of trait-oriented questionnaires and dimensional models, assessment remains complicated because personality pathology often presents as heterogeneous, overlapping trait constellations rather than discrete disorders, limiting the reliability and validity of strict categorical classification systems and making clinical formulation more important than simple diagnosis (Widiger & Samuel, 2005; Krueger & Markon, 2014; Livesley, 2012). For this reason, psychodynamically oriented projective techniques such as the Rorschach Inkblot Test and the Thematic Apperception Test are often considered useful in personality assessment, as they aim to assess underlying personality structure, defence mechanisms, object relations, affect regulation, and unconscious themes that may not be accessible through self-report methods (Meyer & Kurtz, 2006). Personality is increasingly recognized as central to psychological diagnosis because it reflects enduring patterns of thinking, feeling, relating, and defending that shape how symptoms develop, are experienced, and respond to various treatment models. The PDM-2 evaluates personality organization across neurotic, borderline, and psychotic levels, a dimensional perspective influenced by the structural theory of Otto Kernberg, which emphasizes identity integration, reality testing, and defensive operations as core components of personality structure (Lingiardi & McWilliams, 2017; Kernberg, 1984). While trait-based models such as the Five-Factor Model and DSM-5 Alternative Model focus on variable-centered traits, the PDM-2 emphasizes person-centered formulations, including internal working models, core conflictual relationship themes, and implicit

relational knowledge (Fairbairn, 1952; Bowlby, 1969; Luborsky & Crits-Cristoph, 1996). This dimensional and structural understanding of personality is particularly important in clinical settings because overlapping trait constellations and comorbidity often make categorical and trait-based questionnaire approaches insufficient for case formulation, whereas assessing personality organization, defensive patterns, and relational themes provides more clinically meaningful information for treatment planning and prognosis (Westen, Shedler, & Bradley, 2006; Hopwood et al., 2018). For example, obsessive symptoms at a neurotic level versus obsessive symptoms in borderline or psychotic personality organization, which require different therapeutic approaches (Caligor et al., 2018) . Thus, this approach offers clinical nuance and qualitative difference between various presentations of OCD but may reduce inter-rater reliability compared to DSM-5-TR.

Therefore, in the diagnosis of OCD and other disorders, understanding personality structure helps clinicians determine not only what symptoms are present, but why they occur, how they are maintained, and how treatment should be tailored, making personality assessment a foundational component of comprehensive psychological diagnosis rather than a secondary or optional consideration.

Theme 3: Insight and Mental Functioning

The DSM-5-TR includes insight specifiers- good or fair insight, poor insight, and absent insight/delusional beliefs to acknowledge variability in reality testing and the degree to which individuals recognize their obsessive–compulsive beliefs as unreasonable; however, these specifiers function primarily as descriptive modifiers that influence clinical presentation but do not alter the structural diagnosis itself (American Psychiatric Association, 2013). Research indicates that poor insight in OCD is associated with greater symptom severity, increased chronicity, and poorer treatment response, making it an important prognostic indicator rather than a diagnostic subtype (Huang et al., 2023; Jacob et al., 2014). In contrast, the PDM-2 situates insight within broader mental capacities on the M Axis, including identity integration, affect tolerance, mentalization, and defensive flexibility, thereby conceptualizing insight not merely as cognitive awareness but as a reflection of overall structural integration and personality organization (Lingiardi & McWilliams, 2017). From this perspective, insight is linked to the individual's capacity to reflect on internal states, regulate affect, and understand self and others, which are central components of mental functioning and psychotherapy prognosis (Fonagy et al., 2002; Bateman & Fonagy, 2016; Kernberg, 1984). M-axis assessment relies on clinician inference about capacities such as mentalization, defensive functioning, and identity coherence, its reliability may be lower than structured diagnostic systems, and it requires significant clinical training to apply consistently. Critics argue that while the PDM-2 model may improve clinical usefulness and case formulation, it may reduce diagnostic standardization and inter-rater reliability, making it more suitable for psychotherapy planning than for epidemiological research or large-scale diagnostic classification (Clarkin et al., 2006; Fonagy et al., 2002; Hilsenroth, 2007). Thus, DSM insight specifiers provide descriptive reliability, whereas PDM-2 M Axis insight provides structural and treatment-relevant validity; ideally, both approaches can be used together, with DSM contributing diagnostic clarity and the PDM contributing depth of psychological understanding and guidance for therapy planning.

