OPD Task Force (Eds.) Operationalized Psychodynamic Diagnostics OPD-2. Manual of Diagnosis and Treatment Planning

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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

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

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

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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