Task Force OPD (eds.)

Operationalized Psychodynamic Diagnosis OPD-2

The Manual for Diagnosis and Treatment Planning

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Preface

"The particular is eternally subject to the general;
the general must eternally be of service to the particular."

Johann Wolfgang von Goethe

When Norman Sartorius was asked at the first international presentation of OPD, ten years ago, what future prospects he saw for OPD, he responded by saying, ask him again in five years' time. A time span of this order normally reveals whether a system can withstand, and survive, scientific criticism. If all were to go well, there might perhaps be a second version of the instrument published by then. Now it has taken not five, but ten years for the second version of the Operationalized Psychodynamic Diagnostic to be available in Manual format. The reason is that this publication contains not only a revision of the first version, but a new Manual, which complements the diagnosis by adding treatment planning tools.

The new Manual provides options which, from our point of view, have great clinical-practical use for psychotherapists. More so than the first version, the second version takes care to ascertain that the diagnosis serves not only to describe and differentiate individuals, but, more importantly, is a tool guiding the actions of psychotherapists. The task of psychotherapy is to indicate a psychotherapeutic measure based on diagnostic knowledge, or to formulate specific therapeutic tasks and goals, and to plan suitable therapeutic interventions. Therefore, in the clinical context, diagnosis is always in the service of therapy.

With OPD-2, therapy goals can be determined and respective foci selected for the treatment. This allows one to track changes in the patient along these parameters. By linking process descriptions to therapy outcomes, they can be made the basis for treatment evaluation. Even more than the earlier version, the new OPD allows the combination of both process and outcome research, as well as an evaluation that meets the criteria of quality control.

In substance, the second version has maintained the conceptual structure of the OPD. The multiaxial psychodynamic diagnostic is still based on the five axes defined as "experience of illness and prerequisites for treatment", "interpersonal relations", "conflict", "structure", and "mental and psychosomatic disorders in line with chapter V (F) of the ICD 10". The changes effected refer to the fact that OPD-2 is no longer predominantly a tool for making cross sectional diagnoses only, but focuses to a greater extent on therapeutic processes, enabling treatment planning by allowing the determination of therapeutic foci.

The system of the Operationalized Psychodynamic Diagnostic (OPD) has become very successful not only in German-speaking countries. The instrument has had great resonance not only with clinicians, but also with researchers in psychotherapy worldwide. Four editions of the first version of the Manual were published; it was translated into several languages (English, Spanish, Italian, Hungarian, Chinese). This new Manual, like the previous one, is also published in English and Spanish, appearing soon after its German publication. In 2002, a working group of child and

adolescent psychotherapists and developmental psychologists published an OPD Manual for the psychodynamic assessment of children and adolescents.

Its success is mainly based on the fact that clinicians appreciate the essential tools that the categories of the multiaxial diagnostic system offer for their daily practice. For the Manual to be reliably applied, 60 hours of training (three training seminars on three different dates) are required. The practice-oriented skills that are learnt via videotaped examples or live-interviews with patients are highly appreciated. By now, more than 3000 physicians and psychologists have undergone the training seminars and are using the system, or parts or categories thereof, in their practical work.

Meanwhile, OPD has also been employed in numerous research projects. A prerequisite for its scientific application were the good reliability measures collected in several multicentre studies. The current Manual summarizes the extensive research results on the instrument published so far in a separate chapter (Chapter 2).

The OPD Task Force is well aware that an operationalization of a psychodynamic diagnosis (cf. Chapter 1.7) has its limitations. An operationalized diagnosis can only grasp the richness and complexity of human mental life in a very limited sense. Structure, conflict, and relationship diagnostics permit only a kind of pattern recognition, which offer the therapist anchor points, or guidelines, for the therapeutic process, while meaningful connections of an individual's experiences may get lost. OPD has limited its goal to the understanding of the individual patient in the context of his own personal life history, and only to such degree as is relevant for an actual diagnosis and treatment planning containing therapeutic foci.

The new system of the OPD was developed over the past few years by a group of psychodynamic psychotherapists working in the fields of psychoanalysis, psychiatry, and psychological psychotherapy, attempting to formulate operationalizations of the therapeutically relevant psychodynamic aspects. The names of these persons and their function in the OPD Task Force can be found in the list of authors. Not all founding members of the OPD are still active in the current Task Force. Besides many others who cannot be named here, the group is indebted especially to Sven Olaf Hoffmann, the first OPD spokesperson, as well as to Ulrich Rüger, for their continued commitment to this extraordinary project.

The present OPD group has grown into a team which has worked on the conceptualization of this instrument in a spirit of friendship, collaboration, and debate for many years. The group is rightly proud that it has successfully managed, over the years, to keep up its creative involvement in the subject matter.

The members of the Task Force continue to feel committed to an attitude of open-minded curiosity towards the concepts and further development of OPD. For the conception of the current version of the OPD, we have endeavoured to use the experiences gained from the many training seminars, as well as the results of empirical studies with OPD. OPD-2 is no end result, but once again, is an intermediary step. We are convinced, however, that this instrument is one big step

on the path to a scientifically founded and quality assured psychodynamic psychotherapy.

Manfred Cierpka, Heidelberg
OPD Spokesperson

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1. Theoretical Background

In 1992, a group of psychoanalysts, psychosomatically oriented therapists and psychiatrists in Germany set up a task force that called itself "Operationalized Psychodynamic Diagnosis" (OPD). It has been the objective of this task force to expand the symptom-based, description-oriented classification of mental disorders by adding some fundamental psychodynamic dimensions. The OPD Task Force developed a diagnostic inventory and a manual (OPD Task Force, 1996) for experienced therapists for training purposes and clinical application. Furthermore, checklists for individual axes were published (Grande/Oberbracht, 2000; Rudolf et al., 1998) to make the assessment process more practicable and reliable.

The multiaxial psychodynamic diagnosis is based on 5 axes defined as "experience of illness and prerequisites for treatment", "interpersonal relations", "conflict", "structure", and "mental and psychosomatic disorders, in line with chapter V (F) of the ICD 10". After an initial one or two hour interview, the clinician (or an external observer) assesses the patient's psychodynamic profile along these axes and records the data on evaluation forms.

As many readers may already be familiar with the features of the OPD-1, we begin this book with a summary of the changes that have been made to OPD-1 resulting in OPD-2. After this introduction we briefly revisit the history of the OPD, its objectives, and the conceptualization of the axes. This is followed by a discussion of the literature on psychodynamic diagnoses and attempts at their operationalization. Those already familiar with OPD-1 may wish to go straight to chapter 2, which summarizes the research findings generated by OPD-1. The new operationalizations of the OPD-2 axes are described from chapter 3 onwards.

1.1 From OPD-1 to OPD-2

In this book the second version of OPD is introduced. After 10 years of experience with the first version (OPD Task Force, 2004) and its application in various settings – training seminars, postgraduate study, outpatient and inpatient clinics, quality assurance, and scientific research – this largely revised new version is presented. Besides offering basic theoretical and conceptual considerations, it makes available a diagnostic manual which uses the four psychodynamic axes (I to IV) familiar from OPD-1 to identify patients' psychodynamically relevant characteristics: first, how patients experience their illness, and, closely related to this, the prerequisites they bring to treatment; second, their dysfunctional relationship patterns; third, their unconscious conflicts; and fourth, their structural characteristics and structurally-based vulnerabilities.

This second version of OPD is more than just a revised edition of the original manual. After many years during which studies were conducted with OPD-1 and from the available research findings (cf. chapter 2), with regular feedback from training seminars, and experiences gained from clinical use of the tool, the necessity to further develop the OPD from a purely diagnostic instrument into an instrument of therapy planning and change measurement became more and more apparent. The four main areas which have been changed made can be highlighted as follows:

- OPD-2 is no longer predominantly a tool for making cross sectional diagnoses only, but focuses to a greater extent on therapeutic processes,
- OPD-2 attempts to take into account a patient's resources and strengths,
- OPD-2 is now able to conceptualize, to a greater degree, interfaces between its axes,
- OPD-2 enables therapy planning by allowing the therapist to determine therapeutic foci.

Process orientation

The process of therapy planning must rest on the three pillars of diagnosis formulation of treatment aim, and identification of the appropriate therapeutic steps. The effects of these steps can then be evaluated, if need be, in everyday clinical practice. The diagnosis here serves to describe key problematic characteristics and/or attributes that would merit change, but also acknowledges resources and competencies of the patient. The process of therapy planning is here seen more or less as happening within the framework of an interactional exchange between therapist and patient.

Therapy planning and the examination of the effects of therapeutic interventions require diagnostic concepts which in turn allow a researcher to define and operationalize variables; such variables can then be measured in the therapeutic process. A cross-sectional diagnosis, via the description of the individual, allows the comparison of individual cases with previously assigned empirical norms. In this way it can be determined how far the patient differs in relevant characteristics from the sample group. Cross sectional diagnoses are helpful at certain points in time, mostly at the beginning and at the end of therapy, in order to identify problems or symptoms, and to assess their severity. This includes the recognition of all factors which may contribute not only to the maintenance, but also to the dissolution of symptoms. The classification of the complaint, problem, or symptom into a higher-order classification system (as for instance the ICD-10) forms a part of the diagnosis of the state too. The first version of the OPD had been conceptualized predominantly as a "state diagnosis" system in this sense.

The current manual goes beyond this to allow the description of the process of change in the patient. With the OPD diagnosis, dysfunctional relationship patterns, stressful internal conflict configurations, and structural conditions in the patient can be identified, which all can be used to deduce therapeutic foci if they are connected with the patient's symptoms and suffering. Changes brought about by psychotherapy may thus be tracked progressively in the identified OPD categories.

OPD-2 thus follows current requirements of psychotherapy research to pinpoint the effects of change as it unfolds in the process of psychotherapy in order to identify how mechanisms of psychotherapy can be effective. Knowledge about the process then is incorporated into each further step of the treatment when considering therapeutic approaches and suitable interventions. The aim is to make the therapeutic process favourable for the patient.

With its new system OPD-2 is moving in the direction of the principle which Strupp and Schacht (1988) named the "problem-treatment-outcome congruence". The meaning of this formula is that there must be a similarity, a congruence,

between the evaluation of the clinical problem, the conceptualization of the desired change through therapy, and the description of clinical success. Such success should not just be measured with arbitrary objectivizing questionnaires or through observational methods, but by using those categories and concepts initially employed to formulate the clinical problem. In this way a common conceptual basis is employed for the problem to be treated, for the intervention process, and for the outcome of the treatment. By adopting this new direction OPD-2 intends to reflect the clinical practice of psychotherapists in a more direct way.

Psychodynamic psychotherapeutic diagnosis is in no way an end in itself, it should always be understood as a tool guiding one's actions with respect to the therapy being carried out.

Identifying resources

A further change in OPD-2 was made to allow a greater consideration of a patient's resources. On axis I the patient's stresses are contrasted with available resources. Axis II is not restricted to the formulation of dysfunctional relationship themes; it can now also be used to identify relationship themes which are a resource for the patient. Equally, there is now the option, on the "structure" axis, to describe the capabilities of the patient which would allow for adequate interaction with his environment and with himself.

Interfaces between the axes

The third area of change attempts a theoretical integration of the axes. Section 2.6 conceptually elaborates the interfaces between the individual axes. Chapters 5 to 9 develop the practical consequences for the diagnosis and choice of focus. Until now, the axes had been conceived of as more or less standing side by side and were conceptualized as being independent of each other. It has, however, always been clear that the findings identified on the individual axes are interrelated. The current formulation regards, for instance, dysfunctional experiencing of relationships and dysfunctional behaviour in relationships not only as the result of inner conflicts arising from a patient's life history, but also of deficits in structure and structurally-based vulnerabilities. This conceptualization requires no small decision on the part of the therapist: Do I see the painful relational patterns the patient engages in in the context of symptoms displayed as due to either conflict or structure, or do I see both conflictual and structural characteristics as triggers which maintain the symptomatology? Different therapeutic strategies result from this diagnostic decision.

Determination of focus and therapy planning

A separate chapter introduces the planning of therapy with OPD-2. In the new manuals, all axes allow the determination of a focus. Foci are defined as those characteristics of the OPD findings which contribute to the cause of and maintain the disturbance and thus play a vital role in the psychodynamics of the illness. This goes with the assumption that something needs to change with respect to these foci if substantial therapeutic progress is to be made.

When a focus is being determined, the relative contribution of structural or conflictual aspects may vary depending on the kind of disturbance; this ratio needs to be reflected in the selection of foci. In unequivocal cases a selection of exclusively

conflictual or exclusively structural foci may be made. In most cases, however, both aspects are important. The OPD starts from the assumption that foci may change as the therapeutic process unfolds. The formulation of foci at the beginning of a treatment leads to therapy planning, which during the course of the treatment may be modified as necessary. What is essential is that the therapist accounts to herself for the strategies used, and makes her concepts about change transparent to the patient.

OPD-2 must pass the test of clinical practice. Unlike OPD-1, the new edition provides a short version for each axis which is suitable for routine clinical use. In addition, more expanded versions are still available which are meant to be used for research purposes or in the preparation of expert opinions. In this way, the OPD is developing more into a modular system for diagnosis and treatment planning and can thus be employed in different areas of application.

1.2 Aims of the OPD Task Force

Psychodynamically oriented psychotherapy classifies mental phenomena mostly against the background of (meta-)psychological constructs from psychoanalytic theory. Freud (1923b), in his structural theory, for the first time described personality in terms of ego, id, and superego, thus creating the basis for a psychoanalytic classification of mental phenomena. Similarly, the concept of pregenital and genital drive development could be used for classificatory purposes. Later on, "regression to points of fixation", as well as specific defense mechanisms and configurations were linked to different types of illness. To this day, current psychoanalytic literature uses drive theory to differentiate personality and classify mental illness, complemented by ego-psychology, object relations theory, and self psychology (cf. e.g. Shapiro, 1991).

In the clinical situation these constructs are used in order to grasp mental functions and their disturbances. Psychotherapists use them, for instance, through the initial interview process, to conceptualize the case history in order to describe the links between the patient's symptoms and disturbances in his emotional-cognitive development. The material which the patient brings to the diagnostic and therapeutic situation and the psychotherapist's observations and perceptions within the therapist-patient interaction are then brought together to form a psychodynamic diagnosis.

Over time, however, many metapsychological theories were being formulated with such high levels of abstraction that they became further and further removed from clinically observable phenomena and became speculative. This led to very heterogeneous theories and ambiguities in psychoanalytic terminology and concept formation.

In addition, for constructs that lie closer to observation like transference patterns, affect configurations, or specific actions which were being formulated at a lower level of abstraction, the agreement between clinicians was less than adequate. These problems provided a starting point for an initiative like the "Operationalized Psychodynamic Diagnosis (OPD)".

A further impetus for setting up the OPD Task Force was the dissatisfaction with existing descriptive systems of classification (DSM-III, IV, and ICD-10) which could

only offer limited guidance to a psychodynamically oriented psychotherapist as to the treatment of patients.

These diagnostic systems not only abandon the concept of neurosis, but moreover, they largely maintain phenomenological and biological concepts which neglect the validity of diagnostic categories over their reliability (cf. Schneider/Freyberger, 1990; Schneider/Hoffmann, 1992). To reiterate, a purely descriptive, symptom-centered diagnosis offers little guidance for action for the clinician in terms of indication, and for how to conduct the psychotherapy. What is missing here for psychodynamically oriented psychotherapists are, for example, statements on intrapsychic and interpersonal conflicts, on the level of structural integration of the patient's personality, or on his subjective experience of the illness.

This lack is perceived even more clearly as therapists of this genre generally have a wealth of clinical experience with the psychoanalytic concepts of illness mentioned earlier. It is with the help of those concepts that they establish links between the symptoms, the conflicts that trigger them, the dysfunctional relationships of the patient, and his life history in the largest sense.

So a need arose, subsequent to the development of the psychiatric classification systems, for other relevant levels be taken into account as well. In order for this need to be met, a psychodynamic diagnosis, complementary to a phenomenological diagnostic system, could identify, in its turn, constructs close to observation.

In September of 1992, on the initiative of Manfred Cierpka and Wolfgang Schneider, the task force "Operationalization of Psychodynamic Diagnosis" (OPD) was founded. Members came together to form a multi-centre project, working cooperatively, with the objective of expanding the symptom-oriented descriptive classification of mental disorders of the ICD-10 by adding some psychodynamic dimensions: the aim, structure and method of working being regulated by statute. It is the responsibility of the Task Force to support the project as a whole, to ensure it is scientifically sound as well as on a sound material footing, to represent it to a specialist public, and ideally, coordinate it with international classification efforts within the ICD and DSM groups regarding mental illness. The Task Force decided which axes were to be developed and the structure of the organization. The spokesperson and representative of the OPD Task Force, until 1998 S.O. Hoffmann, and since then M. Cierpka, has the task of co-ordinating the whole group and convenes the regular meetings. In addition, the Task Force elects an Executive Committee which handles all tasks at hand in as far as they concern the OPD's main objectives and results achieved. There are several working groups of scientific experts who are charged with the actual operationalization of the various axes and of the interview, and who besides this are responsible for the updated manuals, including the clinical examples. Beyond this work groups have been established for research, quality assurance, and OPD training.

Since its foundation the OPD has had regular meetings of its Task Force to keep the project moving. While the Task Force is of course subject to some fluctuation in its membership, the core group has remained fairly constant. It took over 4 years to complete the second version of the OPD. A list of current members is included at

the end of this book. The principles the founding group had agreed on are still valid today, namely that:

1. the work should generally follow the ICD-model, since this is the model traditionally used by psychotherapeutic institutions, and
2. supplementary to the ICD-10 classification, psychodynamically relevant diagnostic axes should be developed and evaluated.

As a shared conceptual framework it was agreed to create a clinically relevant, psychodynamically-oriented instrument that would take into account and adapt to already existing approaches.

Such an instrument should be useable while at the same time adhering to "a medium level of abstraction", situated between "pure" description of behaviour on the one hand and "pure" metapsychological concept formation on the other.

The Task Force further endeavored to create a possibly unified and precise, linguistic and terminological reference system across schools without recourse to terminology belonging to any specific school of treatment.

An operationalized diagnosis, in this case, has the following purposes:

1. To provide clinical-diagnostic guidelines formulated in a relatively open manner so as to leave users enough scope to apply their own judgments.
2. To be useful for psychodynamic psychotherapy training precisely because it provides practice with respect to psychodynamic as well as phenomenological classifications.
3. To improve communication within the scientific community regarding constructs of psychodynamic theory.
4. To be used as a research tool in scientific studies and thus contribute to more homogeneous samples in research projects by employing stricter diagnostic criteria. This may be through the collection of phenomenological and psychodynamic "baseline data" at the beginning of a study, the recording of the course of an illness, the examination of therapy indications and differential indications, the identification of individual patterns in different areas of life, and the investigation of efficacy and/or effectiveness of therapy.
5. By determining psychodynamically relevant foci, OPD can be used for therapy planning. If, within the framework of the process-oriented OPD-2 important aspects of an unconscious conflict, of structural limitation, and dysfunctional behaviour in relationships are identified as main problem areas, the focal aims for a planned treatment can then be formulated.

1.3 The Concept of the Operationalized Psychodynamic Diagnosis (OPD)

OPD is composed of the four psychodynamic axes described earlier and one descriptive axis. The first four axes are based on a psychodynamic understanding derived from psychoanalysis. We proceed from the assumption that the main determinants in these four axes correspond to partial psychoanalytic concepts (personality structure, intrapsychic conflict, transference), whereby final conclusions

inferred on the level of the unconscious are to be drawn only with care and with reference to the respective operationalizations.

Why these five axes?

Axis I: Experience of Illness and Prerequisites for Treatment.

Axis I was chosen because of the obvious practical relevance of the categories involved here, which to some extent are borrowed from cognitive psychology: The patient must be "picked up from where he is at and where his expectations lie", that is to say, one must proceed from the symptoms related to his complaint and his expectations from treatment. The emphasis hereby is less on illness behaviour than on elements of experience, motivations, and existing resources. These components have been well investigated in psychology and are relatively easy to operationalize.

Axis II: Interpersonal Relations.

Axis II is partly rooted in psychoanalytic diagnosis, which is and has been, at all times, also a relationship diagnosis as it attributes critical importance to the interplay of transference and countertransference. In contrast to axes III and IV, this axis does not provide prototypical configurations or patterns, but offers a system of categories of behavioural modes which are close to observation and can be freely combined.

Axis III: Conflicts.

In Axis III, conflicts, a piece of classic psychoanalytic diagnosis is claimed for use in OPD, namely the central role of inner conflicts. In using this axis, life-determining internalized conflicts can be juxtaposed with more externally determined current conflictual situations. Working through a conflict can be defined as a goal of therapy.

Axis IV: Structure.

This axis depicts the qualities and/or inadequacies of mental structures. Amongst other things, it comprises for instance the possibility and/or impossibility of setting internal or external boundaries, the capability or incapability of self-perception and self-regulation, amongst other things. Sub-aspects of structure can be categorially determined in conjunction with a conflict or without, as therapeutic foci.

Axis V: Mental and Psychosomatic Disorders.

Axis V incorporates into OPD the established descriptive-phenomenological diagnosis of the ICD-10 and DSM-IV. This emphasizes the necessity of precise identification of psychopathological phenomena, which must also find a place in a psychodynamic diagnosis. Furthermore, the group used this axis to make suggestions as to how to enhance the ICD-10 in the area of psychosomatic illness (F54).

It becomes evident when looking at the axes that they overlap in some areas as to content and also interact closely with each other: psychic structure, as it were, forms the backdrop against which conflicts with their well or poorly adapted patterns for solution are played out. As "epiphenomena", relationship patterns are closer to observation than mental structure and internal conflict. Habitual dysfunctional

relationship patterns can be understood as an expression of internal conflict and structural characteristics, and simultaneously, as an expression of the coping strategies towards their mastery; they therefore reflect problematical aspects in both areas. In the interfaces of the axes and the interrelationships on the level of the item lists the architectural structure of the OPD becomes manifest. Section 3.6 "On the interrelationship of the axes" discusses this in more depth.

1.4 Fundamental considerations on a multiaxial diagnosis

A multiaxial approach offers the possibility of better reflecting the complex set of conditions, which we find in a majority of mental phenomena and mental disturbances. Some fundamental considerations are necessary to understand the interplay between and combined effects of these axes, and also when dealing with the question of what an axis is and how we understand mental phenomena and disturbances.

Psychosomatic medicine, psychotherapy and psychiatry, and thus also the axes of the OPD, are founded on subjective mental experience and the behaviour of the individual. The basis for an understanding of mental phenomena and their interrelationship with somatic factors is the bi-directional biopsychosocial model: all these phenomena and disturbances are biological, as subjective experience arises from the functioning of the brain (brain mind), yet mental phenomena equally affect the brain (mind brain). A multiaxial classification thus proceeds from neurobiological foundations and findings: that the brain is dependent on its use, that is to say, the more a system is activated, the more permanently embedded its consequent functions become (e.g. playing the piano, mobilizing fears, etc.). The development of higher mental functions proceeds from simple to complex forms. The development of the higher systems presupposes a healthy development of the more fundamental systems (structure → conflict). As different systems have different timings for the development of their central features, there are different critical developmental periods for different functions (constitution of the self, regulation, abstract thinking, etc.). As the majority of these developmental periods lie in childhood, the basis of the neuronal networks of the brain is thus being established fairly early on (Schüßler, 2004). It therefore applies that mental and psychosomatic disturbances are deviations (dysfunctions) of functions of learned and acquired behaviour and that the deviations must be described with cultural/social/statistical norms in mind.

In the whole field of psychosocial sciences there are no fixed "units of illness" as such. There is broad agreement that the main mental phenomena (anxiety, depression, intelligence, etc.) can best be described by a continual dimensional approach (Beutler et al., 2000). Such a dimensional approach accounts for the fact that transitions from one form to another are fluid, and for the complexity of the phenomena. It appears that within the framework of this dimensional approach, a threshold model without clear and obvious boundaries between normality (health) and mental disturbance, but with some natural boundaries between the most important syndromes, is the model that makes the most sense and leads farthest in terms of scientific progress. In this dimensional continual approach deviations can of course be defined (for example, letting depression begin as of a threshold value X, conflict as of an intensity X, and disturbance of impulse control starting as of a circumstance X).

This dimensional continual approach uses prototypical configurations (classifications) in order to guarantee sufficient reliability, that is to say, clinical applicability (Kendell/Jablensky, 2003). The patterns described on the axes "structure" and "conflict" are "prototypes", while in reality we only find approximations of these patterns. Proceeding in this way generally assures a higher validity than would be obtainable from a purely atheoretical classificatory effort like the DSM-IV and ICD-10.

Mental phenomena and disturbances are complex and thus multifactorial. This multifactorial interactive complexity demands a pluralism of explanations with information gathered from different vantage points so as to approach the complex phenomenon. OPD's multiaxial approach is based on this pluralism of explanations.

In mathematical-theoretical thinking, axes are always independent of each other and thus, in a mathematical space, are perpendicular to each other (e.g. the x and y-axes). This does not apply to different clinical axes, on which mental phenomena with varying depth (i.e. conscious/unconscious experience and behaviour) are captured. Rather, the OPD's multiaxial approach resembles the famous Indian parable about the touching of an elephant by several blind people. All parts belong to the elephant, all parts interact with each other, and everyone correctly identifies a different part - but not the whole. Axes I to IV of the OPD are therefore not independent of each other in what they record and how they record it. Rather, they record, from different perspectives, different aspects of the person, or deeper (unconscious) phenomena, which of course interact with each other.

1.5 On the operationalization of psychoanalytic constructs

Attempts at operationalization have generally had a rather sceptical reception within psychoanalysis. For the evaluation of past efforts at operationalizing psychoanalytic constructs, it is important to know to what degree these studies and respective findings are scientifically relevant. Are they, for example, suitable for verifying broader or more specific theories or terms, or for rejecting them as inadequate?

It is, therefore, a crucial question whether the subject areas and theoretical constructs under study still retain a closeness in content to psychoanalytic concept formation or theoretical ideas, or whether due to the process of operationalization, the relationship as to content between the psychoanalytic construct and the concrete object of research is being lost. This problem arises, as discussed by Eagle (1991), not only with respect to general theoretical models (e.g. the concept of repression in the context of the psychoanalytic theory of personality), but also in regard to assumptions about the concept of treatment, or other psychoanalytic variables of effectiveness, respectively, like the presence of transference processes and their role in the treatment.

Similar difficulties are inevitably encountered with operational research approaches where the central task must be to establish a link between the levels of theory and observation. For this, it is necessary to explicate and specify the relevant constructs in order for them then to be translated into research operations. This forms the prerequisite for an empirical examination of the theoretical concept.

In line with traditional empirical experimental psychology with its recourse to statistics as a method of hypothesis testing, but also of hypothesis generation, research operationalizations are primarily geared towards the logic of experimental design, and in this way substantially influence the translation of the original theoretical term into an operational term. This creates the discrepancy described earlier between a theoretical construct and its operationalized observation.

This does not pose a problem for positivistic psychology, as it understands itself to be a science that does not know "a priori-things" (Herrmann, 1979); its hypothetical constructs are merely understood as empirically gained "organizational schemas" (Herrmann, 1972).

This is different for psychoanalysis with its complex psychology of personality and development, and theory of illness and treatment. Because of the scope of its theories and concepts they largely resist attempts to be incorporated into a research design. Frequently, things like the Unconscious, processes of repression, affects, or transferences are not directly observable but must be inferred from their "derivatives". Starting from a situation like this requires research procedures which can deal flexibly with the multitude of possible observational data, as well as the methods of systematic observation, evaluation, and interpretation suitable to the task. Of course, the various data differ as to their relevance; the criterion, however, cannot only be to make the data statistically safe. One may, for instance, speculate about how scientifically useful a statistically proven uninteresting state of facts (e.g. a barely significant effect on a complaint scale in a large sample) can be, when compared with, e.g. the hypothesis generation about a highly complex subject matter (like the working out of a 'relational mode' between patient and therapist) by means of a qualitative content analysis on the basis of transcripts.

Judging the valency of findings is dependent on (often contentious) presuppositions. The problem in a multi-modal approach which considers both "hard" biopsychosocial data and the individual and subjective perspective in the aggregate of a patient's biography, by e.g. also employing qualitative research methods, is one of integration of the various levels. Psychosocial issues allow only unsatisfactorily a stringent interlacing of findings based on quantitative operationalizations (e.g. standardized questionnaire results), on the one hand, and findings gained from open "narrative" interviews, on the other. What one often finds is that jumping to interpretative conclusions is unavoidable, or that there is a clear gap between the contents of both these levels. Nevertheless, if we allow ourselves to oscillate in our attentive focus between these levels, we are able to throw more light on the subject. Particularly problematical is the attempt to form an overall picture based on somatic, mental, and social information. It would be naive indeed to believe that these seamlessly combine into a psychosomatic whole. As Tress and Junker-Tress (2002) have emphasized, the functional causal-analytic and the hermeneutic-intentional approach both open up different horizons, which, though each of them represents "true knowledge", cannot be thrown together into a single piece of overarching uniform knowledge about the whole person. We have to operate, so the authors believe, simultaneously in several scientific languages, which offer either a "causal analytic or an understanding hermeneutic" approach to the human being. These methods, just like their results, are complementary to each other. What is important is to establish their respective

scope and relevance for the area under study, to recognize points of contact between those two levels, and, if need be, to revisit each point in a systematic manner.

If empirical studies for the examination of psychoanalytic/psychodynamic concepts were generally suitable to "test" psychoanalytic hypotheses, one must ask next to what degree psychoanalysts or psychoanalytically-oriented psychotherapists are ready and willing to deal with incongruent? theoretical or clinical findings and to integrate them adequately into their own theoretical edifice and theory of action. Published research results are seldom taken into account and many clinicians tend to deny such works and their results, or in the case of positive findings, tend not to register them, perhaps because they do not read the respective journals. Respected representatives of the psychoanalytically or psychodynamically-oriented psychotherapy community have argued therefore that the results of clinical research were never going to influence clinical practice (see e.g. Luborsky, 1969). Today this view has changed. As Kächele (1995) puts it, psychodynamic psychotherapy research shows a good deal of proximity to the "complex requirements of therapeutic practice", as reflected for instance in the papers in the "Handbook of Psychodynamic Treatment Research" (Miller, 1993).

An alignment with the neophenomenological orientation displayed in the diagnostic glossaries which currently dominate the field leads us to a cross-roads regarding the operationalized definition of psychoanalytic contents. With some effort all psychoanalytic terms can be "defined down" to a point where they can be grasped in a purely descriptive way. The superego, for instance, turns into the conscience, the superego conflict becomes the guilt feeling. This loses something of the dynamic concept of the psychoanalytic term, but in this example, not all that much, as guilt feelings do indeed make up the greatest part of superego conflicts. If one was to consistently substitute the word superego blame in the definitions with guilt feelings, one gains considerably in terms of comprehensibility while losing some dynamic content. Very likely in practice, not a few psychoanalysts travel this road of compromise. It would, however, not be acceptable in the authors' view to reduce, for instance, the concept of the unconscious to "that which cannot be verbalized". In actuality, the concept of the unconscious, especially of the dynamic unconscious, however difficult its definition may be, is much more far-reaching than the concept of "that which cannot be verbalized".

Therefore the authors of operationalizations of psychoanalytic concepts must find a middle way, which may allow a gain in clarity and unequivocalness, without at the same time removing the concept too far away from its dynamic content. It appears, therefore, reasonable to assume that users of psychodynamic operationalized glossaries basically accept terms like the dynamic unconscious, internal conflict, defence, mental structure, ego and self, self- and object representations, and others. Ideally, an understanding of such fundamental terms should be ascertained via consensus, and not be defined on the basis of real or presumed degrees of truth. This means that the dynamic presuppositions can be part of a definition, without making it circular or without deviating from the prescriptions of the operationalization. To emphasize, operationalization should, strictly speaking, in the definition, always be able to manage without recourse to facts which themselves cannot be operationally defined. But for the

operationalization of psychoanalytic contents, the strict adherence to this principle is not possible without distorting the essence of that which is to be defined to the point of no recognition. In this sense, it is sensible to speak of psychodynamic operationalization (more precisely: the operationalization with the inclusion of psychodynamic constructs). The goal of such a procedure would be to gain as much freedom from contradiction as possible while preserving as much dynamic content as possible. Perhaps it would be more correct to speak not of "consensus", but of the "smallest common multiple". A generally accepted consensus amongst psychoanalysts is a rare thing indeed! What is called for here is a compromise, and in view of today's quick and easy devaluation of the ability to compromise, one is reminded that the psychoanalyst Zacharias (1974) regards it, in substance, as the very precondition for the creation of peace. The OPD's suggestions for operationalization are compromises in this sense.

1.6 Past approaches of operationalization of psychodynamic constructs

Scientists have complained long and hard about the ambiguity and lack of clarity of psychoanalytic terms. So it is not surprising that psychoanalysis, since the time of Freud, has been far more successful in generating new hypotheses than in validating existing ones. The serious admonition of the then president of the American Psychoanalytic Association, A. Kaplan, that the task of our times was the validation of psychoanalytic theory, not the constant creation of new theories (Kaplan, 1981), went unheeded. Even if one accounts for the fact that psychoanalytic concept formation finds itself poised in that field of tension between hermeneutics (interpretation) and empirical science, one cannot avoid the impression that the ambiguity of the terms is not only tolerated by a majority of psychoanalysts, but is being actively maintained. One underlying reason is probably that the non-falsifiable status quo of theory and practice does the least amount of injury to psychoanalytic narcissism, and that each psychoanalyst can have their needs met in a satisfactory way in clinical discussions where, due to the nature of the terms used, no contradiction is possible and thus no revision of opinion is ever required.

This does not exclude the fact that psychoanalysts with a research interest have always suffered from this state of conceptual ambiguity which characterizes psychoanalysis. Nearly all attempts at new formulations and even at operationalizations are therefore, not surprisingly, the result of research projects.

In the Hampstead Index of A. Freud (cf. Sandler, 1962) the intention was diagnostically to differentiate symptoms, biographical data, drive development, characteristics of ego-functions and superego, points of fixation and tendencies of regression as well as conflict characteristics. In line with this the authors sought to distinguish between a developmental pathology (deep disturbance in the development of drives, ego, superego, and object relations) and neurotic pathology pertaining to more mature level of development.

The model of the descriptive developmental diagnosis of Blanck and Blanck (1974, 1979) is oriented on ego-psychology and along these lines strives to describe the developmental levels of ego functions. Based on this operationalizion of ego-functions, Bellak and others (Bellak/Goldsmith, 1984; Bellak/Hurvich, 1969) have

developed a multi-scale measuring tool where patients are classified in one of three categories of development of the ego (neurotic, borderline, psychotic). These first efforts at [a] systematization of a psychoanalytic diagnosis can principally be used in therapy planning, and also in the examination of treatment effects.

In the context of the work on the Hampstead Index, Sandler writes: "This has lead to a number of new formulations, for those that were available in the literature were at times inadequate, imprecise, or contradictory" (Sandler, 1962, p. 317). A series of authors who were committed to psychoanalysis regaining its connection to the international scientific community, which it had gambled away, have since taken the thorny road of new formulations. To describe this path is beyond the scope of this work, yet some short notes may be useful. Dating back also to the early 60s is the example of the working group of G. Bibring who worked on a possible link between pregnancy and early mother-child attachment. These authors developed a whole range of variables for observation, and, what is perhaps more interesting still, a new version of the catalogue of defence mechanisms, which then contained partially operationalized definitions (Bibring et al. 1961). A similar approach had been undertaken around the same time by Prelinger and colleagues (1964), who defined a series of psychoanalytic personality variables for systematic evaluation. In the time that followed, glossaries of psychoanalytic terms were published, of which the best known is Laplanche and Pontalis, followed by Moore and Fine (Laplanche/Pontalis 1991; Moore/Fine, 1968). The former defines exegetically in line with Freud's work, that is to say, in a purely prescriptive manner; the latter proceeds on the basis of a consensus omnium; it is the result of the efforts of a working group which had taken a lot of trouble to try to record what the majority of American psychoanalysts understood by the defined terms. Rycroft's (1968) Critical "Dictionary" of Psychoanalysis, in many instances, defines in logical-critical ways and frequently moves away from consensus but is, despite its qualities, hardly known in Germany.

A similar systematic approach by Perry and colleagues (1989a) focused on the definition of ideographic basic conflicts. Perry also contributed considerably towards a systematization of defence mechanisms. Haan (1972) looked at the relationship between defence and coping, but compared to other authors stayed on a rather theoretical plane. In contrast, Vaillant and co-workers (1986) empirically examined a hierarchical model of (adaptivity of) defence mechanisms as to its validity. Further empirical approaches for the classification of defence mechanisms were presented by Ehlers and colleagues (Ehlers et al., 1995; Ehlers/Peters, 1990). Thus this area so far shows the most extensive operationalizations (for an overview see Hoffmann, 1987). The OPD group has adopted Perry's categorization of defence mechanisms into the OPD system. It is reproduced in the Appendix (see Chapter 14.3).

In psychotherapy research, meanwhile, a series of operational approaches have come into being, which try to capture interpersonal behaviour from a psychodynamic point of view (see overview by Schauenburg/Cierpka, 1994). Lester Luborsky's model of the "Core Conflictual Relationship Theme" (CCRT)" (Luborsky/Crits-Christoph, 1990) offers an operationalized approach of a relationship diagnosis, which scientifically met with great interest, however, is hardly used in the clinical diagnostic process. Based on a semi-structured interview

the patient (proband) is asked to describe relationship episodes which are characteristic for him, which then are classified based on a system of categories. The conflictual relationship themes worked out in the interview can then be used as a basis for differentiated therapy planning. In axis II, interpersonal relations, it is being pointed out that the interviewer, in the framework of the normal OPD-interview, should ask for at least two such relationship episodes. Over time the CCRT has been modified and further developed (e.g. Albani et al., 2002b). It is valid to ask though, in this context, whether and when ever more elaborate diagnostic criteria will begin to lose their appeal and become irrelevant for clinically practicable diagnosis.

The axis of interpersonal relations also employs the Structural Analysis of Social Behavior, or SASB (Benjamin, 1974; Tress et al., 1990), which equally focuses on diagnosis of relationships. This approach has been primarily developed against the background of interpersonal psychological theories. This relationship diagnosis has a highly differentiated methodical approach which includes external observation as well as self-observation and description, but its integration into psychodynamic diagnostic approaches makes good sense. It is suitable, too, for the deduction of therapeutic aims and treatment approaches, with the one reservation that the scope of its application lies more in the scientific arena than in clinical practice, given that its application in many ways requires a lot of input.

Further operationalizations of interpersonal psychodynamic diagnoses can be found in the theoretical part pertaining to the axis on interpersonal relations (cf. section 3.2).

With the Transference Focused Psychotherapy (TFP), Kernberg and collaborators (Clarkin et al., 1999; Kernberg et al., 1989) have developed a therapy approach (especially for borderline patients) which proceeds from circumscribed and systematized diagnostic characterizations to formulate the therapy aims, and from these problem formulations infers the relevant therapeutic essentials.

The outcome goals of therapy can be determined with the help of the Structured Interview for Personality Organization (STIPO, Clarkin et al., 2004b). This particular instrument represents an operationalization of the structured interview by Otto F. Kernberg. In it, the interviewer asks and then explores structured questions on 100 items and then rates the results according to anchor-point descriptions. Items are summarized on eight dimensions (identity, object relations, primitive defence, coping, rigidity, aggression, value judgements, as well as reality testing and distortion of perceptions). The evaluation of each dimension is carried out both arithmetically and clinically by way of further anchor-point descriptions. In the final step, the personality organization of a patient is recorded in terms of categories on six levels (normal, neurotic 1 and 2, borderline 1, 2, and 3), and a dimensional description of the personality organization in the form of a structural profile based on the previous dimensions with their respective subdimensions is generated.

With the Karolinska Psychodynamic Profile or KAPP (Weinryb/Rössel, 1991) we are offered a rather comprehensive diagnostic tool with a psychoanalytic background. This external evaluation system is, like the OPD, based on a clinical interview closely modelled on Kernberg's structural interview. The 18 subscales of KAPP assess, among other things, the following areas: quality of interpersonal relationships,

level of mental functioning, differentiation of affects, experience of one's own body, sexuality, and personality organization.

Provided that the raters are sufficiently trained, KAPP offers a high interrater reliability, and its validity is also considered satisfactory. First studies have shown positive interrelationships between individual areas of the KAPP and dimensions on the "structure" axis of the OPD (Grütering/Schauenburg, 2000).

1.7 Limits of the OPD

OPD accentuates in particular the reflection of patterns in relationship behaviour. It also highlights modes of behaviour and experience arising from conflicts, and from structural characteristics. From this, a lot is gained in terms of clarity about the mental condition of the patient in his current life situation. However, the OPD also does without some of the things that are usually regarded as essential in the psychoanalytic discussion. Aspects of the interpersonal encounter and the intuitive awareness of the other recede somewhat into the background. Instead of taking a holistic view of the patient, a collection of detailed findings along the individual axes is undertaken first, and only later are these findings to be synoptically combined.

The diagnostic interest is not primarily in the biographical context, the narrated life, the meaningful construction of the past. It is therefore possible that psychoanalytically trained examiners are initially missing something which so far they had been accustomed to in their dealings with patients. In turn, OPD-trained diagnosticians often feel that the working out, together with the patient, of clinically important themes which are then made into a therapeutic goal, is missing in psychoanalytic examinations.

Like any diagnostic system, OPD has its limitations. The psychodynamic diagnosis given, for example judging the importance of certain conflicts or of structural limitations, will always be a hypothesis based on the experiences gathered at one point in time during the interpersonal situation of the therapeutic interview. It may happen, therefore, once a therapy has been started and is taking its course, that precisely then other conflicts gain in emphasis or other structural characteristics come to the fore. While the operationalizations prescribed by the OPD contribute to the standardization of observations, still, any statement on a psychodynamic diagnosis remains closely tied to a theory-lead interpretation of another person's inner world. This limitation continues to apply for OPD, just as it continues to apply for any other psychodiagnostic system. Nonetheless, the behaviour-oriented OPD descriptions as evidenced by the quite reasonable figures on interrater reliability, may contribute to prevent psychodynamic considerations from running wild, more so than in a non-operationalized kind of hypothesis formation. Occasionally it can be seen that individual therapists link OPD terms (as e.g. individuation, oedipal, or identity) with certain "private" ideas and convictions. It must, therefore, continually be pointed out in the training courses how important it is to refer to the operationalizations of the manual and the checklists, and to proceed from these definitions, even if single aspects deviate from one's own habitually held opinions. It is our experience that newly trained therapists can be led in this way far more easily, whereas experienced therapists tend to hold on to their personal usage of terms and the theoretical convictions of their therapeutic peer group.

2. Experiences and empirical findings with OPD-1

OPD serves not only state but also process-diagnostic purposes. OPD, with its diagnostic categories and their operationalizations, is a considerable enrichment on the diagnostic horizon, precisely because it contributes to making psychodynamic constructs measurable which are relevant for therapy and change. It thus can be put to use in the planning and evaluation of therapy as well.

In clinical practice, a thorough assessment using OPD can provide helpful hints for decisions and actions within the framework of therapy planning. The rating results from Axis I, for example, reflect relevant aspects of how a patient experiences illness, of his concepts of illness, and his motivation for change. On this basis the clinician is able to decide whether, at that point in time, the patient would benefit from a specific psychotherapeutic measure or whether more basic? interventions are indicated to stabilize the patient first, perhaps gradually leading him towards psychotherapy. The OPD rating results from the other axes can reveal the patient's core problem areas, which may assist with the formulation of treatment aims, as well as with the development of therapeutic interventions. Such core problem areas can be dysfunctional relationship patterns (Axis II), life-determining conflicts (Axis III), or "critical" structural characteristics (Axis IV) which describe particular vulnerabilities or limitations of the patient. These problem areas, which are laid down in the categories of the OPD, can be the foci that guide psychotherapeutic treatment. Moreover, the assessment of the patient's structural level is per se an important piece of information about whether a more structure-oriented psychotherapeutic procedure is indicated, or rather an interpretative-disclosing intervention, which focuses on the dysfunctional handling of unconscious conflicts (Rudolf, 2004b).

An OPD-based model for the determination of therapy foci and therapy aims was developed during the course of a long-term analytical therapy practice study, or, in its German original, "Praxisstudie Analytische Langzeittherapie" (Grande et al., 2004b; Leising et al., 2003; Rudolf et al., 2001a; Rudolf et al., 2002a). It has proved its worth in in-patient and out-patient settings as clinically practicable and usable for the scientific evaluation of psychodynamically-oriented therapies. This model uses the so-called Heidelberg Structural Change Scale as an instrument to measure change by tracking the progress in the patient's ability to deal with problem areas that are to be restructured through therapy (Grande, 2005; Grande et al., 2001; Grande et al., 2003; Rudolf et al., 2000).In addition, the formulation of a focus in terms of relationship dynamics has been helpful in in-patient treatment in order to promote a patient-centered attitude within the team (Stasch, 2003; Stasch & Cierpka, 2006).

2.1 Quality criteria of OPD-1

With the publication of the OPD manual (OPD Task Force, 1996) a phase of intensive research began. The first reliability studies were quite satisfactory and had already been incorporated into the first OPD manual (Freyberger et al., 1996a). Consequent to this, interrater reliabilities were collected for the Axes II to IV on the basis of videotaped initial clinical interviews in the area of in-patient treatment.

Experience gained from teaching the system and from its application has shown that not only the training, but also the quality of the material examined, and the clinical training and professional experience of the raters, play an important role in the quality of the ratings.

A study by the OPD-1 working group (cf. Cierpka et al., 2001) recruited 269 patients from 6 clinics for psychosomatic medicine to test the reliabilities of Axes I to IV. As the rating conditions in the various clinics differed along important parameters, the experimenters were able simultaneously to look at what conditions improved or worsened the reliability of the assessments. The measure they used was the weighted kappa (Cohen, 1968), which in contrast to the intraclass correlation coefficient (ICC) makes no parametric demands and was thus better suited to the data than the latter. To determine the weights, the intervals on the rating scales, which each contained four subscales, were assumed to be equidistant for the Axes I, III, and IV; this leads to a kappa that can be interpreted similarly to a Pearson correlation coefficient (Fleiss/Cohen, 1973). On Axis II "interpersonal relations", the experimenters also calculated the weighted kappa. The procedure in this case corresponded to the standard procedure used in the Structural Analysis of Social Behavior (SASB, Benjamin, 1974); in this, deviation weights in kappa are adjusted to the logic of the circumplex model of interpersonal behaviour with a method described by Grawe-Gerber and Benjamin (1989).

Reliability was high with data from interviews which had been carried out for diagnostic purposes and which were videotaped. Reliability was measured on the basis of independent ratings of these videotapes. For Axis II "interpersonal relations", these conditions were met in 2 of the 6 clinics; the weighted kappa was calculated as .62 and .56, respectively. The reliability of Axis III "conflict" was only studied in one clinic under the above conditions. All 9 types of conflict on the axis averaged a mean of .61, the range in relation to the individual conflicts was .48 to .71. Reliability, however, was best for Axis IV, structure. In two clinics the mean values were .71 (range .62 - .78) and .70 (range .60 - .81) across all 6 structure dimensions. No studies on the basis of videographed diagnostic interviews exist as yet for Axis I.

According to classifications by Fleiss (1981) and Cicchetti (1994), kappa values of between .40 and .59 can be considered "fair", and kappas between .60 and .74 "good". Still higher agreements are considered "excellent". This corresponds approximately to Landis and Koch's (1977) assignments, which, however, set the cut-off point for "excellent" at a somewhat stricter .80. According to these assignments the reliabilities for Axes II interpersonal relations and III conflicts can be regarded as "fair" or "good", those for Axis IV structure as "good" or "excellent".

In 2 of the 6 clinics the interviews were conducted under conditions of everyday routine clinical work. This means that the interview was conducted under practical constraints of normally available resources for patient care, which implies limited time. The assessments were made by the interviewer himself and an additional rater who sat in on the interview. In these two clinics mean values of between .30 and .50 were found for all four axes (Axis I: weighted kappa = .47 in one study, .43 in the other; Axis II: .50/.45; Axis III: .40/.43; Axis IV: .30/.48). These figures roughly

correspond to the results of an earlier OPD practicability study (Freyberger et al., 1996a), which was also conducted under conditions of routine clinical work.

In a further clinic, ratings were conducted also on the basis of videographed diagnostic interviews, but with inexperienced students as raters. In this study the mean values were .42 for Axis II "interpersonal relations", .33 for the "conflict" axis, and .55 for the "structure" axis. As these students had undergone the standard training, it can be concluded from this study that a lack of clinical experience represents a grave disadvantage for the OPD rating. As the evaluated studies reveal, the required qualifications for a sufficiently reliable use of OPD comprise, in addition to a thorough training in OPD, a minimum of 2 to 3 years of previous clinical experience. Overall, the reliabilities for Axes II "interpersonal relations" and Axis III "conflict" are satisfactory, and good for Axis IV "structure", if the assessment is based on an interview carried out especially for the purposes of OPD. In addition, this particular assessment was not direct, but was made on the basis of a video recording. After all, these are the conditions for research. What must also be taken into account for the assessment is that other diagnostic tools like, for instance, the ICD-10 are applied in every day clinical practice with similarly moderate levels of reliability. The following presents and discusses the studies with regard to the validity of the individual axes. All studies were carried out using the first OPD version.

2.2 Axis I: "Experience of illness and prerequisites for treatment"

As concerns criterion-related validity for this axis, reference is made to the fact that there are only a limited number of testing procedures relating to similar issues, which could serve as external criteria. The ‘Fragebogen zur Psychotherapiemotivation’ (FMP, Schneider et al., 1989) shows at least in part a high similarity in content to the items or characteristics of Axis I. Findings from studies on various clinical disorders, of patients in different clinical settings and of different age groups (Schneider et al., 1998) have shown good indications for the clinical validity of Axis I. Axis I discriminates between these groups with respect to pre-treatment expectations. Older patients or patients of the so-called psychosomatic liaison service show less insight into psychodynamic or psychosomatic contexts and are less motivated to have psychotherapy, displaying a higher motivation for somatic treatment. Franz and colleagues (2000) were able to find that patients' impairments in the psychosomatic, mental, and the domain of social communication, as identified by the OPD, were reflected in the expert rating of the impairment scores (BSS) and in patients' self-reports (SCL-90). To test the predictive validity, psychotherapy in-patients were studied in pre-post comparisons, while SCL-90 and IIP-diagnoses were made concomitantly. In order to identify possible interactions between Axis I characteristics and other clinical parameters, the patients were divided into two groups with a high, or low, incidence of Axis I characteristics, respectively. There was a multitude of main effects in one-way analyses of variance, but also a series of differential effects (changes) not only on the Global Severity Index and on the sub-scales of the SCL-90 (OPD item 7, capacity for insight into psychodynamic contexts, and above all item 15, symptom presentation - emphasis on mental symptoms, but also on the IIP sum score (items 9, 10, 13, 14, 15) and its subscales. The item "symptom presentation - emphasis on mental symptoms" (15) is the one that best allows a predictive statement about

therapy success. For testing the construct validity of Axis I, factor analyses may be carried out in order to highlight links between the items. Franz and collaborators (2000) found a three-factor model (total variance explained 54 percent). The factors describe "insight", "resources and strengths", and "body-related items". Another factor analysis (Wietersheim, 2000) found five factors (break off criterion eigenvalue <1) which accounted for 68 percent of the variance. Factor I (somatic experiencing and coping with illness) explained 30.6 percent of the variance and included the degree of severity of the somatic findings, the extent of the physical impairment, as well as the somatic presentation of symptoms, and a more somatically-oriented motivation for treatment. Factor II (mental experiencing and coping with illness), variance explained 13.3 percent) included the impairment through mental symptoms and experience of self and motivation for psychotherapy. Factor III (capacity for insight; variance explained 11.2 percent) comprised the capacity of the patient for insight into psychodynamic, psychosomatic and somatopsychical contexts. The fourth factor (resources and strengths, support, variance explained 6.8 percent) consisted of the items relating to psychosocial integration and support. A last factor (compliance) loaded the negatively correlated leading items of compliance and of secondary gain from illness. The construct validation via the above factors presents itself as particularly plausible and confirms the hypotheses on which the conception of the axis was based.

In summary, these results exemplify the high clinical relevance of Axis I. The axis allows statements about the capability and readiness of the patient to engage in psychotherapeutic-psychosomatic treatment. On this basis, specific interventions intended to increase motivation and further the capability to cope with illness, may be deduced as necessary. These may help to prepare the patient for psychotherapy in a more specific sense.

2.3 Axis II: "Interpersonal Relations"

The characteristic intended to be diagnosed or predicted by OPD's interpersonal relations axis concerns dysfunctional behaviour patterns in interpersonal relationships. The "Inventory of Interpersonal Problems" (Horowitz et al., 1993) and the "Structural Analysis of Social Behavior" (SASB; Benjamin, 1974) are valid and recognized methods for the criterion area involved here and were therefore introduced for the purposes of concurrent validity (in the sense of an internal criterion-related validity). Given that the IIP is a self-report questionnaire, only the experiential perspective of the patient, or Position A, "The patient repeatedly experiences himself as ..." was used in a study by Stasch and collaborators (2004) as a validity control measure of the OPD interpersonal relations axis. As the description of the IIP-scales (for example "too dominant" or "overly caring") is similar to the categorical clusters on the OPD circumplex, they were then compared with each other. The resulting correlations are based on a sample size of (n =) 274 patients. The rating was conducted following a detailed diagnostic conversation, or special "relationship episodes interview", respectively. The resulting validity coefficients when comparing a self- versus an external rating procedure reached an mean correlation of 0.21 and were thus within an acceptable range. When interpreting these results, one should also consider that the compared instruments differ markedly as to construction and intended area of application. In a different

study (Leising et al., 2000) the question was explored of how well the OPD relationship diagnosis and the independent results of a Structural Analysis of Social Behavior (SASB) of relationship episodes described in the OPD interviews agreed with each other. It could be shown that the OPD relationship diagnostic has a greater than chance concordance with the SASB-ratings of the individual episodes. In addition, it can be concluded that, in the OPD Axis II, the ratings of a patient's experiential perspective (Perspective A) is oriented towards those behaviours most often mentioned by the patient himself. With a view to the theoretical aspects of testing, there were several proposals for improving the OPD relationship axis (Cierpka/Stasch, 2000).

For an interpersonal understanding of psychopathology it is relevant to know the quality in which relationship fantasies and readiness for action are realized in the patient's current interpersonal relationships (predictive validity). In particular, the wishes and desires a patient brings to the relationship are described as less flexible than the reactions of his interactional partners (Crits-Christoph et al., 1994). Cierpka and colleagues (1998) demonstrated that the rigidity of interpersonal wishes correlated positively with the degree of the psychopathology. Crits-Christoph and Luborksy (2001) were able to show that the so-called pervasiveness (continual dominance) of the reactions of others, and also the reactions of self (as measured by how strongly they register in the CCRT-categories) can be lowered by psychotherapy. Those changes towards higher interpersonal flexibility then correlate positively with the symptomatic outcome. Taking the circular variance of the behavioural clusters as depicted in the OPD circumplex model as a starting point, 100 patients were studied during the course of an in-patient psychotherapy as to changes in interpersonal flexibility (Stasch/Cierpka, 2000). Individual diagnostic subgroups were examined separately from each other in a pre-post comparison and the correlations between interpersonal outcome measures and symptom improvement were calculated. As expected, it could be shown that in affectively disturbed patients (n=28) and in patients with adjustment disorders (n=13) an increase in interpersonal flexibility is positively correlated with symptom improvement. For the subgroup of depressive patients the Pearson correlation coefficient between symptomatic improvements (measured by the Global-Severity-Index GSI of the SCL-90 R) and the change in interpersonal variability was 0.39 with a one-tailed p value of 0.02. In the group of patients with adjustment disorders r was 0.57 with p (one-tailed) = 0.02. In patients with anxiety disorders (n=12) the trend runs counter to expectations. In these cases the symptomatic improvements correlate negatively with an increase in variability (r= -0.42, p (one-tailed) = 0.08). That is to say, anxiety patients benefit by an increased rigidity in their interpersonal experience of self, a finding that could be explained by reference to their increased self-assertion and demarcation from the wishes of others. Overall these results show that OPD diagnosis and measures derived from it are able to discriminate between various diagnostic groups as to symptomatic outcome.

OPD relationship diagnosis is based on the so-called Circumplex Model of Interpersonal Behaviour (cf. Kiesler, 1983; Leary, 1957) which has a long tradition in personality, social and clinical psychology, and consequently, has been well studied empirically and validated. As various authors (Foa, 1961; Guttman, 1954) were able to show, the circumplex model has considerable power as a predictive model and represents a nomological net which can be used for construct validation. If one

wants to examine the goodness-of-fit of a construct, the areas of which should be on a circle by reason of hypothesis, one must verify whether the pattern of the predictable correlations of the construct can be reflected in the circumplex. The circumplex construct-correlation curve shows a cosine function that is unequivocally identifiable numerically and graphically (for procedure cf. Gurtman, 1992; Kiesler, 1996). Construct validation was performed using the German version of the Inventory of Interpersonal Problems (IIP), the circumplex structure of which is empirically proven. The results refer to the sample described under “agreement validity” (see section 2.5). It could be shown that the majority of OPD interpersonal relations axis clusters can be depicted in accordance with the construct, namely, in a circular manner, and that they possess specific interpersonal content. A criteria-related comparison between the relationship axis and IIP with respect to some behavioural and experiential clusters revealed differences as to content, which, besides indicating differences in construction (self-rating or external rating), may also reveal higher or lower clinical conciseness. The OPD clusters have meanwhile been modified in content; this consisted not in adapting to the empirically rich, but perhaps also imprecise scales of the IIP, but in emphasizing the clinical importance, which shows itself through, in particular, the experience of painful relationship episodes.

2.4 Axis III: "Conflict"

As regards agreement validity of the unconscious conflicts described in the OPD, the use of other measures poses a fundamental problem that can only be partially resolved at this time: There are no other instruments which can capture unconscious conflicts as a recognized validity measure (Schüßler, 2000). Styles of attachment in adults can be compared, especially with conflict I "autonomy vs. dependency" and conflict III "need for care vs. autarky", as set out in OPD-1 and often controversially discussed as to their respective boundaries. Both conflicts revolve around the basic and conflictual theme of attachment, although in different forms of expression. In accordance with the Attachment Prototype Rating (BPR; Pilkonis, 1988) three main categories of attachment can be distinguished: secure attachment, ambivalent attachment (excessive dependency, impulsive-unstable and excessive care), as well as avoidant attachment (avoidant-fearful, rational-controlling, and excessive demand for autonomy). Müller (1999) studied 55 women with personality disorders using OPD and the Attachment Prototype Rating. The level of agreement between raters for both the autonomy-dependency conflict (kappa=0.64) and the need-for-care versus autarky conflict (kappa=0.56) can be considered good. As this sample was made up of severely ill patients, there were, as expected, no securely attached patients; rather, 22 percent showed an ambivalent, 31 percent an avoidant and 47 percent a mixed style of attachment. The more ambivalent the attachment, the more the researchers found the conflict "need-for-care versus autarky"; the more avoidant the relationship, the more the conflict "autonomy versus dependency" was detected and the more unlikely they were to find the conflict "need-for-care versus autarky". A global assessment of the security of attachment showed that the more secure an attachment was rated, the more the conflict "need-for-care versus autarky" was found, and the less secure an attachment was rated, the more the conflict tended to be "autonomy versus dependency". These results provide a first indication of the validity of conflict differentiation into autonomy/dependency

versus need-for-care/autarky. In a study done in Ulm, Germany (Zlatanovic, 2000), good agreement of the OPD conflicts with the "core conflictual relationship themes" (CCRT) in a sample of 44 female in-patient psychotherapy patients was found. The studies in Heidelberg and Münster (Rudolf et al., 1996; Schneider et al., 1998) were able to show a preponderance of conflicts I-IV in a clinical context. The conflict need-for-care versus autarky showed a lesser degree of physical impairment and shorter hospital stays, which in turn confirmed the problematic areas typically ascribed to this conflict using different criteria from the above. Contrary to this, a higher degree of intensity in the conflict area "limited perception of conflicts and feelings" comes with a higher degree of physical impairment; this also enhances the specific description of conflicts. As concerns the concept of typical "leading affects" of the conflicts described in Axis III, a validation attempt was carried out in the above-mentioned study by Leising and colleagues (2000) using the described methodology: with the help of a clinical list of emotions (Leising, 2000) a frequency profile was established for each patient for self-reported affective experiences. An independent rater was given the task of comparing this profile with the indices on Axis III on the two most important conflicts and the mode of processing. A further external emotion profile was then added, assigned by chance. In 9 out of 13 trials a correct assignment was achieved ($p=0.087$; binomial test) so that the 5 percent level of significance was missed. From this the authors conclude that the relationship between intrapsychic conflicts and the preponderance of certain leading affects is at least not as unequivocal as the OPD manual had assumed. In a therapeutic framework, predictive validity is of particular importance. No major links could be detected between the predominant conflicts and treatment success in 30 in-patient psychotherapy patients - with the exception of the conflict category "limited perception of conflicts and feelings" which was not found in any patient from the group with marked therapeutic success (Strauß et al., 1997). In the study by Rudolf et al. (1996) the patients with a predominance of the conflict type "autonomy versus dependency" showed less therapeutic success. The conflicts "oedipal/sexual" and "control versus submission", however, showed a positive correlation with the treatment result. As construct validity also includes content-related and criteria-related validity, we have so far been able to provide first hints that individual conflicts by all means depict and differentiate the underlying constructs. In summary, the scientific difficulties in testing the validity are huge, as only external criteria exist for each conflict and as comprehensive test procedures to identify unconscious conflicts do not exist. The system that has been developed for conflicts is very usable and applicable for training and clinical issues. Individual conflicts studied so far show good agreement with related test procedures. In addition, these individual conflicts can be differentiated well using the related test procedures. A sufficient link between the defined operationalized conflicts and the construct "dynamic conflict" can thus be assumed.

2.5 Axis IV: "Structure"

As structural characteristics are defined on the basis of observed behaviour and require only little theory-led interpretation, the structure axis in particular showed good clinical practicability, and the best interrater reliability (Freyberger et al., 1998; Rudolf, 1996; Rudolf et al., 1997; Rudolf et al., 2000) in comparison with the other axes. In addition to the assessments of the 6 structural dimensions, it has

proved useful to employ the 21 structural characteristics as had been done in therapy studies (Grande et al., 1997) with the Heidelberg Focus List (Heidelberger Fokusliste). An option for even greater differentiation of the structural characteristics on the various levels of integration was presented with the structure checklist (Rudolf et al., 1998). It allows the use of prototypical statements which are then assigned to the individual characteristics so as to precisely determine the structural level of the individual characteristics. The psychotherapy studies of the Heidelberg working group clearly showed a wide range in the structural level in in- and out-patients and also revealed the nature of the links between the structural level and the OPD conflicts and relationship patterns. The studies also showed which diagnoses (especially personality disorders) are related to this (Grande et al., 1998b; Grande et al., 2001; Grande et al., 2002; Rudolf/Grande, 2002; Rudolf et al., 2004a; Rudolf et al., 2002b; Spitzer et al., 2002). It became evident that with an increasingly less integrated structural level diagnoses of serious personality disorders (e.g. borderline personality disorder) are made far more frequently. Equally, the measures for the ability to have relationships (e.g. OPD Axis II or IIP) exhibit a clearly negative quality, which include elements of hostility, rejection, isolation, or aggression. Correspondingly, the countertransference reactions of the examiner are equally negative (Oberbracht, 2005).

A series of studies concerns itself with the agreement between assessment of structure and other simultaneously collected data (agreement validity). These studies can be further subdivided into those which have selected an external (objectively rated criterion), or an internal criterion of validity (other test procedures recognized as valid). In the first group is a study by Nitzgen and Brünger (2000). The authors looked at 171 male patients with long-standing drug addiction at the beginning of their hospital stay. These patients showed the lowest self-regulation scores (mean=2.2; 2 corresponds to "moderate", 3 to "low" integration). This was the result that was to be expected theoretically, because this part of structure comprises, amongst other aspects, affect tolerance and impulse control. Reymann and colleagues (2000) confirmed these results in a study of 22 alcohol-dependent male patients in an open detoxification clinic which also found a structural weakness in self-regulation (mean=2.32) and object perception (mean=2.44). The first study further substantiated the validity with respect to agreement with ICD-10 diagnoses. Patients who were given diagnoses from the spectrum of neurotic disorders (mean=1.97) proved to be better structured than patients with personality disorders (mean=2.37, $p<0.01$). In a study that examined links between symptom diagnoses on the basis of ICD-10 and OPD-results Rudolf et al. (1996) were unable to find significant links. However, this study showed that a less integrated structural level carries with it a longer duration of psychogenic illness (-0.38, p=0.06), which is probably due to fact that these patients, in terms of their structure, have fewer possibilities of self-regulation. Among the second group of validity studies, which had chosen criteria for internal validity, is a study by Schauenburg (2000). He studied 49 consecutively recorded cases of inpatients in a psychotherapy ward and found that secure attachment (attachment diagnosis by Pilkonis) (-0.30, p=0.05) and excessive dependency needs (-0.29; p=0.06) are accompanied by a more integrated structural level, while borderline traits (0.27; p=0.08), exaggerated demands for autonomy (0.32; p=0.03), and antisocial characteristics (0.55; p=0.00), are all associated with a lower level of structural

integration. Grütering and Schauenburg (in press) used the same sample and added independent raters to compare the degrees of intensity on the scales of the Karolinska Psychodynamic Profile (KAPP; Weinryb/Rössel, 1991) with the dimensions on the structure axis and found the expected correlations as to content: The capacity to self-regulate was related to the scales intimacy and tolerance of frustration, but also to the (missing) experience of feeling needed and belonging. Also, a correlation was found between a higher level of integration in object perception as well as communication, and the ability to experience intimacy. In a further validation study the structural assessments gained from a sample of 48 psychosomatic in-patients were compared to assessments carried out on the basis of the "Scales of Psychological Capacities" (SPC) by Wallerstein (Rudolf/Grande, 1999). Unlike the OPD, SPC identifies, besides structure-based vulnerabilities which form the content of the OPD structure axis, also habitual modes of dealing with conflict, or of defence formation, respectively, and subsumes them under the term "structural capacities". An interesting consequence of this is that the pathological behaviours described in the SPC only correlate with the dimension of the structure axis if indeed structurally caused limitations are being captured (for example, $r=0.30$; $p<0.05$, as between the SPC scale "drivenness" and the dimension "self-regulation"). If, however, limitations due to conflict are being described, the respective correlations can be found in certain degrees of intensity of conflict on the OPD Axis III (for example, a correlation of $r=0.41$; $p<0.01$ between the SPC scale "moralism" and the conflict "submission versus control"). Empirical testing revealed as a further result a greater than chance concordance between a less integrated overall structural level and a difficulty in expressing emotional resonance (-0.41; $p<0.01$), as well as the difficulty of being able to rely on others (-0.43; $p<0.01$). These two SPC items refer, more than the other items of this tool, to the interpersonal capacities of a person and thus come especially close to the theoretical concept of the OPD structure axis, which places the capacities and vulnerabilities of the self in its relationships with others at the centre of the analysis of structure. Predictive validity was addressed in the earlier-mentioned study by Rudolf et al. (1996). The structural assessment at the start of in-patient treatment proved to be a very good predictor both for the patient's (0.30) and the therapist's (0.40; $p<0.05$) perception of treatment success. A look at the individual structural dimensions reveals that the ability to form attachments (patient 0.42, therapist 0.46; $p<0.01$) is especially relevant for prediction. It appears that the ability to permanently invest others with positive affect is a good guarantor for the success of the interpersonal therapeutic venture.

Schneider and colleagues (2002) were able to show that the structural level varies according to whether patients were recommended for out-patient or in-patient psychotherapies or for psychiatric treatment. Schulz (2000) found in an experimental group of 8 patients that patients with a higher level of structural integration showed clearly richer facial expression. An examination of 30 patients in in-patient psychotherapy treatment confirmed that patients with a higher level of structural integration are more able and likely to benefit from therapy (Strauß et al., 1997).

As a contribution towards the establishment of construct validity, a factor analysis in another Heidelberg study (unpublished) revealed that the items on one of the main factors load with a very high eigenvalue. A high internal consistency of 0.87

for the structural dimension and 0.96 for structural foci also point in a similar direction. These results, too, indicate that "structure" is essentially a unidimensional construct and that the various partial functions of structure act interdependently. Both in theoretical and clinical understanding, the structural status or constitution represents a permanent and stable characteristic of a person; it is therefore further evidence for the validity of the construct of the structure axis that in a pre-post comparison of a 12-week in-patient psychotherapy the structural measurements (a pre-post agreement of 84.4 per cent for the overall assessment of structure) were stable over time (Grande et al., 2000). In summary, and judging from the experiences gained so far, it would appear that the OPD structure axis is well suited for the description of a psychodynamically conceptualized personality structure.

2.6 Conclusion

The first experiences with our classification instruments show that the axes we constructed are useful for clinical practice and can be reliably assessed.

Based on empirical findings and the experiences gained in clinical work with OPD, and with the knowledge obtained from OPD training seminars, an initiative was formed to fundamentally modify and expand OPD into OPD-2. Against the backdrop of research results and due to practical requirements of clinical work, OPD will have to be constantly adapted. This necessity conflicts with our efforts to provide an instrument that offers some continuity and clarity. It is a problem we hope to have been able to solve in a creative and user-friendly way.

3 Operationalization of the axes according to OPD-2

3.1 Axis I - Experience of illness and prerequisites for treatment

3.1.1 Introduction

In order to arrive at an indication for therapy,(independently of whether a somatic treatment is indicated in patients with organic illnesses, or whether we seek clarification regarding differential psychotherapy indications), a very important factor to be considered is the manner in which an illness is experienced and processed. Each method of treatment here places greater or lesser demands on the emotional and cognitive readiness of the patient to cooperate, and on how he tolerates the related stresses. For a differential indication for psychotherapy, it is important, for example, to take into account the patient's subjective suffering, to determine whether he shows insight into the psychodynamic interrelationships with regard to the illness within the specific environment; whether he can be motivated to undertake the planned modality of psychotherapy; and, whether he has access to the necessary personal and social resources. In the psychiatric liaison service the issues, however, are more often more general in nature. First, we must examine to what extent an in-depth psychosomatic-psychotherapeutic diagnosis is indicated for a patient. Also relevant as criteria for indications for such specialist, psychosomatic-psychotherapeutic assessment, are aspects of a patient's experience of illness and prerequisites for treatment. Only when this has been better clarified in diagnosis, can we answer the question as to when differential diagnosis is relevant and necessary.

When deciding on an indication for psychotherapy from a psychodynamic point of view, what is also important, besides the existing illness and its specific symptoms, are the relevant underlying psychological conditions which can be causal and influence the course of an illness. For psychodynamic theory, these are, in particular, aspects of personality structure, as well as typical unconscious conflictual themes or motives and the relationship patterns they give rise to. In addition to this, OPD has introduced the concept of conflictual external life stresses which is an etiological construct that sees the cause of illness not in conditions acquired over the course of life, but in actual stressful psychosocial configurations.

The psychotherapeutic method specifically indicated in the individual case cannot, however, be exclusively deduced from the set of specific and concrete causal circumstances, but as a rule, is modified by the patient's expectations of, and motivation for treatment. More often than not, we find a link here between personal characteristics, the manner in which the illness is experienced, and the patient's motivation for treatment; specific modes of illness experience and of treatment motivation may express specific structural characteristics, or characteristic conflictual patterns of experience or action (Schneider, 2002).

In the clinical practice of making an indication for treatment, a decision is arrived at successively in a series of different steps. Generally and first of all, we must ask which kind of therapy the patient needs based on the existing illness, or set of problems, and the psychological variables this rests on. In the next step, we need to investigate what kinds of prerequisites for treatment and motivation for change

the patient displays. The procedure of establishing an indication would take into account respective resources or obstacles that may be relevant for treatment, as well as the patient's concrete motivation for treatment and bring them into congruence with respect to the generally indicated methodical procedure. This means that for a patient for whom the treatment of choice is a conflict-centered, understanding-oriented procedure, due to the conditions that existed at the origin of the mental illness and its characteristics, the following must be clarified a) how far the patient currently possesses the necessary resources with respect to the preconditions tied to this therapeutic approach on the level of self-reflection, or the level of stressful emotional experiences he can tolerate, and b) how far he is also motivated to cooperate with such a psychotherapeutic venture. To the extent that relevant internal or external obstacles or limitations exist for the patient to engage, there and then, in this kind of psychotherapeutic process, a different therapeutic approach may have to be chosen at that time (e.g. emotional-supportive or actively structuring procedure), or, the therapist may have to work with the patient in a first phase of treatment to create the affective and cognitive preconditions (including the motivation for treatment) for a conflict-centered psychotherapy.

Against this background, operationalization of how the patient experiences illness and of the prerequisites for treatment becomes necessary, so as to start the process of diagnosis and of making a differential decision as to which specific treatment modality is indicated for a given patient. Terminologically, we prefer to talk about 'experience of illness' as opposed to 'illness behaviour', the former term being introduced by us, as in our understanding, it better emphasizes the importance of emotional and affective processes.

The question of a patient's cooperation with treatment has been taken up by compliance research (Basler, 1990; Becker et al., 1982). As regards the question of processing an illness, a host of theoretical and empirical research approaches have been developed since the 1960s against the background of stress research under the heading of "coping" or "dealing with illness". They produced important findings for our axis. However, in our opinion, other relevant aspects have, been neglected in coping research so far, due to the complexity of the model.

The early coping models can be distinguished according to "stimulus- or reaction-centered" concepts. Stimulus-centered stress models regard single or comprehensive stimulus conditions as stress and proceed from the assumption that these conditions cause stress largely independently of the individual. For psychosomatic medicine, "life-event research" as a stimulus-oriented model of stress has been of foremost importance for a long time. The classical reaction-centered concepts of stress understand the unspecific state of activation of an organism as stress, which is mediated by humoral and physiological reactions (Selye, 1974). Coping models emphasize the individual aspect of working through events and examine in particular the meaning (e.g. desirable or undesirable) which is being attributed to an event by the affected individual (Thoits, 1983).

The most elaborate coping model is presented in the transactional approach by Lazarus (Lazarus, 1966; Lazarus/Folkman, 1984), which assumes a process-like bidirectional relationship between environmental and person variables. It regards cognitive assessment processes as the central mechanisms in an individual's adaptation to stressful person-environment relationships (e.g. the illness); these

processes refer to either the subjective well-being of the individual or the coping mechanisms he possesses. It is arbitrary, according to Lazarus and co-workers, whether in the analysis of coping behaviour, the situational conditions or the individual coping mechanisms are being focused on, as both are continually changing because of their continued mutual interaction. For Lazarus, "stable" personality "traits" that are continuous over time play no particular role in coping compared to rather situationally determined "states".

The concept of coping is confusing in that it is used, on the one hand, in a more biological sense as a successful process of adaptation (e.g. Levine, 1983), and on the other, as a broad range of patterns of reactions, which are being mobilized in order to cope with a situation (Lazarus/Folkman, 1984). They can be more or less adaptive. We thus find divergent views as to how close a relationship there is between coping and the effectiveness of mastery. It is naturally difficult to establish criteria for adaptive and successful coping. As concerns the range of coping reactions and their schematizations, various authors differ greatly (cf. Billing/Moos, 1981; Carver et al., 1989; Lazarus/Folkman, 1984). On the basis of the currently rather limited knowledge about coping processes, Steptoe (1991), for example, suggests fairly broad dimensions for a taxonomy and distinguishes problem-focused coping reactions from emotion-focused coping mechanisms. Both coping activities can play out at the behavioural as well as the congnitive level. His approach, like the earlier one by Lazarus, considers not only open action-focused, but also intrapsychic reframing processes, which in part are also taken from the psychoanalytic concept of defence. There are differences in the assessment of the functionality of these adaptive mechanisms. Haan (1972) looked at the affective part of dealing with illness and regards goal-directed, flexible, and reality-oriented adaptation as a consequence of coping processes, whereas rigid, reality and affect distorting adaptations are seen as a consequence of mechanisms of defence.

Vaillant (1971) uses a maturation model of defence as a backdrop and distinguishes the different processes of adaptation in terms of their degree of maturity, and thus their adaptational value in conflict solutions.

Coping researchers, by all means, have borrowed from psychoanalytic concepts of defence. In comparison, psychoanalysts have only made few references to the concepts of "coping" and mastery.

To the degree that defence is not only seen as a dysfunctional pathological process, but also as an ego-performance that supports adaptation (see e.g. Steffens/Kächele, 1988), the juxtaposition of defence and coping as performed by Haan, does not seem reasonable. Both defence and coping may each be understood as distinct ego-functions each unfolding and being integrated into the individual personalityl. Defence would then primarily be seen as serving the purpose of intrapsychic regulation (processing of affects), while coping would be considered to be more about adaptational tasks to deal with problems connected to everyday reality, specifically mastery of the illness (Steffens/Kächele, 1988). The adequate defence against threatening affects or experiences which endanger the integrity of the self, is thus the precondition for the ability of the individual to constructively deal with the demands related to the illness (coping, working through).

Even if we try here to draw the constructs of coping and defence onto a common horizon of understanding, we are still far from having elucidated the problem area theoretically and empirically. A number of questions are still to be clarified, which may not generally be amenable to answers. They concern, for instance (see also Rüger et al., 1990; Schüßler, 1993):

- the kind of interaction between emotional, cognitive, and behavioural factors when dealing with illness;
- the extent to which personality aspects that are stable over time (traits), and more situational moments (states) are involved in dealing with illness;
- the relationship between rather general forms of coping and specific modalities of dealing with illness;
- the problem of how far specific forms of an illness (e.g. chronic physical illness or mental disturbances) have their own characteristic forms of dealing with it;
- the aspect of whether the illness must be dealt with, in the totality of its symptoms and impairments, and/or aspects of threat to the integrity of the person.

In line with the theoretical and empirical state of research, OPD does not try to operationalize coping and illness behaviour in overall terms. We limit our approach to the aspects of how the illness is experienced and the prerequisites for treatment, which are of immediate importance for an indication in the sense of a more in-depth psychosomatic-psychotherapeutic diagnosis (basic module), or, in the case of an indication for psychotherapy, they are of importance for the question of a differential indication for a specific modality of psychotherapy (psychotherapy module). In the forensic-psychiatric area the indication for therapy is influcenced by further, specific factors which are compiled in a separate module (cf. 4.1 and 13.1).

3.1.2 Experience of illness and prerequisites for treatment

In conceptualizing the axis we started from the assumption that the experience of the illness and the prerequisites for treatment can be derived from specific characteristics of personality in the sense of trait variables, from social conditions, factors of the psycho-social environment on the one hand, and from the doctor-patient relationship on the other.

Axis I describes the factual experience of illness, and those aspects of coping which are relevant to change and the respective indication.

We understand experience of illness as a partial area in the larger theme of processing and coping with the illness, which on the one hand affects the individual's coping competencies, and on the other hand, is influenced in turn, in the sense of a process model, by the patient's coping mechanisms. The experience of illness comprises emotional, cognitive, and behavioural processes, which among other things are influenced by the following factors: nature and severity of the existing illness, social environment, patient-doctor relationship, personality characteristics, psycho-social environment, and motivation for treatment.

These factors interact with each other in a complex way. They vary within a single individual and also between different individuals. In what follows we briefly characterize those individual aspects and describe their possible interactions.

3.1.2.1 Nature and severity of the existing illness

The illness (here not understood in the sense of the classic disease but rather as the process of being ill within the parameters of the medical system) can, as a rule, influence the experience of illness in manifold ways:

- via the physical or mental symptoms and impairments linked with the acute or chronic illness;
- via the diagnosis as such; medical diagnoses as a rule carry diverse meanings which may lie, for example, along the dimensions of "vital endangerment" (high threat e.g. in cancer illnesses) or on the dimension "stigmatization" (social discrimination or isolation). Illnesses like AIDS currently carry a high potential for stigmatization, just like mental illnesses.
- via the different treatment procedures required. These therapeutic measures can cause considerable physical and mental strain (e.g. when having organ transplants, or when encountering side effects such as tardive dyskinesias during or after administering neuroleptics);
- via all of the above aspects, which can contribute to a multitude of impairments of the individual's social adjustment (loss of job, social isolation, etc. and many more).

As mapped out, different aspects of the illness may act simultaneously or in sequence as "stressor" or "threats", whereby the extent of the physical, mental, and social stresses may vary at different points in time during the course of an illness, thus further affecting a person's experience of illness. It can be said, therefore, that there is no linear relationship between the severity of an illness, its experience as a threat, and the patient's subjective suffering. The expression of symptoms alone is generally not sufficient reason to seek medical assistance. Other factors must be included, although some have often been neglected.

3.1.2.2 The Importance of the Social Context – The Doctor-Patient Relationship

The societal frame of reference in the entirety of its economic, social, and normative requirements, influences all socialization processes and thus the psycho-social conditions for individual development. It plays, therefore, a crucial part in the characteristics developed by the individuals socialized within it.

Of particular relevance for experiencing and dealing with illness are the material and institutional conditions in the health care system, the scientific orientations and standards in the health care sector (medicine, psychology, etc.), and the respective mindsets and orientations concerning health and illness. It is against this background that not only the important concepts of illness and treatment develop, but also the characteristic stigmatizations and prejudices, which may have an effect on individual coping styles related to health, illness, and treatment. Whether any one illness behaviour is being judged as deviant, depends amongst other things on medical practitioner and the institutional way of thinking, and, as the case may be, on socio-political considerations. In addition to the effect created by the established health care system, paramedical, pre-scientific concepts and behaviour patterns, influence individual concepts of illness and treatment, and how illness is experienced and dealt with at an individual level. The media also play an important role in relation to how we deal with illness. It influences for instance the general

level of attention that is given to certain symptoms, specific conceptions of illnesses, and treatment procedures.

The features of our medical services and health care system, and of somatic treatments as they are currently practised, exert their influence via the doctor-patient relationship directly on the patient, and how he experiences and deals with illness. Here, the system of medical care, which is generally oriented towards the organic model of illness, assigns the patient a passive-receptive role in the process of diagnosis and treatment. The patient is made a technically neutral relationship offer, which encourages his thinking in a somatic way but neglects his individual emotional input in the origin and maintenance of his complaints. His own personal experience is thus quite rarely taken into account. More often than not the doctor-patient relationship serves to confirm psychical normality and thus guides the patients who prefer this concept of illness, towards a tendency to somatize (Franz/Bautz, 1990). We are of the opinion that this kind of doctor-patient relationship generally encourages somatizations and leads to development of chronic ailments in the sense of iatrogenic impairment. What the patient learns from this perspective is that he can be assured of the doctor's attention and care only by presenting ever more serious reports about physical symptoms and new complaints. In this understanding, taking advantage of the medical care system would thus be a behaviour that is less a consequence of physical complaints; the processing and expression of bodily symptoms could rather be seen as a consequence of the experience gained in the diagnostic and therapeutic process (iatrogenic somatization, e.g. Simon, 1991). The increased frequency of somatoform disorders in certain populations thus becomes the consequence of the organization of the particular health care system, a fact hardly known among physicians. Psychoanalysis in particular has emphasized the special dynamics of the doctor and patient relationship in this area (Beckmann, 1984). One particular inference drawn from this is how far the therapeutic efforts may fail if the emotionally determined interactions between doctor and patient are not attended to (transference/countertransference collisions). The patient who wants to use a given therapy must be seen against the background of preceding treatment experiences.

3.1.2.3 Personality Traits

Against the background of psychodynamic theory, experience of and dealing with illness are seen primarily as a consequence of characteristic personality traits at the level of emotional, cognitive, and also behavioural resources, or their limitations.

Of particular importance in this context is personality structure.

This includes the dimensions as described in the structure axis. Amongst them figure processes of self-perception, tolerance of stress, or the repertory of an individual's ego-functions which comprises for example, the type of defence mechanisms, tolerance of frustration and anxiety (capacity to self-regulate), reality testing, and ability to form relationships. These functions influence the affective and cognitive flexibility or rigidity of the patient. Health-related convictions or prejudices are closely related to these factors.

Aspects of the patient's self-image, or, how he handles his self-image under conditions of illness play a further important role. It is significant in this context whether the patient is able to maintain, or else appropriately modify, his self-image

despite the illness. Personality characteristics and intrapsychic conflict configurations are factors of influence, which, according to the psychodynamic view, are also causal in the manifestation of illness and further on are important as to how illness is experienced and dealt with. In the same manner, specific expectations from, or modes of relationships, which as a rule mutually interact with characteristic personality traits, and with the conflictual motives of the patient, may influence his expectations of change. Moreover, sex, age, or education can be factors which influence how the patient experiences and deals with illness.

We do not, at this point, explicitly take up hypotheses about probable individual, motivational, or structural conditions underlying the way a patient experiences or deals with illness. These thematic issues are focused on more by the other axes, and respectively, are discussed in the integration chapter (3.6).

In principle, the nature of the personality does, to a significant extent, provide structure to the emotional, cognitive, and behavioural prerequisites for illness experience and the resources for dealing with illness. This applies for all three types of illness, mental, psychosomatic, and organic. The relevant personality characteristics for these processes are usually trait variables; at the same time, however, personality characteristics offer a framework for determining how far situational factors (state variables) can be an important influence on the kind of illness experiences and coping strategies.

In the following, illness and treatment-related characteristics which constitute Axis I, are to be explicated and, as a rule, are closely linked to relevant personality characteristics.

3.1.2.4 Relevant Theoretical Constructs of Axis I

Subjective Suffering

Historically, Freud saw subjective suffering as a necessary precondition for a patient's willingness to enter therapy. He later stated that "the primary motive force in the therapy is the patient's suffering and the wish to be cured that arises from it." (Freud, 1925 (1913)), and regarded this wish as a necessary precondition for therapy motivation also during the course of the therapy. Heigl (1977) attributes an important prognostic function to subjective suffering. In these circumstances one would have to examine "whether the patient suffers from his actual impairment or symptoms, or from the unrealistic, purely subjective meaning of his symptom. In the latter case we are dealing with a more severe neurosis" (Heigl, 1977, p. 40; tr. E.R.). What is added here to the quantitative weighting of the subjective suffering (how great is the patient's subjective suffering?), is a qualitative perspective (the kind of subjective suffering) where it is asked what the patient suffers from primarily.

This differentiation would be of particular relevance for the question of tindications for therapy, or therapy prognosis, as the kind of subjective suffering is an indicator for inferring what expectation of change the patient brings to the therapy. From a traditional psychoanalytic vantage point Heigl (1977) asks whether the patients desires to change his personality, or whether, on the basis of a neurotic-unrealistic subjective suffering, only wants to change his symptoms. Heigl illustrates this point by way of an example, namely, that against the background of

a narcissistic personality and its related high vulnerability, a minor symptom may produce a high degree of subjective suffering, but without the patient wishing to change his personality.

We do not share this "judging" perspective, which originates in the psychoanalytic concept of illness and personality, but we regard the differentiation of subjective suffering into a quantitative and a qualitative dimension as important for treatment planning. A certain "quantitative" degree of subjective suffering is undoubtedly a relevant prerequisite for a patient to even seek change and assistance. What the patient wants to change is then more likely going to be related to what he suffers from.

In the process of treatment planning, we will, as a rule, have to set out from this point of the patient's subjective suffering, and together, will have to seek a common approach towards change - this is to say, we will, as a rule, also strive for a minimization of subjective suffering. As a matter of fact, in the process of therapy the nature of the patient's subjective suffering, and thus also the nature of his treatment goals can change, depending on the patient's own developmental processes.

Concept of illness

Fundamental studies on lay models were presented in the 1980s (Bishop, 1987; Millstein/Irwin, 1987; Rutter/Calnan, 1987). There were numerous studies about causal attributions, or explanatory models, or else about people's ideas about the causes of mental illness (Brewin/Furnham, 1986; Furnham, 1984; Rippere, 1981).

Furnham and Wardley (1990) found a close relationship between motivation for therapy and attitudes towards and convictions held regarding the reason for, effectiveness of, and the actual course of a psychotherapy. Studies on lay conceptions and attitudes as regards effectiveness of and the actual carrying out of psychotherapy are, in the view of these authors, closely related to lay theories about the causes of mental illness. When deciding on psychotherapeutic treatment, or when undergoing a psychotherapy, expectations form essential determinants as far as the use of psychotherapy services is concerned.

Incongruous explanatory models between patient and therapist about the existing disturbance which happen to go unexpressed or unnoticed in the interaction process, are contributing factors leading to a lower therapy acceptance. If one is to arrive at an indication for therapy, it is therefore important that the therapist gain an idea about the patient's conception of illness.

The acceptance, or integration, of concepts from cognitive psychology referring to illness-related behaviours and use of medical services, gradually took place in the area of psychoanalysis over the course of the 80's. Rosin (1981), or Streeck and colleagues (1986), for instance, pointed out the importance of the illness explanation model in terms of expectations from therapy, the subjective insight into the need for therapy, the selection of therapeutic treatment goals and therapy procedures, and the shaping of the patient's role. According to Rosin, the respective explanatory model enables the patient to understand his disturbance and allows him to establish a link between symptoms and etiological concepts. A patient's subjective theory of illness represent essential conceptions which influence the use

of psychotherapy services. Becker (1984) distinguishes preconscious or unconscious theories of illness and points out the importance of the physician's sensitivity and readiness to perceive unconscious-magical theories of illness. This is, in the author's view, a precondition for the doctor's and the patient's theory of illness coming closer together so as to increase acceptance of treatment. Becker sees the patient's subjective perception of and attitude towards illness and health as one of the most important factors that influence their health- or acceptance of treatment-related behaviour.

Ahrens (1982) studied the illness models of different patient groups. In psychosomatically and somatically ill patients, he found an explanatory model that was stress-oriented and directed more towards external or somatic factors. Neurotic patients, in turn, tended to show more convictions towards an internal locus of control and to have an explanatory model that was oriented on psychological factors. Correspondingly, neurotic patients differed as to their therapy expectations (they expected offers of support related to their personalities, critical attitude during the consultations) from psychosomatically ill patients (who expected somatic therapy offers based on drugs and showed fewer delays in seeking consultation and only a rare change of doctor).

With some caution it could be said that a concept of illness that orients itself on psychological or social (interactional) factors correlates with positive expectations from psychotherapy and with the readiness to use psychotherapeutic help. This is why the comprehension of the patient's existing, conscious explanatory model of illness is also important for indications for and prognosis in psychotherapeutic treatment.

Personal resources

Personal resources are all those characteristics of personality and capabilities derived from these which help a patient to constructively and adaptively cope with his illness/disturbance, or, respectively, symptoms and problems and their consequences. What this means here is that, in terms of coping with illness, a distinction is made between personality characteristics anchored in the ego structure and their psychosocial manifestations. Health-relevant characteristics anchored in personality structure, as seen from a psychodynamic perspective, are essentially: autonomous self-worth regulation, experience of object constancy, flexible impulse control, tolerance of frustration and conflict, and affect differentiation.

These personality characteristics are differentially assessed on Axis IV, structure. In the context of the personal resources which are to be outlined here, we are interested only in the behaviour-related translations of these personality characteristics as they have been laid down, for instance, in health-psychological concepts (Schwarzer, 1996). Among these are: experience of effectiveness of self, active and healthy lifestyle, capacity for enjoyment, adaptive relationships, capacity to be on one's own, capacity to distance onself, ability to relax, optimistic attitude towards life, capacity for suffering, social-communicative and emotional competencies.

Psychological mindedness

Psychological mindedness is here understood as the openness of a person towards a psychological consideration of causes and meanings of existing physical, mental, and behaviour-linked problems. Psychological mindedness, as a basically available resource, thus refers to the capacity and inclination of patients with psychogenic illnesses to engage with a psychoreactive genesis of their complaints. The meaningfulness of one's own thoughts, feelings, and unconscious or long- standing patterns of reacting, processing and relating, in the process of becoming ill is at least principally acknowledged (an individual aspect) and the patient is able and willing to enter into discussion with a psychodynamically orientated therapist about this, and to engage with interpretations (an interpersonal aspect).

Psychological mindedness has been circumscribed with in terms like capacity for psychological insight, capacity for introspection, or self-awareness. Silver (1983) defined psychological mindedness as: "The patient's desire to learn the possible meanings and causes of his internal and external experiences as well as the patient's ability to look inwards to psychical factors rather than only outwards to environmental factors.... [and] to potentially conceptualize the relationship between thoughts, feelings, and actions" (Silver, 1983, p. 516)". The construct is empirically operationalized and measurable with a validated, video-based rating method (PMAP; or Psychological Mindedness Assessment Procedure) proposed by McCallum and Piper (1997).

In the psychodynamic and depth-psychological literature and research, the degree of a patient's psychological mindedness is considered predictive for a successful therapy (McCallum et al., 2003). Psychological mindedness is therefore an essential criterion for indications for a psychodynamically oriented treatment, as patients must at least be able to avail themselves of the techniques of psychodynamic psychotherapy which aim to produce greater insight, in order to benefit from psychotherapy. Technique and procedure of psychodynamic psychotherapy aim to convey insight to the patient about ways in which his problems are linked to intrapsychic conflicts between wishes, anxieties, and defence/coping behaviours, so that he may work out new options of behaviour based on a more complete self-image.

This process is kept going, amongst other things, by interpreting current complaints/modes of behaviour outside and within the therapeutic relationship against the background of unconscious, biographically deeply engrained patterns of perception, processing, and behaviour. Therefore the patient's basic capability and desire to link current problems, thoughts, feelings, and behaviours with old patterns, is an important prerequisite for a successful psychodynamic treatment. The patient is able to do so with the help of the therapist whose task it is to give explanatory hints (interpretations) which then create the respective connections (Appelbaum, 1973).

In this context the patient's model of illness, too, can be of importance, as it may influence the process of attunement between patient and therapist with respect to the more or less open way the patient feels able to respond to interpretations. . A psychological, explanatory model which makes reference to interactions is more likely correlated with positive expectations from psychotherapy, and with the

readiness to avail oneself of psychotherapeutic help, as well as the existence of relatively mature ego-functions, like the capacity for self-reflection and introspection. This is why, for an assessment of psychological mindedness, the existing model of illness on the part of the patient (pre-rational, rigid, magical, etc.), can be of importance, too.

When determining the construct operationally, items were graded in a way so as to take into account individual patient characteristics on the one hand (interest in gaining insight, model of illness), and interpersonal aspects (dealing with interpretations) on the other.

Psychosocial support

We regard psychosocial support as an interactional variable in which not only aspects of personality but also environmental factors (family, friends and acquaintances, professional helpers) interact with and influence each other.

In line with the cognitive-transactional concept of stress, social support must be seen as a resource. Social and personal resources are protective factors, which, as a resource of the social environment, must be compared with stressful demands, and which themselves are valid constructs (Lazarus, 1991, 1993). Their function is to moderate the coping process, i.e. to facilitate or accelerate it. In the context of Axis I, we look at illness/disturbance under the aspect of stress, that is to say, the axis captures how social support can become important in coping with illness/disturbance. Social resource can exert its influence on the stresses experienced in two ways: first, on the assessment of the threat posed by the illness, or disturbance (situational demands), and second, directly on the coping process.

When talking about social support, one must distinguish terminologically between structural and functional aspects. Structural aspects are those discussed in the context of social integration. They comprise extent (number of persons available, frequency of contacts), and aspects of the structure (intensity and duration of contacts, quality of available persons) and,, of the social network available to a person, or of which a person is a part. At the other end of the spectrum of social support we then find social isolation.

Social integration is an important precondition for social support and holds the potential for positive, and also for negative, interactions. This quantitative-structural aspect of social support in the sense of a social network or back-up, has proved itself to be only of limited value in health research (Leppin/Schwarzer, 1997). By comparison, the qualitative functional aspect of social support denotes interactions designed to change the painful problem of someone seeking assistance, or making the problem more bearable, by enlisting a helper (Schwarzer, 1996). Social interactions may have a variety of contents. The support given can be emotional, instrumental, or informative (e.g. attending to, or comforting a person versus doing chores for them and doing their shopping, versus giving information and advice). There is empirical evidence of a low correlation between structural network measures and functional supportive measures (Pierce et al., 1996). An important distinction is made between perceived versus received support. In one instance we are dealing with the cognitive aspect, that is to say, the conviction about the availability of the social network, in anooother we refer to a behaviour-related aspect, that is to say, to the frequency and quality of the support given.

These aspects can then again be operationalized from different perspectives, from a subjective/retrospective and from an observer's point of view. The perspectives of helper, receiver, and observer only coincide to a limited degree (Leppin/Schwarzer, 1997), whereby the cognitively perceived level of the receiver has been most researched. Special importance is attributed to this perspective because of the increased interest in the effect of social support on close relationships and social affiliations (Stroebe/Stroebe, 1995). What this aspect also stresses is that social support is not a passive, but an active interactional process.

