OPD Task Force
(Editors)

Operationalized Psychodynamic Diagnosis OPD-3

Manual of Diagnosis and Treatment Planning

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EUROPE:	Hogrefe Publishing, Merkelstr. 3, 37085 Göttingen, Germany Phone +49 551 99950 0, Fax +49 551 99950 111; E-mail publishing@hogrefe.com

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Dedication

In memory of Cord Benecke, 1965–2025.

Contents

Preface

It is with great joy and pride that we can now present the English translation of the third version of the German-language system of *Operationalized Psychodynamic Diagnosis* (OPD). OPD-3 was first published in German in 2023 and has since rapidly established itself as a standard reference in the clinical fields of psychiatry, psychosomatic medicine, and psychotherapy throughout the German-speaking world. It offers a concise and coherent synthesis of the psychoanalytic and psychodynamic diagnostic tradition across four relevant axes: The subjective experience of illness, maladaptive relational patterns, central intrapsychic conflicts, and structural capacities in terms of personality functioning.

At the same time, the OPD is more than a useful and practical synthesis of psychoanalytic traditions. It also builds bridges to other psychological and psychotherapeutic approaches and perspectives. Behavioral and systemic therapists alike find the OPD to be a valuable and horizon-broadening framework in everyday clinical practice.

Our experience with OPD 2, published in 2006, demonstrated the crucial importance of the English translation for the international dissemination of the OPD. Numerous further translations were subsequently based on the English edition. We are therefore especially pleased to take this next step with the present translation and hope that the work developed over the past decades will continue to resonate with and inspire clinicians as well as researchers in other countries.

A major driving force behind the development of the third edition of the OPD was Cord Benecke, who served as the spokesperson for the OPD Task Force from 2017 until his death in December 2025. His contributions to this process are beyond measure. We miss him deeply as a friend, colleague, and a source of inspiration, and we are committed to continuing his work in his spirit – not least as a way of preserving his legacy.

Henning Schauenburg and Stephan Doering
for the Coordinating Committee of the
OPD Task Force

Preface

With this book, the OPD Task Force presents the third version of the Operationalized Psychodynamic Diagnosis (OPD). The OPD was developed in Germany in the 1990s by a group of psychoanalytic researchers and clinicians. The first manual was published in 1996 and quickly spread both in the clinical-practical field and in psychodynamically oriented research in German speaking countries. The manual for the second version (OPD-2) was published in 2006 and is now in its third edition. OPD-2 has been translated into several languages: English, Spanish, Italian, French, Portuguese, Turkish, Czech, Hungarian, Romanian, Russian, and Chinese.

In addition to the central OPD manual and numerous research studies (including empirical validation), other supplementary writings have been published, such as OPD for substance abuse disorders, trauma-related disorders, and OPD in psychotherapy applications.

A working group of child and adolescent psychiatrists, child and adolescent psychotherapists, and developmental psychologists published a manual for Operationalized Psychodynamic Diagnosis in Childhood and Adolescence (OPD-KJ) in 2000, which is available in a second version in English (OPD-CA-2 Task Force, 2017).

Meanwhile, OPD represents a widely accepted standard in psychodynamic diagnostics for both clinical practice and research. It has also found a permanent place in psychodynamic/psychoanalytic training institutes. It is expected that OPD is to be taught in the new Psychotherapy Master's programs in Clinical Psychology, in Germany. This success story is partly due to a significant advantage that OPD has over other interview-based diagnostic systems: The OPD interview is conducted like a normal clinical conversation; it is not a structured interview where every question is pre-formulated and must be asked exactly as written to reliably assess the OPD axes. The OPD is therefore suitable for psychodynamic research and can be seamlessly integrated into any practice and clinical routine for accurate indication and treatment planning. As with the previous versions, a large group of psychodynamically oriented psychotherapists and researchers from the fields of psychoanalysis and psychodynamic psychotherapy, psychosomatic medicine, and psychiatry collaborated on OPD-3. This collaboration took place over many years, striving for innovations and the provisionally "best" result. We believe that the OPD-3 represents another significant step forward: The stronger dimensionalization has made the instrument even more suitable for research, and the stronger linkage of the axes allows a better representation of the clinically significant complexity of psychological processes. During the revision process, the OPD Working Group, and other groups, suffered a severe and unexpected loss: Manfred Cierpka passed away in December 2017. He had led the OPD Working Group for many years as a key initiator and spokesperson with wisdom, determination,

and foresight. The OPD Working Group is a fairly heterogeneous group, quite contentious and conflict-prone. It is largely thanks to Manfred Cierpka that this diverse group has been so productive and has repeatedly come together over the years. We will strive to develop the work further and continue with the OPD in this spirit.

Cord Benecke†, Kassel
Speaker of OPD Task Force

OPD Task Force – Members and Their Function Within the OPD Task Force

Spokesperson

Cord Benecke (Kassel)†

Members of the Coordinating Committee

Reiner W. Dahlbender (Barmelweid)
Stephan Doering (Wien)
Johannes C. Ehrenthal (Cologne)
Miriam Henkel (Kassel)
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Inge Seiffge-Krenke (Mainz)
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Michael Stasch (Heidelberg)
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Spokesperson until 12/31/2022:
Gerhard Schüßler (Innsbruck)
Spokesperson starting 01/01/2023:
Carsten Spitzer (Rostock)

Axis II
Henning Schauenburg (Heidelberg)

Axis III
Spokesperson until 12/31/2022:
Gerhard Schüßler (Innsbruck)
Spokesperson starting 01/01/2023:
Cord Benecke (Kassel)†

Axis IV
Stephan Doering (Wien)

Members of the Working Groups

Axis I
Markus Burgmer (Münster)
Reiner W. Dahlenbender (Barmelweid)
Isa Sammet (Göppingen)
Gerhard Schüßler (Innsbruck)
Carsten Spitzer (Rostock)

Axis II
Manfred Cierpka (Heidelberg)†
Ulrike Dinger-Ehrenthal (Düsseldorf)
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Claudia Oberbracht (Frankfurt a.M.)
Henning Schauenburg (Heidelberg)
Michael Stasch (Heidelberg)
Matthias von der Tann (London)

Axis III
Cord Benecke (Kassel)†
Markus Burgmer (Münster)
Reiner W. Dahlbender (Barmelweid)
Miriam Henkel (Kassel)
Gereon Heuft (Münster)
Gerhard Schüßler (Innsbruck)
Gudrun Schneider
Viktoriya Wörmann (Osnabrück)

Axis IV
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Michael Dümpelmann (Rosdorf)
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Sebastian Seifert (Dresden)
Claudia Subic-Wrana (Cologne)
Jana Volkert (Berlin)
Dorothea von Haebler (Berlin)

