

Operationalized Psychodynamic Diagnosis. **Tailor-made: the experience of meeting with the patient in diagnosis and during the therapeutic process**

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ABSTRACT. – The article presents the *Operationalized Psychodynamic Diagnosis* in its newest third version (OPD-3), as a clinical, educational, and research tool capable of responding to the needs of so-called “real therapies” in institutional contexts and in daily clinical practice. Drawing on a critical reflection on the limitations of categorical diagnostic systems and the inherent difficulties in defining “fact” in clinical practice, the article explores the role of theories, beliefs, and “private theories” between patient and therapist in the process of psychodynamic observation and understanding. The risk of premature closure of clinical thinking, linked to the Bionian concept of “chosen fact” and the notion of “overvalued ideas”, is discussed, stressing the importance of bottom-up tools that foster a phenomenological description that is rigorous but open to complexity. In this framework, the OPD is presented as a multi-axial and procedural diagnostic model, capable of integrating different levels of observation – disease experience, interpersonal relationships, intrapsychic conflicts, and personality structure – while maintaining a balance between standardization and attention to

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the uniqueness of each case. Ample space is devoted to the theoretical and clinical framework of the OPD-3, to the main innovations introduced in the third edition of the manual, and its use for diagnosis, planning, and monitoring of treatment.

Key words: Operationalized Psychodynamic Diagnosis, OPD-3, psychoanalytic diagnosis, therapeutic factors, real therapies.

“If we want to understand the world we must begin to comprehend how the mind is structured, or rather the principles that regulate its functioning, making experience possible.”
(Kant, 1781)

The *Operationalized Psychodynamic Diagnosis* (OPD) originated from the need to consider different areas of human functioning that are useful for drawing a map that helps the clinician, who is careful to collect data from detectable clinical facts in session with the patient or with his/her history and narrative. The emphasis on a bottom-up approach has the advantage of facilitating the collection of “raw” data and thus also the recognition by the clinician of the complexity of the field of observation and the constant tension between specific clinical elements in their continuous evolution, stimulating an additional interpretative effort to keep the observations together and make sense of them.

The OPD was designed as a diagnostic system, but as it developed, it became more process-oriented and treatment-oriented and aimed at therapy planning. This bottom-up approach makes the system particularly usable not only in diagnosing but also in the analysis of the change process, which often starts with an attempt to reconcile and make sense of further variables that have not yet emerged or been recognized. Attention to observable clinical data, recognizable through the work to operationalize concepts that are important for understanding the functioning of the individual, has also proved to be very useful in its educational function, getting clinicians used to – even if they are of different theoretical orientations – constantly substantiating their hypotheses from what emerges and then seeking a meaningful configuration, instead of starting from *ex ante* constructed categories, within which to seek points of contact with the patient’s experience.

In the OPD, the observables, that is, the areas of functioning, have been divided into four axes that organize the clinical information collected and are placed as vertices from which the integration and construction work of the functional diagnosis develops; the axes deal with the experience of illness and the conditions for treatment, interpersonal relationships, unconscious intrapsychic conflicts, and the structural aspects that characterize the functioning of a person. These areas were then studied, considering the existing literature, in order to describe them clearly and bring them closer

to clinical examples that can serve as an effective comparison with the clinical nuances that we are faced with when in session with a specific patient.

Our group, *Gruppo Zoe Association*, has been involved in this from the start, with the view of integrating knowledge, the processes that define the paths of therapy, their outcome, and the factors that contribute to it, in a positive or negative sense, up to the development of diagnostic systems capable of functioning as a tool for framing and monitoring treatment. We have always been concerned with understanding and experimenting with this set of factors in the context of what we have termed “real therapies”, meaning therapies that are widespread in public and private settings, rather than the “special cases” or “exemplars” that underlie most clinical work, which have been the subject of subsequent generalizations.

The work of integrating knowledge is necessary so that knowledge that depends on different disciplines, anchored in different theoretical and epistemological bases, can be used synergistically in everyday practice. An important goal in our work has been the proper functioning of mental health services. Achieving good results – as we shall see – is not only due to investing in staff, but to the use of effective procedures; “much can be done with less, but well”. Another interest of ours is to contribute to training with innovative methods and institutional discussions, improving communication among professionals of different orientations and schools.

Since its introduction in Italy with the second edition, the OPD has been used satisfactorily in clinical settings, in public institutional contexts (the ASST [Local Health Authority] of Lecco and the AUSL [Local Health Unit] of Parma, Italy), private settings (Santagostino Psiche, Italy), as well as in specialist activities in private practice and also as a training tool for many young psychotherapists (let us cite as an example in Milan the schools of specialization in psychotherapy that have integrated it into their training proposal: *Coirag, Isipsè, Nuove Cliniche Nuovi Setting*).

Understanding how to improve the quality and effectiveness of “real” therapies in mental disorders is therefore an objective that must be pursued. To achieve this goal, we must try to be as independent as possible; that is to say, to be able to set aside affinities, personal theoretical beliefs, and narrow definitions of disciplinary areas, according to the pragmatic principle: “It does not matter whether the cat is black or white, what matters is whether it catches the mouse”, an eastern variant of “*Hypotheses non fingo*” (“I feign no hypotheses”) with which Isaac Newton (1713) stressed the value of the observation of “facts” and their concatenations. This objective, to understand the “facts”, that is, what is directly observable, hides a considerable complexity. In particular, we are referring to the methods that can be used for this purpose, to their limitations and potential; the diagnostic process, which is the basis of understanding and therefore of curing, is affected by the diversity and variety of approaches that characterize our field of action.