It can be emphasized then that social integration must be regarded as a distal variable, which can, as epidemiological studies have shown, reduce risk behaviour through, on the one hand, the feeling of enjoying a social network and of belonging, and, on the other, via the social control that is exerted over it.

In contrast, the perceived social support lies closer to the stresses experienced or illnesses suffered and acts as a proximal variable directly on the ongoing processing. It does this, possibly via exerting an influence on the patient's psychical well-being and affectivity, which in turn can strengthen positive health-behaviours and favourably influence neuroendocrine processes. Then again, perceived social support is influenced by modes of relating, and also by individual styles of attachment, and therefore can be regarded as a personality characteristic.

From the point of view of a patient's suitability for psychotherapy, and the absorption of the concomitant stresses, it is, in our view, less important whether a social network is potentially available, but more, whether under the actual condition of the patient's limited perception due to the illness/disorder such a network is perceived to exist, and whether the patient feels able to mobilize this network for himself when necessary. This is why we are interested in the patient's integrative modes of perspectives on this issue. Of primary interest is how far the patient has an internal representation of the social network and how far he has access to these social resources.

Secondary gain from illness

Traditionally, psychoanalysis distinguishes between "primary" and "secondary" gain from illness. From the point of view of drive psychology, undesirable drive impulses find a certain degree of satisfaction through symptom formation, leading to a reduction of tension. The individual further experiences some relief through the fact that "frowned upon" drive impulses are not directly acted out in the outside world. Laplanche and Pontalis (1991) see the real "motivation for neurosis" in the primary gain from illness.

Secondary gain from illness, in contrast, is seen as the product of all gratification which the individual receives, more or less "consciously", through his illness. This may include supportive or relieving reactions from the individual's environment. From a cognitive behaviour-therapeutic perspective, the maladaptive behaviour (in the case of a neurotic development) is reinforced by positive psychosocial consequences.

By means of the illness and the relief from workplace demands in connection with this, continual conflictual intrapsychic motives, like for instance the "refusal" to comply with demands experienced as wrongfully made upon one, can be

satisfied: "impulses of revenge" or "desire for reparation" can be acted upon. In addition, regressive modes and wishes can be lived and satisfied through the illness and its development into a chronic condition.

Taking up of the role of a sick person comprises, as a rule, a series of gratifications. These can include, e.g. the inability to work, receiving a pension due to reduced earning capacity, emotional attention in the personal environment and in the health sector, which all go towards motivating the individual to maintain the illness and the role of being a sick person. The individual is released from a series of social commitments and obligations in the personal and work environments, which, during the illness, are taken over by medical care institutions (Horn et al., 1984).

In the case of chronic illness, processing routines play an important role. They are structured not only by individual capabilities or resources, but also by the conditions of the social context, which include personal and family life, work life, and last but not least, the health care system and/or the system of social benefits (e.g. pension insurers).

However, against the background of “cost-benefit analyses”, illness processesing behaviours can also take a maladaptive course, if, for example, an illness becomes chronic and if this development is connected with the relief of being removed from stressful working conditions. Similarly, it may become maladaptive in cases where the lack of perspective in the financial and social domains, and the danger of stigmatization for being unemployed due to being given a pension on the basis of reduced earning capacity, are mitigated by acquired social entitlements and the redefinition of the social attribution processes.

The number of sick days taken for mental and psychosomatic illnesses has increased considerably since 1995, whilst the duration of illness-related absences for patients with other illnesses has decreased. The latter phenomenon has been unanimously ascribed to the increased pressure in the job market.

In addition, in terms of reasons given for granting pensions on the basis of reduced earning capacity, mental and psychosomatic disturbances are quite a long way out in front. They are the leading causes for granting pensions to women, and rank second for men, after illnesses of the connective tissues, muscle and skeletal systems (WHO, 2001).

Certainly, and in view of a drastically changing labour market, and the related job insecurity that comes with it, this development is in many instances also motivated by aspects of secondary gain from illness.

Of further note is the fact that gain due to an illness may not only benefit the person affected by the illness, but may also, as seen from different perspectives, have a positive meaning for the immediate family: financial relief, social benefits, increase of social acceptance due to the cessation of stigmatization.

From a systemic point of view, the conditions at the origin of secondary gain from illness are dependent on complex interactions between different social groups and institutions and the actual individual. In this context, different value systems, and socio-political and financial interests can be brought to bear on the situation. A good example here is the development of an illness into a chronic condition, where the treating physician quite often might certify someone unfit to work or advise

him to file for a pension, because he wants to remove the burden of stressful working conditions or unemployment from the patient. Such behaviour may be motivated by compassion and the wish to provide practical support for the patient, as well as the desire to "please" the patient. Doctors working for the German Federal Labour Office, who find it difficult to place job seekers who are incapacitated to some degree, frequently support or encourage the wish for a pension, orienting themselves primarily by the limited placement possibilities of their own institution.

It is well known in the area of medical rehabilitation that patients who have already filed for a pension display little motivation for change, and consequently, only rarely benefit from rehabilitation measures.

The concept of secondary gain from illness tends to carry a meaning of stigma and devaluation for patients, if it maintains the illness and is attested to them by their treating physician or an expert. In the final analysis it must be taken into account that the consequences of illness in each case have a different meaning for the person involved and his environment. One and the same factor, e.g. reaching pension status, may subjectively be seen as a gain, through the establishment of social and financial security, or as a loss, through the "falling out" of the social contexts and the loss of professional identity.

The subjective meaning that consequences of illness eventually produce in the actual situation, or in different phases of the course of the illness, has to be carefully examined in every single case. Any assessment will certainly also be influenced by the yardstick of our own evaluations.

Motivation for change

The motivation for treatment constitutes itself on the basis of the factors we have worked out above relating to experience of illness and expectation of change. The spectrum of possible expectations from treatment fundamentally spans all forms of paramedical, medical, or psychotherapeutic treatment options. Patients may, however, also refuse all and any treatment, or again they may be motivated to undergo various treatment methods (e.g. somatic treatment and psychotherapy).

All in all, it can be said that research has largely neglected the term motivation for psychotherapy . In particular, there are hardly any empirical studies on the basis of the operationalization of the construct. As in coping, there are cognitive explanatory models for motivation for psychotherapy (e.g. Krause, 1966; Künzel, 1979) and models that take into account both affective and cognitive aspects of treatment motivation (Muck/Paal, 1968; Schneider et al., 1989b). According to Schneider, motivation for psychotherapy can be understood as a characteristic emerging in process-like fashion, which is structured via different affective and cognitive factors influencing each other. The primarily affective component parts are represented by the subjective suffering and the gain from illness and reflect the relevant elements of the experience of illness. The patient's subjective suffering is the precondition or motive for an individual with a mental or physical illness to actively seek out possibilities of change.

The patient, against this background, builds up a subjective theory (concept of illness) about the origin of the disorder, develops attitudes towards possible

treatment procedures and seeks information relevant to the problem. The development of the subjective theory of illness, of the general attitude towards treatment and of the motivation for change are all influenced not only by personality characteristics, but also by aspects of the illness and social and medical context variables as we described them earlier.

Schneider and Klauer (2001) were able to show, for example, that patients with somatoform disorders primarily oriented themselves, as far as their concepts of illness and expectations from treatment were concerned, to procedures from organic medicine.

In particular, psychotherapeutic procedures place high demands on the patient's readiness to suffer treatment-related stresses, on his capacity for tolerating frustration and anxiety, and for introspection or reflection (psychological mindedness). However, the various psychotherapeutic measures differ markedly with respect to the treatment prerequisites required from patients (see Nübling, 1992; Rudolf/Stille, 1984; Schneider, 1990; Schneider et al., 1989b).

Basically, we can differentiate a patient's motivation for treatment according to whether he shows expectations oriented more towards the somatic model of treatment, or is more motivated by psychotherapy treatment, or whether he seeks out support and assistance in coping with social problem areas. We have maintained this classification throughout the operationalization of Axis I.

3.1.2.5 On the operationalization of experience of illness and prerequisites for treatment in the OPD

We have presented here the idea of a model of the experience of illness and the prerequisites for treatment, and against this background, we have carried out the modification of Axis I.

An important goal in the revision of Axis I was to achieve a high degree of proximity to and relevance for clinical practice. What is central in Axis I is to work out therapy-relevant statements for different clinical contexts and types of problems. Against this background, the idea of differentiating Axis I into a basic module and further modules was developed.

What has become evident in the clinical work with Axis I of OPD-1 was that especially in the psychiatric liaison service the question must first be answered whether an in-depth psychosomatic-psychotherapeutic diagnosis is in effect necessary for the patient. This issue is clarified either by the treating specialist doctors - in so far as these are sufficiently qualified for this type of psychosomatic basic diagnosis - or by the liaison psychiatrist. Only after this indication has been established is the patient then given an extensive psychosomatic-psychotherapeutic diagnosis (initial interview and perhaps diagnostic tests), a result of which might be the differential indication for psychotherapy. In order to do justice to this successive process in the diagnosis and indication, we have, in OPD-2, separated Axis I into a basic module and an extension module for specific in-depth issues for the area of psychotherapy.

To make the application of Axis I more problem-centered for other special areas of psychotherapeutic work (e.g. work with addiction or forensic patients), OPD provides the option to build on the basic module and develop further specific

modules, which can be used in addition to the basic module. The schematic presentation in table 4.1 (section 4.1) shows how additional modules are linked into the basic module. As a first example, we have mentioned the psychotherapy module. In addition, there is now a module for the area of forensic psychotherapy which is able to reflect the particular conditions of this patient group. This module has been integrated in table 4.1 as an example of a context-dependent additional module.

For operationalization, the groups of characteristics were formulated in such a way so as to make them applicable for patients with mental, and with psychosomatic or somatic illnesses.

As the concrete differential indication for a (psycho)therapeutic measure is not made exclusively on the basis of information derived from Axis I, but rather represents an integrative decision making process into which information and results from all five OPD axes are adopted, it is only made at the end of the OPD overall rating.

3.1.2.6 Changes made to Axis I resulting in OPD-2

The axis "experience of illness and prerequisites for treatment" of OPD-2 has changed from OPD-1 in relevant points of content and form.

From a content point of view we aimed for a more stringent, more solidly theory-anchored construction of Axis I, and also for a more systematic exploration of specific characteristics. In doing so, we have integrated two internationally established assessment scales for the "objectifying" assessment of the severity of the disorder, the GAF and the EQ-5D. These scales enable a better systematic procedure in the psychosocial area (GAF) and in the area of physical and functional impairments (EQ-5D). This will also allow a comparison with results from other studies using these same instruments.

Axis I then further comprises aspects of experience of illness, presentation of illness, concepts of illness, as well as motivation for change, which can all have somatic, mental, or psychological and social characteristics, respectively.

Given that the resources for and possible impediments to change, too, are of great relevance for the issue of a differential indication, we have expanded this area of characteristics and made it more specific than in OPD-1.

For a better and less ambiguous applicability of Axis I, when establishing indications, we have proposed a systematic evaluation scheme, which includes criteria of decision making (see section 4.1).

The main aims of the modification of the axis, as far as its area of application is concerned, was to increase the probative relevance of Axis I for the differential indication, to enable a differentiation for the indication of further psychosomatic diagnosis/counselling, and for psychotherapy in a more specific sense. Along similar lines, such a modification was to enable clarification of specific problems and issues pertaining to the indication decision which may arise in specific clinical areas like the work with addiction or forensic patients. In order to achieve this aim, we have developed Axis I in the fashion of a modular construction kit which contains, apart from a basic module, specific other modules, like the psychotherapy and forensic

modules. In the future, additional modules for specific problem areas can be developed depending on clinical or scientific requirements. A module in the area of addictions could, for instance, build on the work of Nitzgen (2003) and Sporn (2005).

In practical work with Axis I it is obligatory to always use the basic module, while the use of one or more of the additional modules is optional. The basic module especially helps to clarify how far a more in-depth psychosomatic/psychotherapeutic diagnosis and intervention are indicated in a patient at all. This is an issue which arises in particular in the field of the psychiatric liaison service. In so far as a psychotherapeutic treatment is indicated, the psychotherapy module is additionally used, as it gives first hints for a differential psychotherapy indication.

3.2 Axis II - Interpersonal Relations

The diagnosis of dysfunctional relationship patterns is of utmost importance for psychotherapy, as disturbances in the area of interpersonal relationships make up an important part of the complaints which patients bring when they go to see a psychotherapist. They shape transference relationship offered by the patient and shape the therapeutic relationship about to develop where biographically important relationship figures are being reenacted. They thus become the material and subject of the therapeutic work which picks out such scenes and attempts to show their meaning to the patient. They are ultimately those areas where therapeutic progress becomes most conspicuous and can be felt very clearly.

The relationship diagnosis in OPD refers to both the problematic relationship behaviour as perceived by the patient himself, and those relationship aspects which others, including the examiner, experience in the encounter with the patient. By dysfunctional, habitual relationship patterns we refer to a specific configuration, which is painful for the patient, which results time and time again from his relationship behaviour and the typical modes of reacting of his social partners.

3.2.1 Introduction

Interpersonal behaviour is being recognized by all the major schools of psychotherapy as an essential factor in the origin and maintenance of mental disturbance. How someone shapes and experiences his relationships with others is of central importance especially in psychodynamic psychotherapy. Intrapsychic conflicts contribute substantially to dysfunctional relationship behaviour, while in reverse sequence they may be inferred from the specific manner in which the relationship is handled. In addition, relationship patterns are always also an expression of the structural possibilities and limitations of a patient, when they reveal, for instance, weaknesses in self-regulation or serve to protect against certain vulnerabilities.

The relationship diagnosis in the context of the operationalized psychodynamic diagnosis picks up on these complex events at the interface of the intrapsychic and interpersonal levels. It does this by mainly resorting to observable and describable relationship behaviour, but includes especially those relationship aspects which the examiner experiences in the encounter with the patient, that is to say, which he perceives in the relationship the patient forms and in the countertransference.

We understand relationship behaviour as the expression of the dynamic between the more or less conscious relationship wishes, the patient's related anxieties that come up and have an effect intrapsychically, and his concerns about how the other person might react to these wishes. The anxieties and concerns we refer to here may be linked to conflicts or be structurally caused. Habitual relationship behaviour can then be understood as an ongoing psychosocial compromise formation between wishes and the related anxieties in relationships. Habitual relationship behaviour thus describes an interpersonal attitude which, in a patient, appears to be the dominant one towards his outside world and which has a more or less continual effect.

What we refer to as a dysfunctional habitual relationship pattern is a specific configuration, quite painful for the patient, which results from a patient's habitual relationship behaviour and the typical modes of reactions of his social partners.

In the initial clinical interview, the examiner obtains diagnostic information from the patient's narratives of relationship episodes with important others. It is in these everyday episodes that particularly rigid and repetitive relationship experiences become evident. Additional information can be gained from the fact that a transference relationship is starting to unfold between patient and interviewer. From the reactions and impulses which the interviewer observes in herself she can draw conclusions about how others feel and perhaps behave in an encounter with the patient. In this way the countertransference experience is being used as an instrument to diagnose dysfunctional relationship. The diagnosis of the habitual relationship behaviour thus always comprises these two perspectives: that of the patient, and that of others, including the interviewer.

3.2.2 Relationship experiences and their intrapsychic organization

From the point of view of developmental psychology, relationship experiences are made in manifold ways, are conveyed by various perceptual modalities, and stored partly in procedural (e.g. as attachment patterns: Ainsworth et al., 1978), and in part in episodic memory. There are many reasons to support the fact that subjective experiences are to a high degree organized by emotional experience. What is remembered, and with what specific meaning something is remembered in each particular case, depends, amongst other things, on the feeling tones and the intensity of feelings that the memory has been connected to in the past and present (Stern, 1985). Subjectively organized memory and meaning structures are incorporated into and modulate how a person deals with current and anticipated relationship information. Relationship experiences, especially those with meaningful attachment figures of one's childhood and adolescence, crystallize at the intrapsychic level into internalized object relations (e.g. as self- and object representations). The internalized images are woven here into a context of subject- and object-related feelings, wishes, expectations, concerns, and habitual interpersonal interactions. In the tradition of Jacobson (1964) and Mahler (Mahler et al., 1975), Kernberg (1992) understands such "self-object-affect-triads" as the primary determinants of intrapsychic structure formation. Such internalized schemata represent the subjective processing of interpersonal experiences and interactions rather than representing " objective reality". As compromise formations, they can also serve defensive purposes, in cases where certain relationships are connected with unpleasant affects or anxieties. When such

schemata are being created, a reliable redundancy of certain (but not only) infantile relationship experiences is of particular importance. It is, especially in the early developmental phases, the precondition for the achievement of "object constancy" and later on of the"identity" of the person (cf. Axis IV Structure).

While Kernberg describes early ego-formation as a delimitation of the primary undifferentiated self from the mother as the primary object, Stern (1985) and Emde (1988) see the infant from the very start as an affective, active and regulating being, distinct from the caregiver. They understand its development as a series of increasingly complex intersubjective regulation processes of the self in an exchange with the caregiver. In this tradition we also find attachment theory, which has become widely accepted in the last years. It proceeds from the assumption that children develop permanent behaviour styles as adaptation to the relationship offers from their primary caregivers, whereby such behaviours are intended to maintain closeness to adults who provide safety. These patterns become established in the form of "internal working models of attachment" which are amplified or modified through interactions (e.g. Bowlby, 1988).

Children do not only identify with the caregiver and familial relations and functions, they also influence and change them from the beginning of their lives. It can be said therefore that the child identifies with relationship patterns, to which it has itself contributed in a major way (Cierpka, 1992). As the remembered relationship experiences also contain contradictory self- and object images, they become a substantial part of the formation of the way intrapsychic conflicts are organized (cf. Axis "Conflict"). Dahlbender (2002) used the OPD axes and furnished empirical proof for the clinical hypothesis that the severity of the psychopathology was the result of the fact that experiences shape life history.

These experiences are stored in the form of mental representations of relationships and may lead to dysfunctional predispositions of the patient's experience and behaviour, which again limit his susceptibility for change through psychotherapy.

3.2.3 The interpersonal presentation of intrapsychic conflicts and structures

In their interactions with others, people are generally interested in creating a situation of safety, personal well-being, and trust. The partners in an interaction are interested in creating a situation in which these basic requirements are met and which maintains the intrapsychic equilibrium for each person involved. As long as this condition is met, it is relatively easy for relationship wishes to be brought into the relationship.

There can be many reasons for failure in building a relationship. Clinically, we often make the transference responsible, (that is to say, the experience of an actual relationship from the vantage point of past relationships) for the fact that experience and behaviour in relationships may appear distorted (Freud, 1925 (1912)). Transference processes which are based on unconscious wishes, decisively determine the position which a person may take up in interpersonal relations and the role he may assign to other people. More recently, Albani and colleagues (2002a) were able to show that the severity of a mental illness and the degree of intensity of negative core relationship patterns are closely related. It is thought that an important role is played here by structural vulnerabilities, which, amongst other

things, may lead to emotional self-regulation failing more easily in some situations. This will then necessitate abrupt defensive reactions which consequently make any interaction more difficult and put a continous and lasting strain on relationships (Rudolf/Grande, 2002). In a sample of young women in inpatient psychotherapy, Dahlbender (2002) used the OPD axes and was able to create, on an empirical basis, a model of hierarchical interrelationships; he proved that internalized relationship patterns are the result of intrapsychic conflicts which, in their turn, are anchored in psychic structure, and their defence, or mastery.

The more limited a person is in his ego-capacities and defence possibilities, the more he is dependent on shaping interactions along familiar lines in order to limit the extent of new and taxing experiences. He will then also try to establish familiar situations in instances where these have not had positive outcomes in the past. The more limited the capability to organize and integrate new and sometimes also conflicting information, the more the necessity arises to shape situations with an interactional partner in such a way that one's own fantasies, desires, and action patterns with the other person are realized in a more or less uniform way. We therefore frequently observe with patients that they attempt to create relatively stable and unchanging themes, predispositions for actions, feelings and fantasies with their interactional partners. It therefore applies that the more rigid and extreme the experience and behaviour of a subject in relationship situations, and the more these relationship configurations operate in an "automatic" way outside the patient's awareness, the more likely they are going to be continued and perpetuated (Cierpka et al., 1998).

The arrangement of relationships can lead up to the point of disintegration, if patients are only able to have unstable, conflicting, or dichotomous relationships, as is the case, for example, in borderline personality disorders. This makes an adequate perception of the wishes and needs of others, as well as of the overall situation, almost impossible. While the diagnostic identification of relationship patterns may, under these conditions, only be possible with great difficulty, it can become altogether impossible in psychotic patients with fragmented object relationships.

In contrast to this, we speak of interpersonal flexibility when a patient is able to have various and differentiated relationships. Such flexibility is crucially dependent on the capacity of the ego to mediate between the internal needs of the individual, the demands of the superego and the environment, which presupposes a sufficient level of structural integration. Defence mechanisms (A. Freud, 1987 (1936)) protect the ego in this function and contribute fundamentally to a stable internal equilibrium. If this is successful, a person is able, more or less, to tune into another person's experiential world and to perceive that person's wishes, anxieties, and behaviour strategies etc. Someone who is equipped in this way has more capabilities for regulating his social relationships depending on situational and contextual factors.

In relationship diagnosis, such flexibility may show in the fact that the patient has recourse to a wide range of possibilities for the handling and shaping of relationships and that there actually are interactional partners who do not react in the typical way described as dysfunctional by the patient. Apart from the central

task of describing dysfunctional patterns the interviewer should look for such exceptions, as they are expressions of the healthy parts or resources of the patient.

3.2.4 The diagnosis of the patient's readiness for transference relationships

As intimated above, the psychodynamic diagnosis is centrally based on the assumption that when patients establish therapeutic contact, a central relationship pattern is unconsciously induced which assigns a particular transference role to the therapist (cf. Sandler's 1976 concept of role responsiveness). It is modeled on the role assigned to significant others. Krause and collaborators define transference as "a set of specific behaviour modes which are to coerce social partners to behave in concordance with specific unconscious expectations" (Hans et al., 1986, tr. E.R.). This also refers to what König (1982) describes as the "interactional part of the transference" (tr. E.R). On the part of the patient this is often about compromise-driven behaviour, into which not only wishes and impulses enter, but also anxieties and concerns and the associated defences. The experiences from interpersonal relationships are processed subjectively and are then internalized as a "readiness" to realize certain transference configurations (so-called transference "readiness"). In human interactions the moment of neurotic distortion can contribute towards the development of maladaptive vicious circles, towards personal expectations that are doomed to failure from the outset, and a resulting negative self-evaluation (Strupp/Binder 1993). Neurotic transference in psychotherapy is characterized by the patient selectively attending to a certain aspect of behaviour and personality in others, particularly in the therapist, and unconsciously behaving in a way that provokes reactions which are congruent with his expectations (Gill/Hoffmann, 1982). The therapeutic task is to create an interpersonal space where the therapist does precisely not act as expected (Weiss/Sampson, 1986), perhaps interprets the patient's transference "readiness", and helps him gain new experiences in a safe relationship. We must be critically reflective here and take into account that the therapist's transference readiness, too, may have an influence - a distorting one in unfavourable cases - on the therapeutic interaction.

3.2.5 On the relationship between transference and scenic re-enactment

Historically speaking, the term transference developed from the concept of displacement. It refers to the displacement of experiences from the original object onto another object, or respectively, to the transfer of energetic investments from one internal object representation to another. Transference, according to this concept, was seen as a defence, as a protection for the ego when recalling to memory pathogenic early object relations (Bettighofer, 1998). Long after Freud's paper on analytic technique (Freud, 1925 (1912)), transference was understood as a unilateral event which only refers to the patient. Gill (1982) amongst Anglo-American and Thomä (1981) amongst German authors were the first to hold the view that in each therapeutic situation both patient and therapist contribute, in the sense of an "interactional symmetry" (Ermann, 1992), their respective share to shape the transference activated in each case. The term scenic enactment refers explicitly to the interactional aspect of the actualization of generalized interaction schemas in the therapeutic relationship. This "mise en scène", or scenic enactment, finds its most likely correspondance in the Anglo-American literature in the term 'enactment'. By enactment, Jacobs (1999), refers to those behaviours in the therapist-patient relationship which arise in response to conflicts and fantasies that

have become awakened in both during the course of the therapeutic work. These behaviour modes are linked not only to the interplay of transference and countertransference, but also, via the memory, to thoughts, fantasies and interpersonal experiences from the past. Jacobs explicitly states that such a definition of enactment also contains aspects of re-enactment, that is, of the revival of pieces of the mind's past experiences. Other authors (Sandler, 1983; Stolorow, 1992), too, stress the relational character of the transference, which, according to them, can only be understood when the whole field of intersubjective relations is taken into account. The OPD relationship diagnosis is strongly oriented towards the actual experience and behaviour during interpersonal situations and incorporates the concept of a 'renewed putting on stage', i.e., of the re-enactment. In this sense, "re-enactment" not only comprises transference phenomena, but also the scenic reproduction of the transference in the actual shaping of the relationship which, by definition, cannot be one-sided. Re-enactment as a central concept of psychodynamic psychotherapy can be empirically proven (Stasch et al., 2002) and is highly useful from the point of view of psychotherapeutic technique, as the kind and the manner of the re-enactment allow conclusions to be drawn about the patient's transference "readiness" and thus about intrapsychic representations of relationship experiences (Stasch, 2004).

3.2.6 Empirical approaches for researching relationship patterns

No matter how convincing it may be in the individual case, a theory of habitual dysfunctional relationship patterns hardly has any practical meaning for everyday clinical work, unless it succeeds in identifying these patterns reliably. Since the early 70s, numerous researchers and clinicians have endeavoured to come up with systematic formulations for the description or presentation of interpersonal problems from a psychodynamic point of view (overview in Schauenburg/Cierpka, 1994).

To delineate the framework within which we have elaborated our proposition for a relationship-diagnostic instrument, we shall, in the following, describe mainly those procedures which have their origin in the psychoanalytic and interpersonal traditions. Reference may be made here to work done in the field of social psychology (e.g. SYMLOG; Bales/Cohen, 1982), in the area of family studies (overview in Cierpka, 2003; Cierpka et al., 2005), and behaviour therapy (e.g. Caspar, 1989). For an operationalized psychodynamic relationship diagnosis as described by us here the following methods have been especially important and influential:

1. "Structural Analysis of Social Behaviour - SASB" (Benjamin, 1974; Benjamin,1982; Tress et al., 1990; Tress, 2000);
2. "Core Conflictual Relationship Theme - CCRT" (Luborsky/Crits-Christoph, 1990);
3. "The Plan Formulation Method" (Weiss/Sampson, 1986);
4. "Role-Relationship Conflict" (Horowitz, 1991);
5. "Patient Experience of the Therapist - PERT" (Hoffmann/Gill, 1988) and
6. "Cyclical Maladaptive Pattern - CMP" (Strupp/Binder, 1993).

All methods have in common a focus of observation that centers on interpersonal interaction. The spectrum here reaches from a microscopic examination of

individual acts of speech (SASB), via the description of individual components of the interaction (wishes, anxieties, reactions of the objects and the consequences for the self in the CCRT or CMP), to configurations of intrapsychic and interpersonal schemas (Horowitz), and up to those instruments that aim to capture complex transference events in psychodynamic therapies (e.g. "Plan Formulation Method", PERT).

All procedures start with the assumption of one or several likely central interpersonal patterns in a patient. Clinical judgement forms a part of all these procedures, with variations as to the extent of the necessary interpretative conclusion. Basically, the situation is such that any increase in complexity also leads to an increase in the amount of subjective conclusions ("level of inference" after Luborsky/Crits-Christoph, 1998), which has an effect on the quality of interrater reliability. The more abstract the categories that are to be rated, the more difficult it is to achieve high agreement.

The "Structural Analysis of Social Behaviour - SASB" (Benjamin, 1974; Benjamin, 1982, 1993) allows a differentiated, and at the same time, reliable description of the more complex relationship events. The method can also be used to identify stereotypes in the observable dyadic interaction process, and to describe relatively invariant interpersonal and intrapsychic behaviour patterns of individuals. Fundamental to an assessment with SASB is the assignment of actual relationship behaviours to the two orthogonal dimensions love-hate (affiliation axis) and control-submission (interdependence axis), which form two axes of a circle. SASB was developed in the tradition of the circumplex models of interpersonal behaviour (Leary, 1957).

Luborsky's method of the Core Conflictual Relationship Theme (CCRT) examines relationship episodes as narrated by the patient and captures the wishes contained in it, as well as the reactions of others to these wishes, and the reaction of the subject to others. These three elements often form the interpersonal basic structure of stories ("narratives"). Difficulties with this procedure result, as unconscious wishes frequently cannot be inferred directly from the observable behaviour, while superficially visible motives often appear trivial, when compared to the complex intrapsychic events they are based on and from where they originate.

For both the SASB and CCRT-methods, a series of studies are available now which demonstrate their reliability and validity (cf. Albani et al., 2003; Schauenburg/Cierpka, 1994).

The method of the Cyclical Maladaptive Pattern (CMP) (Strupp/Binder, 1993) has equally influenced our conception of the OPD relationship diagnosis. This model also proceeds from a neurotic repetition of childhood conflicts, with a determining influence being attributed to a core conflict. Its intention is basically practical. In accordance with an interpersonal understanding of transference (e.g. Gill, 1982), the therapeutic work is, to a very considerable extent, to take into account what happens in the relationship between patient and therapist. References to earlier life-contexts are considered less important than the current and actual relationship behaviour. The Cyclical Maladaptive Pattern is therefore strongly action-oriented and uses predominantly action-related formulations. It describes the expectations and thoughts a person brings to an interaction, the reactions these cause in the

other person, and how these responses about his own person and about others shape or confirm his views. A Cyclical Maladaptive Pattern is thus defined as a repeating sequence of interpersonal events aggregated in a self-reinforcing feedback loop. We draw on this model in the instructions for relationship-dynamic formulations of our Manual. From the CCRT-tradition and the CMP, we borrowed the categories "response of the subject" and "response of the object" and in addition, the systematic use of relationship episodes as material for the diagnosis. The circumplex models of interpersonal behaviour, amongst them especially the Structural Analysis of Social Behaviour (SASB), formed the heuristic foundation for the generation of the items or item lists which were necessary for capturing habitual relationship behaviour.

3.2.7 The concept of relationship diagnosis in the OPD

The following will briefly outline the concept of the OPD relationship diagnosis; for details the reader is referred to the Manual (chapter 4). The aim is the identification of a patient's habitual dysfunctional relationship pattern. Dysfunctional relationship patterns can be understood as specific interpersonal configurations in which a patient's behaviour patterns interweave with those of the others in a relationship to form a repetitive gestalt. These configurations may basically be described from the patient's experiential perspective , and from the perspective of others (his interaction partners); in addition, each of these perspectives may also be used to look at the behaviour patterns, not only of the patient, but also of his objects. From these distinctions result four analytic units to which we refer as interpersonal positions:

How the patient experiences himself: The focus here is on the patient's relationship behaviour, the interpersonal behaviour described is that which the patient time and again experiences in himself and which he relates in his relationship narratives in a more or less ongoing manner.

How the patient experiences others: This refers to that relationship behaviour which the patient again and again experiences in the others in his relationships and, possibly, complains about.

How others always experience the patient: this captures how others, including the examiner, repeatedly experience the patient. As a rule, this latter perspective comprises more than the patient is able to describe himself, that is to say, it also includes aspects of his offers of relationship which are unconscious to him.

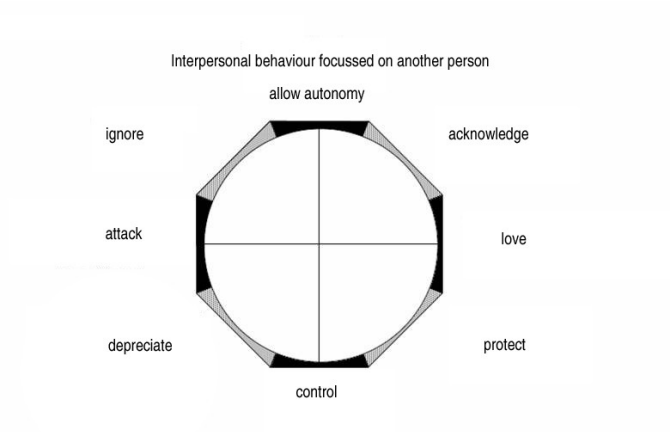
How others experience themselves time and time again with the patient: this captures the reactions which the patient induces in another person in the sense of a role. This element corresponds to the procedure in the psychoanalytic countertransference diagnosis (cf. Mertens, 1993; Thomä/Kächele, 1989).

These four interpersonal positions are linked in a relationship-dynamic formulation so that a psychologically coherent connection between facts is created which agrees with and explains the dysfunctionality and stability of the relationship pattern. In this formulation, we track how the patient, in contrast to his own experiential perspective, in fact (unconsciously) handles his relationships in a way so as to induce others time and time again to produce responses which he perceives as painful, disappointing, or threatening.

3.2.7.1 Categories of interpersonal behaviour

One requirement an operationalization of a psychodynamic diagnosis must meet is that the description of the interpersonal positions be made in a standardized way. This is achieved with an items list generated on the basis of a so-called circumplex model of interpersonal behaviour. Circumplex models proceed from the assumption that people orient their relationship behaviour in a manner suitable for defining a certain status or for arranging a desired proximity. What these models all have in common is that each instance of interpersonal behaviour is arranged on the area of a circle (see figure 3-1) which is formed by two orthogonal dimensions, which are each bipolar and represent those two basal categories of status and proximity: control (dominant/controlling vs. obedient/submissive), and affiliation (loving/attached vs. hostile/distanced). The most varied qualities of interpersonal behaviour can be determined as a ratio between these two basic dimensions, and thus as positions on the circle area they form. These circumplex models, and the measuring instruments derived from them, have been well studied and validated within personality, social, and clinical psychology (Wiggins, 1991). More recent studies support their importance for capturing relevant personality variables in psychotherapy research (Gurtman, 2004). Further to this, they form the core structure of dimensional models which are being developed for the description of personality disorders from an interpersonal perspective (Widiger/Simonson, 2005).

Figure 3-1 shows the active and reactive level of relationship behaviour in two circles. This differentiation is based on a further development of the circumplex model of interpersonal behaviour which goes back to Benjamin (1974) and has been a major influence on the model we use. In each of the circle areas the horizontal axis represents the dimension of affiliation, which, at the furthest right, deals with the themes of affection and friendly approach, and rejection or hostile approach on the furthest left. The vertical axis corresponds to the dimension of interdependence, of which one pole is formed by the themes of autonomy and self-assertion, and the opposite pole by control and submission.



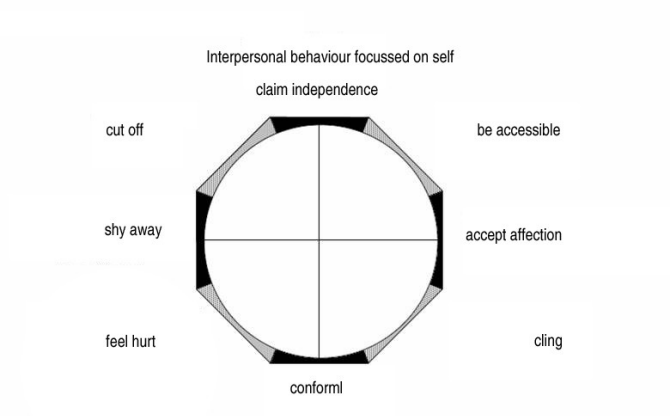


Figure 3-1: The two levels of the interpersonal circumplex model (after Benjamin, 1974)

A close look at the items reveals the internal order of the circumplex models of interpersonal behaviour (cf. Benjamin, 1993): modes of behaviour that lie on opposite poles refer to contrasting behaviour. The categories lying along the 45 degree-angles each refer to relationship qualities which express relative proportions of the affiliation and control dimension. The degree of friendliness/hostility or of control/submission is less in these positions than one would find at the extremities of both axes. Modes of interpersonal behaviour which are located in identical positions on the circle above and below are complementary to each other. This means that in each case an offer of relationship matches a relationship response. In addition to this, there are complex forms of relating which combine different or even contradictory relationship modes. These may be understood as two or more categories being activated at the same time.

3.2.8 Summary

The assessment of a patient's relationship behaviour follows the clinical-diagnostic interview. This interview should help to clarify which central dysfunctional relationship pattern the patient establishes time and time again in diverse areas of his life. This pattern is captured by examining four interpersonal positions, that is to say, by the description of the patient's behaviour and that of his interactional partners from two experiential perspectives, namely from the perspective of the patient himself and from that of others (his objects). The description uses a standardized list of relationship items, which were generated from a circumplex model borrowed from Benjamin (1974, 1993). Through a relationship-dynamic formulation the four positions are finally linked in such a way as to make the dysfunctional character of the pattern understandable and to explain its persistence.

3.3 Axis III - Conflict

3.3.1 What are conflicts?

The general meaning of conflict (from the Latin: clash) refers to the concurrence of different positions within one person (an inner struggle between motives, wishes, values, and ideas) or between several persons (Brockhaus German Encyclopedia, 1990). Conflicts are universal phenomena. Psychologists agree on a definition of

conflict as the collision of diametrically opposed tendencies of behaviour (motives, needs, wishes). Different theories, like for example biological behaviour theory, field-theoretical conflict theory, or cognitive dissonance theory, put forward different reasons as to why conflicts arise. For a psychodynamic understanding the concept of conflict is of decisive importance. Since Freud, psychodynamic thinking has assigned a central position to a person's internal conflicts. In Studies on Hysteria (Freud, 1952 (1895)), Freud, together with Breuer, describes conflicts as the causal factor in the origin of the neuroses, whereby conflicts are described as caused by "irreconcilable ideas",that is to say, by ideas that cannot be brought into agreement with norms, values, and thoughts. These embarrassing thoughts are subject to repression, are defended against, and are thus unconscious. For Freud, the reason for the universality of conflicts lies in the contradiction that exists between the pleasure principle and external reality. If such conflicts are successfully dealt with, the ego learns to mediate between internal and external demands. If the ego is incapable of mediating, unconscious neurotic conflicts arise. In agreement with cognitive theory, these conflicts are characterized as "dysfunctional conflicts", that is to say, conflicts which hinder the development of a person by making demands on his (defensive) energies, or by interfering with his interpersonal relating.

Psychodynamic conflicts are thus internal, unconscious conflicts and must be delineated from external or internal stressful conflictual demands. Internal, unconscious conflicts play a decisive role in the origin of mental and psychosomatic disorders. But also conscious, external and internal conflicts, if they are persistent and of a particular intensity, can lead to disturbances and, in this sense, produce a conflictual effect (Heuft et al., 1997b, 1997a; Hoffmann/Hochapfel, 1995; Schüßler, 1995).

Unconscious intrapsychic conflicts are unconscious internal clashes of diametrically opposed motivational bundles, for instance, the basal wish to be cared for and the basal wish to be self-sufficient.

Still another way to illustrate the connection we have thus established would be this: "If I get fully involved with another person, I will be disappointed sooner or later; the resulting fear of separation or the pain of actually separating is too much to bear, therefore I have developed defensive mechanisms so as not to let the relationship with another person become so intense that I might one day become dependent on it." (Mertens, 1992b). This inner tension, the contrariness of the firmly established bundles of motives, which keep each other in check and persist for prolonged periods of time, lead to an increase in tension. The concept of psychodynamic conflicts is based on the fundamental assumption of a dynamic, unconscious, mental activity, that is to say, the assumption that human behaviour is continually influenced by unconscious thoughts, wishes, and ideas. In addition, an ongoing conflict implies fixation at a rigid and undissolvable state of either-or, without a solution or decision being brought about.

Conflictual stresses, however, are conscious and generally amenable to being processed and resolved. Dührssen (1981) in this sense speaks of "normal and antinomic" conflicts. By this, she understands intrapsychic or interpersonal difficulties of which the concerned individuals are aware, like the pleasure-oriented wish to eat a scrumptuous meal while at the same time wanting to stay slim for

aesthetic or health reasons. An antinomic conflict, according to her, is characterized by an unresolvable contrariness due to external reasons, for instance a woman's wish to marry and have a family as opposed to having a career, where a solution can only be achieved through some sacrifice.

The ongoing and persistent psychodynamic conflict, in turn, is characterized by an individual's predetermined patterns of experience, which, in the respective situations, lead to continued similar patterns of behaviour, without the person being aware of them, or able to overcome them with his or her own free will ("neurotic fixation"). The question of a voluntary influence over behaviour helps, above all, to distinguish psychodynamically effective conflicts from simulation or aggravation.

Which unconscious processes do we assume then, and can unconscious items be captured at all? Freud himself used three different frames of reference for the concept of the Unconscious: he described the Unconscious, first, dynamically, as the repressed Unconscious, which includes not only the id, but also parts of the ego and the superego, that is to say, unconscious drive impulses, defensive attitudes, and conflicts; second, he explained the Unconscious from the unconscious parts of the ego, parts which are not repressed but remain forever unconscious; and third, Freud used the term Preconscious to refer to all those ideas and feelings which are generally accessible to consciousness, but which, as a rule, remain unconscious (Freud, 1925 (1915)).

What evidence do we have about the Unconscious? And if we assume an Unconscious, which one will it be? The majority of the brain's activities happen unconsciously. These unconscious activities are neither preconscious, nor do they represent a dynamic Unconscious (see above). The cognitive sciences, too, to a considerable extent, take into account unconscious processes (Posner/Rothbarth, 1989). All mental processes are unconscious by nature, that is to say an individual cannot track the way his or her brain operates and how memory and language function. Information processing happens in a symbolic and sub-symbolic manner, with only symbolic processes being accessible to our consciousness. Symbolic processing can happen verbally and in images. In line with these information processing pathways, information storage systems or memory sub-systems are distinguished as either declarative (explicit) or procedural (implicit) memory. Implicit (procedural) memory denotes behaviours or habits which we use unconsciously. From our developmental beginnings all through our adult life our life experiences get condensed in forever repeating references to interactions. These interactions incorporate the conscious and unconscious parts of the object (of the attachment and interaction partners), as well as the experiencing of the object with its pertaining motives and emotions, which from then on, determine the individual's future experience and behaviour. In these continually repeating experienced interactions and episodes, cognitive-affective schemata are being constructed, which Stern (1985) referred to as "Representations of Interactions that have been Generalized (RIGS)". Parental conflicts are thus transferred by way of conscious and unconscious behaviour of the parents, through gestures and phantasies, and find their precipitation in the child's representations of interactions, that is, patterns of behaviour, perception, and affect.

Unconscious processes can be inferred and operationalized, be it that which is being dynamically repressed, or which has been implicitly unconsciously learnt. But not only unconscious, but also conscious things must be inferred! The therapist has no direct access even to a patient's conscious experience, but is dependent on the patient's reports and behaviour. Conscious as well as unconscious content both must be inferred by the observer through communications and indirect indicators. If what is unconscious is being expressed in all actions and important interpersonal relationships, it becomes necessary and possible to infer it not only in the intrapsychic but also in the intrapersonal context: relationship patterns and relationship schemas are represented intrapsychically and expressed in interactions. Relationship and transference thus cease to remain phenomena which are bound to the analytic situation only. Rather, they enable the description of fundamental conflictual relationship patterns and structural problems as an expression of unconscious or preconscious conditions. While conflict mainly comprises unconscious maladaptive cognitive-emotional schemas, structural disorder as a term refers to a basic disorder of the cognitive-procedural-emotional processing (for an overview see Schüßler, 2002).

Conflicts within the classical analytical developmental theory

Psychodynamic conflicts, in the context of the development of the agency-model by Freud, were regarded as essentially intersystemic conflicts, that is to say, conflicts between the ego and the id, ego and superego, ego and reality. Later on, intrasystemic conflicts were added, that is to say, conflicts, for example, between different component parts of the superego.

Traditional psychoanalytic theory attempts to describe a small number of conflicts with the help of the concepts of libido and aggression, to assign their origins to a psychosexual stage, and by doing so, arrive at a specific relationship between drive conflicts and types of neuroses. Today, we can say that this attempt has failed, at least as concerns the unequivocal assignment of symptom neuroses to a developmental stage (e.g. obsessiveness to the anal stage). We cannot proceed from the assumption that individuation conflicts arise only in the so-called "oral" phase, or, for that matter, aggression and autonomy conflicts appear only in the "anal" phase of development. Similarly, "oedipal" conflicts are not restricted to the phallic-oedipal stage, but have their beginnings already in the child's capacity to form symbols and take on roles (Dornes, 1993; Hoffmann/Hochapfel, 1995; Schüßler/Bertl-Schüßler, 1992). Even if it is to be assumed that all motivational systems are effective from the beginning to the end of life (Stern, 1995), they develop, first of all, in response to developmental steps (ego functions, development of self, symbolization), and secondly, we must note that certain motivational systems are more important during specific phases of development than they are during other phases (e.g. formation of identity and conflicts in puberty). Anna Freud (1965) with her developmental lines was the first to attempt a description of how these motivational systems mutually influence each other during development, and of their interaction in the here-and-now (cf. section 3.3.3), although she remained firmly grounded in the libido-aggression-drive system.

On the relationship of conflict and structure

The existence of internal, unconscious and ongoing conflicts is bound to certain conditions in the structure of the ego, without which such a conflictual process and a working through process is impossible. In the case of clear ego structural disorders, classic conflicts of that kind are unlikely to arise in threshold situations, nor will they arise because of internal and external triggers ("trigger situations"; Dührssen, 1954/55). Conflictual stresses of an objectively far lesser degree are then sufficient, as a rule, to lead to clinically relevant disturbances. For pathogenesis, conflict and structure thus form a complementary series and presuppose each other. This is also true for the biographical background of ongoing conflicts on the one hand, and of structural disorders on the other. Biographical conflicts arise from a conflictual relationship experience, i.e. repetitive modes of relating, which can go as far as constituting traumatization. The consequences of extreme traumas in childhood development will most likely show up predominantly as structural deficits, that is to say, as obstacles and delays to development (deficits).

Neurotic dysfunctional conflicts thus presuppose the following constellation:

- a predominance of internalized, unconscious conflicts which lead to dysfunctional behaviour and experiencing and may include symptoms,
- an ability to basic affect regulation, and
- an ability for basic self-regulation (Fonagy, 2005).

As conflict and structure are the poles in a clinical complementary series (Mentzos, 1991), it can be said that conflict and structure behave like figure and ground, or like a play (conflict) that is being performed on stage (structure): the stage is the precondition for the performance (cf. Chapter 3.6). Everyday clinical practice offers many instances of interaction between structural and conflictual conditions. Neglect during childhood can have its sustainably negative effect in that it impedes the integrative solution of the consecutive developmental tasks (structure). This then blocks, or renders impossible, the equilibrium within and the integration of motivational development, as well as the ability to overcome difficulties connected with it. Traumatic separations during development, for instance, interfere with the mastery of the topic individuation versus dependency, with the consequence that we are dealing not only with structural deficits, but also, simultaneously with conflictual events (an oscillating between dependency and forceful autonomy). This is not, however, about an actual unconscious conflict, but about a conflictual set of circumstances which the patient is essentially conscious of, and which we shall call conflict schema, for reasons of delineation. In short: in a low level of structural integration, all motivational systems are, of course, being addressed, more often than not, in a dysfunctional and contradictory manner, however there exists no circumscribed stable conflictual pattern.

We can thus draw a dimensional line, from sub-clinical conflictual tension (an individual's personal characteristics as to how he experiences and deals with conflicting motivations), via neurotic conflicts (repetitive, dysfunctional, interpersonal and intrapsychic patterns), to conflicting schemas in cases of less integrated structural levels. The term schema describes the overall positioning (e.g. the schema 'building' implies the existence of a roof and walls) and in the sense of conflict schema, refers to the overall and imprecise recognition of patterns: There is

a conflictual set of circumstances which, however, upon more in-depth analysis fails to show a specific, stable expression. This can be modeled with the image of a "sandwich" and will be illustrated with the example of the conflicts of self-worth.

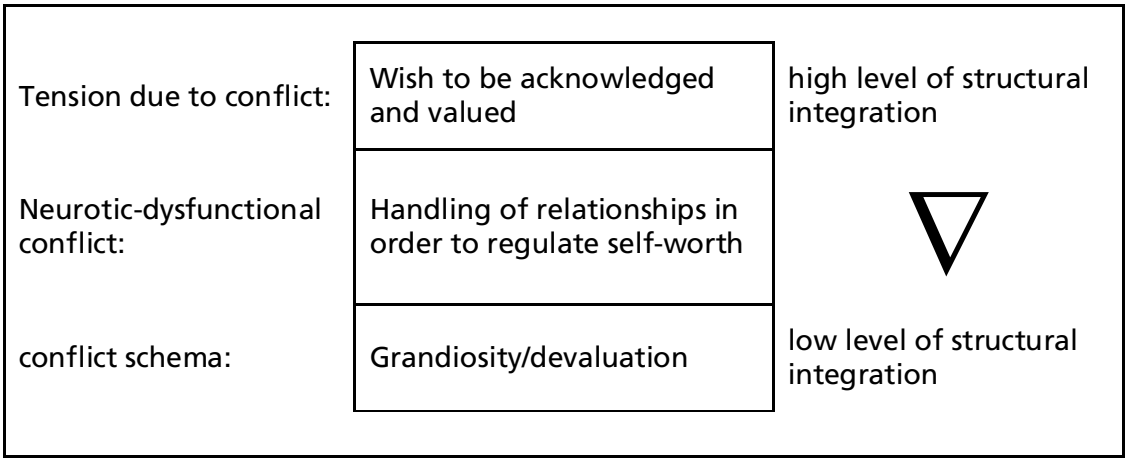


Figure 3-2: Layered Model: the conflict theme of self-worth in relation to structure

Every individual has the wish to be acknowledged and valued, as well as the capacity to value others. Cultural and individual socialization, in each case, has led to the respective individual solutions and internal patterns, which time and time again lead to conflictual tension (for example, daily insults depressing the feeling of self-worth, and so forth) and which can essentially be managed by adaptation.

In neurotic conflicts, biographically unsuitable or one-sided "either-or" solutions develop (dysfunctionally), e.g. active excessive compensation, active mode of processing the conflict. In situations that address the aforementioned area of self-worth this leads repetitively to similar patterns of coping with the pertaining affects (e.g. narcissistic rage; devaluation of others).

In a low level of structural integration a stable self-system does not exist, the conflictual schema self-worth versus object-worth vacillates, at times abruptly, between grandiosity and devaluation, or feelings of unworthiness and idealization, often with minimal triggers. Abusive insults of the other person may then equally serve to defend against fears of separation etc. The motivational intentions of the conflict schemas can then no longer be assigned to a stable conflict pattern.

Conflictual tensions, patterns, and schemas are interpersonal (e.g. hurts suffered through others) as well as intrapsychical events (ideas, phantasies, feelings, such as the phantasy of losing one's teeth). In situations of substantial to serious life-event related stresses, a considerable number of individuals develop an apparent motivational conflict, against the background of their own individual patterns of experiencing and behaving (conflictual tension).These stressor-induced conflicts must be differentiated from neurotic, repetitive conflict patterns. The following may serve as clarification: patient X showed a pattern of adaptive processing of the conflictual themes care versus autarky (with the latter being of great importance in his life). After falling seriously ill with cancer, all this man wanted from that point on was being passively taken care of. In the clinical situation, the examiner is struck by the conflictual behaviour, while the anamnesis reveals no trace of a neurotic experiencing of conflicts and behaviour!

The repetitive conflictual patterns of experiencing and behaviour lead to symptoms in trigger situations, on the one hand. On the other, if they are strongly present they show a conflictual personality, which may even result in a personality disorder (e.g. dependent personality disorder). In the past this had been termed a "character neurosis", and today, in accordance with the ICD-10, is diagnosed as a personality disorder. Again, structural criteria must be taken into account! The obsessive personality thus comprises not only a conflictual personality (neurotic), where a non-adaptive solution of, e.g. the conflict control versus submission, results in a clinically relevant impairment of an individual's experiencing and behaviour (with an absence of apparent symptoms), but also a personality disorder which shows predominantly structural deficits.

Conflict and diagnosis

Diagnostic identification of psychodynamic conflicts requires inductive as well as deductive procedures. Inductive refers to a number of repetitive modes of experience and behaviour, proceeding from observable phenomena, whereby those modes can be traced back in the patient's personal history and through the course of his illness. At the same time, we witness, by deductive observation the patient's efforts to resolve these conflicts adaptively (successful adaptation to life circumstances; productive work life; personal relationships). Maladaptive solutions can be recognized by their dysfunctionality. They lead to social problems (e.g. in an intimate relationship) which are connected with clinical symptoms and/or disorders of the personality.

Conflict and lead affect

Furthermore, conflicts become evident in the interview situation in the transference and countertransference, and in the lead affects (Heigl-Evers/Henneberg-Mönch, 1990), e.g. narcissistic rage after insults. The connection of emotions and motivational systems requires closer scrutiny. Motives are connected with emotions (Krause, 1998). "Emotion is the realization of motivational potentials, if they are triggered by suitable stimuli" (Buck, 1988, p. 25; tr. E.R.).

This applies especially to the basic emotions of anger, sadness, fear, disgust, interest, suprise, and happiness. Anger arises, for instance, when a wish is being frustrated and aims to eliminate the obstacle to wish fulfilment, sadness is caused by the loss of an object. Emotions are biopsychosocial mechanisms of regulation in the service of survival. Emotions inform one's own body and give signals to another (e.g. anger warning before the attack). Emotions have functions in the area of relationships (happiness, sadness, anhedonia), in the individual's intersubjective orientation to the world (curiosity, loss of interest), or protective functions (surprise, fear). Emotions show themselves not only as short-term affects such as anger, but also as background emotions (Damasio, 2003), or as moods. Background emotions are longer lasting emotions like, tension, relaxation, nervousness, despondency, despair, exhaustion, anticipation; as all emotions they manifest in bodily changes, but not, however in changes in facial expression (Damasio, 2003). Enduring emotions are referred to as good or bad moods (e.g. depression). They, too, share the same bodily reactions which are typical for emotions: changes in the autonomic nervous system, in the endocrine system, and of a musculoskeletal nature.

Building on the primary emotions, more complex social emotions develop which originate in even more strongly determined social-interactional contexts: empathy, shame, pride, jealousy, gratitude, admiration, and contempt. The social emotion of contempt, for instance, uses the bodily patterns of the basic emotion disgust; the form it takes, however, is dependent on individual-social factors. Guilt and shame as social emotions capable of giving rise to conflict, are equally subject to considerable cultural and individual moulds (e.g. shame or guilt-based cultures). Feelings of shame point to a defect of self, whereby the self, as a rule, is not the perpetrator. They lead to humiliation and go as far as anger, and are linked to strong autonomous reactions. Guilt feelings result from moral (superego) infringements, the self is the perpetrator, they lead to indignation and in consequence, have no autonomous concomitant reaction (Krause, 1998). Guilt feelings are undone by self punishment and/or restitution.

Emotions consist of several components ranging from motor, autonomous, and facial expression components to awareness (feeling) and regulation of behaviour. The awareness of unwanted emotions especially, is influenced by higher mental functions (cortical centres) and is one of the most important maturational steps of the individual (affect recognition and regulation Ψ structure). Where the maturation succeeds, emotions can still be transformed and changed by mechanisms of defence (rationalization, affect isolation, turning against the self, etc.), or attempts can be made to defend against them to the greatest possible extent (repression).

If such mechanisms are prevalent, this may lead to difficulties with any kind of recognition of feelings and needs in oneself and in others. This particular form of "conflict management" may be defined as awareness of conflict and feeling which is defended against.. A leading affect is, of course, not present here, as it is the very absence of feelings which characteristizes this pattern. The defence against feelings is mainly aimed at the general avoidance of anhedonic affects. This reveals the protective function which defence against awareness of conflicts and feelings has for the ego, and possibly even for the self.

3.3.2 What drives a person - from motivation to conflict.

Motivational systems which have developed by way of evolution from the drives, have a biological basis, in the special case of the human being, however, they can be changed and formed through learning. It can generally be assumed that all motivational systems (other than those directed at the self) are aimed more towards the object than towards pure "pleasure" (Fairbairn, 1952). The development of motivational systems (and equally of structure) in humans is an ongoing, lifelong process which has a past, shows itself in the here-and-now, and points to the future. Early developmental steps differ from later ones in that they are formative: interpersonal experience gained in first relationships creates patterns and prototypes as to how to behave towards a close and caring object and what to expect in terms of satisfaction and frustration (Emde, 2005; Stern 1995). This intersubjective orientation of a human being creates the precondition for the internalization of individual experiences, a process that progresses all through childhood and adolescence. In adulthood, these prototypes of the emotional schemas "self in relation to others" (Stern, 1995) become activated by similar relationship experiences. Sandler and Sandler (1978) translate drive (or motivation)

into a represented wish, which contains the desired or expected reaction of a significant object. Patterns of wishes arise, with their aim and action directed towards others, and in relation to oneself.The development of all psychical activity is relationship-focused and dependent (Loewald, 1971) on internalization (learning) as the process driving development. Even if motivation is based in the biological, and, as in the case of sexuality, organ-pleasure is essential, sexuality is given its meaning only in the experience of the relationship matrix. If neurotic conflicts presuppose a sufficiently developed structure, their coming into being is to be located less in the earliest developmental stages, but more in later childhood and adolescence with an increase in structural-symbolic capabilities.

In the general psychology of motivation, Maslow's model (1970) is the most established; it proceeds from a hierarchy of needs (fulfilment of basic needs first, and only then addressing the next motivational stage). The basis is formed by the biological needs (food; sexuality), then the need for safety, the need for attachment (need to belong, to live connected to others and be loved), and finally the self-worth motivation system (self-worth and recognition through others). Cognitive needs constitute a further basic need (needs for knowledge, understanding, and the need for new experiences).

The basic developmental needs of early childhood according to Emde (2005), are these: activity, self-regulation, social orientation, monitoring of affects, and cognitive maturation. As regards the development of motivational systems, neurobiological basic research provides little in terms of unequivocal evidence: "Motivation is thus a complex behavioral process that depends on controls provided both by internal stimuli homeostasis and by external incentives, the latter often dependent on learning. These stimuli together enable state-dependent selection and coordination of different sequences of behavior that have flexible anticipatory elements and more stereotyped terminal elements" (Squire et al., 2003, p. 1125). Of importance is the statement that behaviour (terminal elements) in humans appears determined - unconsciously, in a rather individual manner. Panksepp (1998) identifies five fundamental neurobiological motivation systems: the seeking system (curiosity), pleasure system (sexuality), rage system (self assertion), fear system (safety), and separation distress system (attachment) with the sub-system of care.

Proceeding from a developmental biological and psychological perspective, different conceptions of motivational systems exist. Lichtenberg (1989), against the background of neurobiological and infant research, describes five elementary, distinct motivation systems, which are based on behaviours that are clearly observable from birth:

1. the necessity to fulfil physiological needs
2. the need for attachment
3. the need for self-assertion and exploration
4. the need for contradiction and withdrawal
5. the need for sensual pleasure or sexual excitement.

Each functional motivation system has a biological basis. Affects are of central importance, as they - beside language and in conjunction with it - are crucial for human communication. Each functional motivation system proceeds from inborn and learnt interaction patterns. Later on, each system is shaped on the basis of

intersubjective, interactional experience. A favourable development leads to stability. In case of considerable dissonance between motivational needs, wishes, and their satisfaction, conflictual patterns become established.

In his motivational model, König (1988) attempts to reconcile concepts from psychoanalytic drive theory, ego-psychology, and object relations theory. His model distinguishes between the wish for the familiar and the wish for the new as a "basic relational wish" on the one hand, and the wishes for merging, being taken care of, control, and recognition of one's own sexual characteristics as "central relational wishes", on the other.

The most elaborate motivation model is that of Bischof (1985). It combines what is known in the field of ethology with psychodynamic approaches. Attachment needs linked with a striving for safety, and a sense of adventure coupled with a striving for excitement, form the initial needs, followed by curiosity, need for self-effectiveness, and sexuality. Bischof demonstrates that motivations are conditional upon each other, are intertwined or can mutually impede each other (familiarity and trust in the family prevents sexuality: incest taboo).

If one was to summarize the above in a bio-psycho-social theory, it would reveal that at the start of human development is the need for physiological satisfaction, self preservation and regulation, directed towards the intersubjective world (curiosity, excitement, safety). This reflects again the intentional phase according to Schultz-Hencke (1931), with the leading theme that all contact is directed towards the environment.

There follow attachment needs (Bowlby, 1969; Harlow, 1971) with wishes for proximity and comfort and well-being, safety, belonging, the experiencing of care, intimacy and tenderness. Bowlby's theory of attachment which states that the biologically grounded need for attachment is aimed at achieving a state of safety, is thus an essential, but not the whole part in this motivational complex. In opposition to this motivational system are the strivings and wishes for independence, autonomy, self assertion, the wish for possession and ownership (control, power).

What develops thereafter is the need for self judgement, together with self-worth in the third or fourth year of life, dependent on and building upon the development of the self, as Stern (1985) has sketched, with the emerging self, core self, subjective self, and the verbal self ("I") (Schüßler/Bertl-Schüßler, 1992). Self and object worth are complementary, object worth develops from successful positive object experiences.

In late childhood and during puberty the development of the self finds its (of course not final) termination with the formation of an identity. Its aim is to achieve an identity that is unequivocally unique, as free from contradictions as possible, with the elements of self preservation, self assertion, self awareness, and social competence. The motivational system of care (tending the young) and altruism unfold in close interaction with the development of the superego.

The sexual motivation system starts with preliminary forms of bodily pleasure and the development of gender identity (man/woman in relation to parents and social networks) in childhood and, beginning with puberty, aims at sexual activity and seduction, the sexual pleasures of watching and showing.

The interplay with other motivational systems can be illustrated with the example of sexuality: a successful development of the sexual motive without previous successful attachment or secured development of self is difficult to achieve (Bischof, 1985). These basic motivation systems are the foundation for manifold sociocultural and individually specific social emotions (see above). Anna Freud (1987 (1936)) with her developmental lines was the first to attempt a description of how motivational systems mutually interact in their development and how they affect each other in the here-and-now.

Developmental lines according to Anna Freud

- From infantile dependency to adult love life (biological continuity), love of the anaclitic type, stage of object relationship, ambivalent relationship of the anal-sadistic phase, oedipal phase, latency period, pre-puberty, puberty stage),
- to bodily autonomy (from babyhood to independent eating, from cleanliness training to cleanliness, from no responsibility to responsibility for one's own body),
- the path from egoism to participation in the human community,
- the path from autoeroticism to toys and from play to work.

These developmental lines are changed by external (later on internalized) conflicts. Anna Freud gave the following timelines:

External conflicts in their timely sequence

- Fear of annihilation with loss of motherly care (fear of separation, fear of object loss)
- Fear of loss of love (after establishing a constant relationship)
- Fear of criticism and punishment (during the anal-sadistic phase)
- Fear of castration (in the phallic-oedipal stage).

This development can be imagined as the weaving of a tapestry: it begins with a single thread (motivational system) which is connected with other threads, together they come to form an individual pattern, the threads are conditional upon each other and influence each other. Bischof presents a comparable scenario in a complex flow chart (Bischof, 1985, p. 467).

3.3.3 Past approaches to conflict diagnosis

The lack of clear definitions and of a systematic way of establishing conflict diagnoses and psychodynamic formulations (psychodynamics) is a great drawback to further clinical and scientific development in psychodynamic psychotherapy and is generally lamented. As early as 1959 Weisman described three basic criteria which a psychodynamic conflict formulation should contain:

1. a psychodynamic formulation must proceed from descriptive (phenomenological) and psychodynamic observations;
2. the language of psychodynamic formulations must be precise, generally understandable and allow standardization;
3. psychodynamic conflict formulation must, thirdly, be inferable from a clinical interview.

The most extensive and influential attempt to systematically and comprehensively conceptualize psychodynamic conflicts and their formulation goes back to Anna Freud. With her colleagues from the Hampstead Clinic (Eissler et al., 1977) she developed a "diagnostic profile" which encompassed the scope of the instinctual wish, how the ego is shaped, and superego positions with the respective points of fixation and regression pertaining to the conflicts. The application of this instrument remained limited, however, firstly, because of its considerable length, and secondly, because of its exclusive reference to classical psychoanalytic theory. Her elucidation of the developmental scenario enjoyed a wider application (Anna Freud, 1968).

Psychodynamic developmental image according to A. Freud

- Reason for the examination
- Description of the child
- Family history and child's life history
- Environmental factors
- Developmental dates with drive development:
- Libido (libidinal development, libido distribution, object libido)
- Aggression (extent, form, direction)
- Ego, superego development (ego functions, ego defence)
- Fixation points and regression
- Conflicts (external, internalized, and deep internal conflicts)
- General characteristics and attitudes
- Diagnostic criteria.

The work of Malan (1979) and Strupp and Binder (1993) especially, within the framework of their short-term psychotherapies and based on clinical material, deals with the working through of central conflicts in the period that followed. Both approaches share the assumption that the patient's current problems represent a repetition of the central conflict between certain wishes and fears. The importance of structural factors is often overlooked in these situations. The formulations rest on three elements: the wish (impulse), the pertaining fear and the defence which become evident in the patient's life history, current problems, and the transference.

Another approach is that of Perry (1990), who attempted to objectivize psychodynamic conflicts in his "Psychodynamic Conflict Rating Scales". Psychodynamic conflicts, according to his definition, comprise the most important wishes and the fears that oppose them, that is to say, the way in which an individual tries to avoid these conflicts and his vulnerability to certain stresses. Perry describes 14 conflicts, including, for example, the wish to control others, object hunger, the fear of merging, the conflict around sexual pleasure versus guilt, or the conflict over counterdependence. Each conflict carries a short description. To illustrate, let us take the example of counterdependence: "Individuals with this conflict feel the need to maintain autonomy by disavowing their own dependency

needs. Their vulnerability lies chiefly in fears of loss of control and autonomy at times when dependency or affection feelings and wishes arise toward others."

The reliability of this instrument has not been sufficiently examined. In a clinical application study, however, defined conflicts were very useful in separating out different diagnostic groups (Perry et al., 1989a; Perry et al., 1987; Perry et al., 1989c). Perry incorporates into these conflict formulations, however, not only the conflict with its conscious and unconscious manifestations, but also elements of structural adaptation. A clear diagnostic separation is therefore very difficult to achieve.

Weisman's requirements as presented above, regarding the ideal characteristics of a psychodynamic measuring instrument were best met - beyond the OPD - by the Karolinska Psychodynamic Profile (KAPP; Weinryb/Rössel, 1991). This procedure captures the quality of interpersonal relationships, specific aspects of personality, of affect differentiation, bodily awareness, sexuality and social relevance.

The conflicts described are:

1. Intimacy and reciprocity
2. Dependency and separation
3. Controlling personality traits
4. Alexithymic traits
5. Conceptions of bodily appearance and their significance for self-esteem
6. Sexual satisfaction
7. Sense of belonging
8. Feeling of being needed.

These psychodynamic basic conflicts are phenomenologically defined. The category "dependency and separation" with its three tentative solution proposals may serve as an example here:

> "The ability to establish mature dependency relationships and the ability to grieve and work through the loss of important persons, ideals, parts and functions of the body as well as material possessions
>
> 1. Can establish mature dependency relationships.
> 2. Can establish dependency relationships.
> 3. Can only establish infantile dependency relationships."

This category, taken as an example, is more likely show an assessment of structure, rather than an assessment of conflict. So far, the interrater reliability of KAPP has only been tested with a small number of interviewers (five raters), however, the achieved reliabilities were very high at 0.7 to 1.00.

3.3.4 Conflicts in OPD

In consideration of the theoretical and empirical basis we have presented so far, the OPD arrived at the following definitions of "ongoing" conflicts:

1. Individuation versus dependency
2. Submission versus control
3. Care versus autarky
4. Self-worth conflict (self-worth versus object worth)
5. Guilt conflict (egoistic versus prosocial tendencies)

6. Oedipal conflict
7. Identity conflict (identity versus dissonance)

This selection, on the one hand, is a traditional psychodynamic one. It is particularly true for the dependency, dominance, guilt, and oedipal conflicts. However, the selection is also new in the emphasis it puts on little recognized, but clinically relevant motivation systems and conflicts, above all on the need for care versus autarky conflict, and the "pure" identity conflicts which, to our mind, have been traditionally undervalued.

Need for care versus autarky is often merged into the conflict individuation versus dependency. This is in line with the Freudian as well as behaviourist assumption that the emotional bond is a consequence of how caretaking has been experienced. Yet according to Bowlby (1969) attachment (and in consequence, the experience of dependency) is a genuine motivational system, the evolutionary inheritance of all primates and most mammals. This theory, which had its precursors in psychoanalysis also must be regarded as safely established. It cannot be disregarded in the clinical context, either, once some degree of familiarization with the following differentiation has been acquired, that a distinction between dependency and care needs must be made. In the same manner, needs for individuation and dependency can be distinguished. Self-worth conflicts, too, continue to be underestimated, in our opinion, in their pathogenic importance. What contributes to this seems to be the fact that, in Kohut's (1971) understanding, they represent "intrasystemic tensions" rather than intrapsychic conflicts. Identity conflicts share the same fate of being underestimated as to their role in pathogenesis; they are generally put into the category of self-worth conflicts in the sense of a "narcissistic hotchpotch".

Along similar lines, the developmental sequence and frequency of the conflict constellations we have selected differ, too. The conflict with the highest frequency seems to be the dependency-individuation conflict.

Our conflict definitions clearly do not refer to traditional, psychoanalytic developmental psychological assumptions. Rather, they are in accordance with basic motivation systems; and, although reference is made to inter- as well as intrasystemic conflicts, there is no relationship to the classical psychoanalytic three-agencies model (ego, id, superego). Traditional psychoanalytic terms are further avoided as often as possible, because of the untying of our definitions from developmental psychological assumptions and because of school-specific ambiguity (e.g. terms like anal or oral conflict). The conflict model we present here avails itself of the conflictual interactional experience of an individual as a basic unit. These experiences can be deduced from their phenomenology (surface) and inferred and explicated as far as their unconscious meaning.

Complementary to these "ongoing conflicts" and against the background of drastic life changes and stresses, we find the so-called stressor-induced conflicts (life-event stresses). What is meant here are stressful events, which, due to their severity, often trigger a struggle between feelings, thoughts and experiences, and which therefore appear "conflictual" yet without there being a biographically determined ongoing unconscious conflict. Although Anna Freud made a point of also taking into account external conflicts (A. Freud, 1965), classical psychoanalysis

has shifted the emphasis so much in the direction of the inner or internalized conflicts that the relevance of external conflicts has all but disappeared. The argument was, as a rule, that external conflicts apparently can only become dynamically effective if they had an inner (conflictual) representation, that is to say, if they were internal or internalized conflicts in the first place. This is right and wrong at the same time: Each extraordinary life-event stress in an individual does of course encounter all of his or her motivational and structural conditions; if the coping mechanisms were functional up to that time, it is to be noted that a life-event based conflictual dynamic is not an ongoing neurotic situation (Heuft et al., 1997a; Heuft et al., 1997b).

3.3.5 Similarities and differences between the conflict axis in OPD-1 and OPD-2

A further operational clarification of the contents addressed in the conflicts such as the addition of the life areas of body/sexuality and an improved delineation regarding content (individuation/dependency instead of autonomy/dependency in OPD-1) are important new developments. Putting neurotic conflicts on a basis that goes beyond the psychoanalytic libido theory, in a motivational developmental model is the aim of OPD-2. It allows an improved conceptualization and differentiation of the areas of conflict and structure in a continuum model that spans from tension due to conflict, via repetitive neurotic conflicts, to the representation of conflictual schemas.

3.4 Axis IV - Structure

3.4.1 The term structure

Structure descriptively denotes the ordered arranging of parts together in a whole; to explain structures, reference can be made to the rules that govern them and to the history of their origin.

It is in this sense that the term structure is used in many different disciplines, for example in terms like "the geological historical structure of the Rhine River Fault", the molecular structure of a crystal, the age structure of a population, the governing structure of a society, the structure of texts, of systems of symbols, of languages and communication".

For a relevant and purposeful understanding of structures, we turn to, as a rule, the history of their development, that is to say, the origin of their organization and functioning under the conditions of the historic past. As function, organization, and history of structures are always subject to hypothesis formation, it may be true to say that structures which are not accessible to direct inspection or examination, have the character of models and explanatory constructs. The latter can only be formulated within the framework of theoretical assumptions. This is why these structural models always refer to specific theories and are formulated in their particular language and terms. Dealing with structure-related terms therefore requires the constant critical examination of their underlying theoretical assumptions.

Structures can be mostly understood as an aggregation of sub-structures, and these in turn, as a part of higher-order arrangements with/in a network of influencing variables. They form an ensemble of pieces of information which in its turn organizes and processes experiences. Herein lies the proximity to the systems

concept which in its turn emphasizes the dynamic processes of homoeostasis in the sense of feedback systems and the coming into effect of non-linear processes.

3.4.2 Structure as a psychological term

Structure in a psychological sense denotes the overall organization or arrangement of mental dispositions. They comprise all that, in the experiencing and behaviour of the individual, runs a regular, repetitive course (consciously or remote from consciousness). Structure forms the basis of the ongoing, personal style (Shapiro, 1965) in which the individual time and time again reestablishes his intrapsychic and interpersonal balance. An unimpeded structure possesses flexible and creative availability of functions which have a regulating or adaptive effect in an intrapsychic and interpersonal context.

Structure is not rigid and unchangeable, but shows developmental processes throughout life. Nonetheless, the speed of change of these processes is so slow that the impression of constancy predominates; herein lies the point of contact with terms like identity, character, or personality. In order to counteract too rigid a conception of structure, we refer to arguments which suggest considering structure under dynamic aspects: seen from a developmental perspective, mental structures are dynamic, as they continually form through an individual's life. It is true that they are based upon genetically determined personality characteristics, however, they are only being shaped during childhood and, in the developmental course of life, are subject to more or less important changes. Mental structures are dispositions and as such not observable; they become manifest only in actual real-life situations from which conclusions are drawn referring back to ongoing structural characteristics (situation-dynamic analysis of structures). Such conclusions are never exhaustive; the description of personality structure is always preliminary and incomplete (with the logical restriction, as we know, that stability can be assumed). In addition, the structure term implies an ongoing stability, but which it may only be accorded to a limited extent on the psychological plane: based on the background assumption of a potentially lifelong development of the personality, the structure term also implies aspects of a developmental dynamic with a time-related, if slow potential for change (slow-change model). Structures change through integration of new information, thus establishing new sets of rules, until they again change through the integration of new information.

3.4.3 Structure in a psychoanalytic sense

Similar to other sciences, no uniform term for structure can be found in psychoanalytic literature. The historical evolution of the present discussion, however, allows the distinction of several focal points:

The topographical-structural model: In "The Ego and the Id" (Freud, 1923a), for example, or in the "New Introductory Letters" Freud talks about the "structural relations of the mental personality" when he describes the interplay of ego, id, and superego. This structural model does not undertake a description of individual content, but rather, of the interplay of different contents, of the codified rules of mental functioning in the topography of the "mental apparatus", for example, in order to distinguish the systems Conscious/Unconscious.

The character structure: This is about terms which, in a reduced form, describe typologies of character attitudes. The typologies in this have a theoretical basis, that is to say, are derived from metapsychology and developmental psychology (oral personality, anal character, etc, cf. Abraham, 1925). As a diagnostic category, the term character neurosis forms the opposite type of neurosis to that of conflict neurosis. There are overlaps with what, in contemporary diagnostic systems, is described as personality disorder.

The neurosis structure: Schultz-Hencke's (1951) psychological concept of the neuroses talks about the hysteric, obsessive, depressive, schizoid structure of neurosis. This is a drive-theoretical concept which describes the character-related consequences of the repression of certain drives. As a rule, what is clinically diagnosed is the existence of several structural parts side by side (e.g. depressive-hysteric neurosis structure) (cf. Schwidder, 1972a, 1972b).

Ego structure: In line with the formulations of psychoanalytic ego-psychology (Hartmann, 1960), it became possible to systematize ego-functions (Bellak/Hurvich, 1969) and later also operationalize them, so that an assessment of ego-structural functioning ("ego-strength, ego-weakness") could be derived.

The structure of object relations: The psychoanalytic theory of internalization processes with its maturational steps like the establishment of object and self representations was systematically set out by Kernberg, and, with reference to the disorders of the personality, became useable in clinical-therapeutic practice (Clarkin et al., 2004a; Kernberg, 1976, 1977, 1980, 1984). Kernberg undertook to integrate as many proven and trusted psychoanalytic concepts as possible into this formulation and to use them as criteria for establishing the level of functioning of the personality.

3.4.4 The developmental psychology of structure

In the last several decades, special importance for an understanding of the concept of structure has been attributed to infant research which had evolved against the background of academic developmental psychology and also of attachment research, and which was taken up more and more by psychoanalysts (Dornes, 1997; Emde, 1981; Fonagy et al., 2002; Fonagy/Target, 1997; Gergely, 2002; Grossmann et al., 1989; Lichtenberg, 1983; Papoušek, 1989; Stern, 1979; Stern 1985). The findings emphasize the infant's inborn, object-seeking activity and its early development of compentency to involve the adult care giver in social interactions. These pleasurable interaction games also incorporate bodily care and feeding, two procedures which classical theory (in the sense of orality or early libidinal relationships) has awarded central importance. In these early developmental phases the ego begins to organize itself by orienting itself in an interested, ready-for-action, and emotional manner towards the non-ego, that is to say, the world of objects (intentional-communicative function of the ego; (Rudolf, 1977)). The repetitive interactions between the infant and its available, emotionally supportive objects can exercise structural functions, especially through the experience of being emphatically understood and appropriately treated. The development of the structure of the self reaches a temporary end point when the ego is capable of taking itself as an object and thus reflexively refer to itself. An opening of a mental space and the early representation the experiential world in word and symbol can be observed from

the approximate age of 18 months. In this context, the working group around Fonagy highlights the aspects of an increasing mentalized affectivity and mentalization which finally finds expression in the availability of the self-reflexive function (Fonagy et al., 2002). In the constant relationship with the world of objects the regulating organizing function of the ego becomes differentiated, on the one hand, while on the other, images of the self and of important objects (self and object representations) come to be formed. The objects are experienced as separate from the self, are recognized, endowed with affect, and internalized. The emotional attitudes experienced by important objects, and especially the affectively charged interactions between child and caregiver, not only colour the image of these objects and the child's attitude towards them, but also the image of the self and self-worth. Hence the structure of the self and the structure of the object relations mature developmentally in a closely intertwined way. The self continues to gain in coherence, differentiation and ability to self-organize. Concomitantly, the attachment to safety-giving others is strengthened. The safety of the attachment to the object in turn favourably influences the development of self-autonomy which in further steps leads to the strenghtened self beginning to detach from the objects and learning to deal with them. At the end of this development there is an autonomous self which has formed a sense of identity and which is capable of regulating its self-image and self-worth as well as its capability for control in ever new ways.

3.4.5 On the operationalization of structure in OPD

In line with the work of Rudolf (1993), OPD attempts an integration of the previously described psychodynamic concepts of structure; in doing so, it refrains as far as possible from using traditional psychoanalytic terms in order to, instead, determine the behaviour and experiencing of the patient as close to observation as possible. This approach leads to a functional description of structure as the self in its relation to objects (Rudolf, 2002a; Rudolf et al., 1995).

In the same way as all mental processes are simultaneously expressed on the bodily plane and by this very fact give rise to an apparent dualism, all structural functions can be linked not only to the inner world of the psyche, but also to the external world of social relationships, that is to say, to self and objects.

The structure of the self: The self is characterized by its reflexive function (self-reflexion): the ego takes itself as an object of inner perception. It thus gains an image of itself, and due to the constancy and coherence of this process, an experience of identity. The self sees itself as judged by others and therefore judges itself (self-worth). It integrates all mental functions and dispositions into a coherent whole and regulates the internal processes (affect regulation, impulse control, self-worth regulation). The availability of a flexible defence system with reference to an internalized system of norms forms part of the regulating activities.

As a precipitate of important relationship experiences, internalization processes occur from infancy on and not only establish an internal image of important objects (object representations), but also shape the image of the self (self-representations).

A reference to internalized, sufficiently good objects plays a key role for the function of self and affect regulation, especially of self calming and self consolation. The self-reflexive relationship to one's own inner world implies, in a

structural sense, the ability for internal communication, for an inner dialogue, whereby a individual's emotionality, world of needs and fantasies and all that the body experiences, carry particular weight.

The relationship to objects: All aspects of self mentioned so far have a correspondence with the relationship to external objects. From a developmental psychological point of view, relationship experiences form the basis for the development and regulation of the self. Parallel to the reflexive perception of the self, there is the realistic perception of the objects. It becomes realistic in the adult sense by the safe differentiation between self and object, by the delineation of both, and by the acceptance of the object's own reality, independent from the self.

As concerns the correspondence that exists to the processes of self-control, this is about the structural ability to shape relationships in such a way that one's own and outside interests can be appropriately safeguarded, and, at the same time, an emotionally important relationship can be protected from one's own interfering impulses and affects. This includes the ability to anticipate the reactions of others.

The fact that others can be experienced as differentiated, separate objects, requires it, given that they are not one and cannot know everything about each other, to make oneself understood by way of communication. This happens either through emotional expression which must reach the other, or through being touched emotionally by the other. In this situation, the ability temporarily to put oneself into the inner world of the other (empathy) plays a crucial role.

Structure, therefore, according to OPD, can be described along four dimensions, each distinguishing the relationship to self and the relationship to objects.

Self perception and object perception
- Ability to self-reflect
- Ability to perceive others realistically and as a whole

Control of self and of relationships
- Ability to regulate own impulses, affects, and self-worth
- Ability to regulate relation to another

Emotional internal communication and communication with the outside world
- Ability to communicate internally via affects and phantasies
- Ability to communicate with others

Internal attachment and external relationship
- Ability to avail oneself of good internal objects for self-regulation
- Ability to attach and detach

3.4.6 Structure and structural disorder: Different levels of integration

From a developmental psychological perspective adult structure is understood as the result of a maturational process characterized by increasing differentiation and integration, which also bears the features of increasing "mentalization". This is about the establishment of the intrapsychic representation of the external world of objects (object representation), as well as the experiences and attitudes of the self

in dealings with the object world (self representation, representation of interaction). A disorder-free structure implies that an individual can avail himself of this mental space and can regulate it via intrapsychic processes in such a way that he can also establish and maintain interpersonal relationships in a satisfactory manner. Structure is, to a large extent, individually shaped, not only with respect to restrictions and weaknesses, but also to the resources and strengths an individual has developed.

Structural disorder may mean that certain structural differentiations and integrative steps did not occur, in the sense of a developmental deficit. The self is neither able to be autonomous, nor regulate itself sufficiently, nor reflect itself; a reliable attachment with supportive others could not be established.

In the case of a structural vulnerability, structure was able to develop, but it is not stable enough, with the consequence that, in situations of internal and external stress, structurally anchored functions are lost and affective states of tension and disintegration become activated.

From a differential diagnostic perspective it is important to distinguish habitual structural ability from such conspicuous states as might appear in severely stressful situations. Emotionally stressful real conflicts (e.g. relationship crises, arguments, or stressful life events) can, in conjunction with other stressors like lack of sleep, strenuous physical exertion, excessive enjoyment of alcohol, nicotine, medications and drugs, etc., set off regressive processes which become apparent as structural irregularities (e.g. loss of affective control and self-worth regulation, doubt about one's own identity, gaps in communication, projective mix-ups of self and object etc.). These reactions to stressful real-life events and the possible structural weaknesses caused by them are not the object of the assessment of the structural level. The structural level, rather, refers to the ongoing, typical way of structural functioning of an individual within a period of the past one or two years.

The literature shows that the logic of the different structural levels is applied based on different theoretical foundations. Kernberg's structural interview (Kernberg, 1977, 1981), for instance, distinguishes between a neurotic, borderline, and psychotic structural level and offers a descriptive operationalization of the levels which define themselves, above all, via the concepts of identity, defence, and reality testing. In a different context, Kernberg distinguishes different structural levels (higher level, intermediate level, lower level, psychotic) using the assessment criteria of superego, ego identity, reality testing, drive development, defence, character features, object relationships, and affects (Kernberg, 1970, 1998, 2001). A differentiated system based on a similar psychoanalytic logic is described by Lohmer and colleagues (1992). It is their aim, too, to enable a distinction between neurotic structure, moderately integrated structure, and borderline disorders, by way of assessing the type and pathology of the object relations, ego structure, and defense mechanisms, superego development, quality of anxiety, and doctor-patient relationship.

The gradation of structural levels which OPD suggests distinguishes four stages:

- High level of structural integration
- Moderate level of structural integration
- Low level of structural integration

- Disintegrated level of structure.

For the operationalization of the different structural levels the reader is referred to section 4.4.2. The Structure Check List (Rudolf et al., 1998) which was developed for research and training purposes, has been adapted for OPD-2 and is published in section 13.4.

3.4.7 Structural diagnosis

The structural patterns that are available in the patient become manifest in interactional behaviour. For the diagnosis this means that the interviewer experiences parts of the structure of her patient in the immediate situation of the therapeutic encounter, and that, from the patient's description of his daily life and life history, she gains a picture of his structure. A structural diagnosis is facilitated by the option of speaking with the patient about the availability of his structural functions and lets the patient himself provide a picture of his typical experiences and behaviours.

The recognition of mental structure is by necessity linked to communication and interaction. The prerequisite for an assessment of structural aspects is the diagnostic interview which allows a self-presentation of the patient in relation to the interviewer. In order to reflect the phenomena and be able to interpret them, the examiner must have a basic knowledge of the theory of personality, and also have gained diagnostic experience. If feasible, she should have self-experience in order to be able to switch, in the experience and judgement of her own countertransference, between observation and introspection.

The diagnostic assessment of structure is not oriented to disorders that have reached the clinical level of illness, but on the underlying structural potential which can be inferred from the patient's interactions within the last one to two years; acute disorders do not automatically determine the assessment of structure, they rather have a role of indicators for structural potentials.

3.4.8 Experiences with the structure axis and its further development leading to OPD-2

When it became clear, as early as the first therapy studies, that OPD diagnostic findings under psychotherapeutic treatments did not show massive change (cessation of conflicts, marked increase of structural level), the Heidelberg study group started to employ the logic of focus-related restructuring (Grande et al., 2000; Grande et al., 2001). For this purpose OPD foci from the relationship, conflict and structure axes are defined and assessed as to the intensity of the therapeutic processing, their coming into awareness, the responsibility being taken for them, and their possible integration. This happens with the help of the Heidelberg Structural Change Scale (Rudolf et al., 2000). Restructuring not only means a change in the area of structure, but refers to a verifiable change of the overall organization of the personality, i.e. on all OPD axes.

The definitions of the OPD structure axis and the relevant instruments allowed a more thorough diagnostic registration of structural problems in the area of clinical psychotherapy; it focused attention on a goal-directed psychotherapeutic working-through of these topics, so much so as to complement the central emphasis that rests on such conflict-centered psychodynamic therapies, with structure related

dynamic psychotherapy. The experiences thus gained were put into practice and conceptualized on several occasions (Horn/Rudolf, 2002; Rudolf, 2002b, 2002c), and finally published as a therapy manual for an OPD-based, structure-related psychodynamic therapy (Rudolf, 2004b). Tailored to the topic of structure, the book in question already contains some important aspects of OPD-2, in particular the therapy plan, and the focus-related carrying out of the therapy based on the OPD diagnosis. In this context clinical experiences with forensic patients were incorporated into a revision of the structure checklist, and here especially, in the area of the disintegrated level (Rudolf, 2004b).

3.4.9 Similarities and differences of the structure axis in OPD-1 and OPD-2

Of the six structural dimensions of OPD-1, the first three related to the self (self-worth, self regulation, defence), and the remaining three referred to the relationship with objects (object perception, communication, attachment). The 21 structure-related items of the Heidelberg Focus List were assigned to these dimensions. Dealing with these structural foci in practice and the experiences of focus-related psychotherapy in particular, made it advisable to rethink the inner coherence of the items. The result took the form of a systematic approach which lists four fundamental structural dimensions: the ability to perceive, to regulate, to communicate emotionally, and to relate to objects; each dimension includes a self and object-directed focus (Rudolf, 2004, p. 161). What was taken out was the structural function of defence, observation of which is less close to behaviour and has to be assessed in a more theory-led fashion. It now appears in section 14.3 as a complementary module.

The framework that was thus constructed, with its four structural dimensions directed towards the self and the object, could now easily absorb the focal points of OPD-1, some items were added. First experiences with this system led to minor reorganizations of content for the final version of OPD-2 compared to the 2004 publication. They were done with the aims of OPD-2 in mind, to take into account all those characteristics which are relevant for the planned psychotherapy treatment.

3.5 Axis V - Mental and psychosomatic disorders

3.5.1 Introduction

Axis V intends to diagnostically reflect the syndromal-descriptive diagnoses in accordance with chapter V (F) of the ICD-10. For this purpose, the "research criteria" must be applied for clinical documentation and clinical-scientific issues. In order to maintain compatibility with the operationalized concept of the DSM system, an approach was chosen which provides for the ability to record mental disorders on Axis Va and personality disorders (categories F60 and F61) on Axis Vb. To meet the special requirements of psychosomatic medicine and psychotherapy, the classificatory approach for psychosomatic disorders (category F54) has been extended and differentiated.

3.5.2 Theoretical background

Chapter V (F) of the ICD-10 (Dilling/Freyberger, 2001; Dilling et al., 1993; Dilling et al., 1994; WHO, 1993a, 1993b, 1993d) operationalizes the area of mental disorders

in accordance with descriptive principles on the basis of simply defined criteria, comparatively speaking, in terms of psychopathology, time and course of an illness.

In these characteristics the emphasis is very clearly on data which are relatively easy to observe and explore. More complex pathological phenomena or aspects of experiencing which might require a higher degree of theoretical or interpretative abstraction are, to a large extent, neglected. In certain combinations those criteria constitute single diagnoses, provided that certain sets of rules (algorithms) are followed. Subdivisions according to degree of severity are solidly anchored, at least within the affective and anxiety disorders, as an integral part of diagnostic rules of connection. Diagnostic remainder categories (Fxx.8x and Fxx.9x), which can diagnostically reflect patients to whom no specific disturbance can be assigned, become, in an hierarchical gradation system, an integral part of this classification approach.

The classification systems of the DSM-III and IV not only abandoned the concept of neuroses, but moreover, they established a classification system that is strongly oriented to biological-psychiatric principles, which neglects the validity of diagnostic criteria in favour of their reliability (Schneider/Freyberger, 1990; Schneider et al., 1995; Schneider/Hoffmann, 1992). Not least because of clearly improved reliability (Freyberger et al., 1990a; Freyberger et al., 1995; Freyberger et al., 1990b; Schneider/Hoffmann, 1992), this kind of approach leads to a better communicability of diagnoses, as well as to a more precise recording of the symptomatology (Freyberger et al., 1992; Stieglitz et al., 1992), a fact that secures, at least for the scientific application, a better comparability of samples taken in the various areas of psychological medicine.

In accordance with the different areas of application the ICD-10 offers its availability within a so-called "family of instruments" in the shape of diverse ICD-10 manuals and instruments, which are also relevant for the area of psychotherapy and psychosomatic medicine:

1. as so-called clinical-diagnostic guidelines for clinical use, which, due to their relatively openly formulated diagnostic criteria ("guidelines"), leave the user some diagnostic space.
2. as so-called research criteria for the scientific application, comparable to the DSM-III-R (APA, 1987), or the DSM-IV (APA, 1994), which, via stricter diagnostic criteria, are intended to contribute to a stronger homogenization of samples.
3. as a so-called short version for adminstrative use within the framework of the systematic list of the complete ICD-10 (WHO, 1993d). This text offers, in addition to short descriptions of Chapter V (F), the diagnostic categories for the other (somatic) chapters of the ICD-10, so that a coding of somatic illnesses becomes possible.
4. as a so-called Primary Health Care Classification (PHC) for use in primary health care (Müßigbrodt et al., 1994; WHO, 1993c). In addition to diagnostic criteria, this manual formulates therapeutic guidelines for 24 diagnostic main groups.

Further to this, there are numerous structured (e.g. "Schedules for Clinical Assessments in Neuropsychiatry (SCAN", (Gülick-Bailer-von Maurer, 1994; WHO,

1993e) and standardized (e.g. "Composite International Diagnostic Interview (CIDI)", (WHO, 1991; Wittchen/Semmler, 1992) diagnostic interviews with which the complete area of mental disorders and specific fields of mental disorder (Mombour et al., 1994; Zaudig/Hiller, 1993) can be recorded, and which, in part, allow a computerized diagnosis. While these interview approaches may bring undeniable advantages for scientific studies, their particular symptom orientation in the recording of diagnostic characteristics leads to a reduction in the significance of psychodynamic material, including an at least partial exclusion of the relational aspect, with the respective consequences for both the treatment process and for training. But the level of symptoms, in this context, represents a relevant diagnostic dimension. It allows the formulation of hypotheses about the type and nature of the illness and, in the context of psychotherapy, is an important variable to be considered. Even though our therapeutic work is not primarily symptom-orientated, symptom reduction is a relevant treatment aim within psychoanalytically-oriented psychotherapy. In line with this symptom and syndrome orientation, ICD-10 follows the descriptive approach also in its internal structure. The classification uses an alpha-numerical system: while the letter F is used to denote the psychiatric chapter within the whole ICD-10, the chapter paragraphs which list the groups of disorders under theoretical and phenomenological aspects, are described with an initial digit (Fx):

- F0 Organic, including symptomatic, mental disorders
- F1 Mental and behavioural disorders due to psychoactive substance use
- F2 Schizophrenia, schizotypal and delusional disorders
- F3 Mood disorders
- F4 Neurotic, stress-related and somatoform disorders
- F5 Behavioural syndromes associated with physiological disturbances and physical factors
- F6 Disorders of adult personality and behaviour
- F7 Mental retardation
- F8 Disorders of psychological development
- F9 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

A third digit (Fxx) denotes the main diagnostic group (e.g. F40 phobic disorder), a fourth digit, separated by a full-stop, the diagnostic category (e.g. F40.0 agoraphobia), and a fifth one is used to indicate a further differentiation, often by reference to degree of severity (e.g. F40.00 agoraphobia without panic disorder).

3.5.3 Multiaxial diagnosis in psychiatry

The World Health Organization (WHO) has presented its own multiaxial system for the psychiatric area and added it to the ICD-10 (Siebel et al., 1994, cf. table 3-1). On axis II, it provides for a scale-related recording of impairments in social functioning in different areas (in accordance with the WHO Disability Diagnostic Scale: WHO-DDS). Following concepts from life-event research, Axis III is intended to reflect environment/situation-dependent influences and problems related to life-style and life-management difficulties which are related to the origin and maintenance of symptoms. They were compiled from chapter (Z) "Factors influencing health status and contact with health services" of the ICD-10.

DSM-IV puts into practice analogous axes. Axis II of ICD-10 finds its correspondance in the Global Assessment of Functioning Scale (GAF) which had already been part of DSM-III and DSM-III-R, but which has now been modified. Axis III of ICD-10 finds its correspondance in an analogous coding schema of the DSM-IV for psychosocial and environment-related problems. In the appendix of the DSM-IV additional axes were published (Defense Functioning Scale; Global Assessment of Relational Functioning Scale, Social and Occupational Functioning Assessment Scale). These axes should be used in case comparability with psychiatric reference samples is to be ascertained in specific research issues (see also Mezzich, 2005).

3.5.4 Construction and operationalizations of Axis V in OPD

It was the aim of the working group to adapt Chapter V of the ICD-10 in its current version to the diagnostic requirements in psychiatry and psychosomatic medicine. The particular emphasis here was to avoid the introduction of changes so as not to endanger the better communicability and comparability of diagnoses which this operationalized approach would allow. Therefore, the elaboration of new concepts became necessary, both for purposes of diagnostic indications and documentation, and for further differentiation of problematic diagnostic categories.

3.5.4.1 Making diagnoses and the principle of comorbidity

Generally, ICD-10 follows the rule to code as many diagnoses as are necessary for the description of the clinical picture. As a main diagnosis, that category must be coded which is of the greatest current importance, or which as a so-called "life-time diagnosis" is of the highest relevance. Further diagnoses in the sense of additional or supplementary diagnoses are thus explicitely desired (cf. Dilling et al., 1993).

In the context of the comorbidity principle this implies, as has been shown in broader application studies on the ICD-10 (Dittmann et al., 1992; Freyberger et al., 1995; Schneider et al., 1993) that the average number of descriptives per patient diagnoses is about three to four, in extreme cases eight to ten, without any etiological or pathogenetic concepts being incorporated in a theoretical frame of reference. This appears problematical, for instance in the area of personality disorders, where, due to overlapping criteria, often several categories are satisfied, or, where numerous additional diagnoses must be made, which, according to the classical understanding, are inherent in the disorder in question.

