

OPD Task Force (Eds.)

# Operationalized Psychodynamic Diagnosis OPD-2

Manual of Diagnosis  
and Treatment Planning

OPD-2

HOGREFE



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# Foreword

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

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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 Rürger, 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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# OPD Task Force

## Members and their function within the OPD Task Force

### Spokesperson

Manfred Cierpka (Heidelberg)<sup>1</sup>

### Secretaries

Reiner W. Dahlbender (Bad Saulgau)<sup>2</sup>

Michael Stasch (Heidelberg)<sup>1</sup>

### Members of the Steering Committee

Peter Buchheim (Munich)<sup>3</sup>

Manfred Cierpka (Heidelberg)<sup>1</sup>

Reiner W. Dahlbender (Bad Saulgau)<sup>2</sup>

Harald J. Freyberger (Greifswald)<sup>4</sup>

Tilman Grande (Heidelberg)<sup>5</sup>

Gereon Heuft (Münster)<sup>6</sup>

Paul L. Janssen (Dortmund)

Gerd Rudolf (Heidelberg)<sup>5</sup>

Henning Schauenburg (Heidelberg)<sup>5</sup>

Wolfgang Schneider (Rostock)<sup>7</sup>

Gerhard Schüßler (Innsbruck)<sup>8</sup>

Michael Stasch (Heidelberg)<sup>1</sup>

Matthias von der Tann (London)<sup>9</sup>

### Spokespersons of the Axes

#### Axis I

Wolfgang Schneider (Rostock)<sup>7</sup>

#### Axis II

Manfred Cierpka (Heidelberg)<sup>1</sup>

#### Axis III

Gerhard Schüßler (Innsbruck)<sup>8</sup>

#### Axis IV

Gerd Rudolf (Heidelberg)<sup>5</sup>

#### Axis V

Harald J. Freyberger (Greifswald)<sup>4</sup>

### Members of the Working Groups

#### Axis I

Reiner W. Dahlbender (Bad Saulgau)<sup>2</sup>

Matthias Franz (Düsseldorf)<sup>10</sup>

Karsten Hake (Rostock)<sup>7</sup>

Reinholde Kriebel (Geldern)<sup>11</sup>

Doris Pouget-Schors (Munich)<sup>12</sup>

Wolfgang Schneider (Rostock)<sup>7</sup>

#### Axis II

Manfred Cierpka (Heidelberg)<sup>1</sup>

Reiner W. Dahlbender (Bad Saulgau)<sup>2</sup>

Tilman Grande (Heidelberg)<sup>5</sup>

Henning Schauenburg (Heidelberg)<sup>5</sup>

Michael Stasch (Heidelberg)<sup>1</sup>

Matthias von der Tann (London)<sup>9</sup>

#### Axis III

Markus Burgmer (Münster)<sup>6</sup>

Reiner W. Dahlbender (Bad Saulgau)<sup>2</sup>

Gereon Heuft (Münster)<sup>6</sup>

Sven Olaf Hoffmann (Hamburg)

Paul L. Janssen (Dortmund)

Elmar Mans (Bad Kreuznach)<sup>13</sup>

Gudrun Schneider (Münster)<sup>6</sup>

Gerhard Schüßler (Innsbruck)<sup>8</sup>

#### Axis IV

Stephan Doering (Münster)<sup>14</sup>

Tilman Grande (Heidelberg)<sup>5</sup>

Thorsten Jakobsen (Heidelberg)<sup>5</sup>

Marianne Junghan (Thun)

Joachim Küchenhoff (Basel)<sup>15</sup>



Doris Pouget-Schors (Munich)<sup>12</sup>  
Claudia Oberbracht (Frankfurt/Main)  
Gerd Rudolf (Heidelberg)<sup>5</sup>

**Axis V**

Harald J. Freyberger (Greifswald)<sup>4</sup>  
Wolfgang Schneider (Rostock)<sup>7</sup>

**Interview**

Reiner W. Dahlbender (Bad Saulgau)<sup>2</sup>  
Cord Benecke (Innsbruck)<sup>16</sup>  
Stephan Doering (Münster)<sup>14</sup>  
Tilman Grande (Heidelberg)<sup>5</sup>  
Paul L. Janssen (Dortmund)  
Gudrun Schneider (Münster)<sup>6</sup>

---

<sup>1</sup> Universitätsklinikum Heidelberg, Institut für Psychosomatische Kooperationsforschung und Familientherapie

<sup>2</sup> Klinik am Schönen Moos Bad Saulgau, Klinik für Psychosomatische Medizin und Psychotherapie

<sup>3</sup> Technische Universität München, Klinik für Psychiatrie und Psychotherapie

<sup>4</sup> Universitätsklinikum Greifswald, Klinik und Poliklinik für Psychiatrie und Psychotherapie