Authors Without Axes Affiliation

Valentina Albertini (Berlin)
Markus Bassler (Mainz)
Peer Briken (Hamburg)
Andreas Dieckmann (Berlin)
Lukas Forschner (Blankenheim)
Johanna Jedamzik (Münster)
Martin Lüdemann (Schlangenbad)
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Ole Karkov Østergård (Aalborg/Denmark)
Jan Odendiek (Möckern)
Silke Pless (Giessen)
Harald Sporn (Sprockhovel)
Darius C. Tabatabai (Berlin)
Klaus von Ploetz (Möser)

Authors Affiliated With Prior OPD Versions

Peter Buchheim
Manuela Burgmeier-Lohse
Susanne Davis-Osterkamp†
Barbara Dierse
Wolfram Ehlers
Matthias Franz
Harald J. Freyberger†
Gabriele Frevert
Tilman Grande
Karsten Hake
Sven Olaf Hoffmann
Paul L. Janssen
Peter Joraschky
Marianne Junghan
Reinholde Kriebel†
Elmar Mans
Stavros Mentzos†
Aribert Muhs
Gerd Rudolf
Ulrich Rüger
Wolfgang Schneider
Frank Schwarz
Günther H. Seidler
Michaela Strack
Bernhard Strauß
Manfred Tetzlaff
Jörn von Wietersheim

Translation

Henning Schauenburg (Coordination)
Johanna Behringer
Stephan Doering
Miriam Henkel
Florian Juen
Carsten Spitzer
Esther Stalujanis

ChatGPT 4 was used for a first English version, which was then thoroughly revised by the group.

All members of the OPD Task Force and their contact details can be found on the OPD website https://www.opd-online.net

1 Introduction and Theoretical Background

Psychodynamic diagnosis has a reputation of being unreliable, which is related to the high level of abstraction and complexity inherent to the underlying psychoanalytic concepts. Prior research has demonstrated that the diagnostic process, for instance is guided by strong stereotypes (Blaser, 1977), therapist personality play a role (Rudolf & Stille, 1984), or the inclusion of additional information can significantly impact diagnostic outcomes (e.g., Langer & Abelson, 1974).

In contemporary psychodynamic literature a differentiation of personality and the classification of mental disorders continue to be based on drive theory, with the incorporation of additional theoretical frameworks from ego psychology, object relations, and self-psychology (Shapiro, 1991). In the clinical context, these constructs are employed to elucidate psychological functions and their associated disorders. During the initial interview, for example, psychotherapists utilize these conceptual frameworks to organize the case history in order to shed light on the interrelationships between the patient's symptoms and disturbances in their emotional and cognitive development. A psychodynamic diagnosis is derived from the material reported by the patient and the observations and perceptions of the psychotherapist within their interaction. The differentiated assessment of transference/countertransference, conflict, and structural characteristics enables individualization in this process (Schüßler, 2002) and offers the advantage of describing patterns of patients and identifying information that guides action, such as that relevant for differential indication (cf. Rudolf et al., 1996). It should be noted that the determination of indication must also be considered a highly intersubjective process (Döll-Hentschker et al., 2006).

Nevertheless, this form of diagnosis is not without its own set of disadvantages: The diagnostic statements of analytical psychotherapists may be perceived by some critics as diagnoses formulated in "artistic freedom" (cf. Rudolf, 2001), which can impede the scientific discourse. For this reason, several instruments have been developed in recent years in parallel to the OPD – to operationalize psychoanalytic concepts (for overview see Section 1.1). Since 1996, the Manual for Operationalized Psychodynamic Diagnosis (OPD) by the OPD Task Force (1996; in the second version OPD-2 from 2008) has been available. The Manual presents three central psychodynamic axes "Interpersonal Relations," "Conflict," and "Structure." The OPD system allows for the formulation of clinically relevant and precise diagnoses that meet overall satisfactory quality criteria (see Section 1.3). The present OPD-3 represents a further development and refinement of both the diagnostic and therapeutic perspectives.

A further motivation for the formation of the OPD Task Force was with the recognition of shortcomings in the existing descriptive classification systems (DSM-III, -IV, and ICD-10). These systems offer limited guidance for psychotherapists with a psychodynamic orientation. They not only abandoned the concept of neurosis, but also adhered predominantly to phenomenological and biological concepts, which neglected the validity of diagnostic cate-

gories in favor of reliability (Schneider & Hoffmann, 1992). A diagnosis that is exclusively descriptive and symptom-centered provides the clinician with limited guidance for determining indications and for conducting psychotherapy. For instance, psychodynamically oriented therapists are deficient in statements regarding intrapsychic and interpersonal conflicts, the structural level, or the subjective illness concepts. With the assistance of these they establish a connection between symptomatology, the triggering conflicts, the patient's dysfunctional relationships, and their life history in the broadest sense, and therefore derive a concrete treatment strategy.

Consequently, the development of new psychiatric classification systems highlighted the necessity for a more unified instrument that would also consider other diagnostically relevant levels. In light of these considerations, an operationalized psychodynamic diagnosis should aim to capture and encompass observation-based psychodynamic constructs as an additional component to phenomenological diagnostics.

In the early 1990s, the OPD Task Force was founded by a group of psychoanalysts, psychosomatic clinicians, and psychiatrists in Germany. The objective of this task force is to expand the symptomatically descriptive classification of mental disorders to include fundamental psychodynamic dimensions.

The OPD Task Force developed a diagnostic inventory and provided a manual (OPD-1, published in 1996; a revised version, OPD-2, followed in 2008) for training and clinical application. The multiaxial psychodynamic diagnosis was based on five axes, as follows:

Axis I: Mental Disorders, Experience of Illness, and Prerequisites for Treatment
Axis II: Interpersonal Relations
Axis III: Conflict
Axis IV: Structure
Axis V: Mental and Psychosomatic Disorders according to ICD-10

In the OPD-3, the classificatory diagnoses (formerly designated as Axis V in OPD-1 and OPD-2) have been eliminated from their own axis and are now recorded at the beginning of Axis I. Additionally, it was deemed inappropriate to categorize ICD or DSM as a sub-aspect of OPD. Nevertheless, it is evident that syndromal diagnostics remain a fundamental aspect of the diagnostic process. Accordingly, it is now situated before the entirety of the OPD. The OPD axes then serve to elucidate the etiology of the symptomatology.

Following an initial interview of between one and two hours of duration, the clinician (or an external observer) is then able to assess the patient's psychodynamics based on the OPD categories and record this assessment in the evaluation forms. The use of an interview guideline facilitates the acquisition of information pertinent to the diagnostic process within the OPD framework. In contrast to other diagnostic systems, such as the Structured Interview for Personality Organization (STIPO, German abbreviation for "Strukturiertes Interview zur Persönlichkeitsorganisation"), Scales of Psychological Competencies (SPK, German abbreviation for "Skalen Psychischer Kompetenzen"), Reflective Functioning (RF), which necessitate a highly structured and standardized interview format, the OPD interview guideline is designed to be flexible, allowing for the conduct of the interview in a manner that closely resembles a typical open psychodynamic interview. This better enables the OPD to be employed in non-research settings and renders it considerably more practice-oriented than numerous other instruments.

