OPD: A Brief History and the Four Axes of OPD-3

Compiled from Cierpka et al. (2007, Psychopathology) and the OPD Task Force's OPD-3 manual, Operationalized Psychodynamic Diagnosis OPD-3: Manual of Diagnosis and Treatment Planning (Hogrefe).

History: From OPD-1 to OPD-3

The Operationalized Psychodynamic Diagnosis (OPD) system originated in the early 1990s, when a working group of psychoanalysts, psychosomatic clinicians, and psychiatrists came together in Germany. Their goal was to move beyond the purely symptom-based, descriptive classification systems of the time – the ICD and DSM – by adding an empirically grounded, operationalized layer of psychodynamic assessment: conflicts, relationship patterns, and personality structure that classical phenomenological diagnosis does not capture.

The first OPD manual (OPD-1) was published in 1996 (English translation: 2001) and was quickly adopted in clinical practice and research throughout the German-speaking countries. It organized psychodynamic assessment into five axes: Axis I (Experience of Illness and Prerequisites for Treatment), Axis II (Interpersonal Relations), Axis III (Conflict), Axis IV (Structure), and Axis V (a syndromal diagnosis per ICD-10). A revised and expanded manual, OPD-2, followed in 2006 and has since been translated into English, Spanish, Italian, French, Portuguese, Turkish, Czech, Hungarian, Romanian, Russian, and Chinese. Companion manuals were also developed for related populations and purposes, including a child-and-adolescent version (OPD-KJ, first published in 2000; second edition in English, OPD-CA-2, 2017) and applications for substance-use and trauma-related disorders. Manfred Cierpka led the OPD Task Force for many years as a key initiator and spokesperson until his death in December 2017.

OPD-3, the third version of the manual, was first published in German in 2023 and has since appeared in a second German edition (2024) and in this English translation. It preserves the basic architecture and empirical grounding of OPD-2 but reflects a substantial revision: stronger dimensionalization of the rating criteria (to better suit research use) and closer linkage between the axes, allowing a more integrated picture of clinically complex cases. The most visible structural change is that the separate syndromal Axis V (ICD-10/ICD-11 or DSM diagnosis) was discontinued and its content folded into the beginning of Axis I, so that OPD-3 now works with four axes instead of five. Axis III was renamed from “Conflicts” (plural) to “Conflict” (singular), and its seven basic conflict themes were formally relabeled C1 through C7, with an eighth category, C0, for repressed conflict and emotion awareness. Axis IV's six structural categories were reorganized into five paired dimensions (Perception, Regulation, Defense, Communication, and Attachment – the last replacing the older term “Bonding”). Cord Benecke succeeded Cierpka as spokesperson of the OPD Task Force and led the OPD-3 revision process together with a large, multi-year collaboration of psychodynamically oriented clinicians and researchers.

The Four Axes of OPD-3 – Summary

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

Axis I provides an objectifying, external assessment of the patient's mental and/or somatic disorder, its severity and course, and the prerequisites for treatment. Since OPD-3 folded the former Axis V into it, Axis I now begins with the descriptive-phenomenological diagnosis (ICD or DSM). From there it assesses the patient's subjective illness concepts (somatic, externally oriented, and intrapsychic), the change and treatment concepts these give rise to, and the patient's motivation for treatment. It also captures resources for change (distress tolerance, coping, psychosocial support, openness) and impediments to change (external and internal resistance, secondary gain from illness). Together, these criteria give clinicians an initial, integrated picture of a patient's readiness and suitability for psychotherapy.

Axis II: Interpersonal Relations

Axis II identifies a patient's recurrent, dysfunctional relationship patterns, since these patterns typically shape the therapeutic relationship itself and become a focus of treatment. The assessment is organized around four "interpersonal perspectives": how the patient experiences others; how the patient experiences and portrays themselves in relationships; how others (including the examiner) repeatedly experience the patient; and how others experience themselves in relation to the patient – the last two perspectives corresponding to countertransference. Items describing these perspectives are drawn from a circumplex-style item list and combined into a relational dynamic formulation that explains why the pattern is dysfunctional and self-perpetuating.

Axis III: Conflict

Axis III addresses unconscious intrapsychic conflicts – the clash of desires, needs, and anxieties that Freud considered central to neurosis. OPD-3 defines seven core conflict themes, each rooted in a basic human need and expressed through a desire, an associated signal anxiety, and a defense mechanism: C1 Dependency vs. Individuation, C2 Submission vs. Control, C3 In Need of Care vs. Self-Sufficiency, C4 Self-Worth Conflict, C5 Guilt Conflict, C6 Oedipal Conflict, and C7 Identity Conflict, plus C0 for repressed conflict and emotion awareness (an overarching denial of conflict rather than a distinct motivational theme). How a conflict manifests depends on the patient's level of structural integration: at higher levels it appears as a mild, flexible "conflict tension"; at moderate levels as a rigid, repetitive "neurotic conflict"; and at low levels of structural integration as an unstable "conflict schema" – a category new to OPD-3.

Axis IV: Structure

Axis IV assesses personality structure – the relatively stable intrapsychic and interpersonal capacities that underlie how a person regulates themselves, relates to others, and copes under stress, independent of the specific content of their experiences. OPD-3 organizes structure into five dimensions: Perception, Regulation, Defense, Communication, and Attachment (each, apart from Defense, split into self-related and object/relationship-related sub-facets, for 27 facets in total). Each facet is rated along a continuum of integration from good, through moderate and low, to disintegrated. Axis IV parallels – and historically influenced – the Alternative Model for Personality Disorders in DSM-5 and the severity-of-personality-dysfunction approach in ICD-11, and can be used for personality diagnostics more broadly, though its scope and psychodynamic grounding go well beyond that.

Current Activities and Outlook

The OPD Task Force treats OPD-3 as a step in an ongoing process rather than a finished product: it explicitly expects clinical experience, feedback from training seminars, and further empirical findings to drive future revisions, and it is already looking for ways to balance that continual refinement against the instrument's need for stability and clarity. In parallel with the interview-based manual, the group continues to develop and validate brief self-report instruments built on the same constructs, including the OPD Conflict Questionnaire (OPD-KF) and the OPD Structure Questionnaire (OPD-SF), which extend OPD-based assessment into settings where a full semi-structured interview is not practical. OPD is now firmly established in psychodynamic and psychoanalytic training institutes across the German-speaking world and is expected to be incorporated into the new university Master's programs in Clinical Psychology in Germany, while translations of OPD-2 and OPD-3 continue to expand into additional languages to support international clinical use and cross-cultural research. The Task Force is also pursuing closer alignment with mainstream diagnostic frameworks, most notably the convergence between the OPD Structure axis and both the Alternative Model for Personality Disorders in DSM-5 and the dimensional severity-of-personality-dysfunction approach in ICD-11 – a development the group reads as external validation of its structural concept rather than as competition with it. This work continues under changing leadership: after Manfred Cierpka's death in 2017, Cord Benecke took over as spokesperson and steered the OPD-3 revision to completion; this English edition is dedicated to his memory following his own death in 2025. The Task Force, now comprising several dozen clinicians and researchers organized into axis-specific working groups, continues under new leadership, carrying forward the same collaborative, consensus-driven process that has shaped the OPD since its founding in the early 1990s.