We therefore believe that it is necessary to consider the conceptual tools involved in this type of path and the meaning of the terms that will be used. Every type of “fact” presupposes an observation perspective, so understanding the perspective through which we observe a “fact” and redefining it in its limitations and characteristics is a mandatory step. This topic, usually used to support radical “subjectivist” viewpoints, can be considered from another point of view: as E. Nagel (1967) happily observed, knowing the limitations of our methods of understanding does not diminish their value but makes them more accurate and precise. That is the meaning of Kant’s phrase in the epigraph: to reflect on our ways of understanding.

While it is clear that there are no facts entirely independent of the observer’s theories/beliefs/perspectives/contexts, this topic is all too often used to value one’s beliefs by avoiding empirical assessments, comparison with other viewpoints, and diminishing the power of innovative ideas. Even the subjective experience of the moment can be considered a “fact”, indeed – we could say – “the fact” par excellence. But what is a “fact”? Zeno, head of the Stoics, argued that “falsehood cannot be perceived; only the truth can be perceived”. “Fact” is therefore connected to what can be perceived with our senses, including personal feelings, and which tends to disrupt any pre-existing theoretical construction. The concept is picked up again by Aristotle and Saint Thomas with the formula “*contra factum non valet argumentum*” [against a fact, you cannot argue] (indicating that a thing cannot be and not be at the same time and in the same respect). Goethe (1833, 1840), centuries later, argued that “every fact is already theory”. The history of medicine is full of examples of how contradicting expert theories, even by demonstrating “facts”, has often elicited dangerous reactions, including the risk of being burned at the stake. Michael Servetus, for example, was the first to deny the permeability of the interventricular septum, based on anatomical observations, and was burned at the stake, or Semmelweis, who discovered the role of infections induced by non-sterile maneuvers during childbirth, who died alone and forgotten. Can we therefore say that “theory falsifies observation”? Perhaps this perspective may seem somewhat radical; however, as Piaget (1972) demonstrated, when a deeply held conviction encounters a fact that initially appears to contradict it, the fact itself may go unperceived. Subsequently, it is reinterpreted to align with the existing belief, and only at a later stage can it foster a genuine developmental shift, which Piaget defines as “*équilibration majorante*” (Mattana, 2017). Britton (1998) also speaks of the need to overcome one’s beliefs, those in which we invest, as a liberating act that presupposes a process of mourning.

This premise stems from the need to recover, especially in training courses, in diagnostic procedures, and in the perception of changes that take place in therapy, the ability to grasp the “facts” that arise from experience/direct observation and that may belong to the content of narratives, of behaviors,

of what is perceived, and also to the area of what is subjectively experienced by the therapist in terms of emotions, thoughts, and fantasies.

The “chosen fact” Bion speaks of indicates the ability to connect individual elements (facts) perceived before they are structured in theoretical form. For Bion, the expression “chosen fact” describes an emotional experience in which a process of synthesis occurs, carried out by the clinician and accompanied by feelings of coherence and discovery. In *The Imaginary Twin*, Bion (1970) calls “evolution” the “connecting via a sudden intuition, a series of phenomena apparently unrelated and which, after intuition, have assumed a coherence and meaning that they did not previously possess”. Unimaginable but unambiguous connections that emerge from the patient’s speech.

This does not concern only the world of psychoanalysis and psychology in general, but is a common experience in countless fields. Even a footballer follows the theoretical ideas and suggestions of their coach, but when taking a shot, they are guided by instinct. Moreover, they may spontaneously attempt something they have never tried before, responding to specific circumstances and discovering its effect.

Britton and Steiner (1994), however, begin by considering the extreme proximity between the “selected fact” and an “overvalued idea”. The feelings of uncertainty and confusion caused, at times, by the material in the session push the patient and analyst to seek a complete meaning made with feelings of urgency. The search for and the apparent emergence of a constant conjunction on which to construct an interpretative hypothesis do not protect us from false paths or misunderstandings. Britton and Steiner define the analyst’s overvalued idea as selected facts, which are actually determined by the analyst’s defensive reactions, their need to confirm theories, or to ward off anxiety about certain material. The overvalued idea thus becomes a refuge for the analyst or the dyad in moments of particular confusion, compensating for a lack of psychic stability. In this way, their own theories are misused, shifting from a living heritage into zones of non-thought.

A contribution to understanding the relationship between theories and “facts” comes from the construct of “private theories” (Werbart & Levander, 2006). This construct is based on the idea that from the start, patient and analyst develop beliefs about the nature, genesis, and possible solutions of psychological suffering (diagnosis/therapy) and that these, as the therapeutic work progresses and the related transformations that this entails in the vision of self and relationships, can change and evolve. The patient’s private theories are linked to fantasies about the genesis of suffering, gratification of desires, and dealing with or avoiding pain (Chichi *et al.*, 2025; Fava *et al.*, 2025). In therapists, private theories can be described as an amalgam of official theories, elements of their own clinical and life experience, individual values, and transference and countertransference elements (Hunter, 1996). The perspective of interpretation in which analysts

place themselves (traumatic-relational, conflictual-intrapsychic, or deficit-structural) also plays a role in the interpretations of the patient's suffering and the subsequent strategies of treatment (Sabucco *et al.*, 2020). Other research has highlighted how the nature and characteristics of these theories affect analytical work and, in particular, how the discrepancy between the expectations and beliefs of the patient and analyst about therapy and the analyst's inflexibility in planning therapy may influence its outcome in terms of its premature or negative conclusion (Tzur Bitan *et al.*, 2021; Werbart & Levander, 2006; Wile, 1977).

