Diagnostic Classification Systems Based on Psychoanalytical Principles

Vahap Ozan KOTAN¹ , Zeynep KOTAN² , Gamze ÖZÇÜRÜMEZ BİLGİLİ³

¹Department of Psychiatry, Başkent University Medical Faculty, Ankara, Turkey

²Department of Psychiatry, Dr. Abdurrahman Yurtaslan Ankara Oncology Training and Research Hospital, Ankara, Turkey

³Department of Psychiatry, Mersin University Medical Faculty, Mersin, Turkey

ABSTRACT

The diagnostic classification systems in psychiatry practice which are used worldwide extensively, The Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Statistical Classification of Diseases and Related Health Problems (ICD) are far away from the psychoanalytical point of view. It is thought that this gap results in the difficulty to understand psychiatric patients in clinical practice for many years. It has also created an obstacle to scientific researches addressing the validity and reliability of the psychoanalytical principles. On the other hand, psychoanalysis has been much criticised for years due to the lack of empirical foundations. As a result of this paucity, psychiatry is led by the biomedical approach. Without enough grounds in evidence-based medicine, psychoanalytical principles could not

become widespread in psychiatric practice. To survive criticism and strengthen its place in contemporary psychiatry, empirical research in psychoanalytical discipline has gained momentum in the last two decades. Development of objective psychodynamic diagnostic tools enabled the design of such studies. The aim of this review is to introduce such diagnostic tools, namely Psychodynamic Diagnostic Manual (PDM) and Operationalized Psychodynamic Diagnosis (OPD), and to discuss the possible contributions they provide for psychoanalytical perspective to take its deserved place in the psychiatry discipline.

Keywords: Psychoanalytical principles, diagnostic classification systems, evidence-based medicine

Cite this article as: Kotan VO, Kotan Z, Özçürümez Bilgili G. Diagnostic Classification Systems Based on Psychoanalytical Principles. Arch Neuropsychiatry 2018;55:91-97. <https://doi.org/10.29399/npa.19505>

INTRODUCTION

The history of systematic researches on the methods and results of psychoanalytical therapy is recondite. Although Freud described the psychoanalysis as the “science of the mind”, the fact that he continued his studies in the field of *subjectivity* led him to set aside the need for empirical researches which form the basis of science, and ensure the accumulation of knowledge. This situation, which lasted until his death, brought about controversial debates questioning whether psychoanalysis is scientific. Though, the first studies conducted in this field date back to 1917 (1). Its significant increase, however, may be associated with the third edition of the American Psychiatric Association's official classification system Diagnostic and Statistical Manual of Mental Disorders (DSM).

It was when the psychoanalysts who had emigrated from Europe in 1940s due to the World War II that the psychoanalysis was first included in the college curricula in the United States (2). In the following period; psychiatry, which is shaped under the influence of the psychoanalytic movement, had become a psychotherapy-oriented and theory-based discipline rather than being an experimental medical discipline closely related to neurology. One of the key indicators of this was the description of the etiology and symptomatology of the disorders within the framework of psychoanalytical theory at DSM-I (1952), and DSM-II

(1968). However, as the DSM-III was published, the radical change that the psychiatry underwent from the 1960s to 1980s was strikingly revealed. First proposed by Kraepelin at the beginning of the XXth century, the descriptive approach, based on objective observation and research was back. As of the third edition of DSM, none of the etiological explanations reflecting significant psychoanalytical perspectives were included in the diagnostic categories since they were not proven.

Within this period, the biologically-oriented psychiatrists heavily criticized the lack of empirical researches in the field of psychoanalysis whereas the psychoanalytically-oriented clinicians resisted considering their patients on the basis of categorized diagnostics which constitute essentially the medical model. By the end of the 1980s, the psychoanalytically-oriented psychiatrists oscillated between accepting and ignoring the diagnostic labels of the DSM, or developing alternative diagnostic formulations involving dimensional, contextual, cause-effect relationships specific to psychoanalytic approaches. It can be, however, observed today that the psychoanalytical discipline has accelerated empirical researches to consolidate its place in the contemporary psychiatry. There is no doubt that the objective psychodynamic diagnostic tools developed has contributed greatly to the acceleration of such researches. This review

paper aims to increase the recognition of psychodynamic diagnostic classification tools –particularly that of the Psychodynamic Diagnostic Manual (PDM), and Operationalized Psychodynamic Diagnosis (OPD)– and to draw attention to their contribution to the psychoanalytical perspective within the psychiatric discipline.