As a foundational premise for the development of the OPD, it was established that a clinically relevant psychodynamically oriented instrument should be created, taking into account and adapting existing approaches. This instrument should be sufficiently abstract to facilitate its use while remaining situated between pure behavioral description and pure metapsychological conceptualization.

arately. A systematic recording of (dysfunctional) relationship patterns is not found in the instruments mentioned above, this has been operationalized and made assessable in separate concepts, such as the Cyclic Maladaptive Pattern (CMP, Strupp & Binder, 1984) in combination with the Structural Analysis of Social Behavior (SASB, Benjamin, 1974) for psychodynamic psychotherapy (see also Tress, 1993; Benjamin, 1993). The OPD devotes a separate axis to this clinically important level: Axis II (Interpersonal Relations).

1.2 The Concept of Operationalized Psychodynamic Diagnosis (OPD)

The OPD-3 consists of four psychodynamic axes:

I. Mental Disorders, Experience of Illness, and Prerequisites for Treatment
II. Interpersonal Relations
III. Conflict
IV. Structure

The four axes are based on a psychodynamic understanding derived from psychoanalytic theories. We assume that the essential determinations in these four axes correspond to underlying concepts (personality structure, intrapsychic conflict, transference, defense, resistance), and that conclusions at the level of the unconscious are drawn only with caution and with reference to the given operationalizations.

Why these axes?

For *Axis I, the Mental Disorders, Experience of Illness, and Prerequisites for Treatment*, the obvious practical relevance of the categories (rather borrowed from cognitive psychology) spoke in favor: Patients must be "met where they are and where they expect to be" – that is, in terms of symptomatology and expectations of therapy. The focus here is less on illness behavior and more on elements of experience, motivation, and available resources and obstacles. These levels are well researched in psychology and relatively easy to operationalize.

Axis II, Interpersonal Relations is partly rooted in psychodynamic diagnostics, which is always also relationship diagnostics, and which gives crucial weight to the interplay of transference and countertransference. This axis does not prescribe ideal-typical constellations or patterns (unlike Axis III and IV) but provides a category system of observation-based behaviors with multiple possibilities of combinations. Although the axis is designed in analogy to interpersonal circle models (particularly the SASB, Benjamin, 1974; Tress, 1993), it clearly goes beyond them by explicitly capturing countertransference aspects and linking them to the patients' experiences.

Axis III, Conflict asserts to the implementation of a fundamental tenet of piece of traditional psychoanalytic diagnostics, the pivotal role of internalized conflicts. The conceptualization of conflicts is anchored in universal motivational systems. Seven conflicts are delineated, each with a passive and an active coping mode. Here, life-determining, internalized conflicts are juxtaposed with more current, externally determined conflictual situations. The resolution of such an internalized conflict can be defined as a treatment goal.

Axis IV, Structure represents qualities or deficiencies in psychic functioning. The structural functions can be understood as fundamental psychic abilities. Such functions include, for example, the capacity for internal and external differentiation, the ability to perceive and regulate one's mental states and so forth. The availability of these structural functions has a significant impact on the manifestations and ways of dealing with internal and external conflicts. The assessment of the structural axis has a decisive influence on the determination of the indication.

Upon examination of the axes, it becomes evident that they exhibit some degree of content overlap or are to be perceived as being in closely related interaction with one another.

2 Axis I: Mental Disorders, Experience of Illness, and Prerequisites for Treatment

2.1 Summarized Presentation of Axis I

As an initial step for psychodynamic diagnostics, Axis I comprises the assessment of the mental disorders, the current subjective experience of illness and the prerequisites for psychotherapy.

For the indication and implementation of psychotherapeutic or psychiatric/psychosomatic treatment, the type of symptoms, the externally assessed severity of the disorder, and the patient's subjective experience of illness and treatment prerequisites are crucial.

This is an external assessment, i.e., an objective evaluation of the subjective information provided by the patient. Descriptive diagnostics according to ICD-10/1 or DSM-5, previously depicted in Axis V of the OPD, are integrated into Axis I in the present version to emphasize the necessity of accurately capturing psychopathological phenomena. Patients seek help due to complaints and symptoms, and these should be systematically recorded. The course and severity of the mental and/or somatic disorder, along with their consequences, are also assessed. Furthermore, subjective illness concepts and subjective change and treatment concepts are interrelated and influence each other mutually. These include a somatic illness concept, an external oriented illness concept with emphasis on social and/or alternative dimensions. Furthermore, an internal illness concept captures the extent to which the patient acknowledges mental and interpersonal aspects in the development of their disorder.

These subjective illness concepts lead to subjective change concepts, which essentially drive the motivation concerning the chosen treatment. The assessment and consideration of these areas of motivation must be taken into account before treatment and during subsequent therapy as they influence compliance/adherence. The change resources include the level of distress and coping resources, current psychosocial support, and openness to a psychosocial genesis of the complaints and problems.

External and internal impediments to change can oppose treatment, both in outpatient and inpatient settings. These include fears of negative social consequences. Internal impediments to change and treatment are described as conscious and unconscious resistance phenomena against change and treatment. Additionally, a distinction is made between primary and secondary gain from illness.

If there is an indication for the application of a psychotherapeutic procedure and sufficient motivation for its implementation/realization, it is helpful to understand what therapeutic activities the patient expects to achieve their goal: The primary focus is usually the desire to reduce psycho/somatic symptoms. Additionally, many patients find it important to understand

Table 7. Symptom level scores and anchor descriptions for the socially oriented illness concept *(continued)*

Level	Feature expressions	Anchor examples
Level 2 Moderately present	This level is chosen when the patient can identify external factors as causes for their complaints, but these do not stand out prominently or are accompanied by uncertainty, and/or the patient fluctuates in the certainty regarding external social stressors.	**Example 1:** A patient, besides recognizing his biological vulnerability for recurrent depression, can also identify external factors as equally significant. He suspects that the current depressive episode may have been triggered by his separation from his wife and moving out of their shared home. **Example 2:** A patient is not yet sure about her illness concept. With the help of the examiner, social-external factors (e.g., job loss) can be identified and acknowledged. However, she remains uncertain about their significance.
Level 4 Very highly present	This level is chosen when the patient is confident that external social factors have caused their illness. It is without doubt for them that other people or "circumstances" are to blame for their illness.	**Example 1:** A patient reports complete chronic exhaustion that developed since the imminent bankruptcy of his company. Since employees were laid off, his supervisor has been giving him more work, which can only be managed with a 13-hour workday. This is the cause of his illness. **Example 2:** A 50-year-old patient shamefully reports physical abuse by a family member during her childhood and adolescence, which only ended after her suicide attempt at the age of 17 and blames her parents for the fact that she cannot sustain a lasting partnership.

