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BOOK DETAILS

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Freud's diagnostic explorations served to exclude somatic illness or psychosis. The founder of psychoanalysis never hesitated to take on seriously ill patients. As soon as the elementary preconditions had been satisfied and questions of payment and appointments were settled, the fundamental rule was explained and the analysis began. Then as now, general psychosocial factors such as education, age, and motivation

were highly relevant. Freud did not take a detailed history until the first phase of treatment; his preliminary interview was brief, as can be seen in the case of the Rat Man (1909d, p. 158). The problem of diagnosis and resulting selection first arose when demand began to outstrip supply, as Fenichel reported about the clinic of the Berlin Psychoanalytic Institute (Fenichel 1930, p. 13).

However by and large the psychoanalytic profession only reluctantly dealt with issues of elaborated diagnostics, even when over the years the nosologic system was adopted from psychiatry. On the other hand the influences of psychodynamic thinking on psychiatry were perceptible as early as the 1930s. The individual steps have been traced by Gill et al. (1954), whose important contribution is the definition of the psychodynamic interview technique. They contrast the traditional psychiatric exploration with the "dynamic interview“. In the course of the 1950s, numerous different psychodynamically oriented interview strategies were developed by psychoanalysts working within dynamic psychiatry.

Kernberg's "structural interview" (1981) was a good example of the second generation of psychoanalytically oriented psychiatric initial interviews following in the tradition of psychodynamic interviewing. He relates the history of the patient's personal illness and his general psychic functioning directly to his interaction with the diagnostician. The main goal is clarification of the integration of ego identity or identity diffusion, the quality of the defense mechanisms, and the presence or absence of the capacity for reality testing. This permits the differentiation of personality structure into neuroses, borderline personalities, functional (endogenous) psychoses, and organically determined psychoses. He is

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particularly concerned to appraise the patient's motivation, his capacity for introspection, his ability to work together with the therapist, his potential for acting out, and the danger of psychotic decompensation. From the patient's reactions, conclusions can be drawn which help the therapist decide on further diagnostic and therapeutic measures.

The structured classification of differential diagnosis follows the nosologic system of psychiatry in the division into three main categories — endogenous and exogenous psychoses and neuroses. Kernberg added borderline disturbances as a fourth category. Through his use of terms like "diagnostics," "exploration," and "cardinal symptoms," Kernberg shows that he stands with one foot planted firmly in descriptive psychiatry. The interviewer's structuring activity naturally affects the interaction. A certain restriction of freedom in the way the relationship between patient and therapist begins to form is accepted in order to gain the information necessary for differential diagnosis. The structural interview is nevertheless a balanced blend of psychopathologic description and relationship analysis, and meets the diagnostic, therapeutic, and prognostic demands placed on the initial consultation.

A third generation of structured psychodynamic interviewing that claims to meet the necessities of research and clinical work had been delevoped by a group of German academic trained psychoanalysts first published in German in 1996. Meanwhile translations in other languages have appeared (english, italian, spanish, hungarian). Recently a second edition of the English version has been published (OPD-2). Operationalized Psychodynamic Diagnosis (OPD) is a form of multiaxial diagnostic and classification system based on psychodynamic principles, analogous to those based on other principles such as DSM-IV and ICD-10. The OPD is based on five axes: I = experience of illness and

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prerequisites for treatment, II = interpersonal relations, III = conflict, IV = structure, and V = mental and psychosomatic disorders (in line with Chapter V (F) of the ICD-10). After an initial interview lasting 1–2 hours, the clinician (or researcher) can evaluate the patient's psychodynamics according to these axes and enter them in the checklists and evaluation forms provided. The new version, OPD-2, has been developed from a purely diagnostic system to include a set of tools and procedures for treatment planning and for measuring change, as well as for determining the appropriate main focuses of treatment and developing appropriate treatment strategies.