Psychodynamic Diagnostic Manual (PDM)

PDM is the product of an effort to create a psychodynamics-oriented diagnostic system aiming to bridge the gap between the need for experimental and methodological validity, and the clinical complexity (3). It was authored under the presidency of Stanley I. Greenspan, Nancy McWilliams, and Robert S. Wallerstein, with the cooperation of the American Psychoanalytic Association, the International Psychoanalytical Association, the Division of Psychoanalysis of the American Psychological Association, the American Academy of Psychoanalysis and Dynamic Psychiatry, and the National Membership Committee on Psychoanalysis in Clinical Social Work. The purpose of the manual is described by the team, as to complete the DSM and ICD (3). Beyond offering just a diagnostic classification, the manual also constitutes a comprehensive guide to explain a person's psychodynamic evaluation, whether or not such a person would have a mental disorder (4). The manual consists of three chapters: 1) Adult mental health disorders, 2) Child & adolescent mental health disorders, 3) The researches and conceptual texts constituting the basis for the psychodynamic classification system for mental disorders. Both of the chapters on children and adults include 3 axes: Personality patterns and disorders (P axis), profile of mental functioning (M axis), and manifest symptoms and subjective experience (S axis). The chapter on children and adolescents is also divided into two sections, namely one concerns the child and adolescent disorders, and the other relates to infant and early childhood mental health besides developmental disorders. The diagnoses provided in the adult and child/adolescent chapters were enriched by case examples. Even though the diagnostic categories were attempted to rank as parallel to the DSM as possible, another path was followed due to the large number of categories, and different theoretical bases (4). For example, whereas the diagnostic categories begin with P, M, or S in the adult section, they begin with MCA (Mental Child Adolescent), PCA (Personality Child Adolescent) or SCA (Subjective Experience Child Adolescent) in the child/adolescent section, and with IEC (Infancy/Early Childhood) in the infancy/early childhood section. While the adult section begins with personality patterns and disorders, the child/adolescent section begins with profile of mental functioning which reflects on the developmental differences. The descriptions are often supported by the literature, and each part ends with a long reference list. Besides clearly acknowledging their psychoanalytic biases, the authors also states that they hope that the manual would provide benefit both for the learners and educators of other schools (5).

Classification of Adult Mental Disorders

P Axis: Giving priority to personality in the adult part, is a reflection of the following statement: "Accumulating evidence indicates that symptoms or problems cannot be understood, assessed, or treated in the absence of an understanding of the mental life of the person who has the symptoms." (3). The P axis of PDM-1 is grounded on the theoretical and experimental approaches developed by Kernberg (6), McWilliams (7), Blatt (8), and Westen and Shedler (9, 10). Primarily, it divides an individual's personality organization into four levels including healthy, neurotic, high or low level borderline, explaining each in the context of functionality. The term "borderline" used in the PDM does not indicate a specific personality disorder as it is in the DSM.

Once the level of organization is determined, it comes to the evaluation of personality disorder. To achieve this, first the paragraphs introducing the predictive psychodynamic factors were given, and then each personality disorder specificity was defined within the following six domains: 1)

Table 1. Personality Patterns and Disorders – P Axis

Schizoid
Paranoid
Psychopathic (passive/parasitic or aggressive)
Narcissistic (arrogant/entitled or depressed/depleted)
Sadistic and sadomasochistic
Masochistic (moral or relational)
Depressive (introjective or anaclitic, and hypomanic as converse manifestation)
Somatizing
Dependent (passive-aggressive or counter dependent as converse manifestation)
Phobic or counter phobic as converse manifestation
Anxious
Obsessive-compulsive (obsessive or compulsive)
Hysterical/Histrionic (inhibited or demonstrative/flamboyant)
Dissociative
Mixed/Other

Coexisting structural-developmental patterns. 2) Basic stress/anxiety. 3) Basic affects. 4) Typical pathogenic beliefs about self. 5) Typical pathogenic beliefs about others. 6) Basic defense mechanisms. Thus, each disorder is characterized by its core tension, distinctive pathogenic beliefs, and basic defenses. The personality disorders in P axis are listed in Table 1.

The personality disorders in PDM-1 are broader than those defined in DSM-IV-TR, and were classified by their organizational levels. Some diagnoses, such as narcissistic and obsessive-compulsive personality disorders, were divided into certain subdiagnoses (Table 1). Such diagnoses as depressive and passive-aggressive personality disorders were re-included. The "avoidant" personality disorder was re-named as "phobic" personality disorder. This change reflects the importance attached by PDM to the dynamics underlying the behavioral patterns defined. The sadistic, sadomasochistic, and masochistic personality disorders that have existed in psychoanalytic theory since past were also included in the P axis. "Antisocial" was offered as an alternative for the old term "psychopathic". The return of the term "hysterical", which has not been used for a long time, is however unexpected. Apart from the fact that the term is used in a clearly insulting sense in colloquial speech, it reflects the ancient medical view that hysteria is etiologically related to the uterus. However, the recently-introduced term "histrionic" is thought to both have a more equally edge towards the genders, and reflect more the behavioral pattern defined by the category. Therefore, the return to "hysterical" expression in PDM can be criticized.

