Operationalized Psychodynamic Diagnosis OPD-2

Manual of Diagnosis and Treatment Planning

OPD Task Force (Eds.)
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English Translation by Eva Ristl
English Translation edited by Matthias von der Tann
The contemporary effort to develop a system of classification of mental illness that does justice to recent scientific developments; the need for a clear, circumscribed specification of psychiatric syndromes for research purposes; and, above all, a diagnostic evaluation geared to facilitate the clinical diagnosis, treatment planning, and prognostic assessment of individual patients has proven to be a major challenge to psychiatry and allied mental health fields. The complexity of the relationship between descriptive symptoms and personality traits, the underlying normal and psychopathological developmental features, and the unresolved conflict between contrasting schools and models regarding the integration of biological, psychodynamic, and psychosocial etiological features of psychiatric illness have created multiple problems in arriving at an acceptable classification. At the extremes, there have been tendencies to arbitrarily or artificially separate illnesses derived from biological or organic causes from those with psychodynamic or psychosocial etiology. The integration of genetic disposition, constitutional developments, early life experience, and present psychosocial situations, with varying proportions of each of these factors influential in individual cases, has further complicated classification efforts. Both the clinician and the researcher are confronted with a broad spectrum of patients within all major categories, and a challenging overlap of clinical syndromes.

Practical solutions have been attempted in classification systems based upon “purely descriptive” manifestations of illness, “free of etiological biases.” These approaches have inspired the DSM-IV classification system, and, to a lesser degree, the ICD-10 system. Both systems, however, in their effort to simplify and thus facilitate communication and research have reduced the richness and clinically appropriate level of diagnosis in psychiatry. On the other extreme, some psychoanalytic clinicians have decried all classification systems on the basis of the “uniqueness” of psychopathological manifestations in each individual case. This nihilistic reaction to the challenge of classification of mental illness is not useful to the clinician, and denies such progress as has been achieved both in the biological and the psychodynamic realm.

The Operationalized Psychodynamic Diagnosis proposed in this volume is a major effort to bridge the gap between descriptive clarity and precision, on the one hand, and clinical sophistication and appropriate individualized differentia-
tion, on the other. This system utilizes our current knowledge in ways that respect both the need for precision in the differentiation of syndromes, and provide the clinician with an in-depth understanding leading to an adequate diagnosis, prognosis, and treatment plan for the individual patient. It is a diagnostic system that successfully attempts a synthesis between descriptive and dynamic features, and respects the interaction between biological, psychodynamic, and psychosocial determinants of illness. The five axes of the OPD comprehensively include the nature of the present symptomatology, and the patient’s reaction to his or her symptoms and disposition to treatment; the influence of the patient’s personality features and interpersonal relations in the present illness; the dominant conscious and unconscious conflicts etiologically determinant, complicating, or consequential to the illness; and the patient’s overall personality structure, the level of personality organization that, from a clinical viewpoint, is so fundamental in the patient’s capacity to accept, participate in, and benefit from the efforts to treat his or her illness. A distinguished group of German psychiatrists has achieved this contemporary synthesis of an evaluative process that should help the clinician, as well as facilitate the empirical evaluation of pathogenesis and treatment. The authors themselves describe this diagnostic approach as a dynamic system that is open to further development and modification from data collection across multiple clinical sites. We believe that the OPD will be an important stimulus for resuscitating the restrictive and reductionist systems presently in vogue.

This new version, OPD-2, has significantly increased the clinical usefulness of its diagnostic system, by including a set of tools and procedures for treatment planning and for measuring change with treatment. It now facilitates determining the appropriate, central focus indicated as part of an appropriate treatment strategy, clearly relating the diagnostic assessment with the corresponding optimal treatment approach. The OPD-2 is warmly recommended to all professionals in the mental health field.

New York, July 2007

Otto F. Kernberg and John F. Clarkin
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Preface

“The particular is eternally subject to the general; the general must eternally be of service to the particular.”

Johann Wolfgang von Goethe

When Norman Sartorius was asked at the first international presentation of OPD, ten years ago, what future prospects he saw for OPD, he responded by saying, ask him again in five years’ time. A time span of this order normally reveals whether a system can withstand, and survive, scientific criticism. If all were to go well, there might perhaps be a second version of the instrument published by then. Now it has taken not five, but ten years for the second version of the Operationalized Psychodynamic Diagnostic to be available in Manual format. The reason is that this publication contains not only a revision of the first version, but a new Manual, which complements the diagnosis by adding treatment planning tools.

