X

DEVELOPMENTAL PROFILE

I N T E R V I E W

DEVELOPMENTAL PROFILE - INTERVIEW **No: /**

Name : m/f
Date of birth : Profession:
Address :
Therapist: Date of Interview:
Report sent to : date:

Explaining the interview to the patient
The aim of this interview is to examine in some detail various aspects of your daily life. This will require several interview sessions. I have read the letter from your GP/specialist and I know what you have already told our people at the clinic/outpatient clinic. Your therapist will receive a summary of the interview.

A. SYMPTOMS AND PROBLEMS (25')*[1]

A.1 Can you tell me briefly why you are here/what your symptoms/problems are? How long have you had these symptoms/problems? What made you decide to come here now?

A.2 How do your symptoms/problems affect your daily life? What do you not do now that you used to do? How long has this been the case?

A.3 How do you react to your symptoms/problems? What do you usually do to lessen their effect or to make the situation as bearable as possible? How is this brought about?

[1] Indication of the investment of time per chapter.

A. SYMPTOMS AND PROBLEMS (continued)

A.4 UNDERSTANDING: (not including therapy) Do you talk to anyone about your symptoms/problems? (if so) With whom? Does it help? (if not) Why not?

A.5 SUPPORT: (not including therapy) Is there anyone who supports you, helps you to cope with your symptoms or make the situation as bearable as possible? (if so) Has this actually helped? Who is this person? What does he or she do? How important is this to you? (if not very important) Why not?

A.6 THERAPY: (Recent) Have you sought treatment for your symptoms during the past year? (if so) What kind of treatment was this? How often did it take place? For how long? Did you feel as if you were understood? Did the treatment help? (if so) What exactly do you feel was helpful? (if not) Why not? (In the case of symptoms which have continued for some time without therapy) Why did you wait until now to seek treatment?

A.7 THERAPY (past): You have previously (in the last 10 years) undergone psychotherapeutic/psychiatric treatment. When? What were your complaints? What type of treatment was this? How often did it take place? For how long? Did you feel as if you were understood? Did the treatment help? (if so) What exactly do you feel was helpful? (if not) Why not?

B.

LIFE-STYLE

(

15')

B.1 **HOME SITUATION:** Do you live alone? (if not) Have you ever lived alone (in the last 10 years)? (if not) Why not? (if so, or if living alone now) What do you do about meals, housework, laundry? Are you often home alone? Do you feel at home in your room/flat/house? (if not) Why not?

B.2 **STAYING AT HOME ALONE** (if not living alone): Do you ever spend an extended period of time at home alone? (if so) How long? How often? Do you enjoy this?

B.3 **TRAVELLING:** Have you ever gone on holiday, or for some other reason spent a week or longer away from home? (if so) When? (in the last ten years)? For how long? Did you enjoy yourself?

B.4 **ACTIVITIES OUTSIDE THE HOME:** Do you have any activities outside the home in addition to work? (if so) What kind of activity is this? How often? Is this alone or with others?

B.5 **MILITARY SERVICE** (in the last 10 years, when applicable): Did you fulfil your military service? (if not) Why not? (if so) How did you experience this period?

C. SCHOOLING (10')

C.1 What schooling or training have you had (after elementary school)? How long did this last? Did you complete this schooling or training? (if not) Why not?

C.2 (if the patient has not been in school for the past 10 years, go on to question D.1) Why are you following this course?/ What will it help you to achieve?

C.3 Are you satisfied with the results? Why?

C.4 How do you react when something happens you do not agree with? Could you give me an example? Are you satisfied with your reaction? (if not) Why not?

C.5 (Only if the schooling/training is important) Does this course of training/schooling suit you? Why?

D. WORK (10')

D.1 (If not employed, the last job held during the past 10 years; if not employed during the past 10 years, go on to question D.7) What type of work do you do? (if applicable) What does this entail? How long have you done this work? Do you work on your own or under direct supervision? Do you supervise others?

D.2 Why do you do this work? Is it important to you? Why?

D.3 Are you satisfied with your work situation? Why?

D.4 (if in salaried employment) Is your employer/boss satisfied with your work? And your colleagues? (if dissatisfied) How do you feel about this?

D.5 Are you yourself satisfied with the way you do your work? Why?

D.6 How do you react when something happens you do not agree with? Could you give me an example? Are you satisfied with your reaction? (if not) Why not?

D.7 (Only if the work is important) Does the work you do (did) suit you? Why?

D.8 Have you (during the last 10 years) done other work? When? For how long? Was your employer satisfied with your work? Why did you change jobs/switch to another type of work? (Where there are gaps in the patient's work history) What did you do during this period? (If no longer employed) How long has it been since you last worked? Why are you no longer working? How do you feel about this?

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E. PARTNER (25')

E.1 Do you have a partner? (if no partner, last relationship with a partner in the last 10 years; if no partner in the last 10 years, go on to question E.13) How long have you been living together?

E.2 Could you tell me something about your partner?

E.3 What do you consider good in this relationship? What is less good or even bad? And how does your partner feel about the relationship? Has your relationship changed since the beginning? (if so) How?

E.4 How important are you to him/her? How important is he/she to you? What role does he/she play in your life?

E.5 Are you satisfied with the present arrangement regarding housework, money matters, the upbringing of the children? (if not) Why not? And your partner? (if not) Why not? How do you feel about this?

E.6 Do you ever have disagreements? (if not) Why do you think this is? (if so) Could you give me an example? How do you feel about your partner's reaction? Are you satisfied with your own reaction?

E.7 Do you talk to your partner about what interests you / what you consider important? And does he/she do the same with you? Are you satisfied with this situation? (if not) Why not? And your partner? (if not satisfied) Why not? How do you feel about this?

E. PARTNER (continued)

E.8 What leisure activities do you engage in together? Are you satisfied with this situation? (if not) Why not? And your partner? (if partner not satisfied) Why not? How do you feel about this?

E.9 How often do you have sex? Are you satisfied with the way this happens? (if not) Why? Do you have an orgasm? How important is sex to you? How does your partner feel about this? (if partner not satisfied) Why not? How do you feel about this?

E.10 Have you ever felt you wanted to have sex with another man/woman (same sex as partner)? Has this ever happened? (if so) How did you experience this? And your partner? How do you feel about this?

E.11 Have you ever felt you wanted to have sexual contact with someone of the same sex you are? Has this ever happened? How did you experience this? Do you feel that this suits you?

E.12 Have you previously (in the last 10 years) had other partners? When? For how long? (with regard to the longest relationship) Why did you break up? Who took the initiative? How did you feel about this?

E.13 Does living together with the present partner or living without a partner suit you?/ Is this what you want? Why?

F. CHILDREN (10')

F.1 Do you have children? (If no children, go on to question F.4, if so) What are their ages and sex?

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F.2 Were the children planned? How important is having children to you? What do you do with/for them?

F.3 Are you satisfied with the way in which you fulfil your role as mother/father? Why?

F.4 (if no children and under 30 years of age, go on to question F.5) (if no children and over 30 years of age) You don't have any children. Is that by choice? Why? (if there are children) Is the role of mother/father something that suits you? Why or why not?

F.5 Are there other people, animals or particular events in society for which you feel responsible? (if so) How do you express this?

G. OTHER RELATIONSHIPS (10')

G.1 Are you in touch with your parents? How often to you talk to them? What does this mean to you? And to them?

G.2 Do you have brothers/sisters? How often to you talk to them? What is your relationship with them? What does this mean to you? And to them?

G.3 Are there other people who are in some way or other important to you? (if more) Who are the most important of these? (a,b)

G.4 (a) (Note name) How long have you known each other? How often do you talk to each other? Why is he/she important to you? Are you important to him/her? Why?

G.5 How do you react when something happens you do not agree with? Are you satisfied with your reaction? (if not) Why not?

G.6 (b, As for G.4)

G.7 (As for G.5)

G.8 (if no sexual contacts with a regular partner) What about sexual contacts? (if not) Do you ever masturbate? (if not) Do you ever have sexual fantasies or desires?

H. RELIGIOUS, POLITICAL AND OTHER SOCIALLY ORIENTED ACTIVITIES (5')

H.1 Do religious, political or other socially oriented activities play a role in your life? (if so) How long has this been the case? How much time do you spend on such activities?

H.2 Why do you take part in these activities? Are they important to you? Why? (if not important) Then why do you take part in them?

H.3 Do these activities suit you? Why?

I. SPORT AND HOBBIES (5')

I.1 Do sport and hobbies play a role in your life? (if so) How long has this been the case? How much time do you spend on such activities?

I.2 Why do you take part in these activities? Are they important to you? Why? (if not important) Then why do you take part in them?

I.3 Do these activities suit you? Why?

J. DISTRESSING EVENTS/SITUATIONS (15')

J.1 Have you experienced events or situations you found difficult or distressing? (if so) Which of these events did you find the most difficult or the most distressing? (= a) And the next most distressing? (= b)

J.2 (a) When was this? What exactly happened? How did you experience this? What did it mean to you? (where applicable) Why?

J.3 How did you react to what happened? What did you do to cope with the situation?

J.4 Have you talked to anyone about it? (if so) With whom? Did that help? Did anyone give you support to help make the situation as bearable as possible, to change the situation or to solve the problems?

J.5 (b) When was this? What exactly happened? What did this mean to you (where applicable) Why?

J.6 How did you react to what happened? What did you do to cope with the situation?

J.7 Have you talked to anyone about it? (if so) With whom? Did that help? Did anyone give you support to help make the situation as bearable as possible, to change the situation to solve the problems?

K. SPECIAL EVENTS/THEMES (10')

K.1 Have you even been involved with the police or done anything that could have gotten you into trouble with the law? (if so) When was this? What exactly happened?

K.2 Why did you do it?

K.3 Were you found out? (if so) How? Were you punished? (if so) How do you feel about this?

K.4 How did you react? (directly, to deal with the consequences; indirectly, to avoid a repetition?)

K.5 Looking back on what happened, how do you feel now?

K.6 Has anything else happened that has significantly affected your life? (if so) When was this? What exactly happened? How did you experience this? What did it mean to you? (where applicable) Why? How did you react?

K.7 (if aged 50 or over) Do you ever think about the end of your life? (if so) Has that led to any changes in your life? (if so) What has changed?

L. NEEDS (5')

L.1 Most people have needs, something they feel is necessary for them. Do you have such needs? What do you consider most important (a), slightly less important (b)?

L.2 (a) What does this involve exactly? Why is this important to you? Could you give me an example of this? To what extent has this need been satisfied? How do you experience this? (if not satisfied) How do you react to this?

L.3 (b)

M. ANXIETY (5')

M.1 Most people are at some time anxious or afraid. Is this true of you? (when applicable) Could you mention a number of events or situations (a, b) in which you are generally anxious or afraid?

M.2 (a) What exactly happens? What are you anxious about or afraid of? (when applicable) Why? How intense is the sensation? How long does it last? How often does this occur? What do you do?

M.3 (b) As for M.2

N ANGER (5')

N.1 Most people get angry once in a while. Is this true of you? (when applicable) Could you give me a number of events or situations (a, b) in which you became angry?

N.2 (a) What exactly happened? Why are you angry in such situations? At whom? How angry? For how long? How often? What do you do? How do you experience that?

N.3 (b, as for N.2)

O. GUILT AND SHAME (5')

O.1 Most people feel guilty or ashamed at some time. Is this true of you? (when applicable) Could you give me a few examples (a, b)?

O.2 What exactly happened? (if very important) Why do you feel guilty? Is the opinion of others important? (if important) More important than your own opinion? How do you react? (directly, to remedy the situation; indirectly, to avoid a repetition?)