The P axis was created in the light of empirical studies conducted using the OPD and Shedler-Westen Assessment Process (SWAP) systems to be introduced later. However, it is not specific enough to allow the clinicians and researchers from all fields to make a reliable assessment. One should have a good command of psychodynamic concepts to make a P axis assessment.

M Axis: The profile of mental functioning (M axis) constitutes a short, concise part. M axis defines the following: 1) The capacity for learning, attention and regulation. 2) The capacity for relationships and intimacy (in terms of depth, range and consistency). 3) The capacity for internal experience (level of confidence and self-regard). 4) The capacity for affective experience, expression and communication. 5) The level of defensive patterns. 6) The capacity to form internal representations. 7) The capacity for differentiation and integration. 8) The self-observing

capacity (psychological-mindedness). 9) The capacity for internal standards and ideals (sense of morality).

The competence and diversity in mental functioning are graded by means of a checklist. Creating such a profile requires both recognizing the patient considerably, and having a good theoretical background and practice. The starting line of the graded range is M201, and refers to the level of “optimal mental capacity within the framework of appropriate flexibility and integrity”. On the other hand, M208 has the lowest functionality, and refers to “major defects in basic mental functions”.

S Axis: The S axis “Symptom Patterns and Subjective Experience” is based on DSM-IV-TR diagnostic categories. Nevertheless, the following statement appears on page 93: “Although there are evidences showing the contribution of biological agents to most mental disorders, we believe that the presence of a large number of mental symptoms is not necessarily the comorbidity of different mental disorders, and these symptoms are actually indicative of a basic complex disorder in mental functions.” Also, the symptoms are examined in terms of developmental appropriateness, and it is emphasized that age-related variables are indicative of the person-specific treatment approach. The category of psychotic disorders includes both schizophrenia and other psychotic disorders, whereas the bipolar disorder is included in mood disorders as is in the DSM.

One of the most important contributions of this chapter is the elaborate discussion on what patients experience subjectively. The clinician would see the useful descriptions on the conscious and unconscious connections of mental disorders, and would make sense of how these disorders are shaped by developmental experiences and psychodynamic factors.

Classification of Mental Disorders in Children and Adolescents

As is in the adult section, the child and adolescent section also evaluates in depth the conditions affecting the age group, compared to the DSM. The child and adolescent section begins with a discussion on the mental functioning which reflects the developmental differences. It gives priority to an overview and a holistic assessment rather than revealing the newly-formed personality traits, and the signs representing thereof. The neuropsychological dimension in infancy/early childhood part is integrated into a guide containing specific observation and evaluation models. Determining the point that the baby or child matches with on the functionality range of developmental stage constitutes its clinical benefit.

Articles Supporting Psychodynamics-Origin Classification System

The last section of PDM is composed of the articles authored by the internationally-recognized psychoanalysts and researchers (3). Four articles summarize the historical and conceptual theories. Wallerstein provides a comprehensive history of the development of psychoanalytic-based nosology. Braconnier et al., on the other hand, evaluate the psychoanalytical psychotherapy indications from the perspective of Lacan and his pursuers. Greenspan from U.S. and Shanker from U.K. provides the definitions of developmental framework in psychoanalytical terms, and the healthy emotional functionality. Shevrin discusses the possible contributions of cognitive behavioral and neurophysiological findings to psychodynamic nosology. Eight texts refer to international researches. Wallerstein examines the results obtained from empirical researches, along with their reflections on the future. Having defined two different personality modes, including self-definition and interpersonal relatedness, and shown the importance of these modes in determining the therapy technique to be applied, Blatt et al. addresses the measurement of variables associated with treatment efficacy. However, Dahlbender et al. narrates the methods that allow for assessing the efficiency of

the applied psychotherapies. Leichensening examines the meta-analyses of the researches evaluating the efficiency of psychodynamic psychotherapy. Shedler and Westen describe the reflections of SWAP, which is their own diagnostic system, on the PDM. Herzig and Licht examine the diagnostic classification based on the symptom clusters in DSM, and discuss their validity and reliability. Westen et al. assess the validity of the psychotherapy assumptions used clinically in the light of findings from empirical researches. Fonagy describes the evidence-based psychodynamic psychotherapies.

Contribution to the Discipline

PDM has become increasingly widespread, and has been used in psychodynamic psychotherapy trainings and research in various countries such as France, Spain, Italy, etc. It has also served as a source for the developers of new evaluation tools. For example, Gazzillo et al. conducted the validity & reliability studies of the three scales they developed from 2008 to 2010, namely “Psychodynamic Diagnostic Prototypes”, “Core Preoccupations Questionnaire” and “Pathogenic Beliefs Questionnaire”, using the P axis of the PDM (11). On the other hand, Gordon and Stoffey has found out that the results of the “Psychodiagnostic Chart” based on the adult section of PDM were consistent with those of the Minnesota Multiple Personality Inventory-2 (MMPI-2), and Karolinska Psychodynamic Profile and OPD (12).

