The use of international classifications in everyday life of a positive psychotherapist

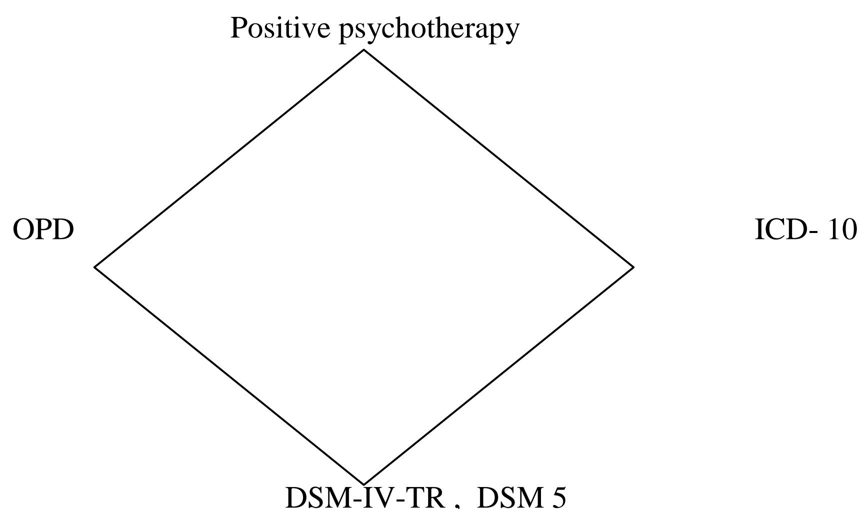
Cristina Vata, MD
Senior psychiatrist
Cardiomed Clinic, Cluj-Napoca , Romania

So very often I heard psychotherapy lacks rigor and methods of "evidence based" which are highlighted in the clinical research nowadays. As a positive psychotherapist I find myself torn apart between building a therapeutic relationship to my client, empathic and unconditional acceptance and the tendency to label the difficulties of my client, to see in a clinical perspective " what are we standing for".

While in training we used the European classification (ICD-10) and the American classification at the time (DSM –IV-TR) which are the psychiatric classifications and later on the new and very exhaustive DSM 5 .

Since 2013 we were introduced to OPD (Operationalized Psychodynamic Diagnosis (OPD-2) The OPD is based on the conception that the main determinants correspond to partial psychoanalytic concepts (transference and countertransference, intrapsychic conflict, personality structure).

The purpose of this work is to take one long-term client and find the pros and the cons for using International guidelines and classifications, how we can use and get help from ICD, DSM and OPD and finding the common ground with psychodynamics and positive psychotherapy.



In the following paper I will try to emphasize one clinical case and use the four classification system. The point of this working sheet is to find some common ground and helpful tools in clinical practice for daily use.

John, 22-year man, comes after a sentimental rupture of a 1 year relationship because he feels sad, irritable at the end's wits, with a significant drop in performance and an inability to focus , nothing in his daily activity gives him any pleasure.

He is a student in third year in Computer Science University, at the same time doing an internship at an IT company where he does his job very well, and there are certain tasks he performs with pleasure.
He comes from a family in Tarnaveni smaller city in Transylvania , he is the older brother and has a half-sister (by his mother) 8 years younger than him. His father left and the parents divorced when he was very young (2years) practically without any relationship with him, except for the last year he found out that his father had emigrated to the US and John contacted him on the social networks and spoke sporadically.
His mother works as a psychological counselor in school, working close with all the teachers John had when he was a pupil. She was pushing him to go "only for the "A"-s, told him all the time that "he wasn't good enough".
Mother remarried when John was 4 years, his stepfather, a pale and insignificant figure "obedient and alcoholic", doing small jobs, "my mother wishing to rescue him from alcohol" and also the relationship with John does not seem to be of particular significance.
John's sister, currently studying at the music school in her hometown, has a good relationship with him and is also a model of the patient, especially in the way to relate to her mother "my sister does not let her mother stress her" . In high school, John says he was a good, obedient and good school pupil, and he had only one friend, both very good at mathematics and computer science, and "it was somehow understandable that we are going to Computer Science in Cluj." Otherwise he did socialize very little and he did not miss them, and with his friend (best friend in high school) he quarreled and cooled relations after an event that I will tell you later.
John is in Cluj for 3 years, he is a student in third year in Computer Science University.
John has entered into a relationship with a girl who describes as "Dolly is like my mother but without me". A relationship without much detail in her main period, in the final part Dolly starts drifting off and he starts calling her often and asking more and more of her time . Dolly "gives him a cold shoulder" and then he understands it's over. He stops seeing her altogether.
At that moment Dolly chasing him hard and he is finding it hard to tell her to go away. She is very active on social networks and contacts him in this game and when he retreats she is very demanding. This love game starts to wear him down but after 6 months with on-off relationship he blocks her completely on his phone, mail, and social account because it was hurting him too much. This was the episode which brought him in therapy.
John is a young and tiny young man, with glasses, very sensitive and attentive to verbal expression, his words are very carefully chosen and the therapist matches his exact expressions (countertransference being touched with exact expressions). He feels sad, alone, without any pleasure in any of his activities, didn't attend college classes and work, and particularly disturbed by obsessive thoughts about numbers.
He broke the friendship with his colleague and a 10-year friendship because when they came with his car from home and John does not stand the radio volume to be on a certain numbers (eg