In order to document main and additional diagnoses in the area of psychosomatic medicine/psychotherapy no more than three further diagnoses should be coded, next to the main diagnosis, so that clinical use can be warranted. The main diagnosis, principally, should be one which has the highest relevance from a clinical and psychodynamic point of view. Further diagnoses should only be coded if they contribute substantially to an understanding of the overall picture, or if they describe aspects that modify the course of the illness. For research issues where, following the comorbidity principle, a comparability with psychiatric examinations is desired, it is suggested to code up to five additional diagnoses and to proceed according to strictly descriptive principles. Only in this context should the use of diagnostic instruments be considered, so that in addition to the above mentioned interviews, one might select so-called diagnoses check lists which can be used post-hoc (cf. for instance Dittmann et al., 1995; Hiller et al., 1990; Stieglitz et al., 1992). While for clinical documentation clinical-diagnostic guidelines should be used,

research issues, in turn, where homogenization of samples is of relevance, require the application of the research criteria. For the documentation of physical illnesses the systematic classification list of the ICD-10 is available (DIMDI, 1994).

Contrary to the DSM-III-R (APA, 1987) and DSM-IV (APA, 1994), the ICD-10, for clinical use, prescribes simultaneous coding of diagnoses for mental and somatic illnesses on one axis, while the DSM system uses separate individual axes for both somatic and personality disorders. In order to warrant comparability with the DSM approach especially for scientific use, syndromal ICD-10 diagnoses are coded here in the OPD on Axis Va, personality disorders after ICD-10 on Axis Vb, and somatic illnesses on Axis Vc. In all, no more than two personality disorders of the ICD-10 categories F60 and F61 should be diagnosed, whereby here, too, main and additional diagnoses must be differentiated. This approach is compatible with developments in the field of the (psychatric) multiaxial ICD-10 diagnosis, where there appears to be an increasing prevalence for this type of classification. In this context the documentation sheets must separately specify whether, clinically, Axis Va or Axis Vb is more relevant.

With the approach of the multiaxial system of Operationalized Psychodynamic Diagnosis in mind, it must be pointed out, though, that personality disorder diagnoses according to ICD-10 should be used in a purely descriptive manner, so that they will have to be recorded in parallel with the structural diagnoses of Axis IV. In a psychoanalytic understanding, these descriptive diagnoses serve essentially to record persistent disturbances in social behaviour.

In order to enable a simultaneous recording of DSM-IV diagnoses for research purposes, the option to code additional diagnoses according to the DSM-IV was included in the documentation sheet. As concerns the order and weighting of the diagnoses the same procedure as with the diagnosis according to ICD-10 should be followed.

3.5.4.2 Prerequisites for Axis V diagnosis

As application and reliability studies have shown so far (cf. for instance Dittmann et al., 1992; Freyberger et al., 1990a; Freyberger et al., 1995; Schneider et al., 1993), a training is required for the appropriate and reliable use of the descriptive diagnosis in accordance with ICD-10. Such training may be self-provided and completed within working groups, whereby under the condition of an in-depth knowledge of the respective manuals patients should be diagnostically assessed and discussed, in exemplary fashion, for each individual ICD-10 section, either by way of live-interviews or video recordings of diagnostic interviews. A number of supplementary materials, the use of which may be considered in seminars (Freyberger/Dilling, 1993; Freyberger et al., 1993a, 1993b; Schneider/Freyberger, 1994), are now available for this purpose. Additionally, several working groups offer ICD-10 training seminars (contact: H.J. Freyberger or W. Schneider) in which the descriptive diagnosis can be systematically trained according to a curriculum developed for the purpose.

3.5.4.3 Prospective development of the ICD and DSM diagnosis

Since the publication of ICD-10 and DSM-IV numerous other studies on reliability and validity of the diagnostic categories contained in the systems have been published. Both the American Psychiatric Association (APA) and also the World

Health Organization have meanwhile established international working groups which sift through existing empirical findings and are called to devise revision proposals for ICD-11 and DSM-V (Mezzich/Berganza, 2005). Not only are numerous changes, especially of diagnostic criteria and individual categories of disorder, being brought about; in addition, some conceptual changes relevant for psychosomatic medicine and psychotherapy are becoming evident in the following areas: what emerges not only in the area of personality disorders (cf. Widiger/Simonson, 2005), but also for the classification of anxiety, depressive, and somatization disorders is that in addition to the categorcal approach of the systems, dimensional models will be aso used. This very likely will include an increased consideration of so-called sub-syndromal disorders, as they have already been introduced, for instance into ICD-10, with the categories of mixed anxiety and depressive disorders (F41.2 and F41.3), as well as the recurrent brief depressive episodes (F38.10). Especially in the area of multiaxial diagnosis it seems highly likely that approaches will be presented which allow the recording of health resources which are very relevant for the course and treatability of mental disorders (Mezzich, 2005).

3.5.5 Supplementation and clarification of diagnostic ICD-10 categories in connection with OPD

In three areas supplements to the ICD-10 diagnosis were introduced with regard to psychosomatic medicine and psychotherapy. In the category of specific personality disorders (F60) narcissistic personality disorder was added unter code F60.81 because of its particular theoretical as well as clinical relevance. In order to safeguard the internal consistency of the descriptive classification approach of the ICD-10, the diagnostic criteria of the ICD-10 research criteria manual were applied.

The second supplement refers to a further differentiation of the category F54 (Psychological and behavioural factors associated with disorders or diseases classified elsewhere) which is designed to describe the psychosomatic illnesses in a more specific sense within Chapter V of the ICD-10. The concept pursued by the ICD-10 here is to classify these illnesses primarily within the somatic chapters. Category F54, which is not further subdivided, is to be used as a secondary category in cases where mental disturbances contribute to the clinical picture which do not meet the criteria of another mental disorder of Chapter V. The concept we developed following a suggestion by v. Wietersheim and Jantschek (1994) suggests the use of the first three digits of category F54, designate symptom selection with the fourth digit, and then to employ the fifth digit to classify the kind of psychosomatic interaction. In this way we intend to obtain, on a descriptive level, better differentiated diagnostic statements not only about the symptoms displayed, but also about etiological and pathogenetic interrelationships. Empirical studies could provide evidence if and to what degree an approximation to biopsychosocial and psychodynamic models can be achieved.

The third supplement refers to a broader understanding of adjustment disorders and post-traumatic stress disorders. In adjustment disorders and post-traumatic stress disorders a close relationship in time exists between the onset of the disorder and

a) a traumatizing event of extraordinary severity (diagnostic guidelines ICD-10), or
b) a significant life change or a stressful life event, or also a severe physical illness ("adjustment disorder" in accordance with ICD-10).

The two disorders thus differ with respect to the severity of the individual stresses that precede them. In both disorders, however, individual vulnerability plays a decisive role: even in severe traumatizations not everybody affected develops a post-traumatic stress disorder, in the same manner as considerable physical and mental strains (e.g. acute heart infarction) do not lead to a (depressive) adjustment disorder in everybody, but only in about 20 to 30 per cent of the population thus affected.

In cases of traumatic stress by acute danger to life, helplessness, and loss of agency, a collapse of the defensive function and a structural regression ensue, which, however, in their turn depend on the premorbid personality constellation. Under these aspects the traumatic trigger situation is comparable across individuals, leading to short-term reactions in everybody affected by it. The development of a post-traumatic stress disorder, however, must be understood against the background of the individual's potential to process and cope with the related stresses.

Adjustment disorders with their physical and/or mental symptoms follow the occurrence of relatively severe external events which, however, have not reached the extent of an existential traumatic threat. The internal vulnerabilities and resources of a patient, even more so than in cases of post-traumatic stress disorders, form the preconditions for an adjustment disorder. The probability of an adjustment disorder occuring is therefore determined by:

1. the extent of inner motivational conflictual tension and of external stresses
2. the available (vulnerabilities) defensive structure, resilience, social support, and other.

Generally, a reduced tolerance to stressful events is referred to as vulnerability. It is determined, first, by motivational conflictual tension, second, by the developmental history of an individual's structural abilities, third, by the social network as well as fourth, by the individual biological conditions of a person (e.g. innate mild mental retardation), processes of dementiq in old age, and so forth). The motivational conflict-related vulnerabilities referred to here may interlock with the structural and biological ones. A diverse set of conditions may therefore contribute to the development of an adjustment disorder, it can, however, also arise due to only structural or biological vulnerability. Very substantial to most severe stresses lead to adjustment disorders in many individuals, in the sense of a stressor-induced conflict (conflictual stress), that is to say, what transpires clinically is a conflictual motivational contradiction - which however, is consequent to the stress rather than to a repetitive dysfunctional conflict pattern.

The ICD-10 reserves the diagnosis of adaptation disorder (depressive adaptation disorder, anxious adaptation disorder) for cases where no "... symptom is clearly predominant, and neither type of symptom is present to the extent that justifies a diagnosis if considered separately". In other words: if depressive symptoms of medium severity exist, the diagnosis that should be used, consequent to this

diagnostic prescription, is that of depressive disorder - not adjustment disorder - , that is to say, adjustment disorders represent a remainder category, as a rule of lesser severity. This diagnostic procedure is simply wrong empirically, that is to say, in cases where an adjustment disorder and depressive symptoms of medium severity co-exist, the diagnostician should be able to use the diagnosis of adjustment disorder, which, according to the ICD-10 logic, is not possible. Adjustment disorders, in accordance with the ICD-10, are therefore always considered "mild" disorders.

As a matter of principle, when using both ICD-10 and OPD diagnostic systems, care should be taken not to automatically "cross diagnose", meaning that not every obsessive personality disorder according to ICD-10 simultaneously shows low structural integration (OPD Axis "structure"). Rather, a diagnosis of personality disorder must also comprise the conflictual background and the precipitates it has had onto the personality.

3.6 Conceptual cross-references and interactions between the axes

3.6.1 The process of compiling the diagnostic material and its integration

Two opposite trends or movements can be traced in the diagnostic process based on OPD. The first path towards the compilation and recording of the diagnostic material starts out with aspects which relate to the patient's basic accessibility to diagnostic exploration and which are part of what is described on Axis I as "experience of illness and prerequisites for treatment". Of importance here are, for example, the patient's conception of illness and his psychological mindedness. The investigation then proceeds to the patient's relationship experiences which are of central importance for diagnostic access to psychodynamic issues, and for the detailed exploration of which the OPD interview offers step-by-step guidance. Not only from the patient's descriptions of his relationships, but also from his directly observable handling of the relationship can his typical interpersonal enactments or arrangements then be inferred, which are depicted on Axis II. These relationship patterns represent, as it were, a surface where his conflict potentials show up, which he copes with in compromise-like fashion in his encounters with others. The quality of such engaging or coping eventually directs one's view to the patient's functional capacities, that is to say his structural possibilities and limitations which set a more or less solid framework for the dynamic interplay of psychic forces.

The second path towards the integration of diagnostic material leads in the opposite direction. It begins with the structural prerequisites. In the authors' view they represent a fundamental diagnostic dimension which to a very large extent (co-)determines the quality and character of the other characteristics described by the OPD. The extent of the structural limitation influences and limits the weight that conflictual dispositions the patient has acquired in his development are accorded in the origin and maintenance of complaints. It determines the habitual relationship patterns which, at higher degrees of structural limitation, become increasingly inefficient and brittle so that any establishment of a permanent relationship is eventually doomed to fail. The state of an individual's structure determines further whether the "illness" is meaningful in the sense of neurotic symptom formation, or whether the type, variety, intensity, and fluctuation of complaints indicate the impairment of basic mental functions and that an

individual's regulation capabilities are constantly being overworked. All of this eventually touches on the preconditions and possibilities of a psychotherapeutic treatment which must be strictly tailored to the nature and severity of the structural difficulties.

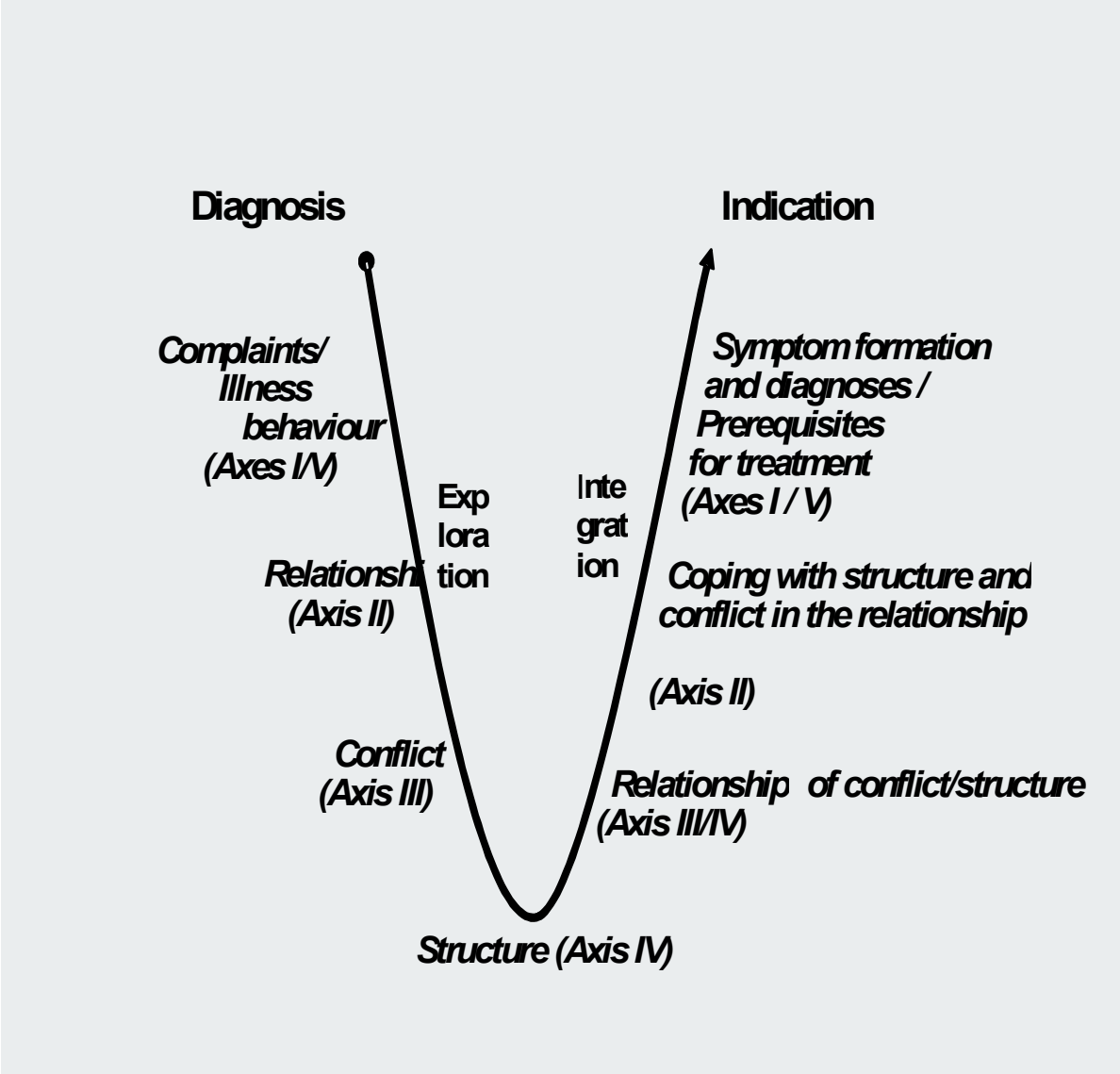


Figure 3-3: Compilation and integration of diagnostic material

Legend: Representation of the diagnostic process, starting top left with the compilation and recording of the diagnostic material, down to the investigation of the structural prerequisites, then from the base proceeding upwards to the integration of the axes-related findings into a coherent overall picture as the foundation for indication.

3.6.2 On the interrelationship of the axes

Conflict and structure (the relationship between Axes III and IV)

As already set out, the conflict diagnosis in the OPD is based on a continuum model which distinguishes clinically relevant conflicts from so-called conflictual themes (see 3.3.1). The choice of the term conflictual theme acknowledges the fact that, in a low or disintegrated structural level of mental functioning, areas of conflictual tension may be found, yet are of no decisive importance for the disorder, as they would be for instance in cases with better stuctural integration. They often are of a varied content and lack a clear shape, are very likely changing in importance during the diagnostic interview, and are lacking a clear, permanent "Gestalt". It is with reference to such phenomena that we speak of conflictual themes instead of life-determining conflicts, thus toning down the meaning somewhat. To classify a conflictual issue as a life-determining neurotic conflict in turn presupposes the predominance of internalized, unconscious conflicts which lead to dysfunctional experiencing and behaviour and even symptoms, and the availability of capabilities like those of basic affect regulation and self-control (Fonagy, 2005). Conflict and structure represent the poles in a clinical complementing series (Mentzos, 1991).

Similarly, as in the conflict diagnosis, a continuum of structural integration can be put forth, with the poles of safe availability on the one hand, and severe impairment of structural functions on the other. In cases where a patient can avail himself of these functions without problems, they tend not to elicit diagnostic interest and instead form the backdrop for the conflictual happening which is the predominant focus of attention. If those functions are, however, limited, or fail altogether, the diagnostic perspective is redirected from a focus on the contents of the conflictual-dynamic occurrences (the unconscious motives, anxieties, and defences) to the patient's structural capabilities. Conflict and structure relate like content and form, that is to say, one refers to the "why" and the other to the "how" of a disorder. If the structure is solid, content and meaning dominate, if it is fragile, the impaired functional processes come to the fore.

The metaphor of the stage (Rudolf/Grande, 2002) illustrates the above: Imagine a visit to the theatre not knowing what the play is about. In this case one would instinctively try to find dramatic content which explains the acting of the persons on stage, that is to say, the conflicting motives and strategies of action of the protagonists. This corresponds to the conflict orientation. As a matter of course, one presupposes that the performance is not being disturbed, let alone determined by influences which have nothing to do with the content of the piece, as might be: unsupported sets or wings which must be avoided, wrongly placed or breakable furniture, unprepared or unsuitable players, etc.. In the case of a structurally caused set of problems, the search for a dramatic action which would make what happens on stage understandable, would fail. One would continously be irritated by occurrences that don't fit in and would finally realize that a performance was being attempted, which, however, was disrupted by functional impairments of the set or the protagonists in such a way as to prevent the content/s from ever becoming conclusive. This would be the moment where those framework elements are pushed into the foreground which are otherwise taken for granted to form the background of the action, and which are to support the action without any problems. This corresponds to a structural orientation.

If a disorder is present, dysfunctional conflicts and structural impairments may be responsible for it in different ratios. If the structural problematic on the low or disintegrated level of structure predominates, signs of conflict must frequently be attributed to so-called conflictual themes which (figuratively speaking) are merely "the attempt to stage a play" and contribute little to an understanding of the disturbance. Conflictual demands may play a role here in that they make the structural problems apparent, if individual structural functions are called upon and overexerted in the process; as a cause for such overexertion they are, however, diagnostically secondary in comparison to the vulnerability of structure which they reveal, and which is the patient's actual problem. With higher structural capabilities the importance of conflicts increases, which then (as a latent script so-to-speak) gradually determine more and more what happens on stage, thus rendering it meaningful and understandable. Mixed forms, which may place high demands on the diagnostician, are of course most frequent. However, the structural levels and types of conflicts as defined in the OPD cannot be combined at will. As Grande and colleagues (1998b) show in a study of 100 outpatients, specific OPD conflicts (above all dependency versus autonomy) occur at a lower level of structural integration and are thus diagnosable also "when the set is brittle", while other conflicts are only encountered in a moderate (e.g. care versus autarky) or high level of structural integration (oedipal conflicts).

The stage metaphor characterizes the structural state of a patient as a more or less unilateral precondition for a potential shaping of conflictual events. From different vantage points, however, conflict and structure tend to appear, rather, as mutually contingent. This applies first of all from a developmental aspect. It is to be assumed that certain ways of processing conflicts - e.g. psychosocial arrangements, avoidance, or rigid defenses - lead to an insufficient development of structural functions or, over the course of time, to their restricted availability. Restrictions which, at one point in time, appear as a conflict solution in the sense of compromise formation, may later be a sign of a structural incapability (i.e. of an impaired or underdeveloped mental function). For the diagnostician's task this type of interaction is, however, not relevant. She basically reflects the result of such processes and examines, as concerns the actual state of a person, whether functions that are, in principle, available are only impaired due to conflict, or whether they are absent in the repertory of structural functioning, or of limited availability.

A further aspect is addressed by the consideration that structurally impressive limitations may equally well be understood in a conflict dynamic manner, in cases where structural capabilities are overexerted through especially hefty conflicts, or where vulnerable areas of structure give way under pressure from conflicts. Even an intact stage is not armed for all types of plays. An even further-reaching idea is contained in the fact that structural capabilities may be given up as part of an unconscious, active display of coping or defensive functions, in order to regressively reach, in this way, an (essentially neurotic) conflict solution (harking back to the concept of ego-regression, Freud, 1916). These models have considerable consequences for the practice of psychotherapy if they imply that via a conflict-related, that is to say, interpretative approach structural functions can be restored, which also implies that the principle availability of these functions must then be assumed. Although such differentiation in the individual case may be difficult, the structural diagnosis of the OPD, quite unlike those models, proceeds on the basis

that, in a conflict-caused limitation of function, it must be possible to show positively that a patient is fundamentally able to exercise structural functions. This usually succeeds in areas which are less burdended with conflicts. In situations where a massive conflictual occurrence is assumed, one should look for, as it were, individual "windows" in the diagnostic material, through which it can be observed, in an exemplary manner, what a patient is actually capable of. The better the visible capabilities, the more extensive the area of those limitations will become of which it may safely be assumed that they are not the signs of structural impairment, but are (unconsciously) caused by the patient's handling of his inner conflicts.

On the mastery of conflict and structure in relationship patterns (The relationship with Axis II)

In our understanding habitual relationship patterns which, from an outside perspective, appear dysfunctional, are primarily measures of adaptive regulation in human relationship, used by patients in an attempt to cope with not only their conflictual tendencies, but also their structural vulnerabilities. The aim here is to control interpersonal situations in such a way as to achieve the greatest possible degree of satisfaction of interpersonal needs and interests, while at the same time securing sufficient protection for the self. The resulting habitual relationship behaviour is often conceptualized as a compromise formation between wishes and anxieties (for example, Luborsky, 1988). From the point of view of the Operationalized Psychodynamic Diagnosis it must, however, be taken into account that protective measures not only refer to those anxieties due to conflictual wishes, but also to anxieties and tthreats experienced on the basis of structural conditions (Rudolf, 2000). Furthermore it must be considered that the patient, in his relationship behaviour, possibly copes with different conflictual dispositions and/or structural sensitivities at the same time. If these possibilities are taken into consideration, a number of principles result which effect the shaping of relationship patterns:

Simple compromise formations: In primarily conflict-based disorders relationship patterns can be understood as a compromise formation between a wish and the related anxiety. For example: A patient experiences unconsciously his wish to be cared for as unacceptable to others, and, fearing their rejection, presents himself as particularly self-reliant. His compromise formation lies in the fact that he intensely cares for others, while unconsciously expecting to acquire, for himself, an indirect right to care and attention.

Interlacing of conflicts: More complex constellations which have the character of a compromise formation arise when two or more conflictual dispositions are interlaced. In the example above, if there is an additional conflictual theme in the area of control, or submission, the altruistic attitude the patient displays might well appear as subservient and dutiful, while his helping behaviour towards others might, at the same time, fulfil unconscious needs for control.

Protection of structural vulnerabilities: In structurally-caused disorders relationship patterns can have the task of protecting especially vulnerable aspects of a patient which are touched on in the encounter with others. These patterns, too, can be described as compromise formations; they tend to occur, however, in situations where object-related needs of any kind are conflicting, in unspecific

ways, with anxieties and threats which arise by overexerting the structural functions in the contact with other people. Anxieties of this type come up, for instance, in situations likely to bring about closeness, dependency, and intimacy, or in the reverse case when there is a threat of unavailability of important objects. In addition, such demands in general represent a stress test for the structural function.

Interlacing of conflict and structure: A further clinically important constellation comes about when structural weaknesses are compensated for by resorting to relationship figures which, at a first superficial glance, appear to be primarily conflict-motivated. In a relationship pattern, for instance, that is governed by the theme of control, it may be easily overlooked that the constant power struggle is a very effective way of coping with structure-related fears of closeness (e.g. insecure self-object differentiation). Structural limitations are frequently also linked with massive problems of self-worth, so that motives connected to this (envy, resentment, rivalry) may imprint a conflictual appearance on the relationship.

In the analysis of dysfunctional relationship patterns it must further be considered that patients, in their coping efforts, can only resort to those capabilities that are structurally available to them. A relationship pattern, for instance, which is characterized by a marked conflict in the area of submission/control may be expressed in distinctly different ways depending on how well the capacities for empathy or impulse control are developed. A patient's level of structural development thus has a twofold influence on how he handles his relationships: one, via the vulnerabilities which must be protected in the encounter with others, and two, via the functional capabilities he can employ to master not only conflictual dispositions, but also structural vulnerabilities.

As various authors have shown, relationship patterns function like maladaptive feedback loops (Schacht/Henry, 1994; Strupp/Binder, 1984). These loops condition their own stability, insistence, and resilience towards any attempt at change. At the core of these loops are unconscious, dysfunctional convictions regarding one's own person and other people which have solidified as the result of the individual developmental history and which work, so-to-speak, as a lead sample: relationships are unconsciously arranged in such a way as to make the other person confirm the unconscious conviction (Anchin, 1982; Strupp/Binder, 1984). This view is complementary, in an important way, to the principles set out above, because it explains the origin and maintenance of dysfunctional relationship patterns, as it were, 'in situ'. In the case of severe structural impairments it is to be expected, though, that the maladaptive loops appear more disorganized (e.g. more volatile and changeable), because emotional self-control fails more quickly depending on the situation, and abrupt defensive reactions become necessary. Cases of a clear lack of structure may then give the impression that a well- formed, repetitive type of relationship pattern barely exists, but rather, that what is diagnosed in such cases is a pattern of abrupt terminations of relationships which keep repeating over and over.

The formation of symptoms (The relationship with Axis V: "Mental and Psychosomatic Disorders")

Based on what has been said so far, the following ways of symptom formation can be described (cf. also Rudolf, 2000, p. 137). For the individual case we must proceed

from the assumption that several of these principles have a joint effect and that symptoms are thus multiply determined:

- In disorders with a conflict-dynamic background, a differentiation must be made between a neurotic, conflictual personality and individuals with repetitive-neurotic conflicts. In the conflictual personality we find clear signs of motivation-based tension which gives rise to a permanent clinically relevant impairment of experiencing and behaviour, for instance, because strong attitudes of avoidance, rigidity, or fearfulness. The narrowing of experiencing, interpersonal relationships, and scope for action that come with it can be so considerable as to gain the quality of a symptom. An example here would be an obsessive personality disorder with an absence of symptoms, but with relevant impairment of experiencing and behaviour. An important aspect of the conflictual personality is the characteristic habitual, dysfunctional relationship pattern that copes with conflict-related wishes and anxieties in a compromise fashion, whereby the manner in which this coping happens has the quality of a symptom.
- The traditional neurotic conflict is accompanied by clinical symptoms which have an intrapsychic or/and interpersonal effect. Temptations and refusals, just as threshold situations and situations with internal or external triggers (trigger situations) lead to an increased motivational ambivalence and thus to a weakening and collapse of a balancing that had been successful up to that point. Symptoms form which can be understood as compromise formations between the conflicting forces (wishes, anxieties, and defences), and which therefore, from a psychodynamic point of view, show the positive aspect of successful adaptation.
- In the context of a structural disorder, those characteristics that cannot be "masked" by coping may, under certain circumstances, and if considered individially, take on symptom quality. Among these are impulsive outbursts, affect flooding, distortions in object perception, or a proneness for suffering hurts. These kinds of symptoms are, above all, frequently present in the so-called "dramatic" personality disorders (DSM-IV, Cluster B), for example in the borderline personality disorder.
- Structural vulnerabilities are rarely found on the surface, as they are reshaped and thus made acceptable by processes of working-through. As described in the last paragraph, such working-through processes aim centrally at regulating the interactions with others in a way that guarantees sufficient protection for the self and its sensitivities. The processing patterns developed in this manner may, however, shape behaviour and experiencing in a way that has itself symptom quality. This is the case, for instance, in relationships of a schizoid or narcissistic type. In contrast to the above-mentioned concept of the "conflictual personality" we are here dealing with defensive ways of coping designed to protect structural vulnerabilities, whereas the conflictual personality presents itself as a complex, characterologically solid form of compromise formation into which active, drive-related or wish-based strivings and their defences are incorporated. The possible interlacing between structural sensitivities and

conflict potentials in habitual relationship patterns was described in the previous paragraph.

- Finally, as Rudolf (2000, p. 137) points out, symptoms often arise because of a weakening of the coping mechanisms. Coping through compensation is costing energy and strength, leads to exhaustion over time and therefore is not able to withstand the unavoidable changes and stresses during the course of a lifetime. The collapse of the coping capacity leads to the formation of diverse symptoms: for example, acute and dramatic symptoms as in a suicidal crisis in narcissistic personalities, or perhaps to chronic symptoms, for instance in patients with a somatization disorder.

If the acute stresses that cause the coping mechanisms to collapse are exceptional or extreme, we may validly assume that a clinically manifest disorder would not have developed without the outer event. In this case one has to diagnose an adjustment disorder in the sense of a conflictual stress (or a stressor-induced conflict, respectively), that is to say, the stress brings about a motivational contradiction which, in consequence, is followed by an illness. In line with the OPD's concept of stressor-induced conflict this presupposes that the disorder in this case is not the consequence of a repetitive pattern with both a life-determining, and a dysfunctional character.

These principles of symptom formation are effective in the development of those disorders which are diagnosed on Axis V "Mental and psychosomatic disorders". Clearly, it is again the weighting of the neurotic conflicts, on the one hand, and the structural limitations on the other, which plays a decisive role n the resulting types of disorder. Based on this logic, Rudolf (2004b, pp. 177) presents a typology of disorders, starting with neurotic conflicts on a high level, up to structural disorders on a disintegrated level of structural integration, the latter category including the most severe personality disorders and severe perversions.

Experience of illness and prerequisites for treatment (The relationship with Axis I)

Both experience of illness and expectations of change are multi-determined and not only derive from the psychological characteristics (structure, conflict, relationship) as listed in the OPD. Apart from the personal variables, of which the OPD characteristics represent a selection, the experience of illness as well as the motivation for change are both determined by psychosocial context factors in their interaction with an individual's personal characteristics. Among these are social norms relating to illness and the treatment of illness, and values which are transmitted via the patient's social network, the media, or also through the treating physician.

In the diagnosis of the experience of illness and prerequisites for treatment, numerous characteristics are recorded which reflect how a patient positions himself with respect to the interviewer, that is to say, what he expects of her, and which tasks he attributes to her. Indirectly, this addresses his habitual relationship potentials so that a close link with the OPD relationship diagnosis can generally be assumed. This connection, however, cannot be more closely determined, as the diagnosis of habitual dysfunctional relationship patterns is an individualized diagnosis. Links to Axis I must be investigated on a case by case basis, they are not easily amenable to discussion in a general way. It can, however, for instance be

expected that patients with a dominant relationship behaviour of "comply/submit" carry the respective expectations over to their therapist from whom they passively expect a therapeutic "treatment", or that patients with withdrawal tendencies have more difficulties building a reliable working relationship and are therefore less compliant.

As concerns Axis III "Conflict", connections can, however, be described. In this axis the patient's way of handling illness forms one of those areas for which criteria have been formulated explicitly in the OPD Manual. Thus an immediate interface exists. The Manual describes specific complications for each of the conflicts which typically develop in the encounter with the illness and the therapists. A passive and active mode of working-through is being distinguished in each instance: in the passive mode, regressive forms of conflict management predominate, in the active mode they are more reaction-forming, counter-phobic or compensatory. When comparing these criteria for the various conflicts it becomes evident that the predominant mode of conflict management plays an important role in the experience of illness and as prerequisites for treatment.

Generally, it can be said that patients with a predominantly passive conflictual mode (independent of the type of conflict) emphasize their suffering and complaints more and assign an active, responsible, role to the therapist. This leads us to expect that, more likely than not, they cite complaints the causes for which lie outside their own responsibility and sphere of influence. The illness concept is, therefore, likely to contain a larger number of somatic or social (external) stress factors, the expectation for treatment is likely to be more directed to a somatic treatment. If psychotherapy is desired, this is linked, with greater likelihood, with the idea of active support or consultation. The patient's passive attitude intrinsically carries the risk that the disorder is being maintained, to a relevant extent, through factors like secondary gain from illness.

In those cases where an active mode dominates the various conflicts, the risks are of a different kind. This concerns patients who experience their illness rather as a threat of their autonomy, self-determination and control. They have a tendency to counteract this threat by minimizing their difficulties, refusing assistance, or controlling the therapist. If they prefer a somatic model of illness, this may have the purpose of defending against the questioning and intimidation which is anticipated to go with a psychological approach. If they are in favour of psychotherapy, they are likely to prefer a form of treatment which they experience as controllable, or which promises to restore the competencies with which they can regain a feeling of self-determination. Suitable procedures would be those that promise to teach skills, possibly also insight-oriented treatments, which, to the mind of those concerned, enable cognitive control, or self-control, respectively.

The Axis "experience of illness and prerequisites for treatment" certainly has a multitude of connections with Axis IV "structure". In principle, it is to be expected that all dimensions contained in the structure axis have a more or less pronounced effect on the experience of illness. Of central importance regarding treatment prerequisites in the area of mental or psychosomatic disorders is the question of how far the patient experiences his issues more on the mental and/or more on the somatic plane. In addition to the type of complaints and issues, this crucially depends on the patient's ability for self-perception. How far an individual develops,

or is able to develop, an access to his "inner world" is determined by, amongst other things, whether and in what way affects are mentally organized. In our view, a "lively inner world" where affects and mental themes/conflicts/motives or ambivalence can be admitted, is first of all an expression of a relatively "good" (i.e. well-integrated) structure. The thoughts and ideas a patient has about his difficulties, and which models of illness and change he develops, essentially depend on his ability for self-perception. What also plays a substantial role is the readiness of the individual to engage in and tolerate cognitive or affective dissonance. This is another important structural dimension and refers to the capability for self-control, which comprises the functions of affect tolerance, self-worth regulation, as well as impulse control. Beyond this, the patient's capability for self-control forms the basis for two further characteristics that are conducive to treatment like stamina and endurance.

Experience of illness and prerequisites for treatment are finally also influenced by the types of symptoms (Axis V). More body-directed complaints suggest first and foremost a somatically-oriented concept of illness. If the attributions to the somatic domain become further validated by doctors, or by diagnostic and therapeutic measures from somatic medicine, this concept may further be strengthened, in the same manner as the expectations for somatic treatments that link into these will increase. In this case it is predictable that the "body" and "the treatment" will become those fields of acting out on which the individual conflicts, relationship patterns and structural difficulties are played out.

4. Manualization of the axes according to OPD-2

4.1 Axis I - Experience of illness and prerequisites for treatment

OPD Axis I is constructed in a modular way. The basic module consists of 19 items, which reflect the current severity and duration of the illness, how it is experienced and presented by the patient, the concepts a patient may have about his illness, and in addition, his resources for and impediments to change. An assessment may additionally make use of specific items from the psychotherapy module and/or further modules. The psychotherapy module reflects the wish of a patient for a specific psychotherapy, his psychological mindedness for psychotherapy, as well as any secondary gains he may obtain from the illness.

As an example, we also include a context specific module. This is the forensic module, which is currently being developed and offers the possibility for a more detailed examination of the particular conditions of forensic patients.

Table 4-1, module overview, shows in a prototypical way how any additional modules are interwoven with the basic module.

Table 4-1: Axis I module overview

Basic Module	Psychotherapy Module	Forensic Module
Objective rating of the illness/the problem		
1. Current severity of the disorder/the problem		
1.1 Severity of the symptoms		
1.2 GAF		GAF without rating 20-11
1.3 EQ-5D		
		1.F1 Type and severity of the paraphilic/perverse disorder
		1.F2 Type and severity of substance abuse
		1.F3 Type, severity and frequency of delinquent and/or antisocial behaviour
		1.F4 Level/nature of security
		1.F5 Level/nature of coercion into treatment
2. Duration of the disorder/of the problem		
2.1 Duration of the disorder		
2.2 Age at onset of the disorder		
		2.F1 Age when antisocial behaviour first manifested
		2.F2 Age when first convicted, jailed as a juvenile offender, or when antisocial action was first documented
Patient's experience and presentation of illness; concepts about illness		

3. Experience of illness and presentation of illness		
3.1 Subjective suffering		
3.2 Presentation of physical complaints and problems		
3.3 Presentation of psychological complaints and problems		
3.4 Presentation of social problems		
		3.F1 Presentation of delinquent behaviour and/or antisocial behaviour modes
4. Patient's concepts about illness		
4.1 Illness concept oriented to somatic factors		
4.2 Illness concept oriented to psychological factors		
4.3 Illness concept oriented to social factors		
5. Patient's concepts regarding change		
5.1 Desired type of treatment: physical		
5.2 Desired type of treatment: psychotherapeutic		
	5.P1 Reduction of symptoms	
	5.P2 Reflective-clarifying, conflict-oriented treatment	
	5.P3 Emotional-supportive treatment	
	5.P4 Treatment centered on active education	
5.3 Desired type of treatment: social/community		
		5.F1 Attitude to placement
		5.F2 Attitude to coercion into treatment or contractual structure
		5.F3 Attitude to the prospect of change with respect to reducing antisocial behaviour
Resources for change/ Impediments to change		
6. Resources for change		
6.1 Personal resources		
6.2 (Psycho-)social support		

	6.P1 Psychological mindedness	
		6.F1 Openness towards consideration of psychological factors influencing offending/antisocial behaviour
		6.F2 Openness to associations between offending/antisocial behaviour and subsequent mental states
7. Impediments to change		
7.1 External impediments to change		
7.2 Internal impediments to change		
	7.P1 Secondary gain from illness/conditions that maintain the problem	
		7.F1 Comorbidity
		7.F2 Psychosocial advantages because of delinquent/antisocial behaviour
		7.F3 Psychosocial advantages because of (court) ordered measures and involved services
		7.F4 Utilization of mental disturbance with regard to delinquent/antisocial behaviour

4.1.1 Current severity of the disorder/problem

4.1.1.1 Severity of symptoms

Definition

The degree of severity of findings in the somatic and mental domains shall be assessed not only in organic, but also in psychosomatic and mental illnesses. In this context, however, those mental problems shall also be assessed which are not classifiable in the sense of a mental disorder (according to ICD-10). These can include, for example, relationship problems, relevant interpersonal conflicts in the workplace, also massive adjustment problems in the social environment (for example, criminal behaviour).

The assessment is exclusively concerned with rating the findings, or respectively, the impairments in the somatic, mental, and social areas, irrespective of the type of existing illness. It therefore applies that the findings are more important than the nosology!

What is to be assessed is the current severity of the disorder, or problem.

Operationalization

The severity of the mental and/or somatic disturbance depends on type, extent, and on the degree to which the disturbance and, respectively, the symptoms, have become chronic.

An assessment of somatic complaints looks at current physical symptoms, impairment of bodily functions, or physical disability. Here, current physical impairments are assessed. These may or may not correspond with the severity of the physical illness.

There is a connection between, on the one hand, severity of psychical symptoms, or problematic issues, and resulting individual intrapsychic stresses, and, on the other hand, problems on the level of psychosocial adjustment. To give an example: an individual may experience massive anxiety attacks which put him under extreme intrapsychic stresses, and yet the anxiety disorder may also, due to avoidant behaviour, lead to substantive restrictions on behaviour and relationships. Of relevance for assessing the severity of the mental disturbance is thus the extent of integration or disintegration of the personality, and its capacity for social adjustment in the areas of job, leisure activity, family.

The time window for the assessment is usually the week prior to the interview.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	The physical and mental symptoms are present to a limited extent only. Example: A patient with a mild anxiety disorder accompanied by feelings of fearfulness and worrying, which shows only few signs of vegetative arousal on the bodily level.
2 - medium	The patient shows relevant symptoms and impairments either

	in the mental or the physical domain, or both. Example: A patient with an anxiety disorder linked to mild feelings of derealization and depersonalization and with clear avoidance behaviours. On the bodily level the patient displays marked signs of vegetative overstimulation (tachycardia, sweating, dizzy spells, etc.) during more frequently occurring anxiety states.
4 - very high	The patient displays extensive physical and/or mental symptoms Example: A patient with a generalized anxiety disorder, with intermittently occurring panic-type attacks. He shows a high degree of "basal fear" which is in fact always present and is also linked with vegetative symptoms. Concomitantly, he is massively impaired in his activities, showing a marked tendency towards withdrawal and avoidance. During the irregularly occurring panic states he has mortal fears, a fear of going crazy, and shows massive bodily fear-related symptoms.

4.1.1.2 Global Assessment of Functioning (GAF)

Definition

The GAF (Global Assessment of Functioning) scale corresponds to Axis V of the DSM-IV (Sass et al., 2001). It assesses the general level of functioning in the areas of mental, social and work-related functioning.

Operationalization

The assessment of the level of functioning refers to a recent period in time (the week prior to the interview). Mental, social, and occupational functioning is being thought of as existing on a hypothetical continuum ranging from mental health to illness. What is rated here is the maximal value in level of functioning.

100-91	Superior functioning over a wide range of activities.
90-81	Good functioning in all areas.
80-71	No more than slight impairment.
70-61	Some mild symptoms or some difficulties.
60-51	Moderate symptoms or moderate difficulties.
50-41	Serious symptoms or serious impairment.
40-31	Major impairment in several areas.

30-21	Serious impairment or inability to function in all areas.
20-11	Some danger of hurting self or others. (As forensic patients always qualify in this area, this item is not to be rated for this group of patients)
10- 1	Persistent danger (of serious self-harm or of hurting others) or persistent inability to function.
0	Not enough information available.

Maximum score for the last 7 days: [__] [__] [__]

4.1.1.3 EQ-5D

Definition

The EQ-5D is a health questionnaire which supplies a unidimensional unit of measurement to measure quality of life. The original version of the EQ-5D was developed by the EuroQol-Group as a self-report instrument (Rabin, 2001). The five dimensions of the original EQ-5D have been reformulated for our purposes into an instrument for external rating.

Operationalization

It is to be indicated on five dimensions which statements best describe the health status of a patient. The description proceeds from the current health status (time of the interview) of the patient (Rabin/de Charro, 2001).

Table 4-2: EQ-5D

1. Flexibility/Mobility	
The patient has no problems getting about.	[_]1
The patient has some/moderate problems getting about.	[_]2
The patient is bed-ridden.	[_]3

2. Self-care	
The patient has no problems caring for himself.	[_]1
The patient has some/moderate problems washing of clothing himself.	[_]2
The patient is unable to wash or clothe himself.	[_]3

3. Usual activities (for example, work, study, household duties, family or leisure activities)	
The patient has no problems carrying out his normal, everyday activities.	[_]1
The patient has some/moderate problems carrying out his usual activities	[_]2
The patient is unable to carry out his usual activities	[_]3

4. Pain/discomfort	
The patient has no pain or discomfort.	[_]1
The patient has moderate pain or discomfort.	[_]2

The patient has extreme pain or discomfort.	[_]3

5. Anxiety/depression	
The patient is not anxious or depressed.	[_]1
The patient is moderately anxious or depressed.	[_]2
The patient is extremely anxious or depressed.	[_]3

4.1.2 Duration of the disorder/of the problem

4.1.2.1 Duration of the current problems

The duration of the described complaints/problems is of interest both for the assessment of the severity of a disturbance, and for the prognosis of a measure designed to bring about change. Here, we only consider the main complaints or problems as stated by the patient. In a chronic disturbance of longer duration, we find, as a rule, dysfunctional adjustment processes at the somatic, mental, and social levels (for instance in illnesses with chronic pain), which develop their own dynamic and are capable of substantially influencing not only the individual's personal integration, but also his psychosocial adjustment.

In this context, the duration is recorded to elucidate the extent to which the condition has become chronic.

< 6 months	6-24 months	2-5 years	5-10 years	> 10 years

4.1.2.2 Age at first onset of the illness

The age at which the current problem or the illness appeared for the first time should be recorded here (cf. Chapter 13.7 for the Rating Sheets). This age when first manifestations become apparent may give hints as to an illness having become chronic, but need not necessarily do so. We are surely not dealing with a chronic illness if a patient suffered from agoraphobic symptoms first at age 20, and then again at age 50.

4.1.3 Experience, presentation, and patient's concepts of illness

4.1.3.1 Subjective suffering

Definition

The purpose here is to document the patient's subjective suffering, which may be a possible source for the motivation for therapy. For the most part, subjective suffering is consequent to, not only the severity of symptoms, the type of diagnosis and its effects, the treatment procedures that are put into place, but also to the patient's particular attitude and society's attitude in general toward the illness (stigmatization). A high level of subjective suffering means that the patient suffers intensely from the described aspects of his illness. Importantly, the stress here is on the subjective. Thus, the level of subjective suffering has to be rated as high even in cases where the patient shows only minimal symptoms, but nevertheless reports great suffering. As a rule for the rating, the subjective suffering should either be verbalized by the patient, or become evident to the interviewer from the patient's behaviour. The rating of subjective suffering which is not verbally expressed (for example, suffering that is denied or trivialized) requires a high degree of unequivocal evidence! Subjective suffering is given an important motivational

function in the development of the patient's expectations from and cooperation with the treatment.

Operationalization

What is to be rated is the suffering subjectively experienced by the patient, independently of whether that corresponds to the "objective" discomfort. It is important to assess the subjective suffering that exists at a given moment. The assessment period should cover the month prior to the interview. The rating of this item involves, usually, considering physical as well as psychical aspects. The more the symptoms are integrated into the various areas of functioning of a patient's personality, the less the patient's self-experiencing will be negatively affected. During the course of the interview, it is relevant to note how the patient talks about his subjective suffering, and how this is played out in his facial expression and gestures, and/or at the behavioural level. If the emotions related to the suffering appear trivialized/dissimulated, or dramatized/aggrandized even after the patient's socio-cultural background has been taken into account, the interviewer should attempt to verify this impression by more probing in-depth questions, or through further observation. If verbal and non-verbal, or, for that matter, scenic, presentations are discrepant, a weighting is applied in line with the overriding impression, or the predominant mode.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	This rating is applied if a patient does not reveal any kind of suffering in the course of the interview. This can be the case in situations where the patient does not give expression to any identifiable signs. It can, however, also occur in a patient who, because of internal demands ("boys don't cry") rigorously suppresses any signs of emotional involvement. The patient does not cognitively engage with the stresses or problems. Example: A patient who experiences problems in his marital relationship while his wife is going through a depressive crisis does not feel, overall, that he suffers any impairment in his life as a result of this illness and its consequences, and therefore considers any treatment unnecessary.He refuses further diagnostics, as he generally does not feel any strain.
2 – medium	A medium level of subjective suffering is present if the patient has clearly suffered from the illness and related impairments or is currently still suffering from both.

	Example: A female patient with a persistent sleep disorder and job-related stress frequently visits her doctor, and is close to tears each time; this behaviour is taken as an indication of her unspoken request for help with a prescription.
4 - very high	Subjective suffering is high as a result of interfering internal and external/situation-bound stresses (for instance, anxiety, massive worsening of symptoms, extremely stressful treatment procedures, total cessation of social support). There can also be a discrepancy between the cause of suffering and its expression. Here the patient uses all means available for the expression of content and affect, in his effort to seek help from others, constantly expressing his suffering through gestures or enacted scenes (for example through parasuicidal actions), and/or pressing for instant remedial action. Example: A female patient with repeated and intense panic attacks reports that she finds the related thoughts and feelings overwhelming, feeling persecuted by her fear of the fear. She cannot sit still, and paces the interview room with a terror-stricken expression on her face, and, with her voice cracking, demands an injection and instant transfer by ER physician to a clinic as she is unable to bear this state any longer.

4.1.3.2 The presentation of physical complaints and problems

Definition

It is recorded here to what extent the patient expresses in the interview physical aspects of the suffering from his disturbance(s), in the form of physical complaints, descriptions of symptoms, attempts at explaining the origin of, or the influences impacting on his illness(es), or its treatment, and how much attention he accords to this.

Operationalization

During the interview it is of interest to note how far the patient does report physical aspects verbally, in the interaction, and/or how far he scenically enacts them.

What is rated here is only the extent of apparent physical complaints, irrespective of which basic illness (somatic or mental) has been diagnosed in the patient.

This is purely about the presentation of the complaints; the extent of the presentation of psychical or social symptoms is irrelevant for the assessment of the extent to which physical symptoms are presented. If verbal and non-verbal, or scenic, presentations show discrepancies, a weighting is applied in line with the predominant impression, or the overriding mode that is used.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	This rating is applied if physical complaints and problems do not at all figure in the patient's description or only occur to a minimal extent. Example: "I don't know whether I am in the right place here. My folks at home told me I should go and see the doctor, because something with my tummy is not in order", the patient replies to the interviewers opening question. The interviewer has to quiz the patient before finding out that he has had abdominal pain for four months but has not done anything about it because he thought that it "wasn't so bad". Finally the interviewer is able to piece together the anamnesis of the pain and the relevant medical data. He tries in vain, though, to uncover psychosocial aspects of the illness. The patient does not seem to understand what it is the interviewer wants to know of him: "Everything is fine."
2 – medium	This rating is given if a patient's physical complaints and problems and/or the supposedly physical causes of his complaints are given ample space verbally, through gestures, or enactment in scenes, but do not predominantly or exclusively take up his attention. The patient may well be aware of these physical issues and find some relief through this perspective. He does, however, not use this in the sense of it generating an understanding for him so he can cope with his disorder or problems - other issues beyond this also require his attention.

	Example: "I have not been feeling well for three weeks. I suffer from stomach pain, nausea, and have thrown up a few times. I don't enjoy my food and coffee any more. I've lost 3 kilos so far, and, because of the pain, my sleep is worse than it used to be", the patient replies to the interviewer's opening question. He gives the impression of being a little worried and adds, with certainty: "I want you to check me out thoroughly, at my age it could be some serious problem, for a change!". He has no issues with acceding to the interviewer's request for information and in a matter-of-fact way reports the key medical facts. Effortlessly, the interviewer is able to determine the patient's current psychosocial situation. In this context, the patient is able to communicate to the interviewer that he is in a phase of transition, professionally, which causes him some stress.
4 - very high	This rating is given if a patient's presentation of physical complaints and problems and/or attempts at explanation of the physical suffering through words/gestures/scenes, dominate/s during the interview without much prompting by the interviewer. Example: "I am totally worn out, shattered. I can't take this any more. I am fifty now and this additional on-call duty is finishing me off. I can"t cut it any more!", the patient bursts into the conversation. With an expression of long-suffering, he details, almost without any cues, his complete medical history, explicitly describes numerous treatments and repeatedly surmises about what effects on his body they might have had. He reports with special intensity and great involvement about an abdominal surgery and the particular aspects/difficulties/complications related to his convalescence. In a reproachful tone he comments that since that time everything in his tummy is a mess, that nothing works

	properly any more, and that he is unable to do anything at all. The interviewer succeeds only in part in clarifying that the patient suffers from recidivist abdominal pain and how "terribly" this restricts him in his daily life. He tries in vain to highlight the psycho-social aspects of the illness. Indefatigably, the patient carries on with physical complaints. Again and again he runs both his hands over his abdomen, saying: "I tell you, it's all about my tummy, and it's not gonna take any more!"

4.1.3.3 Presentation of psychological complaints and problems

Definition

What is captured here is the extent to which a patient, during the interview, expresses mental aspects of his suffering from his illness(es), and how much attention he accords to these. These may, for example, take the form of psychical complaints, descriptions of symptoms, attempts at explaining the origin of, or influences impacting on his illness(es), or its treatment.

Operationalization

During the interview it is of interest to note, firstly, how far the patient verbally describes mental aspects in the interaction, and/or how far he scenically enacts them, and secondly, how far the interviewer is able to adequately comprehend the suffering as reported by the patient, or how far it might appear to have been trivialized/dissimulated or dramatized/aggrandized, keeping the patient's socio-cultural background in mind. The extent of the presentation of physical or social symptom is irrelevant for the assessment of the mental symptom presentation. If verbal and non-verbal, or scenic, presentations show discrepancies, a weighting is applied in line with the predominant impression, or the overriding mode [that is used].

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	This rating is applied if, in the patient's presentation, psychical complaints and problems do not occur, or are very limited. The patient may use the illness itself, psychical defence mechanisms or successful adjustments, as well as medication and/or treatment measures, in order not to leave any or only minimal space to psychical processes, despite the existence of a mental disorder. Example:

	According to reports from the patient's wife, the patient has been depressed for four months, has not been to work for one week, "burrowing" himself in the house. The patient blocks the interviewer's questions on the mental anamnesis: "I am fine!". Upon the interviewer's inquiry, the patient reports a difficult-to-regulate diabetes mellitus: "The doctors said I should start thinking about ordering myself a new kidney. But other than that, I'm fine. I have no mental problems." He does not understand why his wife is so angry about the fact that he does not want to talk much and wants to be left alone.
2 - medium	A medium level is present in patients who clearly give space to the presentation of psychical complaints and problems and the psychical causes of their current state through words/gestures/scenes. That space is, however, not completely taken up by the complaints. The patient may well be aware of the psychical issues and finds some relief through this perspective. Example: A female patient who appears visibly anxious and dysphoric reports not having felt well for three months, to have lost interest in everything, and to be fearful of large crowds. She even has to force herself to take the dog out, which she used to enjoy. When she sits in front of the TV, she reports that everything is passing her by, "because in my head, things are working all the time." Spontaneously, she adds: "One does have occasional problems, but I've never known anything like this. I've been wondering what has hit me, perhaps it is my daughter's puberty." Then she moves away from this topic only to revert back to it, ambivalently, because of her extensively reported medical problems, and after suitable interventions by the interviewer.
4 - very high	The presentation of psychical symptoms and complaints predominates in patients who are rated at this highest level. Gaining an

	explanation and understanding of their symptoms on a psychological basis is part of their perspective. This is the central theme during the interview, enabling the patient to demonstrate to the interviewer, unasked and independently, that because their symptoms originated on the psychical plane, this requires the respective psychotherapeutic treatment. - This may appear appropriate to the interviewer, or it may appear constructed and seriously out of touch with reality. Example: A patient comes across as being very tense as he describes his depressive moods, because of which, and with sleep disturbances caused by ruminating, he has been unable to pursue his profession as a travelling salesman for the past eight weeks. He fears that he would not be able to keep calm during the long hours in his car. Up till now the thought his former psychotherapist has always helped him. This three-year therapy has enabled him to resolve a serious relationship conflict, and for ten years he has been free of symptoms, until he separated from his wife half a year ago. The presentation of the background information, beginning from his late adolescence, paints a picture of a sensible person who is dependent on others, and who, with the exception of the current crisis, has managed most of the time to make psychical symptoms and their triggers understandable and usable for himself.

4.1.3.4 Presentation of social problems

Definition

This is to capture the extent to which a patient, during the interview, gives expression to the social aspects of his suffering caused by his illness(es), and how much attention he accords to these. They may, for example, be voiced as complaints about social stresses placed on the family (illness/care of a close relative), work-related stresses (threat of loss of job/loss of job, bullying), or as complaints about strains affecting the circle of friends and acquaintances (through illness, death, separation), or they may encompass explanatory attempts about the origin of the illness(es) containing a social bias, the influences impacting on it, as well as its treatment.

Operationalization

During the interview it is of interest to find out, firstly, how far the patient verbally reports social aspects, and/or how far he scenically enacts them. It is to be noted, secondly, how far the interviewer is able to adequately comprehend the suffering that the patient reports and attributes to social causes as appropriate, or how far it might appear to be trivialized/dissimulated, or dramatized/aggrandized, keeping the patient's socio-cultural background in mind. The extent of the presentation of physical or psychical symptoms is irrelevant for the assessment of the social symptom presentation. If verbal and non-verbal, or scenic, presentations show discrepancies, a weighting is applied in line with the predominant impression, or the overriding mode that is used.

Symptom level scores and anchor-point descriptions	
level grade 0 - absent to minimal	This rating is applied if, in the patient's presentation, social aspects of his suffering do not occur or are very limited. Depending on the course of the illness, the presence of psycho-social defence mechanisms or successful adjustments, and/or treatment measures, a patient may, despite most severe social stresses, accord none or only minimal space to the social aspects of his suffering. Example: A patient with a depression following cancer states that there are no problems in his social domain. His family supports him when coping with his illness. Reentering professional life is not a problem at all, and he is very secure financially.
2 - medium	This rating is given if a patient's social complaints and problems and/or supposedly social causes of his complaints are given ample space verbally, through gestures, or enactment in scenes, but do not predominantly or exclusively take up his attention. The patient may himself be aware of these social issues and find some relief through this perspective. He does, however, not use this in the sense of it generating an understanding so he can overcome his disorder or problems - other issues beyond this also require his attention. Example: A patient reports depressive moods and anxiety states after having lost his job. Work

	had always been an important pillar of support in his life, in times of joblessness self-doubts, which have been tormenting him since adolescence, would markedly increase.
4 - very high	This rating is given if a patient's presentation of social complaints and problems and/or attempts at explanation at the level of social aspects through words/gestures/scenes, dominates during the interview without much prompting by the interviewer. Example: A 58-year-old patient reports his despair and hopelessness, he finds himself unable to sleep. The problems started when he quit his job three years ago, all subsequent job applications were turned down with reference to his age. He fears having to sell his house, if he were only to receive reduced unemployment benefits. Due to his lower income he was forced to cancel his theatre subscription and his membership in a sports club. This led to his social contacts becoming more and more sparse.

4.1.4 Patients' concepts of illness

4.1.4.1 Concept of illness oriented to somatic factors

Definition

This item describes the conscious, subjective model a patient uses to explain, to himself and others, the origin and course of his illness and complaints.

It captures how far the patient's understanding of illness rests on explanatory models from the medical-somatic area. It describes how far the patient regards his complaints and problems as caused or influenced by physical defects, ailments, illness-engendering processes and mechanisms, etc.

Operationalization

The interviewer, in the conversation with the patient, gains an impression about the patient's concepts of illness. In doing so the interviewer, on the one hand, takes up the patient's spontaneous thoughts about how his complaints were triggered, or how they developed, and on the other, specifically inquires about the patient's ideas as to the origin and development of his complaints and problems. It is irrelevant whether the patient's ideas make medical sense or not. This is rather about finding out how far the patient has developed any ideas about triggers and causal interrelationships of his disorder, and how specific they are. Low scores on the scale refer to an understanding of illness which is only marginally oriented on

somatic factors, or incorporates only vague ideas about triggering somatic factors, whereas high scores, in turn, designate a relatively specific, coherent, model of somatic illness and disturbance.

It is not intended to capture here how far the patient is fixated upon a specific explanation of the cause of his illness. This results from the profile of the three psychodynamic axes 2, 3, and 4.

Symptom level scores and anchor-point descriptions	
level grade 0 - absent to minimal	This rating is applied if a patient, in explaning his complaints, makes no assumptions whatsoever which might have to do with the physical causes of his illness. Upon specific inquiry he refuses to consider a physical cause for his complaints. Example: A patient with chronic bronchitis is repeatedly told by his physician to give up his consumption of 30 cigarettes per day. He replies that the coughing could not possibly come from smoking, his grandfather and father had smoked a lot more and had never coughed. "The men in our family have always had strong lungs."
2 - medium	This level is used to rate patients who consider a physical cause of their symptoms, for instance through an infection, or genesis of toxicity, but who are not really sure about it. Example: A patient describes symptoms of tiredness, depression, and morning sickness. He had gotten himself information from the internet about the so-called "sick building syndrome" and now hopes that the diagnosis could either be confirmed or rejected by a thorough examination.
4 - very high	This rating is given if a patient is convinced that his symptoms and complaints have a physical cause. He is able to state clear interrelationships between effects, up to diagnoses or biophysical external influences. Example: A patient claims to suffer from a borreliosis.

	He is organized through a borreliosis self-help group and pressures the treating physicians again and again for new antibiotic therapies. The patient refutes the treating physician's objections that neither the typical signs of a tick bite nor antibodies were found with him by presenting print-outs of internet reports on seronegative borreliosis.

4.1.4.2 Concept of illness oriented to psychological factors

Definition

This item captures how far the patient claims psychical and interpersonal aspects (psychologically interactive aspects) have had an effect on the formation and development of his complaints and problems, and how far he is open to a psychological approach to explanation. Does the patient see his own attitudes, ways of thinking and modes of behaviour as being related to the formation and development of his complaints and problems, and/or does he consider his own reactions with respect to his social environment.

Operationalization

The examiner attempts to gain a picture during the conversation of how far the patient is, at least basically, open to psychological approaches to explanation and how far he has developed ideas in this respect, i.e. how far those factors influence his concept of illness (interactions with the environment play a role here in so far as they are not entirely externalized).

Low scores on the scale refer to a marginal psychological (psychosomatic) understanding of illness, and/or vague ideas about psychological triggers, high scores, in turn, designate a relatively specific and coherent, psychologically based model of illness or disturbance. This item does not intend to capture how far the patient is fixated upon a specific explanation to explain the cause of his illness. This results from the profile of the three psychodynamic axes 2, 3, and 4.

Symptom level scores and anchor-point descriptions	
level grade 0 - absent to minimal	The patient recognizes no psychical/psychological or interaction-based cause for his complaints, upon inquiry he categorically rules this possibility out. Example: A patient describes depressive symptoms, but confesses to having "no clue" as to what they might be related to. The therapist attempts to reflect back to her that the conflicts she described in her relationship might be a possible cause, which the patient denies. "I have had problems with my

	husband for so long, why should I get depressed by them now?"
2 - medium	The patient is not sure whether mental, psychological, or interaction-based factors have a causal influence on the origin of his complaints. He does, however, consider this possibility and takes up the hints of the interviewer in this respect. Example: The therapist suggests to a diabetic patient, who constantly "forgets" to take his medicine, that there might be a connection with the unconscious rejection the patient has felt from his mother who also suffered from diabetes. The patient, who initially thought that the "memory disorder" was a delayed consequence of the diabetes is able to understand the interpretation of the therapist, and thereafter reports how disgusted he had been as a child by the sick, demanding mother.
4 - very high	The patient is convinced that psychical/psychological, or interaction-based influences are causally effective as the trigger for the complaints he reports. The interviewer is confronted with a mental or interaction-oriented illness concept, which can, however, be flexibly handled when modifying hints are introduced. In each case, the patient considers himself part of the existing relationship conflicts, reflecting his own conflictual share in this context. Example: A patient with agoraphobia states her assumption that her anxiety may have appeared now in order to "wake her up" to think about her future. For many years she has been living in an unsatisfying relationship which she had only maintained because of the children. She basically wants to separate, however, has great fears about living alone.

4.1.4.3 Concept of illness oriented to social factors

Definition

This item captures how far the patient conceives of his complaints and problems as caused by his social environment. This may be expressed in a very unspecific manner (society, the social system, "those up there"), but ideas about the influence of social conditions and people may also take very specific and concrete forms.

Operationalization

The interviewer attempts to gain a picture to what extent the patient sees social systems and conditions (unemployment, unemployment agency, legal conditions, cut-backs), and others (the "mobbing" female colleague, the degrading boss) as causal triggers for his complaints and problems, and how far he considers these influences impact upon him - specifically or generally (workplace, boss, downgrading of the job, unfavourable work conditions, etc.).

Low scores on the scale refer to vague ideas about social context having an influence, medium scores point to influences being effective in the sense of stresses and strains, more or less general or specific. High scores, in turn, designate conditions which the patient experiences as not susceptible to his influence.

Symptom level scores and anchor-point descriptions	
level grade 0 - absent to minimal	The patient recognizes no social or external factors in his environment as causally responsible for the development and the course of his reported complaints. He refuses to acknowledge respective suggestions. Example: "Why should my back pain be related to my work situation?" It is actually quite good that I have not become head of department, this way I won't have to struggle with all those unmotivated colleagues", the patient replies to the interviewer's question about the occurence of the pain and the promotion that did not happen.
2 - medium	The patient is not totally convinced that social factors or influences from his environment are causal in the complaints he reports. He does, however, consider such links and takes up the respective suggestions, with his own and external causal factors more or less balancing each other. Example: After suggestions by the therapist a patient confirms the link between the occurrence of

	heart palpitations and being unemployed. "Well yes, you are right. I have been unemployed several times in the past, but now I worry a little more about whether I can still find a job at my age. And the debts, too, I cannot pay back as easily as I had been telling myself."
4 - very high	The patient exclusively attributes social factors, or factors from his environment, or his immediate surroundings, as the causes for the origin and the development of the reported complaints. He is convinced that the actual cause for his complaints lie outside himself and names specific external stressors as responsible. Moderating hints or other alternative possibilities of explanation do not change his conviction in this respect. Example: "For years and years you break your back getting your job done and now it is not even to be recognized. I go from expert to expert and they keep telling me that my back pain is no reason for a retirement pension. Well, do I have to be half-dead first? The politicians are having a good time, and the likes of us are supposed to pay for it, that is really something to despair about. This government has finished me off", the patient replies, visibly aroused, to the interviewer's opening question.

4.1.5 Patient's concepts about change

4.1.5.1 Assessment of the patient's desired form of treatment (physical treatment)

Definition

This item captures to what extent the patient desires a physical treatment for the management of his disorder/problems. What is not rated here is whether the rater also considers such a treatment appropriate. By physical treatments we mean the type of intervention that effect direct bodily changes, for example by the administration of medications, through medical procedures (for instance surgery, etc.) or physiotherapeutic measures. Not included here are body-centered interventions within the framework of psychotherapy (for example Alexander Technique, body awareness and so on).

The different forms of treatment desired by patients as listed in Axis I are not to be judged alternatively. This means a patient may want physical, and/or psychotherapeutic treatment, and/or support in the social area.

Operationalization

In the diagnostic process, attention should be paid to directly expressed wishes by the patient for physical treatment. In addition, scenic aspects, which may reveal the wish for physical treatment, are of interest. The emphasis is on the assessment of the patient's current treatment request. An extensive presentation of past physical treatments may suggest a highly active current treatment wish.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	This rating is applied if patients in the interview seem to express no wish for physical treatment. This may be the case when the patient utters an exclusive wish for psychotherapy or for social support, however, it may also be the case in a patient who has no idea whatsoever as to which kind of treatment may help with his problems. Example: A patient with ulcerative colitis desires psychotherapy in order to find out about "mental causes" and psychical consequences of his illness. He refuses drug treatment.
2 - medium	A medium level is present in patients who desire physical treatment alongside and on a par with other forms of treatment. They consider one form of treatment as not sufficient in dealing with the problem. This level is also appropriate for rating patients who express some reservations about a physical treatment. Example: A cancer patient agrees, after extensive conversations, to a chemotherapy. In addition, he wishes to have conversations with the ward psychologist, as he believes that he can only cope with the stresses of a chemotherapy by enlisting psychotherapeutic help.
4 - very high	This 'very high' level rates patients who unequivocally desire physical treatment. What is rated here is the presence of very high expectations from treatment, independent of whether this is regarded as appropriate by the interviewer. Such an

	expectation may be found in patients for whom an exclusively physical treatment is indicated, in patients displaying great resistance to psychotherapy, but also in badly prepared and informed patients, who are aware of no other treatment possibilities. Obviously, in cases of psychosomatic illnesses, or comorbidity of somatic and mental illnesses, a marked wish for somatic treatment can also be accompanied by requests for psychotherapeutic treatment. Example: A patient with a somatization disorder is sent to a psychotherapist. He hardly engages in the interview, and remarks at the end of it that he had "no problems with his head, but constant back pain". He refuses the pain management programme suggested to him and expresses his disappointment that no helpful new pain medication or other somatically oriented pain management treatment is being recommended to him.

4.1.5.2 Assessment of the patient's desired form of treatment (psychotherapeutic treatment)

Definition

This item captures the patient's wish for psychotherapeutic treatment. Here, too, what is to be assessed is only the wish, and not the appropriateness of the wish.

Operationalization

When rating the wish for psychotherapy, attention should be paid to any direct expression of this wish, but also to indirect clues, which might hint at a wish for psychotherapy. The patient's level of education and the structure of his personality must be taken into consideration, as they can influence how the wish for psychotherapy is expressed. An openness towards psychotherapy may also be reflected by the interest shown in talking about personal and social areas of life.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	This rating is applied if patients seem to express no wish for psychological treatment in the interview. This may be the case, when, on the one hand, a patient utters an exclusive wish for a different form of treatment (for instance physical treatment), or, on the other, has no idea which form of treatment may help with his problems.

	Example: A patient with a heart phobia declines the psychotherapy offered to him. He is of the opinion that his heart is faulty and that the cause of this has not yet been found. He presses the interviewer to recommend invasive diagnostic measures and considers psychotherapy "a dangerous waste of time".
2 - medium	A medium level is present in patients who desire psychological treatment alongside and equally with other forms of treatment. They consider one form of treatment as not sufficient in dealing with their problem. Example: A patient suffering from pain in the framework of a somatization disorder appears in the psychotherapy walk-in clinic with a request for a pain management therapy. He wants to learn how to optimize his pain medication. He considers psychotherapeutic measures as helpful, but on their own, not sufficient for the treatment of his pain.
4 - very high	This 'very high' level rates patients who have a marked and constant desire for psychotherapeutic treatment. This could, for instance, highlight a good capacity for introspection, and a good understanding of psychological factors, but can also result from the patient's fear of, or resistance to medication or invasive somatic treatments. Example I: A patient describes agoraphobic symptoms and passive/vegetative anxiety symptoms. She regards a problematic relationship as the cause of this and expresses a wish for group therapy treatment for her anxiety, in order to treat the restricting symptoms. Thereafter she wants to work on her conflict-burdened relationship in an individual psychodynamic psychotherapy. Example II: Another patient reports a racing heart, and

	that he tends breaks out in sweats, and has sensations of weakness in his legs. He desires a psychotherapeutic treatment for his anxiety, as it is clear to him that unresolved marital probems are entirely responsible for his problems. He declines a thyroid diagnostic as an additional treatment which could be used to ascertain a possible hyperthyroid condition.

4.1.5.3 Assessment of the patient's desired form of treatment (social area)

Definition

This item captures to what extent a patient desires help in the social area. This may, for instance, be a wish to have a social worker assigned, or to have counselling for worries such as debt reduction, work placement, pension applications, rehabilitation options, etc. It also includes the wish for counselling through institutions, which does not constitute psychotherapy in a specific sense: child rearing advice/parenting classes.

Operationalization

The wish for interventions of a social types is hardly going to be expressed through scenic aspects, so what needs to be paid attention to here, is, rather, the patient's concrete utterances in the interview. As the case may be, the interviewer may need to ask further questions.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	In the interview, the patient expresses no wish whatsoever for treatment/counselling in the social area. Again, this may mean that there is no objective need, or that the refusal is an indication of a patient's resistance. Example: A patient declines to take action on all suggestions by a social worker to take steps towards reintegration into the work force. During the course of the therapy it transpires that he wants to apply for a pension.
2 - medium	A medium level is present in patients who, in addition to somatic treatment, also desire social therapy/counselling. Example: A borderline patient has become aware, through therapy, that his frequent changes

	of workplace and residence, which had led to considerable debt, result from disturbed impulse control due to an illness. In addition to working things through in a psychotherapy he wants to seek debt counselling and participate in measures towards a step-by-step professional reintegration.
4 - very high	A 'very high' rating is given to patients who only express the wish for social care/counselling. Other treatment offers are not accepted, even if they may possibly be indicated. Example: A patient with a heart phobia repeatedly frequents a parental guidance clinic, hoping to pick up "tips" on how to deal with his anorexic daughter, who "with her fasting was about to drive him to a heart attack".

4.1.6 Resources for change

4.1.6.1 Personal resources

Definition

This item rates to what degree a patient currently possesses capabilities and modes of behaviour which are beneficial for his health and help him to adjust to disorders. It does not rate the extent to which the patient had these capabilities in the past.

A patient with a high level of personal resources can actively engage with his illness and maintain his existing lifestyle, or even change it to one that benefits his health more. His experience of self-effectiveness will be only mildly shaken by the illness and its consequences. He will keep his fundamentally optimistic attitude and be able to, in flexible and emotionally responsible ways, open up, for himself, new life perspectives even in the face of (serious) illness.

Operationalization

In the diagnostic conversation attention should be paid to those coping activities that constructively help with adjustment, as they occur in the patient's everyday life, and whether the patient, despite existing limitations, leads an active life (or is confident enough to do this). This is not about rating individual coping mechanisms, but about an overall assessment of the coping resources a patient has access to. The interview is to focus on exact descriptions of the everyday handling of strains and stresses within the context of the disorder and the consequences brought about because of the disorder. The assessment covers the last six months.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	This level is rated if the patient, subjectively and objectively, has no, or hardly any

	personal resources at his disposal to constructively cope with his disorder. Example: A passive-regressive patient with chronic, somatoform pain, who with respect to his illness, experiences himself as largely helpless and exposed, and who pessimistically focuses on his illness, who cannot engage in any other meaningful conversations with others, who has drastically reduced his activities, is unable to relax or distract himself, and who feels the need to reject any coping activity as ineffective and useless.
2 - medium	A medium level of personal resources is present in the patient, who is able to maintain an active way of life in some areas, despite existing complaints and impairments, and who, partly uses these resources by way of compensation. He strives for opening up new perspectives on life that are independent of his illness. Example: A chronically ill patient with fibromyalgia is capable of being active through the use of physical exercises. He has acquired some experience with and practice of a relaxation technique and begins to accept the continued existence of painful states, while living his life in a way that is not exclusively focusing on these states. He can begin to imagine being able to integrate persistent complaints in his perspective on his life.
4 - very high	A 'very high' rating is given to patients who can avail themselves of a broad range of considerable personal resources for coping with illness. They are capable of maintaining a positive attitude to life, despite severe mental and psychogenic stress. They have health promoting habits and/or initiate these. They are able to make use of differentiated emotional capabilities and high-quality social relationship competencies for this purpose. Example:

	A female patient with an anxiety disorder and the occasional anxiety attack has developed a variety of activities in order to help her get through these attacks (distraction, relaxation, self-calming). She has educated herself well about the fundamentally not life-threatening nature of her illness, and feels able to exercise some degree of influence over these symptoms. She is prepared for the occurrence of the attacks, taking them into consideration in her daily routine. With those limitations she can basically continue with her job and leisure activities. She is able to talk about her anxieties with her boyfriend and a female friend.

4.1.6.2 (Psycho)social support

Definition

This is to assess whether the patient is currently able to mobilize and also use, objectively available resources of support from his social environment. The interviewer will therefore have to assess the formal aspects (existence of a social network), as well as the subjective aspects (awareness of, and use of available resources of support) of support gained from relationships, family, and social resources and cross-reference them with each other.

Of interest are, therefore, not so much the objective (structural) parameters of the social network, (he number and kind of individuals), but more, whether the patient is able to recognize, and avail himself of support from his environment in the sense of a resource, when dealing with his disorder and problems.

Operationalization

On the one hand, this covers the possibilities of social support, which an outside observer is able to recognize, and on the other, it captures the social support the patient himself recognizes as being available to him. Furthermore, it addresses the patient's capacity to avail himself of these social resources. These components of social support are put into relationship with each other. Various types of social support (instrumental, emotional) are hereby also taken into account.

The interviewer must get an idea of whether the patient, first of all, was able to form attachments with high quality supportive interaction partners at an earlier stage, and whether these are now potentially available to him (formal aspect). Secondly, he must assess whether the patient, under the conditions of his current disorder, recognizes that he can actually avail himself of these sources of support (awareness of social support), and, thirdly, whether he displays behaviours which make his need for help apparent to these persons (mobilization of social support). This means the patient must be able to talk about his stresses, to ask for help, to

show a positive reaction to offers of support, and to behave in a constructive manner towards those offers.

As regards the types of supportive exchange, a distinction is made between emotional and instrumental kinds of support. Emotional support comprises closeness with others, understanding, empathy, affection, appreciation, compassion, consolation, supportive conversations, relationship-maintaining offers like phone calls, and assurance of continuation of the relationship despite the illness. This may comprise finding information or giving advice, as far as this is experienced as strengthening the relationship. Instrumental support means that others are doing chores for the patient, for example, doing their shopping, dealing with bureaucratic demands, giving neighbourly support, like, for instance watering flowers. This may also include giving advice and finding information, in so far as this is experienced as an aid to problem solving. As far as the rating is concerned, informational support is not a separate issue. The assessment covers the last six months.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	There are none or hardly any people in the picture from which the patient might receive instrumental and/or emotional support. The patient clearly emphasizes that he considers it unnecessary or impossible to open up possible avenues of support for himself. Example: A patient with a narcissistic-schizoid type of personality lives an isolated existence in his own appartment. He tolerates his mother stopping by to bring him his clean laundry, beyond that there are no contacts with family. The patient is divorced and unemployed. He has fallen out with the few friends that remained. He just wants to be left alone, thinking only that everybody just wants to manipulate him.
2 - medium	There are people from whom the patient might receive instrumental and/or emotional support. The patient avails himself of their help, and is occasionally in touch with them. He is, however, unable to use these contacts for himself in the sense of instrumental or emotional support for coping with his disorder or problems. Example: A patient with a depressive disorder following or resulting from his wife's death

	has withdrawn into himself. Although the circle of acquaintances and friends of the couple are still available for practical support (doing the shopping, help with household chores) and offers emotional support ("stop by anytime"), the patient refuses help out of loyalty to his lost object. With reference to the loss suffered, he does not know how to talk about it, as his partner was the one who always said everything for him.
4 - very high	From the patient's report several persons stand out from whom he may obtain instrumental and/or emotional support. The patient is able to actively avail himself of and use these possibilities of support, not only with regard to instrumental, but also emotional aspects, in order to cope with his disorder and problems. Example: A female agoraphobic patient who has a very involved circle of friends and acquaintances, is able to initiate active help from any person from this circle with respect to dreaded everyday activities (for example doing the shopping, getting to work). In particular, she is able to relate her anxieties to her mother and feels very understood by her.

4.1.7 Impediments to change

4.1.7.1 External impediments to change

Definition

In order for the motivation for change to be translated into action, in the sense of the patient entering therapy, contextual variables are of importance. They comprise, for instance, the availability and affordability of psychotherapy, or of in-depth diagnostic psychosomatic conversations, in order to clarify whether psychotherapy is indicated, the respective social background (job situation) which may facilitate the start of a therapy, as well as an attitude of acceptance in someone's immediate environment vis-à-vis an in-depth psychosomatic diagnostic process, or psychotherapeutic treatment. If any of those indvidual environmental factors are only present to a limited extent, or not at all, they may act as external impediments to entering therapy. The patient, in every single case, will weigh the expected benefits against the cost of starting therapy. This includes real-life obstacles to utilizing psychosomatic contacts, or psychotherapy, or to translating into action, respectively, an existing motivation for change. What must also be

considered is an absence of, or restricted availability, of methods that would need to be indicated in a particular case, or the disproportionate amount of hours needed to reach a psychotherapist or psychosomatic physician. In addition, a lack of, or limited finance can be an obstacle to translating a basically existing motivation for change into appropriate action. Additional external impediments may include a threatening job loss, lack of available child care, or care for relatives, when a patient intends to enter into an in-patient psychotherapy. Fear of stigmatization, or undesirable social consequences too, may be ascribed to external conditions that influence the motivation, for example, the reactions of those in the work place.

Operationalization

It must be assessed how far the indicated diagnostic or psychotherapeutic measures are available at all, or whether, for instance, beginning a therapy would involve other costs, like those linked to long hours of commuting. Along similar lines, a lack of or limited funding by health insurers may be another obstacle. Social impediments become apparent when, for instance, the patient fears suffering significant professional disadvantages because of starting psychotherapy (threatening job loss, when in-patient psychotherapy is begun, or reduced chances of promotion), or if a mother is unable to begin in-patient treatment because she cannot find childcare for her children. Furthermore, it is important to assess to what degree beginning therapy is accepted by a patient's social network; real, feared, or imagined stigmatization may constitute obstacles here. The magnitude of external impediments results from the strength of individual impairments, or the interplay of several of them.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	There are no relevant external impediments. Example: A patient with a mental or psychosomatic disorder, who is basically motivated to change and to have psychotherapy, finds a suitable psychotherapist, or suitable psychotherapeutic setting, in his regional area. The question of who covers the costs has been clarified and the planned treatment can be adequately and largely unproblematically integrated into the context of his family and work.
2 - medium	Individual external impediments exist, which can, however, in effect be overcome. Example: A patient with an anxiety disorder, who is motivated to have psychotherapy, cannot find a therapist for the indicated outpatient behaviour-therapy in his regional area. For

	him to start treatment, he must accept relatively costly and lengthy travel times. As an alternative, he could begin an in-patient treatment.
4 - very high	There are grave external impediments. Example I: A senior executive suffering from a mental or psychosomatic disorder, who is essentially motivated to have psychotherapy, finds no suitable psychotherapist in his regional area and would have to seek inpatient psychotherapy as an alternative. This raises a number of serious problems for him. The patient fears that yet another extended period of absence, after an already rather long period of sickness leave, may lead to professional disadvantages with respect to a possible promotion. In addition, he fears that his colleagues and his employer might find out that he is suffering from mental problems, which in turn might bring professional and personal disadvantages for him Example II: A single mother of two children, aged 10 and 12, is to begin inpatient psychotherapy for a serious anxiety disorder. The patient is essentially motivated to undergo this type of treatment, however, sees no possibility of beginning the treatment as she has no one who could comprehensively and reliably care for her children during that time. Example III: An unemployed patient with a chronic pain disorder, which in a relevant way is manifested through psychosomatic factors, has filed for a pension after a series of "failed" somatic treatment and rehabilitation measures. He is basically open to psychotherapeutic-psychosomatic rehabilitation measures suggested to him by an expert in psychosomatic medicine, as he can imagine being helped through this measure. He fears, however, that his pension

	application would be rejected if his health situation changed, and that he would continue to remain in an unstable unemployment situation, or even that of a social security recipient.

4.1.7.2 Internal impediments to change

Definition

This item comprises the "internal impediments" of the patient which can be traced along the path of his specific mental development. They include, for example, characteristic, psychodynamically active, unconscious conflicts, but also possible typical characteristics of mental structure (for instance, a limited capacity for self-regulation, or for tolerance of stress). These may be the prerequisites for developing relevant resistance to change, or displaying regressive developments, which make participation in a therapy more difficult or might even prevent it altogether.

Operationalization

One way of determining possible intrapsychic impediments to change would be to look for intrapsychic conflictual motives, which may make participation in psychotherapy more difficult for the patient. This may include the conflicts of individuation versus dependency, or submission versus control (cf. Axis III). Another way to rate therapy cooperation would be to ascertain how far certain structural features would oppose a patient's participation in psychotherapy. Impediments due to non-existent emotional or cognitive resources may also arise in situations where a patient desires to undergo a reflective and motive-clarifying therapy, which, however, he can only utilize insufficiently, or not at all, because of a limited ability for introspection and reflection. Similarly, the absence of a capacity for internal regulation and tolerance of stress may be detrimental,in the long term, to the patient's ability to undergo therapy. In addition, narcissistic motives may have a negative effect on an apparent motivation for psychotherapy.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	There are no relevant internal impediments. Example: A young patient with an anxiety disorder shows good motivation for psychotherapy, as well as displaying good affective and cognitive prerequisites for psychotherapy. Overall, he seems to have adequate stress tolerance. For him, the planned psychotherapy represents a good chance for further development, a position he can stick to with respect to himself, his family and his job-related environments.
2 - medium	The patient either displays a great number of "internal impediments", or individual

	impediments of considerable intensity. Example: A lawyer who has pretty good emotional and cognitive resources obtains, at the same time, considerable and complex secondary gain from his illness. This includes, for instance, a pension granted due to his inability to work, and massive relief through his family from unpleasant everyday chores.
4 - very high	A range of very marked "internal impediments" is present. Example: A patient with a somatization disorder has very limited access to the psychosocial conditions of his illness and, overall, has a narrow range of emotional expression. In addition, he experiences the fact that a psychosomatic diagnosis is indicated in his case, as "insulting". He fears that he will be considered "mad" by the people in his environment and thus takes a rejecting stance towards psychotherapy.

4.1.5P Patient's concepts about change (Psychotherapy module)

This concerns the desired changes a patient currently aims for. What needs to be taken into account here is that patients' aims or wishes for change evolve with reference to, and are dependent on, various influences. The development of therapy aims shows a process-like character. In particular, the experiences gained in initial psychotherapeutic interviews, or during psychotherapy, can lead to changes in the aims that patients are striving to achieve. Correspondingly, a central task of the initial interview is thus to work out and elaborate adequate therapy aims together with the patient. Not only the interview, but also the psychotherapeutic process itself will often be about elaborating and further developing aims that are appropriate for the patient. The modes of change we have elaborated must not to be regarded as alternatives; a patient may have desires for change simultaneously at several or all of those levels.

4.1.5.P1 Symptom reduction

Definition

As a rule, a patient with a mental or psychosomatic disorder will have a particular interest in eradicating or reducing his symptoms. A patient may, however, despite existing symptoms, also be interested in changing personal characteristics, modes of experiencing, and relationship and behaviour patterns. In many instances, patients will be motivated to change symptoms as well as personal or interactional factors.

By itself, the change a patient desires says nothing about whether a patient is motivated at all for psychotherapy in general.

Operationalization

The kind of change for which the patient is motivated can be assessed based on how he presents his problems in the interview, and on how the aims for change are formulated. Besides the actual content of the conversations, scenic information (for example nature and extent of symptom presentation) is important, too, for an assessment of the kind of change for which the patient is motivated.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	The patient wants to change or develop. The symptoms themselves only produce slight pressure for change. Example: A patient with relatively mild pain issues, who is interested in psychotherapeutically working through or clarifying possible psychosocial conditions which might be related to his symptoms. These may include long-lasting or current mental stresses. A quick change in symptoms is of secondary importance to the patient at this time.
2 - medium	The patient considers a quick and lasting reduction of his complaints and symptoms important. He also emphasizes a working through and clarification of the psychosocial stresses related to these symptoms. He expects the treatment to be equally effective in both areas of his problem. Example: A depressive patient is aware of his dependency issues and desires to work on this lifelong personality trait In addition, he considers it important that his depressive symptoms (brooding, despondency, lack of internal involvement) be mitigated in a quick but lasting way.
4 - very high	All the patient expects is a quick and permanent reduction of his symptoms, beyond this he is not interested in working on any other mental or psychosocial stresses. One reason for this may be that the pressure of the symptoms is this high that he has no resources available for dealing with other

	problems that are potentially worthy of change, or perhaps, that the patient has none or only limited access to any further psychosocial stresses. However, we may also find patients who do have very differentiated access to their problems, but, based on a current specific situation, but whose only motivation is for a quick and defined symptom reduction. Example I: A patient with a somatoform disorder wishes to change bodily symptoms exclusively, because he has no access to additional psychosocial problem areas. He has, along the lines of the concept of "psychological mindedness", none or only limited access to intrapsychic problem areas. Example II: A patient with a massive fear of exams is shortly to take an exam. He feels a high need for symptom reduction and therefore welcomes all measures that might bring about change as long as they do so quickly and successfully.

4.1.5.P2 Reflective-clarifying of motives/conflict-oriented

Definition.

With reference to psychodynamic theory, it is of interest here to note how far the patient, during therapy, wishes to gain affective and cognitive access to a possible psychosocial (psychodynamic) background for his symptoms/problematic issues.

This may include not only intrapsychic motives, conflicts, and personality dimensions in a more specific or broader sense, but also problematic interpersonal issues.

Operationalization

This assesses how far the patient can focus on selected conflictual experiences and motives, as well as on cognitive attitudes, while striving to change these with therapeutic help. What is assessed is the general readiness of the patient, independent of his ability. The patient should have demonstrated a certain amount of self-reflection, and a readiness and ability to engage in a close therapeutic relationship, as well as in processes of regression.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	The patient has no motivation for gaining affective or cognitive access to a possible

	psychosocial background for his symptoms. He does not reflect on his attitude towards his disorder. He is not interested in identifying and working on conflictual areas of his life. Possible links between conflicts and symptoms which the therapist points out to the patient are rejected. Example: A patient expresses his explicit wish "not to dig so deep", or shows marked (unconscious) resistance, for instance in the form of "forgetting" connections that had already been worked out. The reason might be that the patient has no access to, or fears intra- or interpersonal stresses.
2 - medium	The patient shows an interest in the psychosocial/psychodynamic background to his symptoms. His motivation to change something therefore also comprises the affective and cognitive access to the background of his symptoms. The patient desires to understand the underlying background and wishes to solve the conflictual constellations. Example: A patient is able to describe the psychosocial/psychodynamic background of his symptoms and the emotions and affects connected with it. Among other things, he regards the offer of therapy, involving the clarification of motives as an important means to solve his conflicts.
4 - very high	A patient strongly desires to gain affective and cognitive access to the underlying background of his symptoms. In his motivation to bring about change, he puts particular emphasis on the wish to understand the problem constellation and its crucial intra- and interpersonal psychical aspects. Example: A patient utilizes his good cognitive and emotional access to understanding his problems, independently constructing links between them and the apparent symptoms.

	His main therapeutic goal is to understand the conflictual constellation.

4.1.5.P3 Emotional supportive

Definition

This assesses to what extent the patient seeks predominantly emotional support and relief, consolation or assistance in the therapy. Even if one considers that motivation for supportive psychotherapy is not exactly contradictory to a reflective motive-clarifying psychotherapy, it would generally apply that a patient who is primarily motivated towards having a supportive psychotherapy is less interested in working on internal conflictual motives.

Operationalization

In the diagnostic process, attention should be paid to the degree to which the patient presents himself as helpless, dependent, and support-seeking, or directly expresses the request for emotional guidance and support in coping with his problems.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	The patient shows no motivation to seek out a therapy where he would obtain emotional relief, support, consolation or help. He either has no need for or no interest in those kinds of therapy elements. He defends against respective needs. Example: A patient in a situation of crisis does not take up help offered by the therapist or other personnel on the ward, as he is relatively stable emotionally and/or finds sufficient emotional support in his social environment so that he does not need it in therapeutic form.
2 - medium	The patient is interested in obtaining emotional relief and support through therapy, but is also able to engage in therapeutic processes which emphasize other therapeutic elements. His wish for those elements of therapy is, however, not very strong. Example: A patient utilizes reflective and motive-clarifying therapies in order to obtain emotional relief for himself. At times he directly, or indirectly, through behavioural enactments, requests the therapists' support with regard to his emotional needs.

4 - very high	The patient is primarily interested in obtaining emotional relief through therapy, to get consolation and assistance and to get the feeling of being emotionally contained and supported in the relationship with the therapist. He refuses a therapy that lacks supportive elements. Example: A patient repeatedly seeks out the therapist or the staff on a psychotherapy ward in order to obtain emotional relief for himself. He has difficulty in reducing his tensions without the help of others. Interpretative and confrontational therapies place excessive demands on him and may lead to an increase in symptoms.

4.1.5.P4 Active-directive intervention

Definition

In order to cope with problems, the patient seeks a primarily active and directive type of support. His readiness, and possibly also his ability to deal with himself and his problems in a reflective way, is low at the present time. The patient is pragmatically oriented towards methods which lead to direct change of behaviour, rather than expecting in-depth emotional support from the psychotherapist through a psychotherapy.

Operationalization

What is assessed here is how far the patient seeks out, in particular, active types of assistance to help him cope with his problems. He expects them to be transmitted to him by way of information or exercises (for example pain programme, anxiety management programme) through one or several therapists. This may include measures like relaxation training, self-assurance trainings, and mobilizing measures like physiotherapy, etc.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	The patient regards active-directive measures as unimportant. This may be adequate, in a patient with a reflective capacity, as he needs no active-directive measures. In a different case, it can, however, be an expression of interpersonal difficulties or resistance. Example: A patient with a narcissistic disorder refuses to take part in therapy modules where he has to follow detailed directions. As the

	reason for his refusal, he mentions that these therapy modules were "too trite" and have nothing to do with his problem.
2 - medium	To a particularly great extent, the patient expects help through information provided, and through physically mobilizing and therapeutic measures, which aim at direct change of behaviour. Therapies in which these elements are missing are rejected by the patient, but the patient is able to participate in therapies in which mobilizing and directive elements are not the central focus. Example: A pain patient seeks specific help through a manualized pain management programme. He is ready to work on deeper lying conflicts which are being addressed through this, too.
4 - very high	The patient is only interested in help through measures which mobilize or direct him, or which can be carried out on him. These include, especially, body-centered treatments like physiotherapy, pharmacological therapy, training and problem management programmes, or assistance through social workers. Example: A patient with a pain disorder repeatedly utters the request for massage and injections. Single and group therapies are only used by him to reiterate these wishes and otherwise are regarded as not helpful for the "actual problem". Therapists and other staff members who accede to this request for direction are idealized by the patient.

4.1.6P Patient's resources for change

4.1.6.P1 Psychological mindedness

Definition

This item captures the patient's openness towards for instance, a psychological, conflict or interaction-based, contemplation of his existing mental/psychosomatic complaints. It is used to represent the extent of both the ability and inclination of the patient to basically acknowledge a psycho-reactive genesis of his complaints (individual aspect), and to deal with the respective interpretations of a psychodynamic psychotherapist (interpersonal aspect).

Operationalization

An assessment is made here as to how far the patient is able to recognize and express mental processes (wishes, thoughts, feelings) introspectively, and also interpersonally, and how far he relates these to his complaints and impediments. For this purpose it is critical to know to what degree the patient is actually capable of experiencing the recognition of the part that he contributes, including unconscious mental and interpersonal processes, as important and helpful in the development of a broadened understanding of his complaints. In addition, it is to be judged here whether the patient is or is rather not prepared to deal with the suggestions of the interviewer (appropriate trial interpretations, i.e. focussed on defence rather than on impulse) about possible links between inner or interpersonal events and his own problems or symptoms, in an accepting and constructive manner.

In the interview, attention must be paid to the fact of whether and how far the patient establishes connections between his inner experiences, his feelings, thoughts, and relationships, on the one hand, and his complaints, on the other. Such readiness can be judged particularly well, therefore, on the basis of passages from the conversation, which could have enabled the patient to reflect on the origin of, or change in, his symptoms, with respect to the psychosocial context, his personal biography, sexuality, or his emotional experiencing.

Upon detailed inquiry about the trigger situations it should be carefully noted whether the patient reacts with refusal, disinterest, amazement, thoughtfulness, or awakening curiosity to the interviewer's interest in the details around the trigger situation: does the patient remain rather passive, or does he actively explore possible links himself, for example in the context of interpersonal or sexual conflicts? Of similar importance is the patient's handling of suggestions from the interviewer as to possible psychodynamic interrelationships. Attention must be paid therefore to the patient's interest and readiness to reflect on possible psychodynamically relevant interrelationships, besides scenic, emotional, non-verbal and language-based reactions to interpretative statements.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	The patient is unable/hardly able to identify any connection between inner or interpersonal events and his own problems/symptoms and rejects any hints to this effect. Also, after listening to such suggestions he is unable to imagine that this type of interrelationship might be important for him. Example: A patient limits himself to the description of primarily physical complaints, and does the same also when describing dysfunctional relationships, sticking to external facts only. The patient has no access to his inner world

	(no capacity for introspection). The patient rejects having a personal share in the origin of the symptoms, appropriate trial interpretations are not understood or rejected ("The pain comes and goes as it wants, how it wants, most of the time it moves right across here, from the upper rim of the pelvis to the spine and back again. I can't do a thing, although I have tried everything. My doctor once asked me whether I could imagine if this could be connected to my home situation. I think he is just as clueless as I am, even though he's been to university").
2 - medium	The patient, in a very differentiated manner, names intrapsychic events (for example wishes, thoughts, feelings), but is unable himself to establish a link between them and his own problems/symptoms. The patient listens to suggestions with amazement, however, without using them for a broader understanding of his symptoms. Example: The patient describes his complaints or his dysfunctional relationships. In this he succeeds in integrating his inner experiencing ("At times I think that my pain worsens when it is all getting too much for me again.") However, he does not succeed, on his own, in recognizing links between his experience and contextual influences. Suggestions to such possible links do not irritate the patient, but he respects them, for instance as an authoritative expert opinion, without however reflecting on them any further.
4 - very high	The patient describes conditional interrelationships between his wishes, feelings, and thoughts, on the one hand, and symptoms/modes of behaviour, on the other. The patient uses the therapist's suggestions in order to gain further insight into his mode of experiencing and his behaviour and in doing so, is able to recognize biographically anchored patterns

	of processing and behaviour. Example: The patient relates his complaints, or his dysfunctional relationships (introspectively), to his inner experiences, while also referring to his biography. In doing so, he is also able to consider some of his own contradictory wishes, feelings, thoughts ("The pain I feel when I struggle again today caring for my demented father reminds me how much I suffered from this man as a child. Now, as then, he just looks right through me, even though I wished so badly that he would look at me for once.") Trial interpretations are constructively taken up and used for further self exploration.