<sup>5</sup> Universitätsklinikum Heidelberg, Klinik für Psychosomatische und Allgemeine Klinische Medizin

<sup>6</sup> Universitätsklinikum Münster, Klinik und Poliklinik für Psychosomatik und Psychotherapie

<sup>7</sup> Universitätsklinikum Rostock, Klinik und Poliklinik für Psychosomatik und Psychotherapeutische Medizin

<sup>8</sup> Universitätsklinikum Innsbruck, Klinik für Medizinische Psychologie und Psychotherapie

<sup>9</sup> Portman Clinic London, Tavistock & Portman NHS Foundation Trust

<sup>10</sup> Universitätsklinikum Düsseldorf, Klinisches Institut für Psychosomatische Medizin und Psychotherapie

<sup>11</sup> Gelderland-Klinik, Fachklinik für Psychotherapie und Psychosomatik Geldern

<sup>12</sup> Technische Universität München, Institut und Poliklinik für Psychosomatische Medizin, Psychotherapie und Medizinische Psychologie

<sup>13</sup> Psychosomatische Fachklinik St. Franziska-Stift, Bad Kreuznach

<sup>14</sup> Universitätsklinikum Münster, Poliklinik für Zahnärztliche Prothetik, Bereich Psychosomatik der Zahnheilkunde

<sup>15</sup> Universitätsklinikum Basel, Abteilung Psychotherapie und Psychohygiene der Psychiatrischen Universitätsklinik

<sup>16</sup> Universität Innsbruck, Institut für Psychologie

# 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

## 1.3

**The Concept of the Operationalized Psychodynamic Diagnosis (OPD)**

OPD is composed of the four psychodynamic axes described earlier and one descriptive axis. The first four axes are based on a psychodynamic understanding derived from psychoanalysis. We proceed from the assumption that the main determinants in these four axes correspond to partial psychoanalytic concepts (personality structure, intrapsychic conflict, transference), whereby final conclusions inferred on the level of the unconscious are to be drawn only cautiously and with reference to the respective operationalizations.

**Why these five axes?****Axis I: Experience of Illness and Prerequisites for Treatment**

Axis I was chosen because of the obvious practical relevance of the categories involved here, which to some extent are borrowed from cognitive psychology: The patient must be “picked up from where he is at and where his expectations lie”, that is to say, one must proceed from the symptoms related to his complaint and his expectations from treatment. The emphasis hereby is less on illness behavior than on elements of experience, motivations, and existing resources. These components have been well investigated in psychology and are relatively easy to operationalize.

**Axis II: Interpersonal Relations**

Axis II is partly rooted in psychoanalytic diagnosis, which is and has been, at all times, also a relationship diagnosis as it attributes critical importance to the interplay of transference and countertransference. In contrast to axes III and IV, this axis does not provide prototypical configurations or patterns, but offers a system of categories of behavioral modes which are close to observation and can be freely combined.

**Axis III: Conflicts**

In Axis III, conflicts, a piece of classic psychoanalytic diagnosis is claimed for use in OPD, namely the central role of inner conflicts. In using this axis, life-determining internalized conflicts can be juxtaposed with more externally determined current conflictual situations. Working on a conflict can be defined as a goal of therapy.

**Axis IV: Structure**

This axis depicts the qualities and/or inadequacies of mental structures. Amongst other things, it comprises for instance the possibility and/or impossibility of set-

ting internal or external boundaries, the ability or inability of self-perception and self-regulation, amongst other things. Sub-aspects of structure can be categorially determined in conjunction with a conflict or without, as therapeutic foci.

### **Axis V: Mental and Psychosomatic Disorders**

Axis V incorporates into OPD the established descriptive-phenomenological diagnosis of the ICD-10 and DSM-IV. This emphasizes the necessity of precise identification of psychopathological phenomena, which must also find a place in a psychodynamic diagnosis. Furthermore, the group used this axis to make suggestions as to how to enhance the ICD-10 in the area of psychosomatic illness (F54).

It becomes evident when looking at the axes that they overlap in some areas as to content and also interact closely with each other: psychic structure, as it were, forms the backdrop against which conflicts with their well or poorly adapted patterns for solution are played out. As “epiphenomena”, relationship patterns are closer to observation than mental structure and internal conflict. Habitual dysfunctional relationship patterns can be understood as an expression of internal conflict and structural characteristics, and simultaneously, as an expression of the coping strategies towards their mastery; they therefore reflect problematical aspects in both areas. In the interfaces of the axes and the interrelationships on the level of the item lists the architectural structure of the OPD becomes manifest. Section 3.6 “On the interrelationship of the axes” discusses this in more depth.

## **1.4**

### **Fundamental Considerations on a Multiaxial Diagnosis**

A multiaxial approach offers the possibility of better reflecting the complex set of conditions, which we find in a majority of mental phenomena and mental disturbances. Some fundamental considerations are necessary to understand the interplay between and combined effects of these axes, and also when dealing with the question of what an axis is and how we understand mental phenomena and disturbances.