The new Manual provides options which, from our point of view, have great clinical-practical use for psychotherapists. More so than the first version, the second version takes care to ascertain that the diagnosis serves not only to describe and differentiate individuals, but, more importantly, is a tool guiding the actions of psychotherapists. One task of psychotherapy consists in providing an indication for specific psychotherapeutic measures based on diagnostic knowledge, or to formulate specific therapeutic tasks and goals, and to plan suitable therapeutic interventions. Therefore, in the clinical context, diagnosis is always in the service of therapy.

With OPD-2, therapy goals can be determined and respective foci selected for the treatment. This allows one to track changes in the patient along these parameters. By linking process descriptions to therapy outcomes, they can be made the basis for treatment evaluation. Even more than the earlier version, the new OPD allows the combination of both process and outcome research, as well as an evaluation that meets the criteria of quality control.

In substance, the second version has maintained the conceptual structure of the OPD. The multiaxial psychodynamic diagnosis is still based on the five axes defined as “experience of illness and prerequisites for treatment”, “interpersonal...
relations”, “conflict”, “structure”, and “mental and psychosomatic disorders in line with chapter V (F) of the ICD 10”. The changes effected refer to the fact that OPD-2 is no longer predominantly a tool for making cross sectional diagnoses only, but focuses to a greater extent on therapeutic processes, enabling treatment planning by allowing the determination of therapeutic foci.

The system of the Operationalized Psychodynamic Diagnosis (OPD) has become very successful not only in German-speaking countries. The instrument has had great resonance not only with clinicians, but also with researchers in psychotherapy worldwide. Four editions of the first version of the Manual were published; it was translated into several languages (English, Spanish, Italian, Hungarian, Chinese). This new Manual, like the previous one, is also published in English and Spanish, appearing soon after its German publication. In 2002, a working group of child and adolescent psychotherapists and developmental psychologists published an OPD Manual for the psychodynamic assessment of children and adolescents.

The success of OPD is mainly based on the fact that clinicians appreciate the essential tools that the categories of the multiaxial diagnostic system offer for their daily practice. For the Manual to be reliably applied, 60 hours of training (three training seminars on three different dates) are required. The practice-oriented skills that are learnt via videotaped examples or live-interviews with patients are highly appreciated. By now, more than 3000 physicians and psychologists have undergone the training seminars and are using the system, or parts or categories thereof, in their practical work.

Meanwhile, OPD has also been employed in numerous research projects. A prerequisite for its scientific application were the good reliability measures collected in several multicenter studies. The current Manual summarizes the extensive research results on the instrument published so far in a separate chapter (Chapter 2).

The OPD Task Force is well aware that an operationalization of a psychodynamic diagnosis (cf. Chapter 1.7) has its limitations. An operationalized diagnosis can only grasp the richness and complexity of human mental life in a very limited sense. Structure, conflict, and relationship diagnostics permit only a kind of pattern recognition, which offer the therapist anchor points, or guidelines, for the therapeutic process, while meaningful connections of an individual’s experiences may get lost. OPD has limited its goal to the understanding of the individual patient in the context of his own personal life history, and only to such degree as is relevant for an actual diagnosis and treatment planning which involves establishment of therapeutic foci.

The new system of the OPD was developed over the past few years by a group of psychodynamic psychotherapists working in the fields of psychoanalysis, psychiatry, and psychological psychotherapy, attempting to formulate operationalizations of the therapeutically relevant psychodynamic aspects. The names of
these persons and their function in the OPD Task Force can be found in the list of authors. Not all founding members of the OPD are still active in the current Task Force. Besides many others who cannot be named here, the group is indebted especially to Sven Olaf Hoffmann, the first OPD spokesperson, as well as to Ulrich Rüger, for their continued commitment to this extraordinary project.

The present OPD group has grown into a team which has worked on the conceptualization of this instrument in a spirit of friendship, collaboration, and debate for many years. The group is rightly proud that it has successfully managed, over the years, to keep up its creative involvement in the subject matter.