O.3 (b, as for O.2)

P. INFERIORITY (5')

P.1 At some time or other most people feel inferior , even totally worthless. Does that ever happen to you? (when applicable - otherwise go on to question P.4) Could you mention two activities or events (a,b) which tend to diminish your self-esteem?

P.2 (a) What exactly happened? Why did that diminish your self-esteem? Is the opinion of others important? (if important) More important than your own opinion? How do you react? (directly, to remedy the situation; indirectly, to avoid a repetition?)

P.3 (b, as for P.2)

P.4 Which activities or events tend to enhance or strengthen your self-esteem? (when applicable) Could you give two examples (a, b)?

P.5 (a) What exactly happened? Why does that enhance your self-esteem? Is the opinion of others important? (if important) More important than your own opinion?

P.6 (b, as for P.5)

Q. CONCLUSION (10')

Q.1 On the basis of what you have told me, I would like to ask you the following : (missing, vague, contradictory information)

Q.2 Could you give me a brief description of yourself?

Q.3 What to you feel is the cause of your symptoms/problems?

Q.4 What kind of help do you expect?/How do you think you could best be helped? Why? What results do you expect from a treatment?

Q.5 How do you feel about these talks?

Q.6 Are their other topics which should be discussed here/Is there anything else which you would like to bring up?

We have now come to the end of the interview. (when applicable) I would like to make another appointment with you to discuss the results.

XI

DEVELOPMENTAL PROFILE

REGISTRATION PROTOCOL

TABLE 26. THE DEVELOPMENTAL LEVELS

00. LACK OF STRUCTURE: The lack of a frame of reference and/or the lack of certain general human abilities

10. FRAGMENTATION: A lack of inner consistency

20. EGOCENTRICITY: An excessive and/or egoistic attitude

30. SYMBIOSIS: Incomplete separation, an inability to function independently

40. RESISTANCE: The lack of autonomy; a lack of inner freedom

50. RIVALRY: Insecurity about one's own qualities as an adult man or woman, together with a striving to prove oneself

60. INDIVIDUATION: Self-realization; living life in one's own way, taking into account the existing possibilities as well as the interests of others

70. SOLIDARITY: Functioning in a relationship. Being part of a larger entity, without losing one's own personality

80. GENERATIVITY: A true joint responsibility for the functioning of society

90. MATURITY: Decentralization whereby one's personal interests are no longer of primary importance; no longer placing oneself at the centre of things.

LACK OF STRUCTURE (00)

Behaviour on this level is characterized by a '`**lack of a frame of reference**' or a '**lack of general human capabilities**'. The lack of a frame of reference manifests itself in Inconsistency (01) whereby the patient's behaviour is determined largely by momentary internal or external stimuli. Because the patient does not consider the consequences of his actions, but allows his behaviour to be dominated by the desire to satisfy his direct needs, we also see here a Lack of Norms (04). Lack of structure likewise manifests itself in a Lack of Self-Image (03), whereby the patient does not experience himself as an 'organic entity' and in Disorganization (09), i.e. the loss of the ability to differentiate between oneself and others, to steer one's own thoughts and actions and to order them in time and space. The functional incapacity reflects the Lack of Attachment (02), the absence of a need for significant others or a Lack of Needs (05), whereby the patient does not know what it is to have desires, especially desires of a sexual nature. Another functional incapacity is the Lack of Representations (06), whereby the patient is unable to symbolize his experiences. Problem-solving behaviour is characterized by a severe loss of reality testing. This manifests itself as Falsification (07) by means of Disavowal or Delusionary- or Hypochondriac Ideas. In some cases, normal defense mechanisms are lacking so that sexual or aggressive needs which are normally forbidden are expressed or even satisfied without any scruples whatsoever. And finally, the patient may be inaccessible, locked inside a world of his own which is 'incomprehensible' to others. In the profile this is referred to as Autism (08).

INCONSISTENCY (01)

Social attitudes

Operational definition: The behaviour of the patient is determined to a significant degree by momentary internal or external stimuli.

The designation 'to a significant degree' indicates that this is an habitual behavioural pattern. The patient is adrift. His behaviour has no inner consistency. It is determined by momentary circumstances so that it is often **'unpredictable**' or **'chaotic,'** even for himself. The definition does not include planned pre-reflective action, such as intentional free association or creative expression. Inconsistent behaviour may also be reflected in a Lack of Norms (04), but must be distinguished from the latter. Inconsistent behaviour may conflict with the satisfaction of one's own needs, while Lack of Norms (04) is not always accompanied by Inconsistent behaviour. Inconsistency differs from Acting Out (18) by its habitual nature. There is no attempt to alter one's behaviour, which distinguishes Inconsistency from an unsuccessful attempt at Self-Control (67).

Examples:
I went to Z. because that was the first train that happened to come by./I don't know why I went with him. I wasn't planning to.

LACK OF ATTACHMENT (02) Object relationships

Operational definition: The patient does not recognize the need for another person to play a significant role in his life.

Having to do something together with others is often experienced as unpleasant. The fact that the patient does not recognize this need implies that it has never existed for him, which distinguishes Lack of Attachment from Detachment (37). The inability to associate with others or the lack of significant others is only included in the definition if this is not experienced as a deficiency. Paradoxically, an excessive number of acquaintances may be an indication of Lack of Attachment. The patient is able to discuss extremely intimate subjects with everyone, but is not intimate with anyone in particular.

Examples:
I don't feel any need for relationships. / I don't see why I should get married. I don't like sharing an apartment with anyone else. / I have a great many good friends. No, no one in particular.

LACK OF A SELF (03) Self-images

Operational definition: The patient does not feel himself to be an organic entity.

This manifests itself in the feeling that one has no inner frame of reference. Only one's biological needs, external circumstances or the behaviour of others provide orientation upon which to act.

Examples:
I'm afraid that I don't exist. That it doesn't make any difference whether I do something or not./I don't feel at one with myself./Events never mean anything to me./I'm without a core. / Interacting with people gives me structure. I can't provide this myself. /There's nothing inside me to hold on to. If one person says A and the other B, I'm no longer able to think./I don't know what it is to really live. I try to copy other people./I don't know how to say things. I use other people's words./ Hoe do you make contact? How do you get angry? How do you make choices? I just don't know.

LACK OF NORMS (04) Norms

Operational definition: The patient acts without reflecting on his actions, the immediate satisfaction of his own needs being his only goal.

The characteristic feature here is the pre-reflective nature of the behaviour. The patient takes nothing and nobody into account, not even his own long-term interests. The objective is the immedicate 'attainment of pleasure' or 'avoidance of pain'. As a rule, such behaviour does not become evident until it causes damage to others. Because of the pre-reflective nature of his actions, the patient 'honestly' does not consider himself responsible for what

happens, even when this is obviously a consequence of his behaviour. 'I'm not to blame. I didn't do it on purpose'. Often the circumstances or even the victims are held responsible. This is also called **'primitive externalization'**. The patient using higher-level Externalization (Reversal-Projection 57) denies responsibility for the decision, but not for his actions. Where the patient sees his behaviour as wrong or bad, this is because he was punished for it and not because he actually considers it wrong. If the patient later feels guilty because he has done something which he himself considers to be unacceptable, then this is also evidence of Conventional (44, 54) or Fundamental Norms (64, 74).

Examples:
(Man who, with two others, seriously beat up a passer-by) 'It was just for kicks.' / (Contact with the police?) Knocked a woman about at the beach, when she kept going on about me playing my radio too loud. (How do you feel about that now?) I don't know. She was a real bitch. / I sometimes do crazy things. Smashing windows, beating up people for no reason. (What to you think of that?) Yeah, well, you just do things like that. / I didn't kill him. He walked right into my knife. / She didn't want to give me the money. So I had to shoot. / I was in bad company. I couldn't help it.

LACK OF NEEDS (05) Needs

Operational definition: The patient has no desires, especially no feelings of genital-sexual arousal.

The fact that the patient does not recognize any needs implies that these have never existed for him. Not experiencing this as a deficiency distinguishes Lack of Needs from Detachment (37). The lack of sexual arousal implies that the patient has never had sexual contact or only engages in such contact because it is expected of him. He has never masturbated or had sexual fantasies. The definition does not refer to patients whose sexual needs have waned. An indirect manifestation of a Lack of Needs is the **'lack of affectivity'**. The patient is never angry, fearful or happy. The lack of suffering and the habitual nature of this behaviour distinguishes Lack of Needs from a depressive state.

Examples:
I prefer to be left alone. / Sex - I don't need it. I've never understood why it turns other people on. / I don't know what it (sex) is. But apparently people consider it pretty important.

LACK OF REPRESENTATIONS (06) Cognitions

Operational definition: The patient is not able to symbolize his experiences.

The inability to symbolize has to do with verbal as well as non-verbal forms of expression. In other words, the patient is not capable of '**psychologizing**' his experiences. As a rule Lack of Representation is concerned primarily with affect-laden themes. These are often experienced as **'bodily states'**. In contrast to Delusional and Hypochondriac Ideas, these complaints are not at odds with reality. The patient himself may be aware of the fact that he is not able to conceptualize certain subjects. In that case there is also cognitive functioning on a higher level, for example Self-Confrontation (66). If this is the case the patient is usually also able to recognize a description of his experience if one is offered.

Examples:
I have a stomachache (while it is clear that the patient is not physically ill, but is wrestling with serious psychosocial problems).

FALSIFICATION (07) Problem-solving (thoughts & feelings)

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Operational definition: The patient reacts to internal or external stress factors by Disavowal, Delusionary Ideas, Hypochondriac Ideation, or Lack of Defense.

(a) Disavowal: The patient fails to recognize in the outside world what is clearly observable to others and may be expected to be clear to him as well. Unlike Denial (Reversal 57), Disavowal is directed toward the external rather than the internal world. Disavowal is sometimes referred to as **'psychotic denial'**.
(b) Delusionary Ideas: The interpretation of events and situations is not in accordance with the facts. All defense mechanisms result to a greater or lesser degree in a distortion of reality. In the case of delusionary ideas, there is a distortion of the outside world. The difference between delusionary ideas and delusions is a quantitative one. In the case of delusionary ideas the distortion is limited, situational or selective. The patient often knows that what he says is 'not really true'. Delusionary ideas are often referred to as **'psychotic projection'**. **'Concretistic thinking'** also belongs to this behavioral category, as do **'supernatural powers'** and **'magic rituals'** aimed at changing external reality.
(c) Hypochondriac ideation: The patient attributes his psychological symptoms or problems to a somatic deformation or illness without any objective reason for doing so. The definition does not include inexplicable somatic symptoms or a physical illness arising from distressing circumstances.
(d) Lack of Defense: The patient experiences and in some cases acts on impulses generally regarded as highly reprehensible, such as the urge to commit incest or murder, without any qualms whatsoever.

The assessment of Falsification is the sum of the assessments of Disavowal, Delusionary Ideas, Hypochondriac Ideation and Lack of Defense.

Examples:
(a) *I know that homosexuals form a high-risk group for contracting AIDS. But I feel fine, so I guess everything's o.k./* ***(b)*** *Those pictures of nude women on magazine covers and all the sex on TV are intended to knock me off balance. / I know there is no reason to suspect them, but I'm sure they are cheating on me. / When I eat, I feel dirty. / I'm afraid that I'm going to 'forget to breathe' and then suffocate./I'm afraid of the bookcase - it belonged to my father. /***(c)** *(Patient with obvious family or work problems) I have a stomach ache. That's the problem. / I'm ashamed of my penis. It's too small. That means I'm not manly. / I can't bear the thought of going through life with breasts like this. But the surgeon says they're not too large and refuses to operate on me.* ***(d)*** *The thought of my mother going to bed with her new boyfriend arouses me.*

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AUTISM (08) Problem-solving (actions)

Operational definition: The patient displays 'strange' affects, cognitions or actions, making communication impossible.