First published in 2006, the 857-page PDM was produced as a result of two-year effort aiming at return to psychoanalytic-based diagnostic framework. PDM offers a comprehensive diagnostic system for psychodynamic evaluation of disorders, case formulation, treatment plan, therapeutic process, and longitudinal follow-up of results. It constitutes an extremely comprehensive handbook referenced for both clinical evaluation, and psychodynamic research. Due to the same reason, it was criticized for not offering an ease of use (3-5).

PDM-2

Reviewed and renewed in the light of clinical, empirical, methodological developments that took place in the last 10 years in order to increase its effectiveness, the second edition of PDM was completed in September 2016. It is projected to be published in memory of Greenspan, who led the team in the creation process of PDM but died in 2006 shortly after the publishing of PDM-1, and of Wallerstein, who died in 2014. The announcement of the PDM-2 conference to be held in New York June 2-3, 2017 was made months ago.

In the second edition, it appears that there are certain significant changes, however, the multi-axis basic framework is still protected. One of these changes is the restructuring of the P axis following the blending of experimental, clinical and theoretical findings obtained from the studies conducted with Psychodynamic Diagnostic Prototypes, SWAP-200, and its latest versions (13). Thus, for example, the “psychotic-level personality organization” was added to P axis in line with the findings pointed out by the studies since 2006.

On the other hand, three further functions, namely capacity for mentalization and reflective functioning; capacity for impulse control and regulation; and capacity for adaptation, resiliency and strength, were added to the mental functions on the M axis, and thus the number of mental functions was increased from nine to twelve. An assessment procedure with a Likert-style scale will be associated with each mental function.

However, the S axis this time integrated with ICD-10 and DSM-5 classification systems, and included comprehensive descriptions of “affective states”, “cognitive patterns”, “somatic states” and “relationship patterns”. In addition to the patient’s subjective experience, the

Table 2. OPD Axis 1 items

1. Severity of somatic illness
2. Severity of mental illness
3. Patient's subjective suffering
4. Impairment of self-experience
5. Secondary benefit illness
6. Extent of physical impairment
7. Comprehending and accepting psychodynamic and psychosomatic associations
8. Comprehending and accepting psychodynamic somatopsychic associations
9. Evaluation of appropriate treatment (psychotherapy)
10. Evaluation of appropriate treatment (medical treatment)
11. Motivation for psychotherapy
12. Motivation for somatic treatment
13. Compliance
14. Presentation of symptoms - somatic symptoms to the fore
15. Presentation of symptoms - mental symptoms to the fore
16. Psychosocial integration
17. Personal resources
18. Social support
19. Appropriateness of subjective impairment related to the severity of the illness

countertransference of the clinician was also emphasized within definitions.

Since there are significant differences between childhood and adolescence, the adolescent section (11 to 18 years old) was addressed apart from the child section (4 to 10 years old). In line with the clinical and experimental findings, the infancy and early childhood section however incorporates a discussion on the homotypic/heterotypic continuity exhibited by psychopathology with the infancy, childhood, adolescence, and adulthood developmental line. The patterns of attachment as well as the possible effects of these patterns on the psychopathology and normal development was assessed together with the family system. Thus, the nature of the primary relationships (child and caregiver) was aimed to be more comprehensively identified.

PDM-2 also includes a new section named "Mental Disorders of the Elderly", which was not available in the first edition. Another innovation is, on the other hand, the addition of two special sections under the title of "Clinician-Friendly Tools" which help understanding the common approach of the manual. However, the section including researches and conceptual articles forming a basis for psychodynamic classification system for mental disorders, which was available in the first edition, is not included in the second edition. Instead, the empirical studies evaluating different disorders were presented as a systematic reference directory (14).

The preparations for translating PDM into Turkish was started in 2015 by a team of volunteers consisting of members upon suggestion, and under the leadership of Ferhan Dereboy, Coordinator of the Psychoanalytic Psychotherapies Study Unit operating under Psychiatric Association of Turkey. Dereboy has also been striving for a long time to ensure that the PDM is included in the psychiatry residency training. The efforts were interrupted when it was learned that the second edition would be completed in a relatively short time –a year– with the extensive changes outlined above, in order to translate PDM-2 (personal communication).

Operationalized Psychodynamic Diagnosis (OPD)

The OPD study group was founded by German psychoanalysts, psychoanalytic psychotherapists and psychiatrists headed by Manfred Cierpka in 1990 (15). Its objective was to design a more comprehensive diagnostic classification system by adding clinically-validated basic psychodynamic dimensions to ICD-10. The first edition of the OPD, prepared in line with this target, was published as a multi-axis diagnostic system evaluating psychoanalytic structures according to empirical research and treatment planning. The second edition, renewed with a broad review, was completed 10 years after the first edition was published.