5, 7 and worst 17), having to change the volume on the car radio, usually multiple of four, which made him more at ease , releasing his anxiety. His friend noticed it and laughed so hard realising this, which irritated him, he didn't say a word but cut his friend from his life completely.

Obsessive thoughts also accompany him during the day, counting the steps, house numbers being anxious when he had an odd number and a relatively good when the sum is an even number.

He also arranges his clothes in order and days, prepares them for seven days a week to "minimize the number of decisions per week", limiting the number of 7-day decisions.

He recognize this obsessive thoughts as intrusive and parasitic as they go by daily, significantly reduce the quality of life and also admits that he lost a couple of exams later (secluded in the apartment, unable to attend the exams , possibly after a panic attack) and then dropped out of attending college and did not finish the studies.

At this time, his family, mother and sister do not know that he did not finish his studies at the University.

We started medical treatment, John being relatively reluctant and demanding a lot of medical data and details especially related to adverse effects and worrying that the drugs will alter his daily performance. He accepted to give it a try and we agreed that if his condition does not improve in 12 weeks (regarding quality of life) we will discontinue the treatment.

His condition has improved considerably, the rituals have diminished or in any case became bearable, the vitality and the cognitive speed have improved (some parasitic rituals still present). The pleasure of reading books came back (John having a "target" of 10 books per month- in a very ritualized manner, preferably in English in original and also having a certain amount of money allocated to this activity, monthly, books being ordered on a dedicated website on the Internet).

The books are fantastic stories (Dune, science-fiction, with heroes and intergalactic magnifiers, or love stories eg. Wuthering Heights). He is able to quote entire passages in English even in the Shakespearean language and it does give him a great amount of pleasure.

We continued the drug treatment in parallel with a one-month session therapy during which John told me what had happened in the time we had not seen, the family-related conflicts, John continued to work as an intern at a software company, being in the terminal year of the internship and preparing for the next stage of his life.

Surprisingly for me as a therapist was the fact that he did not talk about the fear of not being good enough, perfectionism. John seemingly knows what he does and what is worth at the level of the intellectual and professional performance, he does not worry that he will not find a job and the feed-back the workplace inputs seem to be very good (although they do not really take them into account)

The second episode occurred 9-10 months after breaking up with his girlfriend in a professional context. As the internship is over, John tried for the company's opening and the feed-back was a not what he expected.

The head of the department told him that he is a perfect worker if he has clear and fixed rules, but has difficulty in initiating tasks and is not too socially integrated into the team, works well alone but that at the moment the company needs a leader.

This has greatly affected John, he became reluctant, sad, irritable, with fluctuating mood, burst in tears easily, anxiety, and a noticeable decrease in motivation and activity (hard time mobilizing).

I .In the ICD -10classification the clinical diagnostic is as follows.:

F 43.0 Obsessive-compulsive disorder
Incl.: anankastic neurosis, obsessive-compulsive neurosis
F.32.0 Depressive episode
Incl.: single episodes of: depressive reaction, psychogenic depression, reactive depression

F. 60.9 Personality disorder, unspecified

Character neurosis NOS Pathological personality NOS

II . In the DSM –IV –TR classification the diagnostic is as follows :