From the foreword by Kernberg and Carkin we learn that the international systems for classification of diseases, DSM-IV and ICD-10, „in their effort to simplify and thus facilitate communication and research have reduced the richness and clinically appropriate level of diagnosis in psychiatry" (p. V). They rightly point out that the long time prevailing devaluation of diagnosis by psychoanalytic clinicians is not useful to the clinician, and „denies the progress as has been achieved both in the biological and the psychodynamic realm" (p. V).
The Operationalized Psychodynamic Diagnosis is bridges the gap between descriptive clarity and precision, on the one hand, and clinical sophistication and appropriate individualized differentiation, on the other. Quite similar to its US-american counterpart, the Psychodynamic Diagnostic Manual (DSM[1]) developed by a Task Force of psychoanalytic organisations) the OPD-2 covers by its five axes a) experiences of

[1] * Healthy and disordered personality functioning

* Individual profiles of mental functioning , including patterns of relating, comprehending, and expressing feelings, coping with stress and anxiety, observing one's own emotions and behaviors, and forming moral judgments

* Symptom patterns , including differences in each individual's personal or subjective experience of his or her symptoms

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illness and prerequisites of treatment, b) interpersonal relations, c) conflict, d) structure and e) mental and psychosomatic disorders.

It is easy to agree with Kernberg and Clarkin that the OPD-2 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“ (p. VI).

What is remarkable of the „OPD-enterprise“ unter the strong leadership of Manfred Cierpka – a former student of mine - that it has caught the interest of many young clinicians in many countries. A recent translation into Chinese demonstrates its utility for newcomers and its cross-cultural applicability. The new toolbox provided with the second edition – f.e. a conflict checklist, a structure checklist, a structural change scale and special interview tools for each of the axes- obviously responds to a need of practioners in the age of EBM. Therefore it is now increasingly used by many of them for the Expert Assessment Procedures of the German Psychotherapy Guidelines.

The German study group has provided a fair number of research studies on aspects of reliability and validity that are summarized in this volume too.

The concern of experienced therapists that working with the OPD undermines the preciously guarded evenly hovering attention to do justice to a patient´s individual concerns will remain an issue; alas OPD can be an important stimulus for structuring one´s thinking about a patient´s problems. Many years ago, at the international Psychoanalytic Process Research Conference in Ulm 1985 the late Hans Strupp proclaimed the necessity for „problem-treatment-outcome-congruence“ (Strupp et al.1988). Clearly with OPD-2 we are moving in this direction.

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been satisfied and questions of payment and appointments were settled, the fundamental rule was explained and the analysis began. Then as now, general psychosocial factors such as education, age, and motivation were highly relevant. Freud did not take a detailed history until the first phase of treatment; his preliminary interview usually was brief. The problem of diagnosis and resulting selection first arose when demand began to outstrip supply, as Fenichel reported about the clinic of the Berlin Institute.

However, by and large the psychoanalytic profession only reluctantly dealt with issues of elaborated diagnostics, even when over the years the nosologic system was adopted from psychiatry. On the other hand, the influences of psychodynamic thinking on psychiatry were perceptible as early as the 1930s. The individual steps have been traced by Gill, whose important contribution is the definition of the psychodynamic interview technique. They contrast the traditional psychiatric exploration with the “dynamic interview”. In the course of the 1950s, numerous different psychodynamically oriented interview strategies were developed by psychoanalysts working within dynamic psychiatry.

Kernberg's "structural interview" from 1981 was a good example of the second generation of psychoanalytically oriented psychiatric initial interviews following in the tradition of psychodynamic interviewing. He relates the history of the patient's personal illness and his general psychic functioning directly to his interaction with the diagnostician. The main goal is clarification of the integration of ego identity or identity diffusion, the quality of the defense mechanisms,

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The interviewer's structuring activity naturally affects the interaction. A certain restriction of freedom in the way the relationship between patient and therapist begins to form is accepted, in order to gain the information necessary for differential diagnosis. The structural interview is nevertheless a balanced blend of psychopathologic description and relationship analysis, and meets the diagnostic, therapeutic, and prognostic demands placed on the initial consultation.

A third generation of structured psychodynamic interviewing that claims to meet the necessities of research and clinical work arose within the creation of a new psychodynamically oriented system, the Operationalized Psychodynamic Diagnosis (OPD), which had been developed by a group of German academically trained psychoanalysts and which was first published in German in 1996. Meanwhile translations into other languages have appeared (English, Italian, Spanish, and Hungarian). Recently a second edition of the English version has been published (OPD-2).