OPD-2 has relatively clearly-formulated criterion giving users freedom. Complementing the DSM-IV-TR and ICD-10, the OPD-2 includes four psychodynamic axes: Axis 1. Experience of illness and prerequisites for treatment, Axis 2. Interpersonal relations, Axis 3. Conflicts, and Axis 4. Structure. During the initial assessment taking a few hours, the clinician or therapist examines the dynamics of the patient and fills out the OPD evaluation form. The evaluation form incorporates certain directives that both enables the information received from the patient to be objective, and matches the flexibility required by the psychodynamic interview.

Brief Introduction to Axes

Axis 1. Experience of Illness and Prerequisites for Treatment: The items in this axis are mainly used to evaluate the patient's treatment motivation and psychodynamic psychotherapy indications. Each item is scored as "absent (0), low (1), medium (2), high (3)" on a Likert type scale. Individual diagnoses are given in a glossary of terms. In order to improve diagnostic reliability, case examples were also used. The items in Axis 1 are summarized in Table 2.

Axis 1 indicates that the disease course is related not only to the syndrome and symptoms but also to the subjective and social status of the affected person. Especially in the case of a treatment such as psychotherapy, how the patient perceives the psychosocial support, and his/her illness are considered to be the most important determinants of the course.

Axis 2. Interpersonal Relations: The psychodynamic theory takes the mental disorders also as "relationship disorders". Interpersonal relations are considered to be one of the main determinants of the emergence and progress of mental disorders. Therefore, the forms of establishing dysfunctional and incompatible relationships are at the focal point of the psychodynamic researches. The items in the OPD interpersonal relations axis serves to define the diversity of behaviors observed in relationships (15). The cognitive affective schemata, which are lifelong accumulations of relationship experiences, also forms the basis for the concepts of transference and countertransference of psychoanalysis. The OPD interpersonal relations axis defines this cyclical and interactive structure of human relations.

The axis 2 evaluation consists of two phases. The first phase of the axis aims at the recognition the subjective experiences of self with others. In the second phase, however, the clinician, the current significant other, is asked to define his/her own experience with the patient. The first phase seeks an answer to the question "What does the patient experience with his/her own objects and with the interviewer?" The question of the second phase is, however "What kind of emotions does the patient trigger on the other?". These two phases can be summarized as follows: How the patient is experiencing himself/herself within his/her relationships; how the interviewer describes the behavior patterns that the patient uses against the others. Thus, the therapist can also evaluate transference and countertransference.

Axis 3. Conflicts: Conflicts reveal themselves in subject, object and object relationships. When the patient history is taken, the dominant

conflict can become evident through perceived behavior or modes of experience such as transference, countertransference, enactments, etc. Also, Axis 3 involves a checklist that allows you to determine the types of conflicts associated with different niches. This list allows for defining the basic conflicts and the ways to cope with these conflicts over fundamental niches such as relationship to a partner, family of origin, profession, the importance of possessions, behavior in groups, and experience of disease.

In addition to seven intrapsychic conflicts, Axis 3 also defines a category for limited perception of conflict: 1) Dependence versus autonomy. 2) Submission versus control. 3) Desire for care versus autarchy. 4) Conflicts of self-value. 5) Guilt conflicts. 6) Oedipal sexual conflicts. 7) Identity conflicts. 8) Limited perception of conflicts and feelings.

The assessment includes both ongoing conflicts and the conflicts in response to acute stressors affecting life, however these are separately scored. Seven basic conflicts and the eighth category (e.g., somatizing patients) are scored from “not present” to “present and not significant” to “present and significant” to “present and very significant”. Thus, two main conflicts are identified for each patient.

If we give an example based on the passive situation in the “desire for care versus autarchy” conflict, the patient is excessively dependent on the other and the need for protection and maintenance is the forefront in the passive state. They feel depressed and/or fearful in the case of separation or rejection. In countertransference, the therapist feel worry, helplessness and blackmailed. The close relationships have a pattern that precludes separation, such as financial obligations, etc. The insatiable quest for closeness may lead to reactive defenses in the form of frequently changing relationships. The need for care may have caused the patient to remain dependent on his/her family of origin for a long time. In his/her professional life, the patient seeks for assistants and accomplices; the ordinary professional demands may be taken as the interruption of support and may create depression. Also in a social context, the patient seeks for care-giving relationships, and is perceived as demanding and exhausting by others. During illness, the patients approaches his/her doctor with passive and insatiable expectations. The treatment process is challenging.

Axis 4. Structure: OPD differentiates the structure into four levels of integration, namely “good, moderate, low and disintegrated” (16). The level of good integration means an autonomous self which can contain

intrapsychic conflicts. A moderate integration refers to a case where intrapsychic structures are less differentiated and the functionality is lower. A low integration means that the conflicts can hardly be handled, intrapsychic sphere and mental structures are little developed and the conflicts are predominantly enacted in the interpersonal sphere. Disintegration is determined by fragmentation and the shaping of structure at the psychotic level. The operationalization of structure is based on 6 categories: 1) Self-perception. 2) Self-control/regulation. 3) Defense. 4) Object-perception. 5) Communication. 6) Attachment.