Psychosomatic medicine, psychotherapy and psychiatry, and thus also the axes of the OPD, are founded on subjective mental experience and the behavior of the individual. The basis for an understanding of mental phenomena and their interrelationship with somatic factors is the bi-directional biopsychosocial model: all these phenomena and disturbances are biological, as subjective experience arises from the functioning of the brain (brain → mind), yet mental phenomena equally affect the brain (mind → brain). A multiaxial classification thus proceeds from neurobiological foundations and findings: that the brain is dependent on its use,

this diagnostic prescription, is that of depressive disorder – not adjustment disorder – , that is to say, adjustment disorders represent a remainder category, as a rule of lesser severity. This diagnostic procedure is simply wrong empirically, that is to say, in cases where an adjustment disorder and depressive symptoms of medium severity co-exist, the diagnostician should be able to use the diagnosis of adjustment disorder, which, according to the ICD-10 logic, is not possible. Adjustment disorders, in accordance with the ICD-10, are therefore always considered “mild” disorders.

As a matter of principle, when using both ICD-10 and OPD diagnostic systems, care should be taken not to automatically “cross diagnose”, meaning that not every obsessive personality disorder according to ICD-10 simultaneously shows low structural integration (OPD Axis “structure”). Rather, a diagnosis of personality disorder must also comprise the conflictual background and the precipitates it has had onto the personality.

### 3.6

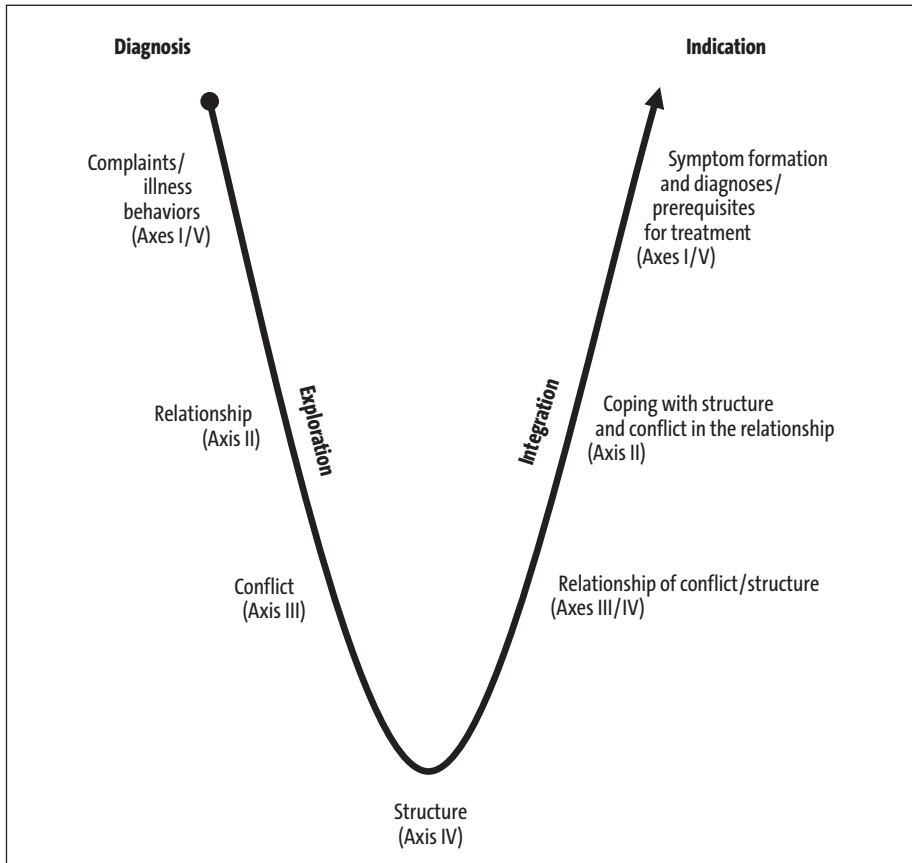
## Conceptual Cross-References and Interactions Between the Axes

### 3.6.1

#### The process of compiling the diagnostic material and its integration

Two opposite trends or movements can be traced in the diagnostic process based on OPD. The first path towards the compilation and recording of the diagnostic material starts out with aspects which relate to the patient’s basic accessibility to diagnostic exploration and which are part of what is described on Axis I as “experience of illness and prerequisites for treatment”. Of importance here are, for example, the patient’s conception of illness and his psychological mindedness. The investigation then proceeds to the patient’s relationship experiences which are of central importance for the diagnostic access to psychodynamic issues. Not only from the patient’s descriptions of his relationships, but also from his directly observable handling of the relationship can his typical interpersonal enactments or arrangements then be inferred, which are depicted on Axis II. These relationship patterns represent, as it were, a surface where his conflict potentials show up, which he copes with in compromise-like fashion in his encounters with others. The quality of such engaging or coping eventually directs one’s view to the patient’s functional capacities, that is to say his structural possibilities and limitations which set a more or less solid framework for the dynamic interplay of psychic forces.