Alternative Illness Concepts

This feature/item/symptom covers the extent to which the patient currently has a subjective understanding of their illness that focuses on alternative disease concepts. The term "alternative" refers to ideas of the patient that cannot be assigned to either a somatogenic, a sociogenetic or a psychogenetic understanding of illness. In the patient's description of their complaints, the causes of their illness, and their treatment ideas, it becomes clear that they attribute their suffering to such alternative reasons. Patients may develop a variety of alternative disease concepts, such as esoteric concepts ("moon phases") or magical-fatalistic beliefs ("fate," "bewitched"), often accompanied by pronounced self-neglect and resignation: "There's nothing I can do!" (Table 8).

2.6.3 Intrapsychic Illness Concept

This feature/item/symptom maps the extent to which the patient currently has a subjective understanding of their illness that focuses on their own mental and interpersonal aspects. The aim is to determine the extent to which the patient recognizes their complaints (e.g., depression, anxiety, sleep disturbances, pain) and problems (e.g., emotional conflicts, interpersonal conflicts) in relation to their own intrapsychic experience and interpersonal behavior. The causes of the complaints and problems are located within themselves, their own experiences and behavior, not externally. Although a patient may report that external social factors (e.g., marriage, childbirth, workplace restructuring, retirement) have served as triggers, they view the illness as rooted in their inadequate internal emotional and cognitive handling of these external social factors. Regardless of external triggers, the patient attributes their disorder to their own interpersonal vulnerability: "Others wouldn't have problems in this situation; I get sick because I can't handle ..." (Table 9).

3 Axis II: Interpersonal Relations

3.1 Summarized Presentation of Axis II

Disturbances in interpersonal relationships occur in many mental disorders. Since these impairments often have repetitive relationship patterns, their identification is crucial for psychotherapy. This is particularly important because such relationship patterns often shape the therapeutic contact from the beginning and become the subject of therapeutic work to varying degrees.

The goal of OPD relationship diagnosis is to identify the repetitive dysfunctional relationship pattern of a patient as well as relevant aspects of transference and countertransference. Dysfunctional relationship patterns can be understood as specific interpersonal constellations in which a patient's behaviors intertwine with those of their interaction partners into a repetitive pattern. The procedure primarily focuses on the dysfunctional aspects of repetitive relationship formations. These constellations can be described from the perspective of the patient's experience and from the experience of others (their interaction partners); from each of these perspectives, both the behaviors of the patients and those of their interaction partners can be considered. These distinctions result in four analytical units called *interpersonal perspectives:*

1. How the patient experiences others: This is about the relationship behavior that the patient repeatedly experiences and possibly complains about with their interaction partners.
2. How the patient experiences themselves: The focus here is on the patient's relational behavior. It describes the interpersonal behavior that the patient repeatedly experiences and consistently portrays in their relationship descriptions.
3. How others repeatedly experience the patient: This captures how others (including the examiner) repeatedly experience the patient. This perspective usually captures more than what the patients themselves can describe, i.e. also the unconscious aspects of their (difficult) relationship offer.
4. How others repeatedly experience themselves in relation to the patient: Here we record which reactions the patient induces in the other person in the sense of a role offer (unconsciously suggested response). This element corresponds to the procedure of psychoanalytic countertransference diagnostics (for comparison, see Mertens, 2004a; Thomä & Kächele, 2006a)

These four interpersonal perspectives are "filled" based on the narratives of subjects or patients. The item lists shown below are used for this purpose. The item lists are available in two versions (see Figure 4 and Figure 5). The clinical version consists of the respective experience/behavior descriptions in a graded format (unremarkable, i.e., not clinically relevant, accentuated, dysfunctional). Each item can be rated individually; however, in clinical practice, ratings may be limited to the most prominent items. The research version is identical to the clinical version in terms of item formulations.

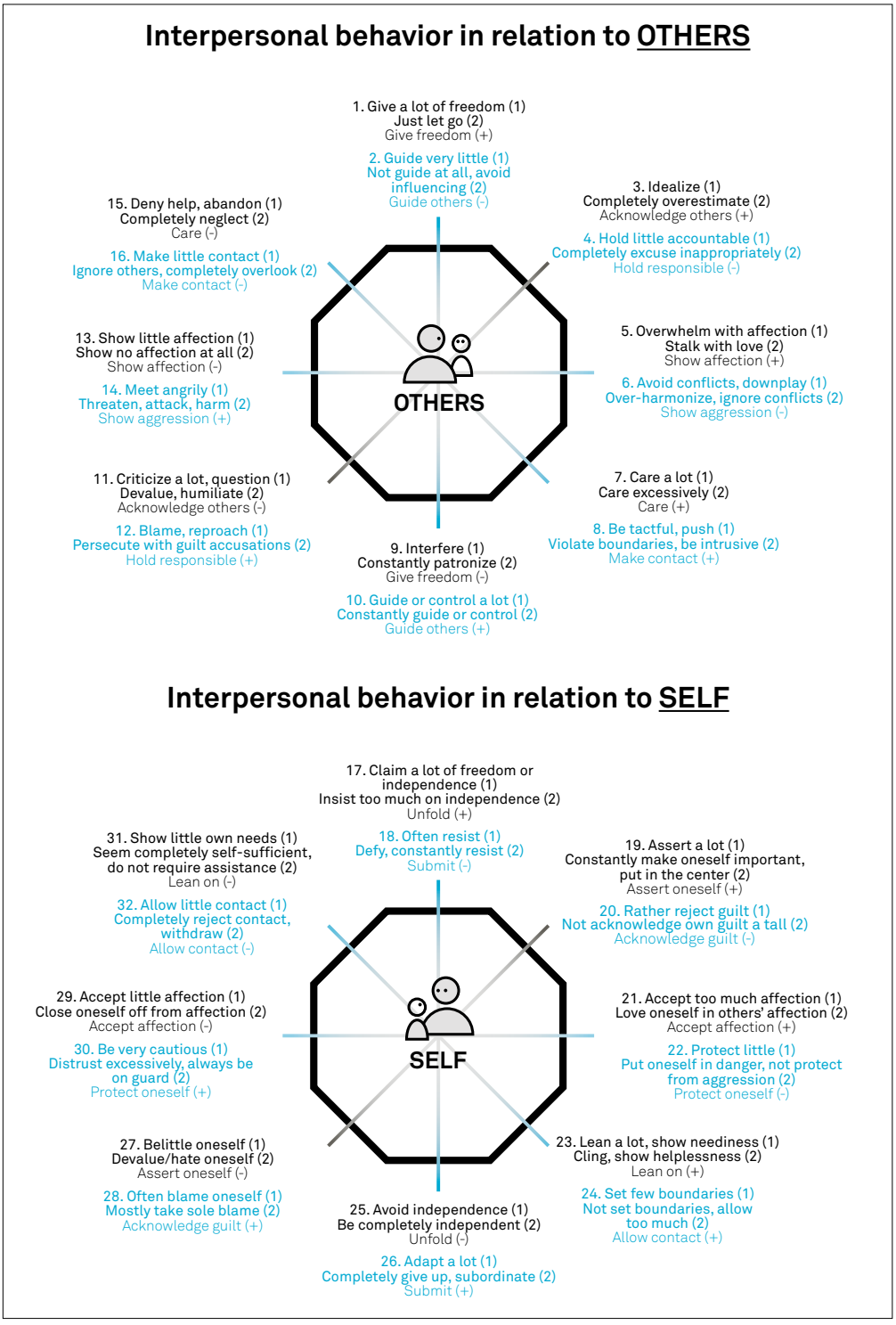


Figure 2. Circumplex model of OPD-3 Axis II. Design by Ludwig Wendt.