The members of the Task Force continue to feel committed to an attitude of open-minded curiosity towards the concepts and further development of OPD. For the conception of the current version of the OPD, we have endeavoured to use the experiences gained from the many training seminars, as well as the results of empirical studies with OPD. OPD-2 is no end result, but once again, is an intermediary step. We are convinced, however, that this instrument is one big step on the path to a scientifically founded and quality assured psychodynamic psychotherapy.

Manfred Cierpka, Heidelberg
OPD Spokesperson
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Members and their function within the OPD Task Force

**Spokesperson**
Manfred Cierpka (Heidelberg)

**Secretaries**
Reiner W. Dahlbender (Bad Saulgau)
Michael Stasch (Heidelberg)

**Members of the Steering Committee**
Peter Buchheim (Munich)
Manfred Cierpka (Heidelberg)
Reiner W. Dahlbender (Bad Saulgau)
Harald J. Freyberger (Greifswald)
Tilman Grande (Heidelberg)
Gereon Heuft (Münster)
Paul L. Janssen (Dortmund)
Gerd Rudolf (Heidelberg)
Henning Schauenburg (Heidelberg)
Wolfgang Schneider (Rostock)
Gerhard Schüßler (Innsbruck)
Michael Stasch (Heidelberg)
Matthias von der Tann (London)

**Spokespersons of the Axes**

**Axis I**
Wolfgang Schneider (Rostock)

**Axis II**
Manfred Cierpka (Heidelberg)
Reiner W. Dahlbender (Bad Saulgau)
Tilman Grande (Heidelberg)
Henning Schauenburg (Heidelberg)
Wolfgang Schneider (Rostock)
Gerhard Schüßler (Innsbruck)
Michael Stasch (Heidelberg)
Matthias von der Tann (London)

**Axis III**
Markus Burgmer (Münster)
Reiner W. Dahlbender (Bad Saulgau)
Gereon Heuft (Münster)
Sven Olaf Hoffmann (Hamburg)
Paul L. Janssen (Dortmund)
Elmar Mans (Bad Kreuznach)
Gudrun Schneider (Münster)
Gerhard Schüßler (Innsbruck)

**Axis IV**
Stephan Doering (Münster)
Tilman Grande (Heidelberg)
Thorsten Jakobsen (Heidelberg)
Marianne Junghan (Thun)
Joachim Küchenhoff (Basel)
1 Theoretical Background

In 1992, a group of psychoanalysts, psychosomatically oriented therapists and psychiatrists in Germany set up a task force that called itself “Operationalized Psychodynamic Diagnosis” (OPD). It has been the objective of this task force to expand the symptom-based, description-oriented classification of mental disorders by adding some fundamental psychodynamic dimensions. The OPD Task Force developed a diagnostic inventory and a manual (Arbeitskreis OPD, 1996) for experienced therapists for training purposes and clinical application. Furthermore, checklists for individual axes were published (Grande/Oberbracht, 2000; Rudolf et al., 1998) to make the assessment process more practicable and reliable.

The multiaxial psychodynamic diagnosis is based on 5 axes defined as “experience of illness and prerequisites for treatment”, “interpersonal relations”, “conflict”, “structure”, and “mental and psychosomatic disorders, in line with chapter V (F) of the ICD 10”. After an initial one or two hour interview, the clinician (or an external observer) assesses the patient’s psychodynamic profile along these axes and records the data on evaluation forms.

As many readers may already be familiar with the features of the OPD-1, we begin this book with a summary of the changes that have been made to OPD-1 resulting in OPD-2. After this introduction we briefly revisit the history of the OPD, its objectives, and the conceptualization of the axes. This is followed by a discussion of the literature on psychodynamic diagnoses and attempts at their operationalization. Those already familiar with OPD-1 may wish to go straight to chapter 2, which summarizes the research findings generated by OPD-1. The new operationalizations of the OPD-2 axes are described from chapter 3 onwards.

