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ORIGINAL ARTICLE

Contributions of Operationalized Psychodynamic Diagnosis (OPD-2) in Colombia: Training,Practice and Research

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Abstract

In this paper we summarize some experiences with Operationalized Psychodynamic Diagnosis (OPD-2) in the colombian context, and put into perspective other possibilities for its implementation grounded on our teaching and clinical practice. Given OPD-2 develops as a modular system for diagnosis and treatment planning, it has been used in different areas of both clinical practice and empirical research. Based on this, we have chosen different application scenarios to illustrate OPD-2'susefulness, focusing on different axes or modules of the instrument, reharding Colombia's interculturality, clinical work at the general hospital, teaching and practice integration, and OPD-2's contributions to dynamic psychology. The possibilities of OPD-2 related to each application area are discussed and gathered into a final conclusion.

Keywords: OPD-2, dynamic psychology, hospitalization, interculturality, teaching, supervision, research

Introduction

After a decade of implementing Operationalized Psychodynamic Diagnosis (OPD-2)[1] system in the academic, clinical and research fields in Colombia, we have stablished a solid working group with the participation of teachers and psychotherapists in both public and private institutions. Therefore, we are encouraged to highlight the possibilities of application of the OPD-2 in some contexts that testify his goodness. In the first part we present a recent pilot exercise in the use of OPD-2 for diagnostic approach within psychological clinical workof the health public service of Medellin city. In this same experience we reflect upon the teaching and supervision activity with the students. The second part highlights the contribution of our group in the dissemination of this instrument, capable of responding to different demands over *knowing* and *doing* in the psychotherapeutic practice. This article presents the process of academic work that we have developed with the OPD-2 manual in Colombia through seminars, meetings, a diploma, national and international congresses, all with the impetus and support of Dr. Guillermo de la Parra. The authors belong to the Research Group on Dynamic Psychology of the University of Antioquia and we are also part of the OPD-2 Medellin Advanced Training Group, Colombia.

Different OPD-2's application areas in Colombia

OPD-2 at the general hospital

It should be noted that the colombian context is marked by interculturality. In this scenario, the challenge in care, evaluation and indication with the culturally diverse consultant makes greater sense of one of the OPD-2's guidelines: *"to pick up the patient where he is at any given moment"* implying also: *"to pick it up there from the cultural framework in which he/she is located"*. Colombia is a multi-ethnic and multicultural country that currently has 48,258,494 habitants, of which 4,671,160 are black; 1,905,617 are indigenous, and 2,649 are

Gypsies[2]. According to the Ministry of the Interior, indigenous population are divided into 82 recognized groups and 18 still remain unregistered[3]. These data reflect the cultural diversity, habits and sectoral lifestyles. In the field of mental health and the problems arising from it, the challenges for the diagnostic approach and the treatment become complex. Although statistical and quality of life data show shared epidemiological records, the subjective experience, the explanatory model of the problem, and the motivation and expectations over a treatment are often due to very different factors[4]

OPD-2, as a clinical and research tool, offers us the possibilities of expanding our understanding field when it comes to serving culturally diverse populations. As example, with Axis I "Experience of illness and prerequisites for treatment"[1], it is possible to answer questions derived from the subjective cultural experience, the cultural model of problem attribution, the motivational cultural aspects, as well as the resources/obstacles associated with the cultural context. OPD-2 it's not far from the problems associated with cultural hybridization, acculturation, uprooting and transculturation, which in terms of colombian public health models are one of the most relevant problem hotspots in ethnic groups. Hence, many of the policies and strategies are directed towards the protection, care and repair of cultural identity.

The recollection of information based on Axis I in the hospital context allowed to clearly account for patient's illness experience. In the same way, the operationalization of these data is consistent with the institutional needs and demands on the psychological approach, in accordance with the current regulations. Thus, clinical history's registration, an institutional request, can be condensed in the language proposed by the OPD-2, without adjustments that undermine the technical requirements of the manual, or ignore the conditions of the records related to the mental health of the patient on hospital settings.

The importance of psychological approach in hospital scenarios has been largely documented in paediatric services and for the care of specific diseases such as cancer, osteomuscular or burns[5, 6]. However, the few studies that give account of application models in general hospitalization are focused especially on long-stay patients[7]. The use of operationazation tools gives the opportunity to delimit psychological interventions in hospital service, understand the emotionally difficult experience of the patient, and propose indications for subsequent outpatient treatments.

The teaching-service agreement, regulated by the Colombian Ministry of Social Protection[8] implies intern's training under strict supervision of an experienced and qualified teacher. Clinical work in the hospital scenario develops in a program of training practices, in which most interventions are carried out in a few sessions, ranging from one to four encounters per patient.

In this context, recently four psychotherapists from the OPD-2 Advanced Training Group of Medellin City, belonging to the University of Antioquia´s teaching team, included the evaluation of OPD-2's Axis I "Experience of illness and prerequisites for treatment", in the above mentioned training practice plan. In the role of tutors, each psychotherapist accompanied and supervised five psychology students in the care of hospitalized patients at the universitary clinic.