The patient is present but inaccessible. His behaviour is experienced by others as **'bizarre'** or **'incomprehensible'**. Communication is impossible due to the absence of a shared frame of reference. This definition does not include disturbed communication on its own or incidental strange behaviour. Similarly, being able to talk but preferring not to does not fall into this category. Autism is not the same as the absentmindedness associated with excessive daydreaming (Pretending 58), where the inner feelings of the patient are understandable and open to discussion.

Examples:
Walks around with two heavy bags stuffed with old newspapers. / Does not react when spoken to. / Often laughs for no reason. / Makes strange movements. Keeps saying 'that's it!'.

DISORGANIZATION (09) Miscellaneous themes

Operational definition: The patient experiences the partial loss of vital psychological functions.

Here 'partial' means for a limited period in time or to a limited degree. The loss of vital functions is concerned with the ability to:
(a) differentiate between oneself and others,
(b) experience time or space,
(c) steer one's thoughts or actions.
The inability to distinguish between the 'me' and the 'not-me' may manifest itself as the lack of a '**stimulus barrier**', the ability to shield oneself from stimuli from the outside world. Another manifestation is '**fusion anxiety**', the fear of losing oneself as a result of contact with others. The inability to order in time means that only the present, the here-and-now, is experienced. What is past can never be retained, which means that it never existed. There is no anticipation of the future. 'Now is always'. This manifests itself in a lack of '**object constancy**', the inability to retain the memory of a significant other when the person is no longer present. The inability to direct one's own thoughts, feelings and actions is usually accompanied by a **'fear of disintegration**', a '**fear of annihilation**' or '**micropsychotic attacks**'. Another manifestation of this inability is being flooded by one's own feelings one experiences as unbearable. The incapacity to concentrate or to remember things is only registered as a lack of ordering if it is accompanied by the anxieties described above.

The assessment of Disorganization is the sum of the assessments of (a) the inability to differentiate between oneself and others; (b) the inability to experience time or space and (c) the inability to steer one's thoughts or actions.

Examples:
(a) *The neighbour's clock is ticking inside me. It's driving me crazy./I feel as if I'm the victim of other people's sounds. / Where do his thoughts end and mine begin? Sometimes I start to wonder. / We used to think the same way about everything - it was queer. / Everyone says I'm the image of my father. It gives me the creeps. He's him and I'm me. / By entering therapy I'm afraid of losing my identity.* ***(b)*** *When my therapist went on a holiday, I felt as if he had disappeared for good.* ***(c)*** *Time stopped. I was terrified. I couldn't move or think. I could only wait for the experience to be over.*

FRAGMENTATION (10)

The patient's behaviour on the level of Fragmentation is characterized by a '**lack of inner consistency**'. The thoughts, feelings and actions of the patient are kaleidoscopic. Tomorrow he may see things in a way totally different from, or even contradictory to, the way he sees them today. Behaviour is characterized by frequent changes in self-determined goals (Changeability 11). The experiential world of the patient is literally structured by his relations (Frame 12). The loss of a relationship or even the threat of such a loss is also experienced as an existential threat. The patient is not capable of characterizing himself. The image that he has of himself is incomplete and often contradictory (Vague Self-Image 13). He may have an extreme view of people, events or situations, but is not able to indicate how he arrived at this judgement (Intuitive Norms 14). Another characteristic of behaviour on this level is Sensation-Seeking (15). The patient has an excessive need for 'pleasant' experiences or the stimulus of dangerous activities in order to avoid the confrontation with a feeling of inner emptiness. Often he is not able to give his experiences a personal affective or cognitive significance, so that his statements are often vague or of a solely factual nature (Lack of Subjectivity 16). When he is under stress, his behaviour is characterized by Splitting or Projective Identification (Distortion 17); by acting without being able to say what the intention or significance of one's own behaviour is (Acting Out 18); or by a temporary change in his consciousness of personality (Dissociation 19).

CHANGEABILITY (11)

Social attitudes

Operational definition: The behaviour of the patient is marked by frequent changes in self-selected goals.

Changeability is typified not only by the briefness of the activities undertaken, but above all by the frequent changes in the patient's involvement. His behaviour is systematic, but his intentions are subject to constant change. As a rule, there is no clear reason for these changes. Another manifestation of Changeability is contradictory behaviour. At work the patient is helpless one moment and in charge the next, or he behaves in both a caring and a

threatening manner towards his children. The fact that the patient's behaviour is planned distinguishes Changeability from Inconsistency (01).

Examples:
I was fascinated by the idea of becoming a doctor. But I decided to study philosophy instead. / Actually, I don't think I'm cut out for university. I'm going to look for a job, or go on a long trip.

FRAME (12) Object relationships

Operational definition: It is the relationship with the other person which provides structure for the patient's functioning.

The patient needs others to maintain his inner stability. Not only a person, but also an institution or a country can function as a Frame. The actual or threatened loss of this relationship is accompanied by a fear of losing one's orientation and thus oneself, eventually resulting in disintegration. Paradoxically, this may also occur in cases where the patient is the one who breaks off the relationship. A characteristic feature is the recurrence of such relationships. Sometimes the patient literally tries to possess the other by arranging everything for him. This is done to safeguard the union, not to dominate (Power 45) the other. To 'prevent' him from leaving, the patient may even kill his partner. This type of object relationship must be distinguished from situations in which the patient feels dependent (Parent 32) or subjugated (Oppressor 42) and from a situation in which the patient needs the other person to demonstrate his attractiveness as a sexual partner (Idol 52). In all these cases the patient is himself capable of structuring his psychological functioning.

Examples:
Since she left me, I've lost contact with the world. I can't remember things. I can't concentrate. / I had to kill her. I couldn't stand the thought of her leaving.

VAGUE SELF-IMAGE (13) Self-images

Operational definition: The patient is not able to characterize himself.

The way the patient - directly or indirectly - describes himself is incomplete, vague and often contradictory. This is also referred to as **'identity diffusion'**. In many cases the patient is aware of this. He says that he does not know who he is or what he wants. A special manifestation of a Vague Self-Image is an **'indistinct sexual orientation'**. The essential characteristic here is the doubt about what constitutes 'a suitable sexual choice', rather than the nature of that choice. Thus what counts is not what the patient chooses, but whether he has made a choice. The definition does not include rejection of one's maleness/femaleness, feelings of shame about sexual characteristics or a fear of sexuality not accompanied by uncertainty about one's sexual preference. A Vague Self-Image is not the same thing as

insecurity caused by a striving for control or perfection (Defensiveness 48). A Vague Self-Image is generally accompanied by a lack of Identity (65), but a distinction must be made between the two. In the case of a lack of Identity (65), the patient knows what is suitable for him, but is forced to conclude that most of his important activities do not meet this criterium.

Examples:
I don't know who I am or what I want. / A description of myself? I don't know. At times I can be really kind. But at other times I don't want to have anything to do with other people. / That's how I feel right now. But tomorrow I might feel differently. /Sometimes I feel homosexual, but then I think 'No, it's not true'. / I've never had sexual desires for men. But it's something I'm afraid of. / I'm heterosexual, but if someone (of the same sex) were to fall in love with me, I wouldn't know what to do.

INTUITIVE NORMS (14) **Norms**

Operational definition: The patient's assessment is inexplicable and absolute.

The patient judges actions, persons or situations, often in an extreme way without being able to explain his criteria. This often involves Changeability (11) and Splitting (Distortion 17). A person may be the Messiah from whom all salvation comes one moment and the Satan, the one obstacle to happiness, the next. This so-called **'moral dichotomy'** is also seen when Selfish (24), Conditional (34) or internalized Conventional norms (44) are operative. Characteristic of Intuitive Norms is the inexplicable nature of the judgement. Selfish Norms (24) refer solely to one's own needs; Conditional norms (34) to the directives of significant others; and internalized Conventional norms (44) to absolute general rules.

Examples:
He's bad. Totally bad. (Why?) He just is./He's a saint, an absolutely good person, through and through, (Why?) Don't ask me why, you can tell at a glance.`

SENSATION-SEEKING (15) Needs

Operational definition: The patient tries to fill an inner void with external stimuli.

These stimuli may be an excess of 'pleasurable' experiences or an attempt to escape from emptiness by 'courting danger'. Sometimes the patient needs to hurt himself to feel that he exists: **'automutilation'**. The emptiness is absolute. There is nothing; there has never been anything. This is in contrast with Detachment (37), where there is still a memory of 'a paradise lost'. Sensation-Seeking is an habitual behaviour which distinguishes it from Acting Out (18). In contrast to Potency (55), it is the excitement rather than the performance that counts.

Examples:
I thought becoming pregnant would fill the hole inside of me. / If I don't start in on all sorts of things at the same time, I feel as if I'm falling into some kind of limbo. / I do everything: drawing, singing, sports. Otherwise I'd be lost. / I need to hurt myself to feel that I am alive.

LACK OF SUBJECTIVITY (16) Cognitions

Operational definition: The patient is unable to attribute affective or cognitive significance to persons, events or situations.

The patient is not able to give a personal view, his opinion is extremely vague or he restricts himself to eyewitness accounts. Moreover, he is not aware of the meaning his behaviour has for others. There is no **'introspection'**. This is also referred to as **'alexithymia'**. A characteristic feature is the **'tautological response'**: Things are beautiful because they are beautiful. Often the patient's behaviour clearly indicates an affective state - for instance, he looks distressed or sad - but he is not himself capable of recognizing this reaction. Sometimes the patient tries to deduce his opinion in a rational way: 'I do this work a long time. So I think I must like it.' Some patients are only unable to attribute a subjective significance to distressing subjects, but otherwise experience no problems in this respect. Lack of Subjectivity differs from Isolation of the Affect (47) in that no cognitive meaning is ascribed to events, situations or persons. If the patient is aware of his limitations, then there is a cognitive functioning on a higher level, for example Self-Confrontation (66). In that case, patients are able to recognize a description of their experience when it is presented to them.

Examples:
And then grandpa died. (What did that mean to you?) Well, dead is dead. I don't know what else to say about it. / And when he wouldn't give it to me, I socked him one. (You must have been very angry.) I can't say. I wouldn't know. / (How do you feel about these talks?) I've talked about a lot of different things. (But how do you feel about them?) Well... you know. / (What kind of relationship do you have with your mother?) Well, my mother is my mother. / People often tell me that I behave in an angry manner, but I don't feel that way.

DISTORTION (17) Problem-solving (thoughts & feelings)

Operational definition: The patient responds to internal or external stress by Splitting or by Projective Identification.

(a) Splitting: the tendency to see oneself, others, events or situations as either entirely good or entirely bad without any reasonable grounds for doing so. The qualification 'entirely' means that the good totally excludes the bad and vice versa. This distinguishes Distortion from Ambivalence (77). The patient's opinions may 'swing' back and forth. But although he

knows that in the past he felt differently, this does not lead him to modify his present standpoint. It is characteristic of Splitting that the views of the patient are not open to discussion. This distinguishes Splitting form Idealization (22 or 52) or Devaluation (27). Splitting is sometimes referred to as **'primitive idealization'** or **'primitive devaluation'.**
(b) Projective Identification: This consists in calling up a reaction from others which legitimizes one's own forbidden or otherwise distressing thoughts and feelings. The innkeeper treats his customers with suspicion and considers his suspicions confirmed when they react strangely. This differs from Projection (Reversal 57) in which thoughts and feelings attributed to others are not experienced by the patient himself. The guests are suspicious, not the innkeeper. Unlike Externalization (Reversal 57), this reaction is not open to discussion.