The OPD detects the integration level individually for each of these structural categories (16, 17). Eventually, a profile indicating the total structural level may be created. In addition, it includes a checklist for scoring each of the items and sub-items. The self and the other framework are assessed over four basic functions, eight primary items and 24 sub-items (Table 3).

Contribution to the Discipline

OPD was translated into many languages after its publication in 1996. The German child and adolescent version was published in 2003. It has become widespread in psychotherapy units since it provides a solid foundation where complex psychoanalytic theories and detailed case discussions can be constructed. In various educational centers in Germany, more than 3,000 therapists received practical training thereon. OPD was also utilized in psychodynamic psychotherapy training. Served as a tool that allows for homogenization of experimental models thanks to its clear diagnostic criteria. Also, it has enabled establishment of a common language with different scientific disciplines. Because it can create reliable psychodynamic formulations, it has been used in many empirical researches at psychosomatic clinics, trauma clinics, and universities. Its second edition was prepared in the light of new research findings ten years after the first edition was released. OPD-2 aimed to more easily identify the focus of the formulation and the therapeutic targets. Its English translation was published with the foreword authored by Kernberg in 2008. Translated into Turkish with the efforts of Mine Özmen and a group of psychoanalysts, psychodynamic psychotherapists, and psychiatrists, OPD-2 will be soon available in our country (personal communication).

In their studies “Assessing the level of structural integration using operationalized psychodynamic diagnosis (OPD): implications for DSM-V” published in 2012, and “The OPD Structure Questionnaire Captures the General Features of Personality Disorder” published in

Table 3. OPD Axis 4 - Categories for structural integration

Function	Self	Other
Perception/Cognition	Self-Perception Self-reflection Affect differentiation Identity	Object Self-object differentiation Whole object perception Realistic object perception
Regulation	Self-regulation Affect tolerance Impulse control Regulation of self-esteem	Regulation of relationships Protecting relationships Balancing interests Anticipation
Communication	Internal Experiencing affect Use of fantasies Bodily self	External Establishing contact Communicating affect Empathy
Attachment	To internal objects Internalization Use of introjects Variability of attachment patterns	To external objects Capacity for attachment Accepting help Detaching from relationships

2015, Zimmermann et al. showed that the OPD-2 system was highly reliable (16, 17). The study "Self-report and observer ratings of personality functioning: a study of the OPD system" by Ding et al., published in 2014, also revealed the reliability and easy applicability of OPD-2 (18). With their study "Cross-cultural adaptation of the Operationalized Psychodynamic Diagnosis (OPD-2) in Portugal" published in 2012, Vicente et al. showed the validity of the Portuguese version and offered strong evidence that OPD-2 was adaptable to different cultures (19).

1.4. Shedler-Westen Assessment Procedure

Shedler and Westen, who contributed greatly to the development of the PDM's P axis, are also architects of a psychometric classification system providing a comprehensive definition of personality and personality pathology. The manual named "Shedler-Westen Assessment Procedure" (SWAP) was published in 1999. It was revised twice in 2004 and 2007 in the light of research findings (20-22). SWAP is a measurement tool through which the patient is assessed systematically by a trained clinician throughout the interview by means of a form. Also, Serra Müderrisoğlu made important contributions to both its development and its validity & reliability studies.

The form consists of eight categories and 200 items each of which is scored from "not descriptive (0)" to "most descriptive (7)". Whereas the original SWAP-200, developed to classify personality disorders, and the revised SWAP-2 are for adults, the SWAP-200-A and the revised SWAP-2-A targets adolescents (21, 23). Enabling the diagnosis of DSM-IV-TR Axis II, SWAP also involves different diagnoses and details. The SWAP personality syndromes constitute an alternative classification of personality in which DSM's limitations are reduced (Table 4).

The SWAP classification system consists of the following headings: psychological health, psychopathy, hostility, narcissism, impairment in emotional regulation, dysphoria, schizoid orientation, obsession, thought disorder (or schizotypy), oedipal conflict, dissociation, and sexual conflict. Through SWAP, a result chart similar to the MMPI profile can be obtained. This chart allows the clinician to make a more detailed assessment in order for making the case formulation, and treatment plan (23).

Shedler and Westen revealed the empirical and clinical validity-reliability of SWAP in 2007 and of SWAP-2 in 2012, in terms of the diagnosis of personality pattern (21, 22, 24). The impact of these results can be understood by looking at the sheer number of researches assessing the case features and approaches using SWAP. One of the most prominent of these studies is the study that evaluated personality patterns of 311 adults who attempted suicide, through SWAP-2 (25). With this study, it was seen that the individuals attempting suicide were classified into 6

personality syndrome subgroups, including internalizing, with emotional dysregulation, dependent, hostile-isolated, psychopathic, and anxious-somatizing. In another study that was conducted using SWAP-2 on 203 adults with traumatic separation in childhood, it was found that these individuals composed five subgroups including internalizing/avoidant, psychopathic, with emotional dysregulation, hostile/paranoid, and resilient (26). Supporting the views of psychoanalytic school on suicide and childhood traumas, and the treatment goal, these findings are important in terms of exemplifying the empirical researches' contribution to the field.