patient and respond interactively from their perspective. Since this can be challenging in practice, working with case vignettes on training or supervision videos might serve as a methodological "bridge" to assess the countertransference behavior of the interviewer as a basis for the suggested relationship response. Pragmatically, it often succeeds in examining one's own experience, especially one's own impulses for action, in the encounter with the patient (as a clinician or video viewer) and accounting for the impulses and feelings that the patient evokes in us. Finally, an attempt is made to align one's own experience with the ideas about the experiences of others regarding the patients. If this is done coherently, the identification of characteristic features of the dysfunctional pattern has likely succeeded. If not, further clarification is necessary: the examiner must then check whether they have possibly overlooked important aspects of the patient's relationship offer or in what specific way the patient distorts their relationships, so that the discrepancy can be explained as a result of such misperceptions.

The Interpersonal Perspectives

Dysfunctional relationship patterns are presented as specific constellations of interpersonal behaviors a) of the patient and b) of the others (their objects). This applies to both experiential perspectives, so four interpersonal perspectives can be distinguished (Figure 3).

Patient's experiential perspective:

- The patient repeatedly experiences others in such a way that they …
  Here, the focus is on the behaviors of the objects towards the patients, as they are more or less consistently experienced and described by the patients.
- The patient repeatedly experiences themselves in such a way that they (others or towards others) …
  Here, the focus is on the interpersonal experience and behavior of the patients themselves. Described are those behaviors that appear dominant and consistently effective in the self-experience of the patients. This

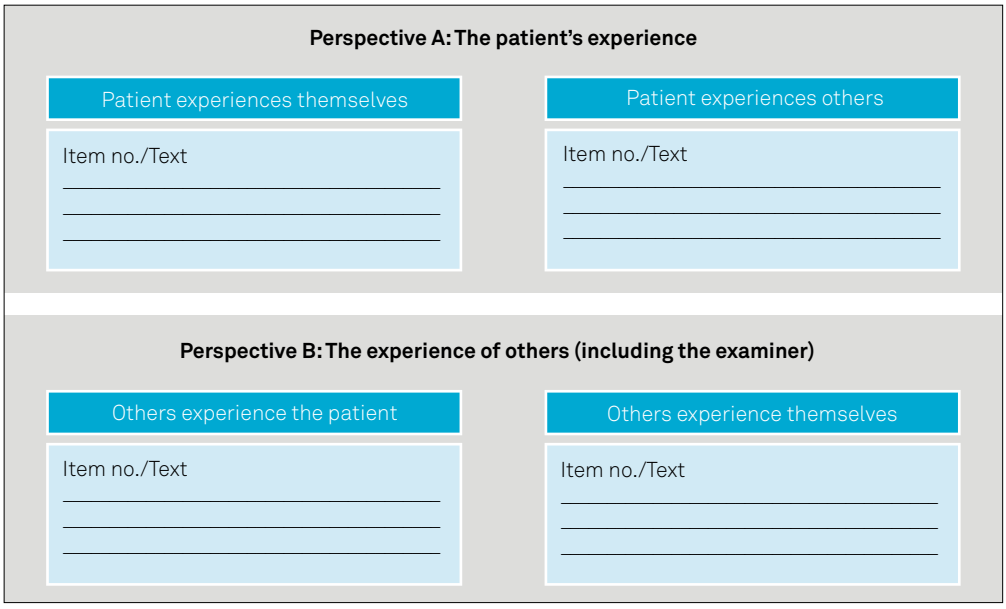
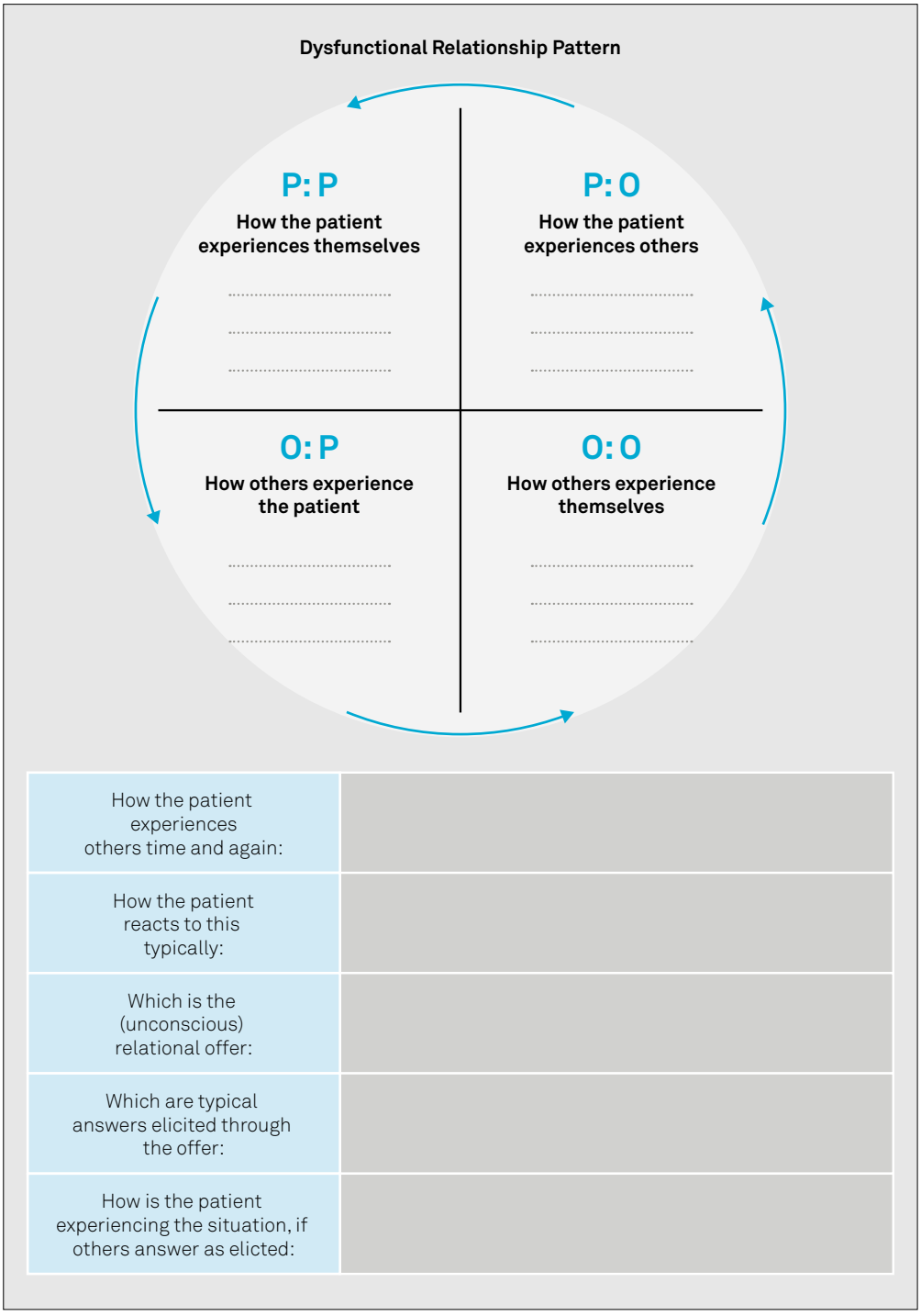


Figure 3. The four interpersonal perspectives.