What appears to affect the process and outcome of treatment is not so much the close congruence between the different theories of the analyst and patient, but rather the ideal tension toward their progressive convergence, as well as the presence, or not, of interventions by the analyst that encourage dialogue between their respective theories, to enhance the patient's point of view (Philips *et al.*, 2005; Weiss, 1998) and mutual attunement. It is also evident that conscious and creative collaboration is not only considered in its rational and cognitive aspects, but also as an expression of a complex interactive process that involves implicit, unconscious, and relational aspects, which characterize the different levels of the therapeutic relationship.

This process begins as soon as we make a "diagnosis", that is, we develop ideas about the nature of the patient's problems and then move on to define the treatment focus and prospects for treatment.

Finally, let us consider that one can share both the idea that perspectives and opinions of patients and analysts, as well as those between psychiatrist biologists, and psychotherapists of different orientations, belong to the field of explicit and implicit "beliefs". Freud himself faces the problem of believing in different contexts. He equated belief with a judgment of reality, a phenomenon that belonged to the system of the Ego and thus to consciousness. He later acknowledged that "even a portion of the Ego can be, or rather is unquestionably unconscious" (1922, p. 481). Ultimately, we might think, with Britton (1998), that believing is an unconscious mental process that produces beliefs that can then be changed relatively easily or constitute solid barriers to change. Britton notes that in psychoanalytic literature "there is surprisingly little about the topic of belief", especially as "it is the daily task of analysts to explore their own conscious and unconscious beliefs and those of their patients" (*ibidem*, p. 22). So, what is the statute of belief? Belief can be considered as the function that confers the state of reality to unconscious fantasies and ideas. "Belief confers the strength of reality on what is psychic" (*ibidem*, p. 26), as perception confers the state of reality on what is physical. What is perceived, therefore, requires a belief to become knowledge. Believing in something means you consider it true. In any case, "our emotional reactions and actions are not based on knowledge, but on belief" (*ibidem*, 26). The discovery of mere beliefs, not knowledge,

is an act of emancipation and a function of psychoanalysis. Realizing that it is a belief is a secondary process that depends on the ability to look at the belief from outside and, in turn, depends on the ability of the individual and the therapeutic dyad to find “another” position from which to observe their belief. This, made conscious and recognized as such, can be tested through comparison with perceptions, memories, known facts, and other beliefs and, consequently, modified (Lichtenberg, 2012). Our beliefs have the quality of a psychic object, on which we invest. To give up on them is thus a process of mourning. If any cognitive bond foreign to the existing belief system in the self is treated as a dangerous link to something foreign, then that bond can be attacked and destroyed (Bion, 1959).

Empirical data, understood as the product of scientific research, in the paradigmatic sense of the word, may be naively confused with “fact”, but in reality, it is the product of well-defined procedures that concern both the choice of “facts” to be considered and the modalities and tools with which they are interpreted and standardized. In this way, the results of studies can only be considered as partial, especially if we want to study complex phenomena determined by many interacting variables. The complexity does not belong only to the observer but also to the way in which reality is structured. Complex systems have the characteristic of being determined by different variables and are highly sensitive to the perturbations they encounter in their development (Ceruti & Damiano, 2018). However, the results of empirical studies, which are properly set up and conducted, are particularly suitable for giving partial confirmation/disconfirmation of theoretical beliefs and opening innovative scenarios. Empirical research has, for example, significantly confirmed the effectiveness of psychotherapies, highlighted important predictive factors of outcome and customization, and highlighted the profound differences between patients with the same categorical diagnosis. It has shown relevant aspects of the functioning of “real” therapies and, finally, the value and basic characteristics of “care relationships”, in particular, the therapeutic alliance (Fava *et al.*, 2016; Norcross & Lambert, 2018).

Each of the diagnostic methods has advantages but also possible biases. Categorical systems, such as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association, 2013), are useful for building general categories (which are the subject of epidemiological studies), for pharmacological prescriptions, and to facilitate communication between therapists of different training backgrounds. They are inadequate, however, in the opinion of the writers themselves (Spitzer & Frances, 2011) in providing accurate information on the mental functioning of individual patients, their resources, possible obstacles in the path of care, the quality of the relationship that can be established with patients, the recognition of signs that indicate potential for change/non-change and the lack of recogni-

tion of the role that the patient has in structuring their suffering and participating in the treatment process (Papini & Fava, 2019). Moreover, categorical systems suggest therapeutic procedures that are too standardized and prefigured *a priori* (top-down), which favor the creation of stigmas and can be used for the structuring of defensive frameworks. The limitations of nosographic-descriptive-categorical systems have also been reported by empirical research: patients with the same categorical diagnosis may be profoundly different in many variables that have prognostic significance or that may guide the therapeutic project differently (Laska & Wampold, 2014; Norcross & Wampold, 2011a, 2011b; Norcross & Lambert, 2018). The methods of classical psychoanalysis, which allow knowledge of implicit levels of psychological functioning, involve considerable risks, such as the selection of special cases to confirm pre-existing theoretical models, institutional conformism, and the absence of tools and procedures for verifying the theoretical convictions of individual therapists (Vigna-Taglianti, 2018).

Ultimately, understanding a “fact” does not seem so simple: among official and private theories, overvalued ideas, beliefs, and generalizations derived from the results of empirical studies, ideological attitudes, and unknown epistemological settings, it is as though we are observing a ship sailing between rocks and faint lighthouses. The ability to integrate knowledge from different approaches and methodologies can help us develop more effective and personalized forms of treatment.

To clarify, this does not mean that the importance of the theoretical conceptions through which we conceptualize our experiences, or of the results of empirical studies, should not be considered, but that the ability to understand the “fact” must be at the basis of the interpretation of any experience or empirical data, or rather, the “clinical fact”. In practice, too often we observe that theoretical conceptions and other beliefs overlap attention in grasping facts, influencing them *a priori*. There may be broad agreement on this, but we need to see whether this principle is actually implemented in therapeutic practice, in training courses, and in institutional discussions. In this sense, we speak of “real” therapies according to the well-known principle of “easier said than done...”