CONCLUSION

Since there is subjectivity in the focus of psychoanalytic theory and practice, it is more difficult to develop objective measurement tools required by empirical researches (27). Although it is not easy to determine the efficacy and efficiency of psychoanalytic psychotherapies by means of the standards applied to other therapies (e.g., only the patient's symptom profile), this has become a necessity in the culture of over-burdened health care that has turned out to be obsessed with costs (28, 29). The importance attached to experimentally proven treatments by the health authorities and the need for evidence-based medicine in modern health services stipulate demonstrating for which patient groups psychoanalytic psychotherapies are appropriate using scientific methods (30). Hence, the psychoanalytical/psychodynamic diagnostic classification systems have an existential importance for making it possible both to make diagnosis using scientifically accepted methods in the clinic, and to conduct empirical researches.

In the literature, the number of studies conducted using such evaluation tools is increasing day by day. Furthermore, the psychoanalytic classification systems are constantly being developed and improved thanks to the findings obtained from these studies (31, 32). Upon being introduced in our country, these systems are supposed to bring a new dimension to intercultural studies beyond contributing to clinical practice and researches. Besides, given the difficulty of understanding psychoanalytic theories especially in the first years of the profession, the psychodynamic diagnostic classification systems that make concepts more concrete may be utilized in the residency training. For all these reasons, we believe that they will bring along important developments once the translation of PDM-2 and OPD-2 is completed and published.

Peer-review: Externally peer-reviewed.

Author Contributions: Concept - VOK; Design - ZK; Supervision - GÖB; Resource - VOK; Materials - ZK; Data Collection and/or Processing - VOK; Analysis and/or Interpretation - GÖB; Literature Search - VOK; Writing - VOK; Critical Reviews - ZK, GÖB.

Conflict of Interest: No conflict of interest was declared by the authors.

Financial Disclosure: The authors declared that this study has received no financial support.

Table 4. SWAP Personality Syndromes

1. Dysphoric (depressive) personality
2. Antisocial-psychopathic personality
3. Schizoid-schizotypal personality
4. Paranoid personality
5. Obsessional personality
6. Histrionic personality
7. Narcissistic personality
8. Avoidant personality
9. Depressive personality with high functioning
10. Borderline (emotionally disorganized) personality
11. Dependent-victimized personality
12. Hostile-externalizing personality

REFERENCES

1. Wallerstein RS. The relevance of Freud's psychoanalysis in the 21st century: Its science and its research. *Psychoanalytic Psychology* 2006;23:302-326. [CrossRef]
2. Wallerstein RS. Psychoanalysis in the university: the natural home for education and research. *Int J Psychoanal* 2011;92:623-639. [CrossRef]
3. Psychodynamic Diagnostic Manual (PDM). PDM Task Force 2006. Silver Spring, MD. Alliance of Psychoanalytic Organizations.
4. Wallerstein RS. The Psychodynamic Diagnostic Manual (PDM): rationale, conception, and structure. *J Am Psychoanal Assoc* 2011;59:153-164. [CrossRef]
5. Clemens NA. The psychodynamic diagnostic manual: a review. *J Psychiatr Pract* 2007;13:258-260. [CrossRef]