How the patient experiences others time and again:	
How the patient reacts to this typically:	
Which is the (unconscious) relational offer:	
Which are typical answers elicited through the offer:	
How is the patient experiencing the situation, if others answer as elicted:	

Figure 6. OPD-3 evaluation sheet Axis II: Dysfunctional relationship patterns; with the four interpersonal perspectives, the relation between perspectives (curved arrows), and empty fields for relationship dynamic formulation.

4 Axis III: Conflict

4.1 Summarized Presentation of Axis III

Unconscious conflicts play a central role within psychodynamic understanding. Conflicts involve the clash of opposing positions, the encounter of motives, desires, needs, values, and ideas. Beyond cognitive dissonances the concept of conflicts introduced here addresses unconscious conflicts, which Freud described as the causal factor of neurosis.

What is at the basis of each conception of conflict is the question of psychodynamics ("What moves the soul"). For Freud, this was drive theory.

Advanced conflict psychology is based on psychodynamic motivation and emotion theory: Each conflict starts as an external one (i.e., rooted in an individual's early life history) and becomes internalized over time. It is thus transformed into an intrapsychic conflict theme, which can significantly and persistently influence mental processes. Conflicts represent a cognitive procedural-affective schema of the self and of the relationship with others, activated by external situational factors. The basic human needs (need for attachment, need for safety and control, need for autonomy or individuation, need for self-assertion and exploration, need for sensual pleasure and sexual arousal, need for self-esteem and need for striving, need for identity and meaning in life) all find their way into the description of Conflicts as defined in the OPD:

C1 Dependency vs. Individuation
C2 Submission vs. Control
C3 In Need of Care vs. Self-Sufficiency
C4 Self-Worth Conflict (Self-Worth vs. Object-Worth)
C5 Guilt Conflict (Prosocial Conscience vs. Self-Centered Motives)
C6 Oedipal Conflict
C7 Identity Conflict
C0 Repressed Conflict and Emotion Awareness

Conflicts C1–C7 follow the basic needs, while C0 describes the overarching repression/denial of conflicts and associated affects rather than a motivational system. Conflicts are conceived and structured along the lines of three core elements: the desire (impulse), the associated signal anxiety, and the defense mechanism, which emerges over the course of a person's life in a person's life story as expressed through current problems and transference.

Identifying psychodynamic (unconscious) conflicts requires inductive and deductive approaches. Inductive means using observable phenomena, and recurrent patterns of living and behaving as starting points. Deductive involves the patient's efforts to adaptively/maladaptively resolve conflicts in their life history. Along these lines, four central components for capturing the conflict theme are defined:

1. The repetitive (dys-)functional motivational pattern
2. Core and leading affects (with core affects referring to affective states that are defended against, while leading affects are defined as the typical or frequently occurring, primarily conscious affects, that are present feelings in each conflict mode)

both themselves and others, as a matter of course which typically is not given much thought.

If, because of specific life experiences, a motivational theme gains a particular inner-psychic conflictual significance, then this theme is easily activated and mobilizes corresponding coping strategies (defenses). The way in which the conflictual-motivational theme or the conflict dynamics manifests itself in experience and behavior depends, on the one hand, on the (active or passive) coping mode, and on the other hand, on the fundamental level of structural integration of the person.

This conflict dynamic is presented in the field of tension of the respective motivational theme (in the following figure, Self-Worth) and on three levels (Figure 8): conflict tension (upper pole, well-integrated structure), neurotic conflict (moderately integrated structure), and conflict schema (lower structural level).

At a high level of structural integration, the respective theme is present and generates a noticeable conflict tension, in that a somewhat accentuated desire for recognition and appreciation becomes apparent, as well as a tendency toward slight arrogance (active mode) or questioning oneself (passive mode). However, these tendencies can be reflected on and regulated through intrapsychic processes, so they rarely lead to interpersonal problems or critical drops in self-worth. Clinically, this theme may become relevant under significant stress, such as the loss of previous sources of gratification.

In the case of a neurotic conflict (at a moderate level of structural integration), the self-worth theme repeatedly dominates both internal and external experiences: the psyche constantly revolves around the "question of worth," and this question permeates all areas of life and relationships. The modes (passive: self-devaluation and admiration of others; or active: self-aggrandizement and devaluation of others) shape experience and relationships and can be reflected on little or not at all. In a triggering situation, the repetitive-dysfunctional conflict patterns of experience and behavior can

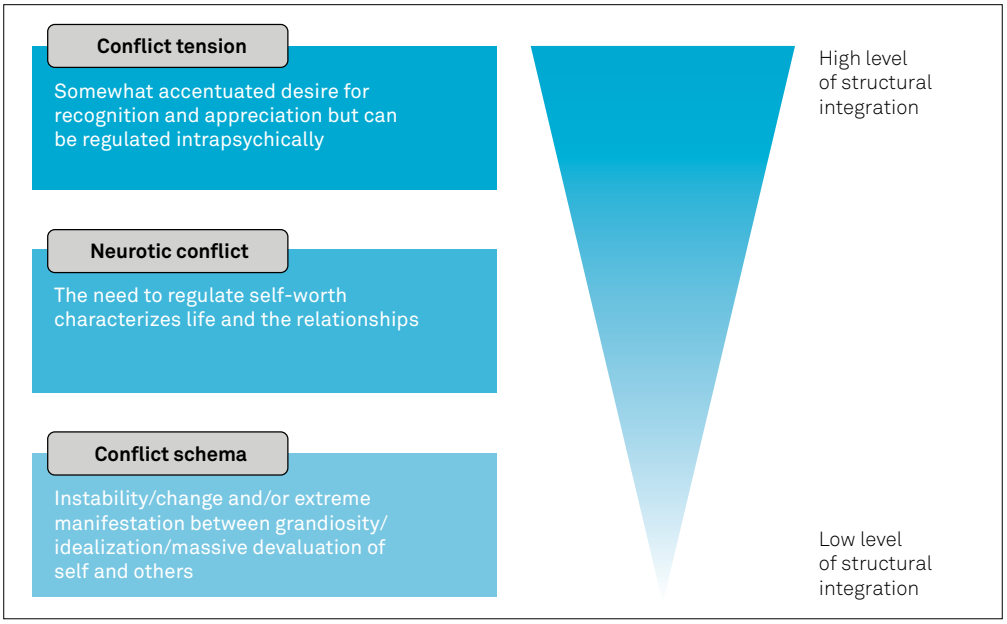


Figure 8. Manifestations of the conflict dynamic "Self-Worth" at varying levels of structural integration.

pressed in the active mode, or selfish aggression/aggressive (moralistic) self-accusations in the passive mode. In the passive mode, lead affects include (self-)blame, fear of punishment, and sadness. The fear of punishment is unconsciously fueled by forbidden selfish impulses. In the active mode, guilt projection, anger (when blamed), and selfish greed are prominent.