4.1.7P Impediments to change

4.1.7.P1 Secondary gain from illness/conditions maintaining the problem

Definition

This refers to a patient's (unconscious or conscious) gain in social benefits resulting from his illness and its consequences. It is expressed, for example, through more frequent sickness leaves, prolongued hospital stays, frequently prescribed visits to health resorts, times of convalescence, and an avoidance of the normal aspects of everyday working life. Very often, the fact of "being covered by insurance" (such as receiving a pension due to the inability to work, claims from an accident insurance and so on) leads to patients consciously or unconsciously maintaining an illness or its consequences, in order to claim those benefits. Patients with a high secondary gain from illness, when compared with other patients with similar symptoms, tend to display stronger avoidance behaviour with respect to demands made on them in the above sense. In these patients, regression can very often also be an unconscious attempt at coping with their illness.

Operationalization

An assessment of whether an event (for instance being certified unfit to work, or receiving pension status) represents an illness gain or not for any particular patient, needs to be made along the parameters of a "individual gain and loss" analysis. This individual gain and loss calculation can occur both consciously and unconsciously. It is to be noted how far certain events, experiences, or other aspects, in sum, represent something "positive" for the patient. Very often conscious or unconscious intentions of the patient may be found which make him cling to or further expand a gain from illness. For this purpose it is helpful to judge the "critical" events or characteristics against the background of the patient's individual development and the overall psychosocial situation. It also makes sense to look at the social network and the interests or needs from that side. The window of observation should comprise the course of the illness up to this point. The "secondary gain from illness" is judged by the interviewer, independently of how

the patirnt himself might represent it during the interview. Care must be taken not to automatically interpret usually typical consequences of illness, as for instance, hospital stays, doctors certifying a patient unfit to work, pensions being granted, as a gain from illness. Frequently, a high gain from illness can be perceived by the interviewer in the countertransference, as these patients often use to block themselves against any change to their situation.

Symptom level scores and anchor-point descriptions	
0 - absent to minimal	A secondary gain from illness cannot be found. The present illness has only negative consequences for the patient. A patient shows no or hardly any secondary gain from illness, although he is receiving social relief because of his illness. Example I: A patient suffers from a serious recidivist depression. Due to the long illness he has lost his job, an application for a pension is pending. Because of the recurring depressive phases his wife has left him, friends have withdrawn. Example II: A patient receives pension status upon the advice and application of his doctor. He wanted to remain in the work force, as recognition from work has always been very important to him.
2 - medium	In addition to the stresses brought about by the illness, there are also clearly perceptible, conscious and/or unconscious "advantages" which maintain the illness or the problem. Example: A patient with an agoraphobic anxiety disorder and panic attacks experiences these as extremely threatening. She is unable to leave the house without being accompanied. Her partner, whom she considered as not supporting her enough, and who had only had his professional career in mind, has to now do all the shopping and take the children to school.
4 - very high	Considerable advantages because of the illness become apparent in indivdual areas of

	life (for example financial advantages, social benefits through pension payments, support through relatives). Or, advantages manifest in several areas of life, which, in sum, represent a large gain from illness. Example: An unemployed patient reports "unbearable headaches" after a nose-to-tail car collision, although doctors were unable to find a somatic correlation and the suffering does not seem comprehensible. He manages to obtain repeated referrals as an inpatient and then obtains considerable financial support from a per-diem allowance from his insurance, applies for a pension and sues the opponent in the accident for damages.

4.2 Axis II - Interpersonal relations

4.2.1 Introduction

OPD offers two types of relationship diagnosis which are conceptually closely linked, but which differ with respect to the amount of rating required: one, the individualized diagnosis of dysfunctional relationship patterns, forms the standard procedure and enables the typical interpersonal entanglements between a patient and his interaction partners to be differentially described, and to reconstruct them as maladaptive cyclical events. This procedure focuses exclusively on the dysfunctional aspects of how the patient handles the relationship. Number two, the rating of themes and resources, in turn, allows the determination of relationship themes which are either very problematic for the patient, or which the patient is coping with particularly well. The latter rating is simultaneously easier and allows for an orienting diagnosis, which is sufficient for many practical purposes.

A prerequisite for both ratings is a clinical-diagnostic interview in accordance with the guidelines of the OPD-interview (see Ch. 5). The diagnostic assessment incorporates the following two sources of information:

- firstly, the relationship experiences described by the patient in the interview. What he reports illustrates how he experiences himself and others in interactions, and how these interactions typically unfold.
- secondly, scenic-interactional information from the direct interaction between patient and diagnostician. This allows the interviewer to directly access, through observation, the patient's relationship behaviour. In addition to the observable behaviour of the patient, the diagnostician may use his own experience and reactions (countertransference) as sources of information.

4.2.2 Changes made to Axis II of OPD-1 resulting in Axis II of OPD-2

Axis II "Interpersonal Relations" has kept its fundamental structure: just as OPD-1, OPD-2 also focuses on describing the central, repetitive and dysfunctional relationship pattern of a patient from two perspectives, namely from the experiential perspective of the patient and from that of his interaction partners. As in OPD-1, the interviewer proceeds on the basis of a list of relationship items from which descriptions adequate for each individual case are selected. At the same time the following changes and additions were made:

- The compilation of the items on the list now follows the logic of the circumplex model of interpersonal behaviour more stringently, making a more consistent use of the structure of the circular model. In the course of this adjustment, the contents of the items were slightly modified, and their number increased from 30 to 32. The cluster heading of loving care again covers a number of items.
- Instructions are now available as to how both experiential perspectives, that is to say, the interpersonal positions described with the help of the items, can be summarized, or integrated, into a relationship dynamic formulation. This allows the incorporation of the relationship dynamic formulations, as an integral part, into the Axis II diagnosis (in OPD-1 only optional).

- For a routine diagnosis, a variant of the method is now available which requires less time and resources to use, and which is limited to determining a patient's central relationship themes.
- Within the framework of the rating of relationship themes, it is also possible now to determine relationship modalities which the patient competently masters and which are therefore available to him as resources.

4.2.3 The standard procedure

The OPD relationship diagnosis employs a series of terms and methodical tools which are introduced and explained in the following: the experiential perspectives of the patient and of others, the so-called interpersonal positions, the item list to describe aspects of the relationship, the circumplex model behind this list, as well as the schema for the relationship-dynamic formulation.

4.2.3.1 The experiential perspectives

Corresponding to the two different sources of information described - the relationship accounts of the patient, and the behaviour that becomes observable in the interview - we distinguish between the experiential perspective of the patient and that of others (including the investigator), when determining the central relationship pattern.

- Experiential perspective of the patient (Perspective A)
  A patient's internal concept about the way he handles his relationships is revealed by his descriptions of his relationship experiences. From these descriptions, it can be ascertained which aspects of the relationship he can himself experience, and identify, in both his own behaviour and in that of his interaction partners. The interviewer is to understand this experiential perspective and reflect it in his relationship diagnosis.
- The experience of others - also of the investigator (Perspective B)
  This perspective examines the question of how others (interaction partners of the patient) again and again experience the patient's offers of relationship and how they react to those. In answering this question, various sets of information can be used. The first option for the investigator is to put himself in the position of the objects described by the patient and examine how he would be likely to experience the patient and how he would respond to him. Secondly, he can examine his own experience in the encounter with the patient and try to account for the impulses and feelings which the patient evokes in him. He can finally attempt to match his own experience and his ideas about how others experience the patient. If he succeeds in bringing these into a convincing agreement, he will then, with some certainty, have identified characteristic features of the dysfunctional pattern. If he does not succeed here, however, further clarifications are required: the investigator must then examine whether he has perhaps overlooked important aspects in the patient's offer of relationship, or establish in what specific way the patient has a distorted experience of his relationships, so that the discrepancy which arises may be explained as based on such incorrect perception.

A further level of observation is added to the assessment process just described, if (for instance in a research context), an assessment is made based on a video tape. In this case the investigator can, firstly, attempt to understand the experiential perspective of the objects (that is to say of others) as the patient describes it; secondly, he can examine the investigator's behaviour on the tape and his reactions; and thirdly, he can observe his own feelings and impulses towards the patient. In this assessment context also, it is necessary to integrate the various pieces of information and to bring them into agreement with each other, in order to arrive at a valid judgement of how the objects tend to generally experience the patient and how they typically react to him.

4.2.3.2 The interpersonal positions

Dysfunctional relationship patterns are represented as specific constellations of interpersonal modes of behaviour of a) the patient, and b) others (his objects). This applies to both perspectives of experience, so that four interpersonal perspectives can be distinguished:

Positions in the experiential perspective of the patient:

- The patient experiences himself (towards others or with others) time and time again as ...
  The focus here is on the patient's interpersonal experience and behaviour. Those modes of relating which appear dominant, or more or less continually effective, in how the patient experiences himself, are described.
- The patient experiences others time and time again as ...
  The focus here is on the behaviour modes of the objects towards the patient, in the way they are more or less consistently experienced and described by the patient.

Positions in the experiential perspective of the interviewer:

- Others - including the interviewer - experience the patient time and time again as ...
  The focus here lies on the patient's offers of relationships towards other persons - also towards the interviewer. What is described are the patient's modes of behaviour as they are perceived by others.
- Others - including the interviewer - experience themselves (towards the patient) time and time again as ...
  This focuses on reactions, impulses and feelings which the patient triggers in others, and that is also in the interviewer. What is described are those reactions which the patient predominantly seems to suggest others might have towards him.

4.2.3.3 The item list

The assessment of the experiential perspectives is made on the basis of items contained in the item list as reproduced in Appendix 13.2.1. In this list, the four interpersonal positions are represented by four columns in which modes of relating

can be marked. The columns which reflect the patient's experience are highlighted with a light background, those that capture the experience of others show a dark background.

The left side is used to mark the behaviour of the patient, the right side for marking that of his objects (others). The items to the left and the right of the central column are identical in content and only differ in their grammatical form (depending on whether the patient or the others form the grammatical subject). With the help of this list the therapist is able to mark, for each of the four interpersonal positions, those items which are important for the description of a patient's dysfunctional relationship pattern. As a rule, a maximum of three items is sufficient in order to adequately capture any one of the interpersonal positions.

Because they describe dysfunctional behaviour, these items show a basic pathological orientation. Some of the items express this orientation through an emphasis on item quality (for example, the patient experiences himself over and over again as attacking/damaging others), others emphasize the quantity, or intensity of the item (for example, the patient experiences himself over and over again as very concerned/caring).

The patient experiences himself (towards others or with others) time and time again as ...				Relationship Themes	The patient experiences others time and time aga			
	Others - including the interviewer - experience the patient time and time again as ...					Others - including the interviewer - experience with respect to the patient time and time aga		
		1	Allowing a lot of space, letting them do their own thing	Allowing space			1	Allowing a lot of space, letting him d thing
		2	Guiding little, avoiding influence	Guiding others			2	Guiding little, avoiding influence
		3	Admiring, idealizing	Acknowledging others			3	Admiring, idealizing
		4	Being apologetic, avoiding reproaches	Attributing responsibility			4	Being apologetic, avoiding reproache
		5	Being invasively affectionate	Showing affection			5	Being invasively affectionate
		6	Harmonizing, avoiding aggression	Showing aggression			6	Harmonizing, avoiding aggression
		7	Caring very much, being worried	Caring			7	Caring very much, being worried
		8	Tactlessy imposing himself	Making contact			8	Tactlessly imposing themselves
		9	Restricting space, interfering	Allowing space			9	Restricting space, interfering
		10	Controlling, making claims and demands	Guiding others			10	Controlling, making claims and dema
		11	Belittling, devaluing, and embarrassing others	Acknowledging others			11	Belittling, devaluing, and embarrassir
		12	Accusing and reproaching	Attributing responsibility			12	Accusing and reproaching
		13	Withdrawing his affection	Showing affection			13	Withdrawing their affection
		14	Attacking and damaging	Showing aggression			14	Attacking and damaging
		15	neglecting, abandoning	Caring			15	neglecting, abandoning
		16	overlooking, ignoring	Making contact			16	overlooking, ignoring

□	□	17	Claiming space and independence for himself	Claiming own space	□	□	17	Claiming space and independence for
□	□	18	Defying and resisting	Conforming	□	□	18	Defying and resisting
□	□	19	Boasting, making himself the centre of attention	Being self-assertive	□	□	19	Boasting, making themselves the cent attention
□	□	20	Denying any guilt	Admitting guilt	□	□	20	Denying any guilt
□	□	21	Losing himself when others show affection	Accepting affection	□	□	21	Losing themselves when he shows aff
□	□	22	Protecting himself insufficiently, allowing dangerous developments	Being self-protective	□	□	22	Protecting themselves insufficiently, a dangerous developments
□	□	23	Leaning heavily on others, clinging	Relying on others	□	□	23	Leaning heavily on him, clinging
□	□	24	Having few boundaries in place, being too involved	Allowing contact	□	□	24	Having few boundaries in place, bein involved
□	□	25	Avoiding autonomy, seeking guidance	Claiming own space	□	□	25	Avoiding autonomy, seeking guidanc
□	□	26	Complying, holding back, resigning	Conforming	□	□	26	Complying, holding back, resigning
□	□	27	Belittling, devaluing himself	Being self-assertive	□	□	27	Belittling, devaluing themselves
□	□	28	Blaming himself	Admitting guilt	□	□	28	Blaming themselves
□	□	29	Shutting himself off, fleeing from other's affection	Accepting affection	□	□	29	Shutting themselves off, fleeing from affection
□	□	30	Protecting himself, especially from attacks, being on guard	Being self-protective	□	□	30	Protecting themselves of his attacks, guard
□	□	31	Not leaning on others, being self-reliant	Rely on others	□	□	31	Not leaning on others, being self-reli
□	□	32	Isolating, cutting himself off, withdrawing	Allowing contact	□	□	32	Isolating, cutting themselves off, with

Figure 4-1: Item list interpersonal relations

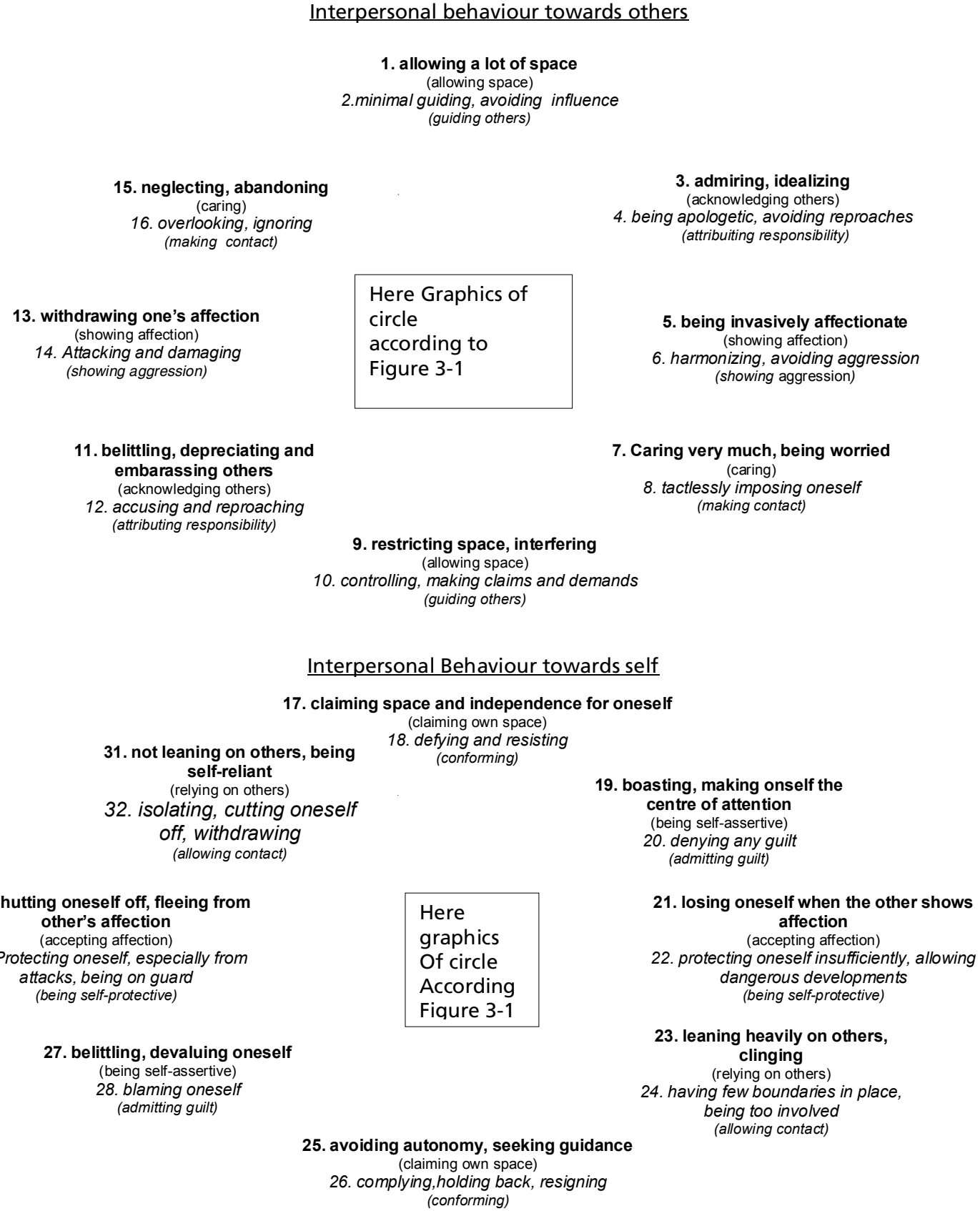
4.2.3.4 The circumplex model of interpersonal behaviour

The item list is based on a circumplex model of interpersonal behaviour which goes back to Benjamin (1974; 1993). In this model (cf. Figure 4-2), interpersonal qualities are arranged on two circles, whereby the upper circle contains active modes of relating, aimed at another person. The items in the lower circle describe reactive, or intransitive modes of relating (directed towards the self). Each of the circles is transsected by a horizontal axis, which has "hostility" as the pole on the left, and "friendly attachment" as the pole on the right. The vertical axis, in the upper circle, represents autonomy granting behaviours, on one end, and controlling behaviours, on the other. In the lower circle, the vertical axis represents self-assertive behaviours, on one end, and compliant behaviours on the other. The specific combinations between any of these two dimensions of affiliation (the horizontal axes) and interdependence (the vertical axes), determine the exact position of a certain relationship behaviour on the circles. The choice and formulation of the items follows a specific logic which we wish to elucidate briefly. To illustrate, let us consider item 7 "to care very much, to be concerned" which is located in the upper circle in the lower right quadrant and which comprises a mixture of positive affiliation and controlling influence (negative interdependence). Opposite it we find item 15 "to neglect, abandon", which shows negative affiliation and positive interdependence (in the sense that the other is left to himself). Those two items are thematically related, for they describe contrary expressions of a common relationship theme which one could describe as "caring". This theme is stated in brackets under both items. In the same manner all other items, which are opposite each other on the same circle, are linked to a common relationship theme.

The logic of the model further implies that items in the upper and lower circle which are in identical positions, describe complementary relationship qualities. The theme "relying on others" which is complementary to the just-mentioned theme of "caring" is represented by items 23 "to lean heavily on others, to cling", and 31 "not to lean on others, to purport to be self-reliant", both of them on the lower circle. Each item pair of a relationship theme thus has its complementary item pair with a complementary common theme, which is assigned to a position on the respective other circumplex. This means that four of the total of 32 items of both circles are always thematically related; correspondingly, there are eight complementary pairs of themes (like, e.g. to care/to rely on others).

Such thematic grouping of the items does make very good sense clinically, in that we often find, in dysfunctional relationship patterns, several items of a thematic area are combined. Some examples may illustrate this: a patient is able to process her experience of having been neglected (item 15) in such a way that she does not rely much on others (31), and that she also very intensely cares for others (7), who in turn rely on her (23) (theme pair: to care/to rely on others). Another patient with problems of self-worth shows a pattern where he devalues himself (27) as well as making himself appear especially important (19), while at the same time both devaluing (11) and idealizing (3) others (theme pair: to acknowledge others/to be self-assertive).

Fig. 4-2: Circumplex Model of Interpersonal Behaviour



4.2.3.5 Relationship dynamic formulation

The aim of the diagnosis is to arrive at a relationship dynamic formulation which connects the four interpersonal positions with each other. This goes beyond a pure description of what is happening in the relationship, expanding and deepening it into a dynamic understanding (cf. Grande et al., 2004a). When such a connection is made, it should be guided by the schema presented in Figure 4-3, in which the typical connections between the positions are shown.

In the patients' experiential perspective the order of occurrence of events is typically from right to left (I. Relationship dynamic link):

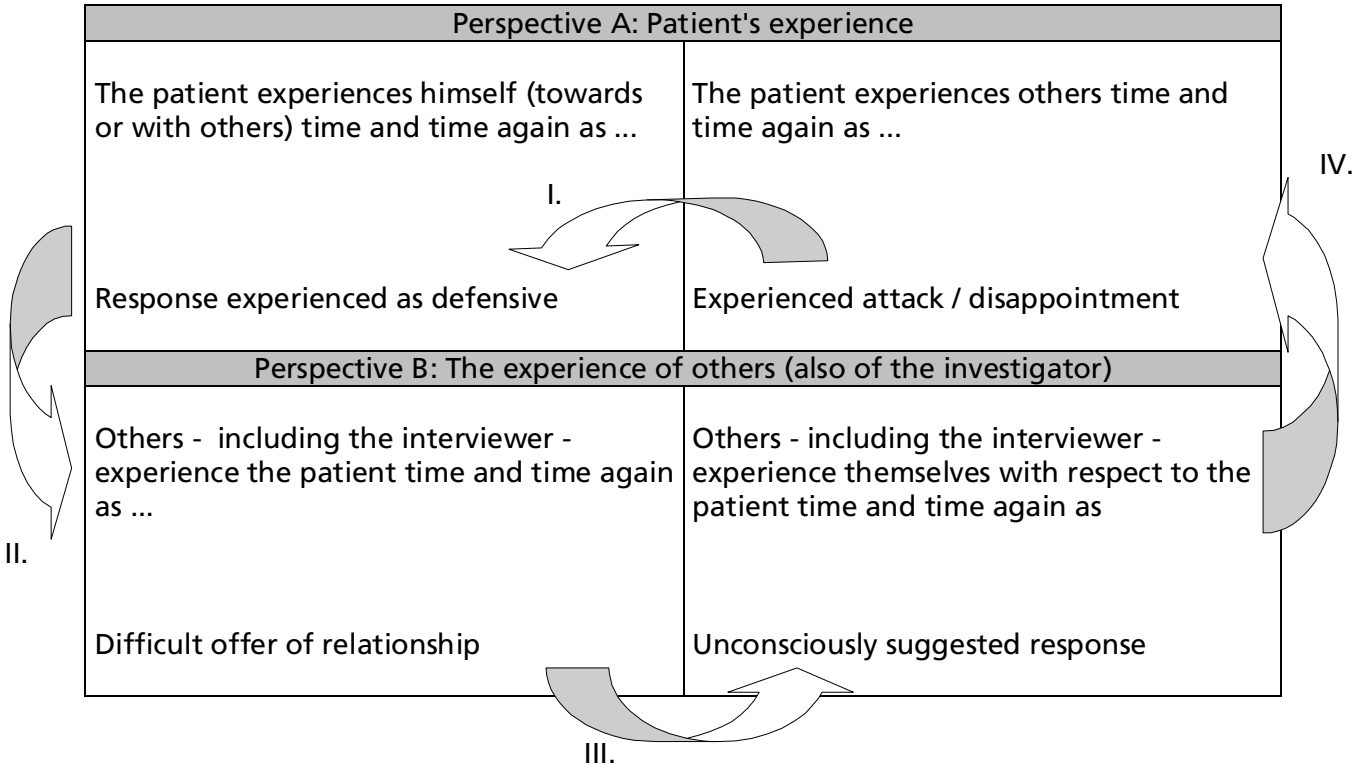


Figure 4-3: Relationship diagnosis schema according to OPD

The patients describe repetitive ways in which others relate to them, which may be disappointing, unpleasant, or hostile, and to which they themselves inevitably react with their own experience. This means that from the patient's perspective of his experience, more active modes of behaviour are frequently attributed to other persons, more reactive modes to themselves. (I. Dynamic relationship connection)

From the perspective of others and that of the interviewer, things are mostly exactly the reverse: What the patient describes as his reaction to the object, appears here as a problematic offer of relationship, which challenges, entangles, or puts pressure, etc. on the other person, etc. Most of the time it is those initiating and active moments in the relationship behaviour which the patient leaves out in his

self-experiencing and which result in a characteristic difference between self-perception and perception by others (II. link).

The third (III.) dynamic relationship connection links the two lower areas of the diagram, from left to right. With his offer of relationship, the patient is suggesting certain reactions, which can be experienced, in the countertransference, as feelings, fantasies, and impulses to act.

The examiner may now test things out: What would the patient experience if I were to give in to those impulses which he suggests I react to through his offer of relationship. Would he then experience my behaviour in just the same way as he experiences the behaviour of other persons again and again but at other times? This question relates to the IV. link between the lower right and upper right diagram areas.

If that last connection can be established so that it agrees with all the other contexts, the interpretation of the relationship dynamic events is complete. It can now be summarized in a condensed formulation: It describes a feedback loop and explains how the patient, by this offer of relationship, produces exactly those reactions which he actually fears and wishes to avoid. The match between the impulses experienced in the countertransference and the patient's experience of his objects forms the decisive criterion for whether the diagnosis of the dysfunctional relationship pattern has been successful.

4.2.3.6 Practical procedure

The standard procedure of the relationship diagnosis requires the investigator to perform three steps:

- As a first step, all items in the item lists are marked that are relevant to the description of the dysfunctional pattern; this is done for each of the four interpersonal positions. These are the problematic aspects of the relationship from the perspective of the patient's experience (as concerns his own behaviour and that of others). In this step, the number of items that can be selected is not yet limited. In the rating, care is to be taken that only typical and dysfunctional items are marked.
- As a second step, the most important items for each of the four positions are determined and entered into the data collection sheet (table 4-4). Each position allows the selection of a maximum of three items. In order to capture the dysfunctional relationship pattern as concisely as possible, it is recommended that a limit of two or even one, is put on the selection of items, but only if the respective case permits this.
- In a third step, the links drawn in Table 4-3 between the interpersonal positions are established and summarized in a relationship dynamic formulation. It must be checked in this context whether the connection between countertransference impulses and the patient's way of experiencing his objects can be conclusively established, as set out above. If this attempt fails, it may become necessary to double check the selection of items and, if necessary, to correct it in a way that the relationship circle can be completed in a convincing manner.

When selecting the items, care must be taken that not only the meaning of the verbal content of an item, but also its positioning in the circumplex model is correct. This means that the relationship aspect to be captured must correspond to those qualities along the two dimensions of affiliation and interdependence which are represented within the position of the item on the circle. An example: A patient reports that he "is resigned". This word belongs to item 26, which is assigned to the relationship theme "conform".

The context of this statement, however, shows that the patient "is resigned" in the sense that he no longer wants to put a lot of effort in as far as others are concerned and wishes to do his own thing. In this case he becomes more independent (positive interdependence), while simultaneously moving away from the others (negative affiliation). This type of behaviour is reactive and is positioned in the upper left quadrant in the lower circle. Inspection of the other items there reveals that item 32 "isolating, cutting oneself off, withdrawing" fittingly describes the patient's behaviour and is therefore the more correct choice.

Axis II - Interpersonal Relations

Perspective A: The patient's experience					
The patient experiences himself (towards others or with others) time and time again as			The patient experiences others time and time again as		
	Item Nr.	Text		Item Nr.	Text
1.	_____	_____	1.	_____	_____
2.	_____	_____	2.	_____	_____
3.	_____	_____	3.	_____	_____

Perspective B: The experience of others (also of the investigator)					
Others - including the interviewer – experience the patient time and time again as			Others - including the interviewer - experience themselves with respect to the patient time and time again as		
	Item no.	Text		Item no.	Text
1.	_____	_____	1.	_____	_____
2.	_____	_____	2.	_____	_____
3.	_____	_____	3.	_____	_____

Figure 4-4: Data evaluation sheet interpersonal relations

4.2.3.7 Clinical Example

A 32-year-old patient is admitted for inpatient therapy after a depressive-suicidal crisis. His girlfriend had left him - from his perspective a totally unexpected move for which he has no explanation - after a six-year relationship, when, due to an illness, he had to stay in hospital for several weeks. His problems relating to how he handles his relationships become apparent in his work relationships: he takes on important and demanding tasks and masters them well, according to his own accounts, but repeatedly comes into conflict with his superiors. They amend his decisions without getting back to him and ignore the arrangements he made, which to his mind, were binding. This apparently happens arbitrarily and by virtue

of their more powerful position, which annoys the patient, and which prompts him to carry on regardless and stubbornly defend his own position. He feels he is totally in the right. The situation eventually escalates to a point where the patient receives notice of termination or angrily quits.

In direct interaction he comes across as inflexible and unassailable like a piece of rock, in practice, not ready to be moved by either questions or doubts. His incredible composure is very provocative, which very quickly causes the other person to feel powerless and inferior to him. In the countertransference, impulses emerge of wanting to engage in a struggle for power and control with him followed by quick resignation due to the fact that he is so untouchable. Eventually, the strongest impulse is the wish to withdraw from the contact.

The items chosen for this example are contained in the evaluation sheet in Figure 4-5. With reference to the schema represented in Table 4-3, the following relationship-dynamic connections can be formulated:

The patient is convinced that he does his job well and that he has the right to expect that his work is respected and acknowledged. He experiences, however, that others ignore this (16), arbitrarily dominate him (10), and possibly want to take advantage of him (14).

Axis II - Interpersonal relations

Perspective A: The patient's experience			
The patient experiences himself (towards others or with others) time and time again as		The patient experiences others time and time again as	
Item Nr.	Text	Item Nr.	Text
1. 18	defying and resisting	1. 10	controlling him, making claims and demands on him
2. 32	isolating, cutting himself off, withdrawing	2. 16	overlooking, ignoring him
3.	_____	3. 14	attacking and damaging him

Perspective B: The experience of others (also of the interviewer)			
Others - including the interviewer - experience the patient time and time again as		Others - including the interviewer - experience themselves with respect to the patient time and time again as	
Item no.	Text	Item no.	Text
1. 10	controlling, making claims and demands	1. 18	defying and resisting
2. 17	Claiming space and independence for himself	2. 26	complying, holding back, resigning
3. 11	belittling, devaluing and embarrassing them	3. 32	isolating, cutting themselves off, withdrawing

Figure 4-5: Data evaluation sheet , example 32-year-old patient

He reacts to this by becoming stubbornly entrenched in his own position (18) and, eventually, by just leaving (32).

From an external perspective, the stubbornness which the patient displays as a totally justifiable response to the unreasonable demands made by others (17), is, in practice, a non-negotiable dominance claim (10). He makes this claim with superiority (11) and without the hint of any self-doubt.

By acting in this way the patient makes others angry, inducing a stubborn resistance in them (18), which, however, remains without effect and therefore deepens their feelings of powerlessness (26). This leads to others breaking off negotiations with him and turning away from him (32). (The investigator, identifying with the patient's superiors, is able to imagine that they would, in the view of fruitless negotiations, eventually proceed to making decisions without consulting with him. In a similar way, he can imagine that the patient's girlfriend timed the separation so that she could avoid an altercation.)

Each time that others break off contact with the patient (32) and cease to negotiate with him, means that, in his view of things, he is again being ignored (16), attacked and damaged (14), and arbitrarily dominated (10).

This last connection (IV.) agrees with the above and thus confirms the items chosen to describe the dysfunctional relationship pattern.

4.2.4 The rating of themes and resources

Experiences with the practical use of OPD have shown that there are areas of application for which the standard procedure is too costly and where a less complex relationship diagnosis meets the respective practical requirements. This is the case, for example, when, in routine diagnosis certain problematic aspects of the patient's handling of his relationships are to be recorded for orientation purposes only. In a research context, it depends on the respective area of interest whether an individualized rating of relationship patterns will make sense. The rating of themes and resources, therefore, presents an instrument which greatly simplifies the diagnostic procedure, while, however, staying completely compatible with the basic structure of the individualized diagnosis.

4.2.4.1 Relationship themes

The link to relationship themes may be most easily established via the circumplex model of interpersonal behaviour as in Figure 4-2. As already explained, items belonging to a set of four from this model can be thematically related to each other. The relationship theme "care", for instance, is linked with two contrary forms of relating which both describe problematic deviations from an appropriate way of "caring": "neglecting, abandoning" (item 15), in the sense of not caring enough, and "caring very much, being worried" (item 7), as an expression of a too-much. Correspondingly, there are two variants for the complementary theme "rely on others " (item 31 "not leaning on others, being self-reliant", item 23 "leaning heavily on others, clinging"). In the simplified relationship diagnosis of OPD-2, the so-called rating of relationship themes and resources, this concept of an adequate manner of relating with problematic deviations towards too-much and too-little is systematically used. The complete rating sheet is reproduced in chapter 13.7. Figure

4-6 shows a segment in which the two themes, together with their complementary themes, "care/rely on others" and "guide others/conform" are presented. Both theme pairs are graphically set off from each other by double lines.

The central column describes relationship themes as competence in the sense of appropriate behaviour. If a patient can avail himself of this competence and use it, he possesses a relationship resource, which is marked in the column R (= resource). Relationship resources may be used therapeutically; they form an intact basis on which the therapist can build in his cooperation with the patient. The columns on the left and right describe dysfunctional variants of the relationship themes, each comprising two levels. Grading the behaviour into these levels makes it possible to describe different degrees of intensity of deviation from the functional behaviour, so that a broad spectrum of relationship behaviours that go beyond what is normally appropriate can be diagnostically assigned. In the rating, the assignment of behaviours to dysfunctional categories is done categorically, however, without considering intensity. For this reason, the extreme left and extreme right columns in Figure 4-6 each provide only one space for marking.

Figure 4-6: Rating of relationship themes and resources

Dysfunctional variants: "too little"		P	Relationship theme	R	Dysfunctional variants: "too much"	
not to care for others at all, to abandon others	to care little for others, neglect others		to show appropriate care and concern for others		to care and be concerned about others very much	to always care and be concerned about others
To purport to be totally self-reliant and not in need of any help	to show little need, to lean on others little		to show oneself as needy, to trust, to lean on others		to show oneself as very needy and lean heavily on others	to cling, to stick closely to others
to shy away from any influence on others	to prefer to avoid influencing others, to guide little		to instruct or guide others appropriately (according to respective role)		to control, to make claims and demands	to be very controlling, make stern claims and demands
to be very resistant and defy any rule	to be quickly resistant, to enjoy defying others		to conform, to comply appropriately (according to respective role)		to comply quickly, to take oneself back quickly	To submit completely, give up, resign,

4.2.4.2 Practical procedure

The relationship diagnosis in the rating of themes and resources requires four steps:

- The diagnostician starts by marking, in the two outer columns on the left and on the right, all the relationship modes of the patient which are dysfunctional. This is done by checking whether any of those descriptions fit the patient. The number of markings is not limited at this stage.
- In a next step, he decides which of those modes are most relevant with respect to the disorder of the patient, and proceeds by marking the related relationship themes in the column marked "P" (= problem). He will mark two themes in this manner, which are thus selected as being problems.
- Then a formulation is made according to the general format "The patient tends to [dysfunctional behaviour], instead of [relationship theme]". An example: "The patient tends to defy any rule instead of appropriately conforming to the role he is expected to play". This formulation descriptively defines the problem and the therapeutic goal, so as to gain an orientation for treatment.
- Finally, the investigator checks whether the patient has particularly good abilities in one of the relationship themes where no dysfunction has been marked. If this is the case, this competency is marked in the column "R" as a resource.

4.2.4.3 Countertransference

Different from the standard procedure, the rating of themes and resources does not explicitly take into account the response of the others (and of the investigator) to the patient. Nevertheless, countertransference plays an important role when determining the problem themes. The investigator is has to examine, which reactions the patient suggests to him by virtue of his relationship offer, and to which theme these reactions are to be assigned. He may, for instance, mark on the sheet that the patient intensively clings in relationships, thereby putting others under pressure. At the same time he may note that he is tempted to just let the patient go and to overlook his predicament. The clinging, as well as the impulses to reject or neglect which result from it, belong to the complementary theme pair "care/rely on others" (cf. Appendix 13.2.2). By including the countertransference, this theme pair is thus being confirmed as a problematic relationship theme.

4.2.4.4 Clinical example

In the example of the above described 32-year-old patient, the most important problem was determined as: "The patient tends to defy any rule instead of appropriately conforming to the role he is expected to play". As second, and partly similar problematic theme, the followingwas chosen: "The patient tends to do everything his own way, instead of developing flexibly and independently, with respect to others, and in an appropriate manner." The countertransference reactions cited in the case description (Table 4-5) "defy and resist" (18) and "comply, hold back, resign" (26) confirm the first problem theme. An interpersonal resource could not be marked for this patient.

4.3 Axis III - conflict

Contrary to the categorical/discontinuous diagnosis of the ICD-10 and the DSM, nearly all empirical studies on mental phenomena show a continuum (for instance, the severity of depression as a continuum from mild to severe). This is equally so for the conflict diagnosis, where the dimensional continuum model makes it possible to delineate normal conflict-related tensions as an anthropological given of subclinical phenomena from their transition to a describable, clinically relevant conflict. Apart from this, the 'fate' of conflictual schemas in individuals with low levels of structural integration, or with a disintegrated structure, may be better understood using such a continuum model. Structural limitations, too, follow a dimensional model, from normal functioning to severe limitation.

Each person is a part of the web of fundamental motivation-based, conscious and unconscious, conflicts, which his or her life brings. Due to an individual's personal history, these conflictual tensions have their own characteristics, which are reflected in individual patterns of experience and behaviour, without their amounting to clinical abnormalities or need for treatment. Traditionally, in psychodynamic terms, this is described as the structure of the neuroses, that is to say, as the interplay of motivational structures shaped by one's biography.

Relative health		Neurotic disorder		Structural disorder
(1.) Subclinical conflict-related tension; possibly "accentuation of the personality" or	→	(1.) Neurotic conflicts with repetitive dysfunctional interpersonal and intrapsychic patterns	→	Sometimes multiple conflictual schemes of alternating relevance in case of low levels of structural integration (OPD Axis IV)
newly emerging motivation-related conflict without repetitive-dysfunctional conflict-related pattern				
(2.) Conflict-related stress (stressor-induced conflict)	↘	(2.) Neurotic (conflict-related) disturbance of the personality		

Figure 4-7: Model of conflictual levels

This level lies below the clinical description, as neither symptoms nor other signs of a disturbance are present. In the OPD interview, these individuals would be able to track conflictual, stressful phases of their life up to that point. They would be able to remember the related affects in a way that, for the investigator, would match his concordant countertransference, and they would be in a position to set out the paths taken to master, or resolve such conflict-related tension. Thus, such an interview covering stressful episodes would therefore render it possible to identify "healthy" individuals without disorders and with adequate conflict recognition, for instance in the framework of field studies. In situations of considerable to severe stress, these individuals may develop conflict-related contrasts of motivations and psychosomatic symptoms, which would then have to be coded as an adjustment disorder. Such conflict-based stress (stressor-induced conflict) must therefore be delineated from dysfunctional, life-determining neurotic conflicts, which already show through in the patient's biography.

The presence of these life-determining dysfunctional conflicts can be shown in cases of conflict-related disturbances of the personality and/or in individuals with repetitive neurotic conflicts. In conflict-related disturbances of the personality, there is a permanent, clinically relevant (often ego-syntonic) disturbance of experience and behaviour (an example would be an obsessive-compulsive personality disorder with an absence of circumscribed clinical symptoms, but with relevant, often heterogeneous disturbances of experience and behaviour). In contrast, the traditional neurotic conflict is accompanied by clinical symptoms which have an intrapsychic or/and interpersonal effect. These conflicts are dysfunctional, "suboptimally" resolved (primary gain from illness) and can be demonstrated in the biography as repetitive conflictual patterns (repetition compulsion; reverting to learned behaviour). In situations characterized by temptations and their frustration, threshold situations, and situations arising from the presence of internal and external triggers (trigger situations), motivational ambivalence increases. When, for instance, through fortunate external circumstances, up to that point in life a successful balance between the ambivalent motivations could be maintained, this would be the moment when a clinical symptom develops.

Of importance for the conflict diagnosis are both the anamnestic scene, which can be reactivated, and the actual diagnostic scene. In the latter, the conflict dynamic becomes effective interpersonally and intrapsychically (transference-countertransference), is close to the level of experience and at the same time determines behaviour, and, depending on the conflictual theme, is expressed through a distinct leading affect. In the conflict diagnosis, the diagnostician has the additional task of distinguishing his own, so far possibly unreflected conflicts, prejudices, value judgements, and norms (self-related transference; Heuft, 1990) from the neurotic conflictual tension that will arise between patient and diagnostician. The time window for assessing the mode (active versus passive) comprises the last couple of months in which the biographically evident dysfunctional repetitive conflictual patterns can be demonstrated in the recognizable disturbance of experience and behaviour, or in the neurotic symptoms.

In low levels of structural integration or structural disintegration of mental functions, all or nearly all conflictual themes may frequently be recognized in many

of the relationship episodes (cf. Ch. 3.6.2), with a focus being formed by the individual's biographical development up to that point. Often, conflictual themes are only "hazily" delineated, possibly quickly changing in importance during the diagnostic interview, and are lacking a permanent "gestalt". This observation shows that in cases of a low level of structural integration (or low capacity for establishing structures) no circumscribed, life-determining, repetitive conflicts can be precisely made out, so that in these cases we would rather speak of conflict schemas.

Conflict rating

In the clinical application of the conflict axis, only the two most important conflicts should be diagnosed. The time window for these two critical conflicts and for the mode (active or passive) of the main conflict is a cross-section of the Here-and-Now, that is to say, relates to the two conflicts which were predominant during the last two months - whereby the repetitive nature can only be securely confirmed via the biographical dimension in the interview. Equally, when rating the mode, what should be rated is not the well-balanced ambivalence of past years, but the Here-and-Now of the currently manifested conflict (for example, from a longer-term perspective, the patient shows an active mode of the conflict care versus autarky, however, in the clinical decompensation the more passive side is in the foreground; this would then be the mode which is to be rated).

Preliminary questions to enable the therapist to rate conflicts

A) Conflicts cannot be rated for lack of diagnostic security.	yes	no
B) Due to a low level of structural integration the recognizable conflictual themes are not actually distinct dysfunctional conflictual patterns but rather conflictual schemas.	yes	no
C) Due to recognition of conflict and affect being defended against the conflict axis cannot be rated.	yes	no
D) Conflictual stresses (stressor-induced conflict) without any major dysfuctional repetitive conflictual patterns.	yes	no

E) Repetitive-dysfunctional conflicts	Absent	insignificant	significant	very significant	not ratable
1. Individuation versus dependency	⓪	①	②	③	⑨
2. Submission versus control	⓪	①	②	③	⑨
3. Need for care versus autarky	⓪	①	②	③	⑨
4. Self-worth conflict	⓪	①	②	③	⑨
5. Guilt conflict	⓪	①	②	③	⑨
6. Oedipal conflict	⓪	①	②	③	⑨
7. Identity conflict	⓪	①	②	③	⑨

Main conflict: _____ Followed by, in order of importance: _____

Mode of processing of main conflict	predominantly active	Mixed but active	mixed but passive	predominantly passive	not rateable
	①	②	③	④	⑨

Table 4-8: Conflict rating schema

The rating schema (Table 4-8) clearly shows the step-by-step diagnosis on the conflict axis. The explanations following the rating schema follow suit, thus representing instructions of how to procede.

A) No diagnostic security

Before any further conflict rating, the investigator must examine whether Axis III can be rated at all. For instance, this is not the case when a patient suffering from an acute stress reaction after a serious traffic accident is interviewed for 30 minutes and is assured by the investigator, cognitively, in a professionally appropriate manner, of the "normality" of his mental reaction. Or also, in cases where the material is not sufficient because the patient refuses to cooperate (rating: "yes").

B) No distinct conflicts

If the level of structral integration is low, no distinct conflicts are, as a rule, identifiable, in the sense of the operationalizations presented here. Even in a low to moderate level of structural integration, manifold conflictual schemas may determine the symptoms displayed to such extent that a conflict rating cannot be carried out (rating: "yes").

C) Perception of conflict and affect impaired by means of defence

It is further to be examined whether the capacity to recognize conflicts and affects is impaired by means of defence.

Table 4-3: Perception of conflicts and affects impaired by means of defence

Perception of conflict and affects impaired by means of defence
General description
This is about people who overlook conflicts within themselves and in interpersonal relationships, and who have difficulty perceiving feelings and needs in themselves and others. Here, cultural influences (stigmatization due to mental symptoms and illnesses) play a major part. We are dealing here with an exaggerated defence, in the sense of a protective function, with the aim of avoiding, and learning to cope with, intrapsychic and interpersonal tension. Because affects are absent or rejected, there is no leading affect. The defence (repression, rationalization, isolation, denial) is primarily aimed at avoiding anhedonic affects, with hedonic affects being incorporated into the defence to a minor degree. Therefore, little conflictual material which can be made use of is offered in the investigation situation. In their descriptions, such individuals make their lives and their relationships with others seem nearly devoid of tension and strongly determined by conventions, although the investigator has some reason to suspect existing tension and conflicts. They present their life situation as if there were never any problems. Their own

experiences and external life circumstances are often described by the formula "everything is normal". They either hardly mention feelings and conflicts at all with respect to other people ("Everything is fine, I am fine" - "We get on well with each other, there are no problems"), or conflicts are solved in a technical mode ("I'll get on top of it, no worries!"; "We will sort it out sensibly, like adults"). Feelings of greater intensity emerging in themselves and in others appear as interfering and negligible. Stressful life circumstances or events are dealt with by displaying activity. When the individual's defensive possibilities fail, predominantly somatic symptoms tend to be experienced and presented. While the investigator may be able to perceive mental symptoms, the patient will tend, however, to relegate them to the background. Sometimes, a certain satisfaction in the patient becomes noticeable with the fact that he enjoys being a rather "unexcitable" type of person. This affectively uniform, or rationalizing, approach makes it difficult for the investigator to gain a clear picture of the interviewee and his inner life. In the countertransference, feelings of disinterest and boredom come up easily. The countertransference may also produce those feelings which individuals tend to leave out or cover up by being factual. Because of the patient's defensive presentation, the investigator may also react with irritation. With regards to psychotherapy, these patients are often rated as unmotivated and difficult. In addition, in individuals with reduced structural capabilities with regard to self- and object perception, as well as self-regulation, there is a reduced perception of affects both in self and in others. In contrast to structurally disordered individuals, in whom anhedonic affects noticeably predominate, those very affects are not found in individuals whose recognition of conflicts and affects is impaired by means of defence.
Areas of life
Family of origin
The relationships are described in a uniform, low-affect, factual manner as "unproblematic", even if really difficult conditions are present. How the individuals deal with each other is determined by conventions. Obvious generational conflicts are either negated, or people try to solve them on a factual level, with a great amount of effort. Separating from, or remaining in the family of origin seem to happen in a matter of fact way and without friction.
Partnership/family
Normality and functionality of family life are in the foreground of the description. Changes in the relationships and, above all, separations, are reported as facts. Partner relationships often come about for external reasons, as husband/wife/children are seen simply as part of a normal life.
Job
In their professional life, these people often seek jobs which are intensely fact-oriented. They may have above average success, if relationships with others are functionally organized. They themselves consider performance important, if it refers to factually solving the tasks that work poses. They are appreciated by colleagues and superiors because of their competency and focus on facts, however, occasionally get involved in conflicts which are uncomprehensible to them, as they do not pay enough attention to emotional relationships.
Social environment

The social context, too, is handled in a functional manner, whereby emotional and conflictual areas are actively avoided.
Possessions
Handling of possessions comes across as functional and fact-focused ("One must be happy with what one has"; money isn't everything"). Not infrequently, their relationship with material things is noticeably more emotional than their relationship with living objects.
Body/sexuality
The way of dealing with their own body is factually based and rational. The body must function like a machine. Sensuous, enjoyable bodily experiences are hardly possible, sexual "functioning" may be important as an expression of normality. Processes of change or aging are denied or referred to the "repair shop".
Illnesses
Illnesses are experienced as fateful events without a great amount of emotional involvement, or as a problem which is to be technically solved. On the surface, there often is good compliance to support the doctor's "efforts at repair". Their somatic concept of illness leads them to prefer technical treatments. These patients are rather difficult to motivate to undergo psychosocial-psychotherapeutic treatments.

Perception of conflict and affect impaired by means of defence

Case vignette: The woman who is unaware of anything

> Mrs. A. (50 years old) was referred from the gastroenterology department of the university clinic. She reported abdominal complaints of more than a year's duration which manifested as convulsive pain, diarrhoea alternating with constipation, frequent passing of stool, mucuous secretion. An in-depth gastroenterological examination revealed no organic cause that correlated with the symptoms. The diagnosis given was "irritable bowel syndrome".
> When asked why she had come to the psychosomatic outpatient clinic, Mrs. A responded that she did not know why she was here. After all, her problem was in her belly, not in her head.
> She is a home maker, has two sons, of whom the younger one had moved out a year ago. When asked how she had felt about this: "Well, that's what life is like." The husband worked as an electrical engineer and was frequently away with his job. She said that she did not mind, it was a part of his work. Apart from that they got on well, there were no problems in the relationship.
> She has her work around the house, which she does as well as she can, and in an orderly fashion. It was also important for her to have a good relationship with the neighbours. In the past, her parents had taught her that it was important to get on well with all people.
> After the younger son had moved out, she took a job in a bakery, but was recently given notice. Her colleagues with whom she was working had complained about her, and to this day she does not understand why. As always, she had only tried to do her job as orderly as possible and was not interested in the colleagues' "gossip".
> She was not worried because of the abdominal complaints. She was sure the doctors would in the end find the reason and correct the problem. At this point the investigator began to feel bored, and several times he had to stifle a yawn.
> In a further interview session, which was conducted with the patient's husband, the investigator learned that the husband had recently told his wife that he had been having an extra-marital affair and was thinking of separating. He had tried to talk

about this with her, however, she refused to believe it. It had always been difficult for him to be and feel close to his wife: she would spend more time on the house, making sure that the house and garden were in ship shape order, instead of joining him for activities together. Although they had been married for 30 years, he knew little about his wife's past history. He was able to find out from his wife's sister that they while they had been taken care of, superficially, as children, they had received little emotional care and were frequently beaten.

D) Conflictual stress (stressor-induced conflict)

Before carrying out a more specific conflict rating, it must finally be decided whether the symptoms can be traced back, more or less predominantly, to a stressor-induced conflict.

Table 4-4: Conflictual stress (stressor-induced conflict)

Conflictual stress (stressor-induced conflict)
General criteria
Considerable to very severe stresses can lead to a contradiction in the patient's motivational system, the cause of which can be adequately explained by the presence of a concrete inner or outer demand, and which is usually sufficient to explain the mental and/or physical symptoms in terms of an adjustment disorder of the patient (period of observation: the last six months). Not every life stressor (such as the stress caused by the death of a spouse, or by divorce) leads to a conflictual stress. What is relevant is the subjective meaning (to be understood through the preexisting motivational conflict-based tension) of the particular stressor. The probability of an adjustment disorder arising is detemined by: (1.) the extent of the internal motivational conflict-based tension and the external stressor (2.) the available resources (vulnerability, defence, structure, resilience, social support, etc.) The stressor-induced conflict is a true conflict in as far as it expresses itself within the antinomies of human motivation (individuation versus autonomy, care versus autarky, self-worth regulation, etc.) and shapes the pre-existing individual conflict-related tension. Analogously, the leading affects are similar as in the repetitive-dysfunctional conflicts. The stressor-induced conflict thus has a conflictual appearance, as the basic motivational patterns like, for instance, individuation versus autonomy, or care versus autarky, determine the inner experience, but without a conflict, in the afore-mentioned sense as an ongoing dysfunctional pattern, being present. Apart from that, different types of dysfunctional internal conflictual patterns may be present. But beware: If an internal and/or external stressful event activates an evident, biographically repetitive, or ongoing dysfunctional conflictual pattern and leads to symptom formation, we are dealing with a trigger situation for a repetitive motivational conflict, and not with a conflict-based stressor. Generally, a reduced capacity for dealing with stress is referred to as vulnerability. Firstly, it is defined by the motivationally determined conflict-based tension, secondly, by the structural abilities a person develops over a lifetime, through their own social network, and thirdly, the individual biological conditions inherent in a human being (e.g. inborn below-average intelligence, processes of dementia in old

age). The vulnerabilities of the motivational system to conflict referred to here may interact with the structural and biological ones and, in most cases, meet the criteria of an adjustment disorder in accordance with ICD-10. An adjustment disorder can, however, also arise in cases of exclusively structural or biological vulnerability (see Axis V).
The conflict-related stress must be differentiated from a posttraumatic stress disorder (PTSD). Traumatic situations which lead to a post-traumatic stress disorder represent the most extreme degree of stress, dimensionally speaking. In these cases, the mental stresses are so pronounced (excessive demands upon ego-functions, defence capacities, etc.) that a motivational conflict can hardly develop, but instead we find the typical clinical symptoms with intrusion, absence of feeling and dissociations. Not all traumatic situations lead to a PTSD, attention must be paid again to the set of conditions of motivationally determined conflict-based tension, structural capacities, and individual biological conditions of a human being.
Basically, both an active or a passive mode of coping with external stresses is possible.
Modes/types/leading affect/countertransference/interaction: as far as concerns their intensities, they correspond to those described in the other conflicts, depending on which motivational system is addressed.

Passive mode	Active mode
General criteria	
In cases of severe stress the passive mode of processing predominates. It takes the form of withdrawing oneself, adjustment, and resignation.	Active, counter-phobic patterns of experience, behaviour and action with an emphasis on defence are predominant.
Areas of life	
The criteria for individual areas of life correspond in their intensity, to the criteria for the passive mode as described for the other conflicts, depending on which motivational system is being addressed.	The criteria for individual areas of life correspond, in their intensity, to the criteria for the active mode as described for the other conflicts, depending on which motivational system is being addressed.

Stressor-induced conflict - passive mode

Case vignette: The senior executive

Seven years ago, 45-year-old Mr. B. changed jobs and took up a position as a senior executive in a large industrial enterprise. This industrial enterprise was located in an structurally weak area and was considered to be an innovative company with good potential for the future. On the basis of his executive job with the company, which came with a long-term income opportunity, he and his wife, with their two daughters aged seven and nine, built their own house close to his place of work, not least because, due to the creation of new jobs, there was hardly any living space available for a family to rent.
About two years before the initial conversation, the company had gone bankrupt, as the foundation of the capital structure had collapsed due to criminal wheeling

and dealing by the management. After plundering the company financially, some of those responsible went missing. Suddenly, Mr. B. was unemployed and could no longer pay the mortgage on his newly built house. It was forseeable that he would not be able to find another comparable position anywhere in this economically weak area. The sale of the house failed, because many others in the area were equally hit by unemployment and it could not de facto be expected that new interested buyers would come to the area. In this situation the mortgage lender foreclosed on the house. Mr. B.'s wife left with their two daughters and moved back to her parents. From the point of view of both spouses it was uncertain whether the marriage still had a future, as Mr. B. reported in the initial interview in the hospital's psychosomatic-psychotherapeutic ward. The reason for his presentation was that, for about 3 months, Mr. B. had been suffering from a feeling of helpless rage: "I don't know how to deal with it, it is as if I had fallen into a press".
This feeling of being overpowered had meanwhile led to a resigned-submissive behaviour, a kind of fatalism. This was linked with a feeling of devaluation: being a loser, both professionally and financially. Mr. B. could cognitively take up the concept that he had no way of forseeing this criminally induced bankruptcy. Emotionally, however, he could not see any way out of these feelings. - On the syndromal level, the illness was conceived as a depressive episode of medium severity.
In the initial interview and also in the diagnostic conversations that followed, the impression was confirmed over and over again that Mr. B., up until the criminally induced bankruptcy of his company, had been capable of dealing with emotional injuries, as well as strivings for dominance versus submission, in a flexible way. There were no hints of repetitive-dysfunctional conflict and relationship patterns, with a level of structural integration that could be described as good to moderate.

Stressor-induced conflict - active mode

Case vignette: The widow

This 70-year-old patient was referred from the university ophthalmology clinic because of a chronic conjunctivitis and corneal opacity with a well-documented absence of tear secretion. No organic explanation could be established. The consecutive visual impairment forced the patient to do without her car. Simultaneously, an arthrosis of medium severity considerably impaired her ability to walk and thus, living in her apartment on the outskirts of town, made her feel cut off from the few permanent relationship figures which she could only reach by car. From a psychopathological point of view, a marked depressive mood with signs of helplessness and despair was noted. In the conversation she came across as help-seeking but without any perspective for the future, however, she was not acutely suicidal. In the biography so far, there had not been any mental disorders or life-determining conflictual behaviour patterns. Three years ago, the patient had suddenly lost her husband due to a heart attack. For some time, she and her husband had tried to consciously adapt to either one of them entering widowhood, and after his death, she had attempted to continue with the well-ordered life she had been used to (active mode). As a consequence, she was psychosocially well adapted. The additional massive restriction due to the eye illness now overtaxed the patient's coping capabilities totally, and led to the depressive symptoms. In an outpatient short-term psychotherapy the patient managed to stabilize herself. The ophthalmologist's results also improved substantially. At the same time, and because she had clarified this conflict-based stress (care versus autarky), the patient was motivated to go out and build up a friendship with a neighbour living closer to her apartment.

4.3.1 Individuation versus dependency

Table 4-5: Conflict I - individuation versus dependency

Individuation versus dependency
Attachments and relationships are of existential importance in everybody's life. They extend between the opposite poles of longing for a close relationship and symbiotic closeness (dependency), and the striving for a well-articulated independence and marked distance (forceful individuation). Individuation and dependency are basic elements of human life and experience, and therefore are inherent in all areas of life. A life-determining conflict exists when this fundamental bipolar tension is transformed into a conflictual polarization. An individuation-dependency conflict is only present if this constellation is of existential importance and is formative in a person's life history: this conflict comprises the activation of experiences that seek or avoid closeness, and not the shaping of relationships in the sense of care or absence of care. The individuation-dependency theme deals with the issue of being on one's own/being able to be together with others. In the pathological conflict version, the issue is slightly different. It is about the having-to-be-on-one's-own, or the having-to-be-with-others, in the sense of an existential necessity. From this we need to differentiate the conflict of care versus autarky: this is about the conflictual shaping of the basic theme of caring for oneself versus caring for others (having the ability to do so).

Passive mode	Active mode
General criteria	
The patient typically strives to establish very close and secure relationships at (almost) all cost. Responsibility and independence are avoided, one's own wishes are subordinated to the real or assumed interests of significant others, so as not to endanger the close relationship. Conflicts and divergent strivings need to be trivialized or denied. Self-perception is characterized by helplessness, weakness, and being dependent on others. The leading affect is an existential fear and a threat of the loss of the object, of separation and loneliness. In the countertransference feelings of worry and responsibility are mixed with fears of overly strong desires for closeness and of efforts at being smothered.	This type is characterized by the efforts made at building an exaggerated emotional and existential independence from relationships. All areas of life are determined by a constant struggle for autonomy and independence. One's own personal needs for leaning on others, closeness, and attachment must be suppressed. In the individual's self-perception, a forceful autonomy dominates, together with the conviction of not needing anybody. The leading affect is a fear of closeness, of merging, and being smothered. In the countertransference, there is little feeling of responsibility for the patient, very little need for caring and protecting, but a worry about defended against wishes of dependency.
Areas of life	
Family of origin	

There is a psychical attitude of not growing up, with the position of 'child' predominating in an individual's self-understanding, and in his handling of real relationships (remaining in the parental home, or intensive and frequent contacts with the family of origin). In many cases, individuals oscillate between the positive and negative in their judgement of primary relationship figures. Not even great disadvantages and stresses are an obstacle to maintaining the familial context.	An internal and external forceful move away from the family, with an acceptance of losses and disadvantages determines the relationship towards the family of origin. Moving out often happens prematurely ("leaving the nest early"), intense conflicts or a break with the family is not infrequent. The position of son/daughter is denied. The importance of primary relationship figures is often played down.To some extent, they are superficially presented as positive, in order to defend against recurring painful memories.
Family/partnership	
The patient voluntarily takes up a subordinate position, which he secures by choosing an appropriate partner and the ensuing form of the relationship. He relinquishes an active and interest-guided shaping of an intimate relationship and passes the responsibility on to the partner. Divergent developments of the partners must be prevented or denied. As a rule, an attempt is made to counterbalance differences harmoniously, trivialize conflicts, or to terminate them quickly by complying ("I don't want an argument"). Changes, especially those leading to greater independence, are avoided or rationalized.	An intimate relationship can only succeed if, by the choice of partner and way the relationship is handled, a position of sufficient independence is securely achieved. In these circumstances, the equally autonomous attachment needs of both partners may lead to relationship arrangements that are stable over time. Where attachment needs are contrary to each other, dependency wishes keep showing themselves, and lead to tensions. Through these contrasting tendencies and through the fact that these patients (have to) live their relationship patterns, a high degree of conflict arises. Such conflicts can be staged in order to assure oneself of a secure independence and distance while simultaneously remaining in the relationship. Moves towards independence are being followed through independently of, but also at the expense of the partner.
Job/professional life	
In their professional life, these patients tend to seek rather subordinate and contributory tasks and shy away from responsibility and performance. Competition and job promotions are avoided, because they endanger closeness and attachment. They are cooperative in their performance behaviour, but strive not to achieve beyond average. They are less inclined to have careers.	These patients are focussed on striving for independence and autonomy in their profession. They strive to occupy niche professions which offer a large degree of autonomy and the greatest possible independence, without the necessity of cooperation and the possibility of competition. Professional career or economic success are secondary. They prefer to be independent in how they shape their

Solidarity amongst colleagues and a sense of belonging to the company are important for them. They remain in the same job for a very long time, stay with their company in times of crisis, often accepting disadvantages. Even when health is impaired, or performance declines, they are reluctant to question their professional activity.	professional tasks. They often have problems working in a team and have a tendency to engage in conflicts with colleagues and superiors. Frequent changes of job, or profession, are not rare. Despite these limitations, they can still be economically successful.
Possessions and money	
Money and possessions are used to make relationships and attachments secure. As a result, they may either strive for, or also renounce possessions and money. A renunciation of money and possessions comes about quickly when the relationship is threatened. Generosity and charitable acts may be related to building up or strengthening close relationships. The reverse is true also: they may strive for a state of no need for possessions, in cases where possessions would "bind" them, that is to say, lead to responsibility and active involvement.	Achievement of a secure financial situation is aimed for as a basis for independence. Possessions are used as a means of securing the necessary independence in relationships. Possessions can serve as a substitute for personal relationships. Or, financial responsibility is avoided because it creates dependency. In an extreme case, they aim for a state of no possessions, which represents the ideal of total independence, which is only in a phenomenological sense equal to the solution according to the passive mode.
Social context	
In a social context, an association with diverse groups is sought. In this context, groups with a strong sense of belonging and a common ideology are particularly attractive. The patients make an effort to be integrated into the group, the feeling of belonging is important. They get involved in the organization and (to a limited extent) the running of these groups.	Belonging to groups is something that these patients would rather avoid. Social contacts are, overall, rather sparse. There is a tendency for changing and short-term social contacts. They seek out opportunities for social contact which correspond to the independence ideal, like, for instance, "chatrooms". In general, social commitments and possibilities tend to be ignored or devalued.
Body/sexuality	
Needs of the body (for instance, body care, sexuality) and its maintenance are subordinated to needs for closeness. Needs and limitations of the body are only recognized in as far as they do not interfere with needs for closeness, but rather, make them possible. They are also used to create dependence and closeness. Bodily changes	Bodily needs and limitations are ignored as far as possible, as their acceptance might result in dependency and closeness. Rather, physical performance is particularly cultivated as a means of achieving independence. Age-related limitations and waning performance are especially ignored and often covered up by an exaggerated

and limitations (disabilities, limitations due to age) are used to strengthen attachment and closeness ("I am dependent on you"). Sexuality is used to secure closeness needs, personal wishes are relegated to the background.	youthfulness. Sexuality is either lived in a non-committed way, or is suppressed.
Illness	
Illnesses, offer the possibility of dependent living more strongly, and of securing closeness. They offer a medical and objective legitimation of dependency needs. These patients are characterized by frequent visits to the doctor and of remaining in the care of a treating physician for years, they are "faithful" patients. During the treatment itself they are quite unable to stand on their own two feet and strive to continue the treatment at the cost of remaining remaining ill. They try to shape the relationship to "their" physician as very close.	Illness is experienced as a threat to independence. Symptoms and consequences are often ignored, a treatment is only entered into at a late stage and when absolutely necessary. They fear that treatment threatens their independence, and in consequence frequently openly reject or discreetly sabotage prescribed treatment programmes. Compliance therefore is often bad. These patients make an effort to turn the doctor-patient relationship into a distant and factual one, the interaction is often characterized by conflict, a change of doctors is frequent in order to avoid the development of attachments.

Individuation versus dependency - passive mode

Case vignette: The housekeeper

Mrs. L. is a 52-year-old woman who comes across as rather unassuming, and who, right at the beginning of the appointment, which had been scheduled expressly as a clarifying conversation, wanted to reassure herself whether this was the regular weekly session, which a therapy, as a rule, consisted of. She said her family doctor had advised her last week to go and see a psychotherapist, and that she would certainly get support there. For one year, she had felt dejected, had been suffering from doubts of self-worth, from a tendency to cry, feelings of loneliness, tiredness, and exhaustion. In addition, she reported sleep disturbances, pain in the joints and headaches. The GP had found nothing which could be a cause for this.
It had all begun when her 24-year-old daughter moved out and, although not far away from home, had moved in with her boyfriend. Since that time they hardly saw each other, although before they had had a close, almost sisterly relationship and had shared each other's confidence. She did not understand the change in her daughter, why she had turned away from her, and thought that probably the daughter's boyfriend must be behind it. Somewhat later, the 20-year-old son went away to college, having obtained the desired place of study in a far away large city, a fact that he did not seem to mind. Now, he hardly came back home, only when he needed something, and this was occurring less and less frequently. Previously, when he was still at school, she had always shared an interest in his life, had supported him, consoled him when he had girlfriend trouble, and given him many a piece of

advice. She missed both children a lot, but that, it seemed, was the way of the world.
If all this wasn't bad enough, there was also trouble with her husband. He had become very strange all of a sudden. Their marriage had not been an easy one for years, but they had nearly made it through to their silver wedding. She had got married at age 18, when after a short period of dating with her then later husband she got pregnant; it had happened almost the first time. She did not mind too much, as she was thus able to leave home. At home everybody had gone their own way, there was no warmth to hold the family together, and no real coherence. Then it became apparent that her husband had problems with alcohol, that he regularly drank too much, and then abused and sometimes hit her. As a man, he took what he needed, she let him have his will, even if she did not enjoy it, but it was part of marriage and living together. Nevertheless, her husband had other women 'on the side' every so often, which she had accepted, as he had always come back to her. Six months ago, however, he seemed to have experienced a "second spring". He was having an affair again - at least this is what she believed - and wanted to move out. This had been horrible for her. She herself moved into the garden shed (so as to make it possible for the pretence of keeping the appearance of living together) and the husband continued living in the house. Now they lived together, but separately. She would cook for him and wash his clothes and would keep the house clean. Sometimes she was allowed to stay a little with him in the house in the evenings, and they would watch TV together, or talk a little. When the husband was gone, she stayed in the house, she liked being there, she could still feel that a little bit of the husband and the children were there. In the evenings and over night, however, she would always stay in the garden shed. She was very sad, but also very afraid that her husband would drive her out of the garden shed or that he would move out himself.
She currently had a part-time job as a housekeeper in an old people's home, where she had been working for 15 years already. She liked it there, enjoyed the work, it was a nice group of female collegues who would stick up for each other. Five years ago she was asked to lead the home's housekeeping department, because "I was so capable", but she did not want to, because she worried about losing the good relationship with her female colleagues. She always went to work, even if as of late she had frequently suffered pain, but this was just the normal wear and tear of life, wasn't it. She believed that her body still had some mileage in it, at home and at work. In the current situation, work was a great support for her, this is why she did not, under any conditions, want to be certified sick by a doctor.
Mrs. L. had no major contacts so far, because she had given her all for her family and had always wanted to be at home. Some time ago she had met, rather by coincidence, a group of women of her own age. She had been well accepted, there was a nice feeling of belonging to a group. She planned to go there more often, but really, she missed what her family had given her in the past. She very much hoped that it would all come back, that she would at least be able to keep the husband.

Individuation versus dependency - active mode

Case vignette: The travelling salesman

Mr. I., 58-years-old, comes for a conversation after having been strongly advised to do so by his family doctor, who for years had tried to motivate him to try psychotherapy. He had, however, not been able to follow up this advice because he worked so much and was frequently travelling, so that he would be unable to come for regular appointments. However, given that he soon would retire, he would have more time for such things. In addition, his complaints had recently intensified so much that he now was forced to do something. He said he had actually been suffering from periods of dejection, oddly diffuse bad moods, feelings of loneliness,

unspecified anxieties, and general exhaustion since adolescense. Beyond this, he had had tinnitus for a couple of years, which occurred especially in situations involving several people. He had had digestive complaints and stomach pains for 15 years, and for the last two years considerable sleep disturbance.
In the patient's history, a constant struggle for independence can be found. Mr. I. had never been able to involve himself in a permanent relationship or work - within the framework of his occupation as a travelling salesman he had often changed employer, had moved a lot, changed relationships a lot, but in all this had been very engaged professionally and had been rather successful. In the countertransference, the wish for automony can be felt, on the one hand, but on the other, there is also a yearning for calm and attachment.

4.3.2 Submission versus control

Table 4-6: Conflict 2 - Submission versus control

Submission versus control
General description
Control of self, and others, is a basic human need. In this conflict, the emphasis is on the individual whose central motive is to dominate the other, or to submit to the other. In this respect, open or latent aggressive impulses play a central role. This motivational level must be delineated from compulsive phenomena in the sense of an attempt at reparation in the service of structural maintenance in cases of low levels of structural integration ("Otherwise everything slips away from me"). Submission and control are non-adaptive extremes on the continuum of being able "to be guided", or, "to guide others", respectively. Behaviour norms, and other personal and societal rules are given a high value. Experiences of power and/or helplessness may influence the individual experience of self-worth in a special way, therefore particular attention must be paid to differentiate them from self-worth conflicts in a specific sense. In the passive mode a distinction must be made as to whether the embarrassment or shame incurred is to be understood from the feeling of having been subjugated or, whether the other person, through the interaction, intended to directly cause a feeling of devaluation in the conscious and unconscious experiencing of the patient. In the active mode, a distinction must be made as to whether the motive of control and power lust is in the foreground, or, rather, that the need is to put the other person down, to devalue the other, in order to look "good" oneself.

Passive mode	Active mode
General criteria	
Overall, the type of passive-aggressive submission dominates. The countertransference concordantly brings up feelings of helpless rage as a leading affect. In the interaction, this can be experienced as latent aggressive behaviour and leads to feelings of irritation. To experience oneself as "subjugated" may be felt as injury and shame, the main motive, however, remains	The patient type of aggressive striving for dominance constantly seeks to achieve control over others or over situations. The lead affect of a defiant aggressivity is felt unconcealed in the countertransference. As to the interaction, a power struggle with every available means stands out, in order to banish the fear of being controlled. Loss of power is experienced as a threat. When the

the struggle with the "above-below" dynamic.	other is devalued and insulted, this happens because of the need to feel and demonstrate power over the other.
Areas of life	
Family of origin	
Submission to a family tradition with the aim of maintaining "law and order". Hierarchically structured relationships within the family are accepted. Familial relationships which have existed over generations regulate each other via responsibilities and duties. The acceptance, without alternatives, of predetermined rules reduces the fear of otherwise necessary tension-filled altercations. Situations in which a sense of rebellion may be felt are absent.	Rigid rules, which apply cross-generationally, are imposed, and under the circumstances, exertion of power may be rationalized via the argument of care. In case of (cross-generational) tensions, contact may be radically cut-off, accompanied by intense utterances of rage ("Who is he/she/are they to tell me!"). Talks to balance out interests seem impossible. An appropriate submission is difficult.
Family/partnership	
Inability to say "no". One's own views or wishes are subordinated. In order to tame the rage, and fear of the rage, resulting from this frustration, family members who are experienced as "determiners" are placed under the obligation to adhere to strict rules and are thus "fettered" ("If you always determine what I wear then you'll have to always buy me clothes!"). The individuals in question appear modest in relationships, satisfied with their subordinate position. Resistance is indirectly and passively lived out by procrastinating, dawdling, stubbornness, etc., and is very often unconscious to a large extent. This kind of behaviour is, however, very easily recognized as resistance by social relationship figures, and often produces annoyance. Because of their inability to contradict, these individuals may appear to sacrifice themselves for the family.	Independence of mind may be intensified to a defiant aggressivity combined with the wish to shape everything according to personal interests and ideas. Deviating suggestions give rise to protest and a feeling of outside-determined regulation. Depending on the context, the behaviour of these individuals has the effect of being extremely dominant, regulating, often interfering, worrying, and even antisocial, or, in cases, comes across as a constant know-it-all attitude. The individual's own rules are not seen as a problem ("What I say goes"). In collusive close relationships with partners who are reciprocating or complementary, this kind of tyranny may initially get overlooked, or gives the impression of a seemingly effective gentleness, or wisdom, or an overly great engagement for the family/partnership ("The others can't manage without me!").
Job/professional life	
Despite chances for promotion, subordinate	In the hierarchy, individuals strive for

positions are maintained. Due to a fear of having to exert power, independence and decisions are avoided. The reverse applies, too, in that work demands are passively sabotaged (by, for example, being overly exact, but extremely slow when carrying out tasks). Often, it is especially difficult to differentiate between factual or apparent reduction of job performance. In the mixed, predominantly passive mode, the position of the successful "eternal number two" is also a conceivable option.	executive positions, or positions offering great autonomy (niches of self-determination; freelancing). One's own judgement and style of leadership are the measure of all things. Even criticism that is constructively intended or suggestions by others (authority in a subject), are misconstrued as an attack on one's own position. Because of the striving for dominance, work, performance, and profession are attributed a high value. Ambition is easily noticeable and contributes to making this behaviour appear especially conflictual.
Social context	
In the neighbourhood, the community, in associations and groups of friends, a rather subordinate position is taken up ("be carried along when things are planned"). The individual subjects himself obediently or uncritically to ideological doctrines on life in general, on religion, or on politics, even if they actually contradict his own ideas. A position involving humiliating determination appears to be tolerated with equanimity.	Social groups, associations, or friends, are judged as to whether they serve the possibility of increasing or exerting power and influence. In order to reach positions of power within such groups, the individual's involvement may appear very "socially" minded and selfless. The claim for power surfaces, however, when differences in opinion, new elections, or altercations with those who succeed in positions once held arise (even, for instance, in an honorary position). Loss of power is experienced as a threat.
Possessions	
Although possessions and money play a central role in life, there exists an apparent willingness to give it away. Sometimes this refers to a defined part of possessions, while a "core possession" is extremely well guarded in order to reduce anxiety. The underlying phantasy might go as follows: "Before I am attacked and robbed, I would voluntarily give up what is not absolutely essential for my life.	Possessions and money are regarded as an important tool for realizing one's own ideas: "Money is power"; "For money, others will do everything (for me)!". If wishes from less-well heeled individuals are recognized, it is thought that these individuals can be recklessly pushed aside as "have nots".
Body/sexuality	
The body can be experienced as an object, the individual surrendering to its demands or needs, or which it must serve. For instance, there is a compulsory need to	The body is an instrument for the individual's own strivings for power ("great tennis player") and, at the same time, is functionalized ("I'm not a wimp!"). In this

maintain the sleeping rhythm, or stick to an arbitrary diet, or to follow the fitness program exactly, as otherwise "disorder" or symptoms will threaten. One is subjected to the demands of the body. Along these lines, the phantasy of having to substitute trace elements may have the character of body idolatry. In the same vein, medical or paramedical instructions need to be followed to the letter. A critical distance is here only possible via passive refusal ("Forgetting the medicines"). If the body's signals are not controlled, there is a feeling of helplessness. In addition, the body itself may serve to convey, by its posture ("drooping shoulders"), submission in a non-verbal way. There is the tendency to submit to the sexual demands of others or to unconsciously reject them.	sense the body is exploited, and bodily limits ("one's weaker self") to the effect that one has only this one body, are ignored. One's bodily appearance can be used as a demonstration of power (Bodybuilding, special emphasis on bodily attributes through dress, uniforms). Doctors are forced to play the role of repairing the body ("Put it back on the rails, doctor!"). Sexuality can be used as a power tool.
Illness	
Illness is seen as a fate to which one must "bow", or "yield". In the doctor-patient relationship, obedience predominates, however, instructions and cooperation which has been agreed in the course of the treatment and rehabilitation may be passively sabotaged. In severe illnesses, these patients may have developed a coping style that involves coping with considerable side-effects, without going to see a doctor ("The doctor prescribed this for me, in consequence I have to suffer the side-effects without complaints".) In a later step this may result in reproaches in the doctor-patient relationship.	The "fight against illness" is fought with all available means, true to the motto: "I won't give in". Beyond a fundamentally positive, active way of coping with illness, the patient's doggedness leads to inflexibility, or difficulties, when dealing with relapse and failure. The movation for arguing with doctors in the doctor-patient relationship lies in the justification for "self-determination", while doctors are experienced as "righteous (powerful) and controlling". This can extend to the hospital/the institution as a whole. The coping style in serious illnesses consists of, predominantly, a defiant reaction against the threat of loss of control ("That makes me all the more determined!").

Submission versus control - passive mode

Case vignette: The civil servant

The 45-year-old Mr. A jumps out of his chair in the waiting room to greet the interviewer with a bow. Initially, he gives extensive accounts of his bowel problems: he has not succeeded in getting a grip on his constipation. His bowels would force him to stay on the toilet for a long time. All the doctors he had seen were unable to help him, although he conscientiously took the prescribed medicines and followed the recommended treatments. He was almost resigned to the fact that he could not

be helped and he expected absolutely nothing out of this conversation (a latent aggressive rejection is noticeable). Asked whether there might possibly be some anger in his life, Mr. A. instantly assures the interviewer: "No, I am not angry, only resigned; I ask myself whether the doctors are sufficiently trained, that is to say, up to date with their knowledge".
He had a working class background. Both parents intended their two sons to have a better life. He, as the older one, had been committed, very early on, to always doing his best. Above all, the parents thought it important that he followed rules. Many times those rules were condensed in the wisdom of proverbs ("You can't teach an old dog new tricks"). "This was an important guiding principle, which I now try to pass on to my own children." During puberty, there had, of course, been discussions with parents, but he had realized very quickly that he had a responsibility for his younger brother and therefore had had to act as a model for him, so that he wouldn't be the cause of his brother leaving the straight and narrow.
In the course of the conversation it became clear that Mr. A., as a civil servant in a surveying office, was threatened by a disciplinary proceeding, as for some time he had not been meeting work demands. For one, he had, despite being at work to go to the restrooms for lengthy periods, and secondly, he tried to be exact with his work, on which the public peace depended, after all ("prevention of boundary conflicts"). In a strong voice Mr. A. emphasizes that he wears himself out doing this, that he often rereads the respective regulations, and stayed in the office longer than necessary, but no one would thank him for his commitment! (lust to submit).
He feels that his new boss, whom he has had for two years, was overly controlling of his work load. Once he had considered handing in a blank sheet of paper instead of the necessary reports, in order to point out that these reports required additional time, which he urgently needed for his work (helpless rage).
This is why he was very often exhausted in his spare time, and was happy if his family or friends just dragged him along to activities. His wife sometimes reproached him for not achieving more professionally and financially, and probably wasn't happy with him sexually (with a hint of shame). He had nothing against money, either, but if asked to choose, conscientious execution of the work ,for him, came before any career strivings.

Submission versus control - active mode

Case vignette: The entrepreneur

Mr. B., (56 years old), drops into a chair in the consulting room and instantly begins to spread a vast quantity of papers on the table between himself and the interviewer. Accompanied by a flood of complaints about symptoms, the investigator felt he was being drowned by the papers (defiant aggressivity). An attempt to preface the session with the investigator's usual introductory declaration is submerged in reproaches: "I thought right away that you would not have enough time to really understand me! You would need hours... !" (countertransference feeling: I will have to see how I survive this conversation, that is, how I can also get a word in.). The patient's physician recommended that he come here, because of his high blood pressure which cannot be regulated. He had thought about changing doctors, as he had proved to himself with an internet-based research that there were still other anti-hypertensives available.
Finally, the reason for seeking the conversation had been the fact that his wife had threatened to leave him. But to his mind, he was giving her everything: a beautiful house, a big car, two healthy children. After all, as an independent sales representative, he was a successful businessman. First he had worked with an insurance company, but the constant "toeing the line" was not his thing. He needed freedom, wanted to be the master of his own destiny. And initially his wife approved of him bringing home a lot of money. Now it seemed she wanted to tie

him to the home, wanted him to take more of an interest in the adolescent children. Yet he had given the children clear guidelines: good grades at school would be rewarded with money: "They know exactly, if they don't fall into line they'll get nothing! I did the same thing with my parents: when they interfered, I broke off contact." The fact that his wife had got in touch with his parents made him furious (rage).
His wife had meanwhile become very controlling, checking the directory of his mobile phone to see whether he had any girlfriends. Well, her jealousy was not totally unjustified: "But when I am travelling I need something to lay my hands on - and my wife just does not give me enough sexually" (lust for power).
As he was a member of many associations, he was not at home a lot. "You know, as a businessman one has to maintain one's contacts, and as president I am able to hand out posts, and for this the others thank me by providing business contacts ... the old saying, if you scratch my back, I'll scratch yours!" That his doctor had told him to slow down showed he was out of touch. "Then I might as well be dead!".

4.3.3 Care versus autarky

Table 4-7: Conflict 3 - Care versus autarky

Care versus autarky
General description
Care versus autarky refers to the fundamental need of individuals to obtain something, to be assured of attention and care, or to give attention and care, as opposed to not needing any care. The wish to be cared for is a basic theme of human existence. The experience of the conflict care versus autarky presupposes that an individual is basically capable of entering into a relationship, that is to say, to form attachments and relationships. How this relationship is shaped and experienced, however, follows specific wishes for care and safety, or the defence against these, respectively. Dealing with wishes for care and safety does not constitute the object relationship, but shapes a relationship that has already been established. Care versus autarky must be differentiated from, especially, individuation versus dependency, it is primarily about dependency in the relationship, not from the relationship. Strong wishes for care and safety may be expressed as "dependency", but differ fundamentally from the existential form of dependency within the framework of the individuation-dependency conflict, which culminates in the need to merge with the object. As both motivational systems exist right from the beginning of development, and as they overlap in many ways, differentiation may become difficult at times. The psychoanalytic concept of orality touches on this issue, albeit without being identical with it. Shaping of the conflicts oscillates between the 'engulfing' pole (to the point of exploiting other people), and the retentive pole (total self-sufficiency in the sense of Schultz-Hencke). The pertinent lead affects are mourning and depression, with the fear for the other, or the fear of losing the other, respectively. The theme of loss plays a central role as a trigger situation. The interaction/countertransference, too, is very quickly shaped by themes of care versus autarky.

Passive mode	Active mode
General criteria	

This typically refers to individuals who are strongly bound, emotionally, to a close relationship figure, and who express a wish for safety and care. Rejection and being left alone, to the point of separation, are situations that are responded to with depressive moods and/or fear. These individuals appear distinctly dependent, clinging, or demanding. Shaping a relationship in this way can be described with the terms "dependent and demanding". Alternative to this, the "contact hunger" appears in the foreground: This is about the attempt to fill the depressive inner emptiness with as much and as many contacts as possible. This gives rise to temporary and short-term (at times even parasitic) relationships (Differentiation from the autonomy-dependency conflict where an "existential dependency" predominates and from the self-worth conflict where those kinds of relationship serve to stabilize the self). Lead affects are mourning and depression connected with the fear of losing the other, or, of the depressive internal emptiness. Envy ("they are getting more") is frequent. In the interaction/countertransference, the investigator often experiences control, clinging, blackmail, and feelings of worry or helplessness.	This type is characterized by self-sufficiency, lack of demands, and modesty as far as the shaping of relationships is concerned. This behaviour may be described as an "altruistic basic attitude". From this we must differentiate the atonement for conscious or unconscious feelings of guilt and/or self-tormenting masochistic tendencies. The point here is a non-demanding, caring basic attitude, in order to obtain (unconsciously), care and safety. Consequently, the lead affect is worry about another person, while latent depressive feelings which are defended against are noticeably present. Feelings of envy ("I give so much and get nothing back") are frequent. Even if these ways of behaving are described and presented with vehemence, the investigator is able to perceive, in the countertransference, feelings of the patient like sadness or yearnings to be cared for. In the interaction, scenes like "do everything for the other person", "not be a burden", come up.
Family of origin	
The distinct wish for care may appear beyond generational boundaries, but show itself particularly in the family of origin. Young adults then remain overly long and overly loyally in the nexus of the family (also, for example, in leisure time). This is rationalized with manifold necessities. What is lacking is the perception that such solutions may be problematical. Beware: cultural and social particularities.	The striving for one's own autarky may lead to take off early from the family of origin ("leaving the nest early"), on the one hand, or to an attitude of selfless, "altruistic" concern and care for the parents, on the other. Finally, and in the hope for a continued experience of safety and care, the attachment is continued by taking the role of actively caring for the parents (to the point of self-sacrificing nursing care). Possible relief is excluded or devalued by rationalization.
Family/partnership	

In a close relationship, the wish for care predominates. Separation from the partner seems impossible, "one" is dependent on the other. The considerable closeness ("always together") is rationalized. The slightest delineation efforts of the partner and separation fantasies trigger depressive episodes and feelings of inadequacy, or fears of being alone, and lead to reactive impulses of clinging and control. This may involve severe reproaches to the point of violent rage towards the partner. The partner tends to react to such a clinging-demanding ways of relating, often experienced as "blackmail", either in an overly caring, or a latent defensive-aggressive manner. If there is also a strong need for care in the partner, symptoms may form on both sides to mutually justify the right to be cared for.	The need for safety may be totally denied in a close relationship. The individuals present themselves as self-sufficient and self-sacrificing, whereby the wish that "this may one day be paid back" remains unconsciously noticeable. In order to be always "there for the other", a close relationship may be demanded. These tendencies in a relationship and the tendencies towards clinging sometimes lead to frequently changing relationships ("I'll get it somewhere else").
Possessions and money	
Behaviour towards possessions reflect the overall conflict very clearly: things and people need to be "possessed", and "giving away" is anxiously avoided. Possessions, which provide a feeling of being cared for and secure, are, however, never enough. The same applies to all other forms of attention and care. If reaction formation is the predominant response, this hunger for care and possession leads to a kind of needlessness. In the social arena this behaviour not infrequently leads to being actively looked after and cared for by others.	Selflessness displayed in one's behaviour towards possessions often contains an aspect of unconscious calculating. Possessions that have been given up remain internally invested; having more the character of a loan, which, besides having to be paid back, require additional interest payments.
Job/professional life	
The individual seeks out work situations which give support and safety. Therefore, these people live far below their capabilities as they do not make their own decisions. They always seek allies and helpers, sometimes avoiding efforts to climbing the	In working life, these individuals appear as irreplaceable, self-sacrificing, capable, employees, who do not spare themselves, but in turn expect eternal goodwill. If the reward to this permanent self-exploitation does not come forth, feelings from

career ladder, so as not to endanger their social safety. Demands placed on them may be experienced as loss of support and be responded to with feeling low and/or refusals.	depression to severe self-doubt might ensue. This professional self-exploitation may also endanger their health. In times of economic downturn (unemployment, companies going bankrupt) the mental health of these individuals is seriously at risk.
Social context	
In their social lives these individuals are rather withdrawn, oriented only towards a few close, caring relationships. In the community, others experience them as demanding and taxing, although they frequently express their needs for care only indirectly.	In the social arena, this type appears more likely to be caring for others - without, however, using this behaviour to build true, mutually enduring relationships. Social engagement often happens in the service of altruistic cessation ("tit for tat"). Frequently, such people do not receive the attention which might be expected because of their commitment, but are abused and devalued. This reaction corresponds, on the part of the carer, to an often secrect (unconscious) contempt for the individual being cared for, or envy towards those who are being cared for.
Body/sexuality	
Needs for care are transmitted to the other via the needs of one's own body ("I need this specific care"). The body is thus the cause of constant attention. In reality, however, the body receives little in terms of true care. Care is supplied predominantly via food, addictive substances, etc. Sexuality, too, is experienced as one way of having that need for care met, and can be functionalized in the form of "sex hunger".	The body is not acknowledged with its needs, signals, and limitations, but rather, is expected to "function". Constantly stepping over the limits may lead to the individual putting his health at risk. Apart from this, the body may itself become an object of care, and, like everything else, be actively cared for. It is conceivable that sexuality is characterized by needlessness, via reaction formation. Beyond this, there may be the possibility of secretly experiencing, for oneself, care and safety.
Illness	
Illnesses and accidents require "even more" care. There is a passive attitude of clinging expectation towards the doctor. Other carers, too, experience such patients often as "taxing" in their wish for care, which causes hardship, or even anger.	When ill, these people show their inability to engage in appropriately regressive behaviour (taking on the role of the sick person) and frequently turn away offers of help. Simultaneously, unconscious wishes to be cared for often manifest as dissatisfaction

In most cases, it is difficult to encourage an active-rehabilitative way of dealing with the illness. A secondary gain from illness is often directly aimed at by trying to gain a pension, whereby the entitlement on the basis of the illness is subjectively experienced as totally justifed.	with the actual care received. In the hospital, help is demonstratively offered to other patients (altruism), which at the same time, however, represents an unconscious criticism of the care received and the performance of the hospital staff.

Care versus autarky - active mode (and guilt conflict - passive mode)

Case vignette: The engineer's wife

Mrs. A., (48 years old), was referred because of daily episodes of diarrhoea, which had been present for many years. The complaint had begun simultaneously with an exacerbation of marital difficulties. Her husband cheated on her with a number of women and verbally abused her: "You're a piece of shit, I'll destroy you". She did not want to admit his womanizing to herself, but suffered immensely from the repeated abuse. When the situation worsened, with the husband now throwing things at her, and she was no longer able to blame it all on herself, she withdrew a large surety that she had taken out for her husband for their company. Since then he heaped even more guilt and anger on her and moved out of their home. For her, a time of suffering and increasingly intense depression began.

Initially, Mrs. A. came across as superficially self-assured and open. Soon it became obvious that even during the conversation she wanted to do everything right. Offers of help were rejected, or understood to be part of her own failures for which only she could be blamed. An underlying sadness was noticeable. Only whilst she was undergoing therapy could she find the courage to separate. The divorce finally came through at the end of her treatment.

Her husband, from Southern Europe, who was about the same age, was a successful, self-employed engineer. As well as looking after him, she had also handled all his financial matters. They had met during his college days. He had wooed her, but from the beginning, this had been a "caretaking relationship": she had looked after him, paid his way through college, and was there for everything. She had always made adjustments to her behaviour, sacrificed everything for the family, and had tended to withdraw when there were arguments, accepting all the blame, even though her husband became more and more aggressive and impulsive. She showered their only son with care and attention, he moved out some years ago. Her husband had never got involved in the upbringing of the child and considered the son as a competitor for the care that, to his mind, was due to him. He was the one who needed care and attention, she was the one to provide it.

The life history reveals a repetitive striving to care for others, in order to maintain close relationships. We are, therefore, dealing with a patient who is generally able to take up a relationship; the handling of it, however, and the way it is experienced, are modelled on the desire for care and safety, or, especially, their defence. Furthermore, this patient is one who always passively takes the blame. The root of these conflicts is found in her biography: she was born in a small village, her father came home from the war a broken and sick man. Her mother - a strong woman full of life - had to work all the time in a small family-owned corner store in order to provide for the family. The patient spent most of her childhood with her maternal grandmother, a very depressed woman who cried a lot. The patient slept at her grandmother's place in order to keep an eye on her, after the grandfather, who had been a police inspector, was arrested at the end of the war, and the family had had to move out of the accomodation that came with the job. After this, the grandmother had become depressed and had made several suicide attempts. The patient had been repeatedly admonished to take care of the grandmother and to

keep an eye on her. One day, however, grandma did commit suicide, and no one recognized at the time how much the patient suffered from the guilt of having failed. From that time on, she carried around with her the feeling that she had to be there for others and had loaded guilt upon herself.

Care versus autarky - passive mode (and Oedipal conflict - passive mode)

Case vignette: The justice department official

Mr. K., (36 years old), came into treatment because of a depression which had increasingly worsened for about one year. Depressive feelings of senselessness had reached the point when he was thinking about suicide. Fears, such as losing his parents, had existed since childhood. The first time he had had depressive symptoms of clinical relevance had been 10 years ago, when his first wife had left him for a new partner. In consequence, he underwent a three-year psychotherapy. During this time Mr. K. got married to his second wife. Soon after, their only daughter was born. Since the birth Mr. K. has felt he is no longer getting any attention at all. The current increase in symptoms, in his mind, is due to the daughter's increasing independence ("She doesn't need me any more") and his promotion as a justice department official. With this promotion, he has left other colleagues behind and has to reckon with a possible transfer to another town.
In the interview, Mr. K. comes across as bland and unappealing, a bit unkempt in appearance, but at the same time displaying clinging behaviour and constantly demanding relief for his "bad" depression: "Will you please do something for me." The lead affect is the constant fear that others might leave him, that he might lose others, and that his depressive feelings might increase. He experiences himself as dependent on the love and care of other people, although he was constantly trying to give to others. Mr. A. appears very stongly inhibited in expressing his own feelings and needs.
Mr. K. grew up in a small town as an only child, his father had attempted to open his own business and failed, and since then his mother had had to provide for the family. His relationship with his mother is still a very close one up to this day. She is idealized, although she appears, at the same time, to be unassuming , not very substantial and, reduced to her role as "provider". The father then tried his luck as a travelling salesman, was hardly ever home, so that the relationship between son and mother deepened further. Mr. K. met his first wife during professional training. ("She was like my mother"). Sexually, there seem to have been considerable problems (this is where a great bashfulness is noticeable in Mr. K.), which, in all likelihood led the wife to turn to another man. He met his second wife, too, in the professional domain, she equally, is described as supportive and caring, sexuality hardly playing a role in their relationship since the birth of their daughter. His professional relationships are subdued and good. He felt safe in his profession, until this current promotion threatened him. In the social environment there are rather fewer contacts without any major conflicts. His symptoms of depression force him to constantly go and see doctors.

4.3.4 Self-worth

Table 4-8: Conflict 4 - Self-worth conflict

Self-worth conflict (Self-worth versus object worth)
General description
What applies for self-worth conflicts, more than for the other levels of conflict, is that they are general: each human being wishes to have their feelings of self-worth satisfied and acknowledged. A self-worth conflict is present when efforts to have

one's self-worth acknowledged appear excessive and unsuccessful, or insufficient or to have failed in the past and/or currently. The conflicts here refer to self-worth versus object worth as the non-adaptive extreme poles of the theme "being able to question oneself", and "to attach a value to oneself". As to their extent, important self-worth conflicts in a patient by far exceed those narcissistic problems which are a part of the other conflict levels. What is therefore not adressed here, is the basic involvement of the narcissistic motivational system (narcissistic "overtones") in any of the other conflicts.
With age, narcissistic destabilization often results, leading to the respective compensation attempts.
As concerns the self-worth (structure), as in all conflicts, a sufficient ability for regulation must be presupposed in order for a motivation-based conflict with a specific trigger situations to arise at all.