Axis I . 300.3 Obsessive–Compulsive Disorder

296.xx Major Depressive Disorder .2x Single Episodes

Axis II . 301.9 Personality Disorder NOS

Axis III . no diagnostic

Axis IV . V61.10 Partner Relational Problem

V62.3 Academic Problem

Axis V : Global Assessment of Functioning = 50-55

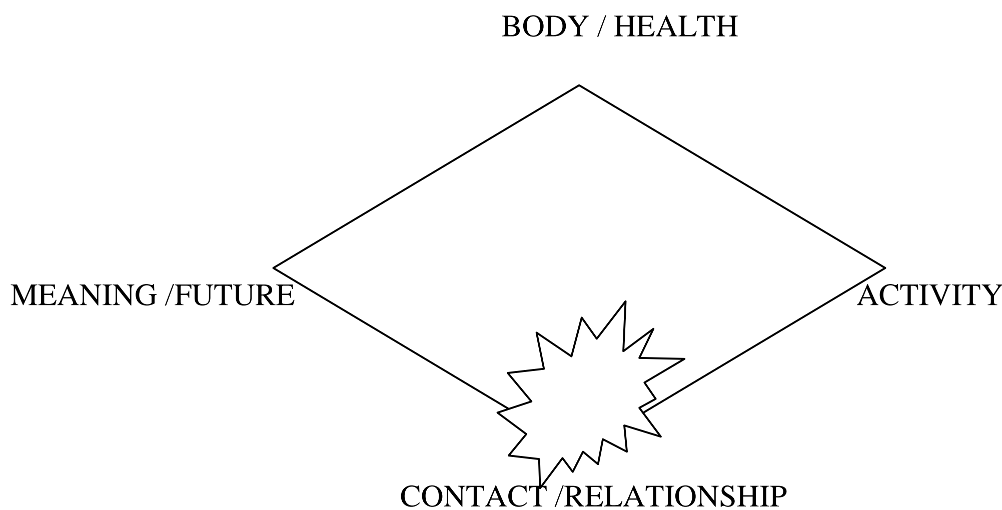
III . For DSM 5   the diagnostic is unchanged
- Major Depressive Disorder
Neither the core criterion symptoms applied to the diagnosis of major depressive episode nor the requisite duration of at least 2 weeks has changed from DSM-IV. Criterion A for a major depressive episode in DSM-5 is identical to that of DSM-IV, as is the requirement for clinically significant distress or impairment in social, occupational, or other important areas of life, although this is now listed as Criterion B rather than Criterion C.
- Obsessive-Compulsive and Related Disorders
The chapter on obsessive-compulsive and related disorders, which is new in DSM-5, reflects the increasing evidence that these disorders are related to one another in terms of a range of diagnostic validators, as well as the clinical utility of grouping these disorders in the same chapter. New disorders include hoarding disorder, excoriation (skin-picking) disorder, substance-

/medication-induced obsessive-compulsive and related disorder, and obsessive-compulsive and related disorder due to another medical condition.

For personality disorders- their basic criteria remain unchanged in DSM-5. On the other hand, the dimensional contribution appears in Section III of the Manual (among the emerging measures and models), so it is complementary and probably not secondary in the clinic.

III .Conceptualization in positive psychotherapy :

I .Actual conflict : chronic events happening in the present time. We are talking often about a string of events, very often an entire situation. The main event may be neutral but then getting more and more personal as the time progresses. The importance is underlined by personal values (capacities) involved in this conflict.



1. Localization : where conflict mainly takes place

- contact /relationship : separation with girlfriend , loneliness

- meaning/future : anxiety , loss of goals and meanings

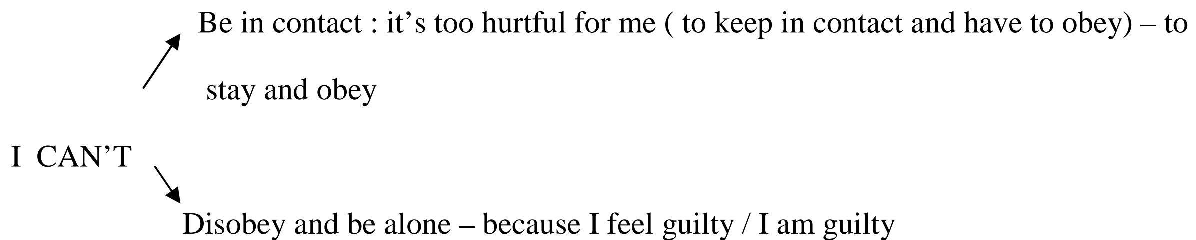
2. Content of actual conflict : time/love/acceptance – vs. – obedience

3. Reaction to conflicts : escape in fantasy ("normal" or symptomatic) or escape in symptoms

II. Basic conflict : a life (family) concept which becomes dysfunctional due to actual conflict (actual life situation) . The content of the basic conflict needs to be defined by two or more actual capacities . One describes our emotional needs (primary capacities) – in John's is CONTACT - ,

the second being a social norm through which this emotional need can be satisfied. For this particular patient the secondary capacity is OBEDIENCE.

III. Inner conflict (the conflict dynamic) . Most of the times the result of clashing motivation in the conscious and unconscious level. We call this conflict “neurotic” because of his fixed pattern in many life areas (relations , activity..) It’s like a crossroad with two dead-ends.