Operationalized Psychodynamic Diagnosis is a multiaxial diagnostic

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and classification system based on psychodynamic principles. After an initial interview lasting 1–2 hours, clinicians (or researchers) can evaluate the patient's psychodynamics according several axes (see below) and enter them in the checklists and evaluation forms provided. The new version, OPD-2, has been developed from a purely diagnostic system to include a set of tools and procedures for treatment planning and for measuring change, as well as for determining the appropriate main focuses of treatment and developing appropriate treatment strategies.

Quite similar to its US-American counterpart, the Psychodynamic Diagnostic Manual – PDM, developed by a Task Force of psychoanalytic organisations, the OPD-2 covers five axes: I = experience of illness and prerequisites for treatment, II = interpersonal relations, III = conflict, IV = structure, and V = mental and psychosomatic disorders (in line with Chapter V (F) of the ICD-10).

It is easy to agree with the foreword from Kernberg and Clarkin in which they state that the OPD-2 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 OPD system has been applied in numerous research projects. The German study group has provided a fair number of studies on aspects of reliability and validity that are summarized in this volume too. The Studies show good reliability in a research context and acceptable reliability for clinical purposes. Validity studies indicate good content, criterion, and construct validity for the individual axes. Alas most of the studies reported are (not yet) available in English

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publications. This is one definite limitation of this volume translated from German. The bulk of the quoted literature reveals how intensive in the German psychotherapeutic world the issues of adequate diagnostics have been dealt with since long, but to an English speaking audience these may not be accessible.

Apart from research-oriented status diagnostics, the most important target area of the OPD system lies in the clinical and therapeutic field. More than 4,000 therapists have been trained in the different training centres in German-speaking countries. In many psychiatric and psychosomatic hospitals, in institutions working with addictive patients, at university departments for psychotherapy and psychosomatics and others, the OPD is used in day-to-day routine.

The OPD findings can supply the clinician with information helping him to decide on differential therapy indication and treatment planning from a psychodynamic point of view. Axis I can help to clarify the patients' basic assumptions regarding their problems and eventual motivation for psychotherapy. The assessment of basic ego function on the structure axis (axis IV) is decisive for the choice of suitable psychotherapeutic approaches, i.e. the alternative of providing more supportive vs. conflict-oriented or expressive psychotherapy, as well as in particular circumstances for deciding between in- or outpatient psychotherapy.

The axis on interpersonal relations allows, similar to the CCRT (Luborsky), the formulation of typical dysfunctional relationship pattern within the interpersonal circumplex. A key advantage of this formulation over descriptive diagnoses is that it may be used to predict how an individual might respond in certain therapeutic

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situations. In the sense of pathogenic beliefs these patterns require special therapeutic attention and interventions so that therapy does not fail due to complications in the therapeutic relationship.
By stressing the most prominent conflicts (axis III) and/or the most prominent structural deficiencies which illuminate vulnerability and available resources to be taken into account, therapy goals can be identified and therapeutic planning can be derived on the basis of the assessment. The OPD system allows a more structured and dynamic understanding of how different pathogenic factors operate and interrelate with each other and it can indicate the foci to be worked on in psychotherapy:

From the foreword by Kernberg and Clarkin we also learn that the international systems for classification of diseases, ICD-10 as well as the DSM-IV, „in their effort to simplify and thus facilitate communication and research have reduced the richness and clinically appropriate level of diagnosis in psychiatry“ (p. V). They rightly point out that the long time prevailing devaluation of diagnosis by psychoanalytic clinicians is not useful to the clinician, and „denies the progress as has been achieved both in the biological and the psychodynamic realm“(p. V).
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The concern of experienced therapists that working with the OPD undermines the preciously guarded “evenly hovering attention” and does not do justice to patient’s individual concerns will remain an issue. To summarize: OPD can be an important stimulus for structuring ones thinking about patient´s problems. Many years ago, at the international Psychoanalytic Process Research Conference in Ulm 1985 the late Hans Strupp proclaimed the necessity for „problem-treatment-outcome-congruence“. Clearly with OPD-2 we are moving in this direction.

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