Passive mode	Active mode
General criteria	
When the passive mode predominates, the patient experiences a critical dip in the feeling of self-worth ("I am nothing any more"). Often, the symptoms that arise are made directly responsible for this. Narcissistic demands tend to be reduced, the needlessness and unimportance of one's own person are emphasized. Blame is, however, either openly or indirectly attributed to others, especially to doctors and public institutions. The patient's lead affect is a clearly noticeable sense of shame. The mode may also come across as a chronic attitude of defence, where the manifest self-devaluation is in the service of an unconscious building up of the self. This shows, for instance, in the transference in an idealizing and clearly embarrassing admiration (for the investigator), and in the countertransference in feelings of wanting support (accompanied, perhaps, by a latent, though noticeable, feeling of devaluation), or of putting the other down.	When the active mode predominates, there is a forceful self-assuredness in the patient towards others as an attempt to cope with a feared or real crisis of self-worth. Patients may come across as self-assured at first glance, but the hidden insecurity is, however, soon noticed ("pseudo self-assured"). The lead affect of the patient may express itself as irritability and anger ("narcissistic rage"), when the positive-narcissistic self-image is questioned. In the interaction, the investigator is often questioned up to the point of a devaluating insult. In the countertransference, the investigator notices feelings of having been hurt and impulses of wanting to justify himself, due to the devaluation by the patient, possibly followed by anger to the point of putting the patient down.
Areas of life	
Family of origin	
The family tradition often carries on a negative self-image ("The things we put up with!"). The patient is often the carrier of	Either the family of origin and the patient's own biography are strongly idealized, and the patient feels a worthy descendant of the

compensatory expectations, whereby the myth of relegation and of his own inferiority remains, in spite of the hardship suffered and efforts made. Alternatively, the patient may tend to display constant self-devaluation against the background of the family's excessively valued attainments which he will never be able to live up to.	family, or they are ignored by the patient, are trivialized, or denied to the point of feigning lack of memories. The underlying shame of wanting to avoid the topic of family of origin may be clearly noticeable here.
Family/partnership	
In intimate relationships, such people not infrequently seek out a steady partner with whom they share and jointly work through a history of insults, humiliations, and stresses problematic to their self-worth, especially as concerns social prestige. The relationship is stabilized via the common theme of "always missing out" and a delineation from others who seem to fare better.	Relationships and choice of partner serve, patterned on so-called self-objects, mostly to stabilize feelings of self-worth. Relationships are shaped so as to make one the object of admiration, or to make the partner so very worthy of admiration (in the hope of being 'upgraded' by association with the partner). A constant devaluation of the partner might also serve to raise one's own profile ("I don't know what I'm doing being involved with someone like this"). People living according to this mode tend to divide the world into friends and foes.
Job/professional life	
In their jobs, these patients show great work and achievement motivation to compensate for hurts and usually have quite some success within the framework of their possibilities. Hidden behind this one can find a heightened vulnerability to insults when their efforts are ignored. Therefore, the beginning of symptoms is not infrequently directly linked to setbacks, or insults, suffered on the job. The patients may also openly display an attitude of refusing work or achievement, which is congruent with their self-image ("I won't manage anyway!").	In their profession, there is the tendency for these patients to overestimate their rank and performance. Work problems and deficits in one's own performance are denied or causally attributed to others. Often, the actual professional positions are not very high, as the patients, due to their vulnerability to feeling insulted, have a tendency to break off relationships and to perform more poorly.
Social context	
The positions selected in social groups are rather subordinate, preferably in groupings with others who are equally disadvantaged.	Very particularly, social groups or contacts with celebrities or well-known personalities are sought out, in order to be assured, in the

The chosen group may live out programmatic demands vicariously ("Association of Displaced Persons"). Often, however, patients withdraw early from the association, because they get frustrated, and rely on themselves, or seek support from a few familiar relationship figures. New social experiences tend to be avoided.	light emanating from the others, of one's own worth ("Your light makes me shine brighter"). Also, these patients have the need to actively set themselves apart from supposed "failures", for fear that the deficiencies of those losers might "taint" their own image.
Possessions and money	
Accumulated possessions, owning one's own house, etc., all appear to compensate, unconsciously, for the insufficient or missing experience of inferiority. They do not, however, create a basis for narcissistic satisfaction, but frequently confirm the subjective feeling of having missed out.	Possessions and money are representative attributes that serve the assertion of self-worth ("fetishes of affluence"). Not infrequently, these attributes are not real, but rather, tend to exist only in the wishes and phantasies of the patient.
Body/sexuality	
The patient experiences his own body as inferior, which not infrequently leads to neglect ("The body gets what it deserves"). Alternatively, surgical procedures may help, by way of futile, often repeated attempts at correcting varying parts of the body, to upgrade one's self-image ("If only my nose was straight ..."). Predominantly, these patients are convinced about their own sexual unattractiveness.	These patients have an overly strong tendency to treat the body in a way to make it appear young, beautiful, and attractive, in order to compensate for perceived, or at times real, weaknesses. In the context of sports, body cult, and further phenomena, hints may be gleaned as to a phantasized bodily invulnerability and a marked libidinal investment of the body. Aging, as a rule, tends to lead to problems and attempts at compensatory behaviour. One's own sexual potency/attractivity is overvalued as a self-worth tonic.
Illness	
Illnesses often confirm the deficits perceived in one's self-view ("Serves me just right!"). Often, illnesses or accidents are consciously or unconsciously experienced as the equivalents of an unjust, arbitrary, or wilful intention to inflict damage on oneself, through others, for instance doctors. In illness behaviour, this may result in resignation or aggressively demanded reparation wishes towards doctors or other authoritative persons.	Illnesses, also trivial ones, threaten the feeling of self-worth and may lead to breakdown. In any case, they demand strong defensive and compensatory efforts, which extend far beyond the actual requirements. In an extreme case, decompensation into the passive mode may happen. Illness behaviour is often characterized by denial and trivialization.

What applies for both modes is that, often, a self-worth threatening effect, in the manner of "I am not worth anything anymore", or a self-worth stabilizing effect, like, "without the pain I would be perfect" is ascribed to the symptom, which goes far beyond what can be understood from the clinical picture. Life can therefore be "organized" around the illness. A possible evaluation of a symptom will consequently be perceived, in the patient's phantasy, not as a relief, but rather as a punishment.	

Self-worth conflict - active mode

Case vignette: The financial consultant

Mr. D., 52 years old, had been referred by his cardiologist, who was unable to find any organic causes for his repeated tachycardias and thus assumed psychological factors. When greeted in the waiting room, the patient took a surprisingly long time before looking up from the magazine he was reading towards the investigator. By this, the scene gave the impression of an audience. On the way to the consulting room, the patient could not hide his disappointment about the youth of the investigator. He had, as a matter of fact, expected to be examined by the clinical director. Nevertheless, he allowed himself to get involved in the conversation, as he was grateful for the time people took with him. He started the conversation and, for the first 15 minutes, asked the investigator about his qualifications and the planned procedure. Eventually it became possible for the patient to talk about his complaints. He reported that, in the last couple of months, he had been feeling down, lethargic, and unmotivated, more so than before, and that he was not able to pursue his usual activities any longer. He had repeated attacks of heart arrythmias, sweating, gasping for air, associated with the fear of dying of a heart attack. This was unfamiliar, he had previously never been ill and had always paid particular attention to his health and fitness.

He had never allowed himself to be sick, and, as an independent financial consultant, had always been very tense. His clients were always very demanding. In this field you could only survive if you gave a one thousand percent performance. "If you juggle the millions of other people, you cannot afford to make mistakes." Only upon further inquiry into his current professional situation, the patient reported having recently suffered a bankruptcy, before the appearance of his symptoms, in which he not ony lost his clients' money, but also his own private assets, in some shady financial transactions, without there being any security. Only with great effort and noticeable shame, which, however, appeared to be split off, his financially desolate situation involving high debt and ongoing court proceedings became evident. The patient trivialized his problems, he basically saw no great difficulties to getting out of this "mess": "Donald Trump, after all, also managed to."

However, something good had come of his problems. Only now had he noticed how he had made himself and his family suffer over the last couple of years. He had neglected his family, had done nothing but work and had not noticed how important his family was to him. Without his wife's help and support he could not have possibly survived the recent weeks. Only now did he realize what a fantastic wife he had. She not only looked very good and everybody had a crush on her, she was also behind him one hundred percent. She was his "jewel".

As he was currently "somewhat tight", he noticed how little he actually needed to be happy. In the past, he had placed much greater importance on big and fancy cars. Today he drove a used small car which his brother had given him. It did the job. He had always thought the luxury that surrounded him important, now he did not need it any more. He noticed time and time again that the little things in life, for example, the flowers along the wayside, were a source of pleasure.
Data for an extended biographical anamnesis could not be gathered, as the patient took up a lot of time with his elaborations. He did not wish to have a second conversation to continue with the diagnosis. He would be able to cope on his own with these "little problems" of his. When he said good-bye, he joked, with a smile on his face, that he would, unfortunately, no longer be available for the investigator as a guinea pig to practise on. He, the investigator, would have to look for another victim.

Self-worth conflict - passive mode

Case vignette: The disappointed

Mr. K., 32 years old, was referred from the neurological clinic, after he had been treated there for a first-time occurrence of an attack of cramps. To the doctors who had previously treated him, his mood seemed depressed. When greeted, the patient appeared friendly, but somewhat insecure and slightly distrustful with the contact. The depressive symptoms were confirmed by the patient, he was familiar with them since the stroke he had suffered some years ago (he suffered from a coagulation disorder that had not previously been recognized). At the time, his whole world collapsed about him, as his then girlfriend left him, no longer wanting to live with a "cripple". He recovered only with great difficulty from this emotional low, when he was, after a while, able to function again properly and resume his job. In the years that followed, another stroke and two heart attacks occurred, which had finally blown him over. In consequence, he was put on a pension, but he himself, saw no sense in life anymore and made an attempt at suicide. His job as head nurse of a ward in a psychiatric clinic had always been very important for him, it had given his life some meaning. Now he felt he had lost that sense and felt worthless. In the psychiatric treatment he had received so far, he had had to recognize that he was now located on the side of the patients, which he had never been able to imagine in the past. He had been especially disappointed, that girlfriends repeatedly left him, and even his siblings had not supported him. He felt that he was no longer able to trust anyone for fear of new disappointments. In the last two years he had had 16 relationships, but each time he had ended them himself after a short while. Every time the relationship had settled and he started feeling good, he became aware of the fact that he did not deserve so much happiness and that his partner would, sooner or later, leave him anyway. In situations like these he preferred to preempt the disappointment that was bound to happen.
In retrospect, he had been a very sensible and reserved person even before the appearance of his physical illnesses. In childhood, he had experienced little in terms of care and love from his parents. His father had died prematurely, and since then he had had a very close relationship with his mother. She had been more like a good friend to him, had always supported him when he had problems. He had often asked her advice, as he was often very insecure when making decisions affecting his life. In contact with others he was able to hide his insecurity well, acting rather brashly instead. If somebody could not stand him, that was this person's problem, and he did not see any value in spending any time with them. And so he managed his life well until the point when he, for the first time, had a girlfriend from a "good family". She had been very rich, which made him, for the first time, question his

own worth. After all, he had only been a nurse. He had tried not to get unnerved by this situation, and had rebelled against the value judgements of his girlfriend by emphasizing his understated life, for example by driving what comes close to a heap of scrap for a car. But after his girlfriend left him, he managed less and less. A short time after this the first stroke occurred.
Over the last couple of years he had repeatedly tried to start an outpatient psychotherapy. Each time, however, he was disappointed by the therapist. One of them told him to go and kill himself if that was what he wanted; the other's attention had turned to other things during their conversations. He had not been able to detect any interest in himself personally and ended the therapy after a short time. Now, however, he was able to imagine a possible therapy being undertaken as he had the feeling of being understood by the therapist.

4.3.5 Guilt conflict

Table 4-9: Conflict 5 - Guilt conflict (self-blame versus blame of object)

Guilt conflict (self-blame versus blame of object)
General description
The feeling of guilt comes up when one actually, or supposedly, hurts another person, or interferes with another's needs or rights. In the context of this conflict, the guilt feeling, as a rule, arises between egoistic and social tendencies. The injuries involved do not need to be actual or imagined offences in the area of interpersonal behaviour, they can also be injuries, or impairments of internalized systems of values and norms. The contents and extent of those internalized norms and the resulting guilt feelings are strongly socially influenced and culture-dependent. A prerequisite here is the ability to feel guilt. This is not about satisfying motivations which revolve around the need for care or self-worth stabilization, but about burdening the self versus the others when conflicts of conscience arise. Each infringement and each violation of social tendencies is signalled through feelings of guilt, whereby such violations may be motivated by a state of self-absorption, by egoism, but also by strivings for independence and autarky. This forces a corrective attitude towards the phantasy, or behaviour, or a defence against the guilt feeling to be formed, by resorting to repression, displacement, reinterpretation of reality, or projection, etc. Doing so, the patient will often place blame on others, with the conflict manifesting itself as a clear-cut contradiction between "looking for guilt in oneself versus in others". Conflictual tensions of this kind are everyday occurrences. Of interest here are unrealistic fixations and commitments, in the sense of a constant tendency to deflect guilt, or the reverse, a tendency to a constant and submissive acceptance of guilt. Hyper-altruistic attitudes can arise in context with reaction formation against aggressive and antisocial tendencies. This may occur in the form of adaptive behaviour, but is more likely to be accompanied by conflicts. A delineation from self-worth conflicts can be difficult. Of help in this context is the lead affect: in guilt conflicts, feelings of guilt predominate, in self-worth problems, feelings of shame are more prominent.

To be able to experience feelings of guilt, a certain level of structural integration is necessary. The conscience, and thus the experience of guilt conflicts, is also subject to processes of psychic maturation.

Passive mode	Active mode
General criteria	
The "guilty type" predominates here. These patients accept guilt in an exaggerated manner, as a constant attitude. They always have excuses ready for others, and tend to blame themselves constantly. They show a submissive, (overly) adaptive and selfless attitude. Their guilt is often compensated by self-determined, or accepted punishment or guilt. Praise or apologies may paradoxically trigger increased self-criticism and self-blame. The lead affect consists of guilt feelings. In addition, fear of loss, punishment, and sadness may arise. What arises in the countertransference are feelings of pity, extreme carefulness, and a striving to counter the patient's self-incriminations, or to overvalue him. Aggressive impulses may be felt, too.	Typically, guilt feelings are denied or repressed and, as a rule, are passed on to others. There is an unconsciously intended "block" to experiencing and admitting guilt feelings in oneself. But beware: this must be differentiated from the absence of guilt feelings, for example in antisocial personality disorders, which have structural causes. At a superficial glance, these people come across as "cold blooded", having only their own interest at heart, and strive for power "recklessly, without any consideration of guilt or responsibility". The more or less predominant repression of guilt feelings results in anger towards others, or a cynical stance, as lead affects. In the countertransference, there is an impulse to confront these people quickly, to judge them morally, or to react with guilt feelings towards them.
Areas of life	
Family of origin	
These people feel responsible for family problems and difficulties and accept the blame attributed to the "black sheep of the family". They are ready to take on a lot for the family and to make sacrifices in favour of other family members. Others are quickly excused while there is a tendency to constantly blame themselves. Guilt is compensated for by self-made or assumed punishment, the harshness of which often bears witness to suppressed anger, resentment, and grumbling.	Responsibility for one’s own imperfections and problems is located in the family or family members. Guilt feelings are repressed or shifted onto others. There is no willingness to accept even a part of the guilt. The family of origin, as well as generational conflicts, are frequently judged and presented from a position of self-righteousness.
Family/partnership	

There is a tendency to accept blame and to make excuses for one's partner and children, while accusing oneself, or even bringing about situations in which one automatically appears guilty. Behaviour is characterized by a submissive, partly even humble attitude.	Guilt is found primarily with one's partner or children. Negative actions and behaviour modes are "collected" and pulled out at every occasion ("accounting"). There is a tendency to make the partner feel guilty at all times. One's own guilt is hardly ever admitted, and if so, is immediately followed by a qualification ("Yes, but ...").
Job/professional life	
Leading positions are avoided and feared. Praise and recognition are not only perceived as supportive, but also as unpleasant and embarrassing, producing a feeling of insecurity. Social climbing, leaps on the career ladder and successes not infrequently lead to symptoms (fears, psychosomatic symptoms, etc.) and sometimes regression to positions held previously. There is the tendency to first of all seek the blame in oneself, even for mistakes committed by others, and often, to carry the blame for the mistakes of colleagues and superiors. A drop in one's own performance is preferably explained by one's own omissions or imperfections, rather than by objectively existing bad working conditions or excessive demands.	As guilt feelings are predominantly defended against, this often causes arrogant or egoistic behaviour. In the extreme, this can lead to reckless behaviour towards others that does not respect boundaries. In order to overlook one's own mistakes, there is the tendency to make others responsible. One's own incorrect behaviour and unsatisfactory performance are blamed on others. "Guilt accounts" are held and (reproachfully) presented to colleagues. One's own omissions and mistakes are only admitted with difficulty and often, only with restrictions. Criticism is instantly deflected.
Social context	
One's own mistakes are "rashly" admitted. Guilt is instantly accepted. These people are mildly derided by others, and looked down upon, and often taken advantage of. Social involvement is frequently found, and groups are preferred where guilt can be "worked off".	The social context is needed to attribute guilt. The defense against guilt feelings leads to a matter-of-course acceptance of "social advantages", to the point of misuse and exploitation. Some move "slightly outside the law" ("I have nothing to do with it"), without overstepping the line into criminal behaviour.
Possessions and money	
Giving and taking as well as possessions are conflictual for these people, because they engender responsibility and pangs of conscience. Gifts and praise can only be	Self-serving and possessive behaviour is perceived as justified ("I am not to blame"). Attempts are made to get the better of others. People are always hunting for

accepted with a bad conscience, and rather, lead to insecurity and the feeling of having to pay back instantly. Frequent presents to and "pleasantries" towards others, and giving up one's own share, or passing it on to others are ways of making sure that the subjective "guilt account" is kept low at all times.	behavioural "bargains" ("It's their own fault"). Nevertheless, there is a tendency to often feel at a disadvantage, cheated, or deceived ("It's all their fault").
Body/sexuality	
Handling one's own body and its needs, including sexuality, is problematic for many people who grew up in guilt-emphasizing, normative communities. The mind is what matters, the physicality must be overcome and fought against. As a consequence, bodily needs, especially sexual ones, trigger feelings of guilt, leading to attempts at atonement. Not infrequently this leads to a disregard for fundamental bodily needs and inappropriate health behaviour.	The effort to actively overcome body-related responsibility and guilt may lead to the point of exploiting one's own body, as one's own responsibility is denied and delegated ("The tocacco industry is to blame for my nicotine dependency"). An attempt is made to live out sexual needs in a "guilt free" manner. In the same way, blame for sexual behaviour that oversteps limits is attributed to the other.
Illness	
Illness is accepted with humility. In their attitude towards illness, these patients overlook and trivialize acts of malpractice or the shortcomings of doctors. Illness is seen as a consequence of one's own wrongdoings, or as logically consistent punishment. Invasive medical procedures are readily suffered and the patient rarely complains. Dissatisfaction is hardly ever expressed. In the doctor-patient relationship, obedience and submission predominate. Orders are diligently followed. In hospital, these people are rather easy to handle. They apologize for their existence and for the work they cause to the hospital staff.	Illness is tolerated badly. Frequently, others are made responsible for one's own illness. Doctors are often accused of having commited acts of malpractice or of having made wrong diagnoses. One's own bad behaviour (for instance a lack of compliance) or behaviours which are detrimental to one's health are trivialized or denied. In hospital, such people attract attention because they are difficult to handle. They overtax the nursing staff, demanding their rights, as if it were the most natural thing in the world, often at the disadvantage of other patients. They impress as "difficult" patients.

Guilt conflict - passive mode

Case vignette: Failing in success

The 36-year-old patient was seeking out a psychotherapist because of her strongly depressed mood, sleeplessness, rumination, guilt feelings due to her unemployment, dizziness, and tachycardias. She was certified sick and therefore off work and was being treated with anti-depressants by her physician.

A year ago this patient had returned to her home town. She mentioned two reasons for this: first of all, the health of her over 90-year-old grandmother had "collapsed"; and secondly, she had withdrawn a paper with which she had intended to qualify for a foreign university, as well as her application for a university position. This had happened because the university lecturer she was working for, as his assistant, had supported her too much in her career and had himself been in a conflict over this. As a consequence, he withdrew and supported her less. She experienced herself as having destroyed the relationship with the university lecturer (a fantasized infringement of interpersonal behaviour with self-related tendencies). She experienced herself as "megalomaniac", she felt she was not allowed to advance in her career as the daughter of a miner's family.
Her grandmother had been very important in her life. Her parents were working class, very ambitious, and envious of rich people. They both worked, so, as a child, the patient was left with her grandmother and grandfather. Both grandparents were loving, but very strict. She had not wanted to go back to her parents when they came back at weekends to pick her up (at times she had not wanted to live any more). In response to her parents' envious, greedy, and egoistic attitude towards life, the daughter developed an altruistic, socially conscious attitude to life. As she was an excellent student, she was able to do a degree in theology and social studies. She blamed herself entirely for the hatred she felt towards her mother and heavily reproached herself whenever there were arguments.
A conflict then began to emerge between her and her new boss. She had accepted a new position, far below her qualifications, in her home town. The conflict with her boss arose, as the latter had used her qualifications to his own advantage and neglected her over others in the team. She had tried to stand up for herself, yet at the same time had despised herself because of her competitive attitude, which led to her devaluing herself. She thought of herself as "unbearable", was submissive, tried to adjust and be selfless, but on the other hand helped an egoistic colleague on her career path.
In the transference she sought the therapist's support. In the countertransference she triggered feelings of compassion and of appreciation, as well as the need to support her in her professional capacity as a valuable and competent colleague.
In her family she instantly took over nursing tasks, as the old and frail beloved grandmother became sick and her parents were unable to attend to her due to their own illnesses. She reasoned that her father and mother were equally in need of help. With her partner, she lived a rather lifeless (and that included sexuality) relationship. She hardly dared change her professional position, although she had been asked to take on an executive role. She was distrustful and sceptical of such acknowledgement. She gave the impression of being well-groomed, but gave little attention to her femininity. She felt relief at being able to accept the psychotherapy offered to her, but at the same time suffered guilt feelings as others were far worse off than her.

Guilt conflict - active mode

Case vignette: Relationship wishes

The 60-year-old patient sought out a psychotherapist via her GP. The GP had encouraged her to begin psychotherapy, and had initially referred her to a neurologist, who, however, did not wish to carry out psychotherapy with her.
For many years she had been in the care of her GP, and of a physician, a gynaecologist, and an orthopaedic surgeon for somatic illnesses, her complaints being partly psychosomatically superimposed: "Back problems, oestrogen deficiency, cold feeling, pain in her hips", and more. She had been prescribed 12 different medications, appeared dissatisfied, blamed the doctors that they did not try hard enough with her, compared with their private patients, and did not want to help

her as a patient having only publicly funded health care. From the prescribed drugs, a polypragmasia could be inferred. More than 20 years ago she had been in psychotherapeutic treatment for a short time because of an anxiety disorder (fear of dying). She had broken off the treatment, equally dissatisfied and angry with doctors and therapists.

Now she complained about various ailments, like panic attacks, fear of urinary incontinence, fear of other people, depressive moods, feelings of numbness, and suicidal ideation. Most prominent among her complaints is the relationship with her husband. For years he would not accede to her wishes for closeness and tenderness, would withdraw, and reject her. There had been no sexual relationship for the past 6 years. Her anger at him is clearly noticeable, meaning that the behaviour of her husband, above all, is seen as the main cause of her feelings of numbness and the uselessness of her existence.

She had been born in Danzig, and, as an infant, had had to flee, together with her parents, to Kiel at the end of the Second World War. She grew up and went to elementary school there. In 1953 she moved to the Ruhr area, finished elementary school and became a retail saleswoman. During the conversation, she particularly emphasized her close relationship with her father, who had been strict and was a loyal follower of Catholic moral conduct. She felt a great need for closeness to him, which he had not fulfilled. She blamed him for her great neediness. Her father had died 10 years ago; her mother about one year ago. The mother had been a resolute woman, had rejected her and had frequently beaten her. She blamed her mother for having devalued her. But at the same time, she had also had a longing for closeness to her mother. As a child she had been afraid of dying, and had asked her mother: "Can I come to bed with you?" She has two siblings, a sister two years her senior, and another sister two years her junior, but has little contact with either of them.

She saw her relationship with her husband as the main problem. She had been married now for 35 years. Before the wedding, she had loved another man. He had been the love of her life. Shortly before they were to go to the registry office, this man pulled out. She had not been in love with her current husband. She felt guilty for marrying him, as a substitute for the man who had fled. She blamed her husband for not having wooed her, or only in the beginning, for not giving her any tenderness, or not radiating any friendliness; nor did he not support her, or talk to her, and for years had had no sexual relationship with her. Their relationship was dull and dismal. Anger and reproaches towards her husband filled much of the conversation, although her husband provided for her, worked regular hours and also supported their children.

During conversation the patient reported, with feelings of guilt, a past, very loving and close, and sexual relationship with a priest, and eventually, she admitted a current relationship with an alcohol-dependent man. This man had been very changeable towards her, very loving at times, but coarse and offensive at others. During the therapy she ended this relationship. For her, the blame for her having turned to these men lay with her unloving husband.

The marriage had produced three children, two sons and one daughter. She did not feel sufficiently acknowledged by her children, although she had done a lot for them. She had, for instance, cared a lot for her son who had had a motorcycle accident and was hovering between life and death for a long time, and had helped him a lot. He was, however, not grateful to her. She had a special problem with her younger daughter. She had not talked to her for about 10 years, because the daughter had blamed her for not having looked after her sufficiently and for only following her own interests.

Only her relationships with other men, which she experienced as being accompanied by guilt, had been shaped in a way that she felt acknowledged, loved, and valued. Her family, in turn, did not manage to develop these feelings towards her.
In the transference, the patient had wished for a paternal figure who had cared about her in an intense and serious, but especially, in an acknowledging and loving manner. The therapist felt guilt feelings when he did not accede to these requests. If he frustrated the patient's needs, she reacted with fear of loss and depressive moods, which in turn amplified the therapist's guilt feelings. Pointing out some positive aspects in her life, like, for instance, the joy she felt at being a member of a choral society, could not change her fundamentally negative view of her life. After 30 hours of therapy (approx. one year) she broke off treatment with an accusing letter. The therapist was considered unreliable, as he had cancelled sessions due to illness. A later attempt at contacting the patient in writing on the part of the therapist was not successful in overcoming this mood of angry irritation with the therapy.

4.3.6 Oedipal conflict

Table 4-10: Conflict 6 - Oedipal conflict

Oedipal conflict
General description
The need to gain attention and recognition as a woman or man is a fundamental motivation, together with the need for obtaining physical-sensual pleasure and sexual excitement. This includes not only genital-sexual experiencing, but also all strivings and feelings of wanting to show oneself to others, being valued by others, and of shaping the contact with others in an erotic-tender way which can provide physical pleasure. These needs must be delineated, in particular, from the areas of motivation relating to attachment, care, and self-worth. The oedipal constellation presupposes the real or imagined presence of three persons, which are held in a field of tension between appreciation, rivalry, and eroticism. The oedipal constellation is characterized by the wish to be acknowledged by one's primary caregiver, in particular, with regard to one's personal and physical attributes. This is about recognition as a man or woman, not about the recognition of one's "value" (self-value). The identification and taking on of gender-specific role requirements as proscribed by parents form a part of this. These originate in the erotic constellation with one's primary caregivers and the resulting development. The conflict discussed here is therefore also about having one's physical-sexual attractiveness acknowledged, about recognition as a man, or woman, and the strivings and inhibitions which might preclude this. This is not, however, a primarily sexual disorder, as sexuality may be used as a motivation in a variety of situations. The interactions are about wanting to be someone (especially as far as aspects of the gender role are concerned), versus keeping in the background, it refers to the ability to compete versus acquiesce, to enjoy physical pleasure versus living a celibate life. In cases of conflict this leads to a strongly varying, to some extent dramatically exaggerated, but also shallow emotional expression, in order to assure oneself of attention and recognition. These people do not rely on their personal strengths and cognitive competencies to attract other people and to influence them, but are dependent on making themselves especially attractive and desirable.

Attention and loving care can, however, be gained in a variety of ways, even by emotional or physical plaintiveness.
In this context, guilt feelings may appear, just as in other conflicts. Here, they have a conflict-specific tone, which results from the simultaneously existing loyalty to both relationship partners, expressed for instance in competitive strivings and rivalry, and not an independent guilt conflict.

Passive mode	Active mode
General criteria	
This is dealing with people who, because of their physical attributes and their character (especially as man/woman) do not feel admired, acknowledged, or sexually attractive. They therefore keep in the background, feel inferior, yield, and repress their sexuality from awareness, communication, and affect. What dominates are features of unattractiveness, harmlessness, childlike-ness. Their self-experiencing is determined by resignation, or an absence of knowledge about the themes of competition-recognition and sexuality. The interest in these themes is, however, present in a substratum and expressed through a certain flirtatiousness, in blunder, and in the countertransference. Passive avoidance may also lead to total unattractiveness, and set the tone of genderlessness. A lead affect in the proper sense is absent. What stands out, rather, is the lack of appropriate affects. Both patient and investigator noticeably feel the shyness and the (shame-based) fear of living with gender-specific capabilities, and even, at times, the fear of castration. In the countertransference, feelings ranging from "gender neutrality" to lack of interest can be felt.	This is dealing with people who, by their physical appearance and inappropriate eroticising or provocative behaviour, try to (especially as man/woman) be the center of attention and to divert attention to themselves. These people are driven to play to the gallery, to take center stage, to be the "Don Juan"/"Diva", to shine and to seduce. Different from the self-worth conflict, the themes of the play may change rapidly and frequently, always, however, requiring an audience. In a forceful sexualization, the sexual referencing and the possibilities of achieving satisfaction may be equally hampered. Not infrequently, the provocative behaviour is embarrassing for the observer. Strongly varying, partly dramatic emotions, eroticization, and competition up to the point of shamelessness are the lead affects. In the countertransference, a fascinating attraction alternates with angry disappointment.
Areas of life	
Family of origin	
The relationship with a primary caregiver is often idealized in a "childlike" fashion, and de-eroticized, whereby, at the same time,	There are often highly emotionalized relationships within the family, mostly with particular attention towards and recognition

the other caregiver, real or imagined, is relegated to the margins. The family history appears grey and lifeless, familial conflicts and sibling rivalry is repressed, there is an anxious conservatism.	of the opposite gender parent. In most cases, the patient carries the role of mummy's/daddy's "favourite" into adulthood, or keeps fighting for this position. In sibling relationships there is constant rivalry.
In both modes, the patients are strongly connected with their family of origin, both atmospherically and in their inner worlds, and influenced by it.	
Family/partnership	
Close partner relationships are mostly stable and concerned with protection and safety while leaving out the area of acknowledgment, competition, and eroticism (at one extreme is the so-called white marriage). Consequently, older partners are often preferred. They often have a similarity with the preferred primary caregiver. Crisis-like developments result when a role change becomes necessary due to the partners advancing in age.	There is a constant playing to the gallery in relationships, too, in order to gain attention and recognition. The theatrical-emotional or contradictory sexual behaviour (entice and block, being involved in an eternal triangle) causes a lot of pain for all participants. As choice of partner is, mostly, modelled on primary objects, the partner is often experienced as inadequate. Crisis-like developments arise when partners advance in age and a role change becomes necessary (for example, "Lolita", or "the party girl" becoming a mother, "Don Juan" becoming a father).
Possessions and money	
On the surface, the use of possessions in the service of one's own attractiveness and competitiveness is avoided. Nevertheless, they can serve as a silent and unconscious compensation.	Possessions and money are used in order to achieve being the center of attention, to compete, and to gain recognition. Accordingly, the house, car, etc., must be particularly striking, whereby things are changed according to the situation and an inner attachment to these things is noticeably absent ("props").
Job/professional life	
In the same manner as in the family, work life, too, is characterized by inconspicuous, reasonably good relationships, in which one's own competencies, especially interpersonal ones, are not used to the full, in order to avoid competition. Therefore, rather subordinate positions are sought out.	These people strive for professional recognition and attention more by playing to the gallery, and to some extent also by displaying eroticizing behaviour, than by showing consistent performance. Overly strong competition only adds stress to the professional situation. This leads to frequently changing professional constellations and professional positions

	which are rather below the individual's abilities.
Social context	
In social groups, stable, unobtrusive relationships are preferred, which put aside the competing, sexual moment, or avoid it altogether (harmonious, sibling relationship; "putting one's tail between one's legs"). This may lead to these kinds of people being not exactly disliked, but no one having any sustained memory of them.	Social groups, associations, and friends are used for putting on one's own show, and are changed rapidly, as required. In this context, relationships are judged as more private than they really are. Triangular, destructive constellations may occur, whereby the desire to destroy close attachments between others is the predominant motive.
Body/sexuality	
Physical attributes and physical appearance are given little attention, yet care of the body is not neglected. Hiding possible attractiveness, sexuality, and rivalry is attempted in order to omit areas that are competitive, involving recognition and the erotic. These problems may persist into old age, whereby the renunciation of physicality is then justified by advanced age („At my age you don't need this any more!"). In extreme cases, a sexual disinterest is prevalent.	The body, or parts of it, are employed in the service of gaining recognition and of competing. Consequently, it is given an inordinate amount of attention, it is "done up" with relish, at times provocatively, and "displayed". The limits to physical attractiveness or its loss in old age thus represent a great threat and, depending on the circumstances, are glossed over ("forever young") which, in the worst case, reaches the point of caricature. There is a pronounced interest in sexuality (jokes, dirty jokes, up to donjuanism/nymphomania).
Illness	
Complaints and suffering offer an unconscious opportunity to gain much desired attention and recognition. In their illness these people come across as weak and pseudo-regressive. Sometimes they strive to have therapeutic procedures undertaken which are a silent replacement for recognition, or for the sexual satisfaction they don't get.	Illnesses may be dramatized in a way that captivates everyone involved, in order to gain attention and loving care. At the same time, no health carer is ever in a position to actually fulfil these needs, so that ever new experts need to be sought out. The role of the sick person further offers opportunity for various identifications. Illness often leads to eroticizing and competing in the doctor-patient relationship.

Oedipal conflict - active mode

Case vignette: The emergency room patient

30-year-old Mrs. B. was admitted to the emergency room because of hyperventilation tetany. For more than two years, these hyperventilation tetany attacks had become more and more frequent, until almost daily events. The first attack occurred when she had a phone call from a girlfriend saying that she had had a baby son.

Mrs. B. was bubbly during the conversation. She was attractive and put on a show again and again for the male doctor. At times she would laugh at totally inadequate moments, or fall into a depressed mood without any warning, and cry. She had been listed as an emergency, that is to say, she had alerted the accident and emergency outpatient clinic that she instantly needed an expert to help her. The interviewer had the feeling of being pleasantly attracted, on the one hand, and irritated because of the inadequate dramatizing, on the other.

Her life history was a series of "wild" experiences and "crazy" plans. She came from a simple family, the second-born child, and the only girl of six children. This had always made her special and daddy's favourite. The latter, however, was a marginal figure in the family, chronically ill and on a pension since her birth. The mother was a housewife, equally ill all the time. The family stuck together well, although there was a constant struggle for loving care and attention. At age 19 she moved in with her first boyfriend: pregnancy, miscarriage, and "wild partying" followed, and then she drank more and more alcohol. After she met her (later) second husband, she left her boyfriend and became a teetotaller. In the time between this, she married (her first marriage) only because of a crazy plan. She had married the man in order to "free" him from prison. Why she had really married him she still did not understand today. Shortly thereafter, they were divorced, without their ever having consummated the marriage. She met her second husband on her own initiative. For a long time, they had been sleeping next to each other, without becoming intimate, he was a good guy, reserved and shy. Since their marriage she had a strong wish to have children, but had not become pregnant. Professionally, she carried out a variety of jobs, some way below her level of ability. She had a lot of friends, but did not have anyone - apart from her husband - with whom she could share her worries. She experienced herself as physically attractive, but sometimes the attention she received from men got too much for her.

Oedipal conflict - passive mode

Case vignette: The student

The 26-year-old law student had referred herself for an interview because of depressive symptoms. When she came in, she appeared as a rather pale and childlike young woman, dressed in predominantly dark hues, who spoke softly, and generally gave a very lifeless, unattractive impression. A marked depressivity was not noticeable to the investigator, rather, what predominated was shyness, inhibition, and shamefaced bashfulness. In the conversation she was extraordinarily passive, talking only with great hesitation about her problems, so that the investigator had to enquire repeatedly to find out more.

The symptoms began to appear rather insidiously about two years ago. During her degree, she felt increasingly compelled to compare herself with her fellow students, but she avoided such confrontation more and more. In addition, a male fellow student from her seminar group showed an interest in her. In order to escape from

this erotic temptation, she tried to cover herself up even more, to hide, and conceal herself as a woman with inconspicuous clothing. Her attempt to have only a "good friendship" with him led to him eventually choosing another student. This confirmed her feelings of inferiority and unattractiveness. At that time the depressive symptoms began to take shape, even if the patient could not, in substance, see any connection here.
Since that time she had intensified her already very intense relationship with her family even further, was on the phone to her parents every day, and spent every weekend with them. Although she described both her father and her mother in a loving way, they came across, however, as lifeless and colourless. The relationship with her father was a "loving and best buddy-type" one. He appeared to be more her best lifelong friend than her father. The mother seemed to play a rather subordinate role in the family set up. There seemed to be no conflicts. The overall climate in the family is described as conservatively protective. As early as childhood, the patient liked to get together with friends and girlfriends, but much preferred rather "inconspicuous" behaviour in a social context. Since puberty she had mainly chosen friendships with girls, but here, too, preferred to stay on the margins. She took the gender-specific developmental steps like dancing class etc., because this was "the done thing", but most of the time had had the feeling that it was "far too early" for her and not fitting. Also in the period that followed, up to the trigger situation, no man had shown an erotic interest in her. In her conscious experiencing this was fine with her. On the other hand, however, she wished to obtain protection and safety, rather more than sexual desire, from a partner.

4.3.7 Identity-(Self-)conflict (Identity dissonance)

Table 4-11: Conflict 7 - Identity-(Self-)conflict (Identity dissonance)

Identity conflict (Identity dissonance)
General description
By self we understand the totality of a person's internal images of himself. This "self"-identity system must be qualitatively distinguished into two areas: the area of regulation of the feeling of self-worth (narcissism), and the area of self identity. In both areas, tension-free states are linked with a feeling of well-being and safety (Sandler/Joffe, 1970). A successful identity formation with sufficient continuity and cohesion leads to a feeling of well-being and of safety. Conflicts arise from contradictory self-representations connected with feelings of insecurity and displeasure. This conflictual dissonance of the areas of the self must be strictly delineated from identity diffusion. Diffusion is a structural problem that is captured and described in the OPD axis 'structure'. If dissonance conflicts in a more specific sense arise, they refer to one's own identity, whereby these conflicts are not entirely unconscious, but frequently conscious or preconscious. This is, consequently, about people who have not succeeded in building up their own identity with the respective feelings of well-being. What is not addressed here are increasingly frequent inner and outer conflicts as they happen to all people, for instance within the framework of migration, (for instance a Muslim coming to a Western society), and which are based on preeminantly real contradictions in the social fabric of life. Patients with structural ego and self disorders (like, borderline or other personality disorders) are reflected on the structural axis, whereas the area of identity-(self-

)conflicts highlights individuals whose self and object representations are endowed with sufficiently intact ego-functions, but whose image of themselves leads to conflicts.

Identity formation is a life-long process. It is reflected in each stage of development in a subjective feeling of identity and continuity. Identity is always linked to a relationship with various objects, that is to say, there are numerous, and different, identities which, in the conflict-free scenario, appear as a coherent and continuous self identity. Examples are gender identity, identity as a father, religious identity, identity as a member of the family, national and ethnic identitiy, etc.

As people are being socialized, in the course of their development, in often very different identities, not only conscious, but also, at times, much more strongly expressed unconscious self representations (Schüßler, 1995) arise. Mention will be made here especially of disturbances in the area of the following partial identities: body, gender, family identity, ethnic, religious, social, political, emotional, and professional identity. A conflict may thus arise, for instance, between the identity of father of a child and son of a father, or between having a foreign family of origin and wanting to be integrated (nationally belong), or the wish to be successful as a man, but retaining femininity, or upward social mobility that involves taking on a new identity conflicting with a feeling of loyalty towards one's social origin and ties. Additional identity conflicts comprise conflicts between various body image identities: female athlete versus female body, disabled body versus bodily integrity, puer aeternus versus aging, but also post-surgery states for example after a breast amputation.

Identity conflicts must be diagnosed when an essential part of the psychodynamic phenomenology appears in that area and not in the other conflicts that have been described (like, for instance, within the context of a guilt conflict).

Passive mode	Active mode
General criteria	
People with a passive mode of conflict management experience a feeling of chronic or recurring lack of identity ("Who am I really? Where do I belong?"). Coping strategies are predominantly trivialization, rationalization, to the point of denial of identity dissonances, which in the extreme case appear as a feeling of total lack of identity. They must, however, be distinguished from people who intentionally hide their identity. The avoidance of life situations that confront the individual with the insecurity of his own identity is an	People with an active mode of conflict management have a general tendency to actively gloss over the insecurities in their own identity. A constant feature of the attempt to cope with a basic identity insecurity in most varied roles is always to resort to compensation, and to avoid identity dissonances (the construction of a family saga, fantasized genealogy, and borrowed identities). The predominant basic feeling is the worry and fear that one's own identity system might be put at risk through the contradictions.

ongoing feature.	
Areas of life	
Family of origin	
The identity of origin seems either colourless or dull, or visibly shaken. There were few attractive and major role models with which an identification would have been acceptable. In the whole family, unclear or contradictory identities are reported, for instance, the father may simultaneously/consecutively be a successful businessman, an exposed con-man, a broken bankrupt, and a humiliated social security recipient.	Identity contradictions in the area of the family are glossed over with the help of active constructions which stand out, most of all, by the intensity with which they are maintained. The reported history of the family of origin contains idealizations and fictitious tales. The economic downfall for instance was caused by an enemy conspiracy, or the particular noblemindedness of the father ("too good for this world"). In a family of origin that is experienced as unimportant or even as having been humiliated, the unconscious wish to set oneself apart and start anew dominates (founder of a dynasty, "all done single-handedly").
Family/partnership	
Partners who would be able to give the patient identity and support because of their own clear and admired characteristics are avoided. This constant discrepancy is hard to take and constantly reminds one of one's own insecure identity. If the patient nevertheless finds a partner with a stable identity, he is likely to unconditionally place his own identity below that of the partner.	Partners, relationships, and families are sought out who, because of their characteristics can better offer the patient identity and support. In the best case, this leads to stable solutions, as in cases where the new in-law becomes the family historian. The forceful or exaggerated adoption of the new family identity may lead to failed adjustments (in the past, for instance, the label "newly rich").
Job/professional life	
In their success stories of learning and achievement these patients often appear contradictory. To be successful, they lack an inner constancy and role security. At times they come across as fake or as not consistent in their professional roles and functions ("he dressed as a doctor"). To some extent they try on many roles and positions.	Professional life is imbued with an inordinately identity-giving role ("always in service"). This is why work and performance behaviour of these people often appear problematical and inflexible, as they sometimes pursue their own values and characteristics in the sense of overvalued ideas (fanatics and inventors). The necessary orientation to facts and the task at hand often take second place after the

	relationship with oneself and one's identity.
Possessions and money	
Pre-existing situations regarding possessions may serve to substitute for the feeling of safety that is absent in the self organization of the individual (having instead of being). Sometimes people do not know what to do with the money they earn ("doesn't go with me").	The situation with respect to possessions serves essentially to stabilize one's own identity ("I am the discriminating conoisseur who owns this collection. I am the avantgardist who has such a house built for him"). Possessions are acquired in order to provide this identity giving function. This must be delineated from the fact that possessions raise the (narcissistic) self-worth feeling.
Social context	
In the social environment these people appear chameleon-like in their attempts to adapt, yet despite this tend to come across as rather colourless ("well-adjusted"). They lack the social profile, which may cause friction with others, but which is necessary for others for "recognition" purposes. This is the reason why they are, in the final analysis, probably not respected. This again may be the reason why they avoid social contacts that could expose them.	Membership in groups is sought and maintained because of the identity giving function ("We artists"). These patients may then stand out because of how they exaggerate these role identities. This may reach traits of caricature. (The "physicist genius" who is recognized by the worn out elbows of his pullover).
Body/sexuality	
The lack of panache and cluelessness, as concerns identity, lead to an indifferent handling of the body. There is no typical model here. If the rejected bankrupt father had a belly, then the emphasized slim line or "conscious eating habits" may form the unconscious delineation from him. Some varieties here may emerge only due to accidental coincidences in earlier and present life. Along similar lines, the way that clothes are used to express one's personality is restricted and not fixed. Strongly changing orientations concerning one's outer appearance point to a rather passively determined identity ("the need to be a follower of fashion").	The forceful style of handling one's own body must be examined with a view to this style having identity giving functions. If a trained body ("six-pack"), three-day-beard, and bald head are social attributes of maleness, then these offer the possibility for stability for the individual who is insecure about his own maleness. Clothes have always provided identity ("dress for success"). Uniforms, national costumes, and designer labels form part of one's identity style, just like "contrived shabbiness" or the punk hairstyle. Characteristic here are limited choice and fixations.

Illness	
Because of their passivity the patients do not succeed in finding, and accepting, a new and adequate (illness-)role. They avoid any confrontation with this and the majority are helpless and passively-obedient.	These patients tend to actively assume and shape their illness roles (Molière: The Hypochondriac). If they were nothing so far, now they are ill. The whole self-presentation is defined via the fact of being ill. At the other extreme is the forceful refusal of the sick role, because it does not agree with ideas about one's own identity ("I'm not one to get this sort of illness". - "You can't possibly put me in bed"). The patients are thus at risk not only because of the possibility of the illness turning into a chronic condition, but also because of the consequences of denying the illness.

Mixed passive and active mode

Case vignette: The Swiss expatriate

The 36-year-old patient began the initial conversation by presenting difficulties apparently present in her relationship. Her husband tells her she does not know what she wants. He thinks it odd that she had been to university and for years had worked in a successful position, and now, of all things, has a wish to study psychology and start again at the bottom. And it was similar in many other areas. He said she was looking for something, did not know what it was, and what she had never made her happy. Such reproaches would then lead to arguments between the couple.

The patient was Swiss born and raised in Zurich, Switzerland. In the initial conversation, she impressed the investigator by the fact that her language did not give away her origin, not even in intonation: she spoke perfect high German. This was made even more surprising by the fact that she, the daughter of a typical Swiss family had only been living in Germany since her marriage to a German, six years ago. Asked about this she smiled a friendly smile and said this was her over-adjustment. It was like this with everything. Many admired this ability of hers. She herself was more sceptical, however. To illustrate, the patient told a story of when she had once been back in Switzerland, and had bought something in a shop. She had, of course, talked in her native language with the shop assistant, but the shop assistant, to her surprise, had answered her in high German - as if she was a foreigner, who tried to speak Swiss German.

The patient was able to report more examples of this kind. In her company, everybody assumed as a matter of course that she was a lawyer, although she had studied national economy. Her father was a lawyer, but as his favourite daughter she had made an effort to distance herself from his wish that she take up his profession. "I may not have fully succeeded here, either", she commented. She had picked up judicial knowledge, a juridical way of thinking, as well as a great interest

in legal matters almost in passing. Because of this, "crazy situations" arose quickly in her company. Her boss asked her how she would assess the statements of the legal specialists. The legal adviser in charge probably hated her for it, but was smart enough to understand that she was the "favourite daughter" here, too, and would discuss with her, seemingly accidentally over lunch, the legal papers that needed to be drawn up. It almost went without saying that her husband was a lawyer, too. The wish to study psychology was understood by this intelligent and reflective patient as a double wish: it was a further attempt to distance herself, to not always be mixed up, and for her, also a clarifying attempt, a hope, to learn more about herself through her studies. "The way I have handled this in the past, I should be a first-rate psychologist", she comments, not without some self irony.
For the diagnostic interview, the patient appeared dressed in true executive style. It was distinctly female and tasteful. It was difficult to understand her statement that outside work, she almost "dressed like a man", as they "had it more comfortable". In the countertransference the impression arose that the patient was probably being coquettish, which might have been, however, unjustified.
She was the youngest after three older brothers ("You had to adjust to survive". This was one of the few remarks that hinted at conflict). The father was a successful business lawyer, the mother was a housewife. Her childhood accounts were strangely pale ("We had everything we needed"). All three brothers studied law, but were engaged in very different professions. As she believed she could not stand the sight of blood, becoming a doctor, which still would have been tolerated by her father, was out of the question. Thus the compromise remained to study national economy, of which she does not think highly. The identity of the family was formed through her father and his language. He was a Swiss nationalist and voted for an anti-immigration party. None of the sons was able to avoid his "gift of identity", but apparently managed to find sufficiently satisfying individual solutions. The patient oscillated between adjustment (+) and resistance (-). Her husband is German (-) and a lawyer (+). National economy is pretty unimportant (-), but does not have any hint of rebellion (+). She is thought to be a lawyer (+), but is not allowed to refer to herself as one (-). She is Swiss by birth (+), but manages to adjust so well to foreigners that she cannot be recognized as such any more (-). She has the wrong gender (-), but does not want children, which could make up somewhat for that damage (+). Because of this, she cannot contribute grandchildren to the family (-), which all of her brothers have done already. Nevertheless, the father is happy with this (+), only the mother, whose role pales into shades of grey, seems saddened. At age 36, the patient is at the threshold of a new attempt to find an identity, and this time her concept is rather revolutionary (-). Therefore she maintains the alternative idea of studying law, after all, which, should not be difficult for her, in her own opinion (++). "Then all I would have to do was learn a reasonable Swiss German again!"
The countertransference is dominated by the overall feeling of helplessness and lack of clarity. The dynamic, so clearly accentuated above, which became more and more evident only during the course of several diagnostic interviews, was presented in a totally bland manner. The high degree of subjective suffering might have been easily overlooked at any time, if one had wanted to do this. In addition to signs of a conflict between need for care and autarky, a self-worth conflict, and an oedipal-sexual conflict, the identity conflict is phenomenally in the foreground. No other conflictual pattern is so pronounced. On the surface, the conflict is played out in the professional area, and less so, in the area of nationality. On a deeper level, and more to be presumed than to be ascertained, is the conflict of gender identity - she feels she is in the wrong shoes, no matter what profession she chooses.

4.4 Axis IV - structure

4.4.1 Introduction

Structure refers to the self and its relations to objects, or more exactly, to the availability of mental functions for the regulation of the self, and its relationships to internal and external objects. The degree of availability, or its limitation, is described based on the level of structural integration of the function in question.

The two constructs of structure and conflict describe different aspects of the system of the psyche. Conflict as a repetitive pattern describes content-based psychodynamic aspects of events, and thus the conditions which may trigger symptoms. Structure refers to the vulnerability of the personality, disposition for illness, and the capacity to process internal conflicts and external stressful events.

The same conflictual themes show different intensities at different levels of structural integration (for example, different quality of affects, varying images of objects, different quality and intensity of needs, different maturational level of defence, etc.). To some extent, studies have found that individual conflicts require a certain level of structural integration (for instance individuation-dependency conflict and self-worth conflict in a reduced level of structural functioning, oedipal-sexual conflicts in a higher level of structural functioning). The lower the level of structural integration, the more difficult it becomes to identify stable conflict patterns. In a disintegrated level of structural functioning, unequivocally identifiable conflicts are largely absent.

What kinds of observations are used in the assessment of structure, and how long are the periods of observation?

The "clinical material" to be examined under structural points of view comprises the following:

- interactions and experiences of life which the patient reports
- structural abilities that the patient shows in the diagnostic relationship
- the countertransference as experienced by the therapist
- the patient's introspective assessment of himself and his behaviour, gained through enquiry or through spontaneous utterances.

The assessment of structure is not necessarily oriented to the current disturbance and/or its quality as an illness, but to the underlying structural possibilities, as they have become evident during the interactional behaviour over the last one or two years. Current disturbances, including regressive states and crises, do not, by themselves, determine level of structural integration, but are indicators for structural potentials.

For assessing structural level, it must be established which of the operationalizations given in the manual best fit the patient. It is possible in this context that varying levels of structural integration may be described in the various structural dimensions. The overall assessment of structure, eventually, is designed to integrate the structural assessment of the individual structural dimensions from a clinical point of view.

4.4.2 Operationalization

General characteristics of the levels of structural integration

High level of structural integration

A high level of structural integration provides an inner psychical space, in which mental experience (cognitions, affects, phantasies, memories, decisions, etc.) can be differentially perceived. In the same manner, conflicts can be struggled with intrapsychically. They occur between different needs and stirrings of needs, on the one hand, and internalized norms (in the shape of a fully-matured superego), on the other.

A high level of structural integration is characterized by the fact that the regulating functions are principally available to the patient and can be maintained, or regained, across long periods of life, even in the case of internal or external stressful situations.

The central fear is focused on the loss of the love of the object.

The countertransference towards such patients is characterized by the therapist becoming aware of stirrings of feelings which bear on the revitalization of biographically relevant experiences with persons from the patient's life history.

Moderate level of structural integration

An aspect of the characteristics of a moderate level of structural integration is that the described capacities and functions remain principally available to the patient, but are reduced. Here, too, intrapsychic conflicts predominate, which, however, are differently shaped and are dealt with differently than in a high level of structural integration: as far as wishes go, we find unconscious strivings of greedy neediness, of exerting power, of submission; at the other extreme, in clearly exaggerated form, we find strict and rigid punishing norms ("immature superego"), as well as exaggerated ideals.

The central fear is of loss of the object, or separation from an important object, combined with the fear of one's own intense impulses.

This corresponds to a countertransference experience which, at times, is very difficult to bear, but which can always be linked back to the patient's relevant relationship experiences through consequent therapeutic self-reflection.

Low level of structural integration

Contrary to the previously described levels of structural integration, the availability of regulating functions is markedly reduced here, in fact, either permanently (in the sense of a developmental deficit), or over and over again in the context of stressful situations or events (structural vulnerability). In contrast to the above mentioned levels of structural integration, the psychical inner space is poorly developed. The self is very needy, very easily hurt, very impulsive, the images of the objects are threatening, persecuting, or wistfully idealized. The normative structure (in the sense of the superego) is dissociated. Stirrings of unconscious wishes are not intrapsychically handled, but are directed immediately to the outside. Thus there are fewer intrapsychic conflicts, but rather, a predominance of interpersonal conflicts (in close relationships, at work, and in the social environment).

The central fear is of self annihilation through the bad object, or through loss of the good object.

The countertransference is characterized by intensity of feelings, by the abruptness of the experience, and by the fact that feeling reactions have an after-effect lasting beyond the patient's actual presence. These patients do not repeat biographically relevant conflicts in their relationships, but tend to mobilize via projective identification mental experiences in the other, of which they are not consciously aware themselves.

Disintegration

Disintegrated does not mean disorganized. The lack of coherence of self and the flooded emotionality are covered up by post-psychotic, post-traumatic, or perverse, etc. forms of organization in the sense of restitution. Images of self and object appear confounded, empathic object perceptions are as good as impossible, responsibility for individual impulsive actions is not experienced (things just happen).

Within the framework of temporary psychotic decompensation there may be projective processing.

The term "disintegrated" refers to the ongoing limitation of structural functions, not to exceptional states, and also not to certain psychotic illnesses or the residues thereof.

The central fear is directed to the uncanny object which appears rather as a medium, not as a concrete object, and in addition, the fear of loss of ego and dissolution of self.

The countertransference is characterized by experiences of that which cannot be understood, which are strange, and dangerously uncanny.

Table 4-12: Criteria for the assessment of the level of structural integration

①	high	Relatively autonomous self; well-structured internal psychical space where intrapsychic conflicts may happen; capacity for self-reflection and reality-based perception of the other; capacity for self-regulation; capacity for empathy; sufficiently good internal objects; central fear: fear of losing care and attention of the object.
1.5		high to moderate
②	moderate	Intrapsychic conflicts are more destructive; self-devaluing and auto-destructive tendencies; difficulty gaining self-image and identity; overregulation and reduced self-worth regulation; object images are limited to a few patterns; reduced ability to empathize; dyadic relationships predominate; central fear: fear of losing the important object.
2.5		moderately to low

③	low	little developed internal psychical space and very limited differentiation of mental sub-structures; conflicts are interpersonal rather than intrapsychic; absence of self-reflection; identity diffusion; intolerance of negative affects; impulsive outbreaks and high sensitivity to being emotionally hurt or injured; defence: splitting, idealization, devaluation; lack of empathy and limited capacity for communication; internal objects are predominantly persecutory and punishing; central fear: annihilation of the self through loss of the good object, or through the bad object.
3.5		low to disintegrated
④	disintegrated	Lack of coherence of the self and flooded emotionality are covered up by defensive patterns in the sense of post-psychotic, post-traumatic, or perverse forms of organization. Self and object images appear confounded. Empathic perception of the object is near impossible. Responsibility for individual impulsive actions is not experienced (things just happen). Central fear: symbiotic merging of self and object representations leading to loss of self.

4.4.3 The individual dimensions of structural assessment

Cognitive abilities: self-perception and object perception

With reference to the self: The cognitive dimension describes the ability to form a differentiated image of one's own self and the related inner processes, especially of one's own affects. This also includes the ability to coherently maintain the self-image constantly over time, as far as its psychosexual and social aspects (identity) are concerned.

With reference to the objects: as far as objects are concerned, this is about the ability to form a realistic picture of the other person, especially, the ability to perceive the other as someone endowed with individual characteristics. The central prerequisite for a realistic object perception is the ability to distinguish, with certainty, between what is one's own and what is the other's (self-object differentiation). This is, of course, not only a prerequisite for realistic object perception, but also for realistic self-perception.

Table 4-13: Self-perception and object-perception

Self perception and object perception	
Perceiving the self	Perceiving the objects
1.1 Reflect and differentiate self-image	1.4 Self-object differentiation: distinguish one's own thoughts, needs, impulses from

	those of others
1.2 Differentiate one's own affects	1.5 Perceive others in their various aspects, that is, as whole persons
1.3 Design and further develop one's own identity	1.6 Ability to design a realistic picture of others

High level of structural integration

A differentiated, reflexive perception of the self is possible. In its fundamentals, the image is constant over time and coherent. Internal processes can be observed with some personal engagement and, as far as the pertaining affects are concerned, be differentially perceived. The experienced affects comprise the whole spectrum of emotions, from joy, curiosity, pride, on the one hand, to fear, contempt, anger, disgust, sadness, guilt, and shame, on the other. The ability for self-reflection may be restricted through conflicts, but without it being fundamentally made inoperative.

The patient is able to, either spontaneously, or upon being questioned, name personal characteristics and abilities, which illustrate the image he has of himself, "what kind of person he is", and what distinguishes him from other people. He is able to differentiate varying facets of his emotional experiencing. The investigator gets the impression that a self-reflective interest can be mobilized and used in the patient.

Affects, impulses, and thoughts can be kept apart with certainty as to their assignment to self or objects. One's own interests and interests of others can be safely distinguished. In this way, a differentiated perception of the other develops; the image of the other is fundamentally constant over time and coherent. It remains stable also in situations of conflict and when under pressure from drive-related interests. Under the influence of relationship conflicts, affects like anger, disappointment, sadness, may become more intense, without the reality of the other being lost.

In his description, the patient is able to bring to life persons close to him. A picture of important relationship figures, including their limitations and possibilities, their strengths and weaknesses, can be formed.

Moderate level of structural integration

The reflexive perception of the self is reduced. It is, above all, directed to the ego as an agent. Introspection as far as one's own affects go, is limited. The coherence of the self image is made fragile by stressful situations and events. Delineation of that which is one's own from that which is other is difficult.

Under interrogation the patient is less likely to describe who he is, but what he did or said in certain situations. The self-image thus generated has a cliché-like appearance, it is dependent on situation and mood. The patient is apparently strongly influenced by situations and moods or tries to keep himself stable by avoiding affect.

The patient's own affects and needs make it difficult to perceive the other as a whole object and realistically. Depending on the circumstances, a one-sided or cliché-type image of the other is drawn up.

The patient is basically able to paint an adequate picture of other persons, this picture is, however, not very stable, especially when strong wishes are made known to him, or when he feels cornered. In these situations the image of the other "collapses", so that, temporarily, difficulties in the relationship arise. It is possible, though, to distance oneself from those strong reactions again, to perceive the interests of the other, and to consider his reality.

Low level of structural integration

Reflexive self-perception, if at all possible, does not result in an understandable, individual image. The patient is able to perceive his own affects in a poorly differentiated fashion. Self experiencing is determined by negative affects, expressed above all in contempt and disgust.

Instead of affective experience, there may be alienation and emptiness of affect. When affects arise, their attribution to inside or outside cannot be clearly distinguished. A feeling of identity is not available, contrasting aspects of the self exist dissociated alongside each other.

Even with support, the patient is not able to picture himself and to describe to the investigator in an understandable way what is going on inside him in terms of ideas and affects. There is no coherent image: "I'm a Jack of all trades, master of none". The self-image is distorted, as the case may be, megalomaniacally exaggerated, or devalued, at times also diffuse and mixed together with the image of important others. The internal preferences, including sexual ones, remain unclear. Contradictory social roles are taken on. In a consultation a few days later, the image transmitted may be that of a totally different person with different expectations. In the investigator's experiencing it may happen that the patient is not remembered, that he will be forgotten.

In the perception of the other, self- and object-perception are confounded. In particular, there is no comprehension that an other has personal strengths and weaknesses, as well as a history of his own. Another person must come up to the patient's expectations in totality, or this other person is not good (idealization/devaluation). Descriptions of others have the quality of wood carvings in their simplicity or exaggeration, that is to say, they lack credibility. The ideal partner is someone who in his or her turn does not make demands, who has no imperfections and with whom everything is possible.

When the patient describes other people, it is noticeable that these people are difficult to imagine. Their behaviours and reactions are incomprehensible to the patient. The picture of the other, therefore, remains pale, or totally exaggerated in the positive and the negative. Again and again it is unclear whether the patient is talking about himself or about another person.

Level: Disintegration

The patient is unable to characterize himself. An image of a personality with mental, social, and sexual aspects of identity does not arise. What is described instead, are self aspects which are either strongly normative (and therefore not

credible), strangely odd (and thus difficult to understand) or partially pompously exaggerated.

A patient who was committed to a forensic institution, describes himself as a "quiet citizen", here to take part in a psychological training programme and assumes that he will be discharged soon.

The description of objects is equally empty or incomprehensible, alienating, threatening, just as the self-perception is. It may be that single characteristics stand for the whole object (blue eyes representing purity of soul). The perception of external objects is totally dominated by the patient's own neediness, objects are judged as persecutory and tormenting, and correspondingly, are feared or fought. Attempts at qualifying object-related fears are not successful. The object images may be totally rigid, but also blurred, whereby good and bad gets confounded.

The patient does not seem to perceive characteristics, or even interests of others. The other is fused with the patient's own personality characteristics and needs, in a way that makes the sexually aggressive patient utter his conviction that the victim got what they asked for.

Capacity to regulate: self-regulation and regulation of object relationship

With reference to the self: The dimension of regulation describes an integrative aspect of mental experience. From it results the ability to experience oneself as the agent of one's own competent actions, and to derive self confidence and self assurance from this experience of self-effectiveness.

Regulation is a bi-polar concept: if present in excess (over-regulation), one's ability to act and possibility for communication with others may be restricted; if it is too weak, in a manner that the integration of affects and impulses is inhibited, the result is an unintended or impulsive acting out of affects and instinctual impulses.

The regulation of feelings of self-worth, too, is part of self-regulation.

The ability to self-regulate accentuates the active, regulatory performance. This is especially evident in, for instance, the ability to control one's own impulses or affects. Understandably, the ability to self-regulate is less and less available the more reduced levels of structural integration become. Things just happen and make the self seem passively at the mercy of whatever happens, and not as a responsible agent with reference to one's own mental processes.

With reference to objects: regulation tasks vis-à-vis objects involve not only the protection of the relationship from one's own impulses, but also the safeguarding of one's own interests, so that they are not lost because of another's influence over them. The ability to predict the reactions of others (anticipation) influences one's own behaviour. In the area of interpersonal relationships, too, the aspect of distancing oneself, of looking closely, and of making decisions, is as important as it is when dealing with and regulating one's own affects or impulses, or emotional hurts. The regulative functions enable a person not to become "absorbed in" or "carried away" by things permanently, but to be able to distance oneself from what is happening, to check in, as it were, with oneself, and from this position, gain new attitudes.

Table 4-14: Regulation

Regulation	
Regulating the self	Regulating relationship to the object
2.1 Distance oneself from impulses, controlling and integrating impulses.	2.4 Protect the relationship from one's own disturbing impulses; intrapsychic instead of interpersonal defence.
2.2 Distance oneself from affects, regulate affects.	2.5 In relationships, maintain one's own interests and take due account of the interests of others.
2.3 Distance oneself from emotional hurts, regulate self-worth.	2.6 Ability to develop a realistic picture of others.

High level of structural integration

The self experiences itself as the agent of competent acting and behaviour. Instinctual impulses can be integrated; gratification is sought, but can be delayed or displaced. Ambivalences are tolerated, compromise solutions are sought. Unpleasant affects need not be avoided. The feeling of self-worth can be maintained, or can be regained when it has become destabilized.

In conversation with the investigator, the patient is able to reflect on discrepancies between his own wishes and the interests of others. He can work to resolve internal contradictions, without reacting moodily or being emotionally hurt.

The relationship with the other is not negatively affected by an interpersonal defensive attitude, or by the acting out of one's own impulses, so that the interests of others as well as one's own interests are adequately taken into consideration. In this context, important aspects in the behaviour of the other can be anticipated.

A patient reports, for instance, setting appropriate boundaries between himself and another, and his successful attempts to channel his anger in a way that the friendship suffers no harm.

Moderate level of structural integration

The possibility of fulfilling instinctual wishes in a socially acceptable way and in accordance with one's own value judgements is clearly reduced. The tendency to over-regulate is predominant, that is to say, affects and instinctual wishes are, on a conscious level, only badly tolerated, and are therefore defended against strongly, so that they can neither be perceived as signals, nor guide actions. The consequence here is stronger self-control and limitation of one's emotional flexibility. In addition to over-regulation, impulsive outbreaks may occur. Simultaneously, the possibility of dealing with instinctual wishes and affects in a more flexible manner, is restricted, as fixation upon certain, repressed wishes is intense. The possibility of postponing or displacing drive satisfaction is reduced, accordingly. Unlived aggressiveness can intra-psychically lead to self-devaluation, self-punishment, and

auto-aggressive tendencies which appear "masochistic". In states where regulation fails, auto-aggressive tendencies may come to the fore.

The regulation of the feeling of self-worth is clearly susceptible to disturbance, which is expressed by an individual being easily hurt emotionally, by his self-aggrandisement, or self-devaluation.

The conversation with the patient is tough going, the patient appears courteously obliging on the outside, but is controlling and lifeless. It becomes apparent that he is only able indirectly to demand attention and care for himself, he cannot show his need for care. More in passing the investigator learns of occasional excessive alcohol abuse and binge eating.

The compromised ability to regulate his own impulses and affects and feelings of self-worth makes the regulation of important relationships more difficult, which thus become negatively affected. One's own interests or the interests of others are not clearly perceived, or are rigidly overemphasized. The ability to anticipate another's reaction to one's own actions is limited.

The patient frequently feels pressured by others and taken advantage of, he is unable to defend against this and keeps getting into trouble. The description of a recent separation is omitted.

Low level of structural integration

The possibility of fulfilling instinctual wishes in a socially acceptable way and in accordance with one's value judgements is minimal, with the possibility of delaying or displacing drive satisfaction equally so. The resulting behaviour is impulsive, experienced by the individual thus affected as ego-dystonic, overwhelming, and painful, or is rejected by the environment as inadequately hostile and overwhelming. Attempts at regulation turn out to be abrupt and ineffective. In phantasies and behaviour, self-destructive tendencies and destructive tendencies directed to others are obvious. Guilt feelings are not worked upon intrapsychically, but lead to self-punishment, and may take the form of auto-destructive tendencies. In contrast to a moderate level of structural integration, under-regulation is predominant. Impulsive behaviour is often triggered by unpleasant affects which are not tolerated intra-psychically, and lead to abrupt behaviour changes.

The very fragile self-worth regulation finds expression in the patient's great sensitivity to emotional hurts, or in unrealistic ideas of grandeur.

The patient grimaces in the initial conversation, when emotionally stressful themes are touched upon. When the (male) investigator addresses these, he instantly barks at him to shut up, he does not want to continue the conversation, he isn't good at talking with men, anyway. Only with great effort can the conversation be continued, when the patient suddenly talks in great detail about his private life.

The patient's relationship with others is characterized by interpersonal defensiveness. He is unable to process intra-psychically his conflict-based needs and fears, but instead, lets them spill over directly into the relationship which is then put under great strain. Balancing the patient's own interests and the interests of others does, therefore, not take place. The interests of others especially find no

consideration. The expected reactions of others cannot be anticipated and therefore cannot be used for regulating behaviour.

Disintegration

With reference to the patient's own behaviour, a feeling of authorship of his own actions does not exist. From the patient's point of view, regulation is not an issue, things just happen.

Aggressive impulses cannot be integrated into the total spectrum of behaviour. The patient appears riddled with destructive hate, which, however, is not experienced as his own aggression, but as a justified reaction to the actions of others.

Sexual impulses are not object-related, but are behavioural impulses based on partial drives which are acted out in role-like fashion (for instance in perversion). There are states of marked loss of regulation in delinquent acts or through temporary use of alcohol and drugs. The sense that feelings and actions originate from the outside may reach the point where the patient feels controlled by outside influences. An internal judgement of one's own actions through normative instances seems absent. From the patient's own perspective, his behaviour is completely natural, necessary, and justified, or is totally denied.

Self judgement moves between grandiosity and a strongly degraded feeling of self-worth. Humiliations, or emotional hurts are annihilating, and require, just as with other negative affects, rapid action in terms of a reaction.

Due to unclear motivation the patient is unable to pursue a subject-oriented goal. He repeatedly drops out of college, and, arbitrarily, begins other training courses. He declares that his superiors were unable to cope with, and were overwhelmed by, what he had to offer in terms of performance and had dropped hints ("danger from snipers") to get him to change profession.

It is difficult enough to delineate an intentional self in a structurally disintegrated patient. But beyond that it is even less possible, from the point of view of the patient, to identify delineated objects, and consider their interests, and anticipate their behaviour.

Emotional ability: internal communication and communication with the external world

With reference to the self: Emotional ability can be understood intrapsychically as the ability to have inner dialogues and to understand oneself. The ability to allow the emergence and experience of affects within oneself is the prerequisite for this. In communication within oneself, one's own phantasies play an important role as mediator of emotional states and designs for action linked to these (including creative solutions). The experience of one's bodily self is also important here (not of the body as an object, but the subjective experiencing of one's own physicality and aliveness).

With reference to the object: By communication one generally refers to the emotional exchange between self and others. In this sense, the structural dimension deals with making contact on the interpersonal-emotional level, the communication of one's own affects to others, the ability to let oneself be reached

by the affects of others, as well as mutual understanding and the "we-feeling" inherent in reciprocity.

Empathy is a simultaneously interpersonal and intrapsychic process . It is the ability to use one's own psychic experience and temporarily put oneself into the shoes' of somebody else's inner life, and to make his view of things meet with one's own - as a prerequisite for the ability to truly understand that other person.

Table 4-15: Emotional communication

Emotional communication	
Emotional internal communication	Emotional communication with others
3.1 Generate and experience one's own affects.	3.4 Make emotional contact: allow feelings towards others, dare to make emotional investments, achieve "we" feeling (reciprocity)
3.2 Create and use one's own phantasies.	3.5 Express one's own affects, let oneself be reached by the affects of others
3.3 Emotionally animate the perception of one's own body, or bodily self.	3.6 Experience empathy.

High level of structural integration

The patient is able to experience situation-appropriate lively affects, and in this, feels alive in his body; he can report lively fantasies which accompany this.

The ability to make contact emotionally and to instigate a communicative exchange is present and makes the relationship with the other person feel real. Depending on the circumstances, the readiness to communicate may be impaired by neurotic conflicts and the associated fear, shame, and guilt feelings, but not break off. Psychical processes in the other may be acknowledged with interest. As concerns empathy, it is possible to put oneself into somebody else's shoes and participate in their experience.

A patient has frequent arguments with her partner over a certain topic, on which they both tend to have different opinions. The investigator gains the impression that the partners are well able to reach an understanding about the topic and discuss it, giving an animated rather than frustrated impression. The patient is able to imagine how her partner feels regarding this issue and discusses with animation the imaginary next steps she could take.

Moderate level of structural integration

The ability to generate affects appears markedly limited, the same applies to fantasies. The general affect limitation makes it difficult for the patient to understand himself. The experience of the body is lifeless, and, as the case may be, ego-dystonic.

The communication is restricted through the patient's dampened affectivity and made more difficult, as far as its content goes, by rigid, restricted behaviour, whereby the patient appears latently irritable and sensitive to emotional hurt. The capacity for empathy seems equally restricted. The interests of others tend to be commented on from one's own perspective. A "we-feeling" does not come easily, it must be struggled for, so-to-speak.

A patient cannot understand why his wife complains, and becomes disappointed when she does not acknowledge his efforts to do right by her. Conversations between the partners often end in discord and are avoided. The investigator, too, has the impression that the partners are telling him a lot indirectly and between the lines. The husband reports in a very matter-of-fact manner about an argument with his wife, whose wish for children he had rejected "for good reasons". He is unable to come up with a concrete picture of what it would be like to be a father. When asked about his hypochondriacal complaints, he thought he needed solid medical advice "so that my body functions again properly".

Low level of structural integration

The patient has difficulty in experiencing clearly recognizable feelings. What he is lacking are, especially, warm, friendly, and tender sensations, but also sadness, and guilt feelings. Instead, there is impulsive emotional arousal, which is described as despair, panic, rage. Experience of the body may be frozen or fragmented.

Emotional contact, if established, breaks off easily or does not succeed at all, there is misunderstanding and talking at cross purposes. The patient reveals that he is totally unable to put himself into the position of experiencing another's inner world. The therapist, therefore, has to contribute strongly to the regulation of the relationship with the patient. The patient may perhaps be unable to distance himself, and be manipulative and crossing boundaries. Confusion and emptiness are glossed over by being argumentative or by as-if communication. A "we"-feeling does not arise (reciprocity).

The investigator finds it increasingly difficult to understand what the patient is talking about, he has doubts about whether it is he who cannot understand, or whether the patient cannot communicate. It is difficult for the investigator to distinguish whether the patient's vehement attacks are directed at him each time, or to the topic he is reporting on. The investigator feels put under considerable pressure and uncomfortable, or switched off, or empty. His impulses alternate between over-engagement and inner withdrawal.

Level: disintegration

Emotionally, the patient appears to be exposed to his intense, unorganized affective states, which cannot be put into words. Alternating with diffuse emotional arousal are states of emotional deadness and rigidity. Fragments of fantasy are difficult to distinguish from memories and facts. The bodily self is experienced as alienated or strange, and, in some cases, is changed by manipulation.

No contact is made, or, it is formal and role-like, without emotional involvement, or hostile and distant. Needs of others are passed over without any empathy. At the same time, internal states of others are sensed and used for one's own purposes. A

proper communicative exchange is not possible; however, everything that happens between the patient and the other may take on communicative meaning.

The therapist tries to talk with the patient about the cosmetic surgery the patient has had earlier in life on his face. To start with, the patient says that this was not surgery, but a natural development. Later, the patient states his intention to have another operation, because "a piece of plastic has remained in the site of the surgery". The therapist's question about whether this was really a piece of plastic or whether it referred to the term plastic surgery is not understood by the patient.

Ability to form attachments: internal and external objects

With reference to the self: these structural functions concern the ability to form emotional attachments to important others in real relationships, intra-psychically and in the interpersonal contact. This starts with the ability to develop internal images (object representations) of important people, to invest them with positive affect, and maintain them: the ability to internalize. The ability to avail oneself of these positive internal objects is a prerequisite for the ability to calm, console, and protect oneself.

If the internalization function develops positively, then different internal objects will be available. These represent different relationship qualities (like, representations of parental images, one's own children, siblings, romantic partners, rivals, etc.).

With reference to the objects: the ability to internalize objects is the prerequisite to form emotional attachments with others in real relationships. Complementing this is the ability to detach oneself from relationships and to be able to part company.

An indicator for the stability of emotional relationships is the ability to experience pro-social affects towards one's internal object representations, as well as one's external real objects; these include solidarity, gratitude, a feeling of responsibility, loving care, but also, when ethical norms have been violated, an ability to experience guilt. It also includes the ability to experience sadness at the loss of important internal or external objects.

An important consequence of the ability to form internal and external attachments is the capacity to use available, good objects in the external world, that is to say, to seek and accept help, well-meaning support, and care from others.

Table 4-16: Attachment

Attachment	
Attachment to internal objects	Attachment to external objects
4.1 Internalization: positive self-representations, positive object representations, ability to build and maintain positive object-related affects	4.4 Ability to form attachments: attach to others emotionally (gratitude, loving care, guilt, sadness)

4.2 Positive introjects: ability to care for oneself, to calm, console, help, protect oneself, to stand in for oneself	4.5 Accepting help: ability to accept support, care, concern, guidance, apologies from others
4.3 Variable and triangular attachments: different internal object qualities; attachment to one does not mean turning away from another.	4.6 Ability to sever attachments and tolerate farewells

High level of structural integration

Important relationship experiences can be retained internally, and result in emotionally positive attitudes towards one's important objects as well as towards oneself. The internal images of important persons are easily distinguishable. Even if stressful conflicts arise, the positive investment of the internal images of others remains stable. Feelings of belonging and of responsibility towards objects are present. With the help of positive internal objects, the patient is able to calm himself down and act in a focused manner.

Social relationships are plentiful, there are descriptions of several important persons. The patient is able to maintain triadic relationships. The described relationship patterns are not dominated by object dependency. Conflicts may possibly occur since contradictions in attachments to various individuals cannot be harmonized, as in rivalries, jealousies, a battle for the love and attention of third persons, etc. The individual has the ability to form stable attachments, and, if necessary, can allow support and help through others, but also has the ability to sever object relationships, to be sad about losses and separations and to tolerate farewells or good-byes. The central fear is the loss of the love of the object.

A patient describes feeling constricted by her husband, as he displays reactions of jealousy. She is emotionally attached to her husband and is confident that she will find a solution for the problem. What she does not notice is the fact that she gives her partner occasion for jealousy by her flirtatious behaviour with other men.

Moderate level of structural integration

The ability to create stable internal images of important partners and, in this way, be independent of their presence in the external world, is made difficult. These images may get lost in conflictual situations. At the same time, the emotional importance of the other may be excessive, so that a pronounced object dependency exists.

The ability to regulate oneself with the help of good internal objects is markedly restricted, so that the presence of real objects becomes important.

The variability of internal object images is reduced, the internal images are limited to but a few patterns dictated by one's own perspective, wishes and needs.

The emotional attachment to others is difficult to assess, as relationship situations are described in a rather normative way. The ability to relate to others appears restricted, the patient does not seem to need others, that is, he seems to need them only in a rather specific and circumscribed function. Farewells are avoided, their

meaning glossed over, or made complicated by extensive clinging. The patient is not, or only to a limited extent, able to form triadic relationships and tends to seek primarily dyadic relationship patterns.

The central fear is separation from the important supporting and regulating object, or destroying it by one's own impulsivity.

A patient describes his relationships to men as very uniform. All men: father, brother, colleagues, are judged by whether they perform better or worse than the patient and whether they want to dominate or belittle him. In fact he expects his wife to listen to his complaints about this, but is afraid that "she cannot stand it any more". On the dissolution of his first marriage he says "that matter's closed".

Low level of structural integration

In contrast to a moderate level of structural integration, the ability to draw on internal images of people and thus to be more independent of their actual presence is seriously disturbed here. The internal images of objects carry threatening and persecuting traits. Socially responsible attitudes towards internalized objects are largely absent. Also the ability to calm oneself with the help of internal objects is strongly reduced, and a dependency on real others may result which is experienced as existential. What follows from this is that the emotional attachment to important individuals is inconstant. Their description results in images which are contradictory within themselves, oscillating between excessive feelings of love and strong hate, or great distance. Feelings of hate are experienced as particularly destructive, the dependency on others is felt as if one was totally taken over.
The central fear is that the self may be annihilated by the bad object or by the loss of the good object.
A patient reports rapidly changing short-term love relationships; the descriptions of the girlfriends are contradictory, they cannot be separated from each other, loving aspects are described, to which, in a disjointed way suddenly totally negative descriptions are added. The patient feels used by women, and deceived. He emphasizes that he will never again have a relationship.

Level: Disintegration

It is difficult to gain an impression of the patient's internal objects, as they are not represented as well-defined ideas of objects, but rather, stand out as patterns of affects and predispositions to act, occasionally as something foreign within the familiar. Consequently, they cannot assume self-regulating functions, quite the opposite, they are a source of worry and impulsivity.
Based on this internal situation, longer-term emotional attachments to others are not possible. Where interpersonal relationships exist, they come across as strange, incomprehensible, and completely disregarding of the interests of another. The central fear is about symbiotic merging of self and object representations with a consequent loss of identity.
A patient comes across as very rigid and stoney-faced in his expression, he reports without any distance that he, in the evenings after he's out of the office, sometimes does the book keeping for a brothel and that he intends to marry one of the girls. He had, however, never invited her home, because you can't trust strangers. He

guards the entrance to his house with a video surveillance system, and "for emergencies" he had some firearms which he was able to get "with a trick" from his gun club. Asked about a person that was important to him, he said: "If someone wants something from me, I will finish them off. I am a well-respected citizen in my community."

As an aside: the structural function of defence

The aspect of defence is important in all structural dimensions. It is therefore always taken into consideration and not rated as a separate category. Of particular interest are the qualitative variations, and the efficacy of the defence on the different structural levels.

High level of structural integration

Defence is intra-psychic and is directed against internal instinctual wishes and affects. The self and object representations of the patient are not essentially changed by this. Certain satisfactions and levels of cognitive performance may be restricted due to conflicts. The pattern of defence is consistently available and flexible, and thus, according to the respective situation, very effective.
The typical defence mechanisms are: repression, rationalization, displacement.
A patient had totally forgotten about an embarrassing experience, in which he clearly had had an, erotic and wishful phantasy which was taboo. His self regulation and his relationship with the other is little affected by this.

Moderate level of structural integration

Intra-psychical defence is strongly present and rigid. Because of this, possibilities for satisfaction are markedly restricted, at times there are impulsive outbreaks. The pattern of defence is strongly restricted in its flexibility and cannot be adjusted to situations. Temporarily, defences may fail, in a crisis, leading to defence mechanisms of the next lower level becoming effective for the time being (idealization, devaluation, splitting).
The typical defence mechanisms are: denial, turning against the self, reaction formation, isolation, projection.
A patient reports without any noticeable affective involvement that his wife had recently left him. He was now thinking about how he could manage to keep the rental contract for their common apartment. Only later in the conversation does he report inexplicable crying fits, which he can't explain to himself.

Low level of structural integration

Intra-psychic defence is not sufficient, the defence therefore comes to effect interpersonally; self and object representations become distorted by the defence. This results in being flooded with needs and instinctual impulses, and in impulsive actions, which, however, do not bring lasting satisfaction.

The typical defence mechanisms are: splitting of self and object images. From this splitting, other defence mechanisms of this level are derived, for instance projective identification, and idealization, or devaluation of objects.
A patient describes his girlfriend to the investigator in an extremely contradictory way: sexually, he found her totally uninteresting and she had no understanding of him, so he more or less ignored her. Without linking his statements with an "on the one hand, but on the other" he reports in a different context that he misses her terribly and feels totally alone when she was away for two days to visit her mother.

Level: Disintegration

The defence achieves an internal balance at the expense of grave reality distortion. The very peculiar defence formation may be maintained longer-term, but can lead to temporary psychotic experiencing even in seemingly small trigger situations. In dissociative states of consciousness, actions may be performed for which responsibility is denied.
In the first part of the conversation, a patient reports difficult childhood experiences which were personally important for him. Following this, he becomes increasingly monosyllabic, taking on a tense, angry, expression. At the end of the available consultation time he demands that the therapist should finally listen to him, and at the same time claims that all doctors are liars and thieves. The therapist's efforts to make emotional connections between the patient's experiences remain unsuccessful.

Table 4-17: Assessment of the structural level

Axis IV Structure	high		moderate		low		disintegrated	not rateable
	①	1.5	②	2.5	③	3.5	④	⑨
1a Self-perception	①	•	②	•	③	•	④	⑨
1b Object perception	①	•	②	•	③	•	④	⑨
2a Self regulation	①	•	②	•	③	•	④	⑨
2b Regulation of object relationship	①	•	②	•	③	•	④	⑨
3a Internal Communication	①	•	②	•	③	•	④	⑨
3b Communication with the external world	①	•	②		③		④	⑨
4a Attachment to internal objects	①	•	②	•	③	•	④	⑨
4b Attachment to external objects	①	•	②	•	③	•	④	⑨
5 Structure total	①	•	②	•	③	•	④	⑨

4.4.4 Case examples

Case example of a high level of structural integration

For four months, this 20-year-old college student has been suffering from bodily feelings of anxiety accompanied by heart palpitations, fears of a threatening illness, and the fear of being unable to fulfil the requirements of his course of study due to his impaired ability to concentrate. He feels very insecure, because he has "not experienced anything like this before".
At school, he had always been just above average, but had placed high demands on himself. Now he had begun a law degree, with the idea of working for an international institution, for instance in Brussels. He had always had a friend, but this friend had gone somehwere else to study. He has been in a "steady relationship" with his girlfriend (a kindergarten teacher two years older than him) for three years, she spends a lot of time at his home (the patient still lives with his parents), and "is part of the family".
The mother (53 years old) is a primary school teacher; the father (56 years old) has an interest in computers and in ecological issues, but in fact is a house husband. The patient grew up as an only child, with nothing of particular notice in his development. He was very attached to his grandmother who lived in the same house. He expressed admiration for his father, because of the father's "genius"; he attributes the father's difficulties in professional life to "societal conditions". The mother has high hopes for the patient ("she has only me").

Conflict dynamic: The difficulty of separating from home for this young man, who is still very attached to his parents, is obvious. He wants to explore the world, while at the same time being strongly attached to his family. The young man, who makes every effort to appear rational and factual, seems very anxious about this new life as a student with its new possibilities for and challenges to his as yet little formed male identity. The anxiety symptoms which surfaced have, for the time being, tied him to the parental home in a regressive manner. But in this context, we will discuss not the individual conflicts, but the structural dynamic.

Structural functions:
Self perception: It is well established. Upon careful intervention, the patient is able to describe his conflicting feelings and look at his ambivalence.
Object perception: It is conflictually restricted as regards the parents and the girlfriend, nevertheless, he is able to paint a lively and largely realistic picture of them.
Self regulation: The ability to self-regulate had not reached clinical levels in the past couple of years. It is currently somewhat restricted because of the pressure from anxiety symptoms. The patient’s behaviour is age and gender appropriate by being typically "cool".
Regulation of object relationship: In the relationship with his parents the patient acts in a neurotically considerate manner, but he is fundamentally able to distinguish other interests from his own in a relationship.
Communication within: There seems to be access to affects and fantasies. The patient comes across as emotionally alive and shows good access to how he experiences his body.
Communication with the external world: A sustainable contact is established in the interview, the therapist seems able to reach the patient well emotionally.
Attachment to internal objects: Important others are represented internally for the patient and are invested in a positive way emotionally.

Attachment to external objects: What stands out here is the patient's difficulty to separate sufficiently from the objects of the primary family, so that he is able to concentrate his attention on the goals set by his course of study. His ties come across as conflictually neurotic and do not suggest a structural vulnerability.
Observation over time: the hypothesis of a worsening conflict with a highly integrated structure can be confirmed in the trial therapy sessions, with the patient quickly gaining access to his conflictual themes and subjecting various aspects of his life plan to a reality testing. He is able to use, in the female therapist, aspects of a transference to a mother who is not clinging to her son and encourages him to be independent. Within the framework of a 25-hour short-term psychotherapy the symptoms recede. As concerns his university studies, the patient now comes across, as less unrealistically ambitious, but as more fact-oriented. He resumed a team sport he used to practise and feels particularly comfortable within his peer group.

Case example of a moderate level of structural integration

The 46-year-old patient puts muscle pain in his right shoulder and arm area at the center of his complaints. It has worsened considerably within the last two years. This was preceded by a bicycle accident several years ago, orthopaedic and neurological examinations found no organic causes. The patient reports a depressed mood, a feeling of weakness and exhaustion, and permanent tension. He spends a lot of time thinking about his health and his future. He does not know how to meet the demands of his office job as controller. Everything became more difficult two years ago when the senior management of his company changed. His wife could not put up with his complaints about physical ailments any longer, she worried more about their daughter, who had a learning disability. The patient was particularly distressed by the fact that his 21-year-old son had moved out in protest a couple of months ago. He was at the end of his tether pretty much in all areas of his life.
He grew up as the oldest child and had three younger sisters. He always took everything seriously, had a tendency for self-doubt and self-reproaches, always wanted to do everything right, thought it important that things were done fairly, and always attempted to be particularly self-controlled. Three years ago he lost it, once, shouting at his wife because of unnecessary spending. Since that time he feared that she would want to divorce him.

Conflict dynamic: The neurotic dynamic is to be seen in the context of a superego and guilt theme, but is also linked to a feeling of having missed out, and of rejection. The related conflicts shall not be discussed in detail here, as this is about assessing the structural abilities.

Structural functions:
Self-perception: The patient is only with difficulty able to perceive his internal situation and differentiate his affects. In particular, he appears unable to distinguish the bodily expression of emotions from primarily bodily stresses. The picture he paints of himself has few facets, he is barely able to see conflictual contradictions. He reports, above all, what he said to his wife, his boss, his son, and not what he experienced when he said it.
Object perception: From his emotional perspective of expectation and disappointment, others, too, are described as rather uni-dimensional. In this way a truly differentiated realistic picture of others cannot be formed.
Self regulation: The patient is noticeably over-regulated with rare impulsive outbursts, his obvious sensitivity to emotional hurts is, however, rarely admitted. He tries to regulate everything in accordance with existing norms.

Regulation of object relationship: Despite the patient's strivings for fairness, interests that any of the partners in a relationship may have, are not balanced out. The patient hardly notices or takes into consideration the interests and needs of others.
Communication within: The patient appears uninvolved emotionally and follows standards of behaviour in a role-like manner. He thinks phantasies are irrational. With respect to his physical body, he is angry with the orthopaedic surgeon "who still hasn't fixed this".
Communication with the external world: The relationship with the patient turns out to be rational and fact-based, while subliminally, disappointment and distrust are noticeable. A feeling of "we" does not arise.
Attachment to internal objects: The images of internal objects in the patient's descriptions all appear similar. They are all about the fact that someone criticizes, reproaches, recovers something, or doesn't get something.
Attachment to external objects: The patient especially tries to appear independent. He does not express any wishes for a relationship, and does not seek help. He avoids topics of separation and sadness, he seems very uncomfortable with them.

Observation over time: In the trial sessions, the ambivalence of the patient intensifies: He pushes for physical examinations and treatments and doubts the sense of "psychological conversations". Alongside these devaluations, the therapist notices the strong unspoken appeal for help. He initially organizes an inpatient psychosomatic therapy, where the pain symptoms of the patient can be treated and mitigated. The suggested psychodynamic psychotherapy should consider the conflictual themes around the need for care as well as the structural limitations of how the patient experiences affects.

Case example of a low level of structural integration

The 23-year-old patient complains that she "can't get on top of things any more". At the social training institution where she was doing an internship she was being harrassed because she supported individuals too much. She lived in fear of constant attacks and reproaches. She also feared that they had heard about her car accident, which she had caused under the influence of alcohol. At times she felt great tension within her; in such situations she cut the skin on her forearms. Sometimes she would lie on the bed for hours, she finds her body "disgusting". She felt worst when she was alone at night, she could not stand this at all. She tried to have her boyfriend with her if possible. He would then be very loving towards her, but at times he had also beaten her. A year ago she had had a sexual relationship with a woman, which was, however, destroyed by the jealousy of that woman.
She had grown up with a very young mother, who worked as a waitress and had had many different partners, and, from the time the patient was five years old, was being treated in various clinics, for reasons unknown to the patient. She was mainly cared for by an aunt, who was very strict with her. The aunt's husband sexually abused the patient when she was between 8 and 12 years old. At age 14 she ran away, at age 15 she was put into the care of an older couple. She felt happy there. When she was 17 she developed an eating disorder, at age 19 she attempted suicide after a boyfriend had left her.
Conflict dynamic: Most discernible are aspects of an individuation-dependency conflict. In addition, the patient's self-worth problems and identity insecurity can be understood less as an expression of intrapsychic conflicts, but rather, as a consequence of structural deficits.

Structural functions:
Self-perception: is very limited, the patient does not know who she is and what is going on inside her. In particular, she is completely unable to perceive her own affects in a differentiated way. Most of the time she feels empty inside, at times she feels unbearably tense.
Object perception: An integral or realistic image of the other person does not arise. They are either "nice", or bewilderingly aggressive, and often alternate between the two.
Self regulation: Needs and affects are experienced as intense and flooding, or are totally lost. Experience of self-worth is, to a high degree, determined by the patient's great sensitivity to emotional hurts. Intolerable feeling states result in self-mutilating behaviour, without the patient being able to do anything about them.
Regulation of object relationship: There is no mutuality in relationships, no balancing out of interests, and no possibility of protecting relationships. They are suffered or bought and have only a short life-time.
Internal communication: When on her own, the patient mostly feels affectively empty or flooded by inner turmoil. She tries to avoid fantasies, because these are predominantly "horror-filled". A feeling of well-being within her own body or a satisfaction with her physical appearance seem impossible.
Communication with the external world: As the patient does not understand herself, she finds it difficult to make herself understood. Her demeanor is rejecting and distrustful. At times she attempts to psychologize about herself and her situation, but this contributes little in terms of understanding. The conversation clarifies little and does not provide relief, an unpleasant tension remains with worse things yet to be feared.
Attachment to internal objects: The patient is unable to describe many internal traces of positive relationship experiences. There are no objects which are positively emotionally invested, to which she might refer to for calming herself. Instead, what predominates are internal voices of criticism, of reproach, of attack, and the respective fears related to the threat this poses for herself (for instance "going mad").
Attachment to external objects: The patient tries to create relationships by clinging and sexualized behaviour, which, however, do not lead to attachments, but quickly evaporate and thus increase her mistrust in people. She cannot imagine help from others, let alone go and seek it. Separation as a process of a dissolution of emotional attachment accompanied by affects of sadness is not possible.

Observation over time: A series of trial sessions could clarify what led to the currently acute problems (the professional over-engagement for the victims which caused excessive demands on the colleagues and the patient's own overexertion). The structural deficits from which the patient suffers most strongly, and ways of how they could be dealt and coped with, were established. This concerns, above all, the fear of not being able to tolerate herself. The patient is relieved by this so that, after a couple of sessions, she declares the treatment complete. After three weeks she reports to the clinic again, full of panic and reproaches, because "it all did not help". A low-frequency psychotherapy with structure-oriented goals is then suggested.

Case example of structural disintegration

The 29-year-old patient is examined in a forensic institution. In the house where he lived, he had threatened a fellow resident with a knife, because this other person played music too loudly, and then had made attempts to set the prams in the hallway on fire. The patient comments on this by saying he is a quiet person and

could not be provoked by anyone. Two years ago the patient showed abnormal behaviour by taking a nine year old boy to his apartment and locking him up there, "in order to protect him from the street". He refuted the suspicion of paedophile actions as slander by his fellow residents. The patient lives alone and on the whole without any contacts, he works irregular hours for a removal company. Occasionallly he watches the training sessions at his shooting club. The history taken revealed a drug addiction from age 19 to 22, followed by several treatments for drug addiction. Now he is drug free.
The patient is the middle child of three brothers. Both parents worked as farmers: his father was alcohol dependent; his mother was continuously depressive, she committed suicide when he was seven. His siblings were sent to live with relatives, the patient remained with his father, who "taught him manners with the whip" - until the youth welfare office managed to have him sent to a home. Thereafter an apprenticeship as a gardener followed, which he did not finish.

Conflict dynamic: Well-circumscribed unconscious intra-psychic conflicts in the sense of noticeable internal contrasts are not recognizable.

Structural functions:
Self-perception: The patient is rather unable to provide an image of his personality. He says of himself, globally, that he is "a free citizen and a bon vivant". What distinguishes him from others he cannot say: "They are all free citizens, too". His perception in the sense of affect differentiation is beyond discussion, he thinks he always has just the right feelings.
Object perception: He finds it difficult to describe others. What he is more able to express is that one has to constantly be on one's guard against "them".
Self regulation: Regulation seems not to be an issue. The patient is unable to see himself as the originator of his actions. Delinquent behaviour, too, is not experienced as the expression of his own intent, and is partially denied. He cannot describe the kind of sexual needs he has, nor how he handles these. He is obviously sensitive and irritable, but does not see it that way himself.
Regulation of object relationship: Relationships in a specific sense are not lived. There can thus also be no give and take or balancing out interests in relationships. He believed that he had had to protect the child he had locked in; simultaneously, there is the suspicion of sexual abuse.
Communication within: The patient is unable to describe an emotional relationship with his own person. For a long time, he had tried to turn his body into a "fighting machine" through intensive muscle training.
Communication with the external world: The patient generally avoids contacts, he feels "constantly provoked" by his fellow residents. In the diagnostic conversation he comes across as very tense, he has to get up again and again to drink water, he picks out the word "interview" and formulates: "I am giving you an interview". An empathic understanding of others, for instance with other residents of the house where he lives whom he threatened, is impossible.
Attachment to internal objects: When asked about people whom he has experienced as particularly important for him, he mentiones the character "The Terminator". Well-circumscribed internal objects cannot be found, rather internal states which are accompanied by a high degree of aggressive tension.
Attachment to external objects: Others seem to represent a diffuse threat to him. As a boy he once brought an injured bird home with him: "And then the father killed 'im".