IV . Key conflict – or the conflict between politeness and honesty . The way the conflict show his “face “ to the outside world . John’s way of reacting is passive –aggressive (sometimes very polite but sabotaging the other in subversive ways). His politeness (the capacity to contain this inner conflict) makes the conflict chronic.

IV. Conceptualization in OPD (Operationalized Psychodynamic Diagnostic)

OPD is one classification born in 1992 in Germany by a group of psychoanalysts and psychosomatically oriented psychotherapists . The objective of the OPD is to expand the symptom-based , description-oriented classifications to more fundamental psychodynamic dimensions for training and clinical purposes.

The multiaxial psychodynamic diagnosis is based on 5 axes :

1.Experience of illness and the prerequisites of treatment : A vital aim of operationalizing is closesness and relevance to practice and defining indication for psychotherapy. We are to define here the severity of physical/mental symptoms, the burden of suffering and the expectation from treatment /readiness to accept the treatment as well as resources.

2. **Interpersonal relationship:** A conflictual relationship pattern can be summarized as follows :

-the patient’s habitual interpersonal behaviour (focus on interpersonal behaviour)

-typical reaction of others to the patient's interpersonal behaviour – (described by the patient but also observed by the therapist in which the interacting partners of the patient rediscover themselves or into which the partners forces them).

A. The patient's experience (patient's perspective)

The patient time and time again experiences himself in such way that he is….	The patient time and again experiences others in such way that they are…
17. asks for space	7. trying to control him
16. defy	8. accusing him
28. take to flight	9. manipulate, blame him

B. The therapist's experience (the others experience , countertransference)

Others, the investigator included, time and again experience that the patient is….	Others the investigator included, time and again experience themselves in their interaction with the patient that they are…
29. seclude himself	6. dominate
30. cutting himself off	7. control
16. defying	?Worrying

3. Conflict: the perception of conflict and affect impaired by means of defence mechanisms. (describes the type of person , lead affect and the countertransference and interactions) We have to exclude stressor induced conflict (stress events)

We have 7 types of conflicts , as follows

-individuation vs. dependency(existential meaning of bonding and relation)

-submission vs. control

- care vs. autarky

- self-worth

-guilt complex (egoistic vs altuistic tendencies, self blame vs. blame of the object)

-oedipus

-identity conflict

For our patient the first and foremost is the 2nd conflict described here (**submission vs. control**) and in secondary we have the 5th – **guilt conflict** (predominantly blame the object by means of projection as defence mechanism)

4. Structure : often view as "the personality " or better yet as the scene where the inner/ outer conflict occur like in a theater ,the scene and the special effects , even the background of the daily activity. There are 4 dimensions, each with 2 sub-dimensions (self and the object)

1/ cognitive ability or the perception – of self (moderate , mostly as mildly bad self-image , identity relatively intact but lack of differentiation of affects)

-of the object(moderate integration , lack of empathy , negative view of the of the object , negative affects concerning objects)

2/ capacity of control – impulse regulation – of self (extreme , good tolerance of affects due to excessive defence mechanisms , anticipation is anxious and the self esteem is mildly affected)

- of object relationship (filtered through the defence mechanisms , lacking kindness)

3/ emotional abilities – internal communication (very perceptive of negative emotions, hard time with positive ones, escape in fantasy)

- communication with external world (lacking empathy , not needing reciprocity , secluded , needing control)

4/ Attachment (the ability to form attachments) -with internal objects (negative and punitive view of internal objects)

-with external objects (hardly makes new friends, very easy cutting off relationships)

5. **Axis V in the OPD overlaps the ICD-10**, chapter F Classification of Mental and Behavioural Disorders- Diagnostic criteria for research .

This seems fairly good idea finding a common ground and a common language using both of them in the european mental health professionals.

For me, as a psychiatrist and also a psychotherapist this kind of clinical approach offers some advantages:

1. Set up a "primum movens" a basic level , a starting point so later in the process it will be easier to evaluate progress
2. Often I am called to offer a "second opinion" with my co-workers , psychologists so a common language and a broader formation is welcomed
3. When the diagnostic is severe or the intensity of troubles is important or when the psychotherapy is a contraindication – or the organic therapy is compulsory (medication , hospitalisation , etc…) it is good to have a diagnostic background for referral
4. Sets up the goals in psychotherapy (e.g. working on the basic conflict , with the aid of primary capacities….. , or working on the 2nd conflict – submission vs control in the OPD)
5. Finding a common ground for the professionals and the families , finding a language easier to understand and to help communication (often psychiatrist are mis-read and mis-understood ☺)
6. Periodically evaluation of the patient's status
7. Forensic importance (with patients at risk)

I can't think of the disadvantages in this method except one of course of great importance which is TIME. This kind of clinical work is time consuming and the future goal is to find more TIME for the benefit of our patients.

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