The assessment of Distortion is the sum of the assessments of Splitting and Projective Identification.

Examples:
(a) *He's a scoundrel. (Last time you said he was your best friend.) That was last time. Now I know he's no good. (There is no factual basis for this change in judgement.)* ***(b)*** *I'm so unsure of myself because people are so unpredictable. / If she were less domineering, my dependence on her wouldn't bother me so much. / You say that the therapy won't do any good as long as I'm so mistrustful. I've never trusted you and now I've been proved right.*

ACTING OUT (18) Problem-solving (actions)

Operational definition: The patient reacts to internal or external stress factors by taking action without being aware of the significance or aim of his behaviour.

This is also known as **'sensorimotor behaviour'**. This behaviour is pre-reflective. Possible negative consequences are not considered beforehand. Often the therapist is able to see a relationship between the nature of this 'unexpected' or 'incomprehensible' behaviour and the situation in which the patient finds himself. Because it is pre-reflective, it is virtually impossible to get the patient to discuss his behaviour. He may realize that his actions are 'incomprehensible' and, looking back, he may regret or try to justify them. Acting out differs from 'ordinary' impulsive actions where the actor does later realize the significance or aim of his behaviour. It also differs from the symptomatic behaviour seen in affective or anxiety disorders, which is constant.

Examples:
When I left here (therapy session in which the therapist told the patient when he was taking his vacation) I walked up to my boss and told him I was quitting my job. I don't know why. I wasn't planning to do it. / It was really strange. When I graduated from high school, I had a strong feeling that I wanted to kill myself. And after I'd worked so hard for that diploma.

DISSOCIATION (19) Miscellaneous themes

Operational definition: Temporary alterations of the patient's personality or his consciousness of personality (depersonalization, derealization), psychogenic fugue, or psychogenic amnesia.

A **'blackout'** or **'blocking',** a temporary inability to think or to act, also belongs to this category.

Examples:
I never go away on holiday. In a strange place, I start to feel alienated from myself (also Suggestive Cognitions 36)./During the whole exam I had the feeling that I was acting in a film. / I was there and yet I wasn't. It was like a dream./ When I woke up, I was walking around in X. I have absolutely no idea how I got there.

SELF-CENTREDNESS (20)

The major characteristics of SELF-CENTREDNESS are '**a superior**-' or '**egocentric**-' attitude. In one's daily life this is manifested as Supremacy (21). Others function solely as Servants (22) to cater to the patients needs. The significance or value the patient attributes

to himself is far greater than warranted by his qualities or accomplishments (Grandiose Self-Image 23). General rules do not apply to him. In his value judgements, the patient takes into account only what is in accordance with his own views (Selfish Norms 24). His needs are keyed to the confirmation of his Excessive Self-Image (Mirroring 25). The patient's attribution of meaning is based solely on his own views (Self-Referring Cognitions 26). Frustrating experiences are recognized, but not accepted. For example, criticism is deflected by devaluating the critic (Disclaiming 27). In addition, the patient reacts to disappointing situations by clinging to what he wants, even when it is impossible to attain (Omnipotence 28). And finally, his behaviour towards others is characterized by Coldness (29), whereby other people are treated like 'objects'.

SUPREMACY (21) Social attitude

Operational definition: The patient behaves in a superior way.

The patient behaves as if he were a president or a king. He does not consider his behaviour as extraordinary. His superiority is obvious so there is no need to prove it. Because he is special, he expects to be treated in a special way. The angry or critical reactions of others he does not consider worth taking seriously are characteristic. This 'natural superiority' differentiates Supremacy from behaviour patterns on the Rivalry (50) level, where a competition for first place must be won. Supremacy is often accompanied by the inability to treat others as one's Equal (62), but here, too, there is a difference. Someone who thinks, feels and acts the same as the patient is seen as 'of the same sort'. And a failure to treat another person as an Equal is not necessarily accompanied by a superior attitude.

Examples:
(patient to his psychotherapist) Any following appointments will have to be on Thursday afternoons, since that's the only time I'm free. Will you keep that in mind?/It was a good meeting. Everyone was totally in agreement with me. / I don't have a deputy. He'd do things differently and that's something I can't stand. / I never go to other people. If they want to talk to me, then I expect them to come to me./Most people I don't consider worth associating with.

SERVANT (22) Object relationships

Operational definition: The patient sees others exclusively as people who cater to his desire for satisfaction.

The key word here is 'exclusively', which makes clear how one-sided the relationship is. A collective such as a group or society, or even God, can also serve to supply admiration, wealth, status, etc. Recognizing the use of others as Servants is difficult when partner and friends accept the patient's attitude. A relationship of the Servant type differs from Lack of Attachment (02) in that the need for a relationship is actually present. In contrast to other

exploitative relationships, such as the Frame (12) or the Parent (32), the patient is the one who is in charge.

Examples:
Friendship 'for as long as it lasts'. Emotionally, there are no real ties. / I married my husband because I was afraid of becoming an old maid. / What I see in her? She looks up to me. / Sex? Just as long as there's a hole between the legs - in the dark they're all the same. / I love my audiences, because they love me./ I never had any trouble attracting women. I could more or less get what I wanted./I want a relationship, but don't want to be bothered when it doesn't suit me./Important people in my life? No, no one I couldn't do without.

GRANDIOSE SELF-IMAGE (23) Self-images

Operational definition: The significance or value the patient attributes to himself is excessive.

The patient's image of himself is not in accordance with his actual qualities and accomplishments. Indirectly, a Grandiose Self-Image may manifest itself in a haughty attitude or an air of disdain. Occasionally this is concealed, in order to avoid other peoples 'nagging'. An indirect manifestation of an Grandiose Self-Image is the honest conviction that one's own - clearly extraordinary - accomplishments are 'ordinary'. Others are often experienced as an 'extension' providing the patient with those qualities he would like to possess, such as beauty or power. To meet his need, he often exaggerates these qualities, which leads to **'idealization'**: 'All my children are very gifted'. The patient often mistakes fair criticism as a disqualification, resulting in **'wounded pride'**. He is not willing to accept his limitations and often refuses the help he obviously needs. The offer of therapy is an insult. To the patient this means that the therapist can do something he himself is not able to, placing him in an inferior position. Paradoxically, a Grandiose Self-Image may manifest itself as **'self-devaluation'**, but this negative assessment likewise fails to correspond to the facts. After making a relatively minor mistake, the patient sees himself as an absolute failure. A negative Grandiose Self-Image differs from rigid Conventional Norms (44, 54) through the absence of an external frame of reference. For instance, 'Others are allowed to make mistakes. But I'm not.' (Why not?) 'I don't know. That's just the way it is.'

Examples:
You're talking about rules for ordinary people. I'm above that sort of thing. / When I organize something, then everyone has to have a good time. Otherwise it's not a success. / Six months ago I started playing the guitar. Now I'm considering starting my own music school. / As a (sex/religion/race), you're always superior. / If something doesn't work out, then I feel like a 'total failure'. / I don't want to restrict myself. That's the one thing I can't stand. / My parents (partner, children, friend, teacher) are extraordinary.

SELFISH NORMS (24) Norms

Operational definition: The patient's assessment of his conduct voluntary only refers to the satisfaction of his own needs.

Action is deliberate and the patient takes into account the expected reaction from the environment. If necessary, the behaviour is concealed or camouflaged in order to avoid sanctions. Expressions of guilt are aimed at escaping punishment. The patient respects the wishes of others as long as this contributes to the satisfaction of his own needs: 'You scratch my back and I'll scratch yours'. This definition does not include the satisfaction of one's own needs as the prime goal in situations where there is no necessity to take one's surroundings into account.

Examples:
Looking back, it was wrong to break in. (Why?) Because I got caught. / (Man guilty of drunken driving). Thank God nothing happened. I could easily have lost my license. / I've taken things before. But they've never caught me. I guess I'm pretty good. / (Man discussing his extramarital relationship) Well, damn it, we all need a change now and then. It doesn't really mean anything. / At work I used to take money out of petty cash every day. A big company like that won't even miss it. And besides, I'm underpaid (also Rationalization - Elimination 47). / (Salesman) I know that toy is dangerous, but that's not my responsibility (also Denial - Reversal 57).

MIRRORING (25) Needs

Operational definition: The patient expects others to confirm his ideas, views and, above all, his exaggerated opinion of himself.

This confirmation can be direct or indirect, explicit or implicit. Indirectly, this need is reflected in the fact that the patient wants to associate only with people who think, feel and act as he does.

Examples:
He's very intelligent. He felt the same way I did. / (What do you consider positive about the relationship?) He admires me tremendously.

SELF-REFERRING COGNITIONS (26) Cognitions

Operational definition: The patient's interpretations are based exclusively on his own opinions, views and desires.

A characteristic feature is the exclusive nature of this attitude. The patient is not able to think in any other way. He expects everyone to share his opinions and everything that happens is

related exclusively to himself. The patient cannot foresee what effect his behaviour will have on other people and cannot accept that others do not share his views. Some of these patients are '**pathological liars**', who falsify reality to make it agree with their wishes. They are capable of seeing their own lies as 'true' and thus often make a 'genuine' and 'credible' impression. Self-Referring Cognitions may be accompanied by Selfish Norms (24), i.e. acting solely in one's own interests, but must be distinguished from it. Self-Referring Cognitions may be detrimental to one's own interests, while someone who acts solely in his own interests may have no difficulty in recognizing that other people have differing opinions and using this knowledge to attain his aims. In contrast to Delusionary Ideas (Falsification 07), the perception of reality is not disturbed.

Examples:
Faith is nonsense. I can't imagine how an intelligent human being can believe in God./ I don't understand why I should have to answer all these questions. They give me a headache. / How my husband feels about our relationship? I don't know. I've never stopped to think. / My wife thinks I treat her like a maid. But of course that's nonsense. (Also devaluation - Disclaiming 27)

DISCLAIMING (27) Problem-solving (thoughts & feelings)

Operational definition: The patient responds to internal or external stress factors by consciously refusing to accept them.

Disclaiming must be distinguished from Isolation of Affect (Elimination 47). A special form of Disclaiming is **'devaluation'**, where a distressing opinion is discounted by criticizing the credibility of the messenger.

Examples:
I knew it was dangerous, But I thought 'It won't happen to me.' / How can a woman you've been married to for eighteen years just leave you? / That doctor says it's cancer, but it isn't. Doctors are often wrong. / They (critics) have never accomplished anything themselves and they take out their frustration on others by writing bad reviews./My girlfriend wants me to tell her that I love her, but I have no use for that kind of nonsense./If somebody doesn't appreciate my art, then he has no taste.

OMNIPOTENCE (28) Problem-solving (actions)

Operational definition: The patient responds to internal or external stress factors by pursuing goals which exceed his actual capabilities.

This behaviour is usually doomed to fail, but once in a while the impossible happens. The patient has taken an irresponsible risk and has had a great deal of luck. In the case of failure, the attempt is repeated again and again. The omnipotent nature of actions sometimes

reveals itself by a lack of any effort to realize one's intentions 'because deciding what you want should be enough'. Omnipotence must be distinguished from Superstition (Suggestible Cognitions 36). If the patient 'truly' believes that he has supernatural powers, then this reflects delusional ideas or even delusions (Falsification 07).If the 'omnipotent' behaviour is in the nature of a 'performance' whereby the patient is completely engrossed in his role, but nevertheless realizes that it is a game, then this is an example of Pretending (58). Omnipotence differs from patterns on the level of Rivalry (50), where the goals are excessive, but not unrealistic and the patient knows that he has to work hard to excel.