The second path towards the integration of diagnostic material leads in the opposite direction. It begins with the structural prerequisites. In the authors’ view they represent a fundamental diagnostic dimension which to a very large extent (co-)determines the quality and character of the other characteristics de-



**Figure 3-3:** Compilation and integration of diagnostic material

Legend: Representation of the diagnostic process, starting top left with the compilation and recording of the diagnostic material, down to the investigation of the structural prerequisites, then from the base proceeding upwards to the integration of the axes-related findings into a coherent overall picture as the foundation for indication.

scribed by the OPD. The extent of the structural limitation influences and limits the weight that conflictual dispositions the patient has acquired in his development are accorded in the origin and maintenance of complaints. It determines the habitual relationship patterns which, at higher degrees of structural limitation, become increasingly inefficient and brittle so that any establishment of a permanent relationship is eventually doomed to fail. The state of an individual's structure determines further whether the "illness" is meaningful in the sense of neurotic symptom formation, or whether the type, variety, intensity, and fluctuation of complaints indicate the impairment of basic mental functions and that an individual's regulation capabilities are constantly being overworked. All of this

# 4 Manualization of the Axes According to OPD-2

## 4.1 Axis I – Experience of Illness and Prerequisites for Treatment

OPD Axis I is constructed in a modular way. The basic module consists of 19 items, which reflect the current severity and duration of the illness, how it is experienced and presented by the patient, the concepts a patient may have about his illness, and in addition, his resources for and impediments to change. An assessment may additionally make use of specific items from the psychotherapy module and/or further modules. The psychotherapy module reflects the wish of a patient for a specific psychotherapy, his psychological mindedness for psychotherapy, as well as any secondary gains he may obtain from the illness.

As an example, we also include a context specific module. This is the forensic module, which is currently being developed and offers the possibility for a more detailed examination of the particular conditions of forensic patients.

Table 4-1, module overview, shows in a prototypical way how any additional modules are interwoven with the basic module.

**Table 4-1:** Axis I module overview

Basic Module	Psychotherapy Module	Forensic Module
<b>Objective assessment of the illness/the problem</b>		
<b>1. Current severity of the illness/the problem</b>		
1.1 Severity of the symptoms		
1.2 GAF		GAF without rating 20-11
1.3 EQ-5D		1.F1 Type and severity of the paraphilic/perverse disorder



Basic Module	Psychotherapy Module	Forensic Module
		1.F2 Type and severity of substance abuse 1.F3 Type, severity and frequency of delinquent and/or antisocial behavior 1.F4 Level/nature of security 1.F5 Level/nature of coercion into treatment
<b>2. Duration of the illness/of the problem</b>		
2.1 Duration of the illness		
2.2 Age at first onset of the illness		2.F1 Age when antisocial behavior first manifested 2.F2 Age when first convicted, jailed as a juvenile offender, or when antisocial action was first documented

**Patient's experience, presentation, and concepts of illness**

<b>3. Experience and presentation of illness</b>		
3.1 Subjective suffering		
3.2 Presentation of physical complaints and problems		
3.3 Presentation of psychological complaints and problems		
3.4 Presentation of social problems		3.F1 Presentation of delinquent behavior and/or antisocial behavior modes
<b>4. Patient's concepts of illness</b>		
4.1 Concept of illness oriented to somatic factors		
4.2 Concept of illness oriented to psychological factors		

her maternal grandmother, a very depressed woman who cried a lot. The patient slept at her grandmother's place in order to keep an eye on her, after the grandfather, who had been a police inspector, was arrested at the end of the war, and the family had had to move out of the accommodation that came with the job. After this, the grandmother had become depressed and had made several suicide attempts. The patient had been repeatedly admonished to take care of the grandmother and to keep an eye on her. One day, however, grandma did commit suicide, and no one recognized at the time how much the patient suffered from the guilt of having failed. From that time on, she carried around with her the feeling that she had to be there for others and had loaded guilt upon herself.

### **Need for care versus self-sufficiency – passive mode (and Oedipal conflict – passive mode)**

#### **Case vignette: The justice department official**

Mr. K., (36 years old), came into treatment because of a depression which had increasingly worsened for about one year. Depressive feelings of senselessness had reached the point when he was thinking about suicide. Fears, such as losing his parents, had existed since childhood. The first time he had had depressive symptoms of clinical relevance had been 10 years ago, when his first wife had left him for a new partner. In consequence, he underwent a three-year psychotherapy. During this time Mr. K. got married to his second wife. Soon after, their only daughter was born. Since the birth Mr. K. has felt he is no longer getting any attention at all. The current increase in symptoms, in his mind, is due to the daughter's increasing independence ("She doesn't need me any more") and his promotion as a justice department official. With this promotion, he has left other colleagues behind and has to reckon with a possible transfer to another town.