3. Triggering Situations: Biographically, recurring situations of temptation and deprivation related to prosocial and egoistic tendencies are expected, with strong socio-cultural influences (e.g., religious socialization vs. exploitative or "rising star" mentality). Trigger situations for psychological symptoms arise when the suppressed side is activated, and the usual defense fails. In the passive mode, this might also include situations that activate aggressive-egoistic tendencies to the point where they can no longer be suppressed, resulting in heightened feelings of guilt. In active mode, situations in which egoistic tendencies fail can lead to increased exploitative behavior (up to disorder levels), or instances in which repressed guilt "seeps through."
4. Transference and Countertransference Dynamics: In the passive mode, prosocial, self-blaming relationships (including toward the clinician) become evident, although underlying egoistic guilt-avoidant tendencies may be present. In countertransference, compassion, overcautiousness, and efforts to counter the patient's self-blame often emerge, sometimes mixed with aggressive impulses. In the active mode (guilt avoidance), responsibility (guilt) is quickly projected onto others (including the clinician), with predominantly aggressive-cynical defensiveness and justification. Countertransference may include impulses to judge and confront the person quickly or wish them illness (punishment).

General Description of the Coping Modes of C5

Passive Mode

In the passive mode, feelings of guilt are experienced, the guilt is compensated for by self-generated or often only expected punishment and guilt. People tend to reproach themselves because they feel they have done too little or failed in their dealings with their group, institutions or society (church, God, etc.). Subtly perceptible egoistic tendencies are warded off and transformed into hypersociality, e.g., by means of reaction formation. Moralistic aggression is more accessible to experience and is used towards people who do not share the same ideas, laws and rules, but "acting it out" usually also directly triggers feelings of guilt.

Active Mode

In active mode, feelings of guilt are warded off, e.g., denied or projected onto other people. Egoistic tendencies determine behavior. Prosocial tendencies are warded off to be able to pursue one's own benefit and advantage to the point of boundless self-interest "regardless of guilt and responsibility."

The selfish, irresponsible behavior triggers rejection in the other person.

Manifestations of the Conflict Guilt at Different Levels of Structural Integration

The theme of prosocial vs. egoistic tendencies manifests across different structural levels in a continuum with fluid transitions (Figure 13; Table 30).

Conflict tension describes a flexible and adaptive expression of the desire for prosocial vs. egoistic tendencies, with a personal empha-

Table 30. Characteristics of C5 on various structural integration levels

Characteristics of C5 at different levels of structural integration	
C5: Characteristics of conflict tension	
(A) Conflict tension in passive mode In the balance between prosocial vs. egoistic tendencies, the desire for prosocial behavior predominates. This tendency can lead to a defense against egoistic motives. Feelings of guilt are easily triggered and activate reparation. As a rule, however, there are no critical or persistent and clinically relevant episodes. In critical situations, however, guilt can certainly take on the character of suffering.	**(A) Conflict tension in active mode** There is a predominance of self-centered self-interest with a tendency to blame others for being free from remorse. Egoistic tendencies are easily activated but can also be withdrawn again depending on the situation, so that this does not usually lead to greater restrictions and interpersonal problems.
C5: Characteristics of the neurotic conflict	
(B) Neurotic conflict in passive mode In the neurotic passive mode, the relationship is characterized by strong prosocial behavior with a predominance of assumption of guilt and defense against egoistic motives. Self-interest triggers feelings of guilt or is transformed into reactive prosociality. These people take on guilt in an exaggerated manner. The interactions are characterized by self-blame. In the countertransference, compassion can arise and the desire to work against the patient's self-blame. If this fails, punitive-aggressive impulses can sometimes be felt.	**(B) Neurotic conflict in active mode** When the active mode predominates, the relationship is characterized by egoistic-aggressive behavior, with a defense against prosocial motives and a predominant defense against guilt (either – or). These people pursue their personal advantages selfishly and, if necessary, aggressively ("regardless of guilt and responsibility"). Feelings of guilt are warded off, denied and transferred to others. The behavior and experience serve to avoid fear and (unconscious) feelings of guilt. In the transference or interaction, the other person is very quickly blamed. In the countertransference, impulses of condemnation and confrontation arise in the therapist. Sometimes there is also a tendency to feel guilty by proxy.
C5: Characteristics of the conflict schema	
A pronounced instability/fluctuation depending on the situation and experience applies to the conflicts with a rather low level of structure, so that dysfunctional experience/behavior can appear both exaggerated and diffuse. As the different motivational systems can be addressed alternately and a conflict issue can fluctuate between active and passive attempts to cope, the conflict issues can often only be recognized incidentally. However, there are also rigid fixations of passive or active modes.	
(C) Conflict schema in passive mode The massive feelings of guilt, which are inappropriate to the situation/reality, occur even on insignificant, real or fantasized occasions and lead to destructive self-accusation. The inner value system (conscience, superego) is destructive but fragile and requires external stabilization. Internalized conscience values can replace each other. If this mode is rigid, self-punishing behavior usually manifests itself. The destructive feeling of guilt can be completely hidden and switched off in other situations.	**(C) Conflict pattern in active mode** There are excessively egotistical aspirations up to and including aggressive greed and exploitation ("Only me and everything for me!"). The experience of guilt is often completely suppressed (or not possible), so that behavior patterns that are harmful to others (but also self-harming) are frequent. The subjective values (conscience and superego) only follow the subjective benefit. If this mode is blocked, anti-social behavior usually manifests itself. It can, albeit rarely, lead to the onset of violent or even self-destructive guilt behavior. This, in turn, is usually warded off by destructive behavior.
In people with a disintegrated structural level, even more extreme compensation mechanisms are possible, sometimes involving a reinterpretation of reality (see Section 4.4).	

5 Axis IV: Structure

5.1 Summarized Presentation of Axis IV

Structure represents the basic framework of personality – the more constant traits and responses, the intrapsychic and interpersonal competencies. It is less about individual coloring and more about the basic abilities and dispositions that usually provide regulatory functions. Structure becomes visible in the way one deals with oneself, with relationships, and with the world, so that diagnostically relevant information is found mostly in challenging situations (under stress) and mostly in the interpersonal realm (including the clinical examination itself). Axis IV comprises five dimensions, four of which are divided into sub-dimensions related to the self and objects/relationships, respectively. Only the third dimension, "Defense," spans both areas as it (almost) always combines intrapsychic and interpersonal aspects.