1.1 From OPD-1 to OPD-2

In this book the second version of OPD is introduced. After 10 years of experience with the first version (Arbeitskreis OPD, 1996; OPD Task Force, 2001) and
its application in various settings – training seminars, postgraduate study, outpatient and inpatient clinics, quality assurance, and scientific research – this largely revised new version is presented. Besides offering basic theoretical and conceptual considerations, it makes available a diagnostic manual which uses the four psychodynamic axes (I to IV) familiar from OPD-1 to identify patients’ psychodynamically relevant characteristics: first, how patients experience their illness, and, closely related to this, the prerequisites they bring to treatment; second, their dysfunctional relationship patterns; third, their unconscious conflicts; and fourth, their structural characteristics and structurally-based vulnerabilities.

This second version of OPD is more than just a revised edition of the original manual. After many years during which studies were conducted with OPD-1 and from the available research findings (cf. chapter 2), with regular feedback from training seminars, and experiences gained from clinical use of the tool, the necessity to further develop the OPD from a purely diagnostic instrument into an instrument of treatment planning and change measurement became more and more apparent. The four main areas which have been changed can be highlighted as follows:

- OPD-2 is no longer predominantly a tool for making cross-sectional diagnoses only, but focuses to a greater extent on therapeutic processes,
- OPD-2 attempts to take into account a patient's resources and strengths,
- OPD-2 is now able to conceptualize, to a greater degree, interfaces between its axes,
- OPD-2 enables treatment planning by allowing the therapist to determine therapeutic foci.

**Process orientation**

The process of treatment planning must rest on the three pillars of diagnosis, formulation of treatment aim, and identification of the appropriate therapeutic steps. The effects of these steps can then be evaluated, if need be, in everyday clinical practice. The diagnosis here serves to describe key problematic characteristics and/or attributes that would merit change, but also acknowledges resources and competencies of the patient. The process of treatment planning is here seen more or less as happening within the framework of an interactional exchange between therapist and patient.

Treatment planning and the examination of the effects of therapeutic interventions require diagnostic concepts which in turn allow a researcher to define and operationalize variables; such variables can then be measured in the therapeutic process. A cross-sectional diagnosis, via the description of the individual, allows
the comparison of individual cases with previously assigned empirical norms. In this way it can be determined how far the patient differs in relevant characteristics from the sample group. Cross-sectional diagnoses are helpful at certain points in time, mostly at the beginning and at the end of therapy, in order to identify problems or symptoms, and to assess their severity. This includes the recognition of all factors which may contribute not only to the maintenance, but also to the dissolution of symptoms. The classification of the complaint, problem, or symptom into a higher-order classification system (as for instance the ICD-10) forms a part of the diagnosis of the state, too. The first version of the OPD had been conceptualized predominantly as a “state diagnosis” system in this sense.

The current manual goes beyond this to allow the description of the process of change in the patient. With the OPD diagnosis, dysfunctional relationship patterns, stressful internal conflict configurations, and structural conditions in the patient can be identified, which all can be used to deduce therapeutic foci insofar as they are connected with the patient’s symptoms and suffering. Changes brought about by psychotherapy may thus be tracked progressively in the identified OPD categories.

OPD-2 thus follows current requirements of psychotherapy research to pinpoint the effects of change as it unfolds in the process of psychotherapy in order to identify how mechanisms of psychotherapy can be effective. Knowledge about the process then is incorporated into each further step of the treatment when considering therapeutic approaches and suitable interventions. The aim is to make the therapeutic process favorable for the patient.

With its new system OPD-2 is moving in the direction of the principle which Strupp and Schacht (1988) named the “problem-treatment-outcome congruence”. The meaning of this formula is that there must be a similarity, a congruence, between the evaluation of the clinical problem, the conceptualization of the desired change through therapy, and the description of clinical success. Such success should not just be measured with arbitrary objectivizing questionnaires or through observational methods, but by using those categories and concepts initially employed to formulate the clinical problem. In this way a common conceptual basis is employed for the problem to be treated, for the intervention process, and for the outcome of the treatment. By adopting this new direction OPD-2 intends to reflect the clinical practice of psychotherapists in a more direct way.

Psychodynamic psychotherapeutic diagnosis is in no way an end in itself, it should always be understood as a tool guiding one’s actions with respect to the therapy being carried out.

Identifying resources

A further change in OPD-2 was made to allow a greater consideration of a patient’s resources. On axis I the patient’s stresses are contrasted with available resources. Axis II is not restricted to the formulation of dysfunctional relation-