In the interview, Mr. K. comes across as bland and unappealing, a bit unkempt in appearance, but at the same time displaying clinging behavior and constantly demanding relief for his "bad" depression: "Will you please do something for me." The lead affect is the constant fear that others might leave him, that he might lose others, and that his depressive feelings might increase. He experiences himself as dependent on the love and care of other people, although he was constantly trying to give to others. Mr. A. appears very strongly inhibited in expressing his own feelings and needs.

Mr. K. grew up in a small town as an only child, his father had attempted to open his own business and failed, and since then his mother had had to provide for the family. His relationship with his mother is still a very close one up to this day. She is idealized, although she appears, at the same time, to be unassuming, not very substantial and, reduced to her role as "provider". The father then tried his luck as a travelling salesman, was hardly ever home, so that the relationship between son and mother deepened further. Mr. K. met his first wife during professional training. ("She was like my mother"). Sexually, there seem to have been considerable problems (this is where a great bashfulness is noticeable in Mr. K.), which, in all likelihood led the wife to turn to another man. He met his second wife, too, in the professional domain, she equally, is described as supportive and caring, sexuality hardly playing a role in their relationship since the birth of their daughter. His professional relationships are subdued and good. He felt safe in his profession, until this current promotion threatened him. In the social environment there are rather fewer contacts without any major conflicts. His symptoms of depression force him to constantly go and see doctors.

4.3.4  
Self-worth

Table 4-8: Conflict 4 – self-worth conflict

Self-worth conflict	
General description	
<p>What applies for self-worth conflicts, more than for the other levels of conflict, is that they are general: each human being wishes to have their feelings of self-worth satisfied and acknowledged. A self-worth conflict is present when efforts to have one's self-worth acknowledged appear excessive and unsuccessful, or insufficient or to have failed in the past and/or currently. The conflicts here refer to self-worth versus object worth as the non-adaptive extreme poles of the theme "being able to question oneself", and "to attach a value to oneself". As to their extent, important self-worth conflicts in a patient by far exceed those narcissistic problems which are a part of the other conflict levels. What is therefore not addressed here, is the basic involvement of the narcissistic motivational system (narcissistic "overtones") in any of the other conflicts. With age, narcissistic destabilization often results, leading to the respective compensation attempts. As concerns the self-worth (structure), as in all conflicts, a sufficient ability for regulation must be presupposed in order for a motivation-based conflict with a specific trigger situations to arise at all.</p>	
Passive mode	Active mode
General criteria	
<p>When the passive mode predominates, the patient experiences a critical dip in the feeling of self-worth ("I am nothing any more"). Often, the symptoms that arise are made directly responsible for this. Narcissistic demands tend to be reduced, the needlessness and unimportance of one's own person are emphasized. Blame is, however, either openly or indirectly attributed to others, especially to doctors and public institutions. The patient's lead affect is a clearly noticeable sense of shame. The mode may also come across as a chronic attitude of defence, where the manifest self-devaluation is in the service of an unconscious building up of the self. This shows, for instance, in the transference in an idealizing and clearly embarrassing admiration (for the investigator), and in the countertransference in feelings of wanting support (accompanied, perhaps, by a latent, though noticeable, feeling of devaluation), or of putting the other down.</p>	<p>When the active mode predominates, there is a forceful self-assuredness in the patient towards others as an attempt to cope with a feared or real crisis of self-worth. Patients may come across as self-assured at first glance, but the hidden insecurity is, however, soon noticed ("pseudo self-assured"). The lead affect of the patient may express itself as irritability and anger ("narcissistic rage"), when the positive-narcissistic self-image is questioned. In the interaction, the investigator is often questioned up to the point of a devaluating insult. In the countertransference, the investigator notices feelings of having been hurt and impulses of wanting to justify himself, due to the devaluation by the patient, possibly followed by anger to the point of putting the patient down.</p>
Areas of life	
Family of origin	
<p>The family tradition often carries on a negative self-image ("The things we put up with!"). The patient is often the carrier of compensatory expectations, whereby the myth of relegation and of his own inferiority remains, in spite of the hardship suffered and</p>	<p>Either the family of origin and the patient's own biography are strongly idealized, and the patient feels a worthy descendant of the family, or they are ignored by the patient, are trivialized, or denied to the point of feigning lack of memories. The underlying</p>

efforts made. Alternatively, the patient may tend to display constant self-devaluation against the background of the family's excessively valued attainments which he will never be able to live up to.

ing shame of wanting to avoid the topic of family of origin may be clearly noticeable here.