6. Kernberg OF. Severe Personality Disorders: Psychotherapeutic Strategies. New Haven, CT. Yale University Press; 1984.
7. McWilliams N. Psychoanalytic Diagnosis: Understanding Personality Structure in the Clinical Process, 2nd ed. New York: Guilford; 2011.
8. Blatt SJ. Representational structures in psychopathology. In: Cicchetti D, Toth S, editors. Rochester Symposium on Developmental Psychopathology, Vol. VI. Emotion, Cognition and Representation. Rochester, NY. University of Rochester Press; 1995. pp. 1–33.
9. Westen D, Shedler J. Revising and assessing axis II, Part I: developing a clinically and empirically valid assessment method. *Am J Psychiatry* 1999;156:258–272. [\[CrossRef\]](#)
10. Westen D, Shedler J. Revising and assessing axis II, Part II: toward an empirically based and clinically useful classification of personality disorders. *Am J Psychiatry* 1999;156:273–285. [\[CrossRef\]](#)
11. Gazzillo F, Lingardi V, Del Corno F. Towards the validation of three assessment instruments derived from the PDM P Axis: The Psychodynamic Diagnostic Prototypes, the Core Preoccupations Questionnaire and the Pathogenic Beliefs Questionnaire. *Bulletin of Applied Psychology* 2012;265:31–45.
12. Gordon RM, Stoffey RW. Operationalizing the psychodynamic diagnostic manual: a preliminary study of the psychodiagnostic chart. *Bull Menninger Clin* 2014;78:1–15. [\[CrossRef\]](#)
13. Lingardi V, McWilliams N. The psychodynamic diagnostic manual, 2nd ed. (PDM-2). *World Psychiatry* 2015;14:237–239. [\[CrossRef\]](#)
14. Lingardi V, McWilliams N, Bornstein RF, Gazzillo F, Gordon RM. The Psychodynamic Diagnostic Manual Version 2(PDM-2): Assessing patients for improved clinical practice and research. *Psychoanal Psychol* 2015;32:94–115.
15. Cierpka M, Grande T, Rudolf G, von der Tann M, Staschf M. The operationalized psychodynamic diagnostics system: clinical relevance, reliability and validity. *Psychopathology* 2007;40:209–220. [\[CrossRef\]](#)
16. Zimmermann J, Ehrental JC, Cierpka M, Schauenburg H, Doering S, Benecke C. Assessing the level of structural integration using operationalized psychodynamic diagnosis (OPD): implications for DSM-5. *J Pers Assess* 2012;94:522–532. [\[CrossRef\]](#)
17. Dinger U, Schauenburg H, Hörz S, Rentrop M, Komo-Lang M, Klinkerfuß M, Köhling J, Grande T, Ehrental JC. Self-report and observer ratings of personality functioning: a study of the OPD system. *J Pers Assess* 2014;96:220–225. [\[CrossRef\]](#)
18. Zimmermann J, Dahlbender RW, Herbold W, Krasnow K, Turrión CM, Zika M, Spitzer C. The OPD structure questionnaire captures the general features of personality disorder. *Psychother Psychosom Med Psychol* 2015;65:81–83. [\[CrossRef\]](#)
19. Vicente CS, Oliveira RA, Silva F, Ferrajão P, Augusto S, Oliveira S, Senra H, Oliveira R, Krieger D. Cross-cultural adaptation of the Operationalized Psychodynamic Diagnosis (OPD-2) in Portugal. *Trends Psychiatry Psychother* 2012;34:129–138.
20. Shedler J, Westen D. Refining personality disorder diagnosis: integrating science and practice. *Am J Psychiatry* 2004;161:1350–1365. [\[CrossRef\]](#)
21. Westen D, Waller NG, Shedler J, Blagov PS. Dimensions of personality and personality pathology: factor structure of the Shedler-Westen assessment procedure-II (SWAP-II). *J Pers Disord* 2014;28:281–318. [\[CrossRef\]](#)
22. Shedler J, Westen D. The Shedler-Westen Assessment Procedure (SWAP): making personality diagnosis clinically meaningful. *J Pers Assess* 2007;89:41–55. [\[CrossRef\]](#)
23. Blagov PS, Bi W, Shedler J, Westen D. The Shedler-Westen Assessment Procedure (SWAP): evaluating psychometric questions about its reliability, validity, and impact of its fixed score distribution. *Assessment* 2012;19:370–382. [\[CrossRef\]](#)
24. Westen D, Shedler J. Personality diagnosis with the Shedler-Westen Assessment Procedure (SWAP): integrating clinical and statistical measurement and prediction. *J Abnorm Psychol* 2007;116:810–822. [\[CrossRef\]](#)
25. Ortigo KM, Westen D, Bradley B. Personality subtypes of suicidal adults. *J Nerv Ment Dis* 2009;197:687–694. [\[CrossRef\]](#)
26. Malone JC, Westen D, Levendosky AA. Personalities of adults with traumatic childhood separations. *J Clin Psychol* 2011;67:1259–1282. [\[CrossRef\]](#)
27. Özçürümez Bilgili G. Psikanalitik yönelimli dinamik psikoterapinin bugünü. *Türkiye Klinikleri J Psychiatry-Special Topics* 2015;8:1–9.
28. Gabbard GO, Gunderson JG, Fonagy P. The place of psychoanalytic treatments within psychiatry. *Arch Gen Psychiatry* 2002;59:505–510.
29. Kernberg OF. Psychoanalytic contributions to psychiatry. *Arch Gen Psychiatry* 2002;59:497–498.
30. Wallerstein RS. Psychoanalytic treatments within psychiatry: an expanded view. *Arch Gen Psychiatry* 2002;59:499–500.
31. Smit Y, Huijbers MJH, Ioannidis JPA, van Dyck R, van Tilburg W, Arntz A. The effectiveness of long-term psychoanalytic psychotherapy –a meta-analysis of randomized controlled trials. *Clin Psychol Rev* 2012;32:81–92. [\[CrossRef\]](#)
32. Fonagy P, Lemma A. Does psychoanalysis have a valuable place in modern mental health services? Yes. *BMJ* 2012;344:e1211. [\[CrossRef\]](#)