How can we make the categorical perspectives coexist concretely, based on the identification of symptoms, the irreplaceable methods of psychoanalysis (and not only), based on subjective experience in its becoming, and the indications that come from empirical research? First of all, the clinical assessment must be based on the identification of the various aspects and dimensions underlying psychological suffering; in this sense, the use of multi-axial systems, which involve systematic analysis of different aspects of the mental functioning of a person and the therapeutic relationship established, uses a series of “anchor points” (examples of clinical situations that orient observation and assessment regarding a specific theoretical concept)

that allows an overall view, which is not polarized on individual aspects and perspectives that are determined *a priori*. This is not too different from a good doctor who first examines a patient and then constructs their diagnosis, compared to a bad doctor who instead formulates their diagnosis from the symptoms that the patient puts in the foreground, neglecting to explore the different areas of patient functioning with an overall view.

Secondly, in line with what has been aforementioned, a phenomenological/descriptive dimension must be recovered as a basis for further analysis and comparisons.

These aspects are not picked up by the “three-level model” by chance (Bernardi, 2014). The three-level model was developed by the International Psychoanalytical Association Project Committee on Clinical Observation to “improve the systematic clinical observation of patient changes during therapy”. This model foresees a development in three phases; the first phase adopts a phenomenological/descriptive perspective. The next phases include a step-by-step approach to observable changes and finally consider more theoretically oriented interpretive hypotheses. According to Marianne Leuzinger-Bohleber (2006): “Considering the multiplicity of the theoretical languages of psychoanalysis, it is useful to begin to describe the discussion using phenomenological language by attempting to standardize concepts using words that include the lowest common multiple of the different theoretical versions of these concepts (OPD-2)”. Marianne Leuzinger-Bohleber makes explicit reference to current diagnostic systems and in particular to the OPD-2 model that “offer a useful description” of these dimensions, particularly in training programs (Leuzinger-Bohleber, 2006). It should be clear that, from our point of view, it is not a question of proposing a new system with a categorical background that is perhaps more sophisticated, but of a path of knowledge of each individual case as it evolves. If we used the OPD-3 as a system to create categories, we would run into the same flaws as all categorical systems. In this sense, the OPD system is placed in a dimensional/phenomenological and process-analysis perspective.

Even in the practice of supervision and in the discussions of clinical cases, we have observed the tendency to describe cases from different perspectives: the historical/pathogenetic one, the one conditioned by pre-established theoretical beliefs, the descriptive sequences of events from the subjective impressions of the therapist and from the narrations by the patient. All of this information is extremely abundant and, when used to draw conclusions, is prone to selective and potentially distorting interpretations. In other words, everyone can draw conclusions from this plethora of data, conditioned by their own beliefs and impressions. Another way of looking at the clinical case or what happens in the analysis room, as it were, is to focus, step by step, on the events that occur in therapy: narratives, silences, actions, fantasies, dreams, countertransference reactions, etc. Each of these

units is observed from the perspective of identifying the “selected fact” on a phenomenological, abstinent, concave basis that is potentially shared because of its own evidence, which can be modified as more information is added to that already considered. It is one thing to grasp the meaning of an extremely rich and comprehensive narrative, but open to endless interpretative possibilities; it is another to establish the meaning of a delimited transaction and proceed with successive and progressive appositions.

We should therefore proceed with a phenomenological exploration, considering several potentially critical areas, collecting them, and summarizing them until we define an initial focus of the problem. As in the mystery picture puzzle, where you color the individual parts and then the complete figure appears, in our case, the figure is not already defined but is evolving. This modality fits well, even if it does not coincide, with the use of multi-axial diagnostic systems such as the OPD-3, which provide observation levels in several distinct areas, facilitating systematic and accurate observation of each event and its final placement in a defined, albeit modifiable, focus.

Clinical example: A patient arrives slightly late for a session. He sits in the waiting room and despite the office door being ajar, he does not knock. The analyst thinks that he has not arrived and, after a while, steps out to check and sees the patient and invites him in. The patient enters apologizing for the delay. The therapist could continue with the session as if nothing significant had happened, but she is struck by this situation. She thinks that this behavior could simply be dictated by politeness, but she is not convinced; she thinks about it. The important thing here is to focus on this event. The therapist asks the patient if he had thought about knocking or entering the office directly since the door was ajar. The patient says something like, “I would never!”, signalling the presence of a relational framework that visibly contrasts with his statements that he feels good and safe with the analyst: there is another truth. Subsequent associations lead to the identification of a relational framework in which an extremely authoritarian analyst can accept him as long as he behaves in a submissive and subordinate manner (Axis II, OPD-3). Non-acceptance would also lead to the danger of abandonment (signaled by anguish), leading to death. This will become one of the main focuses of therapy. The final assessment is constructed by piecing together individual elements.

Let us now go into more detail: The OPD, which we have already defined as diagnostic-procedural, is designed not only to offer a complex, transtheoretical framework for assessment but also to provide practical tools for analyzing the therapeutic process. In 2024, the third version of the OPD manual was published in the original German language; currently, a revision is in progress for the next publication in Italian, which our group has curated in continuity with the previous edition. The third version of the OPD manual presents a refinement of the contents, including recent devel-

opments in terms of research, as well as a reorganization of their presentation (in the new edition, all information relating to each axis is collected in a single chapter), in order to make the consultation more straightforward and easier, avoiding the need for continuous internal references for the reader and promoting greater overall clarity of the diagnostic system.