#### **Family/partnership**

In intimate relationships, such people not infrequently seek out a steady partner with whom they share and jointly work through a history of insults, humiliations, and stresses problematic to their self-worth, especially as concerns social prestige. The relationship is stabilized via the common theme of "always missing out" and a delineation from others who seem to fare better.

Relationships and choice of partner serve, patterned on so-called self-objects, mostly to stabilize feelings of self-worth. Relationships are shaped so as to make one the object of admiration, or to make the partner so very worthy of admiration (in the hope of being 'upgraded' by association with the partner). A constant devaluation of the partner might also serve to raise one's own profile ("I don't know what I'm doing being involved with someone like this"). People living according to this mode tend to divide the world into friends and foes.

#### **Job/professional life**

In their jobs, these patients show great work and achievement motivation to compensate for hurts and usually have quite some success within the framework of their possibilities. Hidden behind this one can find a heightened vulnerability to insults when their efforts are ignored. Therefore, the beginning of symptoms is not infrequently directly linked to setbacks, or insults, suffered on the job.

In their profession, there is the tendency for these patients to overestimate their rank and performance. Work problems and deficits in one's own performance are denied or causally attributed to others. Often, the actual professional positions are not very high, as the patients, due to their vulnerability to feeling insulted, have a tendency to break off relationships and to perform more poorly.

The patients may also openly display an attitude of refusing work or achievement, which is congruent with their self-image ("I won't manage anyway!").

#### **Social context**

The positions selected in social groups are rather subordinate, preferably in groupings with others who are equally disadvantaged. The chosen group may live out programmatic demands vicariously ("Association of Displaced Persons"). Often, however, patients withdraw early from the association, because they get frustrated, and rely on themselves, or seek support from a few familiar relationship figures. New social experiences tend to be avoided.

Very particularly, social groups or contacts with celebrities or well-known personalities are sought out, in order to be assured, in the light emanating from the others, of one's own worth ("Your light makes me shine brighter"). Also, these patients have the need to actively set themselves apart from supposed "failures", for fear that the deficiencies of those losers might "taint" their own image.

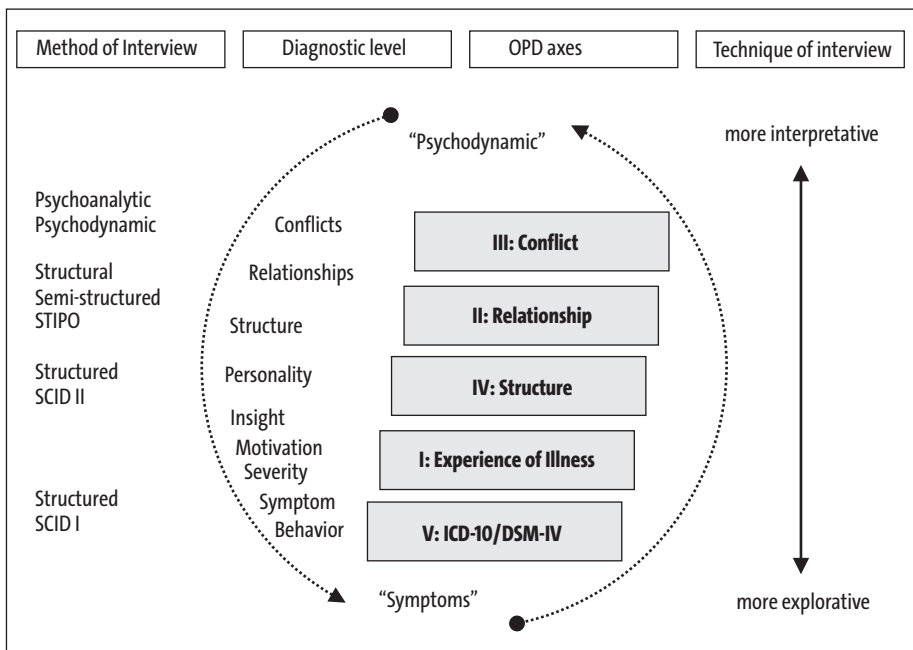
#### **Possessions and money**

Accumulated possessions, owning one's own house, etc., all appear to compensate, unconsciously, for the insufficient or missing experience of inferiority. They do not, however, create a basis for narcissistic satisfaction, but frequently confirm the subjective feeling of having missed out.

Possessions and money are representative attributes that serve the assertion of self-worth ("fetishes of affluence"). Not infrequently, these attributes are not real, but rather, tend to exist only in the wishes and phantasies of the patient.

relationship structures which determine interpersonal behavior become measurable. The Structured Interview for Personality Organization (STIPO; Caligor et al., 2004; Clarkin et al., 2004b) is an attempt to operationalize Kernberg’s structural interview. In it, the interviewer asks structured questions on 100 items on seven dimensions of personality structure and then rates the results according to a six-point scale of personality organization.