Examples:
If I really want something, then I know I can get it. / I always swear I'm going to stop gorging myself. I know I can do it! (Has tried countless times, without success) / I'm getting failing grades at school. I never study for exams. What really gives me a kick is when I still just manage to pass. / (Man who failed as a shopkeeper) Now I'm thinking about becoming a representative for Europe. / I'm sure I could make it without any problem. No, I never tried./ When I've decided that something has to be done, I find it hard to take the time to carry it out.

COLDNESS (29)

Miscellaneous themes

Operational definition: The patient treats others like objects.

As a rule, the patient is not conscious of his own coldness. This often becomes apparent from the way he talks about his contacts or from what others say. Coldness differs from Lack of Attachment (02) in that the patient does set store by the relationship. When he needs someone, the patient may act in quite a 'charming' manner. But this ends abruptly when the other is 'no longer of any use'. Unlike Isolation of the Affect (Elimination 47), Coldness is not accompanied by a general inability to respond affectionately.

Examples:
Just when we'd decided to go into business together, he got run over. That really snarled things up. / My wife says I'm a cold fish. / Actually I don't particularly care whether people can follow my lecture or not. / Lovemaking caused her pain. But I couldn't take that into account all the time. / When we have an argument, my wife usually starts to cry and then stamps out. That really annoys me.

SYMBIOSIS (30)

Symbiotic behaviour is characterized by incomplete '**separation**', i.e. an inability to function independently. In a physical sense, the patient is separated from others, but psychologically this separation is still incomplete. The patient can only function as the 'extension' of his significant others. Without them, he is literally lost. He feels 'deserted' or 'lost in space' and is not capable of taking care of himself. He pines away like a plant that has not received the light or nourishment it needs.

Symbiosis manifests itself as the inability to function in everyday life without the presence and support of significant others (Dependence 31). The patient experiences the involvement of significant others as essential for his functioning (Parent 32) and is continually afraid of losing their 'love'. The value he attributes to himself is determined largely by the assessment of others (External Self-Image 33). In the assessment of his behaviour, the judgement of others is again the most important criterion (Conditional Norms 34). The wishes of the patient are primarily receptive and infinite, i.e. incapable of fulfilment (Passive Need for Love 35). His experiential world is characterized by a direct relationship between his inner world and the outside world (Suggestible Cognitions 36). When he is in a good mood, the sun is shining; when the sun is shining, he is in a good mood. People or situations that disappoint him lose the importance they once had for him (Detachment 378); or he gives up the struggle to realize his original goals (Giving Up 38). The patient may have the feeling that in the whole world he has no place of his own, that no one is interested in him and that he is not worth caring for (Basic Distrust 39).

DEPENDENCE (31) Social attitude

Operational Definition: The patient is not capable of living independently.

The patient's functioning is assessed on the basis of:
(a) living alone,
(b) travelling unaccompanied,
(c) activities outside the home,
(d) staying at home alone if the patient lives with someone else,
(e) making decisions.
Due account must be taken of what is customary in the patient's own culture. Dependence is maximum where the patient is unable to care for himself. The inability to take decisions differs from 'doubtfulness' (Defensiveness 48) in the acceptance of decisions taken by others.
The inventory covers the period before the patient's complaints made it impossible for him to carry out independent activities. Criteria are the patient's actions, not his own assessment of his (in)dependence. Likewise, the reasons for acting as he does are not taken into account. The important thing is what he does and whether he feels comfortable doing it. If someone is always off somewhere because he cannot stand being alone, then it is incorrect to say that he is incapable of acting independently outside the home. It is however, largely correct to say that he is incapable of living alone. Endless requests for help are registered as Passive Need for Love (35).

The assessment of Dependence is the sum of the assessments (a) of the inability to live alone, (b) to travel unaccompanied, (c) to undertake activities outside the home, (d) to stay at home alone and (e) to make one's own decisions.

Examples:
(a) *I really wanted to study geology, but that would have meant moving away from home. So I decided on economics. / Has accommodations of his own, but sleeps at his mother's and has his meals there. / Lives alone, but spends several evenings a week and every weekend at her parents' place. / Lives alone, but is 'desperately unhappy' and does not take good care of herself.* ***(b)*** *Is afraid to travel alone. / Is homesick when on vacation with partner. / Sometimes goes on organized trips, but continues to find this very difficult.* ***(c)*** *Activities outside the home are only undertaken together with partner or neighbours. If they are not available, the patient does not go out.* ***(d)*** *Tries to avoid being home alone. / Does not enjoy staying at home alone or prefers not to.* ***(e)*** *I can't make decisions on my own. When I buy clothes someone else has to go along. / My parents decided what I should study at university. They looked for a job for me. They even chose a husband for me./ I can't hold myself. I need someone to take responsibility for me.*

PARENT (32) Object relationships

Operational definition: The patient experiences the involvement of another as a vital condition.

Involvement means attention, affection, appreciation, understanding, support and the like. The Parent provides the security or energy the patient needs in order to live. A group or an institute can also function as a Parent. The so-called **'transitional objects'** may also acquire a meaning which corresponds to that of the 'Parent' and then be experienced as a source of warmth or support. In an affective sense, the significance of the Parent manifests itself as **'fear of separation'** of being 'lost', both literally and figuratively, when the other leaves. In some cases it is difficult to distinguish this relationship from one in which the patient needs the other person in order to give meaning to his own life, as in the case of individuals with a Lack of Self-Image (03). The symbiotic patient derives from the relationship the 'safety' and the 'nourishment' he needs in order to function. The patient with a Lack of Self-Image (03) imitates others in an effort to compensate for his lack of structure. In other words, the symbiotic patient derives from others the **meaning** of his experiential world, the structureless patient the **form**. In contrast to a relationship of the Frame (12) type, loss of a Parent leads to mortification rather than to disintegration. Not the patient, but the Parent is 'running the show', which distinguishes this interaction from the Servant (22) type of object relations. Recriminations directed at the other for not loving him enough, not taking action or failing to assume responsibility are manifestations of a frustrated Passive Need for Love (35). Indirectly, this relationship manifests itself as an unwillingness to commit oneself for fear of being abandoned or as abandonment by the patient in order to preclude being forsaken oneself. There is however a need for a relationship, which distinguishes this attitude from Lack of Attachment (02). Any opposition to the dependence of the Parent is not directed against domination (Oppressor 42), but rather against a lack of support.

Examples:
She kept me going. Now that she has left, I cann't do anything. / When my therapist fell ill, it was as if my whole life just came to a halt. I felt lost in space. / I need a relationship. When I'm alone, I turn to stone. I can't do anything at all. / When I'm here (therapy) I feel strong, but when I get outside, my heart sinks. / On the advice of my therapist, I stopped seeing my parents. But now I feel totally miserable. I can't stand it. / I don't want to commit myself again. If you commit yourself to someone, he becomes indispensable./ I called the parson, but he wasn't home; neither was the social worker. Then I thought to myself, 'I don't care! It (life) doesn't mean anything to me any more./I live for them. It's because of them that life has meaning for me./I have no one to live for. There's no one waiting for me when I get home. Why am I still alive? / I do my best to see that I won't ever be abandoned, because that would really be the end.

EXTERNAL SELF-IMAGE (33) Self-images

Operational definition: The significance or value the patient attributes to himself is determined largely by the assessment of others.

Most people consider the opinion of others important. In the case of an External Self-Image, however, the opinion of others is much more important than one's own opinion: 'You are what others believe you are.' The 'external' nature of the self-image often emerges when there is a lack of appreciation on the part of the environment. For this patient being deserted means that apparently he is not worth loving. Indirectly, an External Self-Image manifests itself in a striving to please others, a willingness to do anything in order to find favour with them. If this is done consistently from childhood on, then the result is a **'false self'**. The patient's behaviour appears normal, but is in fact 'empty', because it is not oriented towards his own objectives.

Examples:
I have this constant need to hear from other people that I'm appreciated. Otherwise I feel worthless. / What other people think of me is very important. I'm willing to do anything to gain their approval. / When my little girl smiles at me I think to myself: 'See, there's something good about you, after all.' / If someone patronizes me, that makes me feel inferior. / If I do something right, then I feel good about it, but only if others agree. / If I don't get enough attention, then I leave, because that's a sign I'm not good enough. / I'm worthless, otherwise my mother wouldn't have left.

CONDITIONAL NORMS (34)

Norms

Operational definition: In the assessment of conduct the opinion of others is the major criterion.

The opinion of one's significant others, authorities, the public or society itself is decisive. Thus it is not the deed itself or its direct consequences, but the evaluation of others that determines whether the patient's action is 'good' or 'bad'. A relatively harmless example of this behavioural pattern is following the last **'fashion trends'**: copying whatever is 'in' and discarding it as soon as it's 'out'. The behaviour may appear to be inconsistent if the patient's significant others uses different norms in different situations. For instance, disapproving of deceit within one's own group, but accepting it with respect to others. 'Thieves don't steal from thieves.' If concealment or disguise fail, then the immediate reaction is submission: 'You're absolutely right. I shouldn't have done it.' Indirectly, Conditional Norms are manifested in the ability of others to excuse or absolve the patient. Moreover, there is a tendency towards **'self-accusation'**, feeling guilty about everything that's gone wrong, even when the patient has nothing to do with it. In effect, this is a kind of 'conviction without a crime'. The patient can only liberate himself by seeing to it that 'everything works out'. And he tries to see that it does, even at his own expense. In the latter case there is also Self-Punishment (49); 'voluntarily' doing something that is bad for you. There is more to Conditional Norms than a simple reference to the opinion of others. The statement 'I want my customers to be satisfied' may well refer to a Fundamental Norm (64, 74) if it is related to a demand the patient makes on himself. When a patient says that in her mother's eyes she never does anything right, this is only a Conditional Norm if the patient concurs.

Examples:
I always do my very best to get other people's approval. / All my father has to do is frown and I feel as if I've done something wrong again. / Why I feel guilty? They (family) say it's my fault. / I'd said something nasty about him (boyfriend). Luckily he didn't find out, because I would have felt really guilty. / I got that tattoo because I wanted to belong (also Passive Need for Love 35). My parents thought it looked vulgar. I was so ashamed that I went right out and got rid of it. / I'm good at what I do. (Why do you think you're good?) Because everyone says so. / When my mother looks sad; I feel guilty. /So when something goes wrong, I always think it's my fault, even when I couldn't do anything about it./ When I confessed to my wife that I had visited a whore, it was awful, but I felt relieved. / I don't have the right to have a good day, while there is so much suffering all over the world.

PASSIVE NEED FOR LOVE (35) Needs

Operational definition: The desires of the patient are directed mainly towards obtaining satisfaction in an endless and receptive manner.