Observation over time: First of all, foreign and strange things remain in the foreground in the contact with the patient. Reflections on diagnostic attributions

initially do not produce unequivocal results. Within the framework of the institution where the patient has been committed conversations are held with the patient which are to clarify whether there are any therapeutic approaches that can be tried. With a view to the destructive behaviour towards others, the intention is to clarify and highlight the perception and interests of the others, with reference to the patient's structural capacities, which presupposes that the patient experiences a respectful interest in his own person in the therapeutic relationship.

5. The OPD Interview

Subsequent to the introduction of the five OPD axes, this chapter deals with how to obtain the required information for assessing the individual areas on each axis. It had already become clear during the development of OPD 1 that it was not possible to fully rate all OPD axes on the basis of a standard clinical psychodynamic initial interview (Freyberger et al., 1996a; Freyberger et al., 1996b). We therefore developed the idea of an OPD- interview and interview guidelines. In brief, the OPD interview is a synthesis of a psychodynamic interview with a series of more structured interview strategies borrowed from existing diagnostic systems and adapted as required. We begin by describing the psychodynamic interview, its particularities, and the history of its development. Other interview systems are then discussed as far as they are relevant to the OPD-interview. Thereafter follows a description of how to carry out the interview, first proceeding on the basis of general interview strategies, then with recourse to the interview guidelines. In chapter 13.6, work materials or interview-tools for each of the axes are reproduced as they may provide a helpful learning aid for the OPD-interview.

5.1 The theory of the psychodynamic interview

There are two fundamentally different approaches to carrying out a diagnostic interview: 1 An explorative approach, which aims at collecting facts by posing specific questions, and which has its roots in a biologically-based psychiatry; and 2. A relationship-dynamic approach, based on a genuine psychoanalytic attitude, which draws its information from the "recreation of infantile object relationships in the transference-countertransference between psychotherapist and patient" (Janssen et al., 1996). In the field of tension created between these two opposing approaches, the development of the diagnostic interview in psychiatry and psychotherapy has taken place in the last 100 years or more.

Scientific psychiatry, at the beginning of the 20th century, saw the patient as an "object of observation" and endeavoured to "identify and describe signs of illness with the greatest possible exactitude" (Kind, 1978) [tr. E.R.]. As early as 1887 Kraeplin regretted, in this context, that "an examination of mental symptoms seemed so unpromising and unsatisfactory" (quoted by Buchheim et al., 1994) [tr. E.R.]. But even Sigmund Freud displayed a striking diagnostic reticence (Freud, 1925 (1913)). One the one hand he wanted to avoid the possibility that too strong a transference arose in the patient before therapy had even begun. On the other hand he did not believe in the usefulness of a diagnostic exploration as the basis for an indication for psychoanalysis and recommended an experimental treatment of a week or two (1913, p. 125). Freud, in his time, could afford such "diagnostic nihilism", as no psychotherapeutic alternatives for psychoanalysis existed. All he had to do was making sure the indication was appropriate: is a patient suited to psychoanalysis or not? In order to answer this question, an experimental analysis is of course a suitable means. Given the multitude of different forms of therapy we have available today, we must, however, make a differential indication, that is to say, we must ask ourselves which kind of therapy is suitable for the patient. What follows for the diagnostic interview from this modern plurality of possible

treatments is that neither symptom exploration alone, nor the mere stating of the "analysability" of a patient can be sufficient for making such an indication.

The development towards modern, multimodal, and multiaxial interview forms occurred in several steps which we will briefly outline (see also Janssen, 1994):

The first to develop such interviews was Deutsch (Deutsch, 1939; Deutsch/Murphy, 1955) with his Associative Anamnesis, which had the interviewer take up a background role of listener, in order to make it possible for the patient's inner world of conflicts to unfold. He used this method especially with psychosomatic patients.

Somewhat later, the models of Sullivan (1954) and Gill and colleagues (1954) followed. Sullivan in his mostly structured technique of the psychiatric interview emphasized the interpersonal process of the conversation and the role of the interviewer as a "participating observer" (cf. Schüßler, 2000, pp. 92). The gathering of information about the patient's biography and life circumstances takes up a far more important role in Sullivan's interview than in the approach of Gill, Newman and Redlich. These authors conceptualize their Initial Interview in Psychiatric Practice as a social-psychological situation, separate from treatment, in which the relationship between interviewer and patient is to become a central theme; an important goal here was identifying the patient's motivation for treatment. For the first time, this highlights not only the diagnostic but also the therapeutic function of the initial interview.

In the 1970s, it was Hans Kind (1973, 1978) who reimported the psychodynamic interview approaches into European psychiatry. He first published a monograph in 1973 entitled "Guidelines for Psychiatric Investigation" [tr. E.R.] that was essentially based on Sullivan's work and, in its many revised editions (6th ed. Kind/Haug, 2002) has enjoyed great popularity to the present day.

Parallel to this American development which occurred predominantly in psychiatry, a similar process took place in psychoanalysis in Europe. In her 1950 seminal paper Paula Heimann (1950) explicitly pointed out for the first time the enormous importance of the countertransference as a psychoanalytic diagnostic tool: "My thesis is that the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's counter-transference is an instrument of research into the patient's unconscious. [...] The analyst's unconscious understands that of his patient. This rapport on the deep level comes to the surface in the form of feelings which the analyst notices in response to his patient, in his 'counter-transference'."

Even if Paula Heimann did not make these comments with the diagnostic interview in mind, they nevertheless were an essential influence on further developments in the psychoanalytic diagnostic interview. Balint and Balint, in their Diagnostic Interview (Balint and Balint, 1961) which they developed at the London Tavistock Clinic, emphasized the fact that this was an investigation of interpersonal relationships and for the first time explicitly pointed out the importance of the transference for the diagnostic process. Argelander (1970), in his monograph "The Initial Interview in Psychotherapy" (tr. E.R.), elaborated this approach even further. He differentiated three levels of gathering information: the objective, subjective, and the scenic level. While the first two have verbal content - verifiable facts on the

objective level, and verbal communications on the patient's inner experiences on the subjective level, the third or scenic level refers to non-verbal communications in the form of "scenes" (what does the patient do, how does he say it, what does he say?). Argelander saw this third level as the most important one for the initial diagnostic interview: “The kernel structure of the initial interview, the creatively enacted scene, is a crucial piece of information in the understanding of what is happening in another mind. By nature, it has a dynamic or drama of its own which feeds from unconscious sources." (p. 63) [tr. E.R.] “

Since the beginning, the concept of countertransference has continued to develop into what is now a comprehensive model (Gabbard, 1995). While Freud only referred to the transference of the therapist's unconscious conflicts, and Heimann regarded countertransference primarily as a diagnostic instrument for the understanding of the patient's unconscious processes, countertransference today, together with transference, is understood as a mutual, interactive process between patient and therapist. It is a complex interaction of real, actual experiencing, and of the "neurotic transferences" of both patient and therapist.

In order to make such enactments of the patient's relevant intrapsychic processes during the initial interview, that is to say, on the stage created by this interview, possible at all, the therapist must make herself available as a member of the cast - a "two-person play" is created. As the therapist initially does not know the "piece", she must develop an evenly suspended role-responsiveness (Sandler, 1976), which enables her, by way of her actual countertransference experiences, to recognize and accept the role assigned to her.

There is a position widely held in psychoanalysis today, which puts scenic understanding wholly and exclusively in the centre of the psychoanalytic interview (see e.g. Mertens, 1992a). Laimböck (2000) holds the view that biographical data only serve “to further support a relationship diagnosis, without, however, being their basis” (p. 11). She warns of mixing two things here, namely “conducting an initial interview psychoanalytically” and “diagnosing”, and recommends a clear-cut division between procedures that try to understand scenes and those that ask questions (p. 17) [all quotes tr. E.R.].

In Germany, especially, where applications for psychotherapy have to follow the procedures set out in the federal rules and regulations governing psychotherapy, the "depth-psychological biographical anamnesis" forms another of the essential building blocks of a psychodynamic diagnosis. This anamnesis schema was drawn up in Berlin in the 1940's by Schultz-Hencke (1951) and further developed by various researchers (Dührssen, 1981; Rudolf, 1981). It is a diagnostic approach based on the classical model of neurosis, which understands a psychical illness as a consequence of the re-actualization of a defended-against conflict which has its causes in a patient's life history. Thus, what plays a role here is not only a neurotic disposition acquired in early life, but also a situation that can act as a trigger, according to the lock-and-key principle (cf. Doering, 2003). An appreciation of these interrelationships requires information on the patient's social situation, as well as his lifetime-developmental history. Such data are collected within the framework of the depth-psychological biographical anamnesis in the areas of personal relationships, love relationships, immediate family life, family of origin, job-related problems, work performance problems, learning difficulties, experience with and

behaviour towards material possessions, as well as data from the socio-cultural environment. Finally, a hypothesis is formed from the collected data on the interactive effects of early experiences and current situational triggers in the form of a "psychodynamic picture" (Dührssen, 1981).

More recently, integrative interview models have been presented which are intended especially for use in a clinical setting, as here, in contrast to private practice, differential therapy indication and referrals are of central importance. Janssen (1994) presents a technique for a psychoanalytic initial examination which is a combination of the psychoanalytic initial interview, the biographical anamnesis, and the psychoanalytic developmental diagnosis. The results of such a procedure would permit not only a psychodynamic diagnosis, but also a descriptive ICD-diagnosis. In a similarly eclectic manner Doering and Schüßler (2004) describe the psychodynamic initial interview as a consecutive sequence of psychoanalytic initial interview, explorative psychopathological examination, and biographical anamnesis.

Otto F. Kernberg, during his tenure at the Menninger Clinic in Topeka in the 60's and 70's, discovered that neither the classical psychoanalytic treatment technique, nor the usual psychoanalytic initial interview were suitable for his patient clientele. In his work with structurally seriously disturbed patients suffering from borderline personality disorder, he found that he was hardly able to stay in a state of evenly suspended attention for one whole hour; it proved equally difficult to obtain a complete biographical overview within an appropriate time frame. Kernberg therefore developed his "structural interview" (Buchheim et al., 1987; Kernberg, 1981, 1984) especially for structurally disturbed patients. The adjective 'structural' points to the fact that this interview is primarily about identifying a patient's structural level. Kernberg distinguishes between a neurotic, a borderline, and a psychotic level of personality organization (= structural level). In a borderline level of integration we typically find signs of a non-integrated identity (identity diffusion), and primitive defence mechanisms, while reality testing appears to be intact. A particular feature of the interview technique of the structural interview is that unstructured parts continue to alternate with a strongly explorative interview style in cyclical phases. The focus is on the patient's interpersonal interactions, especially the transference relationship. Not only are internalized relationship experiences 'put into scene' or enacted by alternating between an analytic and a structural interview stance; but information is also gained on how the patient experiences himself, others, and his relationships, and whether these perceptions conform to reality, how he copes with job demands, and how he deals with sexuality and moral values. Buchheim and colleagues (1987) rightly referred to these as the second generation of diagnostic interviews, as for the first time explorative and relationship-dynamic interview styles were not merely put together in a serial fashion, but, in line with a new, cyclical interview concept, formed a new integrated gestalt.

Under pressure from evidence-based science which forces psychotherapy to furnish quantifiable proof of effectiveness, a series of research-oriented structured diagnostic interviews was developed which Buchheim and colleagues called the third generation of interview methods (Buchheim et al., 1987). Some of them will be mentioned here by way of example. The Structural Clinical Interview for DSM-IV

(SCID-I and -II; Fydrich et al., 1997; Wittchen et al., 1997) was constructed to capture phenomenological DSM-IV diagnoses. It has the interviewer go through the individual items of the DSM-IV operationalizations one by one. The Adult Attachment Interview (AAI; George et al., 1985) is a semi-structured interview for the attachment diagnostic rating in adults and aims to identify the current representations of early attachment experiences. For that purpose, it poses 18 questions which revolve around the relationship with parents, or early attachment figures, and also to the patient's own children. The interview is evaluated on the basis of transcripts, whereby the coherence of the discourse forms the main criterion for coding the transcripts. The Core Conflictual Relationship Theme method (CCRT; Luborsky/Crits-Christoph, 1990; Luborsky/Kächele, 1988) employs clearly defined criteria to establish so-called relationship episodes, narrative material which thereafter is prepared in a way so that formative internalized relationship structures which determine interpersonal behaviour become measureable. The Structured Interview for Personality Organization (STIPO; Caligor et al., 2004; Clarkin et al., 2004b) is an attempt to operationalize Kernberg's structural interview. In it, the interviewer asks structured questions on 100 items on seven dimensions of personality structure and then rates the results according to a six-point scale of personality organization.

These formalized interview approaches may be mapped on an axis with explorative at one end, and relationship dynamic approaches at the other; if compared to the psychoanalytic initial interview, they would be found at the other end of the spectrum. While the latter, in as unstructured a way as possible, sets the stage for a scene in the transference relationship to unfold, the operationalized forms of interview dispense with this relationship-dynamic material in the 'here and now' of the actual interview situation in favour of a reliable assessment of small and even smaller measurable psychopathological units. Carrying on the typology by Buchheim and colleagues (1994), the OPD-interview thus can be described as the fourth generation of psychodynamic interviews (Dahlbender et al., 2004b). It is the attempt of a synthesis of the preceding interview generations. It requires, first of all, a psychoanalytic stance as a basis, which allows the "recreation of infantile object relationships in the transference-countertransference between psychotherapist and patient" (Janssen et al., 1996). However, similar to Kernberg's structural interview, the unstructured procedure is interrupted by more explorative interview phases in a cyclical manner. These are in part taken from already existing instruments, like, for instance, the identification of relationship episodes according to the CCRT method. Beyond this, the OPD interview contains structured passages of a biographical anamnesis and captures psychopathological symptoms. The OPD interview is multiaxial and multimodal: it collects material for the assessment of the five axes by applying different modes of interview methods (see table 5-2 in: Dahlbender et al., 2004b). A psychoanalytic criticism is that the OPD interview, by its very multimodality, sacrifices too much scenic material, as the more structured parts of the interview do not really allow the development of a transference-countertransference relationship (Mertens, 2004). While this argument cannot be completely discounted, we nevertheless believe that in an OPD-interview carried out with a sufficiently sensible psychodynamic stance as a basis, there will be enough room for the development of a diagnostically usable transference activation. The OPD-interview may perhaps even encourage this by its use of goal-

directed interventions, as Kernberg similarly utilizes them in his structural interview (Dahlbender et al., 2004b).

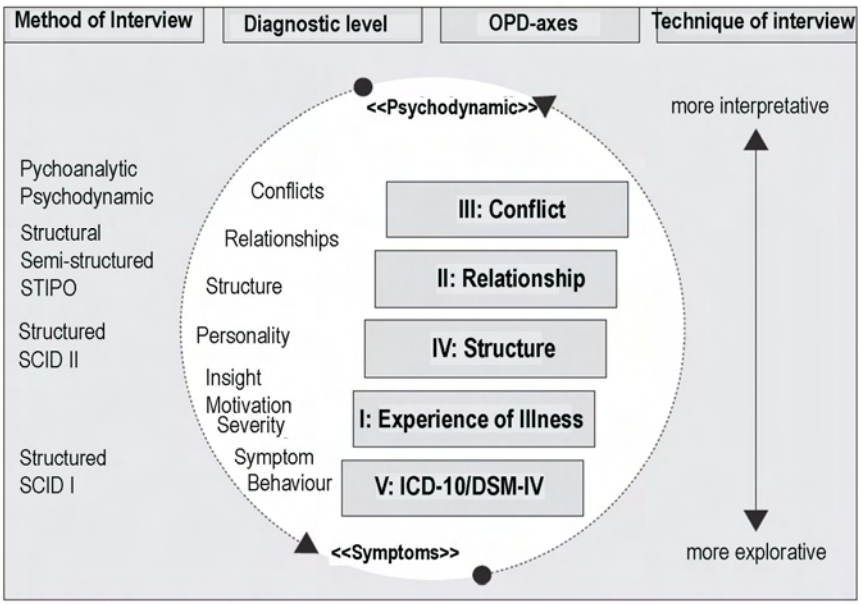


Figure 5.1: Diagnostic Levels and Technical Strategies of the OPD-Interview compared to other Interview Procedures

5.2 Carrying out the OPD-interview

5.2.1 Prerequisites

The aim of the OPD-interview is to generate material so that, if possible, all items and dimensions of the five axes can be reliably rated. In order to facilitate this, the interviewer can avail himself of certain interview strategies, the use of which is tied to the following preconditions:

- The interviewer must have a basic psychodynamic understanding. This does not necessarily presuppose post-graduate training in psychodynamic psychotherapy, although such training would certainly be of advantage. Rather, it requires the interviewer to have the capacity to empathize, which enables him to recognize and understand relational aspects in the 'here-and-now' of the interview situation, and to link symptom formation with relevant experiences in the 'there-and-then'. This demands the interviewer be open, in the sense of Sandler's (1976) free-floating role-responsiveness, to his own experiencing during the interview relationship.
- The interviewer must have knowledge of the contents of axes I to IV more or less at his fingertips, in order to know, during the interview, which areas have been sufficiently covered and which have as yet insufficient material. He can acquire sufficient competency, as a rule, in three 20-hour OPD-training courses, provided that the acquired skills are being practised and applied between courses.

For a reliable assessment of axis V, the interviewer must be familiar with the diagnostic criteria of ICD-10 or DSM-IV, and either have sufficient clinical experience or have undergone the respective trainings for the application of the classification schemas.

5.2.2 Principles

As mentioned earlier, the OPD-interview procedure is multiaxial and multimodal, interspersed with phases of structured passages. The fundamental stance of the interviewer is, primarily, that of the psychodynamic initial interview, which clears the stage for scenic development in the interview relationship, has little structure and does not explore. Although this stance is abandoned temporarily in the structured interview passages, it is a fundamental principle of the OPD-interview to continually revert back to it. This procedure may best be described as an oscillation in attentive focus between a relationship-dynamic and an explorative interview stance. The degrees of structure may thereby vary along the following lines:

- An open, unstructured interview procedure, which serves to bring about a spontaneous unfolding of the patient's inner experiencing and his offers of relationship.
- A moderately structured procedure, which focuses on individual thematic areas in the interview and, by being conservative with interventions, directs the patient's thoughts in certain ways, as for instance in the gathering of biographical data, or the exploration of relationship episodes, self-perception, and perception through others.
- A structured procedure which strives to extract specific details, for example through the exploration of the psychopathological signs and symptoms and the symptomatology so that an ICD-10 syndromal diagnosis can be made.

The individual interview phases into which the OPD-interview is subdivided, should be initiated with an open-minded conversational stance. The patient alone is to decide the importance to be given to specific content, what he wishes to relate first, where he wants to expand, and what he would prefer to mention only between the lines. In addition, the unstructured interview phases create a space for the unfolding of an "enactment" of the transference and countertransference. In these phases, the interviewer is to particularly watch for scenic material, outside of the manifest content of what is being said, for instance in the patient's facial expressions and gestures, subjective judgements, emphases, and omissions. Contradictions frequently occur in psychodynamically relevant places between the content of what is being said and the affective tone. Very careful attention is paid to the patient's offers of relationship to the therapist and the therapist's resulting emotional reaction. From what happens in the interaction, hypotheses may be formed about neurotic conflicts and the dysfunctional relationship patterns of the patient, which may then be explored further in the more structured interview passages.

The aspect of the diagnosis that deals with structure is less interested in open or hidden meanings of the patient's statements or enactments, but in the structural capabilities or limitations which he implicitly denotes, or which he demonstrates directly in the interview situation. The manner in which he deals with stresses and

conflicts shows how far he is able to accurately perceive himself and others, what capacity for self-regulation he possesses, and how well grounded and oriented he is within himself and in the outside world. The diagnostician therefore concentrates less on unconscious content, which determines the surface of the patient's report and the immediate interaction with the interviewer, but on the form in which a patient masters the requirements placed on him by the interview.

In the unstructured and open parts of the interview the familiar psychodynamic intervention strategies can be applied: clarification, confrontation, and interpretation. Clarification implies the exploration of aspects of the patient's presentation, which have remained diffuse, unclear, or contradictory. Clarification discusses these elements but does not question them as yet. We are here dealing with an interaction that happens on the most "factual" of levels, the one closest to awareness.

> Example: "You have told me that once in a while you also like to go out with other women. Last week you had that nasty argument with your partner, in which this topic came up. Is your girlfriend so jealous, or were there perhaps other, still different reasons for her annoyance?"

Confrontation moves one step further, by pointing out to the patient conflicting unconscious or preconscious content, which he, however, considers perfectly normal and unproblematic. The causes for this are mostly, among other things, defensive processes, contradictory self- and object representations, or structural limitations. A confrontation may at times be understood by the patient as provocative, as it implies an open questioning of his viewpoint, and his behaviour. With confrontation, a situation is created in which the structural abilities of a patient (e.g. affect, self-worth regulation, perception) can be directly examined.

> Example: "You are adamant that you do not want to lose your partner. At the same time, you keep having intimate contact with other women, and tell your partner about it. How do these go together?"

Interpretation is the kind of intervention which goes farthest in terms of trying to get at the unconscious level. Here the patient is not only made aware of conflictual aspects, but is also given hypotheses as to which motives and underlying psychodynamic reasons might play a role in the creation of the problem. As at the time of the OPD-interview, there is normally not yet a safe therapeutic framework in place, interpretations must be carefully given as diagnostic trial interpretations so as not to destabilize the patient.

> Example: "We have seen that you always begin to have relationships "on the side" whenever you feel especially close to your partner. And as far as I am concerned, you have also repeatedly pointed out in a particularly intense moment in our talk that you will be seeking at least two more initial interviews with other therapists. Could it be that you start a relationship "on the side" each time the closeness in an important relationship becomes too great, and thus too threatening for you?"

Trial interpretations, on the one hand, serve to understand unconscious processes more in-depth, e.g. in the examination of neurotic conflicts; on the other hand, they furnish important information for axis I, on the patient's capacity for insight and treatment motivation.

In the moderately structured part of the interview the interviewer preselects or focuses on individual thematic areas. What is of importance here is to not let oneself be drawn immediately into asking closed questions, but to start by discussing the respective area in an as open as possible way. In the context of the biographical anamnesis this could sound like this:

> "Could you please describe how you grew up, and what your childhood was like?"

Following on from there a more exact focus may become necessary:

> "Can you please give me an example of what the relationship with your father was like when you were still a child?"

And, if need be, in even more detail, in order to clarify the real situation of the child:

> "Did your father ever beat you with an object, a belt, cane, or similar?"

The same structuring and focusing procedure is used in the interview passages that identify relationship patterns, as well as self- and object perception (see below).

A particularly structured procedure is needed in the ICD-10 interview for the exploration of psychopathological signs and symptoms for the syndromal ICD-10 diagnostic. Here it may become necessary to ask even closed, or selective, questions, in order to clarify factual situations beyond any doubt. This is, for instance, in the case if a depression is suspected:

"T.: You said you were feeling "depressed" lately. What exactly do you understand by this?
P.: Ahem, ... I am feeling down and exhausted, very different from how I used to feel - I normally enjoy life.
T.: This sounds as if you have lost all your joy of life. Is there something that would make you "happy at this moment?
P.: Well, to be honest, I can't think of anything right now.
T.: And you are feeling down?
P.: Yes, very much so, everything is just black.
T.: So no silver lining on the horizon?
P.: ... no, everything black. I cannot even be properly sad, cannot cry.
T.: All black - has it ever been so bad that you did not want to live any more?
P.: Well yes, the thought has come up ...
T.: And have you ever seriously considered taking your life?
P.: Oh no, I could never do that to my family, and besides, I am religious, you know, you cannot do that then.
T.: So you have never attempted to take your own life, or planned to do it?
P.: No, never."

In addition to these general interview strategies the OPD-interview stipulates some specific diagnostic procedures which are compulsory. Among them are the identification of relationship episodes to assess axis II, and the description of self and object in order to assess self- and object perception on axis IV. These techniques will be discussed in the following paragraph and can also be found in the appendix (work materials). Under the heading "interview tools", chapter 13.6 offers differentiated tables for every axis, or every subdimension of an axis, which provide interview aids.

5.2.3 The phases of the interview

The interview is divided into five phases, with each phase, as described, being initiated with a question or intervention. Structuring is least during the initial phase and can increase during the course of the interview. Within each phase, structuring questions are possible. Experience has shown it is unlikely that a complete OPD-interview can be carried out in less than 90 minutes, in some circumstances it may even require two to three hours. For the initial interview, however, the therapist should allow one hour. If sufficient information for a clinical diagnosis cannot be obtained during this time, and no satisfactory material can be gathered on the items of the five axes, the therapist is to arrange for one or two more consultations/interviews with the patient. In between the interviews the therapist can remind himself of which areas of the OPD-diagnostic he still needs to gather information.

5.2.3.1 The initial phase

In the initial phase of the interview the patient is to be informed about the aim of the consultation and the time frame, for example using the following wording:

> "We have one hour for this interview. The aim of this interview is to find an understanding, together with you, of your illness/problem."

The patient, as a rule, will begin by relating his complaints, as he comes with specific mental or somatic problems in order to enter into a conversation about these with the therapist. The therapist should be able to identify the core symptoms according to ICD-10 (Dilling et al., 1993). If he is unsure, careful questions are possible, but without adopting a purely exploratory stance. The patient should at all times have the opportunity to speak about his symptoms freely and openly.

In this phase, the therapist, after a first assessment, will be able to judge the degree of severity of the mental and/or somatic illness and the patient's subjective suffering. He will gain first impressions as to the impairment of the patient's actual life situation and of his self-perception.

Whilst the therapist is listening to the complaints and taking in the actual life situation of the patient, she will take in details of the patient's experience, and facts about his current psychosocial situation, e.g. his intimate relationship, or capacity to work. Possibly, life-determining conflicts may be identifiable at this stage in several areas of the patient's life. They can then be explored in later phases and in more depth as the interview progresses. The therapist should also pay attention to whether the first appearance of the symptoms is in any way linked to certain trigger situations, e.g. threshold events like leaving the parental home, beginning a professional training, rising to a position of leadership, starting a family, or retirement.

> Patient A., at the end of the initial phase, says the following: "Now here I am ... She describes in great detail her anxieties, depressive mood and helplessness, but also her attempts to take up initiatives of her own, particularly the inner tensions she felt, after her return from an inpatient psychosomatic treatment, at the encounter with her husband. The phase is brought to an end with her describing her current state; crying, she says: "I can't take no more".

> Patient B. gives an exact and umoved description of her previous examinations and somatic treatments in the past because of a colitis ulcerosa. She shows the x-rays given to her by the transferring physician. She emphasizes her expectation to be healed by turning to a new form of treatment, psychotherapy, although the internist treating her up to that point had discouraged her.
>
> Patient C. comes to the clinic because of a crisis-like development during a professional retraining. He is suicidal-depressive. In the conversation about his current professional failure his immense susceptibility to being hurt comes through. He speaks in a disappointed and angry way about the conditions of his retraining. His description of external circumstances is confusing. The way he experiences his illness is characterized by helplessness and despair.

Already in the initial encounter between patient and therapist, the "initial scene" (Wegener, 1992), and thereafter, in the initial phase, the interviewer must attentively observe the patient's scenic presentations, as they are being expressed from the moment when contact is established, complaints are related, and how the patient experiences and deals with the illness. These scenic presentations offer orientations for how the therapist might proceed with the interview.

> Patient A., for instance, starts the interview by presenting a referral slip on which a diagnosis is written which she cannot read. She asks the interviewer to decipher the unreadable and to explain it to her. She is thus taking up a relationship with the examiner by presenting herself as ignorant, wanting to be filled in by the examiner. The modality of this relationship structure is determined by her wishes for dependency, which also manifests in the relationship to her husband and father.
>
> The descriptions of patient B. are oriented along a role-like normative adaptation to the medical examination situation. In her report hardly any relationship figures can be detected.
>
> Patient C. instantly puts his great sensitivity to experiencing hurts in the foreground, and links it to a psychosocial situation (retraining).

5.2.3.2 Identification of relationship episodes

When trying to identify relationship experiences and episodes, the therapist must work from two perspectives: one, she must be able to use the analysis of what is happening in the current transference-countertransference, and two, she must avail herself of the analysis of current or biographical relationship experiences. The latter is mainly about relating episodes from the relationships with significant others. Of special interest here are the dysfunctional, ongoing, or repetitive (habitual) relationship patterns. The therapist, therefore, will have to pay particular attention to neurotic repetitions, overgeneralizations, discontinuities, and contradictions in relationships, as well as the degree of differentiation with which the patient’s objects are experienced by him. For this purpose she can refer to actual, experienced, interactions on the one hand, and cumulative interaction experiences, grouped together in a kind of typecast overall view of repetitive patterns, on the other.

To obtain these materials, the OPD-interview compulsorily prescribes the identification of relationship episodes. For this purpose, we employ a method derived from the CCRT-method (Luborsky/Crits-Christoph, 1990; Luborsky/Kächele,

1988) and request narratives of actual relationship interactions which, for the patient, have held difficulties, conflicts, or stresses of any kind. A selection of at least two to three relationship episodes should be available for the OPD-interview. (Suggestions on how to proceed here can be found in the appendix, interview tools for axis II).

When inquiring about relationship episodes, the therapist may refer to the previous interview phases to take up initial hints as to the patient's objects, or inquire about actual relationship situations, or, she can also make a link from the description of complaints to the description of relationship experiences by asking about the reactions of others to the illness, in cases where the patient does not mention relationship figures of his own accord.

> For patient A. it is the relationship to her husband which shows a conflict of ambivalence with respect to her wishes for dependency and tendencies towards autonomy.
>
> With Patient B. it is the relationship with her daughter. The daughter was born out of wedlock. The patient takes great pains to be a good mother. The daughter has so far "prevented" her from being able to realize a loving relationship.
>
> Patient C. describes how he time and again seeks out relationships with idealized women and, in consequence, suffers big disappointments. This pattern is not restricted to women partners, but applies to any and all objects, for example also to professional training situations. It is, therefore, of great importance for the eventual therapy.

The therapist should always show interest in individual interactions, that is to say, in examples of relationship experiences, particularly in patients who, for reasons of defence, tend to only furnish overall descriptions. A very important question is therefore the following:

> "I cannot quite imagine what the relationship with X is like, perhaps you can clarify it for me with an example."

The therapist can also go into greater detail, or be more interested in the typical, or the development over time. She may also ask questions about the development of the relationship in the past, or at the present moment, as appropriate. She can form an impression of whether the narrated relationship is unique in character, or can perhaps be compared with other relationships.

In order to better get at the motives of the relationship dynamic, it can become important in the individual case to ask about expectations, wishes, anxieties - possibly about himself 's'"sand about others - and similar things. Also, the therapist may ask about externally visible reactions to the behaviour of others, and the respective inner experiences, the emotional and cognitive reactions to what is happening in the relationship. Here the following questions might be suitable:

> "Can you please tell me what you expect or fear from X at that moment?"
>
> "How do you think your partner might have felt at that particular moment?"
>
> "Can you tell me what you and/or your partner did or said at that moment?"

If however these are the main phases in which relationship episodes are worked out, proceeding always from the actual relationship situations, with the therapist

able to make first approximations as to the position a patient takes up with his objects, what he expects, fears, and how others behave towards him, there will be still further possibilities during later phases, especially the third and fourth phase, to identify more relationship experiences. The therapist therefore should also pay attention to concrete real-life examples, that is to say, relationship episodes, in the later phases of the interview.

In the relationship episodes, a large part of the necessary information about the existence of repetitive conflictual patterns will already shine through. In general, it can be said that conflicts are not to be explored with a magnifying glass. They leave their trace throughout the interview, affecting both content and scene. Asking increasingly precise questions (including those that test hypotheses/assumptions) helps in the examination of whether the conflict, as assumed by the interviewer, reaches into other areas of life ("Does this affect your job/how you deal with other people? Do you take more after your father or your mother in this one aspect? Do I see this correctly, that the illness brings you into a similar situation yet again?").

5.2.3.3 Self perception, self experience, biographical facts of the patient's life

The third phase of the examination focuses on the patient's experience of himself, which, in essence, is about assessing the structural characteristics (axis IV). At the same time, information can be obtained about areas of life, as experienced by the patient, and about areas of fact (family of origin, immediate family, job and professional life), which are part of the biographical anamnesis. Asking explicitly about a patient's self description, together with the object description as detailed in the following paragraph, represents the second mandatory interview strategy for each OPD-interview. This is the technique also applied by Otto F. Kernberg in his structural interview (Kernberg, 1981, 1984; see also Buchheim et al., 1987). The following suggestion (see also Chapter 13.6.4, interview tools for axis IV) may be used to open up this phase:

> "You have told me quite a bit about your complaints and about your relationships. But I would still like to understand a little better how you see yourself now and how you saw yourself in the past."

If the patient takes up the question, the therapist will then not only know whether the patient is able to describe himself in a differentiated way, but also whether he can delimit himself from his objects, that is, whether he has a clear concept of self. As the patients in specific situations mostly describe themselves, the therapist will also learn about family or job-related areas. More in-depth questions here contribute to identifying not only the biographical situation, e.g. the relationship to parents, siblings, partners in love-relationships, superiors and colleagues, but also the patient's experience of himself in such socially and biographically defined situations. This part of the interview, in conjunction with phase four, can become quite extensive and possibly necessitates further clarification in the follow-on interviews.

Possible questions comprise, for instance, a detailed inquiry about the patient's happiness with his immediate family situation, past and present professional activities, the perceived stresses, salary earned, and his relationships to superiors and colleagues. The therapist should ensure that several areas of life are mentioned so that life-determining conflicts may broadly present themselves.

> Patient A.'s experience of self is determined by her experienced inability to plan and carry out activities independently, and by the feeling of being tied down by her marriage. From an earlier marriage which she contracted upon the death of her father, she reports that her husband used to lock her up until he came home from work. The reasons he gave were that, after all, she would not need to do anything, and he could do everything for her. At the time, the patient found this "amusing". She felt like a "precious gem". However, in the time thereafter, her developing agoraphobic symptoms were accompanied by several futile attempts to separate and distance herself. Her husband's illness created a particular strain on the marriage.
>
> With patient B. her experience of self is determined by her desire for conformity in her job, the care of and worry for her daughter, and by guilt feelings that she is not a good mother, but at the same time by her willingness to be there for her primary family. She sacrifices herself for others.
>
> Patient C. sees himself as the victim, who time and again is getting "a rough deal". His enormous efforts are not recognized. Despite his physical impairment, he had learnt a trade, he lost his job, much to his own surprise. His professional goal has now become to enter the helping professions, "as there are so many difficulties in today's world". The patient is unable to convey a true-to-life image of his person and his real situation.

These examples clearly show that this phase of the interview already reveals fundamental aspects for the assessment of conflicts (axis III) and of structural subdimensions (axis IV).

5.2.3.4 Experience of objects, experience and management of external life

The fourth phase is connected to the third phase. In all likelihood, the experience of self is always described with respect to that of the objects. Nevertheless, in this fourth phase, the therapist should concentrate once more on how the patient perceives and experiences his objects. She should work out how the patient experiences others in the 'here and now' and in the 'there and then'. This also includes an identification of various areas of life , e.g. family of origin, immediate family or current partners, professional life, friends, further social contacts. By analogy to the preceding description of self, a description of objects is compulsorily required here. This phase may be begun with the following question (see also appendix, interview tools, axis IV):

> "You have told me how you currently see and experience yourself, and how you saw and experienced yourself in the past, and you have hinted at how others see you. Can you tell me in more detail how you see X?"

The therapist should establish a connection here to previous object descriptions in the initial phases of the interview. However, if the patient has not already given in-depth descriptions of areas of his life, the therapist will have to ask clarifying and guiding questions in order to motivate the patient to talk about relationships and life themes from both present and past. Clarifying questions may become necessary about his past professional life, his satisfaction with his current job, the related stresses, the salary he receives, how he relates to superiors, and his relationships with colleagues. This can be initiated by asking open questions:

> "You have described to me which profession you have chosen and have told me about the circumstances around your starting your vocational training. Can you tell me a little more precisely how you came to select this profession, and how you experience yourself today in your job?"

Some patients tend to omit areas of their life if an unstructured, non-exploratory procedure is applied. When trying to identify life-determining conflicts, it is, however, necessary to examine several areas of life. Therefore, questions like the following may become necessary:

> "You have given me a good impression about your life within your family. I do not have a very clear idea, however, of how you fare in your job. Can you give me an impression here?"

The therapist must always be aware that this is not about getting at the "historical truth", but rather, about identifying subjective experience and memory, especially the experiencing of objects. In some cases the patient is likely to only hint at important situations. The therapist should make a note of this, but not necessarily urge the patient to communicate things which are very unpleasant for the patient and which he perhaps will only be able to relate to the therapist at a later time. Along similar lines, what is bound to happen, time and again, is that important situations and relationships to significant objects get no mention at all, or are perhaps cut out. The therapist may address these, but she must be aware that sometimes she might only get hints and might meet with a resistance to relate the "real" relationships.

> For patient A. the significant important object is the husband. For patient B. it is the daughter. In the interview, these objects, for patient A., lead to the highly idealized father who had died shortly before the patient got married. For patient B. they lead, via the daughter, to the equally highly idealized mother, who had died shortly before the outbreak of the patient's illness. Patient A. describes her father as an ideal object; she could always turn to him, he was very understanding of everything. She had not yet learned how to cope with his death.
>
> For patient B. it is the mother who did everything for the family, sacrificed herself and was always there for the children, and from who the patient had difficulty separating. The patient expressed intense guilt feelings as the mother had died when she could not visit the family.
>
> Patient C. finds it very difficult to perceive others correctly in a reality-based manner. He oscillates between the extremes of great idealizing hope and bitter disappointment. An inner emotional rapport to any one important individual is hardly recognizable. This also applies, for instance, to his two adolescent children from a failed marriage.

In the exploration of the structural dimensions, of which self and object experiencing are a main part, it is necessary in patients with a low level of structural integration to leave the initially open and unstructured interview stance. The therapist is then able, from a more proactive stance, to make suggestions to the patient about what may be happening inside him, as these patients often are not aware of their internal processes or deficits, or able to name them appropriately. It may be helpful, in this context, to use metaphors, stories, or film scenes to exemplify (see work materials, interview tools for axis IV, chapter 13.6.4).

5.2.3.5 Motivation for Psychotherapy, prerequisites for treatment, capacity for insight

Towards the end of the interview, the therapist should once again, in her mind, go through the scenes and stories of the patient. She should note for herself how she has experienced the patient so far, and what the main problems were which she was able to identify. On the basis of the material collected up to that point, she should formulate an intervention. Depending on the patient's level of structural integration this can also be an interpretation which, making use of the countertransference, refers to aspects of the transference:

With patient A. this interpretation might be the following:

> "You would want to be able to live independently, but feel tied down, and dependent on your husband, and also, as our conversation has shown, on me. You are expecting me to help you out of this difficult situation."

The intervention with patient B. can be formulated along the following lines:

> "You were hiding your mourning and guilt feelings after the loss of your mother for many years. Now they have resurfaced in your conversation with me, and that seems to annoy you as you think you don't have sufficient control of yourself."

Patient C. may be answered in approximately this manner:

> "You've had it very difficult in your life so far. Despite your efforts, you were often not rewarded and fell flat on your face. I think it could be important to find out why this is. Perhaps you have missed the odd thing here and there, or have not really recognized certain aspects in the people you have been dealing with".

Such summary interventions have the aim of "tentatively" guiding the patient towards problematic areas and to test reactions to such interventions. This is essential in order to identify the internal conflicts, or structure, respectively, and also to determine the patient's readiness to enter a clarifying treatment process. The therapist thus will have to establish whether the patient can work with such interventions. She will need to find out how far it is possible, on the basis of a shared understanding and together with the patient, to recognize, also in the currently ongoing relationship with the therapist, the renewed actualization of habitual modes of experiencing, and to work on them. In consequence, this phase of the interview therefore addresses conflicts and levels of structural integration, as well as aspects of axis I which have so far not been clarified. Interview aids can be found in the appendix (interview tools for axis I, chapter 13.6.1).

If the therapist, at the end of this phase, feels able to assess the structure, the conflicts, the relationships and also the experience of the illness and the prerequisites for treatment, she may end the examination. Otherwise she should schedule further interviews.

In cases where this examination is conducted as the initial interview, the interview should not end without pointing out the next steps to be taken. What has been clarified so far and what should still be clarified should be briefly discussed with the patient. Further, the therapist must arrive at an indication for a therapeutic procedure, if already possible at the conclusion of the preceding phases, and let the patient know about it.

5.2.3.6 Mental and psychosomatic disorders

A descriptive clinical diagnosis of mental disorders in accordance with ICD-10 (axis V) as stipulated for the first phase of the OPD-interview requires a complete identification, or examination, of the core symptoms of each ICD-10 chapter, including the psychopathological criteria and their stability over time and over the course of the illness. In principle, the core symptoms can be examined in every patient, and, corresponding to the symptomatology, can be diagnostically mapped in the respective chapter. This should be followed, though, by a complete symptom exploration. A complete symptom exploration cannot, however, be carried out without leaving the interview stance adopted so far in favour of a structured procedure.

The therapist must be familiar with the diagnostic guidelines or criteria for research of the ICD-10. A respective diagnostic training would make sense, as the various application and reliability studies on the use of the ICD-10 (Dittmann et al., 1992; Freyberger et al., 1990a; Schneider et al., 1993) have shown.

Within the framework of clinical research issues, symptom checklists may also be used complementarily (e.g. Dittmann et al., 1992; Hiller et al., 1995).

These are external rating procedures which are to be supplemented by other sources of information, like external anamnestic data, behaviour observations, etc. The relevant individual symptoms or symptom clusters identified in these symptom checklists are mostly related to a diagnosis, so that the therapist who knows the patient thoroughly can collect information post-hoc in additional interviews.

If research issues suggest structured or standardized diagnostic interviews in addition to the OPD-interview (e.g. homogeneous sample, comorbidity), they should be carried out after the OPD-interview and possibly by a different interviewer, so that the exploration will not disturb the patient's relationship to the OPD-interviewer.

6 Case example: "Driven out from paradise"

6.1 Interview vignette

The patient is on time for the initial interview. She is stylishly dressed and, overall, comes across as lively, her face, however, appears tired and weary. She gives a detailed account of her physical complaints. For six years she has been suffering from colonic bleeding. The bleeding occurred periodically, as it were, at "peak periods". When she was under stress because of her work load, there was no bleeding, but when at rest, bleeding would occur. Her GP explained to her that this was similar to an animal that could run very fast and would function perfectly in situations of danger. It was part of her character to, on the one hand, throw herself into her work with great enthusiasm, but on the other, to exhaust herself completely doing it. She had to teach every day for up to seven hours on the computer, and after four days of teaching seminars she felt burnt out.
The therapist briefly clarifies her complaints. According to her account, there is no pain, also no diarrhoea. A colonoscopy had revealed an atypical chronic colon problem. The written reports stated findings of mucous and bloody discharges and a minor inflammation of the colon, ascertained by rectoscopic examination. As a result, she was put on medication. The gastroenterologist had diagnosed a “discreet protocolitis”. She had been treated with cortisone only once, there were no hospital stays.
The therapist asks her about her self-image. She describes herself as an "Aries who, a long time ago, had sown her wild oats". By profession, she is a computer specialist. She describes her work in the training groups where she is very successful. However, she felt like a "show girl" having to pull off her show before the group of trainees and "be dominant". Frequently she was not in the mood for it, and as a consequence felt like a "whore", who always had to be able do it. She describes her teaching job as wearing her out, but simultaneously points out that she is passionate about it.
At one time more intense colonic bleeding occurred when her husband suddenly became unemployed. She was deeply affected at the time and had reacted in a totally uncontrolled manner with crying fits. As already mentioned, this had been the one situation where she needed to be treated with the cortisone. She experienced this situation as existentially threatening, given that they were about to buy a house only a few days later. Her husband had been badly affected by this. She was frightened about his state, as she had never before seen him, having always been a quiet and balanced man, in such a condition. In her teaching job, she had a very hard time keeping herself going, but eventually managed successfully. In order to cope better with her situation, she read a lot in the time thereafter, for example a book entitled "Women who love too much".
Here the therapist intervenes, offering the interpretation that she cried with her body and with her soul to express a very great strain which, for her, has the meaning of an existential threat. She takes this up, carefully agreeing, and then starts to tell her life story: she came from an Eastern European country and had originally been a teacher there. About ten years ago, she emigrated to Germany. The German government paid a lot of money to buy freedom for those emigrants, who, like her, were of German descent. Nevertheless, the patient and her family had to pay a substantial additional sum of money in order to be allowed to leave. Her husband moved to Germany first, she stayed behind with her son and followed two years later.

The description of life in her Eastern European homeland bears idealized features. She describes a world and life full of comfort, safety, and idyll. Some of the pictures she describes appear to be paradisiacal. Money played no role, what counted were other values. The German-speaking enclave was an "ideal world", with large spaces for man and beast. This world was being destroyed in the course of a forceful and oppressive nationalistic policy, whereupon the intelligentsia first left the country. Soon the community was not holding together any more, villages were deserted, families had broken up. Acquaintances in Germany had finally helped her and her family to leave the country.

The patient grows serious and intense when she describes her encounter with, to her, the unfamiliar Western world. She had to work a lot and learn a lot. Everything was new and foreign. After all, she had never before seen a computer. Words and terms familiar to the people here had been totally unfamiliar to her, life in a market economy was entirely unknown to her. She had to struggle through. She lived apart from her husband and son for two years, when, for job-related reasons, she had to move to another town. With particular emphasis she reports how she missed out on a part of her son's development, who during this time had "grown into a man". In this episode, too, a painful loss can be felt. As she was excessively involved as a mother, her absence had, on the other hand, given her son the chance to become independent and to separate from her. She was no ordinary mother, but excessive in everything. She had always held on to attachments intensely. She had always had someone who was totally "her own": When she was a girl, she had a girlfriend, for instance, who for many years had stopped by on her way to school to pick her up. She knew her husband from the time she was 14 years old.

Upon the therapists' request to describe her husband, she calls him "a child of god". He relied on himself. She interjects, could the therapist image someone being the exact opposite of her?. As far as she herself was concerned, she was an extrovert and enjoyed showing off (for instance by driving a red sports car), which meant nothing to her husband. He was reserved and without any such ambition. Also her son was very different in character from her, which she sometimes found difficult to deal with. He showed little emotion and was distant, which, she supposes, is what they call "cool" today. She, in contrast, was very intense and emotional, in positive as well as in negative moods, behaving according to the motto: "up one minute and down the next".

The therapist asks about conflicts and how she handles them: she found it difficult to comment, for there were basically no arguments with her husband and her son. Her husband was easy-going and amicable, you could not have an argument with him if you wanted to. However, in important things he could be firm and unyielding. She eventually reports a past event where there had been a conflict. She had tried, at the time, to bring about a reconciliation between her son and his friend, who had seriously fallen out with each other. Her description reveals that her efforts sprang first of all from her suffering the disharmony and that this was not in the interest of her son who vehemently protested against her interference. She just did not take tension and disharmony well. In this context, she mentions a difficult situation in a former company, where she initially made quite a career for herself, but the company then had suddenly gone bankrupt. The patient was deeply shattered by this event, although she was able to instantly change to another company where she was again very successful. At last she talks about her hyper-sensitivity to criticism. Despite the recognition she received time and time again she would instantly react with extensive self-doubt, if her students only had as much as the slightest reservation.

In response to the therapist's inquiry she talks about her family. She describes her former life in the nexus of a large family, again in an idealizing manner, and thereafter laments the current painful geographical distance that separates her

from her parents and her family. Again she mentions her feeling of "total uprootedness" in a land foreign to her. Funnily though, she had no problems at all in making contacts. She describes the friendship with a colleague with whom she was close friends while being separated, for professional reasons, from her husband and son. The report intimates a close familiarity, so that the question comes up in the listener whether this was perhaps a love relationship. Erotic-sexual things, however, appear somehow very far removed, not only in this part of the conversation, but overall, and are nowhere explicitly talked about.
The therapist moves the conversation back to her family of origin and asks about her parents: Her mother was "pure love". Her father was somewhat "odd", but she liked him. As to her outward appearance, she resembled him, for instance, her hair. In this part of the conversation she hints at a family drama: Her father had originally come from a rich family. The paternal grandfather, however, got into debt and, because of this, shot a bullet through his head, which, however, only injured his optical nerve. Her father had suffered greatly because of this event and because of the grandfather's blindness. After the end of the war he had to do forced labour in Russia for five years. He was 17 years old at the time, and work had been very hard.
The therapist attempts to summarize what has been said so far: She grew up in a safe and sheltered environment and still experiences a great feeling of belonging to her country of origin and her family. Due to the political situation she was uprooted from this life and came to a totally new world where she had to fight for her existence and autonomy. She had lost a lot in the process. The patient is silent, and after a while says she believes this is so. After another short silence, she reports the story of a girl from East Germany who had been imprisoned because of the political situation during the GDR regime. There she had been maltreated by criminal women and was separated from her children. This girl never wanted to go back to her homeland, although this would have been possible. As for herself, she was unable to return to her home country as it had ceased to exist. Everything had changed there, most of her compatriots had left. Only once did she go back, but had only cried while she was there.
Finally, the further procedure is being discussed. It transpires that she was referred for an assessment by a doctor. That doctor had earlier sent her to a psychologist, a "famous man" whose name she does not want to mention. She had had six to seven sessions with him. She eventually ended the therapy as she believed that he actually treated her only reluctantly.
The therapist experiences the patient as differentiated and self-reflective. She shows a marked self-critical attitude which reveals a great insecurity about herself. The transference reveals that she is looking for a friendly, paternal contact, in part the relationship is eroticized. Her appearance and manners, in turn, make her come across as controlled and easily emotionally hurt. In the countertransference, the therapist feels he has to handle the patient cautiously and with care.

6.2 Case evaluation and documentation

Operationalized Psychodynamic Diagnosis (OPD-2) data evaluation form

Axis I (basic module) Experience of illness and prerequisites for treatment	none/ hardly present (absent)	low	medium	high	very high	not ratable
	⓪	①	②	③	④	⑨

Objective assessment of the patient's illness / of the problem

1.	Current severity of the illness/of the problem						
1.1.	Severity of symptoms	⓪	X①❶	②	③	④	⑨
1.2.	GAF: Maximum within the past 7 days		➔	75			⑨
1.3.	EQ-5D Total: ___6___ Item values ➔	1.1	2.1	3.1	4.2	5.1	⑨
2.	Duration of the disturbance/of the problem						
2.1.	Duration of the disorder	< 6 months	6-24 months	2-5 years	5-10 5-10 Years	> 10 years	⑨
2.2.	Age when the disturbance first manifested	in years	➔	__36_			⑨

Patient's experience, presentation, and concepts of illness

3.	Experience and presentation of the illness						
3.1.	Subjective suffering	⓪	①	X❷	③	④	⑨
3.2.	Presentation of physical complaints and problems	⓪	①	X❷	③	④	⑨
3.3.	Presentation of psychological complaints and problems	⓪	①	X❷	③	④	⑨
3.4.	Presentation of social problems	⓪	X❶	②	③	④	⑨
4.	Illness concepts of the patient						
4.1.	Concept of illness based to somatic factors	⓪	①	②	③	④	❾
4.2	Concept of illness based to psychological factors	⓪	X❶	②	③	④	⑨
4.3.	Concept of illness based to social factors	⓪	X❶	②	③	④	⑨
5.	Patient's concepts about change						
5.1.	Desired treatment form: somatic treatment	⓪	①	②	③	④	X❾
5.2.	Desired treatment form: psychotherapeutic treatment	⓪	X❶	②	③	④	⑨
5.3.	Desired treatment form: social environment	X❿	①	②	③	④	⑨

Resources for and impediments to change

6.	Resources for change						
6.1.	Personal resources and strengths	⓪	①	X❷	③	④	⑨
6.2.	(Psycho)social support	⓪	①	X❷	③	④	⑨
7.	Impediments to change						

7.1.	External impediments to change	X❶	①	②	③	④	⑨
7.2.	Internal impediments to change	⓪	①	②	X❸	④	⑨

Axis I (psychotherapy module)	None/ hardly (absent)	low	medium	high	very high	not ratable
(optional)	⓪	①	②	③	④	⑨

Patient's experience, presentation, and concept/s of illness

5.	Patient's concepts about change						
5.P1.	Symptom reduction	⓪	①	②	③	④	X❾
5.P2.	Reflective-clarifying of motives /conflict oriented	⓪	X❶	②	③	④	⑨
5.P3.	Emotional-supportive	⓪	X❶	②	③	④	⑨
5.P4.	Active-directive	⓪	①	②	X❸	④	⑨

Resources for and impediments to change

6.	Resources for change						
6.P1.	Psychological mindedness	⓪	①	X❷	③	④	⑨
7.	Impediments to change						
7.P1.	Secondary gain from illness /conditions maintaining the problem	X❶	①	②	③	④	⑨

Axis II - Interpersonal Relationships

Perspective A: The patient's experience	
Patient experiences herself as Item Nr. Text 1. 26: complying, holding back, resigning 2. 7: caring very much, being worried 3. _____	Patient experiences others as Item Nr. Text 1. 10: controlling, making claims and demands 2. 12: Accusing and reproaching 3. 11: Belittling, devaluing and embarrassing her

Perspective B: The experience of others (also of the investigator)	
Others experience the patient as Item no. Text 1. 10: controling, making claims and demands 2. 11: belittling, devaluing and	Others experience themselves as Item no. Text 1. 26: complying, holding back, resigning 2. 32: isolating, cutting themselves

embarrassing them 3. 12: accusing and reproaching them	off, withdrawing 3. 12: accusing and reproaching her

Relationship-dynamic formulation:

Please describe	
... how the patient again and again experiences others: 🡻	The patient experiences others as demanding and fears failing in the face of these demands and being embarrassed.
... how she reacts to what she experiences: 🡻	She tries to avoid this by adjusting and by going out of her way looking after others.
...offer of relationship the patient makes to others (unconsciously) with this reaction: 🡻	In contrast to this view of herself, she comes across as hard to please, demanding, and critical.
... which answers she suggests to others (unconsciously) that way: 🡻	This leads others to handle her with care and to protect themselves, or to be offensive and correct her.
... how the patient experiences it if others react as expected:	There is the danger that she takes either of the two responses as a sign that she is not meeting the demands and has failed.

Axis III - Conflict

Preliminary questions to enable the therapist to rate conflicts

A) Conflicts cannot be rated for lack of diagnostic security.	yes =① no= X⓿
B) Due to a low level of structural integration the recognizable conflictual themes are not actually distinct dysfunctional conflictual patterns but rather conflictual schemas.	yes =① no= X⓿
C) Due to a recognition of conflict and affect being defended against the conflict axis cannot be rated.	yes =① no= X⓿
D) Conflictual stresses (stressor-induced conflict) without any major dysfuctional repetitive conflictual patterns.	yes =① no= X⓿

Repetitive-dysfunctional conflicts	absent	insignificant	significant	very significant	not ratable
1. Individuation versus dependency	X⓿	①	②	③	⑨

2. Submission versus control	⓪	①	X❷	③	⑨
3. Need for care versus autarky	⓪	①	②	X❸	⑨
4. Self-worth conflict	⓪	①	②	X❸	⑨
5. Guilt conflict	X❶	①	②	③	⑨
6. Oedipal conflict	⓪	X❶	②	③	⑨
7. Identity conflict	⓪	X❶	②	③	⑨

Main conflict: ____3____ Followed by, in order of importance: ____4____

Mode of processing of main conflict	predominantly active	mixed but active	mixed but passiv	predominantly passiv	not ratable
	①	②	X❸	④	⑨

Axis IV - Structure	high	1.5	moderate	2.5	low	3.5	disintegrated	not rateable
1a Self-perception	①	X	②		③		④	⑨
1b Object perception	①	X	②		③		④	⑨
2a Self regulation	①		X❷		③		④	⑨
2b Regulation of object relationship	①		X❷		③		④	⑨
3a Internal communication	①		X❷		③		④	⑨
3b Communication with the external world	①		X❷		③		④	⑨
4a Attachment to internal objects	①		X❷		③		④	⑨
4b Attachment to external objects	①		X❷		③		④	⑨
5 Structure total	①		X❷		③		④	⑨

Axis V: Mental and psychosomatic disorders

Va: Mental disorders	ICD 10 (Research criteria)	DSM-IV (optional)
Main diagnosis:	F 54.13	_____. ____
additional diagnosis 1:	F _____. _____	_____. ____
additional diagnosis 2:	F _____. _____	_____. ____
additional diagnosis 3:	F _____. _____	_____. ____

Vb: Personality disorders	ICD 10 (F60xx or F61.x)	DSM-IV (optional)
Main diagnosis:	F _____. _____	_____. ____

additional diagnosis 1:	F _____. _____	_____. ____

For diagnoses on axis Va and Vb:	① = Axis Va
Which disorder is clinically prevalent?	② = Axis Vb
For diagnoses in line with DSM-IV	① = mental disorder
Which disorder is clinically prevalent?	② = personality disorder

Vc: Somatic illnesses:	ICD 10 (not chapter V (F)!)	DSM-IV (optional)
Main diagnosis:	F _____. _____	_____. ____
additional diagnosis 1:	F _____. _____	_____. ____
additional diagnosis 2:	F _____. _____	_____. ____
additional diagnosis 3:	F _____. _____	_____. ____

Patient:	Code:	Age:	Gender: X❶= female	Date:
	Driven out ..._	___42__	② = male	
Diagnostician:	Code:	Age:	Gender: ① = female	Institution:
	OPD-2 Work group	_____	② = male	_____

6.3 Comments on the evaluation

6.3.1 Experience of illness and prerequisites for treatment

The severity of the disorder is to be rated as comparatively "low". There were few complications in the course of the colitis. So far, only a single serious phase has occurred, which required treatment with cortisone. Currently there is some bleeding; there are, however, no serious symptoms. Psychological complaints are present in the form of depressive moods, which, however, are not greatly detrimental. On the GAF scale, the total item value is 75, based on the subjectively experienced stresses in connection with the teaching activity. The EQD-5 shows no results in four areas (coding 1). In the area of physical complaints, a "moderate intensity" (coding 2) can be marked. The leading symptoms (colitis) have been present for six years (category 5-10 years), at first manifestation of the symptoms the patient was 36 years old.

The subjective suffering is rated as "medium", as the patient is clearly suffering from her illness. The presentation of both physical and psychological complaints and problems is also to be rated as "medium": both the colitis symptoms and the psychical stresses and strains (especially those connected with the patient's work) are clearly presented. The presentation of social probems is marked as "low", as in the patient's report the difficulty does not lie, in the first place, in the objective external (for example, job-related) circumstances, but in the way she places excessive demands upon herself when dealing with them.

The patient's model of illness does not become totally clear in the interview. She seems inclined to acknowledge psychological influences on her colitis and to seek improvement through psychotherapy. This inclination does, however, not appear

genuine, but is at least partially generated by the specialist advice she received so far. It was not explored to what degree the patient's concept of illness is basedon somatic factors; this item is therefore "not ratable". A conception of illness based on psychological factors seems only present in "low" intensity. In the end, it remains very questionable whether the patient recognizes the connections that have been worked out in the conversations as relevant for the disorder. A positive indication here are most likely those statements of the patient in which she describes her way of coping with stress, like her perfect functioning when demands are made upon her, and the psychological collapse afterwards. The patient's conception of the illness also shows a "low" orientation to social factors.

As to the past, stresses of that kind are ascribed to the migration and its consequences, but are currently relegated to the background.

As concerns the desired treatment form, a wish for somatic treatment cannot be discerned ("not ratable"). The wish for psychotherapeutic treatment is rated as "medium", as the patient's own motivation here is limited. Assistance in the social area is not desired ("absent").

The patient's personal resources are rated "medium", as both professionally and privately, she holds on to a way of living unaffected by her illness and is, overall, rather successful with this approach. She is able to recognize her own vulnerabilities, without, however, being able to draw the necessary and lasting practical consequences as to how she could care for herself better. Her social support is rated as "medium", as she appears to have good support from her family, but beyond this, gives the impression of being a single combatant in her fight with life and is able to use other people, including the therapist, only to a limited degree in the sense of instrumental or emotional support for coping with her problems.

External impediments to change are not discernible - with the exception of her strong professional engagement ("none/hardly present (absent)"). Internal impediments to change are rated as "high", as the interview and a previous treatment attempt hashown that she is unable, despite a basic interest, to accept the patient role, that is to say, after all, experiences it as an imposition upon her, which puts her under enormous pressure. She is therefore unable to experience the helpful and beneficial aspects of the psychotherapy on offer.

As the interview, after all, is about whether or not to suggest a psychotherapeutic treatment, the items of the "psychotherapy module" are relevant, too. Judging from the sum of impressions, it is very likely that the patient presented herself, first of all, because of her physical symptoms, and that she wishes to obtain relief here. This is, however, not made explicit, so that in the area of patient's concepts about change the item "symptom reduction" is assessed as "not ratable". In the same way, although the items "reflective-clarifying of motives /conflict oriented" and "emotional-supportive" were not explicitly inquired about, they can be rated as "low", based on the preceding discussion. The patient, who has a strong tendency towards control and self-availability, offers the investigator no position from which she could be addressed in an emotionally-supportive way. The wish for active-directive assistance in the sense of providing expertise becomes clear when a former psychotherapeutic contact is described. The patient reports that she invited her

therapist to give her expert advice, and to enlighten her about her difficulties, instead of leaving the initiative to her (active-directive: "high"). The patient's psychological mindedness is rated "medium". In a differentiated manner, she lists intrapsychic processes, but does not, however, in the final instance, recognize their relevance with respect to her complaints and problems. Secondary gain from illness seems to be "absent", or "hardly" present, as the patient seems not to gain anything, subjectively, through her illness, while on the other hand, her self-image is clearly affected.

6.3.2 Relationship

The patient reports relationships of varying quality, but in doing so, describes one particularly difficult relationship scenario from which she seems to suffer again and again: more than anywhere else, she seems to encounter again and again, the same situation in her job, in which she, to the point of exhaustion, tries to meet the demands and expectations of others. In her job as a trainer she at times feels like a "whore", by making herself available to others and, so-to-speak, letting them use her, without experiencing any pleasure herself. Although she receives a lot of recognition, she feels under constant pressure to perform. She reacts to even the slightest criticism with total insecurity and needs days each time to stabilise herself. From the outside, however, she shows no weakness whatsoever; she always functions, as it were, no matter what is happening.

The relationship scenario described by the patient can also be noticed also in the interview itself. She seems to try to provide answers to the investigator accurately. After 15 minutes a key situation occurs: The patient talks about her migration to Germany and the related stresses, whereupon the investigator asks her whether the colonic bleeding had occurred for the first time then. The patient denies this. Shortly afterwards there is a longer silence, with the patient looking visibly embarrassed. Eventually she ends this pause by saying she had been to see a doctor in the past, at a time when there had been no bleeding. In that respect, her conscience was clearer by far now, as the complaints were acute. Apparently, she took the question of the investigator critically (in the sense of, perhaps, him asking: Has what you are saying here, anything to do with your complaints at all? What then do you want here?) and fears being unable to adequately fulfil his expectations. On the basis of this material, the patient's experiential perspective can be described along the following lines:

Experiential perspective of the patient

She experiences others as critical, demanding, and therefore as controlling (item 10). If she fails to meet their demands, others, in her experience, become dissatisfied and critical (item 12); she then feels put to shame because of her failure. She experiences herself as adjusting to the demands (she "functions"), and caring for others (item 26 and 7).

To the outside world, the patient appears as lecturing, strong-minded, and hard to please. In the interviewer there is a feeling that one has to be on one's guard with the patient, and avoid showing one's igorance, in order not to be subject to reproach or devaluation. At the end of the conversation, she reports an episode from a past attempt at psychotherapy, which confirms this impression. From various signs she thought she was able to conclude that her then therapist was weary of

her and wanted to get rid of her. When, one day, she was waiting for her session, a door was loudly slammed shut, which she regarded as proof that her perception was correct. When she energetically confronted the therapist, he rejected her assumption. After that, she ended the treatment.

With this in mind, but also with a view to how the patient acts and presents herself in the session, a dilemma arises in the countertransference: On the one hand, one is tempted to want to soothe the patient, in order to mitigate her suspicions and to protect oneself against an attack. This, on the other hand, appears risky, because she might experience the caution the other person is taking as a sign of reservation towards her and might feel doubted. Alternatively, one is inclined to take the offensive and correct her distorted perception, which she, however (as in the case of her former therapist), would experience all the more as an embarrassing criticism to which she would respond with an attack.

The experiential perspectives of others

Others experience the patient as demanding and controlling (10) and fear doing something wrong and thereby exposng themselves to her criticism and depreciation (11, 12). They react by either complying, holding back, resigning (26), or by responding in an accusing and reproachful way (12).

A relationship dynamic formulation which integrates both experiential perspectives could be the following:

Relationship dynamic formulation

The patient experiences others as demanding and fears failure in the face of this demand and being shamed. She attempts to avoid this by adjusting, and by caring very much for others. In contrast to this self-perception she appears hard to please, demanding, and critical to the outside world. This forces others to either be very careful with her and protect themselves, or, to correct her in an offensive manner. There is the danger that she experienences both these responses as a sign that she is not meeting demands and has failed.

6.3.3 Conflict

When working with Axis III, a decision must be made firstly with respect to four criteria whether a conflict rating is at all possible. It must be established, whether, based on the available material, there is sufficient diagnostic security (A). In the present example, this is the case. It must further be determined whether the level of structural integration is high enough for well-circumscribed dysfunctional conflicts to evolve and take shape (B). This is also the case. In a next step, it must be ascertained whether conflicts are perhaps not rateable due to an impaired perception of conflict and affect by means of defence (C). This question can be answered in the negative as conflicts and their related affective meanings are clearly recognizable in the interview. Eventually, one must also respond negatively to the question of whether a conflict-based stress, in the sense of a stressor-induced conflict, without dysfunctional repetitive conflictual patterns is present (D). While it is true that the patient has experienced considerable stress because of her migration, her difficulties are caused by ongoing, life-determining conflictual potentials. Furthermore, the reported stress lies very clearly outside the six-month time window mentioned in the manual. It can therefore be concluded that conflict

rating is possible, and that not only conflictual schemas, but also well-defined conflicts are present.

The relationship pattern mentioned in the relationship dynamic formulation above is determined mainly by themes of self-worth, and less so by themes of control. The affect of shame, equally important for both conflicts, clearly stands out, as well as the tendency towards self-deprecation, and the importance of social prestige and reputation. The self-worth conflict is thus rated "very significant", the prevailing mode of coping is "active". In addition, the patient is extremely self-controlling and orientates herself by internal yardsticks of performance; in the contact with the investigator she scrutinizes what is said and tends to lecture. It transpires from her descriptions that she is also very controlling in her private life. The conflict of submission versus control, therefore, is rated "significant", the mode of dealing with this conflict is, again, predominantly "active".

While these two conflicts dominate in the directly observable relationship behaviour, the patient's reports, in substance, concern mainly themes of care. Her life story is characterized by the fate of the migration her family suffered, the uprooting this has caused, and the loss of her homeland. She gives several examples to describe how important family, friends, and relatives are to her, and who provide safety and comfort for her,. The geographical distance between her and her parents who live in another city, is painful for her. On the level of affects, what can be felt is mourning and the theme of loss. The conflict of care versus autarky is thus rated "very significant", too. The predominant mode this time is a passive one, whereby active moments do occur, above all as an "overly caring" behaviour towards others. There is a danger here for clinicians participating in training seminars to overlook this conflict, because they tend to let themselves be impressed by the patient's appearance and behaviour in the conversation and therefore do not properly appreciate the content of her descriptions.

Of lesser importance are two further conflicts: the patient indicates a lovingly-committed closeness to her father, while her mother remains colourless. Apart from her, other women do not get mentioned. The theme of sexuality is avoided and appears strangely remote even in places where the listener's interest is piqued (for example in the story about the close friendship with a work colleague). In contrast to such "naivetë" in the reported stories, the patient's appearance and behaviour have "phallic" features, being dressed in a short-skirted costume adding a provocative note. Additional important aspects of the oedipal conflict are not sufficiently cleared up, those which are visible, however, prove to be "insignificant". The mode of coping is active as to her appearance and behaviour, and passive as to the contents she relates, which is to say, mixed overall. The migration and her effort to adjust to to Western society and to master the demands of a market economy, can, in some aspects, be understood as the overcompensating-strenuous acqusition of a foreign sociocultural role, in the sense of the active mode of the identity conflict. As important parts of this dynamic are, however, already covered by the other conflicts mentioned (especially care, self-worth, and control), this conflict is rated as "insignificant". All other conflicts are rated as "absent".

The main conflict is care versus autarky, the second most important conflict is the self-worth conflict. The mode of coping must be rated with reference to the main

conflict and is therefore "predominantly passive". With a view to the other conflicts, especially the self-worth conflict, and the conflict of submission versus control, an active mode is prevalent, which, as has been shown, governs the patient's appearance and behaviour over long stretches of the conversation.

6.3.4 Structure

The fact that several well- delineated conflicts can be distinguished in this patient, points to reasonable level of structural integration. Although some functions, like, for instance, object perception, may be clearly restricted in times of conflict and stress, the fundamentally available structural abilities became evident again and again in less stressful moments.

The level of integration for self-perception as well as for object perception, in the sense of a cognitive ability, is to be rated between "good" and "moderate". It must, however, be taken into account that, due to her histrionic style, the patient's descriptions frequently appear rather bold and exaggerated; the possibilities actually available to her become more clearly highlighted in individual episodes. It is in these episodes that the patient is able to distinctly perceive herself, that is to say, her inclinations and sensitivities, and to describe the inner psychological processes which are linked to these. A restriction results from the fact that self perception in general is skewed towards the negative (self-critical) pole. Her identity seems solid enough, despite her struggle for recognition and adjustment in a Western society which is all foreign to her. The ability for object perception is also basically existent, with her perceptions, however, strongly dictated by her own needs, thus becoming more or less grossly distorted when she is in a state of stress.

Regulation is rated overall as "moderate". The patient comes across as cleary over-regulated. In the area of self regulation, her emotional flexibility and tolerance for her own affects and drive impulses are correspondingly reduced (for affect tolerance and regulation see also the reflections on emotional communication below). Aggressive impulses become effective especially intra-psychically, as self devaluation. They break through into the outside world only in selected areas and under great pressure (as in the above example of the therapy attempt). The feeling of self-worth is very fragile, thus representing a weakness which has a stressful, but no lastingly destructive effect on interpersonal relationships. However, we can be sure that this represents the most important restriction, relatively speaking, in the area of regulation. In the area of regulation of object relationships, we notice a strikingly high degree of control and rigidity. The interests and demands of others are overemphasized in the patient's subjective experience. Aggressive object-directed impulses which arise especially due to the patient's great sensitivity to emotional hurts are inhibited through the over-regulation and are shown directly only in exceptional situations, so that her relating to others appears chronically strained, or tense.

The various aspects of emotional communication require a more differentiated examination. Communication with the external world is visibly impaired by the patient’s rigidity, and is made more difficult through her sensitivity to being emotionally hurt. There is a clear tendency to interpret behaviour and signals of others from her own perspective. These are all signs of a "moderate" level of structural integration. Even more restricted are her possibilites of internal

communication, or, in other words, of a reanimation of the self in the inner dialogue. The patient's self-referential abilities succeed primarily cognitively (cf. self perception), and less so through a lively association with her own affects, fantasies, and her physicality. She describes her most severe phase of colitis, which needed to be treated with cortisone. This phase happened when her husband was suddenly given notice at his job. The patient comments she had never before seen her husband, who otherwise radiated calm and was solid as a rock, in such a disintegrated state. It had been the one and only time where she had had to be the strong one. Her presentation is very impressive in showing how severley her feeling of security had been shattered by this and how serious the resulting threat was, to which she responded with an agitated panic she could hardly understand herself. Although the conflictual theme of care/autarky plays an important role also in this example (loss of safety and comfort), what this reveals at the same time is a structural vulnerability which points in the direction of a low level of structural integration: The patient is existentially dependent on circumstances and persons which support her, offer her security, and are absolutely reliable; she has great difficulty in representing such strong emotional states intra-psychically, in tolerating the affects that arise in this context (aspect of self regulation, see above), and to work with them internally. Because some capacities for internal communication are basically available to her, even though they are equally restricted in other areas, this dimension is rated overall "moderately" integrated.

In both dimensions of attachment, her attachment to internal objects and the attachment to external objects is rated "moderate". As just set out, there is an intense dependency on supporting objects; the central fear consists in losing the supporting and regulating object. In addition, the ability to regulate herself with the help of good internal objects is just as restricted as the ability to appropriately avail herself of outside help. When all of the discussed structural characteristics are considered and assessed, the level of structural integration must be rated as "moderate", also.

6.3.5 Mental and psychosomatic disorders

The diagnosis F54.13 diagnoses mental and behavioural influences in an illness classified elsewhere, that is to say, in this case, a protocolitis. The digits in third and fourth position, which additionally qualify, point to predominantly depressive symptoms, which, with reference to the basic illness, have a causal and, as concerns the course of the illness, stabilizing effect. The patient further shows the characteristics of a histrionic personality, whereby the abnormalities lie, however, below the threshold of a clinically diagnosable personality disorder.

6.3.6 Integration of the axes

Characteristically for this patient is a specific constellation of several conflicts, which are dealt with in a predominantly active mode (that is to say by compensation, reaction formation, or contraphobic behaviour). This applies for the self-worth conflict, identity conflict, the conflict control versus submission, and to a large extent also for the oedipal conflict. The antithesis to these conflicts is formed by the theme of care (conflict of care versus autarky), with a coping mode that focuses predominantly on the passive. Therefore, as soon as the patient succumbs to her needs for control, prestige, and phallic rivalry within the context of her active

coping mode, her connection with her passive needs for comfort and safety gets lost with the consequence that she exhausts and overtaxes herself. As the predominant active mode of coping reveals itself, above all, in how the patient habitually shapes her relationships, these are characterized by control, prestige, devaluation, and rivalry. The opposite yearnings for safety are hardly noticeable in the patient's offer of relationship and can be inferred, instead, from the contents of her reported life story and from the caring feeling that comes up in the countertransference when listening to her report.

The patient's descriptions of the situations that trigger her symptoms reveal that her most pronounced vulnerabilities lie pretty close to the problematic area of care and safety. As described above, a serious crisis of her otherwise reliably supportive husband leads to severe symptoms of colitis. Further exacerbations occur during times of rest after the strains of her job have passed . It is evident in selected areas that in those situations of basic insecurity or regressive temptation, existential feelings of insecurity and threat come up, which cannot be sufficiently represented and grasped mentally. They are therefore expressed merely as diffuse, panic-like agitation, or through physical symptoms like the renewed phase of colitis. The conflictual events are therefore further complicated by a specific structure-based vulnerability, which is reflected, above all, in the area of affective self-reference (communication within), where overlaps exist with the structural aspects of affect tolerance (self regulation), and of the introjects (dependency on regulating objects: attachment). On the one hand, the symptoms are equivalent to a compromise formation, in so far as a consciously inaccessible need presents itself in somatic form. At the same time, those symptoms directly express the described structural limitation or vulnerability (cf. Chapter 6.3.4).

The patient's habitual relationship behaviour may be seen as an attempt at mastery not only of the conflict potentials, but also of the structure-based vulnerabilities. Its character is active-compensatory, thus avoiding the central sensitivities connected with a passively-dependent position. This relationship behaviour has itself the rank of a symptom, due to its being so readily noticeable and insistent, and displays the characteristics of a histrionic personality, which, however, is below the threshold of a clinically diagnosable personality disorder. With reference to the prerequisites for treatment (Axis I), this mode of coping is problematic due to its active orientation, because, as set out in section 6.3.1, the patient has no choice but to experience her illness as a threat to her self-worth, her self-availability, and self-regulation. The difficulties that arise when trying to establish a psychotherapeutic working relationship, given that the offer of relationship she reveals here, have already been presented when the patient's dysfunctional relationship pattern was discussed.

7 Focus selection and treatment planning

Since the first manual was published in 1996, OPD has further developed from a diagnostic system into a structuring and planning tool for practical therapeutic work. An important step in this direction were two therapy studies (Grande et al., 2001; Grande et al., 2003; Rudolf et al., 2001b) in which OPD was used to measure change beyond the level of symptoms. For this purpose, individual foci are defined for each patient on the basis of the OPD ratings and used to observe the course of the treatment and to record the therapeutic progress that has been made. Details of this procedure to assess change are described in chapter 8.

This procedure can be made available for use in practical therapeutic work without major difficulties. For this purpose, OPD ratings are produced and, from them, those particularly problematical items are selected which cause or maintain the disturbance, and which must therefore be the starting point for the therapeutic work. The selection of those foci simultaneously has consequences for the therapeutic procedure, for example, for the choice of a suitable setting, therapeutic stance, and the appropriate interventions. A particular role is thereby assigned to the differentiation between those parts of the disturbance which are due to conflict, and those which are due to structure and the resulting consequences for the treatment (cf. Rudolf, 2004b). It should fundamentally be possible to formulate specific guidelines along which treatment could be oriented for each focus constellation. What this does, of course, is outline a very extensive and complex programme. The baseline upon which decisions in the focus formulation rest will be introduced in the following for each of the individual axes. Before we do this, however, let us present the steps by which a treatment indication is arrived at with the example of Axis I.

7.1 Establishing the indication for treatment on the basis of OPD Axis I

Axis I aims to establish which treatment is indicated for a patient based on the severity of his illness or his problem, the way he experiences his illness, his concepts about the illness, and his expectations regarding the treatment. In this phase he following differentiations should be made: how far a psychotherapy is indicated at all for a given patient: whether he should be further diagnosed psychosomatically, or receive a consultation: how far a somatically oriented treatment is indicated which should perhaps be supported by motivating measures: or whether perhaps no further treatment is indicated at all. The question of which kind of psychotherapy is indicated in each case cannot, however, be answered on the basis of the results of Axis I alone, but must take into account the results obtained with the whole OPD diagnostic process.

If a psychotherapy is indicated, a next step would be the planning of the treatment, which comprises both the formulation of therapeutic aims (foci) and the selection of the appropriate psychotherapeutic approaches for the realization of these aims. Establishing therapeutic aims follows a process, that is to say, in different phases of the therapeutic process, therapeutic aims or foci are established, which, as a rule, build on each other. This chapter describes how to rate the

findings when establishing an indication for psychotherapy on the basis of Axis I, and thereafter, will show the selection and decision processes which are involved when formulating the foci for the interpersonal relations, conflicts, and structure axes.

The following step-by-step decisions must be taken when clarifying the indication for treatment of a given patient on the basis of Axis I:

1. Clarify whether there is a disturbance at all which needs to be treated, and especially so, one that needs psychosomatic/psychotherapeutic treatment.

In so far as the patient shows evidence of an illness or problem that needs treatment, the following aspects must be examined:

2. Is the patient's subjective suffering sufficiently motivating for the patient to say: "I must change something!"?
3. Does the patient's presentation of his problem also comprise psychosocial aspects?
4. Does the patient take psychosocial factors into account in his concept of the illness?
5. Is the patient basically motivated to engage in a form of psychotherapy?
6. Does the patient have enough internal resources to participate in a psychotherapy constructively?
7. Are there internal or external obstacles to the patient starting a psychotherapy, or to his reliable and continuous participation in a therapy, or is there, perhaps, a marked secondary gain from illness?

The individual items on Axis I have a different relevance for the differential indication:

The ratings on the current severity of the illness/the problem (1.1., 1.2 and 1.3) and the duration of the disturbance indicate first of all whether an illness or a problem requiring treatment is present at all, and how far, judging against this background, relevant impairments of bodily functions and (psychosocial) adaptation (GAF) have occurred. One can assume that a higher degree of severity of the illness, a larger extent of functional impairments, as well as a greater number of adjustment problems would point towards the indication of a more in-depth psychosomatic diagnostic process and consultation, or psychotherapy, respectively.

The item of "subjective suffering", too, is only indirectly linked to the issue of differential indication. A patient with a high degree of suffering will probably have a greater motivation to change; in order to find out which goals the patient has regarding change, and what he imagines the change process - the therapy - to be like, the other items on Axis I must be used. In any case, the patient should show a certain degree of subjective suffering for a treatment (psychotherapeutic or somatic) to be indicated.

To highlight the relevance of items under numbers 3 -to 7 of Axis I for the issue of indication, we put together typically ideal item configurations, the first of which characterizes a patient who is well prepared for psychotherapy (psychotherapeutically-oriented patient), and the second of which represents a patient who entertains rather somatic concepts of illness and treatment expectations.

Table 7-1: The "psychotherapeutically oriented patient"

On the following items, the patient shows a medium to very high score (2-4):	
3.1	Subjective suffering
3.3	Presentation of psychological complaints and problems
3.4	Presentation of social problems
4.2	Concept of illness oriented to psychological factors
4.3	Concept of illness oriented to social factors
5.2	Desired treatment form: psychotherapeutic treatment
5.P1	Symptom reduction
5.P2	Reflecting-clarifying of motives /conflict oriented
5.P3	Emotional-supportive
5.P4	Active-directive
6.1	Internal resources of the patient
6.2	Psycho-social support
6.P1	Psychological mindedness
On the following items, the patient shows a low score (2-4):	
7.1	External impediments to change
7.2	Internal impediments to change
7.P1	Secondary gain from illness /conditions maintaining the problem

Table 7-2: The "somatically oriented patient"

On the following items, the patient shows a medium to very high score (2-4):	
3.2	Presentation of physical complaints and problems
4.1	Concept of illness oriented to somatic factors
5.1	Desired treatment form: somatic treatment
7.1	External impediments to change
7.2	Internal impediments to change
7.P1	Secondary gain from illness /conditions maintaining the problem
On the following items, the patient shows a low score (2-4):	
6.1	Internal resources of the patient
6.P1	Psychological mindedness

As a rule, patients will show "mixed" characteristics/ratings, that is to say, some patterns of items of a given patient suggest a more somatic orientation, while

others signal a stronger orientation towards psychotherapy. In these cases it is possible to compare the number of items with different foci (somatic orientation versus psychotherapeutic orientation) to each other. If the patient shows a clear tendency towards a somatic orientation across all items, the question of whether a psychotherapy is indicated should initially be handled with caution. In this case much speaks for the fact that patients for whom, based on their existing illness or problem a psychotherapy would principally be indicated, first of all need treatment to enhance their motivation for psychotherapy.

"Leading items" for the indication for psychotherapy are considered to be the items "desired treatment form: psychotherapeutic treatment" (5.2, 5.P1-5.P3), "resources of the patient" (6.1), and "psychological mindedness" (6.P1). In so far as the patient, from the investigator's perspective, displays a psychotherapeutic orientation in these item areas, a psychotherapy, or depending on the the presenting problem, a psychosomatic treatment should be considered.

Positive statements that would warrant a psychotherapy indication may, however, be put into perspective by items such as "External impediments to change" (7.1), "Internal impediments to change" (7.2), and "secondary gain from illness/conditions maintaining the problem" (7.P1). Marked external impediments to change, like absence of offers of therapy or costs which are not covered, may result in a well-motivated patient not taking up the respective psychotherapy. If secondary gain from illness is high, this will induce even a patient with a "psychosocial concept about illness" to show only a limited motivation and readiness for change, which applies both to psychotherapeutic as well as somatic treatments.

7.2 Determination of foci on the basis of OPD Axes II-IV

Therapeutic foci are selected based on the diagnostic results from the three psychodynamic OPD axes: relationship, conflict, and structure. The following briefly summarizes again the logic behind these results:

A psychotherapy can be planned and therapeutic foci and strategies determined as soon as the prerequisites for treatment have been clarified, an indication for psychotherapy is warranted, and treatment can be scheduled with the patient. The characteristics gathered on Axis I, like, subjective suffering, the patient's concept about the illness, and his concepts about change, the desired treatment, the impediments to change, and the secondary gain from the illness, have so far represented important, if not decisively critical aspects for the interviewer's decision and for his negotiations with the patient. They now take a backseat, making room for considerations about the content and aims of the planned treatment. It is at this point that the OPD axes relationship, conflict, and structure, which are psychodynamic in a more specific sense, become the centre of attention. Together, they represent the psychodynamic findings and thus form the basis for the selection of those foci, along which the therapeutic work will be oriented. The procedure for the selection of therapeutic foci, as well as the considerations regarding therapeutic strategies will be discussed in the following. As a first step, however, we need to link this with the results of the diagnostic process, in which the essential components of the psychodynamic results in accordance with OPD are briefly summarized.

Relationship

Figure 7-1 shows the schema introduced in section 4.2.3.5 for the diagnostic identification of dysfunctional relationship patterns. The box on the upper right is the access point for the pattern: The patient generally perceives the behaviour of others as a bother, or a disappointment, to which he must react. He mostly experiences himself as passive or responding to things, that is to say, not as someone taking the initiative, and thus someone who carries responsibility (connection I). In contrast, others experience the patient in no way as only reacting, but instead, as offering a difficult relationship (II). With his offers of relationships the patient is suggesting certain reactions, which can be experienced as impulses in the countertransference (III). If others give in to these impulses and react correspondingly, the patient is likely to experience this as a repetition of those disappointments, which he had always expected and feared (IV). In this way, a maladaptive feedback loop develops.

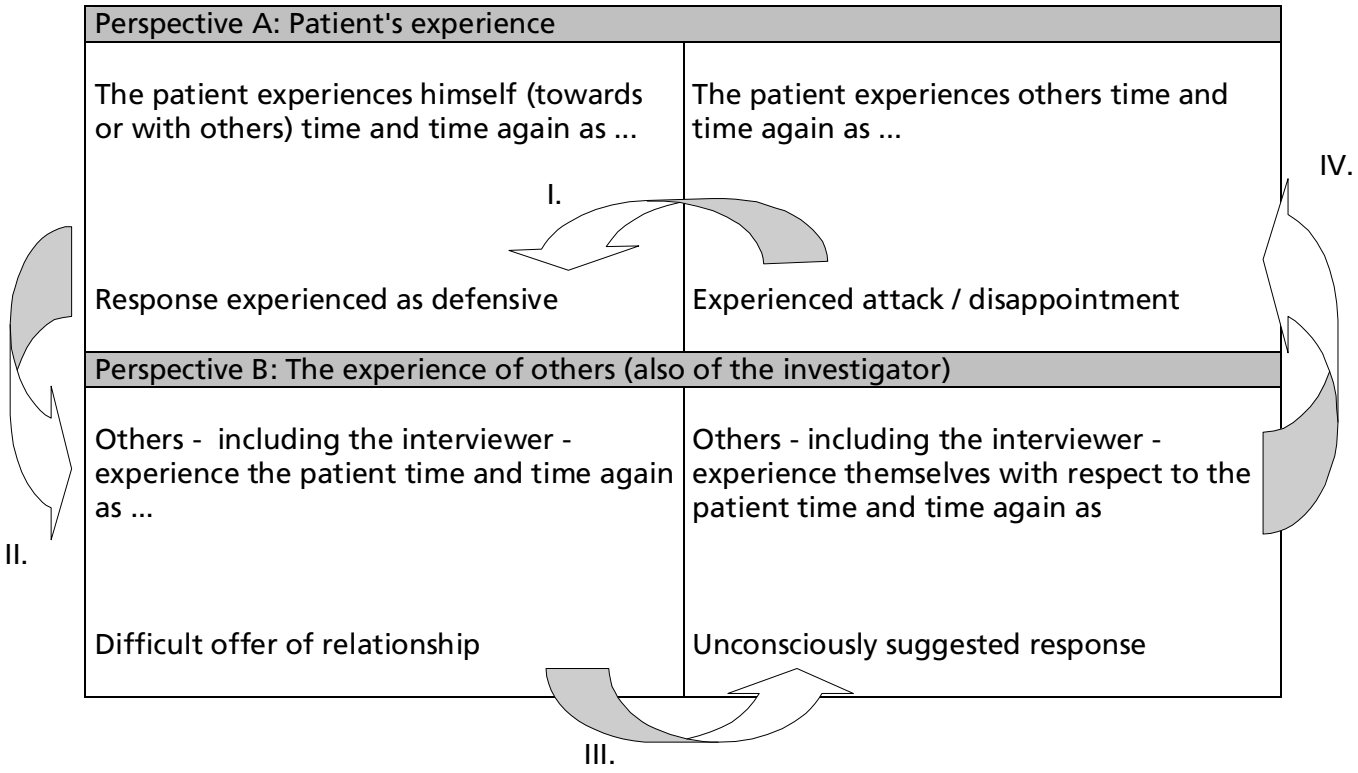


Figure 7-1: Relationship diagnostic schema

By way of example (cf. Chapter 6), a relationship-dynamic formulation in accordance with the above scheme might read as follows: "The patient experiences others as demanding and fears failure in the face of this demand and feeling shamed. She attempts to avoid this by adjusting, and by caring very much for others. In contrast to this self-perception she appears hard to please, demanding, and critical to the outside world. This gets others to either be very careful with her

and protect themselves, or, to correct her in an offensive manner. There is the danger that she experienences both these responses as a sign that she is not meeting demands and has failed".

Conflict

To infer potentially conflictual foci from the OPD findings is a relatively easy task: Basically, those two conflicts are considered foci which, in the rating, were designated as main conflict, and second most important conflict (cf. section 4.3).

C1. Individuation versus dependency

C2. Submission versus control

C3. Need for care versus autarky

C4. Self-worth conflict

C5. Guilt conflict

C6. Oedipal conflict

C7. Identity conflict

Structure

When selecting structural foci we must first of all examine how big a share the structural limitations take up in the actual disturbance of the patient, and secondly, which aspects of the disturbance are based on conflicts. The weighting of the structure-based limitations can be determined, once the eight structural dimensions, including the overall level of structural integration, as well as the intensity of the conflicts, have been rated and assessed and are thus available (cf. Table 4-8 and Table 4-17). A comparison between the structure and conflict diagnoses will reveal the importance of structural characteristics for the diagnostic understanding and for selecting therapeutic aims. If structural aspects are important, they can then be specified in accordance with the list of structural abilities (cf. Table 7-3).

Table 7-3: Overview of structural abilities

Self-perception and object perception			
Self-perception		Object perception	
ST1.1	Self reflection	ST1.4	Self-object differentiation

ST1.2	Affect differentiation	ST1.5	Whole-object perception
ST1.3	Identity	ST1.6	Realistic object perception

Regulation			
Self-regulation		Regulation of object relationship	
ST2.1	Impulse control	ST2.4	Protecting the relationship
ST2.2	Affect tolerance	ST2.5	Balancing of interests
ST2.3	Self-worth regulation	ST2.6	Anticipation

Emotional communication			
Communication within		Communication with the external world	
ST3.1	Experiencing affects	ST3.4	Establishing contact with others
ST3.2	Using fantasy	ST3.5	Communication of affect
ST3.3	Bodily self	ST3.6	Empathy

Attachment			
Attachment to internal objects		Attachment to external objects	
ST4.1	Internalization	ST4.4	Ability to form attachments
ST4.2	Use of introjects	ST4.5	Accepting help
ST4.3	Variability of attachments	ST4.6	Severing of attachments

7.3 Principles of focus selection

When selecting a focus for therapeutic work, numerous aspects play a role which are not exclusively about the type of the disturbance, but also have to do with the circumstantial conditions of a therapy: A treatment may, for instance, be time-limited, which is why the therapeutic task is to be formulated in a way that it can be solved within the limitation. Also, specific aspects of a disturbance may come to the fore with particular intensity, when they have been actualized by certain life circumstances and events. Eventually, it may make sense to start work on those problems to which the patient already has some access, and for which he can be most easily gained as a partner in a therapeutic alliance. In these and similar cases,

the procedure will be to select those foci, from a series of principally available foci, which offer themselves for selection based on the specific circumstances. Only later will an attempt be made to advance to other, possibly more fundamental aspects of the disturbance.

On the other hand it is important, to first of all examine a disturbance without too narrow a consideration of such limitations, and to work out the basic difficulties a patient has in handling his relationships, his conflict potentials and structural characteristics, what he should be changing in all of these, and what should therefore be worked on therapeutically. In such an analysis the OPD findings represent an important piece of support. What can be considered as foci are those characteristics of the OPD findings which (together with other factors) cause and maintain the disturbance, and which, therefore, play a key role in the psychodynamic of the clinical picture. This comes with the assumption, that something with respect to those foci must change, if substantial therapeutic progress is to be achieved. With this proviso, one or more foci may be selected from the OPD findings. As experiences from studies referred to at the beginning of this chapter have shown, several foci are usually needed to give a comprehensive picture of a disturbance in all its various aspects (Grande et al., 2001; Rudolf et al., 2000).

In order to select the therapeutically relevant foci, the therapist must gain a picture of the dynamic interrelationships and dependencies between the various aspects of the disturbance, which are recorded in the OPD findings. They may be interlinked and interact with each other. It may happen, for example, that a problematic conflictual theme imposes itself on the therapist, superficially, which, if studied in greater detail, is found to serve above all for coping with another conflict which lies behind this, or with a structure-based vulnerability, which would then represent the actual, or underlying deeper problem.

Example: A 40-year-old patient handles his relationships by displaying righteous and controlling behaviours, so that in past relationships there had been repeated frustrating power struggles, and eventually, separations (conflict: submission versus control). A closer analysis reveals that the patient uses this behaviour to regulate closeness and distance in relationships and, in this manner, copes with his fear of losing his own boundaries and of being overwhelmed by an intimate closeness of another person to him (individuation versus dependency as the deeper-lying conflict, and thus primary focus).

The selection of structural foci is occasionally made more difficult by the fact that several, or many, of the structural abilities of a patient are similarly restricted, and thus the question arises which of the possible foci should be preferentially selected. The reason for this difficulty is that the various structural characteristics are often closely linked with and dependent on each other, so that the limitation of one function is concomitant with deficits in other functions. When selecting foci it must therefore be examined which specific restrictions of functions are the primary cause of the impairment of structure overall. In most cases, other structure-related difficulties derive from this, but are of secondary importance, and therefore less suited as a therapeutic focus. To give an example: a patient's deficient object perception may be caused through the fact that his identity is fragile, and that he, as it were, "loses" himself in the relationship with others. Developing and

differentiating that which is his "own" would, in this case, be a prerequisite for him to gain stability vis-à-vis the object world and to be able to orient himself there more securely. This would mean that his limitations in the area of self-perception (identity) would form the primary focus when compared to the deficits in object perception, and that, at the same time, one could expect that these deficits will change, quasi "of their own accord", during the course of working on the primary focus.

7.4 Component parts of the foci

As set out in section 3.6, the dysfunctional relationship pattern combines all conflict-based dispositions and structural difficulties of a patient into a complex gestalt. The relationship pattern, therefore, is basically always at the centre of the therapeutic work. As will be shown in greater detail still, the type of therapeutic work done on the relationship may be very different depending on whether it is determined more by structural characteristics, or rather, by conflicts.

When determining the foci on the other two psychodynamic axes, namely Axes III and IV, attention must be paid to the fact that the weighting of the structural and conflict-related parts may vary, depending on the type of disturbance, and that this ratio should be reflected in the focus selection. In unequivocal cases a selection of exclusively conflictual or exclusively structural foci may be made. In most cases, however, both aspects are important, so that a mixture of foci is the rule. Studies have shown that in cases of an overall low level of structural integration certain conflicts (individuation versus dependency) are particularly frequent. In contrast, in cases of high levels of structural integration, oedipal conflicts, for instance, are the most frequent, relatively speaking (Grande et al., 1998a; Rudolf et al., 2004a). Based on our experiences so far (Grande et al., 2001; Grande et al., 2003; Rudolf et al., 2002a) we suggest the selection of a total of five foci according to the following guidelines:

- The dysfunctional relationship pattern summarized in the relationship-dynamic formulation is compulsory and forms one of the foci in any case.
- From the axes "conflict" and "structure", up to further four foci can be selected. The number of foci taken from each axis may vary, depending on the extent of the structure-based or conflict-related limitations. This means that in the extreme case, all four foci may be selected from the structure axis, but also, that any other combination may be chosen. In disturbances which are clearly due to conflict, it may happen that two or three conflicts are sufficient for the description of the disturbance, and structural foci are dropped altogether. This is possible and leads to the selection of only three or four, instead of five foci.

7.5 Treatment planning and therapeutic aims

With the help of OPD Axis I (Prerequisites for Treatment) it can be diagnostically clarified whether type and intensity of a patient's disturbance basically justify the indication of psychotherapeutic treatment, and what attitudes and expectations the patient has in this respect. If a psychotherapy is in principle indicated, a suitable form of treatment must be selected on the basis of the diagnostic results, and respective therapeutic aims must be formulated.