Theme 4: Phenomenological description versus Nested mind-brain system model

The DSM-5-TR conceptualizes obsessive–compulsive disorder (OCD) primarily as a phenomenological and descriptive diagnosis, defined by the presence of obsessions (intrusive thoughts, urges, or images) and compulsions (repetitive behaviors or mental acts performed to reduce anxiety), along with specifiers such as level of insight and tic-related features. It has been criticized for providing limited explanatory depth, it intentionally brackets questions of etiology, psychological meaning, and underlying mechanisms in favor of observable symptom clusters. Critics argue that by focusing primarily on symptom description, the DSM framework risks overlooking the functional role of symptoms, including how they relate to internal conflicts, affect regulation, or interpersonal dynamics, thereby limiting its usefulness for individualized case formulation and treatment planning (Hyman, 2010; Clark et al., 2017). As a result, DSM-5-TR diagnosis is often described as phenomenology without meaning or mechanism, focusing on what symptoms are present rather than why they occur or how they function within the individual's personality and mental life (Insel et al., 2010).

On the other hand, the absence of neurobiological mechanism for mental diorders in OCD has been covered by the contemporary *nested hierarchical brain-mind model*, in which mental disorders are understood as disturbances across interacting levels of brain and mind, rather than as isolated symptom clusters. In this model, primary emotional systems located in subcortical brain regions (such as FEAR, SEEKING, RAGE, and PANIC systems) generate core affective experiences, which are then shaped by learning, memory, and defensive processes, and finally elaborated at higher cortical levels into conscious thoughts, meanings, and symptoms. Mental disorders, including OCD, are therefore understood as resulting from dysregulation in these emotional and motivational brain systems interacting with psychological processes such as conflict, defense, and meaning-making. This model emphasizes bidirectional causation, where brain activity influences subjective experience and psychological processes, and psychological experiences in turn reshape neural pathways.

Thus, symptoms are not viewed as meaningless byproducts of faulty circuits but as emotionally meaningful attempts at regulation and adaptation emerging from dysregulated brain-mind systems, integrating neuroscience with psychodynamic concepts such as unconscious motivation, affect regulation, and intrapsychic conflict (Solms, 2013; Panksepp, 1998).

Theme 5: Universal Classification Versus Singular Subjectivity

The DSM was developed as a universal classification system intended to improve diagnostic reliability through standardized criteria and shared terminology across clinicians and countries, thereby enabling epidemiological research, insurance reimbursement, and pharmacological research trials (Spitzer et al., 1975; Kupfer et al., 2002; Stein et al., 2025). One of its major advantages is that it allows large-scale prevalence studies and data comparison across populations, which is essential for public health planning and resource allocation. It also provides administrative utility in the form of billing and insurance coding, making it highly functional within modern healthcare systems (Frances, 2013). However, critics argue that diagnostic reliability does not necessarily ensure construct validity, and that DSM categories may group together heterogeneous conditions under a single label, as seen in the wide variation in OCD presentations such as contamination fears, harm obsessions, and scrupulosity (Insel et al., 2010; Liu, X. Et al.,2024; Lochner & Stein, 2003). Furthermore, concerns have been raised about the influence of pharmaceutical industry funding on DSM panel members, suggesting that diagnostic expansion may at times align with medication markets rather than purely scientific evidence (Cosgrove & Krimsky, 2012).Studies examining DSM-IV and DSM-5 panel members found that a substantial proportion had financial relationships with pharmaceutical companies, and critics argue that disclosure policies alone are insufficient to prevent potential bias in diagnostic decision-making (Cosgrove & Wheeler, 2013). Furthermore, concerns have been raised that committees responsible for diagnostic criteria and treatment guidelines may shape standards of care that influence drug markets, highlighting the importance of minimizing conflicts of interest in psychiatric classification systems (Neuman et al., 2011).