Being satisfied implies that this satisfaction is provided from outside. This can take the form of either fostering or incorporation, which in turn is either physical or psychosocial: being caressed (physical fostering), obtaining recognition or a position (psychosocial fostering), being fed (physical incorporation), 'soaking up' applause (psychosocial incorporation). The important thing is not what the patient desires -security, love, etc. - but whether this must be given by others. Characteristic of this need is the 'infinite' nature of the patient's desires. These are never fulfilled; he is a 'bottomless pit'. The urgency of the patient's demands stems from the existential nature of his needs. He has no inner resources and is unable to take care of himself, which means that he has to be taken care of by others. Paradoxically, the patient may actively strive for fulfilment of his passive need for love, by performing well and 'earning' the recognition of others or by exacting that recognition by means of helplessness, recriminations, rows and even suicide threats. In the latter case, we speak of **'passive-coercive behaviour'**: 'You have to save me, otherwise I'm lost'. In some cases it may not be altogether clear whether the Passive Need for Love or the need for Power (45) is uppermost. If both needs appear to play a role, then both are registered. Provoking punishment, which results in '**negative attention**', may also be part of a Passive Need for Love. Often the patient himself arranges for the satisfaction of his passive need for love. But the source of his satisfaction is nonetheless external: he 'pampers' himself by self-pity or by means of a hot bath, a film, or a day off by calling in sick. The great significance attached to the satisfaction of the Passive Need for Love may also be reflected in an excessive striving to satisfy these needs on the part of others. By identifying with the receiver of the care the patient is also satisfying his own desires; this is referred to as **'pseudo altruism'**. Where the needs of others are satisfied as well as one's own, then the patient is not only satisfying his own Passive Need for Love but is also providing Care (82). If the patient neglects his own interests, for instance by 'never saying no', then this is also a case of Self-Punishment (49).

Examples:
I want him to understand how I feel, without my having to explain it to him. / I watch TV all day. It takes me into a different world. / Alcohol gives you a warm feeling, relaxes you. / Sometimes I feel so rotten and alone. Then I fix myself a cup of soup, take my favourite stuffed animal and sit real close to the radiator. / If I had my way, I'd spend the whole day sitting on someone's lap. Just sitting there. / I always want to be there for her (mother). She can tell me anything. / I feel all the suffering of other people. / I take care of everyone else, but no one takes care of me.

SUGGESTIBLE COGNITIONS (36) Cognitions

Operational definition: The patient's experiences reflect a direct correspondence between his inner world and the outside world.

In this behavioural pattern the '**semi-permeability**' of the patient's experiential world manifests itself. The outside world, other people, events or situations literally 'create' the patient's thoughts and feelings or the patient expects changes in the outside world to be automatically accompanied by changes in his internal world. In reverse, the patient's expectations 'create' his perceptions of the outside world. This is called **'primitive projection'**. A relatively harmless example of this is '**vicarious shame**'. The patient identifies with someone who has done something wrong or made himself look ridiculous.In contrast to Projection as a problem-solving strategy (Reversal 57) the feared affects or cognitions are not warded off. **'Wishful thinking'**, the ungrounded expectation that reality will change to suit one's wishes, also belongs to this category. Other manifestations are all kinds of **'superstitious beliefs'**. The capability of reality testing distinguishes this behaviour from Delusionary Ideas (Falsification 07).

Examples:
As soon as I put on my uniform, I am somebody. Then I don't let people walk all over me./ This gloomy weather makes me feel low. / I want to move to X. I know I could be happy there. (Patient has never been to X and has no friends or work there.) / If someone says to me 'You're looking a bit under the weather', then I actually feel sick. They can talk me into it./ I always think that people disapprove of me or don't think I'm worthwhile (which is what I think too). / I thought that when I became pregnant he would stop drinking and everything would be all right. / I bought a very powerful talisman. Now I am sure I can manage./ When I saw that man take off his underpants on TV, I was so ashamed.

DETACHMENT (37) Problem-solving (thoughts & feelings)

Operational definition: The patient responds to internal or external stress factors by divesting them of the significance they once had.

Detachment differs from depression in that it is reactive. It is concerned only with the source of disappointment. Detachment is sometimes, but not always accompanied by Giving Up (38). Detachment must also be distinguished from Denial (Reversal 57), where the feelings continue to exist. The loss of feelings of affection for one's partner or the disappearance of sexual feelings in general, is a sign of detachment only when it may reasonably be assumed that these feelings are distressing, for instance when the partner has been unfaithful.

Examples:
If a boyfriend disappoints me, then I lose interest in him./ Since I was passed over for promotion, I can't really get interested in my work./ He jilted me. For the time being I'm staying away from men. I just don't care anymore. They don't listen to you anyway./ If life doesn't have anything more to offer than its meaningless.

GIVING UP (38) Problem-solving (actions)

Operational definition: The patient responds to internal or external stress factors by giving up his efforts to attain goals he had previously set himself.

The patient resigns himself permanently to a situation he experiences as unsatisfactory. When things get difficult, the patient chucks it in and just accepts whatever happens, even though he could do something to improve the situation. Giving up is often accompanied by **'passive stress reduction'** by means of alcohol, drugs, watching TV or sleeping. Habitual '**flight**', when not in the nature of a tactical avoidance reaction (Defensiveness 48), is often accompanied by Giving Up. If the patient tries to attain his goals by indirect means, then this is not Giving Up. Giving up differs from Detachment (37) in that the original goal is not characterized as 'meaningless'. It must also be distinguished from Avoidance and Ignoring (Defensiveness 48) where the original goal is not relinquished. Giving up must also be differentiated from passive-aggressive behaviour (Opposition - Defensiveness 48) where the 'non-action' is meant to be harmful to others.

Examples:
As soon as something bad happens, I just let go. / If someone criticizes me, then I give up right away. / When the reorganization started, I didn't apply for a position. I just sat back and waited to see what would happen. / All I want is just to take a sleeping pill, so I can get away for a couple of hours.

BASIC DISTRUST (39) Miscellaneous themes

Operational definition: The patient has no place in the world, either in his own world, or in that of others.

The patient considers himself without value or significance, either for himself or for others. He is unable to believe in expressions of love or appreciation. The opinion of people who display a positive attitude towards him is questioned: 'They're not being honest'; or 'They don't really know me'. Sometimes the patient overtly disapproves of himself as someone who is basically not worth loving or even worthy of being alive: **'self-rejection'**. Under difficult circumstances he does not call on his environment, because he expects no help from them: **'pseudo-independence'**. Indirectly, Basic Distrust is reflected in attempts to **'buy love'**. The patient assumes he must 'bring a present' or 'contribute something' otherwise he won't be welcome. Contrary to Lack of Attachment (02), the patient experiences this as distressful. Basic Distrust also differs from a frustrated Passive Need for Love (35), where one is angry that one's desires are not being satisfied, but still expects help. Sometimes there is a certain paradox in the patient's behaviour. In a reaction to previous disappointments, he may refuse the fulfilment of his desires while continuing to demand the offer of fulfilment: the **'help-rejecting complainer'**. Rejecting help is not intended to frustrate others which distinguishes Basic Distrust from passive-aggressive behaviour (Defensiveness 48). But Basic Distrust, passive-aggressive- (Defensiveness 48) and even Sadistic behaviour (Power 45) may occur simultaneously and are then also registered as such.

Examples:
I was sure my parents didn't love me, because I wasn't worth it. / I don't belong. For me all doors are closed. / No matter how many times people tell me that I'm a worthwhile human being, I still can't accept it. It just doesn't seem to penetrate. / It's something I don't talk about. Other people won't listen. They just don't want to know. / I starve myself because I don't deserve to be alive.

RESISTANCE (40)

The central theme which characterizes behaviour on this level is **'lack of inner freedom'**, the absence of '**autonomy**'. The patient feels that he is being dominated. In everyday life this is often reflected in an excessive striving for freedom (Liberation 41). There is an excessive opposition to force or injustice, or a preference for forbidden activities. The patient is quick to see others as the Oppressor (42). The significance or value which the patient attributes to himself is derived from his accomplishments (Derived Self-Image 43). His value judgements are based on excessively stern and rigid general rules which he sees as correct, although they are not in accordance with his own views, or his own situation (Conventional Norms - internalized 44). The striving of the patient is determined to a large extent by a need for Power (45). The attribution of significance is impersonal or objective where, in view of the situation, one would expect a subjective or personal standpoint (Classifying Cognitions 46). The patient reacts to unpleasant situations by Isolation of the Affect, Intellectualization, Rationalization and Displacement (Elimination 47). His behaviour may show activities which may reasonably be expected to have unfavourable consequences for him (Self-Punishment 49).

LIBERATION (41) Social attitude

Operational definition: The patient's efforts are to a large extent directed towards obtaining the freedom to think, feel and act as he sees fit.

The need for this freedom implies its absence. The patient wants to do things all by himself, even when help is necessary. He prefers prohibited activities or rebels against reasonable general rules. Often there is an excessive resistance to domination or injustice. The patient wants to be proved right, to get his way, even when this is unreasonable or detrimental to himself. He would 'rather be right than President.' Power struggles with others, are registered as object relationships of the Oppressor (42) type. The striving for dominance is registered under the need for Power (45); rigid tenacity is part of Defensiveness (48).

Examples:
Any kind of authority makes me want to rebel. I can't stand being told what to do. / If someone says I have to do something, that's enough to make me refuse. / If I see someone trying to boss people around, I get furious. / I can't stand those pre-printed forms where they ask you to donate a certain amount to charity. That way you're not free to give what you want to. / I'd rather do things myself, than have to beg others to help. / I'm always on the side of the underdog. / I can't abide injustice. / Sex was fine before we got married - when it was still forbidden.

OPPRESSOR (42) Object relationships

Operational definition: The 'patient' experiences the other as someone who manipulates him.

The characteristic feature here is a lack of inner freedom. Feeling oppressed presupposes **'submission'**, accepting an underdog position, even if the patient opposes his oppressor. Often this results in a **'helpless rage'.** Fate or God may also be experienced as Oppressors. If the patient allows himself to be abused by his Oppressor, then Self-Punishment (49) is also present. Being oppressed is not the same thing as being coerced. A person may be forced to do something by powers beyond his control without feeling oppressed. Nor can being oppressed be equated with a lack of Assertivity (68), where one's own attitude is the main feature rather than the influence exercised by the other. An individual who is not able to stand up for himself does not necessarily see the other person as an Oppressor.

Examples:
Get married and lose my freedom? No way! / I had to end our relationship. My parents didn't think he was the right man for me. / My wife never lets me finish a sentence. Or she'll take over the story I was telling. It really makes me wild. / I wanted to become a doctor, but my father forced me to go into a technical field. / I feel like a marionette: when he pulls the strings, I jump. / We got married because my parents-in-law had their minds set on it.

DERIVED SELF-IMAGE (43) Self-image

Operational definition: The significance or value the patient attributes to himself is derived largely from his achievements.

The qualification 'largely' indicates that the patient's own opinion and that of others is of lesser importance: 'You are what you achieve.' The absolute nature of this declaration distinguishes the Derived Self-Image from normal pride in one's accomplishments. An indirect manifestation of a Derived Self-Image is the preoccupation with not meeting this criterion. In contrast to behavioural patterns on the level of Rivalry (50), such as Conquest (51), Hierarchical Self-Image (53) and Potency (55), the accomplishment is of primary importance, not the success, excelling over others or being exceptional.

Examples:
My house is always clean. My children are all doing well. I make my own clothes. But still I am not sure I am worthwhile. / I've never done anything worthwhile. I'm nothing! /When I do something really good, I feel a little less worthless.

CONVENTIONAL NORMS - internalized (44) Norms

Operational definition: In the assessment of conduct, the criteria employed by the patient are excessively harsh or rigid general rules which are not appropriate to himself or to his situation.