Axis I – *Experience of illness and treatment prerequisites* – integrates elements concerning the illness/disorder/problem and related symptoms (such as severity of clinical picture, chronicity of disorder, and age of onset) for objective assessment with elements emerging from the subjective perspective of the patient. For example, how the patient experiences their own discomfort; what their understanding is of its causes, as well as their expectations and strategies for managing it; the resources they possess, the potential internal and external obstacles, and the ways in which they cope daily to handle these difficulties. There is also a more detailed analysis of psychotherapy, which helps, on the one hand, to understand the patient's desires for a possible path, such as being supported, reducing symptoms, or exploring oneself, and on the other hand, to assess the resources, psychological mindset, or secondary benefits of maintaining the problem. The components investigated by this axis come from conceptualizations of the problem of different theoretical orientations and are closely linked to the idea that “the patient must be welcomed where he/she is in that moment and his/her expectations should be taken into account” (OPD Task Force, 2006, p. 40). Each treatment type requires the patient to be willing, both emotionally and cognitively, to embark on a path that will still involve a certain tolerance to getting to know himself/herself. When considering whether psychotherapeutic intervention is appropriate, but also in its initial planning, it is essential to consider several factors, including the intensity of the patient's distress, their ability to understand and attribute meaning to what they experience in emotional, motivational, and relational terms; it also includes the level of readiness to initiate the proposed course of treatment. It is also necessary to consider the availability of personal and social support resources that can sustain the process of care. Clarification of these dimensions in the diagnostic phase is therefore essential to properly guide the choice of treatment. In this sense, Axis I of the OPD includes key elements for building the therapeutic alliance and identifying a targeted, coherent, and shared intervention.

Axis I of the OPD-3 includes the main descriptive-phenomenological diagnostic categories from the most widely used international systems (International Classification of Diseases [ICD]-10/ICD-11, DSM-IV/DSM-5). This integration underlines the importance of an accurate definition of psychopathological phenomena, which is also fully recognized within a psychodynamic diagnostic framework. The key assessment criteria for Axis I have been retained overall but reformulated in a more basic and accessible way.

Among the most relevant innovations are the introduction of “alternative” concepts with respect to the source of the problem and the change. In the objective assessment of the disorder, the estimation of overall severity and course has been aligned with international standards. In order to increase reliability and validity, the global assessment of functioning has been divided into three distinct areas: symptoms, occupational functioning, and social functioning. In addition, the psychotherapy module, previously separated in the OPD-2, has been fully integrated into Axis I.

Axis II – *Interpersonal relations* – explores the way in which the patient lives and organizes relationships with others, allowing the identification of any dysfunctional relational patterns that tend to recur over time, while also highlighting the relational resources available to the individual. Behavior in relationships is conceived as the manifestation of dynamics that emerge from the interaction between the patient’s relational desires, the anxieties that such desires can trigger – including their intrapsychic effect – and the expectations or fears related to other people’s possible responses. These aspects are deeply connected to the internalized, often unconscious, representations of significant figures; relational functioning is therefore considered in close continuity with deeper levels of psychic organization, which may concern both conflicting areas and structural aspects of personality. The assessment of Axis II is based on two main sources of observation: on the one hand, the patient’s stories of significant relational experiences and situations; on the other, what takes shape in the here and now of the clinical encounter, within the relationship between the patient and the therapist. The focus is on four key perspectives: how the patient typically experiences others and themselves in relationships, and how others – including the therapist – perceive the patient and their own role in relation to them. The integration of these different points of view allows for the development of the so-called “relational dynamic formulation” that describes the dysfunctional relational pattern characteristic of the patient. As an example, we might think of a person who reports feeling neglected by their partner and reacts to that experience by retreating and closing themselves up. This behavior may be interpreted by the partner as a more or less explicit request for space or autonomy, inducing them to distance themselves; however, such a response risks being experienced by the patient as further confirmation of their feeling that they are not being considered, thus strengthening the maladaptive relational circuit. In the psychotherapeutic field, the work on relationships plays a central role, as it offers the patient the opportunity to move from a rigid system of expectations to a wider range of relational possibilities; through emotionally corrective experiences, the subject can experience more satisfying relational modalities compared to their own needs and desires, with consequences also on intrapsychic functioning. The ability to recognize that some relational behaviors may contain unconscious “relational offers” –

such as withdrawal experienced by the other as a demand for space – encourages a more active and responsible position within relationships and their modifiability. Theoretically, the operationalization of Axis II is inspired by the circumplex model originally developed by Sullivan (1970) and later elaborated on by Benjamin (1974) and also incorporates elements of Luborsky's Core Conflictual Relationship Theme model (Luborsky & Crits-Christoph, 1998) for relational narrative analysis. This axis connects in a special way to specific therapeutic factors, such as the accuracy of relational interpretations, the management of the real interpersonal relationship, and work on and through countertransference.

Axis II in the OPD-3 maintains, as in the previous version, the exploration and identification of the main repetitive and dysfunctional relational patterns of the patient from two complementary perspectives: the subjective experience of the patient and the point of view of the significant other in the relationship. The clinical reference material is made up of the narrated relational episodes, on which the selection of descriptive items most relevant to the case is inserted. The list of items remains unchanged in its composition and continues to be organized according to the circumplex pattern of interpersonal behavior, respecting the logic of the circular model. The two experiential perspectives and the process of integrating the selected items into a dynamic-relational formulation, which forms the core of the Axis II diagnosis, are also confirmed. The main innovation concerns the introduction of a dimensional evaluation of items. Each relational pattern can now be placed along a continuum of dysfunction, distinguishing between non-problematic/not relevant, prominently present, and present in a dysfunctional manner. For each item, there are specific descriptions of the different levels, which are collected in a summary table. Furthermore, each pattern can be separately identified as a resource if it is assessed as adequate. The OPD-3 clearly distinguishes between a clinical assessment mode and a research mode: in clinical settings, items deemed significant are selected and dimensionally assessed and then reduced, as before, to three items for each experiential perspective. In the research version, however, pairs of adjacent and conceptually related items are merged, in analogy with the clusters of the Structural Analysis of Social Behavior model; the total number of items is thus halved, but each item must be evaluated comprehensively and independently, allowing for a more precise description of pattern intensity, the construction of relational profiles, and easier statistical analysis of the data.