The reason for patients' admission to this general hospital is "illness or physical problems that require urgent medical attention". It's the treating physician, after a general evaluation, who determines the needs for participation of the psychology team as part of the process to identify emotional difficulties, support needs related to the physiological approach, or likelihood of psychopathology. Patients are usually in multiple acommodation between one or three beds by room, with ongoing nursing assistance who implements medical indications.

This hospital condition has different peculiarities that establish the framework of the diagnosis of relevant mental health features, such as: a) the diversity of physiological pathologies for the admission of patients is highly variable, b) the request for psychological interconsultation does not require prior knowledge of the patient, c) the sanitary stay is determined by the evolution of the disease and it is the physician who decides to discharge, d) the procedures registers are read and recorded in a digital standard format containing the sections of subjective, objective, analysis and referral, with the use of ICD 10 diagnostic codes according to the regulation in Colombian healthcare system.

Within this framework, OPD-2 enabled a differential evaluation for psychological intervention in an agile and easily applicable form. Guided by the application of Axis I in the assessment of mental health, it was possible to identify aspects of clinical relevance about the disease experience and prerequisites for treatment. Based on clinical records and patient direct information, we could establish the observation framework of EQ-5D and GAF values. Although we clearly recognize the quantitative dimension of the ailment, a little more demanding was the consideration of qualitative elements because the patient's information was conditioned by his physiological suffering, which led to a logic that seemed predetermined by this kind of ailment. As the expectations of somatic intervention were imposed, it was necessary an explicit clarification that the evaluation we were carrying out corresponded to the area of psychology. References to social or psychological symptoms were more easily recognized in patients with less organic discomfort.

Patients' willingness to psychological intervention was higher when healthcare workers announced the psychodiagnostic meeting as a part of medical atention. In this way, the collaboration of the patients was significantly greater and facilitated the identification of psychic alterations parallel to the physical ailment. The adverse condition of hospitalization allowed direct observation of coping strategies as well as the possibility to identify whether instrumental or emotional support had been deployed and used by the patient's. When talking about the disposition it is taken into account that psychological openness is determined by medical procedures that may alter states of consciousness of the patient, or that physical pain may impede subjective assessment. However, these hospital conditions do not impede clinical judgment elements for the psychological assessment of patients, their resources for change and the need to guide therapeutic actions to strengthen their coping strategies.

In the evaluation of the psychotherapy module included in OPD-2's axis I, we found that patients' expectations were predominantly oriented to active-directive and emotional supportive interventions; and

reflective-clarifying interventions were found less common. While the development of a psychotherapeutic processes is not a pretension in this hospital scenario, the psychological evaluation process exposed here has motivated administrative conditions to implement subsequent outpatient interventions, within the same public health service, cases in which a rigorous OPD-2 interview could be applied in orden to implement psychotherapeutic processes and clinical research.

Integration of teaching and practice by means of OPD-2's criteria

In the health settings, Cole[9] notes that understanding and formulating cases in an integrative way should include patients' health beliefs and illness representations, evaluation of coping strategies, cultural/social context, cognitive development and health-related understanding. According to OPD Task Force[1], Axis I is no stranger to the assessment of these factors and highlights the need to pick up the patient *"from where he is at and where his expectations lie"*[1] (p. 44).

While the OPD-2 has become in a resource to patient treatment, it has become in the same way in a possibility of transiting through a common language to dialogue with professionals in clinical training, since it allows to share the clinical judgement over factors that have assumed a transtheoretical character[10]. In our experience, this work proposal with OPD-2 has allowed a greater cohesion among students of various psychological approaches, the fine-tuned reading of common factors in psychotherapy, the development of facilitative interpersonal skills that articulate with clinical competences, and the ability to respond to the needs of patients and their support network, on essential aspects to contextual demands.

Achieving a level of cohesion between the training of professionals and the patient-directed support relationship in the hospital context became a challenge arising from the need to make a sensitive intervention for the patient, who suffers in parallel physical symptoms and significant psychic discomfort. Also to promote synergy in clinical reasoning based on a language that allows progress in clinical conceptualization about functioning , the resources and needs to be addressed in the task of providing psychological support to the patient.

In broader terms, others OPD-2's criteria apart from Axis I can also be integrated for teaching and supervision, as Juan[11] states:

> *Each OPD-2's axis can become a key point of supervision and organizes case presentation. The diagnostic profile can be built exhaustively, but the manual also allows more flexible use, applicable to clinical practice, where criteria are used more globally. Applied to supervision field, the OPD-2's criteria provide greater systematization to prepare the case (...) The information on each axis can be a therapeutic focus, which is at the center of clinical atention at the supervision time [Own translation].* (p. 64)

In the same line, "¿what's wrong with the patient?" leads to the question "¿how to provide a better help?". These questions continuously haunt, and should haunt, the understanding and imaginaries of students in their clinical task. It is precisely this way in which the approach of Axis I of OPD-2 "Experience of illness and prerequisites for treatment" has become in an advantage to conduct the patients functioning screening, for sharing approaches and to psychodynamic formulation of cases in the hospital environment.