In contrast, the PDM-2 attempts to improve validity by embedding symptoms within personality structure, developmental history, and subjective meaning, providing idiographic depth and clinically rich case formulations that are often more useful for psychotherapy planning (McWilliams, 2011; Lingiardi & McWilliams, 2017). However, psychodynamic diagnosis requires extensive clinical interviews and interpretive skill, making it time-intensive and less practical in high-volume outpatient departments, particularly in low-resource settings and developing countries where patients often prefer quick diagnosis and medication-based treatment due to financial and accessibility constraints. Thus, the tension between DSM and PDM reflects a broader epistemological divide between universal classification for public health utility and idiographic understanding for individual clinical meaning. The British Psychological Society has emphasized that clinical formulation integrates biological, psychological, social, and cultural factors and is central to effective intervention planning and therapeutic understanding (Johnstone & Dallos, 2013; British Psychological Society, 2011). Such approaches prioritize understanding the individual's subjective experience, life history, relationships, and meaning-making processes, aligning closely with the PDM-2's person-centered and idiographic diagnostic framework. Consequently, while the DSM emphasizes reliability through standardized criteria, formulation-based systems like the PDM-2 emphasize validity and clinical usefulness by situating symptoms within the broader context of personality organization and lived experience.

CONCLUSION

The DSM-5-TR and PDM-2 represent complementary yet philosophically distinct approaches to OCD. The DSM provides a reliable, symptom-based classification system aligned with behavioral and neurobiological research. The PDM offers a structurally informed, person-centered framework that prioritizes meaning, development, and intrapsychic dynamics.
Rather than viewing these systems as mutually exclusive, an integrative model may be clinically optimal. DSM criteria can guide evidence-based interventions such as ERP, while PDM-informed formulation can illuminate personality structure, relational dynamics, and treatment resistance. OCD thus illustrates a broader disciplinary tension: whether mental disorders are best understood as discrete syndromes or as individualized manifestations of dynamic psychological organization.

Limitations

The study is **purely theoretical** and relies on literature analysis- theoretical bias
Application of the framework may vary depending on clinician expertise in psychodynamic formulation.
Case examples are drawn from literature rather than clinical settings, which may limit generalizability.
The findings are expected to contribute to the field by highlighting areas of convergence and divergence between categorical and psychodynamic formulations, thereby enhancing theoretical understanding of OCD. Clinically, this integrative approach may lead to more holistic assessment and treatment planning, encouraging practitioners to consider both observable symptoms and the individual's internal world. Furthermore, the study lays a foundation for future research aimed at bridging structured diagnostic systems with psychodynamically informed frameworks, promoting interdisciplinary dialogue and more nuanced conceptualizations of complex mental health conditions like OCD.

Future Directions

Training and Education: Developing training modules for clinicians to integrate psychodynamic insight into diagnostic practice.

Interdisciplinary Integration: Explore ways to combine psychodynamic formulations with cognitive-behavioral and neurobiological approaches for a comprehensive model of mental health assessment
Openess to qualitative inquiry: To develop scientific temper when it comes to dealing with subjects that inherently require such type of research with coherence & comprehensiveness.