Axis III – *Conflict* – is rooted in the classical psychodynamic tradition – particularly regarding issues such as autonomy, control, guilt, and self-esteem – and in the more recent theories on motivational systems that guide the development of the individual over the entire life span (Lichtenberg, 1995; Stern, 1995). Conflicts arise when needs, desires, impulses, or representations come into conflict with each other; when such tensions give rise

to rigid, persistent, and not fully accessible behavioral modes of consciousness or voluntary control, they are referred to as unconscious intrapsychic conflicts. The OPD model identifies seven major conflict areas: Dependency vs. Individuation; Submission vs. Control; Need for care vs. Autarky; Self-worth conflict; Guilt conflict; Oedipal conflict; Identity conflict (in the OPD-3, the situation in which there is a defense from the perception of conflict and emotions is also assessed). Each conflict is assessed along a continuum of relevance ranging from absence to extremely significant, with the aim of identifying one or more predominant and dysfunctional conflicts, while recording the presence of all the elements in the field. For the main conflict, the prevailing expressive mode is also explored, which can be situated on a more regressive or counterphobic side than the topic in question. For example, in the case of a marked conflict between the need for care and self-sufficiency, a patient may present himself as highly dependent, in need of reassurance, with difficulties in separation, and a narrow but intense relational network characterized by affects of sadness and fear of abandonment; this configuration suggests a regressive mode. On the contrary, a person who denies their care needs could be overburdened with responsibility and present themselves as excessively autonomous, expressing the same conflict in an active and counterphobic form. In many cases, however, mixed or oscillating modes may emerge. The assessment of conflicts is mainly based on the patient's medical history and life history, with particular attention to trigger events and situations experienced as problematic. Further guidance comes from the observation of the therapeutic relationship, including analysis of prevalent affects – such as anger, shame, envy, guilt, or sadness – that serve as useful indicators to guide understanding of the underlying conflict. When therapeutic work is focused on this axis, and the patient structure is sufficiently integrated, the main objective is to promote a more flexible and stable balance between conflicting polarities and a better capacity for self-regulation.

The OPD-3 preserves the seven conflicts already present in the previous versions, each articulated in the two processing modes, along with the category relative to defense from perception of conflict and affects. At the same time, important conceptual and operational innovations have been introduced; in particular, the motivational system underlying each conflict is explained and the functional development trajectory is described, *i.e.*, what is observable when the conflict is not present and the motivation system is well integrated. A further relevant distinction is that between central affects, painful affects, affects that tend to be repressed, and guiding affects, which are more easily accessible to consciousness (and which, as the definition suggests, can lead to recognition of underlying affects). It is also possible to differentiate between persistent lifelong conflicts and current conflicts, facilitating the description of any changes over time, including in

relation to the way in which they are processed. The independent category of “current conflict”, which is often debated, has been surpassed, and the dimension of “current event” is now being used to describe motivational-conflicting themes that permeate the daily psychic experience, even in the absence of a structurally serious and persistent conflict. A significant change is the extension of conflict assessment to all structural levels, including those that are poorly integrated or not integrated. To this end, specific descriptions of the conflict manifestations have been formulated as well-integrated, moderately integrated, and poorly integrated. Another section of the handbook also delves into the integration of the concept of dilemma, according to Mentzos’ model (2015), within the Conflict Axis.

Finally, Axis IV – *Structure* – concerns the personality structure and is the last axis of psychodynamic derivation of the OPD system; the structure can be thought of metaphorically as the configuration of a crystal, the development of which depends on baseline conditions but remains open to transformations over time. This view is similar to the models of non-linear dynamic systems, described by Sander (2005) as continuously moving systems, sensitive to the initial conditions but not rigidly determined by them. In the psychological field, “structure” refers to the relatively stable set of psychic arrangements that organize the experience and behavior of the individual, constituting a basis on which the subject tends to restore their own intrapsychic and interpersonal balance. From an evolutionary and dynamic perspective, personality structure stems from the interaction between early constitutional and relational factors, particularly in care experiences, but remains susceptible to significant changes throughout life. Consequently, any structural description is necessarily inferential, partial, and temporary. The articulation of Axis IV is inspired by the work of Rudolf and Henningsen (1993) and aims to describe the structure of the self in its observable functions, both with regard to oneself and in relation to others. Cognitive-affective skills are considered along a continuum ranging from the most basic functions – such as the distinction between self and non-self – to metacognitive and reflective skills, to the integration of different areas of psychic functioning and self-regulation processes. From a clinical point of view, the therapeutic objective of this axis is to identify the most deficient structural areas and to modulate the intervention in such a way as to facilitate their development, avoiding premature, incomprehensible, or potentially iatrogenic interventions. This is particularly relevant in cases where the patient does not yet have the necessary skills to benefit from interpretative interventions and instead needs supportive work on basic functions such as reality testing, self-other distinction, and mentalization.