As will be clear from the operational definition internalized Conventional Norms are only registered when these are maladaptive. Characteristic is the acceptance by the patient of so called **'ego-alien'** rules, directives which are not in accordance with his personality or situation. Often this results in feelings of guilt and **'self-condemnation'**. Thus the acceptance of these **'moralistic cliches'** is largely rational and often accompanied by ambivalent feelings. In the first place because these rules interfere with the fulfilment of one's own desires and in the second place because they are experienced as an obligation or even a compulsion: 'You must', 'You're supposed to'. In other words Internalized Conventional Norms refer to the demands of a harsh conscience, while Internal Conventional Norms (54) have to do with excessive ideals, what one wants to accomplish. An other important feature is the 'absolute' and 'formal' nature of internalized Conventional Norms. Thinking is equated with acting. So having forbidden wishes is just as bad as violating behavioral rules. In contrast to Fundamental Norms (64, 74), circumstances which justify a bending of the rules are not taken into account. The letter of the law takes precedence over its spirit or intention. Conventional Norms are also products of a particular cultural and historical period. A rule that was acceptable during one period may later be considered ridiculous or even criminal.

Examples:
Wanting something for yourself is egoistic and therefore bad. / I never complain. That's moaning, self-pity. / You shouldn't criticize your parents. / If you don't have an orgasm at the same time as your partner, then there's something wrong with your relationship. / If you're angry with someone, you can't love him. / If you're asked to help, then you always have to say yes. / Orders are orders; no matter what the consequences.

POWER (45)

Needs

Operational definition: The desires of the patient are directed largely towards attaining domination.

The important thing here is the influence itself rather than what it enables the patient to do. 'To rule or to be ruled, that is the question'. The pursuit of Power may be direct, for example striving to obtain a hierarchical function, or indirect, as in a desire for the means of power such as muscles or money or as a preoccupation with **'power games'**. In some cases, the patient acts as a **'tyrant'** treating others in a harsh or **'sadistic'** manner. Here the cultural norms in the environment of the patient must be taken into account. In a corrupt society power is necessary in order to survive. If wealth or position is pursued in order to realise an exceptional achievement, this is evidence of a striving for Conquest (51) or Potency (55). The definition does not include compulsive controlling or collecting or sexual sadism.

Examples:
I want to be rich. Money is power./ I want to become a director, to be the one who makes the final decisions. / I like driving fast and playing cat and mouse with the police.

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CLASSIFYING COGNITIONS (46) **Cognitions**

Operational definition: The attribution of significance by the patient is impersonal and objective where in the light of the situation one would expect a subjective or personal standpoint.

The patient's descriptions characterize the object, i.e. what is described rather than the subject, the person doing the describing. He often makes use of '**stereotypes**' and 'cliches' and his statements are not only impersonal, but also superficial or extremely simple. A tree is beautiful because trees are beautiful and not because the patient finds the tree beautiful. Where a factual representation of events is called for, Classifying Cognitions are functional. They are only registered if they are maladaptive, i.e. if a more personal standpoint might be expected. If it is not clear whether a description is 'objective' or 'subjective', the patient can be asked for further details. For example, 'He's sweet' (Why?) 'He's very friendly and always willing to help other people.' (= characteristics of what is described = Classifying Cognitions)/'We just 'hit it off'. I always feel good when I'm with him.' (= characterization of the describer = Self-Confrontation 66). Expressing oneself in a personal but insensitive manner is registered as Isolation of the Affect (Elimination 47). If the available material does not provide enough information to decide whether the patient is characterizing not only that which is described, but also the one doing the describing, the statement is not registered.

Examples:
What he means to me? He's tall, intelligent, works hard./Foreigners are unreliable./Women are sentimental.

ELIMINATION (47) Problem-solving (thoughts & feelings)

Operational definition: The patient responds to internal or external stress factors by Isolation of the Affect or Displacement.

(a) Isolation of the affect, intellectualization, rationalization: The lack of an expected feeling sometimes accompanied by a cerebral view or an impersonal explanation.
(b) Displacement: for no apparent reason affects, cognitions or actions are associated with people, things or events in a manner or in a situation suggesting these are actually related to someone or something else. A special form of Displacement occurs in the case of frustration, when the patient directs his anger towards himself: 'and it's also my fault that ...'.

The assessment of Elimination is the sum of the assessments of (a) Isolation and (b) Displacement.

Examples:
(a) *I understand that he couldn't keep his appointment. His work is so demanding nowadays. / I am never upset. Feelings are forms of behaviour that have been learned and can be*

unlearned. / Anger? What good does it do? / We make love once a week, for health reasons. / If you have no feelings, you're less vulnerable. / ***(b)*** *If I've had a rough day at work, everyone had better steer clear of me or they're liable to get the back of my hand. / It's my own fault everybody walks all over me. I'm a weakling.*

DEFENSIVENESS (48) Problem-solving (actions)

Operational definition: The patient responds to internal or external stress factors with excessive or ineffective Avoidance, Ignoring, Control, Undoing or Opposition.

(a) Avoidance: Avoiding confrontation with stress related situations. In contrast to Giving Up (38), goal-oriented attempts are not suspended. Behavioural patterns such as 'working very hard, so that you don't have to think about anything' are also included here. In contrast to active stress-reduction (Self-Control 67), this does not reduce the patient's complaints, but only keeps them 'at bay'.
(b) Ignoring: 'Acting as if there's nothing wrong', 'going on as before' or 'grimly holding on'. Often the patient intentionally avoids thinking about the problem: **'suppression'.**
(c) Control: A striving to keep 'on top of things', mainly by means of procedural measures often in a **'perfectionistic'** manner. In effect, this is aimed at self-control, the ability to keep oneself in hand. Because of the excessive nature of this behaviour, it hampers productivity. Unlike the inability to take independent decisions (Dependence 31), here it is a question of not accepting the decisions of others. In confronting strong internal urges, there may be a **'fear of losing control'**. In contrast to disintegration anxiety, the threat is the breaking through of aggressive- or need-satisfying impulses not the expectation of a general falling apart. The patient's uncertainty is reflected in **'indecision'**. This distinguishes Control from Enterprise (88), which is directed towards the external world and in which one's own possibilities and restrictions are taken into account.
(d) Undoing: Activities directed towards eliminating the results of planned or actual behaviour.
(e) Opposition: Rejecting feasible proposals without good reason. Often this occurs in an indirect **'passive-aggressive**' manner. The patient behaves in a stubborn manner, 'forgets' about agreements or, as a result of a 'misunderstanding,' does not carry them out as intended.

The assessment of Defensiveness is the sum of the assessments of (a) Avoidance, (b) Ignoring, (c) Control, (d) Undoing and (e) Opposition.

Examples:
(a) *I always try to avoid an argument. / (Woman who cannot have children) I always try to get there after the children have gone to bed, because seeing them upsets me.* ***(b)*** *When things get difficult, I try to just keep going. / If I'm sick, I pretend there's nothing wrong.* ***(c)*** *Then I just act as if there's nothing wrong. / I never do anything until I'm sure I can pull it off./ I'm so busy arranging things, making lists and checking everything that I never get around to what I'm supposed to be doing. / When it comes time to take a decision, I can't do it. I keep putting things off. / If I let myself go, then it's 'no holds barred'. Then I'm afraid of losing control of myself. /* ***(d)*** *My husband is an egotist. But, of course, he has his good points, too. / I never had a really close relationship with my parents, because there were so many older children. But they both worked hard for all of us. /* ***(e)*** *Right away (before it was clear what was required) I said that I wouldn't do it. / I didn't really want to do it, so I forgot about the agreement. / Due to a 'misunderstanding', I did a different assignment than the one I was supposed to. Looking back, I knew it was the wrong one.*

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SELF-PUNISHMENT (49) Miscellaneous themes

Operative description: The patient voluntary undertakes activities that may reasonably be expected to have negative consequences for him.

The attempt to cause yourself pain or discomfort is the main feature here. The reason for doing so is not made explicit and may differ from one case to another. The qualification voluntary implies a real possibility to act otherwise. By negative consequences we mean events or situations experienced by the patient as being unpleasant or which reduce the chance of pleasant experiences. Self-Punishment is direct if the patient undertakes to do something painful or harmful to himself and indirect if he permits others to do this. Intended self-punishment is aimed primarily at decreasing feelings of guilt. But the patient does not need to experience these activities as self-punishment. Nor is he always aware in advance of the unfavourable results of these activities, provided these could reasonably be expected. In the case of a patient who habitually allows himself to be abused or maltreated by others, he is often not aware of his own part in the events. Thoughts about being bad or worthless are only included in the definition if they are clearly intended to torment oneself. Indirectly, Self-Punishment manifests itself in refusal to accept positive events, undoing them or denying oneself pleasure. During treatment this attitude is reflected in the so-called **'negative therapeutic reaction'**. Just when things are going better, the patient's ceases to progress, shows more and more severe symptomatic behaviour or quits treatment. The definition does not include experiencing as pleasurable being humiliated, beaten or otherwise ill-treated; asking for 'negative' attention; punishing oneself to avoid being punished; self-mutilation to fight off a fear of disintegration or suicide attempts to keep from being abandoned. Nor does it entail basic choices to which sanctions or other unfavourable consequences are attached, as these may be expected to provide the satisfaction of 'being true to oneself'. Here the primary aim is not to cause oneself pain or discomfort.

Examples:
If I don't feel well, that makes me feel guilty. I punish myself by denying myself all sorts of things or by working extra hard./ I am bad. Sometimes I beat myself until I bleed./ I work so hard that I never get a chance to enjoy the results of my work. / I knew he drank, he was belligerent and unreliable. But I went against my parents' advice and married him anyway. / I kept on lending him money when I couldn't really afford it, even though I knew I'd never see it again. / Possibilities, developments that look promising - I manage to ruin everything. / I know it's dangerous to go to bed with someone you barely know without using a contraceptive. But I do it anyway. / People are always taking advantage of my kindness. / I'm only good for the housekeeping and for the sex.

RIVALRY (50)

Rivalry manifests itself as a striving to surpass oneself and others, to prove oneself as a reaction to insecurity over one's qualities as an adult man or woman. In the psycho-analytical literature this attitude is known as **'phallic-narcissistic'**. It is 'phallic'

because, in keeping with the cultural norms in the first half of this century, expansive behaviour was considered typically masculine and 'narcissistic' because of the need to be 'exceptional' or 'special'. In contrast to the behaviour on the level of Self-centredness (20), the patient is aware of the fact that his 'superiority' is not a given fact and that he will have to prove his special capabilities.

The social behaviour of the patient is aimed at achieving social standing (Conquest 51). The relationship with an equally 'special' partner (Idol 51) is primarily a way to prove one is a 'real' man or woman. The significance or value the patient attributes to himself is derived largely from a comparison between his capacities and those of others (Hierarchical Self-Image 53). In the case of value judgements, the patient refers to excessive ideals of a general nature he himself desires to meet (Conventional Norms - internal 54). There is a considerable need for exceptional capabilities (Potency 55). The attribution of meaning by the patient is personal, but insufficiently founded or even totally unfounded, so that it is often 'false' or 'histrionic' (Dissonant Cognitions 56). The patient reacts to stress by Repression, Denial, Reaction Formation, Projection or Sexualization (Reversal 57). Under difficult circumstances capabilities or accomplishment are feigned or fantasized about in daydreams (Pretending 58). And finally, there is a tendency to present oneself as 'superman' or 'superwoman' (Exhibitionism 59).

CONQUEST (51) Social attitudes

Operational definition: The patient's efforts are to a large extent directed towards the attainment of social status.