REFERENCES

1. American Psychiatric Association (2022) Diagnostic and Statistical Manual of Mental Disorders. 5th Edition, Text Revision (DSM-5-TR). https://doi.org/10.1176/appi.books.9780890425787
2. Bateman, A. W., & Fonagy, P. (2016). *Mentalization-based treatment for personality disorders: A practical guide*. Oxford University Press.
3. Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. Basic Books.
4. British Psychological Society. (2011). *Good Practice Guidelines on the use of psychological formulation.* Division of Clinical Psychology Published: 12-2011 DOI:https://doi.org/10.53841/bpsrep.2011.rep100
5. Caligor, E., Kernberg, O. F., Clarkin, J. F., & Yeomans, F. E. (2018). *Psychodynamic Therapy for Personality Pathology: Treating Self and Interpersonal Functioning*. American Psychiatric Publishing.
6. Cervin, M. (2023). Obsessive–compulsive disorder: Diagnosis, clinical features, nosology, and epidemiology. *Psychiatric Clinics of North America, 46*(1), 1–16. https://doi.org/10.1016/j.psc.2022.10.006
7. Chlebowski, S., & Gregory, R. J. (2009). Is a psychodynamic perspective relevant to the clinical management of obsessive-compulsive disorder?. *American journal of psychotherapy*, *63*(3), 245–256. https://doi.org/10.1176/appi.psychotherapy.2009.63.3.245
8. Clark L. A. (2005). Temperament as a unifying basis for personality and psychopathology. *Journal of abnormal psychology*, *114*(4), 505–521. https://doi.org/10.1037/0021-843X.114.4.505
9. Clark, L. A., Cuthbert, B., Lewis-Fernández, R., Narrow, W. E., & Reed, G. M. (2017). Three approaches to classification: ICD-11, DSM-5, and National Institute of Mental Health's Research Domain Criteria (RDoC).. *Psychological Science in the Public Interest, 18*(2), 72–145. https://doi.org/10.1177/1529100617727266
10. Clarkin, J. F., & Levy, K. N. (2006). Psychotherapy for patients with borderline personality disorder: focusing on the mechanisms of change. *Journal of clinical psychology*, *62*(4), 405–410. https://doi.org/10.1002/jclp.20238
11. Cosgrove, L., & Krimsky, S. (2012). A comparison of DSM-IV and DSM-5 panel members' financial associations with industry: a pernicious problem persists. *PLoS medicine*, *9*(3), e1001190. https://doi.org/10.1371/journal.pmed.1001190
12. Cosgrove, L., & Wheeler, E. E. (2013). Industry's colonization of psychiatry: Ethical and practical implications of financial conflicts of interest in the DSM-5. *Feminism & Psychology*, *23*(1), 93-106.
13. Erikson, E. H. (1950). *Childhood and society*. W. W. Norton & Company.
14. Fairbairn, W. R. D. (1952). *Psychoanalytic studies of the personality*. Routledge.
15. Fellowes, S. (2025). *Psychiatry and the philosophy of psychiatry*. In Springer Nature. https://link.springer.com/chapter.
16. Fonagy, P., Gergely, G., & Jurist, E.L. (Eds.). (2002). *Affect Regulation, Mentalization and the Development of the Self* (1st ed.). Routledge. https://doi.org/10.4324/9780429471643
17. Gay, P. (1988). *Freud: A life for our time*. W. W. Norton & Company .
18. Hilsenroth, M. J. (2007). A programmatic study of short-term psychodynamic psychotherapy: Assessment, process, outcome, and training. *Psychotherapy Research*, *17*(1), 31–45. https://doi.org/10.1080/10503300600953504
19. Hoff P. (2015). The Kraepelinian tradition. *Dialogues in clinical neuroscience*, *17*(1), 31–41. https://doi.org/10.31887/DCNS.2015.17.1/phoff
20. Hopwood, C. J., Kotov, R., Krueger, R. F., Watson, D., Widiger, T. A., Althoff, R. R., Ansell, E. B., Bach, B., Michael Bagby, R., Blais, M. A., Bornovalova, M. A., Chmielewski, M., Cicero, D. C., Conway, C., De Clercq, B., De Fruyt, F., Docherty, A. R., Eaton, N. R., Edens, J. F., Forbes, M. K., … Zimmermann, J. (2018). The time has come for dimensional personality disorder diagnosis. *Personality and mental health*, *12*(1), 82–86. https://doi.org/10.1002/pmh.1408
21. Huang, Y., Weng, Y., Lan, L., Zhu, C., Shen, T., Tang, W., & Lai, H. Y. (2023). Insight in obsessive-compulsive disorder: conception, clinical characteristics, neuroimaging, and treatment. *Psychoradiology*, *3*, kkad025. https://doi.org/10.1093/psyrad/kkad025
22. Hyman S. E. (2010). The diagnosis of mental disorders: the problem of reification. *Annual review of clinical psychology*, *6*, 155–179. https://doi.org/10.1146/annurev.clinpsy.3.022806.091532
23. Insel, T., Cuthbert, B., Garvey, M., Heinssen, R., Pine, D. S., Quinn, K., Sanislow, C., & Wang, P. (2010). Research domain criteria (RDoC): toward a new classification framework for research on mental disorders. *The American journal of psychiatry*, *167*(7), 748–751. https://doi.org/10.1176/appi.ajp.2010.09091379
24. Jacob, M. L., Larson, M. J., & Storch, E. A. (2014). Insight in adults with obsessive-compulsive disorder. *Comprehensive psychiatry*, *55*(4), 896–903. https://doi.org/10.1016/j.comppsych.2013.12.016