Axis IV in the OPD-3 retains its basic setup but presents numerous revisions and expansions: the defense dimension has been reintroduced as the ninth structural dimension, completely renewed in terms of content, while

the other eight dimensions have remained substantially unchanged in their object of observation. Significant changes have been made to the facets: some have been newly introduced, such as those relating to Trust, the Pleasure experience, or Affect Differentiation in relation to the object; others have been merged or reformulated more precisely. A further innovation concerns the manualization of the intermediate structural levels, which were previously only implicit; their explicit formulation makes the structural checklist more detailed, differentiated, and clinically usable. At the same time, the content of the less integrated levels has been thoroughly revised, with the aim of increasing its compatibility with psychiatric language and models, avoiding descriptions based on specific psychopathological frameworks; this work has also been made possible thanks to the contribution of experts in the psychodynamic treatment of psychosis. A table describes all facets at each level, including intermediate facets, and is now the central part of Axis IV.

Finally, the OPD-3 introduces two optional evaluations of structural variability: a temporal one, useful for representing changes over time (for example, as a result of traumatic events), and a specific one for areas of life, which allows one to highlight differences in structural functioning between different contexts, such as work and intimacy; this ability to describe structural oscillations gives the diagnosis greater clinical finesse and a descriptive ability more in keeping with the complexity of patients.

In conclusion, to help the reader who still does not know the OPD system to understand its specificity even with regard to the landscape of contemporary diagnostic systems, let us try to use the metaphor of clothing. There are diagnoses that effectively fulfill the function of ready-to-wear: standardized models, built on predefined sizes, indispensable for quick orientation and for communication between professionals to ensure a common base of reference. Like mass-produced clothing, these diagnoses are functional, affordable, and often necessary. However, while well packaged, they remain thought of for a “standard body” that rarely coincides with the real body of an individual.

There are also more refined systems, comparable to high-end boutiques: high-quality garments, inspired by recognizable stylistic schools, capable of capturing deep and elegant aspects of psychic functioning. However, even these outfits remain linked to collections that have already been designed for defined theoretical lines, within which the patient is invited to fit, sometimes adapting more to the dress than the dress to the patient.

The OPD is different; it is more like a tailor-made suit. A tailor who does not start from a predetermined model, but who observes, takes measurements, listens to needs, takes account of asymmetries, postures, and movements. A tailor who knows that it is not always necessary to make a complete suit; sometimes it is necessary to work on a sleeve, reinforce a seam,

release tension, respecting what the client already has and supporting what is missing. A tailor who knows that their work requires time, patience, attention to detail, and a continuous verification of the result as it takes shape.

In this sense, the Operationalized Psychodynamic Diagnosis is not a label to be applied but a shared constructive process. The axes of the OPD are not rigid compartments, but tools for clinical observation that allow you to orient your gaze without saturating it, to collect “clinical facts” while keeping them open to integration and transformation. The result is never a serial replicable product but a unique, unrepeatable formulation, closely linked to that patient, that therapist, and that moment in time.

As in tailoring, in the OPD, quality does not lie only in the final result, but in the method, in the way in which standardization and singularity, rigor and flexibility, systematic observation and clinical sensitivity are held together. It is precisely this combination that allows the OPD to function not only as a diagnostic tool but also as a treatment guide, as a process compass, and as a language that can be shared between different orientations without sacrificing the complexity of the subject.

In a clinical and institutional context that is increasingly pressed by the demands of speed, efficiency, and simplification, the OPD is a counter-current but necessary choice: to take the time to measure, observe, correct, and retrace your steps. This is because, in psychotherapy, as in tailoring, a good suit is what allows a client to move, breathe, feel comfortable in their clothes and sometimes to transform.

REFERENCES

- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders. Fifth Edition*. Washington: American Psychiatric Association.
- Benjamin, L. S. (1974). Structural analysis of social behavior. *Psychological Review*, *81*, 392-425.
- Bernardi, R. (2014). *Three-level model (3-LM) for observing patient transformations*. In: De Litvan M. A., edited by, *Time for change: Tracking transformations in psychoanalysis – The three-level model*. London: Karnac Books.
- Bion, W. R. (1959) *Attacks on linking Second Thoughts*. New York: Aronson.
- Bion, W. R. (1970). *Il gemello immaginario. Analisi degli schizofrenici e metodo psicoanalitico*. Roma: Armando.
- Britton, R. (1998). *Belief and Imagination: Explorations in Psychoanalysis*. London and New York: Routledge (It. trans.: Gilli C.M., Fregonese S., edited by, *Credenza e immaginazione*. Roma: Borla, 2006).
- Britton, R., & Steiner, J. (1994). Interpretation: selected fact or overvalued idea? *The International Journal of Psychoanalysis*, *75*(5/6), 1068-1078.
- Ceruti, M., & Damiano, L. (2018). Plural Embodiment(s) of Mind. Genealogy and Guidelines for a Radically Embodied Approach to Mind and Consciousness. *Frontiers in Psychology*, *9*.
- Chichi, M. G., Fava, E., Margola, D., Vai, B., Galvano, C., Reatto, L., Cumia, I., & Linciano,