Contributions of OPD-2 to Dynamic Psychology in Colombia

The development of the psychodynamic approach in Colombia captures the influence of OPD-2 as a benchmark for clinical and teaching practice, making its waybetween a dense environment of positivist schools, american behavioral psychiatric models and the more orthodox psychoanalysis.

The application of OPD-2 in psychotherapy case studies has been an exercise implemented by the Dynamic Psychology group of the University of Antioquia over the last decade.These efforts have guidedthe students in his final-year's undergraduate projects, and especially in clinical psychology master thesis' research projects[12]. Case studies have the dual ability to allow a rigorously understanding of the research problem and to reveal a culture, a characteristic language, and the context it brings with it[13]. We expose here the synthesis of two of these clinical and research experiences, that illustrate the possibilities offered by OPD-2.

Application of OPD-2's Axis II in three cases of demobilized combatants. Firstly, and based on OPD-2's Axis II "Relational patterns", the rating scale of themes and resources allowed a guiding focus on the clinical study of three cases with a unique population in Colombia, such as demobilized combatants* that were in the process of reintegration into civilian life. These were three female ex-combatants who had in common a deep suffering caused by experiences of neglect in their childhood, school deprivation, and had been victims of both emotional and physical aggression that included sexual abuse, and were forced recruited by an armed group. With the demobilization process they participated in a psycho-educational project of reintegration and repair. Our psychologist provided a space for psychotherapy, by his own initiative, because the state program did not contemplate this kind of intervention. The exploration of the subjective experience and the experience of their sufferings indicated from the beginning a frame of noticeable alterations in structural functioning, so the indication of treatment was oriented towards a supportive psychotherapy.

Interpersonal behavior oriented towards themselves and towards the other (couples and children) were characterized by dysfunctional relational traits recorded with the help of the rating scale of themes and resources as follows: Patients tend to *quickly become aggressive, attack others* rather than *adequately show rejection and aggression,* evidenced in excessive frustrations and excessive development of aggression. The defensive mechanism of *being little interested in and easily overlook others* rather than *make contact with others adequately* was also a way to ensure that they would not be damaged or destroyed by self-aggression, or the agression projected on objects. In summary, to describe the relational focus characterized by the need

* Persons who were part of an armed group outside the law and who lay down the weapons.

for protection against a world of dangerous objects, both internal and external, allowed to offer a empathetic holding that positively contributed to the treatment results.

Body experience linked to the structural function in fitness practitioners. This research experience was oriented to the understanding of the bodily experience through the meaning of body in fitness practitioners[14]. Supplementary module of OPD–2 on the body experience linked to the structural function was used. The psychodynamic interview was conducted with the aim of identifying the representation and relationship that fitness practice has in the body experience of each of the interviewees. Operationalization and analysis of the data was carried out taking into account the theoretical basis of the instrument on "subjective bodyness" ("Being body") and '"objective body" ("Have body") according the above mentioned supplementary OPD-2 module[1]. Discussions and conclusions turned around the perception of the body self, the perception of the object in its corporality, the self-regulation of corporal-self, the regulation of the relationship with the object bodyhood, the body as a mean of communication, communication with the inside of the body (body as an object), the body within the framework of the link with internal objects, and the body within the framework of the link with external objects.

The conception of fitness practice related to corporal experience wasassociated to three factors: 1) transformations achieved in the body at physical level (develop more strength, agility, capacity), emotional level (be safer, happier, accepted) and at the level of health and well-being (being more integral, strengthening habits), 2) criticism of the body as a source of insatisfaction, frustrations and conflicts (not looking good, not accepting the current body, not being pleasant), 3) ideals or goals focused on the body as an indicator of health and/or beauty (being healthy, being attractive). The relationship between fitness practice and corporal experience was established from two elements: a) the body defined as a means of communication (a body that speaks, expresses) and b) the body described as an instrument (a machine to be polished, perfected).

In sum, we found that the influence that fitness practice had on the body experience was oriented towards the individual search for health and well-being, described as practices or habits of self-care and protection (feeling good, being healthy) or described from a social dimension such as culture, style or healthy community (to be accepted, to be recognized).

Conclusions

The use of the OPD-2's criteria, specifically Axis I, pretends to be a guiding tool and fits to the registration and reporting protocols of hospital scenario. Axis I allows a quick focus on patients, their condition and demands, giving a reliable guidance framework for the intervention.

Considering the complex conditions of the exposed hospital environment, the approach to the patient with the guidelines of axis I enables a finely understanding of its functioning, a progress towards the modulation of psychological symptomatology, and a bridge with the medical team to advance in treatment. Also, OPD-2´s

axes allowthe use of common languages on diagnosis and case formulation, with professionals in training who mostly had varied pyschologycal approaches.

Within the work of the Research Group on Dynamic Psychology of the University of Antioquia, and the OPD-2 Advanced Training Group of Medellin, the Operationalized Psychodynamic Diagnosis (OPD-2) has been put into perspective for enhance and systematize the experiences exposed in this article, and to implement studies that respond to the intercultural challenges of psychotherapy.

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