These formalized interview approaches may be mapped on an axis with explorative at one end, and relationship dynamic approaches at the other; if compared to the psychoanalytic initial interview, they would be found at the other end of the spectrum. While the latter, in as unstructured a way as possible, sets the stage for a scene in the transference relationship to unfold, the operationalized forms of interview dispense with this relationship-dynamic material in the ‘here and now’ of the actual interview situation in favor of a reliable assessment of small and even smaller measurable psychopathological units. Carrying on the typology by Buchheim and colleagues (1994), the OPD interview thus can be described as the fourth generation of psychodynamic interviews (Dahlbender et al., 2004b). It is the attempt of a synthesis of the preceding interview generations. It requires, first of all, a psychoanalytic stance as a basis, which allows the “recreation of infantile object-relationships in the transference-countertrans-



**Figure 5.1:** Diagnostic levels and technical strategies of the OPD interview compared to other interview procedures

ference between psychotherapist and patient” (Janssen et al., 1996). However, similar to Kernberg’s structural interview, the unstructured procedure is interrupted by more explorative interview phases in a cyclical manner. These are in part taken from already existing instruments, like, for instance, the identification of relationship episodes according to the CCRT method. Beyond this, the OPD interview contains structured passages of a biographical anamnesis and captures psychopathological symptoms. The OPD interview is multiaxial and multimodal: it collects material for the assessment of the five axes by applying different modes of interview methods (see table 5-2 in: Dahlbender et al., 2004b). A psychoanalytic criticism is that the OPD interview, by its very multimodality, sacrifices too much scenic material, as the more structured parts of the interview do not really allow the development of a transference-countertransference relationship (Mertens, 2004). While this argument cannot be completely discounted, we nevertheless believe that in an OPD interview carried out with a sufficiently sensible psychodynamic stance as a basis, there will be enough room for the development of a diagnostically usable transference activation. The OPD interview may perhaps even encourage this by its use of goal-directed interventions, as Kernberg similarly utilizes them in his structural interview (Dahlbender et al., 2004b).

## 5.2

### Carrying out the OPD Interview

#### 5.2.1

#### Prerequisites

The aim of the OPD interview is to generate material so that, if possible, all items and dimensions of the five axes can be reliably rated. In order to facilitate this, the interviewer can avail himself of certain interview strategies, the use of which is tied to the following preconditions:

- The interviewer must have a basic psychodynamic understanding. This does not necessarily presuppose post-graduate training in psychodynamic psychotherapy, although such training would certainly be of advantage. Rather, it requires the interviewer to have the capacity to empathize, which enables him to recognize and understand relational aspects in the ‘here-and-now’ of the interview situation, and to link symptom formation with relevant experiences in the ‘there-and-then’. This demands the interviewer be open, in the sense of Sandler's (1976) free-floating role-responsiveness, to his own experiencing during the interview relationship.
- The interviewer must have knowledge of the contents of axes I to IV more or less at his fingertips, in order to know, during the interview, which areas

problem, beginning with cutting it off from perception successfully or not perceiving it as such, to slowly starting to perceive it and then explore it with some interest, extending through to active coping efforts. The stages 5 to 7 describe the process of a loosening up of habitual defence patterns, which is conducive to the therapy in that it enables a new organization of the personality. They therefore capture changes which are referred to in the psychoanalytic concept of “restructuring”, or “structural change”.

This scale is used to independently rate, at each rating timepoint, the foci that have been selected for a patient. Interim stages, as shown in Figure 8-1, may also be used. For an assessment, various strategies are available (Grande, 2005) which

The Heidelberg Structural Change Scale (HSCS)		
1. Focus problem warded off	1 1+	Total defence, or avoidance, of the focus area; patient has “no problems” with the critical area
2. Unwanted preoccupation with the focus	2- 2 2+	Symptom pressure, difficulties in interpersonal relationships: unreasonable demands, experienced as external
3. Vague awareness of the focus	3- 3 3+	Passive preoccupation with the focus; traces of acknowledgement of problem, notion of responsibility
4. Acceptance and exploration of the focus	4- 4 4+	Interested in understanding the problem, working relationship, active “coping”, active preoccupation
5. Dissolution of old structures in the focus area	5- 5 5+	Defence becomes fragile, sadness, feeling exposed, confusion, possibly hopelessness
6. Reorganization in the focus area	6- 6 6+	Conciliatory approach to the problem area, spontaneous emergence of new ways of experiencing and behaving
7. Dissolution of the focus	7- 7	Integration, agreement with self, experience conforms to reality, new formations