- A. D. (2025). Le Teorie Private di pazienti e analisti: uno studio esplorativo nella fase iniziale del trattamento. *Rivista di Psicoanalisi*, 2.
- Fava, E.; Gruppo Zoe. (2016). *La competenza a curare: il contributo della ricerca empirica*. Milano: Mimesis.
- Fava, E., Chichi, M. G., Galvano, C., Cumia, I., Reatto, L., Vai, B., & Linciano, A. D. (2025). L'alleanza di lavoro nella ricerca clinica e nella ricerca empirica: la costruzione di un progetto di ricerca sul campo con il metodo PTI (Private Theories Interview). *Rivista di Psicoanalisi*, 2.
- Freud, S. (1922). *L'Io e l'Es*. In: Musatti C.L., edited by, Opere, Vol. 9. Torino: Boringhieri (1976).
- Goethe, J. W. (1833, 1840). *Massime e riflessioni*. Milano: Rizzoli (1992).
- Hunter, V. (1996). *Psicoanalisti in azione. I modelli teorici e la loro applicazione clinica*. Roma: Astrolabio.
- Kant, I. (1781, 1787). *Critica della ragion pura*. Torino: Utet, 2000.
- Laska, K. M., & Wampold, B. E. (2014). Ten things to remember about common factor theory. *Psychotherapy*, 51(4), 519-524.
- Leuzinger-Bohleber, M. (2018). La ricchezza della ricerca psicoanalitica contemporanea. Osservazioni epistemologiche e metodologiche. Alcuni esempi e il metodo di osservazione clinica a tre livelli (TLM). *Rivista di Psicoanalisi*, 64(2).
- Leuzinger-Bohleber, M., & Target, M. (Eds.). (2006). *I risultati della psicoanalisi*. Bologna: Il Mulino.
- Lichtenberg, J. D. (1995). *Psicoanalisi e sistemi motivazionali*. Milano: Raffaello Cortina Editore.
- Lichtenberg, J. D. (2012). Therapeutic Action: Old and New Explanations of Therapeutic Leverage. *Psychoanalytic Inquiry*, 32(1), 50-59.
- Luborsky, L., & Crits-Christoph, P. (1998). *Understanding transference. The Core Conflictual Relationship Theme Method*. New York: Basic Books (It. trans.: Capire il transfert. Milano: Raffaello Cortina).
- Mattana, G. (Ed.). (2017). *Ricerca Empirica in Psicoterapia. Intervista a Emilio Fava*. SpiWeb. Available from: <https://www.spiweb.it/la-ricerca/ricerca-psicoanalisi/ricerca-empirica/ricerca-empirica-in-psicoterapia-intervista-a-emilio-fava-a-cura-di-g-mattana/>
- Mentzos, S. (2015). Dilemmatische Gegensätze im Zentrum der Psychodynamik der Psychosen. *Forum der Psychoanalyse*, 31(4), 341-352.
- Nagel, E. (1967). *Problemi metodologici della teoria psicoanalitica*. In: Hook S., edited by, *Psicoanalisi e metodo scientifico*. Torino: Einaudi.
- Newton, I. (1713). *Philosophiae naturalis principia mathematica*. In Pala A., edited by, *Principi matematici della filosofia naturale*, vol. 1, collana *Classici della scienza*. Torino: UTET (1997).
- Norcross, J. C., & Wampold, B. E. (2011a). Evidence-based therapy relationships: Research conclusions and clinical practice. *Psychotherapy*, 48(1), 98-102.
- Norcross, J. C., & Wampold, B. E. (2011b). What works for whom: Tailoring psychotherapy to the person. *Journal of Clinical Psychology*, 67(2), 127-132.
- Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy*, 55(4), 303-315.
- OPD Task Force (2006). *OPD-2 Diagnosi Psicodinamica Operazionalizzata. Manuale per la diagnosi e la pianificazione del trattamento*. Milano: Franco Angeli, 2009.
- Papini, S. P., & Fava, E. D. (2019). L'integrazione nella valutazione diagnostica dei fattori terapeutici correlati agli esiti: Il sistema di diagnosi psicodinamica operazionalizzata (OPD-2). *Ricerca Psicoanalitica*, 30(1), 37-55.
- Philips, B., Werbart, A., & Schubert, J. (2005). Private theories and psychotherapeutic technique. *Psychoanalytic Psychotherapy*, 19, 48-70.

- Piaget, J. (1972). *L'equilibrage delle strutture cognitive*. Torino: Boringhieri.
- Rudolf, G., & Henningsen, P. (1993). *Psychotherapeutische Medizin und Psychosomatik. Ein einführendes Lehrbuch auf psychodynamischer Grundlage*. Thieme Group.
- Sabucco, G., Fava, E., Agazzi, A., Riva, E., & Schweizer, K. (2020). *L'eclettismo consapevole: una ricerca al Centro Milanese di Psicoanalisi*. Quaderni del Centro Milanese di Psicoanalisi. Available from: <https://www.cmp-spiweb.it/i-quaderni-del-centro-milanese-di-psicoanalisi/>
- Sander, L. W. (2005). Le Teorie dei Sistemi Dinamici come meta-inquadramento della psicoanalisi. *Ricerca Psicoanalitica*, 16(3), 267-300.
- Spitzer, R. L., & Frances, A. (2011). Guerre psicologiche: critiche alla preparazione del DSM-5. Intervista. Si apre il vaso di Pandora: le 19 peggiori proposte del DSM-5. *Psicoterapia e scienze umane*, 2, 247-262.
- Stern, D. N. (1995). *The motherhood constellation: A unified view of parent-infant psychotherapy*. New York: Basic Books (It. trans.: La costellazione materna. Il trattamento psicoterapeutico della coppia madre/bambino. Torino: Boringhieri).
- Sullivan, H. S. (1970). *The psychiatric interview*. New York: Norton.
- Tzur Bitan, D., Ben David, T., Moshe-Cohen, R., & Kivity, Y. (2021). Patient-Therapist Congruence and Incongruence of Process Expectations During Psychotherapy. *Psychotherapy*, 58(4), 493-498.
- Vigna-Taglianti, M. (2018). I gruppi di ricerca sulle trasformazioni nel processo analitico. *Rivista di Psicoanalisi*, 64(2), 239-252.
- Weiss, J. (1998). Patients' unconscious plans for solving their problems. *Psychoanalytic Dialogues*, 8(3), 411-428.
- Werbart, A., & Lavander, S. (2006). Two sets of private theories in analysands and their analysts: Utopian versus attainable cures. *Psychoanalytic Psychology*, 23(1), 108-127.
- Wile, D. B. (1977). Ideological Conflicts Between Clients and Psychotherapists. *American Journal of Psychotherapy*, 31(3), 437-449.

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