The five dimensions are:

1. Perception
2. Regulation
3. Defense
4. Communication
5. Attachment

Each of the dimensions, except for defense, contains 2 × 3 facets, with defense having 1 × 3, which are rated on a seven-point scale and represent the smallest units of the rating (a total of 27 facets in 9 domains). The maturity or integration of the structure ranges from "good" (1) through "moderate" (2) to "low" (3) and "disintegrated" (4). The OPD-3 structure rating allows for the capture of clinically relevant temporal variability (e.g., due to episodes of illness) as well as divergent structural levels in different areas of life (e.g., in psychosis or trauma-related disorders).

Axis IV is closely related to the new conceptions of personality function in DSM-5 (American Psychiatric Association, 2013) as well as the severity determination in personality disorders of ICD-11 (Blüml & Doering, 2021; Hörz-Sagstetter et al., 2021). This is not surprising, as the as the new alternative model for personality disorders draw on psychoanalytic models of structure or personality organization. Thus, Axis IV can easily be used for personality diagnostics from a descriptive-phenomenological perspective, even though it conceptually and in terms of its content breadth goes far beyond that.

5.2 What Is Structure?

5.2.1 Definition

Structure encompasses the fundamental abilities of personality to deal with oneself, relationships, and others in a complex and appropriate manner. It does not capture the contents of experiences, thoughts, and actions but their prerequisites. Structure can be developmentally impaired, which forms the basis for a variety of mental disorders, known as structural disorders, and is of utmost importance for personality disorders. Structural disorders can occur in a variety of mental disorders; conversely, a well-integrated structure is a protective factor for mental health.

Table 41. Overview of the dimensions and facets of structure

Self		Object/relationships	
Self-perception		**Object perception**	
ST1.1	Self-reflection	ST1.4	Self-object differentiation
ST1.2	Affect differentiation	ST1.5	Object related affect differentiation
ST1.3	Identity	ST1.6	Integrated object perception
Self-regulation		**Relationship regulation**	
ST2.1	Impulse control	ST2.4	Protecting relationships
ST2.2	Affect tolerance	ST2.5	Anticipation
ST2.3	Self-esteem regulation	ST2.6	Balancing of interests
Defense			
ST3.1 Living and experiencing possibilities			
ST3.2 Interpersonal impact			
ST3.3 Mechanisms			
Internal communication		**Communication with the external world**	
ST4.1	Experience of affects and fantasies	ST4.4	Making emotional contact
ST4.2	Experience of joy	ST4.5	Intimacy
ST4.3	Bodily self	ST4.6	Empathy
Attachment to internal objects		**Attachment to external objects**	
ST5.1	Internalization	ST5.4	Ability to form attachments
ST5.2	Use of introjects	ST5.5	Trust
ST5.3	Variability	ST5.6	Ability to separate

Note. ST = structure.

one pole into the unconscious and thus withdrawing it from life and ongoing consciousness. Relationship behavior is usually characterized by defense mechanisms (moderately integrated level) or is a direct expression of defense (low/disintegrated level). Of course, the experience of illness and expectations of treatment are also shaped by defense mechanisms. Thus, defense essentially influences and shapes all axes of the OPD-3. This omnipresence of defense and the fact that it is so difficult to objectify because it is never seen directly, but only its results, can be seen as the reason for the traditionally volatile fate of the operationalization of defense. In OPD itself, it was a distinct structural dimension in OPD-1, then seemingly disappeared from OPD-2, only to reappear implicitly in individual structural facets – most prominently in the "Protecting relationships" facet, where it at least appeared in parentheses. It has now returned to OPD-3 as its own dimension and, as in OPD-1, is ranked third among the dimensions. Defense mechanisms have had a similar fate in the DSM: they were included in DSM-IV as the "Defense Mechanisms and Coping Styles Scale" in the Appendix for further research but are absent in DSM-5 because this scale was barely researched and did not make it into the "Personality Functioning Scale." OPD-3 now gives defense as a central ego function a place as its own dimension on Axis IV, recognizing that defense is more than just a structural feature. It has deliberately not been assigned to another structural dimension as a separate facet, as it permeates all structural dimensions. It is strategically located in the middle of Axis IV,

Table 43. Operationalization of self-reflection (ST1.1 in Table 41)

1 Good	1.5	2 Moderate	2.5	3 Low	3.5	4 Disintegrated
The ability to focus on oneself is available. It is possible to realistically recognize what kind of person one is and what is going on inside oneself. This can be conceptualized. Feedback from others is included, relativized or rejected in an appropriate manner. This often leads to new insights.	The ability to focus on oneself and to perceive oneself authentically is generally present, but at times (under pressure) impaired. Terms are only available to a limited extent at times. Abstract attributions rather than vivid situations are described. If something is questioned by another person, irritation arises, but this can usually be resolved.	The ability to self-reflect is limited and inflexibly follows the same paths. It is primarily focused on the acting self (what the person has said and done). The self-image appears less differentiated, but coherent. It is difficult to find appropriate linguistic terms. The person reacts to the other person's relativizing remarks with offence, incomprehension or withdrawal.	Self-reflection is often not possible under stress (emotional situations, criticism). Only under favorable conditions or with support the acting self can be reflected upon and a coherent, albeit less differentiated self-image can be created. With empathic support and suggestions from the other person, the self-image can become clearer and more comprehensible, while critical feedback can significantly increase instability.	Self-reflective perception is hardly possible; even with support, the person cannot create a coherent picture of themselves and their inner situation; contradictory aspects of the self are juxtaposed. No terms for inner processes or drastic and incomprehensible descriptions of affective states and situations. Interest can be interpreted as an attack. Critical feedback leads to massive self-deprecation, uncritical acceptance or is completely rejected.	Self-reflective perception is severely impaired and threatens the coherence of the self. Affective flooding or levelling can occur. Rudimentary aspects of the self exist, but cannot be connected with each other. Reflection of the acting self is only possible under supportive conditions. Feedback remains inconsequential or provokes violent defense reactions. Alternatively, they lead to fundamental questioning or loss of integration of the self.	Attempts at self-reflection are avoided or can lead to affective overload. There is no coherence of the self. The inner and outer world cannot be distinguished, the self can no longer be recognized as distinct. In extreme cases, it is no longer possible to reflect on the authorship of the self. Feedback comes to nothing or reinforces the fragmentation of the self.

		Good integration	With increasing impairment ...
Core sentences	**Self-reflection**	Good self-reflection (mental and physical aspects).	less differentiated self-image and body image, contradictory self-aspects unconnected, some self-aspects alienatingly in the foreground, up to a complete lack of reflection on the self as author.
	Feedback	Feedback is used appropriately.	defense against feedback, increasing collapse in self-image up to complete ignoring/blanking out.

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