Coping

Structural change

**Figure 8-1:** Heidelberg Structural Change Scale

## Forensic Module

### Objective assessment of the patient's illness/of the problem

#### **1. Current severity of the illness/of the problem**

- 1.F1 Type and severity of the paraphilic/perverse disorder
- 1.F2 Type and severity of substance abuse
- 1.F3 Type, severity and frequency of delinquent and/or antisocial behavior
- 1.F4 Level/nature of security
- 1.F5 Level/nature of coercion into treatment

#### **2. Duration of the disorder/of the problem**

- 2.F1 Age when antisocial behavior first manifested
- 2.F2 Age when first convicted, jailed as a juvenile offender, or when antisocial action was first documented

### Patient's experience, presentation, and concepts of illness

#### **3. Experience and presentation of the illness**

- 3.F1 Presentation of delinquent behavior and/or antisocial behavior modes

#### **5. Patient's concepts about change**

- 5.F1 Attitude to placement
- 5.F2 Attitude to coercion into treatment or contractual structure
- 5.F3 Attitude to the prospect of change with respect to reducing antisocial behavior

### Resources for and impediments to change

#### **6. Resources for change**

- 6.F1 Openness towards consideration of psychological factors influencing offending/antisocial behavior
- 6.F2 Openness to associations between offending/antisocial behavior and subsequent mental states

#### **7. Impediments to change**

- 7.F1 Comorbidity
- 7.F2 Psychosocial advantages because of delinquent/antisocial behavior
- 7.F3 Psychosocial advantages because of (court) ordered measures and involved services
- 7.F4 Utilization of mental disturbance with regard to delinquent/antisocial behavior



### 13.3 OPD-2 Conflict Checklist

#### Perception of conflicts and affects impaired by means of defence

##### Perception of conflicts and affects impaired by means of defence

###### General criteria

**Type of person:** People who overlook conflicts within themselves and in interpersonal relationships, and who have difficulty perceiving and recognizing feelings and needs in themselves and others.

**Lead affect:** No lead affect, due to avoidance of, especially anhedonic affects and conflicts through exaggerated defence in the sense of a protective function.

**Countertransference/interaction:** The countertransference may either produce few affects, like disinterest, and boredom, or those affects which the patient tends to leave out or covers up by being factual; possibly anger because of the patient's defensive presentation.

##### Areas of life

###### Family of origin

Despite the existence of possibly difficult conditions, relationships are described in a uniform, low-affect, factual manner as "unproblematic".

The individual's behavior is determined by conventions.

Changes, for example separations, seem to happen in a matter of fact way and without friction.

###### Partnership/family

Normality and functionality are emphasized.

Changes are reported as facts and without emotional involvement.

###### Job/professional life

Often jobs which are intensely fact-oriented.

Performance is important, if it refers to factually solving job-related tasks.

Occasional involvement in interpersonal conflicts at work, because no attention is given to emotional relationships.

###### Social context

Social life appears to be handled in a functional manner, whereby emotional and conflictual areas are avoided.

###### Possessions and money

Handling of possessions is functional and fact-focused.

Sometimes noticeably more emotional relationships with material things than with living objects (for compensation).

###### Body/sexuality

Dealing with the body in a fact-based, rational manner. The body must function like a machine.

Sensuous, enjoyable bodily experiences are hardly possible, sexual "functioning" may be important as an expression of normality.

Processes of change or aging are denied or referred to the "repair shop".

### 13.7 Operationalized Psychodynamic Diagnosis (OPD-2) Data Evaluation Forms

#### Axis I – Experience of illness and prerequisites for treatment

##### Basic module

Axis I (basic module)	none/ hardly present		medium		very high	not ratable
	⓪	①	②	③	④	⑨

##### Objective assessment of the illness/the problem

1. Current severity of the illness/of the problem							
1.1	Severity of symptoms	⓪	①	②	③	④	⑨
1.2	GAF: Maximum within the past 7 days		→	___			⑨
1.3	EQ-5D Total: _____ Item values →	1. ___	2. ___	3. ___	4. ___	5. ___	⑨
2. Duration of the illness/of the problem							
2.1	Duration of the illness	< 6 months	6–24 months	2–5 years	5–10 years	> 10 years	⑨
2.2	Age at first onset of the illness	in years	→	___			⑨

##### Patient’s experience, presentation, and concepts of illness

3. Experience and presentation of the illness							
3.1	Subjective suffering	⓪	①	②	③	④	⑨
3.2	Presentation of physical complaints and problems	⓪	①	②	③	④	⑨
3.3	Presentation of psychological complaints and problems	⓪	①	②	③	④	⑨
3.4	Presentation of social problems	⓪	①	②	③	④	⑨
4 Patient’s concepts of illness							
4.1	Concept of illness oriented to somatic factors	⓪	①	②	③	④	⑨
4.2	Concept of illness oriented to psychological factors	⓪	①	②	③	④	⑨
4.3	Concept of illness oriented to social factors	⓪	①	②	③	④	⑨