25. ohnstone, L., & Dallos, R. (2013). Formulation in Psychology and Psychotherapy: Making sense of people's problems (2nd ed.). Routledge. https://doi.org/10.4324/9780203380574
26. Kendler K. S. (2016). The nature of psychiatric disorders. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, *15*(1), 5–12. https://doi.org/10.1002/wps.20292
27. Kernberg, O. F. (1984). *Severe personality disorders: Psychotherapeutic strategies*. Yale University Press, New Haven.
28. Klein, M. (1946). Notes on some schizoid mechanisms. *The International Journal of Psychoanalysis, 27,* 99–110.
29. Kohut, H. (1971). The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders. New York: International Universities Press.
30. .Kraepelin, E. (1896). *Psychiatrie: Ein Lehrbuch für Studirende und Aerzte* (5th ed.). Johann Ambrosius Barth.
31. *Kraepelin, E. (1921). Manic-depressive insanity and paranoia (R. M. Barclay, Trans.; G. M. Robertson, Ed.). E. & S. Livingstone*
32. Krueger, R. F., & Markon, K. E. (2014). The role of the DSM-5 personality trait model in moving toward a quantitative and empirically based classification of personality and psychopathology. *Annual Review of Clinical Psychology, 10*, 477–501. https://doi.org/10.1146/annurev-clinpsy-032813-153732
33. Kupfer, D. J., First, M. B., & Regier, D. A. (Eds.). (2002). *A research agenda for DSM-V*. American Psychiatric Association.
34. Kuhn, T. S. (1962). *The structure of scientific revolutions*.
35. Leckman, J. F., Denys, D., Simpson, H. B., Mataix-Cols, D., Hollander, E., Saxena, S., Miguel, E. C., Rauch, S. L., Goodman, W. K., Phillips, K. A., & Stein, D. J. (2010). Obsessive-compulsive disorder: a review of the diagnostic criteria and possible subtypes and dimensional specifiers for DSM-V. *Depression and anxiety*, *27*(6), 507–527. https://doi.org/10.1002/da.20669
36. Lingiardi, V., & McWilliams, N. (Eds.). (2017). *Psychodynamic diagnostic manual* (2nd ed.). Guilford Press.
37. Liu, X., Zhao, Y., Wang, P., Yang, X., & Li, Z. (2024). Study on symptom dimensions and clinical characteristics in patients with obsessive-compulsive disorder. *Revista da Associacao Medica Brasileira (1992), 70*(1), e20230676. https://doi.org/10.1590/1806-9282.20230676
38. Livesley W. J. (2012). Integrated treatment: a conceptual framework for an evidence-based approach to the treatment of personality disorder. *Journal of personality disorders*, *26*(1), 17–42. https://doi.org/10.1521/pedi.2012.26.1.17
39. Lochner, C., & Stein, D. J. (2003). Heterogeneity of obsessive-compulsive disorder: a literature review. *Harvard review of psychiatry*, *11*(3), 113–132. https://doi.org/10.1080/10673220303949
40. Luborsky, L., & Crits-Christoph, P. (1998). *Understanding transference: The Core Conflictual Relationship Theme method* (2nd ed.). American Psychological Association. https://doi.org/10.1037/10250-000
41. McWilliams, N. (2011). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process* (2nd ed.). Guilford Press
42. McWilliams, N. (2021). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process* (3rd ed.). Guilford Press.
43. Meyer, G. J., & Kurtz, J. E. (2006). Advancing Personality Assessment Terminology: Time to Retire "Objective" and "Projective" As Personality Test Descriptors. *Journal of Personality Assessment*, *87*(3), 223–225. https://doi.org/10.1207/s15327752jpa8703_01
44. Neuman, J., Korenstein, D., Ross, J. S., & Keyhani, S. (2011). Prevalence of financial conflicts of interest among panel members producing clinical practice guidelines in Canada and United States: cross sectional study. *BMJ (Clinical research ed.)*, *343*, d5621. https://doi.org/10.1136/bmj.d5621
45. Opel, N., Redlich, R., Dohm, K., Zaremba, D., Goltermann, J., Repple, J., ... & ENIGMA Consortium. (2020). Cross-disorder analysis of brain structural abnormalities in six major psychiatric disorders: A secondary analysis of mega- and meta-analytical findings from the ENIGMA Consortium. *Biological Psychiatry, 88*(9), 678–686. https://doi.org/10.1016/j.biopsych.2020.05.034
46. Panksepp, J. (1998). *Affective neuroscience: The foundations of human and animal emotions.* Oxford University Press.
47. Shedler, J., & Westen, D. D. (2010). The Shedler-Westen Assessment Procedure: Making personality diagnosis clinically meaningful. In J. F. Clarkin, P. Fonagy, & G. O. Gabbard (Eds.), *Psychodynamic psychotherapy for personality disorders: A clinical handbook* (pp. 125–161). American Psychiatric Publishing, Inc..
48. Stein, D. J., Ruscio, A. M., Altwaijri, Y., Chiu, W. T., Sampson, N. A., Aguilar-Gaxiola, S., Al-Hamzawi, A., Alonso, J., Chardoul, S., Gureje, O., Hu, C., Karam, E. G., McGrath, J. J., Navarro-Mateu, F., Scott, K. M., Stagnaro, J. C., Torres, Y., Vladescu, C., Wciórka, J., Xavier, M., … World Mental Health Survey collaborators (2025). Obsessive-compulsive disorder in the World Mental Health surveys. *BMC medicine*, *23*(1), 416. https://doi.org/10.1186/s12916-025-04209-5
49. Solms M. L. (2018). The Neurobiological Underpinnings of Psychoanalytic Theory and Therapy. *Frontiers in behavioral neuroscience*, *12*, 294. https://doi.org/10.3389/fnbeh.2018.00294
50. Spitzer, R. L., Endicott, J., & Robins, E. (1975). Clinical criteria for psychiatric diagnosis and DSM-III. *American Journal of Psychiatry, 132*(11), 1187–1192. https://doi.org/10.1176/ajp.132.11.1187