Difficulties during the course of the therapy frequently result from the fact that structural limitations are of importance in a patient and complicate the work on the conflict dynamic. In the OPD, this aspect has been particularly clearly worked out with the help of an elaborate conflict and structure diagnostic. The therapist is thus enabled to assess the relative weight of aspects of the disturbance which are either due to conflict, or, are structure-related. We recommend, first of all, making a strategic decision at the planning stage of the therapy on the basis of these assessments, about whether the principal therapeutic approach needs to be more conflict-related or structure-related; if we have a mixed disturbance, diagnostically speaking, the conflict-related therapeutic work is made more difficult due to structural limitations. This decision can be represented in a diagramme as follows:

Table 7-4: Establishing a structure or conflict orientation

The basic therapeutic approach in this patient is ...

	clearly	more	mixed	more	clearly	
structure related	☐	☐	☐	☐	☐	conflict-related

From the answer to this question strategies for therapeutic action may then be deduced, which, depending on the situation, either emphasize structure-related work, or are challenging and focus on mobilizing conflicts (cf. Table 7-4). These strategies refer to:

- the therapeutic setting,
- the therapeutic stance,
- the hierarchy that is established regarding the selected foci,
- the handling of dysfunctional relationship potentials,
- the therapeutic techniques.

Depending on the weighting of the limitations due to conflict or due to structure, the following proto-typical disturbances can be distinguished: firstly, predominantly conflict-based disturbances, secondly, predominantly structure-related disturbances, and thirdly, conflict-based disturbances further complicated by structure-based limitations.

Predominantly conflict-based disturbance

In this type of disturbance, mental processes take place against the background of a high or moderate level of structural integration; the disturbance is rated as predominantly conflict-based. Psychodynamically, this is understood as the expression of an unconscious intention, or wish, of the patient. Something in the patient "creates" the wish, the defence, and the resulting compromise formations. Even if the patient is initially unable to take responsibility for it, due to repression, the assumption here is that he is at least basically capable of taking such

responsibility. What consequences does this have for the psychotherapeutic strategy?

Setting

In view of a patient's largely available inner psychical space and structural functions, the therapeutic work can be carried out in an individual or group therapy setting. Depending on the indication, treatment can be effected in a psychoanalytic psychotherapy setting which emphasizes regression and transference, or in a focused, conflict-revealing, regression-limiting setting of a psychodynamic psychotherapy. As the patient is fundamentally responsible for his actions, the therapeutic setting does not have a structure giving, limiting, or supporting task, in the sense of the patient needing to be supplied, from the outside, with structural functions which are absent or insufficient. Such an offer would not challenge the patient to a sufficient degree, as conflict-oriented therapeutic work consists in encouraging the patient's latent capabilities,. The setting defines here rather the framework in which the therapy should take place, as agreed upon by the parties; and which are to be maintained even during phases of high tension. Violations of that framework may be addressed therapeutically as needed, and be interpreted as transference phenomena on the basis of current unconscious conflictual events.

Therapeutic stance

The therapist may rightly assume that the patient transfers his unconscious conflictual experiences onto him. Therefore, the therapist directs his attention to his countertransference and examines the unconscious intentions with which the patient turns towards him. An important therapeutic option consists in pointing out these intentions, or the fears linked to them, and to make them conscious to the patient. The assumption here is that the patient is basically capable of assuming responsibility for his own behaviour, once he has understood and acknowledged the underlying unconscious motives. The therapeutic work is to encourage this option and to actively challenge the patient in this respect. It is carried out, therefore, with the therapist displaying an attitude of benevolent abstinence, which does not intend to protect the patient through offers of a predominantly supportive and containing therapywhich would, perhaps, not present enough of a challenge for the patient.

Determining a hierarchy of foci

The task is to formulate a hypothesis about which of the conflicts forms the core of the disturbance, and which further conflicts are associated with the core conflict, or derive from it. Such interlacing of conflicts is frequent and can be analyzed with OPD more easily now, because, with its help, complex clinical pictures become transparent as layerings of distinguishable, simple, conflicts. Work to reveal the conflict may begin on the associated conflict, which, as to its shape in relation to the core conflict, often has the character of a coping mechanism. The coping that is done in this way may be acknowledged in a first step, and be positively framed. Via an analysis of the cost of these coping efforts, the core conflict can be approached in a second step. Again, it is first of all interpreted in terms of its defensive aspects,

before the interpretations can get any closer to the defended against unconscious intentions.

Example: A depressive female patient shows essentially a care versus autarky conflict, which can be derived from the biographical relationship with her parents and which permeates all her current relationships with spouse, children, and friends. Equally recognizable, albeit of a less important weight and deriving from her need for care, are a self-worth and guilt conflict. In relation to the core conflict of care and autarky, they rather have the character of reparation. The uncovering work in this case (relief from guilt feelings, self-worth stabilization) begins at the derived conflicts, because proceding in this way does not affect the patient's central understanding of herself or make her feel insecure, but rather, is designed to offer relief and stabilization for her.

Working on dysfunctional relationships

The therapist examines for himself, which relationship wishes and fears the patient is directing towards him and towards others. He then forms a hypothesis as to the way in which the patient's offers of relationship can be understood as a compromise formation. In his countertransference, he discovers feelings and impulses which the patient triggers. He eventually manages to get an idea of the entanglements that might arise if he was to give in to these feelings and impulses. Together with the patient he examines the latter's anxieties concerning others, as well as the therapist, and differentiates the relevant affects. In a next step, he focuses on the patient's efforts to protect himself in his relationships because of these anxieties, both in the therapeutic relationship and in relationships with others. The therapist accepts these efforts and frames them in a positive manner. He then does not fail to show the patient the dysfunctional side of his efforts, in particular, the likelihood that his defensive behaviour, in the sense of a self-fulfilling prophecy, may lead to others reacting in disappointing ways so that the patient's anxieties do come true and the actual relationship wishes remain unfulfilled. In this context it may be important to demonstrate to the patient which feelings and impulses he triggers, or be likely to trigger, in others, including the therapist, and the consequences this has, or might have, if others react to these impulses.

Interventions

The therapist may apply those therapeutic interventions designed to encourage, and challenge, the patient's basically available capabilities which, however, may be disguised and limited by defence and compromise formations. For this purpose, all interventions which tend to animate and actualize unconscious conflictual circumstances are suitable. This includes techniques of affect mobilization. In long-term psychotherapies, interventions and therapeutic strategies may be used which encourage regression and intensify the transference relationship. As symptoms and difficulties of the patient which have the quality of a symptom tend to be triggered by certain situations which have a subjective meaning in the context of his life history, that is to say, which are determined by unconscious conflicts, those interpretations which are suitable for working out such meanings become important.

Conflict-oriented intervention techniques have been elaborated in an extensive psychoanalytic literature; a practical compilation for use in psychodynamic psychotherapy can be found in Wöller and Kruse (2005).

Predominantly structure-based disturbance

This disturbance is very clearly characterized by a limited availability of structure-related functions, for instance the ability of self-reflection and affect differentiation, of realistic object perception and empathy, self-regulation and mature defence, to emotional communication and internalization of relationships. The overall level of structural integration shows low scores (moderate to low level of integration, low level of integration, low level of integration to disintegration). Conflictual themes become recognizable, but often are varied and not clearly outlined in the individual case.

A key to understanding the psychodynamics is that the patient's difficulties are not taken as arising from unconscious intentions (wish, defence), but are instead understood as a consequence of a developmentally acquired limitation and fragility of the capacity for self-regulation and handling of relationships. In the sense that an unconscious intention could be ascribed to him, the patient is therefore not to be seen as primarily responsible for his difficulties. In dealing with his structure-based limitations he may, however, at times, show dysfunctional behaviours, which in themselves are problematic (for instance destructive ones), and which represent an activity for which he could be held responsible as originator. It is of central importance, therefore, that a distinction be made, in the therapeutic contact with these patients, between their structure-based inability on the one hand, and, in spite of this, their available options of a secondarily constructive or destructive handling of those situations.

Setting

The more serious the structural disturbance, the more it may become necessary to provide external structures (an indication for an in-patient psychotherapy, day clinics, rehabilitation steps, fostered living in the community), and to encourage competence-building steps and offer possibilities of social learning (training courses and leisure time activities). Out-patient psychotherapies must, on the one hand, offer a stable structure (reliable availability), and on the other, must be able to react flexibly enough to anxieties, to tendencies of the patient for actions to make himself feel secure, and crisis-like fluctuations in the patient's well-being. The external form of the treatment and how the therapy proposes to proceed must both be carefully discussed and agreed on. Some essential points can be agreed on in "contracts" (regarding, for instance, suicidal behaviour, eating behaviour, substance abuse, and other forms of self-destructive behaviour). All of these structure-providing external circumstances must be embedded in a (therapeutic) relationship, and be warranted for by the therapist (or the therapeutic team) as person(s), so that the functions that are made available (like control in the service of care, setting of limits, tolerating of difficult affects) may be taken over as structural capacity by the patient for himself (for instance, as ability of regulation in the service of self-care, setting limits, affect tolerance). Violations of rules are not examined with a view to hidden intentions of the patient, but are responded to with boundary setting and firmness. It must always be examined, however,whether

the patient perhaps feels overtaxed and unable to stick to the rules, because he is being assigned a self-responsibility qua setting which exceeds his structural abilities.

Therapeutic stance

In view of the patient's tendencies to withdraw, or, his frequently devaluing and destructive relationship behaviour, the primary aim is to develop a therapeutic stance which contributes towards not making the therapeutic relationship and cooperation impossible, or destroying it. This includes, especially at the start of a therapy, the adoption of "parenting" attitudes, which suggest that the therapist takes over containing functions, adopts auxiliary ego functions, takes care, makes his own perception and emotion available as mirror and response, or also sets firm boundaries. It is equally important to mention and discuss the active capabilities that are available to the patient for coping with his structural difficulties either constructively or destructively. This implies, however, that the therapist does not primarily take the behaviour of the patient as offering the transference, directed to him “personally”, so-to-say, but that he learns – if possible, together with the patient - to see it as a problematical pattern of experiencing and behaving, with which the patient needs to learn to cope better. Part of the "parenting" attitude is, finally, that the patient's utterances are responded to, as it were, in "child-appropriate" fashion, by a more active therapeutic stance. The therapeutic abstinence is, nevertheless, maintained by the fact that the therapist responds not only from the position of 'another person', but from a parental position as well.

Determining a hierarchy of focus

It will have to be examined, initially, which structural functions the patient predominantly needs therapeutic support, with. in order to be able to regulate himself and his relationships. In this context, the following applies: The more severe the structural disturbance, the more it refers to the aspects of the self as described in OPD (self-perception, self regulation). The therapist has the task of encouraging the patient's ability to self-reference, and the autonomy of his self. Patients of this type often show an improvement in the relationships with their objects without any additional help, once they have gained greater orientation and solidity within themselves. In a less severe structural disturbance, object relationships take centre stage (object perception, communication) and can be worked on therapeutically in the very context of the interpersonal relationship between patient and therapist. The therapist may be able to move the therapeutic process along by, amongst other things, bringing himself into play more strongly as conversation partner, or as the "other". It further applies that the more severe the disturbance, the more central those characteristics of the disturbance become, which are described in the OPD structural dimension of attachment. This level of experience is mostly only incompletely accessed by verbal content, so that in such cases attitude and behaviour of the therapist (like, reliability, firmness, benevolence) become more important for the therapeutic effect than the actual content of the conversation.

Working on dysfunctional relationships

Together with the patient, the therapist examines which structure-based difficulties, limitations, and vulnerabilities become apparent in the patient's relationship behaviour. The therapist does not assume that problematical offers of

relationship are addressed to him, personally, but aim to establish a relationship outline, in which the problem that comes up in the therapeutic process is being examined and objectivized, as it were side-by-side with the patient, as a Third. The therapist encourages the patient to take on responsibility for his relationship behaviour, using the new knowledge he has gained, and to regulate it accordingly. Especially in the case of aggressive and destructive behaviours it may be helpful to imagine these, as quasi expressions of an "id", that is to say, parts or forces in the patient which as yet cannot been integrated or regulated (Benjamin, 1993). This idea facilitates the triangulation discussed earlier, and helps the patient to differentiate himself from his behaviour and then distance himself from it. Even at a stage when the patient still seems be completely identical with his own behaviour, the therapist must, nevertheless, be able to draft, internally, a model which captures this difference. Otherwise it would be difficult not to experience the patient as intentionally destructive.

What is important here, however, is the caveat already mentioned that patients with limitations in the level of structural functioning, due to, for example, emotional hurts suffered because of experiences of deprivation , can develop secondary forms of coping which may actually have an aggressive, devaluing, or destructive character. In that case, they act very much as (if only partly) responsible for their actions and must therefore be addressed as the originator of these dysfunctional coping mechanisms: Here it is not the "id" that acts, but the patient himself.

Relationship patterns on the basis of structural limitations are, however, in no case always aggressive, but frequently defensive, or avoidant. Withdrawal and rigid control of relationships have the purpose of protecting structure-based sensitivities, like, a fragile identity, a low self-worth. In this case, the therapist works together with the patient in order to elaborate the vulnerability, so that it can be put into words. The therapist especially works out which events and circumstances, and relationship situations, touch on this vulnerability. He accepts the manner in which the patient protects his vulnerability in relationships, framing it positively, so that the patient's coping capabilities are duly emphasized. In a further step it may then become apparent that such self-protective behaviour has its price, for instance, in that it makes the fulfillment of relationship wishes impossible, or severely limits their realization.

Interventions

The more serious the structural disturbance, the more care and reservation must be shown regarding affect mobilizing techniques, and the fewer offers of therapy are made which encourage regression and dependency (lying on the couch, higher frequency of sessions). Instead, those techniques tend to be applied which bring about a basic stabilization of the self, while object-directed interactional aspects are only intensified in a later phase of the therapy. Non-verbal procedures are often better suited than linguistic interventions for giving the patient an authentic feeling for who he is. As structural limitations become manifest through unspecific stresses, that is to say, are not primarily triggered on the basis of a neurotic conflict by situations that carry an individual meaning based on the patient's life history, interpretations about something that lies "behind", like unconscious motives, or the patient's biography, play a lesser role. The focus is directed to the "how" (that

is to say, on objectifying and differentiating the limitation), and not on the "why" (Grande, 2002). The patient is not to be "questioned", but is to create a distance between him and his difficulty and is to learn to regulate it. The special sequences of the therapeutic action, which, to a great extent, is determined by the therapeutic stance which has been described here can be found in detail in Rudolf (2004b).

With reference to the dimensions of the structural axis, different therapeutic aims and intervention techniques leading to those aims can be distinguished for the purpose of strengthening and developing the respective structural functions:

- At the cognitive level of self- and object perception the therapeutic aim consists in the patient gaining a realistic perception of his self and his objects, and through this, gain support and orientation internally and in the outside world. This equally means that he not only obtains an insight into reality, but also can accept and consider it. The therapist's interventions are designed to support the patient's perceptions through mirroring, demonstrating, differentiating, and confronting.
- At the level of control concerning self-regulation and defence, the therapeutic aim is for the patient to gain an inner distance, circumstaintially, from his own impulses, affects, self-attributions, and relationship wishes. From this position he is thought to be able to set boundaries, self-regulate, decide, and avail himself of functions. The therapist's interventions are to help the patient take up a clearly-defined, observing, and autonomous position, and to remove himself from flooding, overwhelming, or vacuous situations.
- At the level of emotional communication, it is the aim of the therapy to enable the patient to become involved and let himself be emotionally held and affected and, in this way, have his world of experiences become more dynamic and energized. The therapist's interventions are to animate the patient's affects, encourage the encounter with emotionality, and to make the unpleasant and disconcerting feelings triggered by this tolerable for him.
- At the level of attachment to internal and external objects, the aim of the therapy is for the patient to learn to relate to good internal and external objects. The aim here is self-regulation with the help of internalized positive objects, and to develop the possibility to utilize the resources of external relationship. The therapist's interventions are to draw the patient's attention to those fundamentally available possibilities (in the external world, in the therapeutic situation, and in the patient's biographical experience) and encourage their use, as well as work on, or correct, biographical experiences that run counter to this.

Conflict-based disturbances further complicated by structure-based limitations

In this type of disturbance we find clearly recognizable conflicts. A careful diagnosis reveals, however, that there are also structural limitations. Not infrequently, this complication becomes evident only as the therapy progresses: The patient finds it difficult to tackle the conflictual theme that has been uncovered in a constructive way, to accept a different image of the self, and to reconcile himself with his own situation. What becomes evident in such cases is that a stable structural basis for

work on the conflictual theme is missing and must first be created in order to then allow the theme to be integrated.

> An example: A depressive patient's clinginess and strong wish to be cared for by her objects (conflict of care versus autarky, passive mode) shows that she basically has existential doubts about her survival as an autonomous self, independent of her objects. During times when she is not directing her demands and complaints towards her objects, she doubts that "she exists". The therapeutic work on the conflict of care, in this case, brings up basic themes around a failing capacity for internalization, which lead to the feeling that nothing "remains" after good-byes and separations, and that her self-coherence is lost (structural focus: attachment/severing of attachments). In the case of this patient, a restructuring in the area of the core conflictual theme is not possible, so that the themes of need for objects and fear of separation are being worked through over and over again , without there being substantial changes.

Setting

There is no unequivocal recommendation as to setting here. As a rule, the therapy is carried out in an outpatient setting for individual or group psychotherapy. As both therapist and patient, in the case of a mixed disturbance, tend to subsume visible difficulties under conflict-neurotic categories, the danger of overestimating structural possibilities and of overtaxing the patient, or of the patient overtaxing himself, suggests itself. It is conceivable, therefore, that inpatient treatment may become necessary if, in the interim, compensatory coping mechanisms have destabilized. Besides, inpatient therapies contain elements like a structure-giving framework and non-verbal treatment approaches, which may be better suited to the patient, and which, so-to-speak, pick up the patient where he is at in relation to his level of structural development.

Therapeutic stance

The therapeutic stance that is taken depends on the actual need, that is to say, on the nature of the patient's current problems. It is, however, fundamentally structure-oriented, that is, the work on conflictual themes follows the implicit assumption that progress made here is only relative, and that sooner or later a tackling of structural themes will become necessary, in order to then be able, being better equipped, to revert to conflict-based themes. This means that the initial focusing on conflicts happens, so-to-speak, with a reservation attached, and without the hopeful expectation, which patients often tend to offer, actually finding a sustainable solution to the problem.

Determining a hierarchy of foci

As working on conflicts is often impossible without adequate structural competence in place, the task is to attend to structural themes as therapeutic foci, in addition to conflictual themes. Irritations may arise in the therapeutic work if, on the one hand, the work on obvious conflictual themes remains fruitless due to structural limitations, while on the other hand it is being made difficult to focus on structural problems due to conflict-related complications. If in doubt, the structural theme needs to take precedence. If patients offer a conflictual theme, it is important to pay attention to the structural aspects it contains, and to guide the patients to perceive and acknowledge them. In line with the principles set out above, the first

step should be to basically confirm, and positively frame, the patient's coping capability which is included in the conflictual theme. The second step should then make it possible to approach the structural problems, via an analysis of the disadvantages and the inefficiency of the coping efforts.

> An example: A 35-year-old patient time and time again finds himself involved - totally incomprehensibly to him - in interactions in which he is passed over by others and exclude him from important decisions. His reaction to this is one of stubbornness and refusal. He fails to notice, however, that his attitude of refusal frustrates others, tempting them to make decisions without consulting him. In addition to a conflict of submission versus control, what also plays a key role in the interpersonal disturbance of this patient is his clear lack of empathy (a structural limitation). In the context of an inpatient therapy he is able to gradually recognize, within the framework of group situations , that his stubbornness is not exclusively advantageous in the sense of a necessary reaction, but that also, because of it, a lot seems to escape him in relation to what others do and share with each other.

Working on dysfunctional relationships

As the above case shows, there must be an examination as to whether there are any structural limitations which add coarseness to the interpersonal pattern of conflict management (as is the case if an ability for empathy is absent) and exacerbate its dysfunctional character. The therapist should examine, especially if there are aggressive twists, whether these are the patient's responsibility, in the sense of an unconscious intention, or whether they are primarily signs of a structural inability. In other cases the situation may be such that structure-based vulnerabilities are being protected by the relationship behaviour. In both variants, a first step may be for the therapist to accept and positively frame the aspect of conflict management. In the earlier example of the depressive patient this would mean the following: Clinging to objects is a behaviour destined to get help, which, at a superficial glance, impresses as a way of directing demands and complaints towards one's objects, and as a struggle to obtain loving care and attention. From a child's point of view, however, it represents a very worthwhile attempt at coping with basic anxieties of loss and annihilation. The primordial therapeutic aim, therefore, is not to work through the patient's needs for care, but to help her cope with the deeper underlying fragility of the self.

Interventions

The working through of conflicts, or of structural themes, generally proceeds according to aspects mentioned in context with the first two types of disturbances. The therapist should be able to disengage from conflictual themes when structural aspects come into view, even in situations where the patient offers primarily conflictual material. He should be aware that working on relationship conflicts in this type of patient should not be an end in itself, but eventually, should lead to uncovering the structural core of the difficulty, and to examine it together with the patient from the position of a „third“. Finally, he should not lose himself in interpretations of the "why" (the motives and their defence), but instead, whenever necessary, focus on the "how" of the structural limitation and separate out its component parts together with the patient.

7.6 Peculiarities of the psychodynamic work on dysfunctional relationship potentials

In various places throughout this text, it has been pointed out that the relationship aspect of the disturbance, and, correspondingly, the relationship focus in the treatment plan can be understood in a conflict-dynamic sense, as an expression of neurotic attitudes and processes of defence, but also in a structural-dynamic sense, as a consequence of structural deficits and the related coping mechanisms. This is why, in the previous chapter, the therapeutic working through of dysfunctional relationship potentials was focused on aspects of conflict or structure, respectively.

The following paragraph resumes the basic discussion of the therapeutic work on dysfunctional relationship potentials and differentiates it according to various therapeutic aims. This differentiation refers again to the relationship diagnostic schema (cf. Figure 4-3). The following Table 7-6 (Grande et al., 2005) lists potential relationship foci in three blocks:

Table 7-6: OPD-based list of therapeutic relationship foci

Perceiving of and emotionally enriching the relationship experience	■ Differentiation of one's own experiential perspective ■ Differentiation of one's own perspective and the perspective of others ■ Acknowledging and tolerating contradictions between the perspectives
Perceiving and understanding the effects and consequences of behaviour in the relationship situation	■ Perceiving active and reactive aspects in one's own behaviour and in the behaviour of others ■ Insight into the observer-dependent structuring of relationship events ■ Insight into dysfunctional cyclical interrelationships of effects
Understanding and acknowledging intentions and unconscious motives	■ Recognizing and acknowledging one's own intentions and unconscious motives which maintain dysfunctional behaviour ■ Recognizing of dysfunctional convictions which the relationship pattern reinforces in a feedback loop ■ Insight into the test character of one's offers of relationship

The first block contains therapeutic foci in which aims such as perception, objectivization, differentiation, and emotional enrichment of dysfunctional relationship experiences are in the foreground. The interventions of the therapist in this area are above all descriptive and demonstrative. They do not interpret complex interrelationships or motives.

- The differentiation of the patient's own experiential perspective is about the perception, verbalization, and further differentiation of relationship experiences, as well as about the discovery and animation of the

accompanying affects. This focus bears similarities to the technique of "verbalizing the emotional contents of experience" in Person Centered Therapy (Tausch/Tausch, 1990).

- The differentiation between the patient's own perspective and the perspective of others is concerned with the perception of relationship situations from the perspective of others,. It is also about an empathic understanding of the experience of others, and about comparing and differentiating between those various experiential perspectives.
- Acknowledging and tolerating contradictions between the perspectives is about perceiving contradictions in one's own offers of relationship (the way they are "meant" and how they come across), in the offers of relationship of others (their "meaning" and how the patient perceives them), and about tolerating these contradictions between one's own perspective and the perspective of others.

The second block contains therapeutic foci which have the therapeutic aim of linking relationship events with each other through the perception, and the understanding, of their causes and effects. Again, this may happen in a descriptive and demonstrative manner, to begin with, without explicitly touching on the question of authorship and responsibility. This question can only be asked in a second step, in order to work out, together with the patient, how this might possibly be influenced or regulated:

- The perception of active and reactive aspects in one's own behaviour and in the behaviour of others is about the perceiving and acknowledging the fact that reactively experienced personal behaviours simultaneously produce an effect of their own. The reverse applies, too, that others not only pursue their own purpose with their behaviour, but use it also to respond to the patient.
- The insight into the observer-dependent punctuation of relationship events is about acknowledging the fact that interactions are circular, and that the attribution of cause and effect depend on the position of the observer (Watzlawik et al., 1971).
- The insight into dysfunctional cyclical interrelationships is concerned with the perception and acknowledgement of the fact that one's own communicative acts and those of others are linked together in a dysfunctional maladaptive feedback loop (Strupp/Binder, 1984).

The third block finally contains therapeutic foci in which the internal logic, or the meaning of relationship patterns are explained with reference to the patient's intentions and unconscious motives. The patient is thus cast in the role of actor or director, who shares in the responsibility for his interpersonal entanglements, because he partly wants them (unconsciously) and therefore encourages them, even if he experiences their consequences as painful:

- The recognition and acknowledgement of one's own intentions/motives which maintain the dysfunctional pattern is about the insight into the fact that one's own offers of relationship are compromises between wishes and anxieties. It also is about the insight that one's own behaviour is governed by intentions which unconsciously bring about the dysfunctional pattern, or

prevent a more constructive handling of the relationship (transference potentials, cf. Dahlbender/Kächele, 1994; Luborsky, 1988).

- The recognition of dysfunctional convictions (self-images, introjects) is concerned with the insight that one's own offers of relationship help to encourage interpersonal constellations which reconfirm certain convictions about oneself, or which avoid potentially corrective experiences (Anchin, 1982; Schacht/Henry, 1994; Strupp/Binder, 1984).
- Finally, as far as the insight into the test character of one's offers of relationship goes, this is about unconscious plans of the patient to want to test, by making problematical offers of relationship, whether others react in agreement with his own negative convictions, or whether their reactions refute those convictions (Curtis et al., 1994; Weiss/Sampson, 1986).

Which of the options are chosen as a focus depends, amongst other things, on the extent of the structural impairment in relation to the weight of the pathogenic conflicts. In the case of a conflict-oriented psychotherapy all three blocks may be selected, with the third block (understanding and acknowledging of intentions and unconscious motives) touching most directly on the conflictual background of the relationship disturbance. In the case of a structure-oriented psychotherapy (Grande, 2002; Rudolf, 2002a, 2004a; Rudolf, 2004b) interventions of this type are not considered a reasonable option: the clarification of motives has no healing effect, if the limited availability of structural functions forms the core of the difficulty. These patients are unable to benefit from such interventions, because they present their dysfunctional relationship ways not with an unconscious intention, which means, in consequence, that they are being overtaxed when that sort of responsibility is expected of them. They benefit more, if, instead, focused formulations are used which have a descriptive and demonstrative character, as those in the first two blocks. This encourages the perception of structural limitations which thus gain an objective character, as well as the ability to distance themselves from them. This in turn enables the patients to apply self-regulating and coping mechanisms in the face of these limitations.

7.7 Concluding remarks

The previous recommendations must, of course, be understood more as an orientation, rather than a prescription. Also in a focus-oriented treatment, the therapist should preserve, for himself, a basic attitude of openness in order to pick up the patient where he is at at any given moment. The therapeutic focus is not an external thing that is proffered or prescribed for the patient, but is contained in the material which he brings and offers. The focal orientation makes it easier to trace the core therapeutic theme in this material, many times over, and to document it in the work with the patient. This means that the therapist should alternate between a more receptive attitude, and one that is actively focus-directed.

The central recommendation here is to examine the relative weight of conflict-based or structure-based limitations and to determine how far they are relevant to the patient's disturbance. This decision carries far-reaching consequences for the treatment of a patient, that is to say, for the selection of the setting, the therapeutic stance, the selection of foci, and the therapeutic techniques that are to be used. Experiences with the implementation of the focus-oriented therapeutic

strategies presented here in in- and outpatient settings have shown that an adaptation of these techniques to the patient's structural possibilities is important. It is important because it helps to avoid detours and false starts, which can lead to disappointments and discouragement both in the patient and the therapist. It also helps to determine what is feasible in the respective situation, and to define therapeutic tasks that can be solved.

8 Change measurement with OPD

8.1 OPD and change measurement: basic considerations

In line with its psychodynamic orientation, OPD identifies those aspects of a disturbance which are part of the patient's personality and thus are relatively stable (Grande et al., 2000). In the manual, this is reflected, amongst other things, in the fact that there is a relatively large time window of one to two years for the diagnosis of structure; the conflict diagnosis in this context, expressly refers to "ongoing conflicts" (cf. section 3.3). This stability over time of the OPD findings seems appropriate with a view to the underlying psychoanalytic model of illness. It does, however, represent a difficulty for the measurement of change, because therapeutic effects are only reflected if they find their precipitate in a changed relationship, conflict, or structure diagnosis. Smaller therapeutic advances cannot be reflected, in any case, not on the basis of OPD alone.

A yet more fundamental problem arises through the fact that those personality characteristics which are identified by OPD, frequently undergo no change in the sense of a "reduction of a trait". They do not change even if the treatment is considered successful from a clinical point of view. Axis III, for instance, is used to diagnose life-determining and dysfunctional conflicts. The result of a successful psychotherapy may be that a conflictual theme remains life-determining, but has been worked on so successfully that it can be constructively shaped, and productively used by the patient in his life. The change, in this case, would not be measured by the degree of reduction, or the cessation, of the pathogenic conflict, but by the degree of its successful integration. The same applies to structural limitations, or vulnerabilities, and to dysfunctional relationship potentials, namely, that signs of a positive therapeutic change are not to be seen in their cessation or reduction, but in an improved possibility of regulating and handling them in a constructive way.

8.2 Model of an OPD-based change measurement

Arguments like those above suggest that one should consider recording progress in the psychotherapeutic process in the form of changes in the patient's handling of his key problem areas. Such procedure implies two methodical steps. As a first step, those characteristics of the OPD range of findings are selected, which are important for his disturbance. As a second step, it is recorded how he deals with them and how his way of dealing with them changes over time.

Focus selection:

Key problem areas are denoted as foci, because they serve as points of reference for change measurement. They can be, but need not be identical with the therapeutic foci! Problem areas that are considered 'key' are those which cause and maintain the disturbance of the patient, so that something would have to change with respect to them, if sustainable success was to be achieved. The number of foci to be selected can, in principle, be determined as necessary. Our own investigations have shown, however, that a selection of a maximum of five characteristics from the range of findings from Axes II, III, and IV is sufficient in order to fully identify the problems of a patient (Grande et al., 2001; Grande et al., 2004b; Grande et al., 2003;

Rudolf et al., 2002a). It is recommended that the habitual dysfunctional relationship pattern is chosen as a focus in any case (Grande et al., 2004a), while the remaining foci may be selected from the areas of conflict and structure (cf. section 7.4). This includes the possibility, in the case of more seriously structurally impaired patients, to only or predominantly choose foci from the findings on the structure axis, while in patients with a higher level of structural integration conflict foci are selected more frequently. As set out in section 7.4, less than five foci may be sufficient in some cases to describe the relevant aspects of the disturbance. This may be the case when, for example, a disturbance is unequivocally conflict-based, and if only two (or three) important conflicts can be found in addition to the relationship focus.

Heidelberg Structural Change Scale:

The scale represented in Figure 8-1 is used to describe a patient's dealings with the foci. It is a modified form of the "Assimilation of Problematic Experiences Scale (APES)" by Stiles and colleagues (Stiles et al., 1990; Stiles et al., 1992), which was revised with an eye to more closely assimilating it to a psychoanalytic model of process and change (Rudolf et al., 2000; Rudolf et al., 2001c). In seven stages, the scale describes different modalities of how a patient deals with a focus problem, beginning with cutting it off from perception successfully or not perceiving it as such, to slowly starting to perceive it and then explore it with some interest, extending through to active coping efforts. The first few stages describe the process of a loosening up of habitual defence patterns, which is conducive to the therapy in that it enables a new organization of the personality. They therefore capture changes which are referred to in the psychoanalytic concept of "restructuring", or "structural change".

This scale is used to independently rate, at each rating timepoint, the foci that have been selected for a patient. Interim stages, as shown in Figure 8-1, may also be used. For an assessment, various strategies are available (Grande, 2005) which have been employed in previous studies. One of them is to a) calculate pre-post differences of the restructuring values as a measure for therapeutic success. When several foci are selected, the mean of the restructuring ratings can be taken; in this case, the measure of success is the difference between the means of pre and post comparisons (Grande et al., 2001). As progressively higher stages on the Scale describe an increasingly higher-quality treatment success, another strategy to be used is b) the global assessment at the end of the therapy, on its own, as an outcome measure. If several foci are used, the mean of the scores on the Scale across those foci can be used as measurement (Grande et al., 2003).

A special feature of the Structural Change Scale consists in the fact that positive therapeutic changes in the sense of "coping" become conceptually possible as early as stages 3 or 4 are reached, that is to say, once the patient has gained insight into his problem at this stage, and in consequence attempts active regulation efforts in order to cope with the problem. In contrast, the changes described in stages 5 to 7 refer to more basic restructurings of the personality structure, which typically come about spontaneously, that is to say, without the patient's effort, and not infrequently, as a surprise to him (cf. Rudolf et al., 2000). The design principle of this Scale allows the assignment by category of treatment results rated at stage 4 to the "coping mode" as a mode of therapeutic change, and those rated as stage 5, or 6, to the "structural change mode" (cf. Rudolf et al., 2005).

The Heidelberg Structural Change Scale (HSCS)

1. Focus problem warded off	1 1+	Total defence, or avoidance, of the focus area; patient has "no problems" with the critical area	
2. Unwanted preoccupation with the focus	2- 2 2+	Symptom pressure, difficulties in interpersonal relationships: unreasonable demands, experienced as external	
3. Vague awareness of the focus	3- 3 3+	Passive preoccupation with the focus; traces of acknowledgement of problem, notion of responsibility]	coping
4. Acceptance and exploration of the focus	4- 4 4+	Interested in understanding the problem, working relationship, active "coping", active preoccupation	
5. Dissolution of old structures in the focus area	5- 5 5+	Defence becomes fragile, "passionate" about the process, sadness, feeling exposed, confusion	Structural changce
6. Reorganization in the focus area	6- 6 6+	Conciliatory approach to the problem area, spontaneous emergence of new ways of experiencing and behaving	
7. Dissolution of the focus	7- 7+	Integration, agreement with self, experience conforms to reality, new formations	

Figure 8-1: Heidelberg Structural Change Scale

8.3 Reliability and validity

Various studies have produced good to very good interrater reliabilities of r=.77, r=.78, and r=.88 (Rudolf et al., in preparation; Rudolf et al., 2000). In a study on inpatient psychotherapy patients, the global outcome assessments of the therapeutic team correlated highly not only with the score on the scale averaged across foci at the end of treatment, but also with the pre-post difference; this correlation was markedly higher than with all other outcome measures (Grande et al., 2001). In the same study, high positive correlations were measured between the score, averaged over all foci, at the beginning of therapy, and prognostically propitious characteristics like "therapy motivation", "emotional accessibility", and other things. In the context of a catamnesis study it could be shown that the restructuring score at the end of treatment, averaged over the foci, correlated significantly with progressive steps patients had been able to undertake in their external lives after being discharged from the clinic, in addition to being the only outcome measure which could predict such steps at all (Grande et al., 2003). A study by Rudolf and colleagues (Rudolf et al., in preparation) shows that patients in a higher-frequency long-term psychoanalytical psychotherapy achieve a restructuring

in the sense of this Scale (that is to say, a result of stage 5 or higher), significantly more frequently than patients in an only once weekly psychodynamic therapy.

8.4 Clinical application

The Heidelberg Structural Change Scale can be applied as soon as one or more problem areas which cause or maintain the disturbance and therefore must be therapeutically changed, have been selected from among the OPD findings. This makes the Scale easy to use for the practitioner as well. It can be used at the start of the therapy to examine how far a patient has already progressed in the handling of his core problem areas, and to establish the points from where the therapeutic work can proceed. In stage 2, "unwanted preoccupation with the focus", some subjective suffering is present, however, the difficulty is experienced as an unreasonable external demand, which is why the patient displays a more passive attitude, primarily expecting that the treatment take this demand away from him. A psychotherapeutic cooperation in the proper sense is therefore only possible once the patient has at least a vague awareness of the focus (stage 3), meaning he suspects, and shows signs of acknowledging, that he is part of the problem and has some responsibility for it himself. The trial sessions or preliminary interviews before a therapy serve amongst other things to establish a vague awareness of focus in at least one of the focal areas.

During the course of the therapy the therapist may refer to the Scale to recall how far he has already come with the patient with respect to the various problem areas. As mentioned above, both the attainment of stage 4 ("acceptance and exploration of the focus") and of stage 6 ("reorganization in the focus area") may be regarded as valid therapy aims. In stage 4, the patient gains insight into his difficulties, thereby acquiring the capacities to deal with them by way of regulation; this mode of therapeutic change is called "coping" in Figure 8-1.

Stage 5 describes a process of destabilization that has beneficial effects for the therapy and which leads to the disintegration of accustomed coping and defence modes. This brings about a situation with no way out: the patient no longer "does" psychotherapy, he "suffers" it. Correspondingly, his situation is one of total perplexity, doubt, sadness, or even hopelessness. Simultaneously, however, he can be experienced by others, also by the therapist, as positively changed, that is to say, as softer, more transparent, and more authentic. The patient himself is only able, , to notice this positive turn of events later, namely towards the end of stage 5, or at the beginning stage 6. He then typically experiences the changes as something that comes about spontaneously and without his doing. He notices that he can suddenly do and feel things which were previously inaccessible or totally unknown to him. These are the indicators that a fundamental change and reorganization of the personality has taken place. Such change is the aim of intensive long-term psychoanalytic treatments and is referred to as "restructuring", or "structural change".

Focus-related changes may not only be identified and recorded for research purposes, but equally so for everyday psychotherapeutic practice. This is done by assessing the status of the restructuring at the beginning of the therapy, and repeating such assessment during and at the end of the therapy. The therapeutic effect then becomes visible as a progression of the foci on the Scale.

An example: A 37-year-old patient shows a depressive reaction after she made a career advancement. She, for one, does not notice this paradoxical connection. It transpires from her report that she misses the feeling of togetherness, which she had experienced in her old peer group of colleagues. In connection with this loss she talks about the death of her father a year ago. She expresses her sadness about the fact that her family of origin has become damaged or lost as a support and source of strength. After the therapist establishes the link between these events, she is visibly touched and considers it possible that this might have something to do with her depression (focus: care versus autarky, stage 3 of the Scale: "Vague awareness of the focus").
At other times during the conversation the patient comes across as unwilling and impatient: she finds herself totally unbearable in the state she is now, she hates her self-pity, points out she cannot afford that sort of thing in her current position! The biographical anamnesis shows that the patient was closely connected with her father and admired his strength, while the description of her mother, who is soft and dependent on the father, bears critical-devaluing overtones. In her current weakness she unconsciously becomes like her mother, which is not acceptable to her. These interrelationships are totally inaccessible to her, she cannot absorb hints of the therapist to that effect at all (oedipal conflict, stage 2: "Unwanted preoccupation with the focus"). In the framework of a psychodynamic psychotherapy the patient is able to acknowledge her wishes for safety and comfort and can take steps to arrange her life situation with these in mind. She discovers and develops trusted relationships in her personal life and manages, to some extent, to relieve her professional engagement of such needs (care versus autarky, Stage 4: "Acceptance and exploration of the focus"). Her mood becomes largely normalized again. She continues to be impaired by not having a partner. Contacts with men tend to fail time and time again due to their disinterest, but also due to her own high demands. She shows signs of understanding that she feels compelled to contour the image of herself as a woman in contrast to that of her mother, and is restricted by this due to the fact that she cannot feel good being a woman. During the course of the treatment it becomes more and more evident that she does not want to get any closer to this problem area. She eventually decides to end the therapy after 50 sessions (oedipal conflict, Stage 3: "Vague awareness of the focus").

9 Areas of application and quality assurance

9.1 Quality assurance in psychotherapy and the law

Both psychodynamic and cognitive-behavioural psychotherapy conducted by qualified psychotherapists as part of the health care system, can no longer do without developing the appropriate structures for quality assurance. For the German health care system, quality assurance has been a legal requirement since 01.01.1989. This is to guarantee that patients receive those treatments which, according to latest research, are optimal for their particular situation. As the 1988 German Health Care Reform Act has made quality assurance measures compulsory in all areas of medicine, this also applies to psychotherapy, as a part of the medical health care system. The initiatives towards quality assurance and quality management are not ends in themselves, neither have they been created for control and disciplinary purposes. In the final analysis, quality assurance benefits the patient. The acceptance of the instruments used within the framework of quality management is closely related to whether they can be sensibly and efficiently handled, and also, to the clinical relevance of the collected data.

The multiaxial diagnostic system of OPD not only allows a differentiated and reliable diagnostic assessment; in combination with traditional instruments of basic documentation, it is also useful for treatment planning. In numerous psychotherapeutic institutions in Germany, OPD is being used in diagnostics, and increasingly, in treatment planning and outcome evaluation. OPD has thus become a respectable member of a family of instruments for the evaluation of structure, process, and outcome quality in specialist psychotherapy. The following highlights OPD's potential for quality assurance of outpatient psychotherapies, and emphasizes its current status in training, postgraduate training, and expert procedures in accordance with the stipulations as set in the guidelines for psychotherapy. In quality assurance with regard to inpatient psychodynamic (multimodal) hospital treatment OPD has its well established place; as concerns rehabilitation treatment programs, it is about to claim a position for itself there. It may surprise the reader that OPD is also proving to be an almost indispensable tool in the expert assessment of candidates who apply for the specialized areas of psychomatic medicine and psychotherapy.

9.2 Quality assurance in psychodynamic psychotherapies (QPP)

Quality assurance in outpatient psychodynamic psychotherapies essentially centres on the quality of the outcome, assuming a defined dose of treatment: the reduction of pre-existing symptoms, an increase in, or maintenance of the quality of life, and - in order to achieve this - a changed way of handling maladaptive relationship patterns, repetitive dysfunctional conflicts, and structural limitations (Dahlbender et al., 2004a). With the Quality assurance for Psychodynamic Psychotherapy (QPP; www.opd-online.net; qpp@gmx.de) a practicable system for the description of the outcomes of outpatient psychotherapies has been presented, which has further developed the experience gained in the course of studies of inpatient treatments at the Psychosomatic Clinic Heidelberg (Jakobsen/Rudolf,

1998), and in a long-term psychoanalytical psychotherapy practice study (Rudolf et al., 2001b; Rudolf et al., 2004b).

Under conditions of everyday clinical practice a treatment-specific procedure for quality assurance is made available to licensed psychotherapists.. In addition to patient questionnaires, therapist documentation is used, based on the terms and concepts of the OPD (for further instruments see Heuft et al., 2005). A central place is reserved for the Heidelberg Structural Change Scale (Grande et al., 2000; Rudolf et al., 2000) to reflect psychodynamically relevant changes (see Chapter 8). With the help of the conflicts that can be described in OPD, and the expanded list of structural characteristics (Rudolf et al., 1998), the therapist marks four relevant problem areas of the patient. They are to improve during the course of the psychotherapy, in order for a sustainable change in the difficulties/the symptoms to be achieved (see also Grande et al., 2004b). A global assessment of the level of structural integration is helpful when the course of the treatment is assessed at a later stage. An in-depth knowledge for a complete assessment on all four OPD axes is not required, as the OPD rating need not be complete.

The central idea is to provide the treating therapist with feedback by giving him a clear syndromal and psychodynamically operationalized diagnosis and systematic documentation of the course of outpatient therapies. For this purpose, a data evaluation centre arranges the results of the documentation in a clear form that systematically juxtaposes the perspectives of patient and therapist, and which provides a timely feedback for the therapist. This allows him to make another differentiated assessment of the initial situation, or of the course of the therapy so far. QPP is not intended to have a direct, controlling effect on the course of the therapy. What is effective in the sense of quality management is, above all, a review of therapies or therapy segments already carried out. QPP thus organizes the wealth and richness of experience of the therapist in a systematic way, while the documented information is only fully comprehensible to the therapist himself as competent observer of the therapy. Only he is aware of the particuliarities of a given treatment, and of the patient.

Psychodynamic psychotherapies are, to a relevant degree, individual, as they always have to take into account an individual's very idiosyncratic shaping of his life history and psychodynamic factors. An evaluation across psychotherapeutic practices, exclusively on the basis of statistical material is hardly possible. A discussion of the outcomes with colleagues, however, especially of more "problematic" courses, is very sensible. The individual consideration is also facilitated by the fact that the individual case documentation may be contrasted with assessments of comparison groups. An agreement should be made not to pass on the collected data to third parties (funding agencies. etc.), as a meaningful interpretation is hardly possible without the therapist, and otherwise neither patient nor therapist would be willing to openly speak their minds. To gain an overall picture, a minimum number of therapies should be studied with the QPP system in each practice: for example, all recently started therapies (excluding the patients who get only trial sessions). If the total number of examined cases is to be limited, the next series of new treatments are to be documented over a period of time, until the desired number of cases is reached (consecutive sample). The QPP system demands only a minimal amount of work on the part of the therapist, if key

preparatory and assessment work were to be taken over by a data evaluation centre. To present each individual practice with a diagrammatic overview of cases would be possible and sensible; if a sufficient number of treatments was quality tested, participation could be certified.

The rating timepoints are the same for patient and therapist: data collection at the start and at the end of the treatment is necessary in any case. The recommendation is to take a measure at, at least, one interim timepoint, and preferably do a catamnestic data collection. The timepoints for the interim measures and the catamnestic data collection can be freely chosen in a practice; they should, however, be the same for all patients of the practice. A minimum interval of 2 months between the data collections should be observed. Recommendations, in addition to measuring timepoints at the beginning and at the end of a therapy, are: for a short-term psychotherapy, only at the beginning and at the end of the therapy; when short-term therapies are switched to longer-term therapies, after 25 hours, and again after 50 hours, or 80 hours, respectively; for a long-term psychotherapy (one hour) after 50 hours and after 80 hours; for a higher-frequency long-term therapy after 160 hours, and then after 240 hours. The catamnesis as a questionnaire by post should be done at the earliest after half a year, optimally one year after the end of the treatment. Such a practice would considerably buttress the discussion about psychotherapeutic treatment procedures on the test bed of Evidence Based Medicine (EBM; Leichsenring/Rüger, 2004).

9.3 OPD in the expert assessment procedure of the German psychotherapy guidelines

In the general understanding, the expert assessment procedure of the German Psychotherapy Guidelines (overview in Rüger/Bell, 2004) contributes in an important way to quality assurance regarding the provision of psychotherapeutic care. It does this by mirroring, one more time, the expertise of the therapist in terms of the illness and psychotherapeutic treatability of his patient, through the expertise of an expert assessor against the background of the Psychotherapy Guidelines (Rudolf/Schmutterer, 2003). In view of a planned therapy, therapists formulate their clinical judgement as regards their patient, their psychodynamic hypotheses about the disturbance, their therapeutic treatment aims and treatment plan, as well as their prognostic evaluation. The expert assessor examines this text against the background of the Psychotherapy Guidelines, that is to say, the agreements on the necessity, efficacy, and economical justification of defined psychotherapy procedures for a circumscribed catalogue of disorders. He examines the duty of public health insurers to cover the costs in the particular case and recommends, as the case may be, that costs be borne for a certain hourly contingent of psychotherapy sessions.

The issues around diagnostic procedure and diagnostic classification are not undisputed (Rudolf, 2001) in the field of psychodynamic psychotherapy and analytical psychotherapy. Is the use of the OPD system suitable for improving the quality of the diagnostic, treatment planning, and decision about indication? It would have to be clarified in this context, how the expert assessors react to the use of OPD-formulations in the reports. An orienting overview across reports from psychotherapies following applications for funding reveals that in 30 to 40 per cent

of first-time applications, therapists use OPD formulations with different accentuation on the respective contents:

Relatively rarely do we find characterizations of patients on the Interpersonal Relations axis (Axis II). If they are available, they allow one to recognize that the therapists are interested and able to use Axis II to give a very detailed description of interpersonal occurrences, and especially, of the way the therapeutic relationship is shaped.

More frequently we find OPD conflicts (Axis III), whereby the most quoted conflict is the autonomy-independence one (OPD-2: individuation-dependency). The formulation autonomy-dependence seems to mislead one to use this term to diagnostically label manifold life problems which are connected with people's needs for attachment and efforts to become independent - irrespective of the operationalizations the OPD uses for this conflict. (Examples from psychotherapy applications: "The strongly, denied dependency on the mother with a largely absent, fear-inducing father led to a failure of the early autonomy-dependency conflict."; "In his relationships, the patient shows a strong autonomy-dependency conflict. He wants to pursue his own need for autonomy by setting boundaries around the excessively demanding requests of his partner, but fears losing his wife if he does").

It is therefore not surprising that expert assessors at times remark critically on the use of the autonomy-dependency conflict, especially in places where it is used descriptively-associatively, and suggests a psychodynamic understanding which is not plausible with respect to its substance. This difficulty is more often observed in applications for psychodynamic psychotherapy (low frequency), than in those for psychoanalytical psychotherapy (high frequency). In contrast, other, more rarely used OPD conflicts (like care-autarky, guilt, oedipal-sexual conflicts) are often described very precisely, in psychodynamic contexts, and this even takes differentiated therapeutic aim formulations into account. The OPD conflict themes get mentioned similarly more frequently than the level of structural integration, in the sense of OPD (Axis IV). This term is mostly used in connection with the severity of the disturbance and the setting of therapeutic aims. The discussion of structural characteristics, of their diagnostic and prognostic importance, and their effect on the therapeutic technique and procedure is just as often found in applications for psychodynamic psychotherapy, as it is in those for psychoanalytical psychotherapies. As a rule, the structure-diagnosis is mentioned also in the progress reports: in order to specify whether and how a structural stabilization has been therapeutically accomplished. Some therapists refer to structure-related modifications of psychodynamic and psychoanalytical psychotherapies (Rudolf, 2004b; Rudolf/Rüger, 2001), which also had an entry in the leading commentary on the Psychotherapy Guidelines (Rüger et al., 2003).

When OPD formulations are used as psychodynamic shorthand symbols without reference to the relevant psychodynamic in the OPD sense, the same happens as can be observed, at times, when diagnostic terms like "borderline personality disorder", "somatoform disorder", or "posttraumatic stress disorder" are used: they are not being used in their operational definition, but in the context of private meanings. It will be the task of the expert assessor here to press for precise use of those diagnostic terms on which treatment planning rests, not least of all for the patient's

benefit. Therapists with concrete OPD experience use these categories to highlight in their reports diagnostically well-founded points in the area of how relationships are handled, how conflict is experienced, and of the level of structural integration. These categories are used, above all, with a view to making the treatment plan and to bring into focus the therapeutic procedure more precisely with these points in mind. After initial restraint, the group of expert assessors has developed more and more interest in an operationalized diagnostic procedure and is about to familiarize themselves with the system through OPD training seminars. Whenever the OPD Guidelines, following the manual, are used in psychotherapy they certainly contribute to the quality of the psychodynamic understanding of the treatment planning, and the therapeutic actions.

9.4 OPD in inpatient treatment in psychosomatic-psychotherapeutic hospitals

Nearly all psychodynamically oriented hospital departments for psychosomatic medicine and psychotherapy already work with OPD systematically and use its potential - similarly to that of the QPP - in critical quality management of the outcome quality of inpatient treatments. In addition to the collection of socio-demographic data (Heuft/Senf, 1998), an indication for inpatient treatment is based on the syndromal diagnosis (ICD-10), flanked by a an assessment of severity (the German BSS ; GAF; Lange/Heuft, 2002) and the OPD diagnosis. In particular, the structure diagnosis, in the sense of a differential therapy indication, has a guiding function in the treatment decisions (Rudolf, 2004b; Rudolf et al., 2004c). Those repetitive-dysfunctional relationship and conflict patterns which can be recognized already in the outpatient pre-treatment diagnostic stages, can be clearly communicated in the letter to the referring doctor and amongst the inpatient treatment team: "Mr. A. suffers from a conflict of self-worth expressed in the active mode, with a high to moderate level of structural integration. It is to be assumed that he will quickly become involved in damaging dynamics on the ward. Already before admission it was agreed with him, cognitively, that his own share in conflicts which are still largely unconscious to him will be consequently pointed out to him (HSCS: stage 2; Rudolf et al., 2000). If conveyed to him in an empathic way, he will in all likelihood be able to make good use of this."

This example also demonstrates OPD's role in the planning of inpatient therapies, which, within the framework of an outpatient-inpatient-outpatient overall treatment plan, always have a focal-therapy character. The treatment foci of the inpatient part of the treatment may refer to Axes II, III, and IV, as described beforehand in the QPP. In the above example this would be: "Recognition of patient's own share in a developing hurtful dynamic (HSCS: stage 3) and successful anticipation which offers alternatives to such escalations (HSCS: stage 4)". Treatment success can be mapped out using the HSCS. The renewed assessment of severity of the diagnosis in the light of the finished treatment, as well as the formulation of individual therapy aims (Heuft/Senf, 1998) close to the patient's experience and behaviour (possibly together with the patient) complete the final documentation, which offers meaningful insights also to external examiners, for instance through the expert assessment service of the insurance companies, into the curative course of the treatment. A next step will see more intensive studies comparing institutions, with the aim of finding out the following: How much time

does a defined group of patients need, on average, at which dose of therapy (OPS 301, 2.1; Heuft et al., 2002), in order to reach which stage on the HSCS? And also: "Which treatment successes are stable over time?"

A further possible application of OPD is in the psychiatric liaison service with patients on different (somatic) inpatient wards: What likely influence do mental comorbidity, and, for instance, the structure (Axis IV) of a hospital inpatient have on time spent in hospital, on compliance, and on the course of his treatment and rehabilitation (Burgmer et al., 2004)?

9.5 OPD in the psychosomatic rehabilitation treatment

Next to prevention, curative hospital treatment and care, rehabilitation is another pillar of the health care system. The aim here is the restitution of the patient's ability to perform, function, and have relationships in his everyday and working life. The differences between rehabilitative and curative medicine lie in organization and funding structures, technical and housing facilities, different personnel structures, as well as a conceptual orientation according to the "Krankheitsfolgenmodell" (model about the consequences of illness) (Kriebel/Paar, 1999). In this respect, psychosomatic rehabilitation represents a specific form of inpatient psychotherapeutic care: not so much in providing the care for specific groups of mental diagnoses, but rather, in the treatment of illnesses which are already, or are becoming more chronic, with the resulting specific aims for therapy. If outpatient, or, for that matter, inpatient medical and psychotherapeutic measures have not sufficed to improve an impairment and its symptoms, an indication for rehabilitation is given. The same applies when illness-related damage has led to, not only, temporary impairment of activity (in the sense of a limitation of functions carrying out tasks and actions), of one's participation in the work area, or in social life.

The "Krankheitsfolgenmodell" (model about the consequences of illness) in its further conceptual development has come closer to the biopsychosocial paradigm proposed by psychosomatic medicine, in that it understands health and illness as the result of an interlacing of physiological, mental, and social processes. It directs its attention less to deficits as a result of the consequences of illness, but more so to still existing resources (International Classification of Functioning, Disability, and Health, ICF) (cf. Gerdes/Weis, 2000).

Psychosomatic rehabilitation against a psychodynamic background is focal short-term psychotherapy (Kriebel/Paar, 1999). It has a large emphasis on group psychotherapy (Günther/Lindner, 1999; Tschuschke/Mattke, 1997). Group psychotherapeutic work aims to enable patients to experience habitual, dysfunctional relationship patterns, as they have formed in the context of ego-function deficits, of self and self-worth disturbances, and their precipitates in everyday, but also in work relationships. It aims to positively influence the resulting disturbances of social integration, and to allow self-worth stabilization through the unfolding of performance-related professional skills (Lindner, 1992). In line with the particular aims of rehabilitation, its attention is centred on conflicts in the job, situations of excessive demand, work and performance disturbances. Identity conflicts, conflicts with authority, and narcissistic conflicts which lead to chronic distortions in the patient's attitude towards himself and others, play a particular

role. It is of lesser concern to integrate OPD into the existing quality assurance programme of the German national pension scheme, as this scheme is firmly in place, for the time being. Instead, OPD can contribute within the framework of a clinic's or a health-care institution's parallel-running in-house quality assurance systems for the improvement of process and outcome quality in the following way:

1. Use of OPD-diagnostic to elaborate a psychodynamic diagnosis; in the development of an understanding for "difficult" courses of treatment, and for the development of foci in the rehab team (process quality).
2. Use of OPD-diagnostic for the assignment of patients with varied levels of structural integration (Axis IV) to specific offers of treatment: (1.) for patients with a high to moderate level of structural integration: groups for working on the conflict pathology; (2.) for patients with a low level of structural integration: groups that work on ego-structural deficits (developing of restricted ego-functions, enabling of corrective emotional experiences (Günther/Lindner, 1999)).
3. Use of OPD-diagnosis in the socio-medical evaluation to assess the potential for change, as a function of the level of structural integration and the degree of chronicity of the conflict dynamic (Bückers et al., 2001).
4. Use of OPD-diagnostic for the basic documentation (supplementing the ICD-10 beginning and final diagnostic), in order to reflect change processes also in the letter to the referring doctor and to obtain new hints regarding responders and non-responders.

9.6 Training, continuing education, and post-graduate study

The many uses and applications of OPD described in this chapter are only one of the reasons that, within the training of psychological psychotherapists, or post-graduate education in the field of psychosomatic medicine and psychotherapy, as well as in psychiatry and psychotherapy, the teaching of OPD has become an essential component (it is, for instance, implemented in the curriculum for psychological psychotherapists). It also allows professional newcomers to acquire, within a reasonable training period, basic concepts of psychodynamic therapy (for example, through the textbooks of Heuft et al., 2006; Jaeggi et al., 2003). By supplementing the syndrome-led diagnosis in accordance with ICD-10, in a clinically evident form, through the ability, for instance, to describe the conflict-based background of a dysthymia, or the "structural level" of various "personality disorders" (according to ICD-10), it becomes easily understandable what goes to make up a "structural disorder", compared to a circumscribed conflict dynamic. This not only serves to satisfy scientific interest - in line with OPD's original intention. It also serves to elucidate issues around differential psychotherapy indications with a view not only to outpatient, but also to inpatient treatment methods.

In recent years, a great number of colleagues working in modalities of behaviour therapy or psychodynamic psychotherapy, who have been in clinical practice for years, have undergone OPD training seminars (cf. Chapter 10). This speaks for the clinical relevance of OPD. Not least of all, the possibility of an intercollegiate exchange in quality assurance circles about basic therapeutic procedures with the help of "operationalized terms" is experienced as a great help.

9.7 OPD and expert opinion

In psychosomatic medicine and psychotherapy it is becoming increasingly important to provide expert opinions in various legal contexts (for instance, in criminal law, civil law, or social law). For all these areas of law OPD can, in addition to the descriptive psychiatric diagnosis, help understand the mental development of the patient. A forensic opinion, which does not incorporate an understanding of the relevant particular mental developmental lines of the individual, from a psychodynamic and/or behavioral-therapeutic perspective, will be badly suited to making statements about motives, causes of, or also prognosis, about a "critical incidence" (for instance, a criminal act).

Issues of social legislation also comprise the question of whether there is a need for treatment or rehabilitation due to impaired health, and its consequences, like, perhaps, a reduced earning capacity, or inability to work (see for instance International Classification of Functioning; WHO, 2001). If an expert opinion is needed within the context of pension claims, or health or unemployment benefits, it concerns particularly the evaluation of a patient's capacity to perform his job, or his fitness to work. Additionally, in the law governing social claims and benefits, or in compulsory third party or private accident insurance, there are cases that require an evaluation of the causality in damaging events. So far, there are no uniform standards governing expert opinion in the various fields of law, as far as psychosocial dimensions go, that would need to be considered as a rule, or as far as methods for gathering respective data are concerned.

In the following, we focus on issues of social law, because this is where the emphasis of the authors lies. Expert opinion in psychosomatic medicine and psychotherapy comprises the following perspectives:

The descriptive disorder-related diagnosis reflects the psychiatric and psychosomatic symptoms or syndromes with the help of the ICD-10 while also taking into account somatic diagnoses (which might have been established beforehand).

A diagnosis that is oriented to conflict, structure, and behaviour allows the description of repetitive-dysfunctional relationship (Axis II) and conflict patterns (Axis III), or loss of structural abilities (Axis IV) across the lifespan. It allows this in a comprehensible manner for a court that passes judgment. Proof of the existence of such conflicts is part of the syndromal diagnosis in accordance with ICD-10, for example in the diagnosis of somatoform (pain-)disorders. Furthermore, conclusions can be drawn regarding current patterns of experiencing, relating, and behaving, in order to be able to assess a possible psychosocial background (for instance, increased susceptibility to emotional hurts) if a prognosis regarding an individual's performance or resources is to be made.

Aspects of a patient's capacity to deal with illness are often equally important, as expert opinions are, as a rule, commissioned in cases where disturbances and problem patterns exist which have become chronic. Axis I of OPD looks at the experience of illness (subjective suffering, secondary gain from illness) and focuses on aspects of the illness that are relevant for change, like, the patient's access to intrapsychic and interpersonal factors in the illness and their consequences for an assessment of his performance. The systematic collection of data on these aspects in

the process of establishing an expert opinion, and on the patient's expectations from the treatment, is helpful not only for the prognosis regarding the disorder, but also for the prognosis as to the patient's ability to perform.

The assessment of causality in social law (Schneider et al., 2001), in case of a disturbance caused by several factors, considers a factor (like the damaging event) as an essential concurrent cause, if it is regarded of equal value as other factors for the occurrence of the event. If one of several factors has a considerably larger importance in the origin of the disturbance, this factor must be regarded as the sole cause. Not only the damaging event and its particular damaging potential must be assessed, but also how the patient, in his psychosocial development and competencies, or deficits, copes with with the somatic, mental, or social stresses linked to the damaging event. The following aspects need to be clarified in detail during the drawing up of the expert opinion:

- At what stage was the individual development before the damaging event (within the norm, or clinically abnormal)?
- Are there hints as to specific psychosocial and somatic stresses the patient was exposed to before the occurrence of the damaging event, which would be likely to effect the mental or psychosomatic disorder on which an opinion is to be given?
- Has the damaging event (for example, an accident) led to an illness-equivalent disturbance, in the sense of it being considered an essential concurrent cause? To answer this question, the damaging event in its particular quality and with its related consequences for the individual must be examined and put into context with the relevant psychosocial developmental lines of the individual. If the stresses that were already in existence before, and independently of, the damaging event, are found to gravely influence the current disturbance, they are considered an essential concurrent cause. This also applies when maladaptive processes of coping with illness/damaging events are rooted in the individual's mental development across his life span. In accordance with the principles of social law, the damaging event is then not considered as an essential concurrent cause.

In response to the first two points, it will be necessary to describe the probationer's mental development before the occurrence of the event. For this purpose, an exclusive, or focal orientation on pre-existing mental or psychosomatic disturbances is, as a rule, not sufficient. The patient must be described along his basic developmental lines. Especially Axes II-IV of OPD (Interpersonal Relations, Conflict, Structure) are, in our opinion, well-suited to describing the individual development in its relevant basic features, so that conclusions regarding the nexus of causes for later-occurring mental or psychosomatic disorders may be drawn. The operationalization of relevant mental characteristics, and their concomitant structuring and systematization, allow a higher validity of statements, as well as an improved communicability, and comprehensibility. This makes the assessment of causality easier to review and to comment on. In contrast, Axis I (Experiences of Illness and Prerequisites for Treatment) provides only little information which is suitable to judge the issue of causality, as the characteristics that this axis refers to are essentially anchored in the "Here and Now" of the patient.

The aspects of transparency, communicability, and comprehensibility,especially, which the use of OPD encourages, are very valuable for the formation of an expert opinion. The judge, as a rule, will have the task of trying to comprehend the expert statements and assess their quality. The availability of an operationalized diagnostic model facilitates this task for him. We have lived to see that a judge summoned relatives and neighbours of a patient in an argument about the adjudication of a large sum from a private pension insurer, in order to have the patient's repetitive-dysfunctional relationship and conflict patterns described in their own words. Expert opinions constructed in this way turn out to be court-proof.

In summary, it can be said that, although OPD was originally developed as an instrument in empirical psychotherapy research, the manifold fields where it has been applied so far cannot be imagined without it any more; this is true, not least of all, for its role in quality assurance.

10 Continuing education and post-graduate study (with a list of addresses)

The complexity of OPD makes it necessary that it is being taught independently in specific training seminars to those who work clinically and scientifically, despite the fact that its subject matter relates to, in part, familiar categories. Experience has shown that this, as well as its continual use within the framework of supervised diagnostic processes, keep improving the quality of its application. This kind of learning process also allows the "feedback" of criticism, objections, and suggestions for change. From the beginning, the OPD working group has placed particular emphasis on ongoing training seminars and further study, in the same manner as has proven worthwhile for the introduction of the ICD-10 and other psychiatric diagnostic tools.

Interests and needs

The years after the publication of the manual in 1996 saw an increasing interest in OPD develop, which was also expressed in the demand for training possibilities. Among the particulary interested professional groups were, first of all, younger colleagues in psychiatric and psychosomatic-psychotherapeutic trainings, but also established colleagues with many years of clinical experience. Time and time again it has prove very stimulating that even colleagues who had no previous training in psychodynamic diagnostic could be taught psychodynamic thinking in the context of being exposed to OPD. This experience ran counter to the original conception of the system as suited only for those psychotherapists with extensive experience in this area. Over the years, psychotherapeutic training institutions were added (first of all for psychodynamically oriented therapies, later on also for psychoanalysis), whereby the trainings in these cases were often conducted with the multipliers, that is to say, the seminar leaders of the respective institutes.

A further interested group consisted of younger scientists who learned the method for application in research projects. With the publication of translations in several languages, an interest in the seminars developed also in several other countries, including Italy, the United Kingdom, Hungary, Chile, and China.

The organization of OPD training and post-graduate training seminars

Developing uniform diagnostic habits has been a traditional difficulty in the area of psychodynamic therapy methods. This is linked, amongst other things, to the fact that psychodynamically oriented diagnosis has developed especially with the therapeutic process in mind, being less concerned with descriptive and symptom-oriented aspects. The diagnostic process was understood as a possibility of initiating and testing out a relationship with the patient, and besides, served to motivate the patient to have psychotherapy. Only in this context was it intended to elaborate the relevant psychodynamic constructs. A training within the framework of OPD must, therefore, attempt to integrate these two central aspects of diagnostic, that is to say, the categorial and the interactional components.

Training and postgraduate-training seminars should be designed to: give participants an understanding of the contents of the OPD axes; clarify and discuss existing diagnostic habits; provide direct practical opportunity to test out the new system

The training is divided into a basic course and two advanced training courses, which comprise 20 hours each. Adherence to this schedule has proved worthwhile, but there are several options for adapting this to local situations. Altogether, the range and volume of training are such as are customary also for the current psychiatric diagnostic systems.

The structure of an OPD basic seminar

1. Introduction to the particularities and the history of psychodynamic diagnostic and OPD,
2. introduction of the axes, with reference to the traditions within which they originated, and their categories, using videotaped material,
3. rating and discussion of one to two complete interviews (videotaped or live),
4. final discussion,
5. elective: special block on conducting the interview.

The structure of an OPD advanced course

1. More in-depth study about individual axes with the help of selected case material, using segments of videotapes for specific didactic purposes,
2. assessment and discussion of complete exemplary videotapes or live-interviews,
3. final discussion.
4. Depending on the individual requirements, discussion of specific clinical issues and research areas, for example, change measurement with the Heidelberg Structural Change Scale, focus selection with the help of the Interpersonal Relations Axis, application in research projects.

Specific advanced course

A seminar for the introduction to new developments in OPD-2.

Other forms of teaching and training comprise the following:

- Talks giving simple information which could be organized, for instance, for clinics or institutes, as short presentations, or "take-a-snoop" afternoons, through authorized trainers,
- Training seminars for whole clinic teams, which are frequently conducted as regular OPD-oriented offers of supervision conducted over longer periods of time, mostly full or half days,
- goal-oriented seminars for training institutes, or lecturers,
- research-oriented supervision in projects which use OPD as a method, etc.

The contents of the trainings, and main emphasis

Trainees gain an understanding that OPD depicts relevant aspects of the personality, which, in turn, go back to different theoretical and clinical traditions. Their historical origin lies in general health psychology (experience of illness), in research on interpersonal relationship patterns (Interpersonal Relations Axis), in the traditional psychoanalytic drive and object relations theories and in ego and object relations theory (Structure Axis). This forms the basis for an understanding of the system and is taught in the introductions to the seminars.

This is followed by an introduction to the sources of information required to carry out the OPD rating. In this context are not only "objective findings" are used as they result from clinical examinations, medical findings, but also "hard" biographical data. Also, information is to be taken into account which can be derived from the interview, from the way content is selected and reported, from its verbal and non-verbal elements, as well as from the "scenic information" resulting from all of this. In many seminars, the skill of conducting the OPD interview is taught in a separate block (see Chapter 5).

The OPD diagnostic attempts to help identify, and classify, personality characteristics with the use of describable categories still further clarified by examples. For this purpose, the complexity of the original theory must consciously and intentionally be reduced, in order to for it to be accessible to examination and communication. From the beginning, the OPD user is therefore required to critically accept this reduction in complexity. Only in this way can the prescribed definitions and operationalizations be closely adhered to, and thus approximate the required quality criteria according to the theory to test reliability and validity. These problematic issues are discussed at the beginning, when the individual axes are also taught. There is by now copious material for teaching this segment, consisting of edited videotapes, supporting scripts (e.g. checklists, presentations, etc.), which is to facilitate its use in everyday clinical practice.

Overall, case work has turned out to be the best basis for discussion and evaluation. Over the course of the years, the OPD group has documented "standardized" cases on videotape and evaluated them, so that seminar participants may compare their own evaluation with those of an "expert group". In addition, many clinics and other institutions use the possibility of conducting live-interviews with patients of the institution. This allows not only a good introduction to the problems connected with conducting an interview, but also a quasi case-related supervision for the therapists involved. In this context, also the work on focus formulation and on change evaluation (Heidelberg Structural Change Scale) has become an established part of the trainings.

Certification

The standardized cases are also used, when necessary, to give individual participants who have completed the three courses, a certification which permits them to use the system in scientific studies. This certification requires a sufficiently reliable assessment of a case previously assessed by the working group. The criteria for "passing" the reliability examination have been constantly adapted and further developed, based on past experience .

Participants who do not work in scientific projects can, of course, also obtain such a certification, that is to say, gather information on the degree of their familiarity with the OPD system. Court accredited expert witnesses, can, for instance, refer to the certificate as legitimization of their use of the OPD criteria in court. The certificates are issued by the OPD training representative after the seminar participant sends in proof of their participation in the required training seminars and confirmation of a reliability assessment on his rating.

Past experiences gained in the training seminars

The background from which participants of the seminars tend to come has been described above. During the past few years several thousands of colleagues working psychotherapeutically were trained within the framework of open seminars, in seminars as a part of psychotherapy training weeks, in clinics and institutes. In many clinics, OPD, under supervision of trainers, has become a fixture in improving "diagnostic quality" and in post-graduate medical training, and in the training for psychological psychotherapists. The growing interest in OPD from the field of forensic psychiatry and amongst expert assessors within the framework of the German Guidelines for Psychotherapy has also opened up new areas for its application.

Our experience of the first few years has shown that many colleagues find it beneficial to critically engage with OPD and to take part in case-oriented training seminars. The application of OPD allows a categorization of highly complex subject matter into a suitably reduced system of categories. The discussion of concrete cases enables participants to reflect on their own diagnostic habits, as well as to discuss controversial issues with colleagues on the same, as opposed to on hierarchical levels. Many of the objections that came up in the training seminars were taken up by the trainers and the OPD working group and incorporated into OPD-2.

A frequent request was to establish a more immediate link between the diagnostic categorization and clinical-therapeutic practice. Thus the development of the Heidelberg Structural Change Scale made it possible to integrate the elaboration of foci with the help of OPD into OPD-2. Our initial worry that OPD would tempt the therapist to make "low-complexity" diagnoses has not been confirmed. The discussions in the training seminars have shown that the orientation on the "OPD-architecture" leaves enough room, every single time, to take into account individual constellations; quite contrary to the worries, it promotes and facilitates these.

Outlook

Now and in future there will be regular open training seminars in locations across the whole territory of the Federal Republic of Germany (basic and advanced courses) in regular intervals. There will be the continued offer to train the staff of individual clinics, or to accompany them in a supervisory capacity. It is to be desired that ongoing research projects will come up with initiatives which will develop modules for disturbance-specific fields of application, like, forensic patients, patients suffering from addictions (see, for example, Chapter 4.1). Out of such initiatives, corresponding training modules for the respective clinical fields of application can be elaborated.

Training centres

The current structure of the OPD training seminars has a regional orientation. Requests for training seminars should be directed to the representative of the respective regional training centre.

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Authorized trainers

A prerequisite for the accreditation as authorized OPD trainer is not only that applicants must have many years of clinical experience with psychodynamic or psychoanalytic therapy methods, and with OPD itself, but also active participation in one of the OPD-axes working groups. Currently, the following persons are commissioned with conducting OPD training seminars:

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13 Tools for working with OPD

13.1 Axis I – Forensic Module

At first contact, people using forensic mental health services are usually presented or present with their problems as offending or antisocial behaviour. This applies whether people are detained or imprisoned in secure conditions or free in the community. Many of these people do not present their suffering in a conventional way. They may show little awareness of having mental health problems and therefore often present with little or no motivation for psychotherapy, but rather a presence or absence of a willingness to comply with what they see as being required of them. This may be further compounded by being coerced into receiving treatments. Many come from or are still connected to deprived and abusive or chaotic backgrounds, which may interfere with treatment. Many have such limited personal resources that their capacity to engage in treatment is impeded. This is why additional factors have to be represented in the OPD in order to do justice to the specific demands and challenges in the treatment of forensic patients. The severity of the problem and the risk assessment are closely linked to the severity and frequency of the committed offences and the required level of security. The severity of paraphilic tendencies and of the (frequent) abuse of psychotropic substances is of great importance for the process of deciding on a therapeutic strategy and for the prognosis. Apart from this it is of major relevance how much the individual patient is capable to distance himself from the offence while at the same time taking on responsibility for it – which is sometimes only possible after many years. The respective rating on the different levels of the Forensic Modul of axis I (together with the basic and psychotherapy modules and the other axes of the OPD) offers an assessment of the psychological situation of the individual patient which is especially relevant for the process of making a differential decision as to which specific treatment modality is indicated and of assessing the prognosis. The theoretical background and operationalization of the forensic module are going to be covered in a separate publication.

Forensic Module

Objective rating of the illness/the problem
1. Current severity of the disorder/the problem
1.F1 Type and severity of the paraphilic/perverse disorder
1.F2 Type and severity of substance abuse
1.F3 Type, severity and frequency of delinquent and/or antisocial behaviour
1.F4 Level/nature of security
1.F5 Level/nature of coercion into treatment
2. Duration of the disorder/of the problem
2.F1 Age when antisocial behaviour first manifested
2.F2 Age when first convicted, jailed as a juvenile offender, or when antisocial action was first documented
Patient's experience and presentation of illness; concepts about illness
3. Experience of illness and presentation of illness
3.F1 Presentation of delinquent behaviour and/or antisocial behaviour modes
5. Patient's concepts regarding change
5.F1 Attitude to placement
5.F2 Attitude to coercion into treatment or contractual structure
5.F3 Attitude to the prospect of change with respect to reducing antisocial behaviour
Resources for change/ Impediments to change
6. Resources for change
6.F1 Openness towards consideration of psychological factors influencing offending/antisocial behaviour
6.F2 Openness to associations between offending/antisocial behaviour and subsequent mental states
7. Impediments to change
7.F1 Comorbidity
7.F2 Psychosocial advantages because of delinquent/antisocial behaviour
7.F3 Psychosocial advantages because of (court) ordered measures and involved services
7.F4 Utilization of mental disturbance with regard to delinquent/antisocial behaviour

13.2 Axis II

13.2.1 Itemlist axis interpersonal relationships

The patient experiences himself (towards others or with others) time and time again as ...				Relationship Themes	The patient experiences others time and time aga			
	Others - including the interviewer - experience the patient time and time again as ...					Others - including the interviewer - experience with respect to the patient time and time aga		
		1	Allowing a lot of space, letting them do their own thing	Allowing space			1	Allowing a lot of space, letting him d thing
		2	Guiding little, avoiding influence	Guiding others			2	Guiding little, avoiding influence
		3	Admiring, idealizing	Acknowledging others			3	Admiring, idealizing
		4	Being apologetic, avoiding reproaches	Attributing responsibility			4	Being apologetic, avoiding reproache
		5	Being invasively affectionate	Showing affection			5	Being invasively affectionate
		6	Harmonizing, avoiding aggression	Showing aggression			6	Harmonizing, avoiding aggression
		7	Caring very much, being worried	Caring			7	Caring very much, being worried
		8	Tactlessy imposing himself	Making contact			8	Tactlessly imposing themselves
		9	Restricting space, interfering	Allowing space			9	Restricting space, interfering
		10	Controlling, making claims and demands	Guiding others			10	Controlling, making claims and dema
		11	Belittling, devaluing, and embarrassing others	Acknowledging others			11	Belittling, devaluing, and embarrassir
		12	Accusing and reproaching	Attributing responsibility			12	Accusing and reproaching
		13	Withdrawing his affection	Showing affection			13	Withdrawing their affection

		14	Attacking and damaging	Showing aggression			14	Attacking and damaging
		15	neglecting, abandoning	Caring			15	neglecting, abandoning
		16	overlooking, ignoring	Making contact			16	overlooking, ignoring
		17	Claiming space and independence for himself	Claiming own space			17	Claiming space and independence for
		18	Defying and resisting	Conforming			18	Defying and resisting
		19	Boasting, making himself the centre of attention	Being self-assertive			19	Boasting, making themselves the cent attention
		20	Denying any guilt	Admitting guilt			20	Denying any guilt
		21	Losing himself when others show affection	Accepting affection			21	Losing themselves when he shows aff
		22	Protecting himself insufficiently, allowing dangerous developments	Being self-protective			22	Protecting themselves insufficiently, a dangerous developments
		23	Leaning heavily on others, clinging	Relying on others			23	Leaning heavily on him, clinging
		24	Having few boundaries in place, being too involved	Allowing contact			24	Having few boundaries in place, bein involved
		25	Avoiding autonomy, seeking guidance	Claiming own space			25	Avoiding autonomy, seeking guidanc
		26	Complying, holding back, resigning	Conforming			26	Complying, holding back, resigning
		27	Belittling, devaluing himself	Being self-assertive			27	Belittling, devaluing themselves
		28	Blaming himself	Admitting guilt			28	Blaming themselves
		29	Shutting himself off, fleeing from other's affection	Accepting affection			29	Shutting themselves off, fleeing from affection
		30	Protecting himself, especially from attacks, being on guard	Being self-protective			30	Protecting themselves of his attacks, b guard

		31	Not leaning on others, being self-reliant	Rely on others			31	Not leaning on others, being self-relia
		32	Isolating, cutting himself off, withdrawing	Allowing contact			32	Isolating, cutting themselves off, with

13.2.2 Rating of themes and resources

A) Start by marking, in the two outer columns on the left and on the right, all relationship modes of the patient which are dysfunctional. B) Decide which of those modes are most relevant with respect to the disorder of the patient. C) Identify the related relationship themes in the central column. Choose a maximum of two of these themes in the column marked P (problem theme), by putting a "1" for the most important, a "2" for the second most important.	D) You can then make two problem formulations according t format: "The patient tends to [dysfunctional variant], instead of [re theme]". Example: "The patient tends to totally devalue h instead of appropriately emphasizing his own worth [sho off to advantage]". E) Finally, mark in the column "R" (Resources) which interper competencies, in the sense of a resource, the patient posse general format for formulating resources is: "The patient has the a (relationship theme)".

Dysfunctional variants: "too little"			P	Relationship Theme	R	Dysfunctional variants: "too much"		
☐	leave no space for others, patronize them	restrict space for others, interfere	☐	allow space for others and let them to do their own thing	☐	allow a lot of space for others	let others cope all by themselves	☐
☐	seek guidance with others always	avoid independence	☐	develop freely and ndependently in the presence of others	☐	tclaim a lot of space and independence for oneself	do everything totally independently and in one's own way	☐
☐	totally devalue, scathingly criticize others	devalue and embarrass others	☐	value and acknowledge others	☐	admire and particularly acknowledge others	idealize others, totally overrate others	☐
☐	totally devalue, negate oneself	devalue, belittle oneself	☐	show oneself off to advantage, in an appropriate way, with others	☐	claim lots of self-importance	behave in a continual self-important way, make oneself the center of attention	☐
☐	withdraw affection from others for good	withdraw affection from others	☐	show affection towards others	☐	be invasively affectionate	persecute others with one's affection	☐
☐	run when others show affection	shut oneself off when others show affection	☐	get involved when others show affection	☐	getting involved very quickly when others show affection	lose oneself when others show affection	☐

☐	neglect and abandon others	take little care of, and neglect others	☐	care for others appropriately, to worry	☐	take very much care of others, worry about them	care about others all the time, worry about them	☐
☐	be totally self-reliant, need no help at all	show few needs, lean on others very little	☐	show neediness, to trust, to lean on others	☐	show great neediness, lean very much on others	cling, lean heavily on others	☐
☐	totally shy away from influencing others	rather avoid influencing others, not guide others much	☐	guide others role-appropriately, be a leader	☐	control, be hard to please, make demands	be very controlling, very hard to please, stern demands on others	☐
☐	be very resistant, defy any rule	resist quickly, enjoy defying others	☐	conform role-appropriately, comply	☐	adapt quickly, hold back	totally submit, give up, resign	☐
☐	avoid all reproach, instantly excuse others	rather avoid reproach, excuse others	☐	appropriate attribution of responsibility to others for their guilt	☐	reproach quickly, frequently accuse others	constantly accuse others, always complain	☐
☐	totally deflect any guilt	quickly deflect guilt	☐	appropriately accept one's own guilt	☐	quickly accept guilt	constantly take the blame for everything	☐
☐	shy away from any aggression	rather avoid aggression, harmonize	☐	adequately show rejection and aggression	☐	quickly become aggressive, attack others	aggressively threaten or damage others	☐
☐	endanger oneself over and over again, be totally unprotected	misinterpret and overlook slight threats	☐	adequately protect oneself from attacks/dangers	☐	be very careful for fear of attacks	be constantly on one's guard for fear of attacks	☐
☐	ignore the boundaries of others, tactlessly impose oneself	get too close to others, be tactless	☐	make contact with others adequately	☐	be little interested in, and easily overlook others	pay no attention at all, ignore others	☐
☐	be totally transparent towards others, allow everything in	have few boundaries in contact with others	☐	be adequately open in contact with others while having good boundaries	☐	cut oneself off, withdraw from contact	cut oneself off, isolate oneself from others, leave	☐

13.3 OPD-2 Conflict Checklist

Perception of conflict and affect impaired by means of defence

Perception of conflict and affect impaired by means of defence
General criteria
Type of person: People who overlook conflicts within themselves and in interpersonal relationships, and who have difficulty perceiving and recognizing feelings and needs in themselves and others.
Lead affect: No lead affect, due to avoidance of, especially anhedonic affects and conflicts through exaggerated defence in the sense of a protective function.
Countertransference/interaction: The countertransference may either produce few affects, like disinterest, and boredom, or those affects which the patient tends to leave out or covers up by being factual; possibly anger because of the patient's defensive presentation.

Areas of life
Family of origin
Despite the existence of possibly difficult conditions, relationships are described in a uniform, low-affect, factual manner as "unproblematic". The individual's behaviour is determined by conventions. Changes, for example separations, seem to happen in a matter of fact wayand without friction.
Partnership/family
Normality and functionality are emphasized. Changes are reported as facts and without emotional involvement.
Job
Often jobs which are intensely fact-oriented. Performance is important, if it refers to factually solving job-related tasks. Occasional involvement in interpersonal conflicts at work, because no attention is given to emotional relationships.
Social environment
Social life appears to be handled in a functional manner, whereby emotional and conflictual areas are avoided.
Possessions
Handling of possessions is functional and fact-focused. Somtimes noticeably more emotional relationships with material things than with living objects (for compensation).
Body/sexuality
Dealing with the body in a fact-based, rational manner. The body must function like a machine. Sensuous, enjoyable bodily experiences are hardly possible, sexual "functioning" may be important as an expression of normality. Processes of change or aging are denied or referred to the "repair shop".
Illness
Illness is experienced as a fateful event without a great amount of emotional involvement, or as a problem which is to be technically solved. On the surface, often good compliance in order to support doctors' "repair efforts".

Preference for technical treatments.

Conflictual stresses (stressor-induced conflict)

Conflictual stresses (stressor-induced conflict)
General criteria
Considerable to severe stresses (time window: the last six months) can lead to a contradiction in the patient's motivational system, which can be sufficiently explained by the presence of a concrete inner or outer demand. The probability of a stressor-induced conflict arising is detemined by (1.) the extent of the internal motivational conflict-based tension, and the external stressor, and (2.) the available resources. The stressor-induced conflict expresses itself within the antinomies of human motivation and shapes the pre-existing individual conflict-based tension. The stressor-induced conflict thus has a conflictual "appearance", as the basic motivational patterns determine the inner experience, without a conflict, in the afore-mentioned sense, being present as an ongoing dysfunctional pattern (beware: trigger situation). Apart from that, different types and shapes of dysfunctional internal conflictual patterns may be present. The motivational conflict vulnerabilities referred to here may interact with the structural and biological ones and, in most cases, individually or together, meet the criteria of an adjustment disorder in accordance with ICD-10. The stressor-induced conflict must be differentiated from a posttraumatic stress disorder (PTSD). Basically, stresses can be dealt with both in an active or a passive mode. As concerns the intensities of the criteria for the individual areas of life, they correspond to the criteria for the active or passive mode described for the other conflicts, depending on which motivational system is addressed.

C1 Individuation versus dependency

Individuation versus dependency
Existential importance of independence in relationships.
Bipolar tension between the search for a close relationship and intense closeness (dependence), and the striving for a well-articulated independence and marked distance (individuation). In case of accentuated polarization, this conflict can gain existential importance in the life of the individual, in the sense of having-to-be-on-one's-own, or the having-to-be-with-others Delineation: If the attachment constellation is primarily dominated by strivings to be cared for, or by identity problems, etc., other conflicts must be assigned.

Passive mode	Active mode
General criterna	
Type: Close and secure relationships at (almost) all cost, avoiding of responsibility and independence, subordination to the wishes and interests of significant others,	Type: exaggerated emotional and existential independence, a constant struggle in all areas of life for autonomy and independence, suppression of one's own

denial, trivialization, or rationalization of conflicts in relationships, self-percepetion characterized by helplessness, weakness, and dependence on others. Lead affect: existential fear of loss, separation and loneliness. Countertransference: Care and responsibility, fear of overly strong wishes for closeness and of being smothered.	needs for leaning on others and closeness, self-perception is one of great strength, conviction of not needing anybody. Lead affect: existential fear of closeness, of being smothered, and of merging. Countertransference: Hardly any feeling of responsibility, little need for care and protection, worry about defended against wishes for dependence.
Areas of life	
Family of origin	
■ An attitude of not growing up internally, with the position of 'child' predominating in one's self-understanding and in real relationships ■ Prolonged remaining in the parental home to live ■ Maintaining the familial context even at great disadvantages to oneself ■ Oscillating between positive and negative judgements of primary relationship figures	■ Forceful move away from the family, often accompanied by conflicts or a radical break, refusal to play the role of son/daughter ■ Leaving the family prematurely ■ Refusal to adopt the positon of child, feeling adult very early on ■ Struggling against or ignoring family traditions and norms
Family/partnership	
■ Voluntary subordinate position ■ Relinquishing of active and interest-guided shaping of intimate relationships, passing the responsibility to the partner ■ Prevention or denial of divergent developments of the partners ■ Harmonizing of differences, trivializing conflicts ■ Avoiding of changes towards independence	■ Marked independence in intimate relationships ■ Being the dominant partner in the management of the shared lives ■ High degree of conflict due to ambivalent tendencies in partners' relationship patterns ■ Emphasis of differences and living of conflicts ■ Autonomous development independently followed through, also at expense of the partner
Job/professional life	
■ Preference for subordinate and contributory tasks, avoiding of responsibility and positions of authority. ■ Competition and job promotions subordinated to wishes for maintaining	■ Striving for professional niches. They strive to occupy niche professions which offer a large degree of autonomy, without the necessity for much cooperation ■ Maximum self-responsibility and

existing relationships ■ Solidarity amongst colleagues and belonging to the company have significant meaning ■ Remaining in the same job for a very long time ■ Staying in a job in times of crisis, often accepting disadvantages, keep working even when health is impaired	independence, professional career or economic success are secondary ■ Preference for carrying out their professional tasks within a framework of independence ■ Tendency to engage in conflicts with colleagues and superiors, problems working in a team ■ Tendency of frequent changes of job, or profession
Possessions and money	
■ Ranking of possessions below relationships ■ Striving for possessions to create or maintain relationships ■ Avoiding or denying the existence of possessions when they affect relationships ■ Generosity or charitable acts to establish or secure relationships ■ Renunciation of possessions when they threaten relationships	■ Aiming for secure financial situation as a basis for independence ■ Avoiding financial responsibilities ■ Overemphasis on possessions to create distance ■ Possessions used as a means to disengage from relationships ■ "No possessions" as the ideal of total independence
Social context	
■ Seeking an association with diverse groups over individual contacts ■ Gravitating towards groups with a strong sense of belonging and a common ideology ■ Effort to be integrated into the group, feeling of belonging is important ■ Involvement in the organization and running of these groups for the sake of the group and group cohesion	■ Tendency to avoid group membership ■ Tendency towards changing and short-term social contacts ■ Ignoring or devaluing of social commitments ■ Preference for world views and ideologies representing the ideal of independence
Body/sexuality	
■ Bodily needs are subordinated to the relationship and its maintenance ■ Existing bodily needs and limitations are stressed in order to thereby establish closeness to relationship figures ■ Sexuality is used to secure closeness, often	■ Bodily needs and limitations are ignored in order to avoid dependence and closeness ■ Cultivation of physical performance as a means of achieving autonomy and independence ■ Cutting out of awareness bodily

including the renunciation of own personal needs	limitations and waning performance, exaggerated youthfulness ■ Suppression of sexual needs, or living those needs while avoiding attachments and closeness
Illness	
■ Possibility of living out needs for dependence, legitimation of one's personal strivings for dependence ■ Lacking independence during the treatment ■ Frequent visits to the doctor, remaining in the care of a treating physician for years ("faithful" patients) ■ Striving to continue the treatment by remaining remaining ill ■ Attempt to shape the doctor-patient relationship as very close	■ Threat to independence ■ Attempt to ignore symptoms and consequences of illness ■ Tendency to maintain one's independence even during the treatment ■ Rejection of prescribed treatment programmes, bad compliance ■ Doctor-patient relationship becomes factual and distant, frequent change of doctors to avoid attachments

C2 Submission versus control

Submission versus control
The central motive is to dominate the other, or to submit to the other. Submission and control are the non-adaptive extremes on the continuum of "allowing others to guide you", or, "to guide others". Experiences of power and/or helplessness influence particularly the individual experience of self-worth, therefore special attention must be paid to differentiate them from self-worth conflicts in a specific sense.

Passive mode	Active mode
General criterna	
Type: Passive-aggressive submission Lead affect: Helpless rage, lust to submit, fear, shame Countertransference/interaction: Latent aggressive behaviour and feelings of annoyance alongside submissive behaviour	Type: Aggressive striving for dominance. Lead affect: Defiant aggressivity, lust for power, anger and rage, annoyance Countertransference: A power struggle accompanied by the fear of being determined
Areas of life	
Family of origin	

■ Submission to family traditions ■ Acceptance of hierarchically structured relationships ■ Responsibilities and duties strictly regulate relationships, often over generations ■ No-alternative acceptance of predetermined rules ■ Absence of any sense of revolt	■ Imposing of cross-generational, rigid rules ■ Exertion of power rationalized via the argument of care ■ Cross-generational tensions, contact may be radically cut-off, anger ■ Reduced ability to balance out interests ■ Appropriate submission is difficult
Family/partnership	
■ Inability to say "no" ■ One's own views or wishes are subordinated ■ The "determiners" in the family are placed under the obligation to adhere to strict rules, in the sense of a tit-for-tat ■ Passive resistance indirectly through procrastination, dawdling, stubborness ■ Inability to contradict may appear as sacrifice for the family	■ Independence of mind to the point of defiant aggressivity ■ Suggestions by others deviating from own ideas give rise to a feeling of outside-determined regulation ■ Behaviour appears particularly dominant, regulating, often interfering, and may come across as a constant know-it-all attitude ■ Inability to reflect on one's own rules ■ This kind of tyranny may impress as excessive engagement for the family/partnership
Job/professional life	
■ Subordinate position maintained despite chances for promotion ■ Work demands are passively sabotaged ■ Gives the impression of reduced job performance ■ Position of "eternal number two" a conceivable option in the mixed, but predominantly passive mode	■ Striving for executive positions, or positions offering great autonomy ■ One's own judgement and style of leadership as the measure of all things ■ Constructive criticism or suggestions by others misconstrued as attacks ■ Need for dominance leads to overemphasizing work, performance, and profession ■ Ambition gives rise to likely conflictual behaviour
Social context	
■ A rather subordinate position taken up in neighbourhood, community, associations and groups of friends ■ Obedient or uncritical submission to ideological, religious, or political philosophies ■ Suffering the humiliation of being determined	■ Membership in social groups and associations, or friendships, serve to exert power and influence ■ Apparently selfless engagement may turn out to be a claim for power, when differences in opinion, new elections, or altercations with successors in previously held positions arise

	■ Loss of power experienced as threat
Possessions	
■ Apparent willingness to give things away covers up central importance of possessions and money ■ Readiness to give and no-demand attitude is countered by an extremely well guarded, highly emotionaly invested "core possession"	■ Possessions and money are important power tools ■ Less-well heeled individuals can be recklessly pushed aside
Body/sexuality	
■ The body is experienced as an object, to the demands and needs of which one surrenders ■ Health maintaining or paramedical instructions need to be followed to the letter ■ Feeling of helplessness towards uncontrollable signals of the body ■ Body posture may convey submission non-verbally ■ Submission to the sexual demands of others or unconscious rejection	■ The body is functionalized as an instrument for the individual's strivings for power ■ Bodily limits ("one's weaker self") are ignored ■ Demonstration of power through emphasis on bodily attributes and dress ■ Fantasies of dominating the body ■ Sexuality used as a power tool.
Illness	
■ Illness seen as fate one has to suffer ■ In doctor-patient relationship, obedience predominates ■ Passive sabotage of medical instructions and agreed upon cooperation ■ Passive-aggressive suffering as coping style in severe illness	■ Fight against illness "at all cost" ■ Active coping with illness up to a point of doggedness, accompanied by inflexibility, or difficulty, to integrate recidivism and relapse ■ Doctor-patient relationship involves righteous and controlling arguments ■ Coping style in serious illnesses consists of defiant reaction against loss of control

C3 Care versus autarky

Care versus autarky
Basic ability to form relationships is existent, relationship and individual experience are characterized by wishes for care and safety, or their defence.

Exploitation of others and clinging behaviour ("depending and demanding", passive mode) versus a caring, non-demanding basic attitude involving considerable "altruistic" concern and care for others (active mode).
It refers to the fundamental need of individuals to obtain something, as opposed to not needing any care, and thus about dependence in the relationship, and it this is not clear (differentiation to individuation/dependence).