51. Vanes, L. D., & Dolan, R. J. (2021). Transdiagnostic neuroimaging markers of psychiatric risk: A narrative review. *NeuroImage: Clinical*, *30*, 102634. https://doi.org/10.1016/j.nicl.2021.102634
52. Wen, J., Li, H., Zhang, X., Zhao, L., & ENIGMA Consortium. (2025). Coordinated cortical and subcortical alterations across psychiatric disorders: Evidence from large-scale neuroimaging. *Journal of Psychiatry and Neuroscience*, *50*(2), 123–135. https://doi.org/10.1503/jpn.230045
53. Westen, D., Shedler, J., & Bradley, R. (2006). A prototype approach to personality disorder diagnosis. *The American journal of psychiatry*, *163*(5), 846–856. https://doi.org/10.1176/ajp.2006.163.5.846
54. Widiger, T. A., & Samuel, D. B. (2005). Diagnostic categories or dimensions? A question for the Diagnostic and Statistical Manual of Mental Disorders–Fifth Edition. *Journal of Abnormal Psychology*, *114*(4), 494–504. https://doi.org/10.1037/0021-843X.114.4.494
55. Zachar, P., & Kendler, K. S. (2017). The Philosophy of Nosology. *Annual review of clinical psychology*, *13*, 49–71. https://doi.org/10.1146/annurev-clinpsy-032816-045020
56. Zaretsky, E. (2004). *Secrets of the soul: A social and cultural history of psychoanalysis*. Alfred A. Knopf.