Passive mode	Active mode
General criterna	
Type: Clinging, demanding Lead affect: Sadness, depression accompanied by the fear of losing the other, feelings of envy Countertransference/interaction: Clinging, blackmail, worry, exploitation, and annoyance	Type: Non-demanding renunciation in order to do right by the other Lead affect: Worry about the other person, latent depression, feelings of envy Countertransference: "Do right by everyone", not be a burden, "latent yearning", empathy, sadness
Areas of life	
Family of origin	
■ Dependence on care goes beyond generational boundaries ■ The family group stays together for long periods, often overly loyal	■ A forced taking off from the family of origin (fleeing the nest) ■ Active care for the family as a possibility to unconsciously continue a relationship in which one is cared for
Family/partnership	
■ Clinging to, and wish to be cared for by the relationship ■ Close, demanding relationships ("always together") ■ Separation fantasies trigger fear and despondency	■ Self-sufficiency and self-sacrificing in the relationship, wish that "this may one day be paid back" ■ Close relationships ("I am always there for the other") ■ Defending against tendencies to have relationships/to cling by frequently changing relationships ("The other is at my beck and call").
Job	
■ Seeking out of work situations which give support and safety ■ Demands and social rise can be experienced as loss of support, triggering refusal, to the point of despondency	■ Irreplaceable, self-sacrificing, capable, employees, but who expect eternal goodwill ■ Self-exploitation may endanger one's health ■ Loss of or threat to the job/the professional recognition can lead to depression

Possessions	
■ Everything must be "possessed" in order to gain a feeling of being cared for ■ Giving things away is avoided	■ The displayed selflessness implies considerable (also material) responsibilities for the other ■ Because of the selflessness, possessions might be at considerable risk
Social context	
■ Only a few, but extremely close social contacts ■ Other people experience them as demanding and taxing	■ Contacts serve the care of others, but do not create real friendships ■ Others, however, do not feel committed, but tend to display behaviours of exploitation and devaluation
Body/sexuality	
■ The body demands continual care and is the cause of constant worry ■ In reality, however, the body receives little in terms of true care ■ Sexuality is a possibility of having the need for care met; this includes "sex hunger".	■ The body is not acknowledged with its signals and limitations, it is expected to "function" ■ The body may itself become an object of care, and, like everything else, be actively cared for ■ Sexuality represents danger to "give oneself", comprises, however, the secret possibility of attachment
Illness	
■ Illnesses and accidents require "even more" care ■ Carers experience the passive attitude as arduous and anger-provoking	■ Offers of help are mostly refused, absence of adequately regressive behaviour ■ Suffering enables complaining and demanding ■ The actual care received is often "not good enough"

C4 Self-worth conflict

Self-worth-conflict
Each human being wishes to have their feelings of self-worth satisfied and acknowledged (self-worth versus object worth). A self-worth conflict is present when efforts to have one's self-worth acknowledged appear excessive and unsuccessful, or in the past and/or currently insufficient, or to have failed. This conflict does not address the automatic involvement of the narcissistic

motivational system (narcissistic "overtones") when any of the other conflicts arise. As concerns the self-worth (structure), a sufficient ability for regulation must be presupposed in order for a motivation-based conflict with a specific trigger situation to arise at all.

Passive mode	Active mode
General criterna	
Type: Self-image as someone who is worth less than others Lead affect: Clearly noticeable sense of shame Countertransference/interaction: In the transference, idealizing admiration. In the countertransference feelings of needing to affirm (with subliminal noticeable feeling of devaluating elements) or of putting others down	Type: Forceful self-assuredness towards others Lead affect: Narcissistic rage Countertransference/interaction: In the interaction, the investigator is often questioned, to the point of being devalued and insulted. The countertransference reveals impulses of justification, followed by annoyance, or even put downs
Areas of life	
Family of origin	
■ Despite efforts, the myth of failure persists ■ Self-devaluation against the background of the overvalued family	■ Idealization of the family of origin, idealization of one's own biography ■ Trivialization to the point of denying (a possibly shameful) family history
Family/partnership	
■ Stabilization in the relationship through common experiences of injuries and humiliations ■ Delineation from others who seem to fare better	■ Relationships serve to stabilize the feeling of self-worth (self object), one is admired, or the partner is so worthy of admiration ■ Constant devaluation of the partner serves to raise one's own profile
Job	
■ Work and effort to compensate for injuries and hurts ■ Hightened capacity to feel injured when efforts are not noticed or ignored ■ Refusing performance ("This is too much - I won't manage") while stressing one's incompetence, or inability	■ Overestimating one's position and performance ■ Problems and deficits in one's own performance are denied, which causes problems at the work place
Social context	

■ Social contacts preferably with others who are disadvantaged ■ Resigned withdrawal in the face of social demands	■ Contacts with celebrities or well-known personalities are sought out or pointed out for self-assurance ■ Active setting apart from supposed "failures"
Possessions	
■ Accumulated possessions compensate for insufficient or lacking experience of self-worth (“possession as sign of approval”)	■ Possessions and money serve the assertion of self-worth ("fetishes of affluence")
Body/sexuality	
■ Body is experienced as inferior ■ Neglecting one's body ("The body gets what it deserves") ■ Alternatively, futile attempts at correcting various body parts ■ Conviction about one's own sexual unattractiveness	■ Overly strong tendency to make the body appear young, beautiful, and attractive, to compensate for perceived, or at times real, weaknesses; problems with the aging body ■ Fantasy of bodily invulnerability ■ Overvaluing of sexual potency/attractivity as a self-worth tonic
Illness	
■ Illnesses often confirm the deficits perceived in one's self-view ■ Illnesses or accidents trigger fantasies of damage through others (for instance doctors) ■ These fantasies frequently are triggers for reparation wishes ■ Coping through resignation	■ Illnesses may threaten the feeling of self-worth ■ Even trivial illnesses may lead to collapse of the feeling of self-worth ■ Decompensation into the passive mode is possible ■ Coping through denial and trivialization

It applies to both modes that symptoms are often ascribed a self-worth threatening or stabilizing effect which goes far beyond a clinically comprehensible extent.

C5 Guilt conflict (self-blame versus blame of object)

Guilt conflict (self-blame versus blame of object)
The guilt conflict is about heaping blame either onto self, or onto others, beyond any reasonable degree of responsibility.

A prerequisite is the ability to feel guilt.
Either patients feel quickly responsible for difficulties, accept the blame, step back in favour of others, tend to self-blame, compensating guilt by self-imposed punishment.
Or, patients externalize guilt and make others responsible, whereby feelings of guilt are displaced onto others. This is followed by the absence of any readiness to accept even a part of the guilt.
The motives here do not involve need for care or self-worth stabilization, but blaming self versus blaming others when conflicts of conscience arise.

Passive mode	Active mode
General criterna	
Type: Tendency to self-blame, sacrifice, and accept guilt for others Lead affect: Sadness, depression, guilt Interaction/Countertransference: Attribution of guilt, cautiousness, pity	Type: Accusing, blame is always attributed to others, egoistic behaviour Lead affect: Annoyance, guilt Interaction/Countertransference: Incrimination of others ("They are to blame"), rejection, anger
Areas of life	
Family of origin	
■ Acceptance of guilt for problems in the family ■ Frequent sacrifices in favour of other family members ■ Others are excused while there is a tendency to blame oneself	■ Family of origin and close family members are held responsible for problems ■ No willingness to accept even a part of the guilt ■ Family of origin and generational conflicts are often self-righteously judged and presented
Family/partnership	
■ Tendency to accept blame and to make excuses for one's partner and children ■ Accusing oneself and bringing about situations in which one automatically appears guilty ■ Submissive, partly humble attitude	■ Attempt to find guilt primarily with one's partner or children so as to defend against one's own guilt feelings ■ Negative actions and behaviour modes are "collected" and pulled out at every occasion
Job	
■ Preference for being the "number two"; leading positions are avoided ■ Successes, leaps on the career ladder not infrequently lead to guilt feelings ■ Praise and recognition are perceived as unpleasant	■ Leadership and positions of power are quite naturally accepted ■ Attempt not to take responsibility for own mistakes ■ Privileges are considered a confirmation ■ Reckless behaviour towards others is

■ One's own mistakes are "prematurely" admitted; guilt of others is "prematurely" accepted for them ■ Slack in one's own performance is explained by one's own shortcomings	possible ("They are to blame") ■ One's own shortcomings and mistakes are blamed on bad working conditions or mistakes of others ("Not my fault")
Social context	
■ Also in the social area guilt is quickly accepted ■ Preference of social groups where guilt can be "worked off"	■ The social context is needed to attribute guilt ■ "Matter-of-course" acceptance of social advantages, to the point of "guiltfree" exploitation of others
Possessions	
■ Relating to possessions, giving and taking, are highly conflictual ■ Guilt feelings triggered by gifts must be instantly paid back by reciprocating the gift giving ■ "Pleasantries" towards others and gifts ensure the subjective "guilt account" is kept low	■ Self-serving, possessive behaviour is perceived as justified ("This is my right") ■ Receiving presents and praise is taken as a matter-of-course ■ Tendency to always feel at a disadvantage, or cheated
Body/sexuality	
■ Experiencing the body, its needs and sexuality is rather accentuated by guilt ■ Consequently, frequent disregard for fundamental bodily needs and inappropriate health behaviour	■ The body is exploited - responsibility and guilt is attributed to others ■ Sexuality is lived out "guilt free", to the point of being reckless
Illness	
■ Illness is accepted with humility ■ Obedience to the point of submission in the doctor-patient relationship ■ "Easy to handle" patients	■ Illness is suffered badly ■ Constant dissatisfaction and attribution of blame towards individuals and institutions involved in the treatment of the illness ■ Inclination towards conflictuous and difficult behaviour, whereby one's own share in this is not considered

C6 Oedipal conflict

Oedipal conflict
The fundamental motivation is to make oneself especially attractive and desirable for other people, so as to gain their attention and recognition above all others; to shape the contact in an erotic-tender way so as to be assured of one's womanliness, or manliness. This results from the identification with the gender-specific parental roles, and the taking on of these roles, respectively. The oedipal conflictual constellation describes the non-adaptive poles on the spectrum of wanting to be someone, versus keeping in the background, being able to compete versus being able to yield, being able to enjoy bodily pleasure versus having to sacrifice it. This is primarily not a sexual disturbance. The oedipal conflict must be delineated, in particular, from the self-worth, guilt, and identity conflicts.

Passive mode	Active mode
General criteria	
Type: Keep in the background as a harmless, unattractive, and asexual 'mouse' Lead affect: Conflict-specific gaps in communication, shyness (shame), fear Interaction/Countertransference: Repression of eroticism/sexuality from affect, perception, and interaction, unattractive, boring	Type: Be the center of attention in a phallic-hysterical way Lead affect: Heavily alternating, in part dramatic emotions, eroticization/sexualization, rivalry (shamelessness, aggression) Interaction/Countertransference: Attraction alternates with repulsion; eroticization, sexualization, angry disappointment
Areas of life	
Family of origin	
■ Despite attachment, family history appears grey and lifeless ■ Relationships are idealized and de-eroticized ■ Conflicts and rivalries are denied ■ Fearful conservatism	■ Close, at times unconscious/defeded against attachments, especially to the opposite-sex parent ■ Role of mummy’s/daddy's "favourite" often continued into adulthood
Both modes are strongly linked to the family of origin.	
Family/partnership	
■ Stable relationships which are primarily about protection and safety ■ Rivalry and erotic-sexual experiences	■ Gaining attention and recognition at all cost ■ Theatrical-emotional or contradictory

appear repressed and in a lifeless grey ■ Often choice of older partners ■ Crises may result due to role changes required by aging	sexual behaviour (entice and block) ■ Choice of partner mostly modelled on primary object ■ Partners therefore often disappoint
Job	
■ Inconspicuous, partly "good" work relationships, mostly avoidance of competition ■ Seeking out of rather subordinate positions ■ One's own performance and interpersonal competencies are played down	■ Frequent lack of consistent cognitive competency and constant performance ■ Overly strong tendency to compete and sexualize (engaging in "phallic rivalries") ■ At times real successes, but rather positions ? not sure if it is used as a noun or verb, so ,takes positions OR positions himself below the individual's abilities, and frequently changing professional constellations
Social context	
■ Preference of stable, inconspicuous relationships, while the competing and appreciating moment of sexuality is avoided ■ Avoidance of social relationships which emphasize gender roles and competition ("putting one's tail between one's legs") ■ Hardly anyone has a sustained memory of such people, though they are not exactly disliked	■ Social groups, associations, and friends serve to put oneself at the center of attention, through a variety of quickly changing activities ("man about town"/"queen", "bragging") ■ Relationships are often judged as more private than they really are ■ Rivalry to the point of destroying the relationships of others
Possessions	
■ Possessions can serve as a silent and unconscious replacement for attractiveness, sexual prowess, or competitiveness	■ Possessions serve to be the center of attention, to compete, and to gain recognition (particularly striking house, car)
Body/sexuality	
■ Physicality gets little attention, yet care of the body is not neglected ■ The body appears rather neutral and unattractive, is covered up, or hidden ■ Bodily-erotic areas are omitted or avoided ■ In the extreme case, sexual disinterest ■ Reduction of oedipal threat and of neutralization measures with advanced age	■ Physicality is given much attention ■ The body becomes the overemphasized means of expressing attractiveness, rivalry, and recognition and is functionalized in this way ■ In the extreme case, excessive sexual interest ■ Loss of attractiveness, for instance in old

	age, is a threat
Illnesses	
■ Offer an unconscious opportunity to gain attention and recognition ■ In their illness, these people come across as weak and pseudo-regressive ■ Ilnesses serve as silent replacement for recognition and/or sexual satisfaction; possible strivings for therapeutic procedures	■ Illnesses may be employed to gain attention and loving care ■ No health carer is ever able to fulfil these needs ■ Ever new medical experts ("eminent authorities") need to be sought out

C7 Identity conflict

Identity conflict	
Passive mode	Active mode
General criterna	
Feeling of a chronic, or constantly resurfacing lack of identity The coping strategies are, predominantly, trivialization, rationalization, denial of identity dissonances Extreme: Feeling of a total lack of identity Ongoing avoidance of (life) situations that confront one with one's own insecure identity	General tendency: active glossing over the insecurities in one's identity Resorting to compensation for and avoidance of dissonances which reflect one's identity (for example, construction of a family saga, fantasized genealogy, and borrowed identities) Predominant basic feeling: the worry and fear that one's identity system might possibly be threatened
Areas of life	
Family of origin	
■ One's identity of origin seems either colourless or dull, or visibly shaken ■ Few attractive and major role offers with which an identification would have been acceptable ■ Unclear or contradictory identities in the family of origin	■ General tendency to actively gloss over identity contradictions by "constructions" ■ The reported history of the family of origin contains idealizations and fictitious tales ■ In a family of origin experienced as unimportant or even as having been humiliated, the unconscious wish to set oneself apart and start anew dominates

Family/partnership	
■ Avoidance of partners with clear and admired characteristics. The discrepancy would be hard to tolerate and be a constant reminder of one's own insecure identity ■ If the patient nevertheless finds a stable-identity partner, he often places his own identity unconditionally under that of the other	■ Active search of partners, relationships, and families who can offer identity and support ■ In the best case, stable solutions through the adoption of conforming roles in the new "clan" ■ Forceful or exaggerated adoption of the new family identity may also lead to failed adjustments
Job	
■ Contradictions in the success stories regarding learning and performance ■ In most cases, lack of an inner constancy and role security to be successful ■ Professional appearance towards others sometimes appears as fake ("dressed up as") or is inconstant ■ Trying on of many roles and positions	■ Professional life gives an inordinate amount of identity ("in service 24/7") ■ Work and performance behaviour thus often appear problematical and inflexible ■ Necessary orientation to facts and the task at hand take second place after the relationship with oneself and one's identity
Possessions and money	
■ Pre-existing property situations may serve to substitute the feeling of safety (having instead of being) ■ Sometimes people do not know what to do with the money they earn ("doesn't go with me")	■ Property situations serve essentially to stabilize one's own identity and are sought in this identity-giving function
Social context	
■ Chamaeleon-like in the social environment, however, coming across as rather colourless ("well-adjusted") ■ Lack of an independent profile which is necessary for social "recognition" purposes ■ Probably because of that, no respect from society in the final analysis ■ Avoidance of social contacts that would make one feel exposed	■ Membership in groups is sought and maintained because of its identity giving function ("We artists") ■ These patients may then stand out because of how they exaggerate these role identities. This may become caricatures
Body/sexuality	
■ Most likely an indifferent handling of	■ The forceful style of handling one's own

one's own body ■ The way that clothes are used to express one's personality is less important and not fixed ■ At times, strongly changing orientations concerning appearance ("the need to be a follower of fashion")	body assumes an identity giving function ■ Social judgements of a trained body offers, for example, the possibility for stabilization for the individual who is insecure about his masculinity ■ Clothes have always provided identity and have hidden insecurity ("Clothes make the man") ■ Also a "contrived neglect" regarding clothes can give identity ■ Characteristic here are limited choice and fixation
Illness	
■ Because of their passivity, finding, and accepting a new and adequate (illness-)role is difficult in cases of severe illness ■ Patients avoid confrontation, the majority of them arehelpless and passively-obedient	■ Clear tendency to actively assume and shape illness roles ■ If they were "nothing" so far, now they are ill. The whole self-presentation is defined via the fact of being ill ■ The other extreme is the refusal of the sick role, because it does not agree with the ideas about one's own identity ("I'm not one to get this") ■ The patients are thus at risk not only because of the danger of the illness becoming chronic, but also because of the consequences from denying the illness

13.4 The OPD-2 Structure Checklist

1.1 Cognitive ability: self-perception

OPD-2	High level of integration	Moderate level of integration	Low level of integration	Disintegration
1.1 Self reflection	Patient has the ability to direct his observation towards himself and his own internal world. Patient is able to perceive, realistically, what kind of person he is, what goes on inside him, and he is able to find terms to express this verbally.	Patient has little interest in reflecting on himself. Self-reflection is directed, above all, to the acting self (what the patient said and did); self-image appears coarse. Difficulty to find appropriate terms to describe himself.	Reflexive self-perception hardly possible at all; even if supported, patient cannot draw a coherent picture of himself and his internal situation, conflicting self-aspects exist alongside each other. No terminology for internal processes.	Patient's self-report appears arbitrary, out of touch with reality, incomprehensible. The self-image comes across as barely authentic, possibly borrowed, devious. Linguistic formulations are odd, contradictory.
1.2 Affect differentiation	Affects can be perceived differentially, despite limitations due to conflicts. They control behaviour. The patient experiences predominantly positive affects like joy, curiosity, and pride. Negative affects like fear, contempt, anger, disgust, sadness, guilt, and shame show great	Affects are perceived to a limited extent only, or even avoided in difficult situations in order to maintain stability. They therefore also control actions only to a limited extent. Affective experience is dominated by negative affects like rage, fear, disappointment, self-devaluation , and depression.	Affects cannot be perceived in a differentiated manner or described comprehensibly. They are expressed either as arousal, or alienation, affective emptiness, depression, and manic moods. They are thus of no use in controlling behaviour. Affective expression is dominated by chronic	No internal distancing from one's own feelings and no introspective perception of affects. There is only little in terms of a controlling agency between actions and affective experience. Patient is exposed to intense, amorphous emotional states which cannot be named or

	variability.		contempt and disgust, and anger.	put into words.
1.3 Identity	Patient's self-image appears constant and coherent over time, an unequivocal psychosexual identity can be distinguished.	Cracks or changes in the self-image dependent on situation and mood	At different times and situations, varying self-aspects come to the fore; the patient does not convey an impression of a constant, psychosexual and social orientation in the sense of an identity.	Largely absent differentiated psychosocial and sexual identity in favour of distorted or cliché-type attribution of characteristics, at times delusional identity aspects.

1.2 Cognitive ability: object perception

OPD-2	High level of integration	Moderate level of integration	Low level of integration	Disintegration
1.4 Self-object differentiation	Affects, impulses, and thoughts can be kept apart with certainty as to their assignment to self or objects; patient is able to delineate himself clearly and perceive the other from the outside.	No secure assignment of affects, impulses, and thoughts to self or object; delineation from the other and distanced perception of the other is made more difficult.	Self- and object are confounded and are confused with each other; the object is assigned those affects which are unbearable for the self.	The difficulty distinguishing between aspects of self and object, or to perceive objects as separate from self, has the quality of a symptom;
1.5 Whole object perception	Others are experienced as people with their own interests, needs, rights, and personal history; their varying sides can be integrated into a lively picture.	Others are not perceived in their complexity and contradictions, but are experienced according to one's own wishes, so that positive and negative sides are being exaggerated.	Others are experienced in extreme ways as particularly good, or particularly bad, black or white. Contradictions cannot be integrated.	Others are experienced as predominantly aggressive, persecutory, unfair, threatening, and as such are feared and fought; individua characteristics may represent the whole object.
bj ec	Patient has the ability to	Patient finds it difficult to	The image of the other is	The internal and external

	form a realistic picture of the other person.	perceive others realistically as to their internal intentions and their external situation.	determined by the patient's own needs and fears. Independently of this, attitudes of the other may be intuited. .	reality of others is not really accessible to the patient

2.1 Capacity for control: self-regulation

OPD-2	High level of integration	Moderate level of integration	Low level of integration	Disintegration
2.1 Impulse control	Aggressive, sexual, and oral impulses can be experienced, and, in consideration of moral and other values, be postponed and integrated, or alternatively, also satisfied.	Impulses are inhibited by over-regulation, occasionally breaking through, nevertheless. The self is experienced as blocked, or under great pressure. The overly strong super ego is either strongly critical or selectively cut out.	Impulses are not well-integrated, cannot be postponed (under-regulation) or be absorbed by a differentiated value system that guides one's actions. Aggressive tendencies lead to self-destructive acts and destructive acts directed to others. The lack of relationships may be sexualized; perverse solutions.	Unbridled, destructive hate is experienced as the appropriate reaction to the actions of others. Aggression becomes manifest in sexualit and relationship behaviour. Sexual impulses seem to be directed towards part objects Postponement and sublimation are not possible, therefore one finds states of marked loss of control in delinquent behaviour, or in the abuse of alcohol and drugs. Judgements are made in terms of simple good-bad alternatives.
2.2 Affect tolerance	Also intense, negative, or ambivalent affects can be experienced and expressed.	Intense and especially negative affects are badly tolerated; they are preferably dealt with by over-regulating.	Negative affects can flood a person and become so unbearable that they trigger impulsive behaviour	Intense, and especially negative affects cannot be tolerated and trigger extrem arousal, so that they are responded like a reflex through counteracting

2.3 Self-worth regulation	Feelings of self-worth can be maintained, or regained, except for conflict-related limitations, even when there are discrepancies between one's own wishes and those of others.	Feeling a of self-worth can be disturbed, for instance in failures or differences of opinion, which shows in great sensitivity, self aggrandizement or self-devaluation, -punishment, or withdrawal. Confirmation through others is needed.	Feeling a of self-worth is very fragile even in situations of minor hurts and differences between one's own and the wishes of others. This becomes visible in great sensitivity to emotional hurts, unrealistic ideas of grandiosity, shame, disgust at oneself, devaluation, irritability, breaking off relationships, and an inability to accept one's own boundaries.	Feeling a of self-worth can hardly be regulated. This is expressed in considerable distortions in one's self judgement (grandiosity or chronically low feelings of self-worth), distortions of reality perception.

2.2 Capacity for control: Regulation of object relationship

OPD-2	High level of integration	Moderate level of integration	Low level of integration	Disintegration
2.4 Protecting relationships	Patient is able to protect the relationship by working through and dealing with disturbing impulses in himself (intrapsychic defence).	Relationships are burdened by the fact that the patient can process disturbing impulses only with great effort and incompletely.	Disturbing impulses cannot be coped with intrapsychically, but place a stress on the relationship (interpersonal defence).	If the relationship is protected at all, dysfunctional, old, destructiv means are resorted to.
2.5 Balancing of interests	Patient is able to keep his own interests in relationships and appropriately acknowledge those of others; due to conflict, the relationship may be tinted more altruistically, or more egoistically.	One's own interests, or those of others, are permanently in the foreground, so that there is no balancing of interests.	The relationship is characterized by the feeling of threat to one's interests and a lack of imagination regarding the interests of the other.	One's own interests are overvalued and experienced as existential, and are often not readily understandable for others

2.6 Anticipation	The reactions of the other can be anticipated and guide, or regulate, one's actions.	Negative reactions of others in response to one's own actions are anticipated in an exaggerated manner.	Negative reactions of others in response to one's own actions can hardly be anticipated and used to guide and regulate one's actions.	Inability to take into account reactions of others in response to one's own actions.

3.1 Emotional ability: internal communication

OPD-2	High level of integration	Moderate level of integration	Low level of integration	Disintegration
3.1 Experience of affects	Patient can allow and experience a broad range of affects and feel alive in this way. .	Experience of affects is limited; their description is normative.	Negative affects like panic, anger, disgust, contempt, etc., impose themselves in a permanent fashion.	Individual affects may come to the fore in an alienating manner; the alternative is affective indifference.
3.2 Use of fantasies	Patient is capable of expanding his experiential world with the help of fantasies and dreams and prepare creative solutions.	Active fantasizing is clearly restricted.	Negative fantasies quickly acquire threatening certainty.	Reality descriptions and subjective fantasies become one foggy blur.
3.3 Bodily self	Patient is able to realistically describe his body with respect to age, gender, health, attractiveness; he feels alive in his body.	Insecurities as to the bodily self-image; limited experience of the body; ego-dystonic description of the body in the sense of "me and my body".	Fuzzy or fragmented bodily self-image, experience of the body is threatening and rigid.	Bodily aspects of the self are experienced as alienated or strange. Idiosyncratic forms of withdrawal onto one's own body are possible. The

				bodily self may be modified by plastic surgery, which changes aspects of identity, for instance gender.

3.2 Emotional ability: communication with the external world

OPD-2	High level of integration	Moderate level of integration	Low level of integration	Disintegration
3.4 Making contact	Patient is able to make contacts and enter into lively exchanges with others.	Interest in making contact and enter into relationships appears limited and rather impersonal.	Patient avoids making emotional contacts, or engages in pushy, manipulative, non-distanced contact behaviour.	Making emotional contact is impossible, or follows clichés while the situation is emotionally empty or tense.
3.5 Affect communication	Affective involvement makes the communication stimulating, interesting, and fertile. Communication may be restricted or impaired due to conflicts.	Limited capacity for affect differentiation or predominantly negative affects (like disappointment, self-devaluation, depressive affective states, sensitivity to emotional hurts) make it difficult for the patient to communicate. Communication is also difficult due to retentive, demanding, irritable, reproaching, egocentric behaviour, as well as an	Limited capacity for affect differentiation, uninvolvement, inability to empathize, lack of warm affects, predominance of devaluation, make communication very difficult. What arises in the other person is a sense of confusion, emptiness, distance, an "as-if" feeling, lack of relatedness; overinvolvement and resignation alternate with	Affects cannot be controlled and symbolized, so that the situation becomes emotional one's own defensive and aggressive interests are realized, or the frame of the interaction is violated. Communication is avoided by looking the other way, distracting, or being inaccessible.

		excessive sensitivity to emotional hurts.	each other.	
3.6 Empathy	It is possible, depending on the situation, to gain access to the internal experiential world of others, to temporarily identify with it, and to act on this basis of should this be ‚empathic' understanding	Under pressure from one's own wishes and fears, empathy towards the other person is restricted.	The internal experiential world of others can be comprehended only with difficulty. Very limited understanding of and empathy for others.	Experiencing empathy for and understanding of the other appears largely impossible.

4.1 Ability to form attachments: internal objects

OPD-2	High level of integration	Moderate level of integration	Low level of integration	Disintegration
4.1 Internalization	Ability to develop and maintain emotional, stable internal images of important people. The central fear is losing the love of the object.	The ability to develop stable internal images of important persons and thus become more independent of their outer presence is restricted. Internal images can be lost after a short while, or in situations of conflict (out of sight is out of mind). Central fear is losing the important, supporting, regulating object	Relating to other persons leaves no positive, internal images. The object representations which predominate are threatening and persecutory ones. Central fear is t being damaged or annihilated by the objects.	Constant, sufficient mental representations of others do not exist; there is no internalization of positive relationship experiences. Instead, internal objects shov aggressive-destructive tendencies or display the quality of the uncanny. Central fear of symbiotic merging of self- and object representations with consequent loss of identity.
4.2 Use of introjects	Based on internalized positive relationship experiences, the patient is capable of caring for himself, calming himself, and taking responsibility for himself	Patient is less capable of caring for himself well, because his internal objects tend to be rather pushy, criticizing, demanding, and neglecting.	Patient cannot refer back to internal objects, and therefore is incapable of calming himself, caring for himself, protecting himself.	Internalized part objects lead to arousal and confusion.
bl e at	Internal images of	Internal images of important	Internal images of important	All objects appear similar to

	important others are diverse and rich; patient is able to entertain triadic relationships.	persons do not differ much; patient seeks above all dyadic relationships.	persons are predominantly negative and do not differ much; relationships appear functionalized.	each other; if attachments exist, they are predominantly fantasized and happen on a regressive level.

4.2 Ability to form attachments: external objects

OPD-2	High level of integration	Moderate level of integration	Low level of integration	Disintegration
4.4 Ability to form attachments	Others have emotional importance; there is the ability and the wish to attach oneself to them. In order to protect existing relationships, rules for interaction are developed; no object dependency.	Emotional importance of important others may be exaggerated (clear object dependence).	Emotional importance and feelings of belonging only if the object is actually present; because of this, changing, short-term relationships.	Very symbiotic relationships, or anxious maintaining of one's autonomy and avoidance of attachments to objects.
4.5 Accepting help	Patient is able to, if necessary, resort to other people as good objects.	In situations of need and emergency, patient is able only with difficulty to find helpful others and to accept their help; he may try himself to help others to the point of exhaustion .	Help and support through others is rejected by way of reflex in a fearful, distrustful, and aggressive manner. No conception that one might be of help to others.	No conception of helpful others, otherwise engagement in activities which ignore object boundaries.
Severing attachme	Patient tolerates separations and displays adequate feelings of sadness; he is capable of withdrawing	Farewells are glossed over, or objects are clung to in order to avoid feared losses.	The internal experience of detachment, or of bidding farewell involving accepting	Separations are tolerated seemingly without reactions. Nevertheless, themes of separation can trigger

	affective investment from lost objects.		feelings of sadness does not exist; actual separations can nevertheless trigger depression or disorganization.	massive reactions.

13.5 Heidelberg Structural Change Scale

1. Focus problem warded off	1 1+	Total defence, or avoidance, of the focus area; patient has "no problems" with the critical area	
2. Unwanted preoccupation with the focus	2- 2 2+	Symptom pressure, difficulties in interpersonal relationships: unreasonable demands, experienced as external	
3. Vague awareness of the focus	3- 3 3+	Passive preoccupation with the focus; traces of acknowledgement of problem, notion of responsibility]	coping
4. Acceptance and exploration of the focus	4- 4 4+	Interested in understanding the problem, working relationship, active "coping", active preoccupation	
5. Dissolution of old structures in the focus area	5- 5 5+	Defence becomes fragile, "passionate" about the process, sadness, feeling exposed, confusion	Structural changce
6. Reorganization in the focus area	6- 6 6+	Conciliatory approach to the problem area, spontaneous emergence of new ways of experiencing and behaving	
7. Dissolution of the focus	7- 7+	Integration, agreement with self, experience conforms to reality, new formations	

13.6 Interview tools

The first part of this section on interview tools summarizes the key themes to be explored. The two parts below are set out side by side, as they happen simultaneously during the interview.

The left column contains possible questions and suggestions for verbal interventions; the right column points out typical verbal, scenic, and countertransference material which may come to light when examining the specific contents. At the bottom of the tool box are suggestions for in-depth exploration, and also for rating the collected information; they provide a focus for a differential diagnostic delimitation within the axes and between the axes.

We wish to emphasize strongly that these interview tools should be considered as no more than didactic aids. They may be consulted when learning the interview technique, but thereafter should never be used in "cook-book fashion" when carrying out an interview, as this would result in a more formal and structured interview during which important scenic material could easily be lost.

13.6.1 Interview tools for axis I

Themes Experience and presentation of the illness, Subjective suffering, presentation of complaints and problems	
Options for Intervention **Introductory Questions:** • Please describe your complaints, your problems, and your concerns. • Why have you come to see me now? **In-depth questions** • To what degree does the illness restrict your life? • What effects does the illness have on you personally? socially? professionally?	**Sources for Information** **Patient´s Statements** • I don't know what I am doing here. My doctor thinks my backpain may be related to my mental state. • I am continuously in pain, always a 10. I can't do a thing any more, and my wife is also totally exhausted. **Scenic Information** • Is the suffering discernible in the patient's facial expression and gestures? • Are facial expression and gestures congruent with the reported suffering? • Are the restrictions as reported noticeable in the interview? **Countertransference** • Do I get a feeling of plausibility, perhaps feel sorry for the patient, or rather, do I have a feeling of mistrust and rejection?

Themes
Patient's concepts of illness

Options for Intervention	**Sources for Information**
• What is your explanation for your complaints (the origin of your complaints)? • Psychosomatic medicine looks at, amongst other things, the links between, e.g., mental stresses and physical illnesses. Can you imagine that, in your illness, there might be such links?	**Patient´s Statements** • How should I know this. I am no doctor. • I think it is all connected with the death of my husband. • The pain must result from a pinched nerve. **Scenic Information** • Does the patient spontaneously present an - albeit possibly bizarre - concept of the illness? • Does the patient press for a certain diagnostic? **Countertransference** • Can I elaborate a clear concept of the illness? • Can my concept be differentially compared with that of the patient? • Do I get a diffuse feeling of ignorance and helplessness?

Themes
Patient's concept of change, desired form of treatment

Options for Intervention	**Sources for Information**
• What do you think could help you? • Can you imagine that psychotherapy might be a helpful treatment for you?	**Patient´s Statements** • I hope you will give me the correct prescriptions. • My pains are not going to go away by talking, but perhaps it will help me to hear how others deal with it. • If I could find a job, I would no longer be depressed. **Scenic Information** • Does the patient inquire directly about certain forms of treatment or counselling? • Does the patient show interest if therapy options are explained to him? Does he/she ask additional questions? • Can I feel whether the personal relationship is important to the patient? **Countertransference** • Do I feel used? • Do I get the feeling that I can be of help to the patient? • Do I feel under great pressure to offer a certain diagnostic procedure or therapeutic help?

Differential Diagnostic
An urgent wish for a specific form of treatment may hide a low motivation for change, for instance in cases where secondary gain from illness is high. Here countertransference may help to clarify motivation.

Themes
Resources for and impediments to change,
personal resources, social support, gain from the illness

Options for Intervention

- Who or what is helping you cope with your illness?
- Can you describe in more detail how your family reacts each time the pain gets very strong?
- You said you have suffered similar symptoms in the past. What did you do then that made you feel better?
- Have you filed for social benefits? What would change for you if the pension was granted?
- Do you have a per-diem allowance insurance for hospital stays?
- Is there someone looking after things at home while you are in the clinic?

Sources for Information

Patient´s Statements

- When my heart starts to race all I can do is lie down. My husband then does all the housework.
- I have lived through worse illnesses.
- Despite my complaints I manage my life quite well.
- My wife is always able to build me up when I am down.

Scenic Information

- Does the patient say that he/she was sent for an interview (by primary care physician, etc.)?
- Does the patient show resistance when offered treatment options?
- Who scheduled the interview?
- Does the patient come to the interview accompanied?
- Is the patient open to other perspectives or possible solutions regarding his problems?

Countertransference

- Do I get the feeling of wanting to help the patient?
- Am I feeling confident that I am able to work well with the patient?
- Do I get the feeling that all my efforts are being rejected?

13.6.2 Interview tools for axis II

Themes

The interview identifies descriptions of relevant interactions with important other people (relationship episodes). A typical relationship episode consists essentially of descriptions of behaviour and, if applicable, intentions of others, as well as behaviour modes of the narrator which need to be actively inquired about, unless they become immediately manifest. Particularly hidden anxieties or wishes can often only be discovered by making carefully worded interpretations or asking confronting questions. Diagnostically relevant are those episodes which evidently have a conflictual or dysfunctional, and/or repetitive character.

Options for Intervention

Introductory Questions:

- If the patient has already mentioned important persons, a direct follow-up can be established: I cannot quite imagine what the relationship with X is like, perhaps you can clarify it for me by describing to me a situation with X which was especially stressful, difficult and conflictual for you?
- If, after some time, sufficient information on relevant relationships is not available, the therapist can ask directly: who are the most important people in your life? Who is especially close to you?
- Or further: Would you please describe an actual situation you have experienced with X and which was particularly stressful, difficult and conflictual for you?
- Can you tell me what you expected or feared from him/her in that moment?
- ... what he/she actually did in that moment, or might have felt and/or thought?
- ... what you felt that very moment and eventually said or did to him/her?
- Do you think that others react to you in always the same manner?
- I have the impression that you behave in this way, because you secretly fear that otherwise you ...

Sources for Information

Patient´s Statements

- Descriptions of relationship episodes as defined.

Scenic Information

- As the factual, interpersonal behaviour as expressed in contact with the interviewer/therapist is of relevance for the diagnosis, "scenic information" must be captured to obtain a more complete picture of the ways relationships are handled. Nearly all modes of behaviour on the item list of the interpersonal relations axis can be used. Especially important are behaviours that are distrustful, evasive, aggressive, submissive, dominant-controlling, or accusing.
- By observing the liveliness, plasticity, and the degree of differentiation in the description of relationship episodes, a link can be established to the dimension of object perception on the structure axis.

Countertransference

- Countertransference impulses that become noticeable need to be analogously registered; they refer especially to worries, impulses to help, desire for withdrawal, rejection, and anxiety/insecurity.

Differential Diagnosis

Axis III:

- It is important to differentiate between actual conflict and external life stresses and perhaps appropriate behaviours associated with them on the one hand, and repetitive and dysfunctional patterns on the other.

Axis IV:

- Are there any apparent discrepancies between the narrator's self-perception and the perception of others taking part in the interaction?

- Does the interviewer/therapist notice a relationship between his/her own inner reactions and the reactions of the interaction partners of the narrator, as described by the narrator?
- Does the narrator have an understanding of interaction behaviour in others which may perhaps be caused by him/her (capacity to anticipate)?

13.6.3 Interview tools for axis III

Perception of conflict and affect impaired by means of defence

Themes
People who tend to overlook conflicts within themselves and in interpersonal interactions and who have difficulties recognizing feelings and needs in themselves and in others; alexithymia, rationalization, harmonization.

Options for Intervention

- Can you tell me of situations, in which you react with especially intense emotions?
- I get the impression that your life runs especially smoothly and unproblematically, without any major emotional ups and downs. Is this how you see it?
- Has someone ever told you that you are too rational, and/or that you don't show enough feeling?
- I have gained the impression that you always strive to eliminate difficulties and problems with others quickly, instead of allowing strong feelings to surface. How do you experience this?
- I have the impression that it is very important for you that relationships with others are as harmonious as possible, and without conflict? Is this correct?
- Do you know from your close relationships that you tend to take the more rational side, while you would rather leave the more emotional side to others?
- Are you sometimes surprised by how unreasonably, strongly, and emotionally others react?
- I have gained the impression that you are convinced that there are reasonable solutions for all difficulties and problems, no matter what they are. How do you experience this?

Sources of Information

Patient´s Statements

- Everything is within normal range.
- I have no conflicts or difficulties.
- Everything is OK, I am fine.
- We understand each other well, there are no problems.
- No problem, I´ll manage, we'll sort it out reasonably.

Scenic Information

- Does the patient present him-/herself as if he/she has no problems or conflicts whatsoever?
- Is the patient unable to see obvious links between his/her life-situation, his/her internal state, and his/her complaints?
- The flat affective tone or rationalizing description are making it difficult for the interviewer to gain a rounded image of the patient and his/her inner life.
- Because of missing or repressed affects, there is no leading affect.

Countertransference

- Do I experience the patient as lifeless, rationalizing, harmonizing, emphasizing quick solutions?
- Does the patient provoke in me either incredulity as to his unproblematic life-situation, or tension, anger, boredom, because of his tendency to rationalize and harmonize?
- The countertransference can also give rise to those feelings which the patient omits from his/her description or covers up by being factual.
- With a view to psychotherapy, these patients are often assessed as non-motivated and difficult.

Differential Diagnosis

Axis III:

- What is not meant is a neurotic, only partially restricted perception of conflict and affect. The

affects are here reduced across the whole spectrum.
- If several other conflicts shine through and become obvious, the restricted perception of conflict and affect as it is intended here is unlikely.
- Even if, under these circumstances, elements of control of self or others are frequent, the delineation from the conflict "submission vs. control" is very clear, as the patient is motivationally principally not concerned with exerting control over others or subordinating himself to others.

Axis IV: Also in patients with reduced structural capabilities, especially of self- and object perception, and self-regulation, there tends to be a reduced recognition of affect in themselves and in others. However, contrary to structurally disturbed patients, where anhedonic affects predominate, these are mostly absent in people who defend against recognition of conflict and affect, due to the results of active defensive mechanisms.

Stressor-induced conflict

Themes
Moderate to severe stresses can lead to a conflictual constellation in the patient's motivational system which can be adequately explained by the inner or outer demand imposed by the external stressor; such a conflictual constellation is usually sufficient to explain the mental and/or physical symptomatology of the patient (period of observation: the last six months). Not every life stress is followed by a stressor-induced conflict. Of relevance here is rather the subjective meaning (comprehensible because of the preexisting motivational conflict-related tension) of the stressful event. Quite independently of this, differently shaped, dysfunctional inner conflictual patterns may be present. Conflictual overtones patterned on the other conflicts. Coping and defence: passive: regressive (relating to self); or active: counterphobic (relating to object).

Options for Intervention	**Sources of Information**
• Was there a severe stressful life event that may have occurred around the same time as your complaints?	**Patient accounts** • Patient establishes a temporal context between his complaints and a severe stressful life event, but without there being proof for the life-long existence of the motivationally corresponding neurotic conflict. **Scenic Information** • Corresponds in each case to the conflictual overtones according to the pattern of the other conflicts. **Countertransference** • Expression of conflict corresponds to that described in other conflicts, depending on which motivational system is being addressed. • Similar leading affects as in repetitive dysfunctional conflicts.

Differential Diagnosis
Axis III: Although this conflict is "tinted" in accordance with the basic pattern of the other conflicts, there is no ongoing, repetitive conflict, which would account for the actual, conflictual contradiction in motivation (beware: trigger situation). Independently, differently shaped dysfunctional inner conflictual patterns may be present.

- *Axis I:* The likelihood of an external conflict arising is determined by, first, the extent of the inner motivational conflictual tension and the external stresses, and second, the available resources.
- *Axis I and V:* The external conflict must be differentiated from a post-traumatic stress disorder (PTSD). Traumatic events which lead to a post-traumatic stress disorder represent the most extreme degree of stress, dimensionally speaking. In these cases the mental stresses are so pronounced (excessive demands upon ego-functions, defense capacities, etc.) that a motivational conflict can hardly develop, but instead we find the typical clinical symptoms with intrusion, absence of feeling and dissociations.

C1. Individuation vs. dependency

Themes
Existential importance of attachment and relationship. Relationship is oscillating between the extremes of yearning for close relationship and symbiotic closeness (dependency), and striving for explicit independence and marked distance (individuation). Basic fear of loneliness and loss of relationship and attachment on the one hand, and fear of merging and feeling smothered in the relationship, on the other. Seeking of closeness and attachment at all cost, versus exaggerated independence and forced avoidance of attachments.

Options for Intervention

- Are you someone who seeks very close relationships, or do you rather need your distance and independence?
- How much closeness and contact with other people do you need, and how much distance and space for yourself?
- Can you enjoy being alone?
- Is it true that you only feel good if you are with others all the time?
- How did you feel during changes that life tends to bring, like, moving out from home, changing jobs, colleagues or boss leaving, separating from partner, children leaving home?
- Is it more important for you to stay with familiar colleagues and in the same firm than to move away and advance your career in a different group of co-workers or in a new firm?
- How do you experience illnesses where you depend on others?
- Does belonging to associations or other social communities feel good to you?
- Do you know the feeling in relationships that others are getting too close to you, that you are too tied up, or that you are being smothered?
- Do you feel best if you can be by yourself?
- Do you feel lonely easily, when you are by yourself?
- Are you very homesick?
- From your descriptions I gained the impression that you are someone for whom it is very important to have your own space, not to have such close relationships, and to keep your independence. Is this correct?
- As I have sensed during this interview, you feel happiest in very close relationships with others. Do you see it this way, too?

Sources of Information

Patient´s Statements

- To share things with others is most important for me.
- I like to be by myself.
- I like doing my own thing.
- I feel best when I am together with others.
- Separations are difficult for me, I'd do anything to avoid them.
- I feel best within the family, we are very close-knit.
- I work best on my own.
- My colleagues at work are more important to me than a better salary.
- Being ill and dependent on others is a horrible thought.

Scenic Information

- Do eye contact (close and intensive, or short, rare, and superficial) and body posture (close and leaning towards the interviewer, or distant and leaning away from the interviewer) provide hints as to closeness and distance?
- Does the patient endeavour to respond exactly to the interviewer's questions? Does he/she create closeness and contact through what he/she says, or are there frequent misunderstandings, statements that do not fit, or contradictions, which all create distance?
- How does the patient deal with the boundaries set by the interview? Does he/she start talking immedately and intensively, as if it was most natural, perhaps connected with intense feelings - or does he/she carefully feel his way into the conversation, with an expectant attitude and distanced contributions without much feeling tone? Does the patient, at the end of the interview, find it clearly difficult to remove him-/herself from the conversation, or does he/she suddenly break off, almost without saying good-bye?

Countertransference

- Do I experience the patient as particularly clinging and seeking closeness or as particularly distant and independent-minded?
- Do I feel smothered by the patient or intentionally kept at a distance?
- Do feelings come up in me to keep the patient at all cost, to take him into therapy in any case, or are they more feelings of rather not wanting to have anything to do with him, and absolutely wanting to refer him/her to somebody else?
- In identification with the patient, do I feel fear of being smothered or of merging, or rather of loneliness and abandonment?
- Are the described feelings and inner reactions more pronounced in one or the other direction,

Differential Diagnosis
Axis III

- *Submission vs. control:* Is the striving for either individuation or for dependency intended to gain power and control over others?
- *Need for care vs. autarky:* Does the striving for independence lead to the patient not needing anything from others and being self-sufficient? Does the striving for dependency serve to fulfil his/her need for care?
- *Conflict of self-worth:* Does the striving for individuation serve to enact one's grandiosity, to rule out being hurt by others through distance created, or to avoid a hurtful dependency on others? Is the striving for dependency used to camouflage feelings of low self-worth, or to support one's own feeling of grandiosity by being close to others and sharing in their greatness?
- *Oedipal conflict:* Is the striving for individuation, or for dependency, through creating close proximity, or great distance, used to avoid competition and rivalry? Is the individuation a screen to hide a promiscuous inability to form attachments? Is the striving for dependency used to circumvent the issue of recognition as a man or woman, or to control sexual drive-related tendencies?

C2. Submission vs. control

Themes
Dominance-submission, power-helplessness, rigidity, tradition, rules, hierarchy, passive resistance, retentiveness, need to be right, contradiction, spite, obsequiousness, compliance.

Options for Intervention

- How important are rules and orderly behaviour in your life?
- Is it true that you like/dislike submitting to rules and regulations?
- Is it true that you like/dislike setting the tone in contact with others?
- How do you deal with orders and regulations?
- How do you react when rules and regulations that are important to you are questioned?
- Have you in your life often had a problem with authority?
- Is it true to say that you repeatedly experience differences of opinion with others?
- Is it true that you want to be right most of the time when there are differences of opinion?
- Do others tell you that you are relentless or that you always take 'the line of least resistance'?

Sources of Information

Patient´s Statements

- Let me finish telling you this.
- I would rather have you ask me questions, so that I can tell you the right thing.

Scenic Information

- Does the patient become irritated, annoyed, or protest angrily if he feels restricted?
- Does it become noticeable that the patient enjoys contradicting, spiting, and controlling others?

Countertransference

- Do I feel that I am subject to being controlled and undermined by the patient?
- Do I feel an impulse to subordinate myself to the patient?
- Do I feel an impulse to angrily contradict the patient?
- Do I experience the need, or special readiness of the patient, to submit to my wishes?
- Do I feel "seduced" into leading the patient?

Differential Diagnosis

Axis III:

- *Individuation vs. dependency:* has more of a regulatory function for establishing closeness-distance in relationships.
- *Conflict of self-worth:* serves more to protect against hurt or to defend one's self-worth.
- *Guilt conflict:* serves more to placate/avoid, or to project guilt feelings.

Axis IV: In patients with moderate structural integration or threat of disintegration, control may serve to maintain structure, and is not considered motivationally conflictual per se.

C3. Need for care vs. autarky

Themes
Excessive striving to be cared for, safety, or autarky, altruism. Obtaining or losing something, capacity to mourn, depression. Taking care of oneself, giving to others, defended-against need for care, and disappointment.

Options for Intervention

- Do you often feel that others do not care for you sufficiently?
- Are you someone who does a lot for others, but does not claim anything for himself?
- Can you ask for help?
- How do you deal with someone wanting to do something for you, like care for you, cook for you?
- Is it important in your life above all to be there for others, to support others, without taking your own needs into account?
- Do you wish you had more support and safety?
- Do you find it difficult to let go of others?

Sources of Information
Scenic Information

- In the interview, do you experience the patient as clinging and demanding, or else, as very self-sufficient and altruistic?
- Do you experience in the patient a longing to be cared for, or, alternatively, disappointment when these wishes for care are frustrated?

Countertransference

- Do I feel pushed into a corner by the patient, or exploited, blackmailed, and because of this, possibly angry?
- Do I notice impulses within myself to care for the patient, to give much, although the patient appears to make no demands at all?

Differential Diagnosis
Axis III:

- *Individuation vs. dependency:* Is this about obtaining something from the object, or more existentially about whether there is an object at all?
- *Conflict of self-worth:* Are disappointments predominantly about not getting enough, feelings of actual loss, or rather having been hurt, rejected, devalued? Is the self-sufficient behaviour being used to defend against and compensate for wishes to be cared for, or to display one's own greatness and importance?
- *Guilt conflict:* Are demands and reproaches used to blame others, or do they express envy of the other person, the feeling of getting a raw deal?

C4. Conflict of self-worth

Themes
Self-worth vs. object worth; situation-dependent excessive striving in order to compensate for 'cracks' in the experience of self-worth. The conflict may show as personality quirks ("narcissistic personality"); failure, hurt, inferiority, over idealization of others, or own grandiosity, devaluation of others.

Options for Intervention

- Do you often feel inferior and a failure compared to others?
- Do you often experience situations/thoughts/feelings you are ashamed of?
- Have you ever been told that you think too highly of yourself?
- It seems to me you are a particularly self-assured person. Are there situations in which you don't feel so secure?
- Do you often feel that other people admire you particularly?
- How do you feel if you are the center of attention?
- Is there something that hurts and annoys you very much?

Sources of Information

Scenic Information

- Do you experience the patient as particularly ashamed?
- Does the patient, in your experience, present himself as particularly "small and inferior"?
- Does the patient come across as very self-assured, superficially, but very insecure, in reality?
- If challenged by the therapist, is the patient irritated and annoyed?

Countertransference

- Do I feel the need to especially support and strengthen the patient, or to ridicule him?
- Is my impulse to excessively admire the patient more than warranted?
- Do I feel devalued and hurt by the patient?
- Do I have the impulse to "belittle" the patient?

Differential Diagnosis

Axis III: In the conflict dynamic for all conflicts a problematic self-worth plays a contributing role. Here the regulation of self-worth constitutes the leading motive.

Axis IV "Regulating the self":

- If the trigger situations are specific, a conflict is likely. If "everything" is destabilizing, it is more likely that we are dealing with a structural problem.
- If the positions/self-images show an active ("sky high") and passive (deficit) mode, and are stable over time, a conflict is likely. If the picture is determined by recurrent changes, for example in terms of the unusual course of the regulation over time or by a fragile feeling of self-worth, we are more likely dealing with a structural problem.

C5. Guilt conflict (self-blame vs. blame of others)

Themes
Constant tendency to attribute blame to others or take blame oneself; excessive taking of responsibility, or shifting of guilt and responsibility onto others; self-reproach, self-accusation, or self-righteousness and accusation of others.

Options for Intervention

- It appears to me that you tend to seek blame/responsibility especially with yourself/with others, e.g. in your job.
- Do you take responsibility for your partner, your parents, your children when they fail or do you think your partner/parents/children are to blame if you are "feeling bad"?
- How do you deal with someone else blaming you for having done things wrongly? Do you defend yourself or do you take the blame?
- Are you often bothered by thoughts that you have behaved wrongly towards others, or that others did the wrong thing towards you?
- Do you tend to accept illnesses, to overlook serious illnesses, or do you suffer illness badly and consider doctors incapable of helping you?

Sources of Information

Patient´s Statements

- No doctor has ever made the effort to examine me thoroughly, otherwise they would have found the cause of my pain long ago.
- Each time my little daughter cries, I have the feeling of having done something wrong.

Scenic Information

- In the interview and in reports of social situations the patient seeks responsibility/blame predominantly within him-/herself, or almost exclusively with others.

Countertransference

- Do I experience the impulse, to "excuse" the patient, to relieve him/her of responsibility, or to condemn him/her?
- In the interview, is it my experience that I worry about burdening the patient too much and feel responsible if the patient feels bad or misunderstood?

Differential Diagnosis

Axis III:

- Do the reproaches and accusations serve to blame others for wrongs, or do they serve other conflicts?
  Submission vs. control: not wanting to subordinate oneself, or, dominating too strongly
  Need for care vs. autarky: not care sufficiently
- As to motivation, do the reproaches/guilt feelings serve other conflicts?
  Need for care vs. autarky: Superego prohibition of greed and envy
  Conflict of self-worth: Do the wrong doings cause feelings of shame and guilt?
  Oedipal conflict: oedipal superego prohibitions
- In adolescent conflicts, submission vs. control, need for care vs. autarky, forced delimitations in order to safeguard one's identify may play an important role with respect to the age in question.

Axis IV: From a differential-diagnostic perspective, test the structural characteristic "capacity to self-regulate": if the triggers are specific, a conflict is likely, if they are generalized, a structural problem is more likely.

C6. Oedipal conflict

Themes
Recognition as woman/man by primary objects/others, rivalry versus identification with gender-specific roles, physical-erotic attraction, tenderness of sexual contact; competition: wanting to be someone as a woman or man versus keeping in the background, being able to enjoy physical pleasure, versus celibacy, competing versus being able to acquiesce

Options for Intervention

- Could you please give me an example of your relationship with your parents/siblings/partner/work colleagues/people around you.
- Please explain by giving examples, what your relationship is towards your body, eroticism and sexuality/rivalry. How do you cope? How far you are able to enjoy them?
- Can you give me examples of how recognized you feel as a woman/man, whether you feel you attract attention, and to what degree you enjoy this.
- Please give me at least one example which will help me understand how you handle illness and how you cope with it.
- Do I perceive correctly that you generally experience yourself as weak, unpreposessing, and unattractive as a woman/man, and that you tend to shyly-modestly hold back?
- I have the impression that you strive very much for harmony in your social relationships, especially in your relationship with your parents/siblings/partner/work colleagues - and by doing so avoid some tensions and necessary arguments.
- I have the feeling that you value safety and comfort in a relationship more than being considered especially attractive and desirable as a woman/man.
- It appears to me that you tend to exclude eroticism and sexuality/rivalry from your life, e.g. in your relationships/your social relations/your job ... - perhaps because you worry about not being properly acknowledged and desired as woman/man?
- How do you feel at the thought and how do you react if someone seriously desires you, or would desire you, as a woman/man?
- Do I perceive correctly that you generally see yourself as strong, superior, and especially attractive as a woman/man, and that you tend to/have no difficulties in attracting attention in a special way and put yourself at the center?
- Did I understand correctly that it is very important to you to be emotionally close to your mother/father, and that today you still compete with your siblings for the position of "favourite"?
- I have the impression that you frequently want to demonstrate to others, e.g. your siblings/work colleagues ..., that you are better/more capable and more attractive/desirable - and that this leads to tensions and problems, as you are then criticized for putting yourself forward too much?
- I get the impression that your body shape and appearance are very important and that you do a lot to look after them, e.g. body care/fitness studio/cosmetic operations ..., in order to be physically attractive, and, possibly, superior to others.
- I get the impression that illness is a very dramatic event for you and you wish for the fullest medical attention and care, but that you are often disappointed by medical experts and feel misunderstood.
- It seems to me that again and again you (have to) seek acceptance and recognition as a woman/man - perhaps because you are not really sure whether, through the eyes of others, you are indeed so capable, attractive, and desirable?
- It appears to me that sexuality is especially important to you,

Sources of Information

Patient´s Statements

- I have always been/still am today, momma´s/daddy's favourite.
- I never understand why everybody always seems to think I want something from them.
- To truly understand each other in a relationship is, after all, far more important than sexuality.

Scenic Information

- The patient presents him-/herself in the interview as an unattractively shy person, (not very lively, "childlike", idealizing, striving for harmony, safety and comfort seeking, weak, pseudoregressive), or as the "Don Juan"/"Diva", (the "darling", theatrical and emotionalizing, eroticising, rivalizing).
- The patient behaves in a rather shy and modest manner, or is missing the appropriate affects in conflict-specific situations.
- The patient shows dramatic emotions, behaves in a forcefully sexual manner, or is missing the appropriate decency that can normally be expected in an erotic context.
- Omission of or emphasis on eroticism, sexuality, and rivalry in affect, perceptions, social life, and in the interaction in the interview.
- Body is "neglected" or "de-eroticised", or "functionalized in a pleasurable way", perhaps at times sexualized.

Countertransference

- Do I experience in myself feelings of being unattractive or of erotic disinterest in the patient?
- Do I experience feelings of fascination and erotic attraction, which alternate with embarrassment or angry disappointment?
- Do I feel provoked to compete with the patient on a gender-specific basis?

Differential Diagnosis

From a motivation point of view, do the patient's strivings serve their recognition as woman/man, are they an expression of competition, are they in the service of a tender erotic contact and pleasure? The following conflicts must be delineated:

Axis III:

- *Conflict of self-worth:* This is generally about the recognition of one's "worth", not specifically about the recognition as woman or man.
- *Guilt conflict:* This is about separate, generalized guilt issues, not about a conflict-specifically tone of guilt, that is to say, guilt feelings which result from simultaneous loyalty to involved relationship partners (superego prohibitions).
- *Identify conflict:* This is about conflictual, chronic identity dissonance, or about its compensation or avoidance, not specifically about the identification with and taking up of the gender-specific role requirements as proscribed by parents.

Axis IV: For the possible leading affect of "shamelessness" the structural characteristic "self-regulation", or "communication" should be examined in a differential-diagnostic way: If this shamlessness is found to be in a specific erotic context, a conflict is likely, if it is generalized, it is more likely to be a structural characteristic.

Axis V: Sexual dysfunction. The oedipal conflict is primarily not a sexual dysfunction, it can, however, be syndromally accompanied by one.

C7. Identity (self-)conflicts (identity dissonance)

Themes
Delineable, but contradictory self-representations, chronic struggle for identity and well-being, concealment of identity dissonance, compensatory willingness to take on identity.

Options for Intervention

- Do you experience yourself as virtually torn between your role as ... and your role as ... ?
- It appears to me there are situations in which the ideas you have about yourself conflict so strongly with each other that you are not quite so sure what normally characterizes you as a person, whether you are more like this or more like that?
- Do you recognise the feeling of having conflicting ideas about which career or which lifestyle would suit you best?

Sources of Information
Scenic Information

- In the interview, do you experience the patient in certain aspects of his personality as so contradictory that he/she struggles with his/her identity or covers up dissonances in his/her identity?
- Do you experience the patient as torn between these contradictory aspects? Does he/she, with his/her various clearly delimitable self aspects, entangle him-/herself in so many contradictions that his/her identity becomes shaky?

Differential Diagnosis
Axis IV "Self-perception":

- If the trigger situations are specific, a conflict is likely, if there is no clearly defined identity, we are more likely dealing with a structural problem.
- Have the conflictual positions/self images been elaborated well and are they polarized, or is the fragility of the identity in the foreground?
- Can the contradictions as to inner roles/self images be subsumed under other conflicts, or is there still an unexplained area which must be depicted as an identity conflict?

13.6.4 Interview tools for Axis IV

1.1 Cognitive abilities: Self-perception

Definition
The ability to form an image of one's own self and the related inner processes
Themes
Self-reflexion, affect distancing, identity.

Options for Intervention
Introductory Interventions

- You have told me quite a bit about yourself already. Perhaps you can describe yourself to me one more time, in a way for me to get an idea what kind of person you are.
- Can you describe to me what you felt inside in this situation?
- I cannot quite imagine this side of your character. Could you try to tell me more about it?
- Does it happen at times that you don't know how you are actually feeling?
- Can you reflect on yourself? Are there situations when you cannot do this?

In-depth Interventions

- You have just described yourself as ... and now as ..., how do these go together?
- I notice that you have trouble describing yourself.
- Can it be that you ask others for advice because you don't know yourself what is happening inside you or what would be good for you?
- What you describe sounds as if you do not know who you are.
- It seems that XY perceives you totally differently here from how you perceive yourself.
- I have the impression that you see and present yourself very differently in different situations. Do you do this to do justice to others?
- Is it true that you, after you decided to do ..., have not suffered such strong feelings of tension any more?
- These feelings seem to be totally unbearable for you, so that you don't even want to talk about them with me.

Sources of Information
Patient´s accounts and behaviour during the interview

- Patient has no answers when asked about his/her inner life and is at a complete loss.
- The described situations are totally different from how the patient describes him-/herself .
- When questioned as to contradictory experiences or behaviour, the patient cannot take up a reflective stance.
- Over the course of the interview very different sides are described which appear to be unrelated, without the patient apparently noticing.

Reactions of the Interviewer

- Did I maintain an interest in the patient's self-descriptions, did I gain any clarity?
- Do I think the patient's self-descriptions are true to life?
- Am I confused as to who is being described?
- Do I feel an inner detachment?
- Do the self-descriptions appear to be cliché-like and not genuine?
- Are transitions described between different modalities of experiencing so that I am able to understand what was happening inside the patient?
- Do I have an empty feeling in the interview or do I struggle with intense emotions?
- Do I have the impression of being able to trace the emotional movements of the patient in the interview? Has there ever been a minimal development here?

Differential Diagnosis
Axis III "Identity conflict": While in cases of *identity diffusion* unconscious parts of the self are found

next to each other, unrelated, and produce no tension within the affected person, identity conflicts deal with conscious or preconscious contradictory self aspects which create tension in the person (sufficiently well-established ego-functions).

1.2 Cognitive abilities: Object-perception

Definition
The ability to form a realistic picture of the other in a relationship
Themes
Self-object differentiation, whole object perception, realistic object perception.

Options for Intervention
Introductory Interventions

- You have repeatedly mentioned XY. Can you please describe him in a way that I can get a really good idea of him?
- I cannot imagine this side of XY quite so well. Could you try to tell me more about it?
- How would you describe XY compared with yourself?
- Some people have a good knowledge of human nature. Do you have that, too? Can you give me an example?

In-depth Interventions

- You said that XY was ... , does he have other qualities, too?
- You have just told me that XY is ..., but that does not fit in with what you have said before. How can I grasp this?
- In the relationship episode with XY which you have just described, I had the impression that you didn't really understand what he wanted. Do you recognise this?
- When you describe XY, I get the impression that your image of him changes, depending on your own emotional state. Is this possible?
- Might it be that each time someone has this characteristic, you assume something worse, without being able to further check within yourself how things really are?

Sources of Information
Patient´s accounts and behaviour during the interview

- Patient unable to describe his image of the other person in relation to him-/herself and in a differentiated way.
- If asked about a self-assessment, patient immediately starts talking about his partner.
- Patient thinks to have discovered modes of behaviour in his partner which belong more to the patient than to the partner.
- Also when asked clarifying questions, patient is unable to consider the relative merit of his unrealistic point of view.
- Patient incapable of clearly representing his/her own interests against others.
- Patient perceives interviewer in an unrealistic way or misrepresents his/her intentions.
- In descriptions of self, patient's language becomes blurred with descriptions of others.

Reactions of the Interviewer

- Do I feel a lack of clarity as to who the patient is currently talking about – him-/herself or someone else?
- Do I have the impression that the person described could not possibly exist?
- Do I think the motives of the described persons are understandable or do I feel confused?
- Do the descriptions of the others appear graphic and lively?
- Can I emotionally empathize with the actions of the persons described?
- Do the descriptions sound logical and plausible?

Differential Diagnosis
Axis IV "Regulating relations to the object": While in the self-object differentiation we can observe a cognitive and emotional irritation between self and object, we note that in the aspect *protection of the relationship* the patient's own affects cannot be controlled internally any more, but are propelled into the other and unfold their effect there. A lack of *protection of the relationship* makes self-object differentiation more difficult. Nevertheless, in the individual case a delimitation is often difficult.

2.1 Ability for self-control: Self-regulation

Definition The ability to regulate inner experiences. **Themes** Control of impulse, affect tolerance, regulation of self-worth

Options for Intervention

Introductory Interventions

- How do you handle pressure when it builds internally?
- Can you describe a situation in which you had to struggle with intense feelings? What feelings were these, and how did you handle them?
- Are you familiar with the feeling of your mood suddenly changing?
- How do you handle it if you are hurt by someone?
- Would you sometimes like to be more spontaneous than you are able to?
- Do you sometimes have the feeling that everybody is against you?
- Some people are able to internally stabilize themselves such as in embarrassing situations. How is that with you? Does it take longer to compose yourself again?

In-depth Interventions

- I have the impression that you are sometimes so flooded by feelings that all you do is keep your head above water.
- Perhaps you turn away from me now because you don't want me to go on asking you about this.
- You describe yourself as self-assured and independent, but in the situation you just described you have been obviously badly hit.
- I am surprised right now about your intense reaction, as you gave no indication a moment ago of how much this annoys you.
- I had the feeling a moment ago that you felt hurt by what I said. Is this impression correct?
- Have you perhaps reacted so impulsively in this situation because you weren't able to bear your feelings any more?
- I have the impression you cannot bear this feeling. Let's think together about what what is so unbearable about this feeling.
- If you get all worked up about something or experience intense feelings, can it take some time until you have calmed down again?
- Do you sometimes feel so hurt that you break off contact with the person that did it to you?

Sources of Information

Patient´s accounts and behaviour during the interview

- Patient feels attacked in the interview and cannot calm down.
- Patient reports daily food binges.
- Patient admits, when questioned, that he/she lost his/her driving licence and tends to drink excessively.
- Patient comes across in the interview as particularly controlled, tenacious, or blocked. Affective reactions that would seem appropriate appear unbearable and are avoided.
- Patient describes encountering repeated problems at work because others feel attacked by him/her.
- Patient avoids certain themes so as to circumvent the feelings related to them.
- Patient shows abrupt changes in behaviour.

Reactions of the Interviewer

- Do I feel that I can easily hurt the patient and do I therefore avoid certain topics?
- Do I feel frustrated because the patient is inaccessible and does not give me any insight into his/her feelings?
- Do I feel the tendency to brush off the patient or not to take him so seriously?
- Do I feel overwhelmed by strong feelings?
- Do I react at the attacks of the patient badly?
- Am I surprised that the patient secretly drinks when otherwise he/she appears so controlled and orderly in our contact?
- Do I notice that my efforts for a common understanding of the patient's behaviour fail, because he/she wants to have nothing to do with the related feelings?
- Am I shocked by the patient's destructive behaviour?
- Do I have a tendency to want to get rid of the patient because of his/her inappropriate behaviour?
- Have my efforts failed to demonstrate to the patient that he/she has to be responsible for his/her behaviour?
- Do I feel put down or worthless?

Differential Diagnosis

Axis III:

- *Conflict of self-worth:* While in *self-worth regulation* we are dealing more with an ongoing fragility of some duration which needs constant regulating, the *self-worth conflict* in turn is primarily about alternating between the positions of being "worth more or worth less" than the other. In addition to that, the latter tends to be connected with a clear hiatus over the course of time, for instance as when a pension claim is being established.
- *Guilt conflict:* A structurally caused *pathological superego* shows especially through its ubiquitousness, while *guilt conflicts* only occur in specific situations and specific occasions.
- *Axis IV "External communication":* While in *impulse regulation* the heightened and uncontrolled feelings are the cause of inappropriate behaviour, the same behaviour can due to disturbed empathy, result from the inability to imagine what the other person expects. Typically, both cases have different patient populations. The first is frequent in patients with alcohol dependency, and the latter in narcissistic disorders.

2.2 Capacity for self-control: Regulation of object-relationship

Definition
The ability to protect the relationship from one's own impulses while safeguarding one's own interests.
Themes
Protecting the relationship, balancing of interests, anticipation.

Options for Intervention
Introductory Interventions

- How do you behave if you get into a conflict of interest with someone?
- Do you have difficulty imagining how someone else will react to you?
- How do you react if someone has greatly annoyed you?
- Do you find it difficult to make a compromise?
- Sometimes there are situations in life where one has to make concessions which are difficult to make. How is this with you?

In-depth Interventions

- I have the impression that sometimes, you are so overwhelmed by your feelings that you cannot keep your feelings out of the relationship with XY.
- The way this is told sounds like you imagine the consequences of what you do to be exaggerated.
- Can it be that you sometimes have to hold onto yourself in order not to accidentally put your foot in again?
- You feel that an injustice has been done to you. But the way you are reporting this suggests that your partner may have reacted so violently to you because you vented your anger on him. What do you think?
- This sounds as if you are not talking about yourself because you try not to be a burden to others.
- One could imagine that people are making compromises in which everybody loses a little and gains a little. Have you ever experienced this?
- Can it be that, if someone else makes a demand on you, you quickly feel there is no place for your rights?

Sources of Information
Patient´s accounts and behaviour during the interview

- Patient is all too ready to accomodate and make concessions.
- Patient comes across as anxious and overly careful and fearful of making a mistake. .
- Patient behaves inadequately, hostile, and overbearing.
- Patient comes across as demanding.
- Patient's behaviour is narrowed down to a few options. What few ideas he/she has must be realized at all cost.
- If the patient must backtrack, the world appears to be hostile and against him/her.
- Patient thinks that only his/her ideas, or only the ideas of others can be realized.
- Patient shows rash and incomprehensible behaviour changes.

Reactions of the Interviewer

- Can I only resist with effort being dragged into certain things?
- Do I feel that the patient's behaviour affects my well-being in a sustained way ?
- Do I have the strong urge to assert "my thing"?
- Do I perceive the patient's behaviour as reining me in or pinning me down?
- Do I strongly wish to please the patient so a not to endanger the relationship?
- Do I have the urge to say something that is actually 'not me'?
- Do I need to fight for my rights to be respected?
- Do I feel that excessive demands are made upon me?

Differential Diagnosis
Axis III "Submission vs. control": In both cases a person may particularly insist on his/her rights being realized. While in the case of the "conflicts of submission vs. control" this is about asserting an inner need to submit or dominate, the motive for a lack of balance as to intere*sts* is the protection of the self from drowning internally, or being beleaguered by others.

Axis IV "Self-object-differentiation": While in the self-object differentiation we can observe a cognitive and emotional irritation between self and object, we note that in the aspect protection of the relationship the patient's own affects cannot be controlled internally any more, but are propelled into the other and have their effect there. A lack of protection of the relationship makes self-object differentiation more difficult. Nevertheless, in the individual case a delimitation is often difficult.

3.1 Emotional ability: internal communication

Definition
The ability to have inner dialogues and to understand oneself.
Themes
Experiencing affects, using fantasies, bodily self.

Options for Intervention
Introductory Interventions

- Do you remember your dreams?
- Is it easy for you to find out what is going on inside you?
- How well do you think you know your own needs?
- Are you sometimes helped by internal images that then tell you what to do?
- Do you feel enriched and fulfilled by your feelings, or rather annoyed or restricted by them?
- How do you experience your body?
- Does your body, and how you feel about your body, play a role for you?

In-depth Interventions

- With what you were saying before, I had the impression you haven't really understood why you behaved in this way.
- The way you describe this, it sounds as if you don't feel comfortable in your body, but somehow rather rigid within it.
- I have the impression that you exercise a lot, especially when you feel like you would rather like to cry.
- Perhaps you have answered so fast again, though you couldn't be sure this was the right answer, because you don't want to "look stupid".
- It appears that you often don't know what is going on inside you.
- You say that you don't have any dreams, but you don't know why not or how to interpret this.
- You treat your body as if it were a naughty child that is playing up and which only needs to be appropriately controlled.
- I have the impression that you try to "push away" your fantasies and thoughts.

Sources of Information
Patient´s accounts and behaviour during the interview

- Patient seems fully oriented towards reality and the necessities of life.
- Patient is unable to describe, even after thinking about it, what is happening within or how he/she feels.
- When questioned, patient answers with empty, cliché-ridden phrases.
- Patient recalls no dreams.
- Patient feels inundated by his/her feelings.
- Patient seems not to inhabit his/her body.
- Patient experiences body as foreign.
- Patient behaves inappropriately towards his/her body.
- Patient avoids his/her feelings.

Reactions of the Interviewer

- Do I have the impression of not having a feeling (or sense) of what is behind the patient's words (verbal communications).
- Do I feel severed and untouched?
- Do I feel bored?
- Am I bothered by bodily sensations?
- Do I feel excited and carried away?
- Am I inclined to show a lot of feeling towards the patient so as to fill the empty space?
- Do I feel odd in view of the patient's physicalness?
- Do I have the impression that the patient's body somehow does not go together?
- Do I feel that I am becoming heavy, paralyzed, or frozen?

Differential Diagnosis
Axis III "Defended against recognition of conflict and affect": While it can be noticed in people who "defend against recognition of conflict and affect" that certain feelings are being suppressed and

certain situations avoided, the picture is slightly different with a structural weakness in relation to experiencing affects, as this is characterized rather by a general difficulty to have and express feelings. If one was to exemplify this with an image, in the latter case it could be compared to an arid landscape, whereas in the former we would be dealing with, for instance, selective spots of desert due to the higher altitudes. In addition, in structurally disturbed patient´s anhedonic affects predominate. Such affects are less frequent in people with limited recognition of feeling and conflict, due to the results of an active defense.

3.2 Emotional ability: Communication with the external world

Definitions
The ability to engage in an emotional exchange with another person.
Themes
Contact, communication of affect, empathy.

Options for Intervention

Introductory Interventions

- Do you find it difficult to establish contact with others?
- Can you imagine what another person is feeling at a particular moment?
- How well can you empathize with others?
- Do you have difficulties expressing your feelings?
- You have told me quite a bit, however, I haven't got a clear idea yet about how you felt at that moment.
- Some people manage well wherever they are and are generally well-liked by everybody. Is that you? Under what conditions do you find this especially difficult?

In-depth Interventions

- As to the event with XY you just described, I had the impression that you were unable to imagine what was going on inside him.
- I have the feeling that you often feel not understood.
- Perhaps you find it difficult to show your feelings, because you've had the experience that one should not talk about internal motives.
- Perhaps we can think together about why you might find it so difficult to talk about your feelings with me.
- I have the impression that you turn away from the conversation when you feel too pressured internally.
- Do you perhaps avoid talking about feelings in order not to be rejected?
- In your job, you often feel excluded and rejected. At the same time you seem to enjoy your outsider's position, because then you don't feel so pressured by the demands of others.
- I notice that you suddenly appear as if you had nothing to do with our conversation. I am not quite clear how this could have happened.

Sources of Information

Patient´s accounts and behaviour during the interview

- The contact with the patient is complicated, difficult, or painful.
- Patient comes across as interfering and tactless.
- Patient interrupts the interview and goes.
- Behaviour of patient comes across as deviant and scurrilous.
- Patient appears uninvolved.
- Patient is denigrating and distrustful.
- Patient is quiet and seems only to take part in the conversation because he/she has to.
- Patient is evasive.
- Patient's behaviour violates the scope of the interview.
- Patient generally behaves inappropriately in the interview.
- There is no interest in empathizing with others.
- Others are overlooked by the patient or considered impertinent.

Reactions of the Interviewer

- Have I been able to develop a "we" feeling in the interview?
- Do I feel uninvolved?
- Do I worry about safeguarding the framework of the interview?
- Do I notice a feeling of being cut off?
- Do I tend to exhibit blaming, attacking, or disinterested behaviour?
- Do I have the impression that it is absolutely necessary to see things the way the patient does?
- Do I feel misunderstood by the patient?
- Does the patient's inappropriate behaviour go too far for me, do I feel under pressure?
- Do I have the feeling, despite many attempts, of not being able to reach the patient’s internal world?

Differential Diagnosis

Axis IV "Self-regulation": With an impaired ability for self-regulation the heightened and uncontrollable feelings are the cause of inappropriate behaviour, while the same behaviour in impaired empathy can result from the inability to imagine what the other person expects. Typically, both cases are found with different patient populations. The first is frequent in patients with alcohol dependency, and the latter in narcissistic disorders.

4.1 Ability to form attachments: Internal objects

Definition
The ability to develop internal images of important people, to invest them with positive affect, maintain them and avail oneself of them when necessary.

Themes
Internalization, using introjects, variability of attachments.

Options for Intervention

Introductory Interventions

- How do you handle a stressful situation?
- What do you do if you meet with difficulties? Can you then recall what someone close to you might advise you to do?
- Have you actually noticed that in your relationships the same problems keep occurring again and again?
- How do you feel when you are alone?
- There is the ability to recall good early experiences or loved ones. Do you have that ability?

In-depth Interventions

- You have just described your partner. Your description sounds as if she was very similar to girlfriend XY.
- You have just told me that you experienced .... with XY. Have there also been different moments and situations with him? Can you tell me about them?
- You assumed, in that particular situation, that XY harboured hostile feelings towards you. Later it turned out, however, that this was not the case. What are your thoughts on this today?
- I have the impression that you feel let down again and again.
- You always have very high demands for yourself, even if the outside world does not demand that much of you. Could this be because you fear that you will be blamed for not having given it your best shot?
- What you told me sounds like you would be treating yourself negligently and neglect your own interests, just as you experienced in the past from your parents.
- When you are alone, you are unable to take care of yourself, but fall into an abyss, like in the past, when you had been left all alone at night.

Sources of Information

Patient´s accounts and behaviour during the interview

- The patient assumes negative motives in the interviewer against which he/she tries to protect him-/herself one way or another.
- The patient constantly takes up a defensive stance.
- The range of the offers of communication to the interviewer is limited as to their variety.
- The patient is lost internally if he/she loses outside support.
- The patient feels threatened
- The patient must be repeatedly calmed down.
- The patient copes better in a two-person relationship than in groups.

Reactions of the Interviewer

- Does the patient trigger the same feelings in me again and again?
- Do I experience difficulty in opening myself up internally to the patient?
- Would I rather get rid of the patient?
- Do I feel that the patient makes demands on me, or uses me?
- Do I notice that I keep making offers to the patient which are intended to create trust?
- Do I worry about the patient in such a way that I am inclined to support him/her wherever I can?
- Do I notice an awkward atmosphere in the interview?
- Am I inclined to assure the patient of my trustworthiness?
- Do I have a tendency to blame or criticize the patient?

Differential Diagnosis

Axis III Need for care vs. "autarky": Patients with a vulnerability in the area of *introjects* and patients with a marked *"Need-for-care vs. autarky conflict"* may appear similar on the manifest level. The motives for the clinging behaviour though are different. While the first need the object for self-regulating and calming themselves down, that is to say in the sense of an ego-function replacement, the latter deal with increased clinging to a specific person, for that person's sake.

4.2 Ability to form attachments: External objects

Definition
The ability to attach oneself emotionally to others in real relationships, and then to detach again from them.

Themes
Capacity to form attachments, acceptance of help, severing of attachments.

Options for Intervention

Introductory Interventions

- Are you somebody who easily forms attachments?
- How do you experience separations?
- Has it ever happened to you that you could not disentangle yourself from a relationship?
- Are you able to form close relationships or do you fail at it again and again?
- In difficult situations, can you turn to others for help?
- Do you have problems with accepting help from others?
- Some people can tune in to others well, some find this difficult. Which group do you belong to?

In-depth Interventions

- It sounds as if you had to leave a relationship each time there are conflicts, because you cannot bear a threatening conflict/dispute.
- I notice that you avoid any feelings after a separation, in the same manner you were not allowed to talk about things with your mother after the divorce from your father.
- It appears to me that you had to avoid intimate relationships time and again because otherwise you were in danger of losing yourself?
- I have the impression that you cling to your partner because you think you cannot do without his/her support and are unable to face life.
- I notice that you find it difficult, now that our time is up, to end the conversation.
- After what you are telling me, you seem to avoid farewells.
- You obviously find it difficult to get involved on a deep level with another person. Do you have an idea what this might be related to?

Sources of Information

Patient´s accounts and behaviour during the interview

- The patient seems to be unable to sustain relationships for long.
- The patient behaves in a fiercely independent way.
- The patient describes symbiotic relationships.
- The patient avoids accepting help.
- The patient forms an instantly strong attachment to the interviewer.
- The patient does not take up a position of his/her own.
- The patient does not come to an end in the talk.
- The patient describes having decompensated in his/her mental state after separations.
- The patient does not address separations.

Reactions of the Interviewer

- Do I have feelings of sadness in reaction to separations which the patient describes, while the patient seems to have removed him-/herself from it?
- Do I have the feeling that the patient clings to me?
- Am I inclined to take on attitudes the patient has?
- Do I fear the talk will be ended if I should make a mistake?
- Do I feel plunged into an abyss, feel emptiness, or catastrophic moods when the patient describes separations?
- Am I confused by the separation situations as described by the patient?
- Do I think I am imposing my offers of help on the patient?
- Do I feel left out in the cold by the patient?
- Do I feel the interview is banal and so-so?

Differential Diagnosis

Axis III "Individuation vs. dependency": The conflict becomes manifest with the patient oscillating between the positions of individuation and autonomy, while the structural aspect “severing attachments’’ shows either in an avoidance of separations (moderate structural integration) or in a mental destabilization (low structural integration).

13.7 Operationalized Psychodynamic Diagnosis (OPD-2) data evaluation form

Axis I (basic module) Experience of illness and prerequisites for treatment	none/ hardly present (absent)	low	medium	high	very high	not ratable
	⓪	①	②	③	④	⑨

Objective assessment of the patient's illness / of the problem

1.	Current severity of the illness/of the problem						
1.1.	Severity of symptoms	⓪	X①	②	③	④	⑨
1.2.	GAF: Maximum within the past 7 days		➔				⑨
1.3.	EQ-5D Total: ___6___ Item values ➔	1.1	2.1	3.1	4.2	5.1	⑨
2.	Duration of the disturbance/of the problem						
2.1.	Duration of the disorder	< 6 months	6-24 months	2-5 years	5-10 Years	> 10 years	⑨
2.2.	Age when the disturbance first manifested	in years	➔	___			⑨

Patient's experience, presentation, and concepts of illness

3.	Experience and presentation of the illness						
3.1.	Subjective suffering	⓪	①	②	③	④	⑨
3.2.	Presentation of physical complaints and problems	⓪	①	②	③	④	⑨
3.3.	Presentation of psychological complaints and problems	⓪	①	②	③	④	⑨
3.4.	Presentation of social problems	⓪	①	②	③	④	⑨
4.	Illness concepts of the patient						
4.1.	Concept of illness based to somatic factors	⓪	①	②	③	④	⑨
4.2	Concept of illness based to psychological factors	⓪	①	②	③	④	⑨
4.3.	Concept of illness based to social factors	⓪	①	②	③	④	⑨
5.	Patient's concepts about change						
5.1.	Desired treatment form: somatic	⓪	①	②	③	④	⑨

	treatment						
5.2.	Desired treatment form: psychotherapeutic treatment	⓪	①	②	③	④	⑨
5.3.	Desired treatment form: social environment	⓪	①	②	③	④	⑨

Resources for and impediments to change

6.	Resources for change						
6.1.	Personal resources and strengths	⓪	①	②	③	④	⑨
6.2.	(Psycho)social support	⓪	①	②	③	④	⑨
7.	Impediments to change						
7.1.	External impediments to change	⓪	①	②	③	④	⑨
7.2.	Internal impediments to change	⓪	①	②	③	④	⑨

	Axis I (psychotherapy module)	None/ hardly (absent)	low	medium	high	very high	not ratable
	(optional)	⓪	①	②	③	④	⑨

Patient's experience, presentation, and concept/s of illness

5.	Patient's concepts about change						
5.P1.	Symptom reduction	⓪	①	②	③	④	⑨
5.P2.	Reflective-clarifying of motives /conflict oriented	⓪	①	②	③	④	⑨
5.P3.	Emotional-supportive	⓪	①	②	③	④	⑨
5.P4.	Active-directive	⓪	①	②	③	④	⑨

Resources for and impediments to change

6.	Resources for change						
6.P1.	Psychological mindedness	⓪	①	②	③	④	⑨
7.	Impediments to change						
7.P1.	Secondary gain from illness /conditions maintaining the problem	⓪	①	②	③	④	⑨

<u>Axis II - Interpersonal Relationships</u>

Perspective A: The patient's experience	
Patient experiences herself as Item Nr. Text 1. 2.	Patient experiences others as Item Nr. Text 1. 2.

3. _____	3. r

Perspective B: The experience of others (also of the investigator)	
Others experience the patient as Item no. Text 1. 2. 3.	Others experience themselves as Item no. Text 1. 2. 3.

Relationship-dynamic formulation:

Please describe	
... how the patient again and again experiences others: 🡻	
... how she reacts to what she experiences: 🡻	
...offer of relationship the patient makes to others (unconsciously) with this reaction: 🡻	
... which answers she suggests to others (unconsciously) that way: 🡻	
... how the patient experiences it if others react as expected:	

Axis III - Conflict

Preliminary questions to enable the therapist to rate conflicts

A) Conflicts cannot be rated for lack of diagnostic security.	yes =① no= ⓪
B) Due to a low level of structural integration the recognizable conflictual themes are not actually distinct dysfunctional conflictual patterns but rather conflictual schemas.	yes =① no= ⓪
C) Due to a recognition of conflict and affect being defended against the conflict axis cannot be rated.	yes =① no= ⓪
D) Conflictual stresses (stressor-induced conflict) without any major dysfuctional repetitive conflictual patterns.	yes =① no= ⓪

Repetitive-dysfunctional conflicts	absent	insignificant	significant	very significant	not ratable
1. Individuation versus dependency	⓪	①	②	③	⑨
2. Submission versus control	⓪	①	②	③	⑨
3. Need for care versus autarky	⓪	①	②	③	⑨
4. Self-worth conflict	⓪	①	②	③	⑨
5. Guilt conflict	⓪	①	②	③	⑨
6. Oedipal conflict	⓪	①	②	③	⑨
7. Identity conflict	⓪	①	②	③	⑨

Main conflict: _____ Followed by, in order of importance: _____

Mode of processing of main conflict	predominantly active	Mixed but active	mixed but passiv	predominantly passiv	not ratable
	①	②	③	④	⑨

Axis IV - Structure	high	1.5	moderate	2.5	low	3.5	disintegrated	not rateable
1a Self-perception	①		②		③		④	⑨
1b Object perception	①		②		③		④	⑨
2a Self regulation	①		②		③		④	⑨
2b Regulation of object relationship	①		②		③		④	⑨
3a Internal communication	①		②		③		④	⑨
3b Communication with the external world	①		②		③		④	⑨
4a Attachment to internal objects	①		②		③		④	⑨
4b Attachment to external objects	①		②		③		④	⑨
5 Structure total	①		②		③		④	⑨

Axis V: Mental and psychosomatic disorders

Va: Mental disorders	ICD 10 (Research criteria)	DSM-IV (optional)
Main diagnosis:		_____. ____

additional diagnosis 1:	F _____. _____	_____. ____
additional diagnosis 2:	F _____. _____	_____. ____
additional diagnosis 3:	F _____. _____	_____. ____

Vb: Personality disorders	ICD 10 (F60xx or F61.x)	DSM-IV (optional)
Main diagnosis:	F _____. _____	_____. ____
additional diagnosis 1:	F _____. _____	_____. ____

For diagnoses on axis Va and Vb: ① = Axis Va
Which disorder is clinically prevalent? ② = Axis Vb

Vc: Somatic illnesses:	ICD 10 (not chapter V (F)!)	DSM-IV (optional)
Main diagnosis:	F _____. _____	_____. ____
additional diagnosis 1:	F _____. _____	_____. ____
additional diagnosis 2:	F _____. _____	_____. ____
additional diagnosis 3:	F _____. _____	_____. ____

Patient:	Code:	Age:	Gender: ① = female ② = male	Date:
		_____		

Diagnostician:	Code:	Age:	Gender: ① = female ② = male	Institution:
		_____		_____

13.8 Data evaluation sheet Forensic Module

Patient: Code: Age: _____ Gender: ① = female ② = male Date:

Diagnostician: Code: Age: _____ Gender: ① = female ② = male Institution: _____

Axis I (Forensic module)	none/ hardly present (absent)	low	medium	high	very high	not ratable
	⓪	①	②	③	④	⑨

Objective assessment of the patient's illness / of the problem

1.	Current severity of the illness/of the problem						
1.F1.	Type and severity of the paraphilic/perverse disorder	⓪	①	②	③	④	⑨
1.F2	Type and severity of substance abuse	⓪	①	②	③	④	⑨
1.F3.	Type, severity and frequency of delinquent and/or antisocial behaviour	⓪	①	②	③	④	⑨
1.F4	Level/nature of security						
1.F5	Level/nature of coercion into treatment						
2.	Duration of the disturbance/of the problem						
2.F1	Age when antisocial behaviour first manifested	in years	➔	___			⑨
2.F2.	Age when first convicted, jailed as a juvenile offender, or when antisocial action was first documented	in years	➔	___			⑨

Patient's experience, presentation, and concepts of illness

3.	Experience and presentation of the illness						
3.F1.	.F1 Presentation of delinquent behaviour and/or antisocial behaviour modes	⓪	①	②	③	④	⑨
5.	Patient's concepts about change						
5.F1	Attitude to placement	⓪	①	②	③	④	⑨
5.F2	Attitude to coercion into treatment or contractual structure	⓪	①	②	③	④	⑨
5.F3	Attitude to the prospect of change with	⓪	①	②	③	④	⑨

	respect to reducing antisocial behaviour	

Resources for and impediments to change

6.	Resources for change						
6.F1	Openness towards consideration of psychological factors influencing offending/antisocial behaviour	⓪	①	②	③	④	⑨
6.F2.	Openness to associations between offending/antisocial behaviour and subsequent mental states	⓪	①	②	③	④	⑨
7.	Impediments to change						
7.F1	Comorbidity	⓪	①	②	③	④	⑨
7.F2	Psychosocial advantages because of delinquent/antisocial behaviour	⓪	①	②	③	④	⑨
7.F3	Psychosocial advantages because of (court) ordered measures and involved services	⓪	①	②	③	④	⑨
7.F4	Utilization of mental disturbance with regard to delinquent/antisocial behaviour	⓪	①	②	③	④	⑨

13.9 OPD-2 Evaluation Sheet Focus selection

Patient: Code: Age: Gender: Date:
① = female
_____ ② = male

Relationship is an obligatory focus
Please select up to 4 further foci from the conflict and/or structure axis

Relationship foci

You can write the relationship dynamic formulation into the following form

... how the patient again and again experiences others: ↓	
... how she reacts to what she experiences: ↓	
...offer of relationship the patient makes to others (unconsciously) with this reaction: ↓	
... which answers she suggests to others (unconsciously) that way: ↓	
... how the patient experiences it if others react as expected:	

Conflict foci

K1.	Individuation versus dependency	K3.	Care versus autarky	K5.	Guilt conflict
K2.	Submission versus control	K4.	Self-worth conflict	K6.	Oedipal conflict
				K7.	Identity conflict

Structure foci

Perceiving the self	Perceiving the objects
ST1.1 Self reflection	ST1.4 Self-object differentiation
ST1.2 Differentiation of one's own affects	ST1.5 Perception of whole objects

ST1.3 Identity	ST1.6 Realistic object perception
Regulating the self	Regulating relationship to the object
ST2.1 Impulse control	ST2.4 Protection of the relationship
ST2.2 Tolerance of affects.	ST2.5 Balance of interests
ST2.3 Regulation of self-worth.	ST 2.6 Anticipation
Internal communication	Communication with others
ST3.1 Experiencing affects	ST3.4 Making emotional contact
ST3.2 Use one's own phantasies.	ST3.5 Communication of of affects
ST3.3 Bodily self.	ST3.6 Empathy.
Attachment to internal objects	Attachment to external objects
ST4.1 Internalization	ST4.4 Capacity to form attachments
ST4.2 Making use of introjects	ST4.5 Accepting help
ST4.3 Variable and triangular attachments	ST4.6 Ability to sever attachments

Selection of 3-4 Foci

	Nr. (e. g. C2 or ST3.1)	Brief description
Relationship		
Conflict or Structure		
Conflict or Structure		
Conflict or Structure		
Conflict or Structure		

The The basic therapeutic approach in this patient is ...

	clearly	more	mixed	more	clearly	
structure related	☐	☐	☐	☐	☐	conflict-related

14 Additional Modules

14.1 The GAF (Global Assessment of Functioning) Scale

After H. Sass, H.U. Wittchen, and M. Zaudig. Taken from the "Diagnostic and Statistical Manual of Mental Disorders DSM-IV". (Sass et al., 2001).

100-91	Superior functioning in a wide range of activities; life's problems never seem to get out of hand; is sought out by others because of his or her many qualities; no symptoms.
90-81	Absent or minimal symptoms (e.g. mild anxiety before an exam); good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with another family member).
80-71	If symptoms are present they are transient and expectable reactions to psychosocial stresses (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (for example, temporarily falling behind in schoolwork).
70-61	Some mild symptoms (e.g., depressive moods or mild insomnia) OR some slight difficulty in social, occupational, or school functioning (like occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
60-51	Moderate symptoms (for example, flat affect, circumstantial speech, occasional panic attacks) OR any moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with colleagues, school mates, or relationship figures).
50-41	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shop- lifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
40-31	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30-21	Behavior is seriously influenced by delusions or hallucinations OR serious impairment, in communication or judgment (e.g., sometimes incoherent,

	acts grossly inappropriately, intense suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).
20-11	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears faeces) OR gross impairment in communication (e.g., largely incoherent or mute).
10- 1	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
0	Inadequate information.

14.2 EQ-5D

The EQ-5D is a health questionnaire which supplies a unidimensional unit of measurement to measure quality of life. The original version of the EQ-5D was developed by the EuroQol-Group as a self-report instrument (Rabin, 2001). The five dimensions of the original EQ-5D have been reformulated for our purposes into an external rating instrument.

Operationalization
It is to be indicated on five dimensions which statements best describe the health status of a patient. The description proceeds from the current health status (time of the interview) of the patient (Rabin/de Charro, 2001).

Table 14-2: EQ-5D

1. Flexibility/Mobility	
The patient has no problems getting about.	[_]1
The patient has some/moderate problems getting about.	[_]2
The patient is bed-ridden.	[_]3

2. Self-care	
The patient has no problems caring for himself.	[_]1
The patient has some/moderate problems washing of clothing himself.	[_]2
The patient is unable to wash or clothe himself.	[_]3

3. Usual activities (for example, work, study, household duties, family or leisure activities)	
The patient has no problems carrying out his normal, everyday activities.	[_]1
The patient has some/moderate problems carrying out his usual activities.	[_]2
The patient is unable to carry out his usual activities.	[_]3

4. Pain/discomfort	
The patient has no pain or discomfort.	[_]1
The patient has moderate pain or discomfort.	[_]2
The patient has extreme pain or discomfort.	[_]3

5. Anxiety/depression	
The patient is not anxious or depressed.	[_]1
The patient is moderately anxious or depressed.	[_]2
The patient is extremely anxious or depressed.	[_]3

14.3 List of defence mechanisms

After the concept of "defensive functioning" (Perry/Hoglend, 1998), adapted from the DSM-IV (Sass et al., 2001).

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Highly adaptive level of defence

This level of defence leads to optimal adaptation when coping with stress factors. These defence mechanisms usually tend to maximize satisfaction, allowing one to consciously deal with feelings, thoughts, and their consequences. In addition, they encourage an optimal balance between contradictory motivations. Examples of defensive mechanisms at this level are:

- Affiliation
- Altruism
- Anticipation
- Humour
- Self-assertion
- Self-observation
- Sublimation
- Suppression

Level of defence involving mental inhibitions (compromise formations)

The defensive functions at this level cut out from awareness potentially threatening thoughts, feelings, memories, wishes, or fears. Examples are:

- Affect isolation
- Dissociation
- Intellectualization
- Reaction formation
- Undoing things
- Repression
- Displacement

Level of defence involving slight distortion of ideas

This level is characterized by distortion of the self-image, the body image, or other ideas which can be used for self-worth regulation. Examples are:

- Devaluation
- Idealization
- Omnipotence

Level of denial

This level is characterized by the fact that unpleasant or unacceptable stress factors, impulses, ideas, affects, or responsibilities are kept outside of awareness. This may or may not be accompanied by wrong attributions to outside causes. Examples are:

- Projection
- Rationalization
- Denial

Level of defence involving severe distortion of ideas

This level is characterized by gross distortion or wrong attribution of the self-image or the image of others. Examples are:

- Autistic fantasy
- Projective identification
- splitting of self-image and splitting of others' images

Level of action

This level is characterized by defensive functions which deal with internal or external stressors by action or withdrawal. Examples are:

- Apathetic withdrawal
- Acting out
- Help-refusing complaints
- Passive aggression

Level with defensive dysregulation

This level is characterized by a failure of defensive regulation, which serves to inhibit reactions to stressors [stressful events], resulting in a clear break with objective reality. Examples are:

- Psychotic denial
- Psychotic distortion
- Delusional projection.