Status, i.e. the pursuit of a prestigious job, wealth, getting a decoration, winning an award, etc., is the patient's main objective in life. Often this is attained at the cost of leisure activities, relationships or even one's health. Getting the desired position is of primary importance, not actually fulfilling the function. Sometimes it becomes clear the patient did not realize what his goal actually entailed: 'There is more pleasure in the getting than in the having'. An indirect manifestation of this aim is to acquire the capabilities of a famous person by being his student or admirer; **'apprentice love'**. Conquest also implies a hierarchy in which others are less prominent or exceptional. In other words, one's own superiority defines others as inferior. In cultures or subcultures in which the striving for superiority is condemned, this is manifested only indirectly, for example in pity for the loser. These patients are often poor losers. So Conquest may also be reflected in a reluctance to take part, for **'fear of losing'** and being looked down upon as inferior. Losing with honour while retaining one's self-respect is impossible: 'The winner takes all.' Contrary to a Grandiose Self-Image (23), the fact that someone has not yet reached his goal is accepted. The patient realizes that the desired result is not 'automatic' or a 'right', but that it must be earned. This attitude distinguishes Conquest from Supremacy (21).

Examples:
I want a career that will make me famous./ I wanted to become a civil servant. That meant that you were really somebody. / I play badminton. In one of the highest classes. / I drive a 50-ton rig. Not bad, hey? Police escort and everything. / I want success. Success is status. / Ending up as just one of the crowd. That's the worst thing that can happen to you./ My grades are the highest in the class, but I keep them secret, because I don't want to make the others feel bad.

IDOL (52) Object relationships

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Operational definition: The relationship with the partner serves primarily to prove one is a real man or a real woman.

The relationship is 'the proof' of the patient's ability to win a special, preferably sexually desirable partner. Often there is a competitive aspect to this conquest, whereby the partner is 'stolen' away from someone else. This is a '**triangular'** or '**triadic**' relationship. Here, too, the conquest is more important than the ultimate relationship. Once the conquest is won, the patient often loses interest in the relationship. Indirectly, such a relationship manifests itself in a '**pathological jealousy**'. The patient sees all sorts of innocent contacts on the part of his partner as adultery, even though often he knows better. Conversely, the partner is often made jealous or placed within a competitive framework through comparisons with someone else. The genital-sexual nature of this jealousy distinguishes this from jealousy related to object relationships of the Parent (32) type, whereby the desire for 'complete' attention or care is of primary importance. Loving the ideal, but unattainable man or woman 'from afar' is registered as Pretending (58), as is daydreaming.

Examples:
I always fall for macho-type men./ I don't know. I always fall in love with married men. / I cannot stand him even looking at another woman. / When I'm travelling for my job I have those fantasies of my wife being unfaithful to me, even though I know that it is completely ridiculous./ I have to admit that X is a very attractive man./My last boyfriend was much more thoughtful than you are./Why can't you manage to succeed in life. Look at Y (girlfriend's husband).

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HIERARCHICAL SELF-IMAGE (53) Self-images

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Operational definition: The significance or value the patient attributes to himself is determined largely by a comparison with others.

The patient characterizes himself as 'more or less than ...'. This judgement is absolute. You are the best, otherwise you are nothing. So if you want to feel good about your self, you have to be 'better than others.' The Hierarchical Self-Image manifests itself in feelings of **'inferiority'** when the comparison with others is unfavourable. Sometimes there is no overt comparison, but the criteria used are clearly of a competitive nature. Thus it is not the achievement itself that counts, as in the case of a Derived Self-image (43), but the comparison with the accomplishments of others. In contrast to the Grandiose Self-Image (23), this 'being better' is not a given fact, but must be earned. In addition, the qualities of others are recognized.

Examples:

I always feel inferior to others. I'm not brilliant. I've never accomplished anything special. / My sister is much prettier. That has given me an inferiority complex. / If someone else is successful, that makes me feel awful. / (woman) When I walk by a cafe and see all those young girls sitting there, I could just die. / I always divide people into two categories: the ones I can compete with and the ones I can't. / When I see my neighbour's new car in the driveway, I feel really rotten. / I don't feel inferior to my boyfriend. But he is a college dropout, too. / Now that I know that I'm not the only one with problems like this, I don't feel so inferior.
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CONVENTIONAL NORMS - internal (54) Norms

Operational definition: In the assessment of conduct, the criteria employed by the patient are excessive, general rules he sees as proper.

As will be clear from the operational definition, internal Conventional Norms are only registered if they are excessively rigid and therefore maladaptive. They are generally related to the need to perform exceptional feats. In other words, internal Conventional Norms refer to **'excessive ideals'**, while Internalized Conventional Norms (44) have to do with the demands of a harsh conscience, the requirements one places on oneself. The acceptance of rules is not only rational, but above all emotional and for this reason there is little ambivalence. Not only must the patient act in a certain way, he actually wants to do so. Behaviour that does not meet these criteria is accompanied by feelings of shame or guilt. A characteristic reaction is compensating for mistakes by making up for the consequences. If this is not sufficient, we see confession, regret and penance. Often it is difficult to distinguish excessively rigid internal Conventional Norms from an 'unfounded' disqualification in the case of a Grandiose Self-Image (23). In the latter case, the patient assumes he is perfect, while here perfection is a goal he has yet to attain. Rigid internal Conventional Norms differ from Self-Accusation as a manifestation of Conditional Norms (34) by their reference to general behavioural rules instead of the opinion of significant others. This category differs from Fundamental Norms (64,74) in the sense that the patient is referring to a general rule rather than to an individual choice.

Examples:
I'm not easily satisfied with myself. I always feel as if I could do better. / If you really want something, you'll succeed. That's why I feel guilty when something doesn't work out.

POTENCY (55) Needs

Operational definition: The desires of the patient are related largely to the possession of exceptional abilities.

There is an excessive need to be 'special', to show off, to impress, etc. As in the case of Conquest (51) the ability itself is more important than what it enables the person to attain. The need for Potency is often satisfied by the acquisition of 'potent' attributes, such as a 'flashy' automobile or a 'powerful' telephoto lens or computer. Often there is also something Exhibitionistic (59) about the display of these qualities.

Examples:
Every day I spend two or three hours working out, to keep my body in top condition./I have a car that's unique. There are only two or three in the whole world and mine is the only one that's still on the road.

DISSONANT COGNITIONS (56) **Cognitions**

Operational definition: The attribution of meaning by the patient is personal, but excessive.

The excessive nature of the attribution of meaning manifests itself as an incongruity between the verbal and non-verbal behaviour of the patient or between the nature of the event and his reaction to it. For example, the patient says he is 'deeply moved', but this is not reflected in his behaviour. Or he reacts in a highly emotional way to events he has not himself experienced or only at a distance and that can hardly have a personal significance for him. Another manifestation is the frequent use of superlatives. Often there is something **'false'** or **'histrionic'** about the patient's behaviour. Here it should be taken into account there may be subcultural norms in the environment of the patient which in certain situations prescribe the expression of strong emotion.

Examples:
Is devastated by the death of a neighbour (a woman the patient barely knew). / Says that he is 'very depressed' without giving that impression.

REVERSAL (57) Problem-solving (thoughts & feelings)

Operational definition: The patient responds to internal or external stress factors by Repression, Denial, Reaction Formation, Projection or Sexualization.

(a) Repression: Absence of affects or cognitions which might reasonably be expected to be present.
(b) Denial: Indication, without reason, of the absence of certain affects or cognitions. **'Minimizing'** is also part of Denial. Denial refers to the 'internal world' while Disavowal (Falsification 07) refers to 'external reality'. In order to distinguish it from Disavowal, Denial is also referred to as **'neurotic denial'** or **'minor denial'**.
(c) Reaction formation: The manifestation of affects, cognitions or actions in such a way as to suggest these are the opposite of what is going on in the patient's mind. A special form

of Reaction Formation is known as **'turning active into passive and vice versa'.** Another manifestation is an unrealistic 'fear that other people might be harmed' by an accident, illness and the like. This is seen as a way of disposing of aggressive feelings.
(d) Projection: The attribution to others of 'forbidden' affects or cognitions without a plausible reason. By plausible we mean sufficient to convince the therapist. Characteristic of Projection is the fact that the patient claims not to possess these affects or cognitions himself, which distinguishes it from Suggestible Cognitions (36). Other people are aggressive or seductive, not the patient. Contrary to Delusionary Ideas (Falsification 07), these ideas are not incompatible with reality. This behaviour is also known as **'disowning'** or **'non-psychotic projection'**. A special form of projection, mainly in combination with denial, is **'externalization'** whereby 'forbidden' actions are not denied, but the 'fault' is laid at someone else's door: 'I don't want to, but I have to discontinue the sessions. My husband doesn't like my coming here every week.' In contrast to 'primitive Externalization' (Lack of Norms 04), the patient accepts responsibility for his own deeds or for letting others decide for him. In contrast to Projective Identification (Distortion 17), this reaction is open to discussion.
(e) Sexualization: The attribution of a sexual meaning to activities not intended for that purpose.

The assessment of Reversal is the sum of the assessments of (a) Repression, (b) Denial, (c) Reaction Formation, (d) Projection and (e) Sexualization.

Examples:
(a) *The fact that I never talk about the rape? I know, that is a bit strange, but I never think about it either. / (Man who survived the concentration camps) I don't understand why I feel this way. I don't think I have any real problems. / What my parents' divorce meant to me? I really don't remember.* ***(b)*** *When I do something for someone else, I don't expect anything in return. / That wasn't intended as criticism. / I don't want to blame everything on my mother, but ... / I don't dislike my job, but... / Everybody steals sometime. I was just unlucky enough to get caught. It's like getting a ticket for speeding (also Selfish Norms 24). / Yes, it's too bad that my girlfriend broke it off. But there are plenty of other fish in the sea.* ***(c)*** *When I'm down in the dumps, I always start cracking jokes and horsing around. That fools other people and myself. / Your (therapist's) vacation will at least give me time to do some gardening. / I'm always worried something will happen to my children. /(d) When I see a man coming toward me on the street, I'm afraid he's going to act aggressively towards me/ When I'm lying in bed at night, I'm always afraid there are scary men under my bed.* ***(e)*** *I never compromise. That's unmanly. / When a man looks at me, I'm always afraid he's thinking about having sex with me (Also Projection - Reversal 57).*
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PRETENDING (58) Problem-solving (actions)

Operational definition: The patient responds to internal or external stress factors by feigning certain abilities or by imagining them in his mind.

The desire to prove qualities one is not actually sure of possessing is reflected in an excessive demonstration of these abilities. The patient exaggerates his accomplishments or

pretends he is capable of accomplishments actually beyond him. Another manifestation of Pretending is excessive **'daydreaming'** about desired successes or other wish-fulfilling fantasies. A logical consequence is **'performance anxiety'**, the constant threat of not being able to deliver the promised accomplishment, 'being found out' or, as in the fairy tale about the emperor's new clothes, 'being caught without anything on'. This is also referred to as **'castration anxiety'.** In contrast to Omnipotence (28), the patient is aware of the limitations of his capacities.

Examples:
I'm the manager of a soft-drink department (lugs crates around in the stockroom). / As far as my career is concerned, I have a number of different options. (Has started on a variety of courses, but never finished any of them). / I live in a fantasy world; like the novels I read about love and romance. / I'm afraid that when people get to know me better, they'll realize that I'm a nobody.

EXHIBITIONISM (59) Miscellaneous themes

Operational definition: The patient presents him-/herself as 'Superman' or 'Superwoman'. There is an excessive preoccupation with sexuality and relation-less sex and an incomputability between love and friendship on the one hand and sex on the other. Wanting to be considered desirable is not intended to result in a relationship, but rather serves to demonstrate one's own sexual attractiveness. Because the underlying doubt on this point is never confronted, it continues to exist and must be demonstrated again and again. Here, too, the conquest is more important than the prize. There is an inability to proceed from 'being in love' to 'loving'. The most direct manifestation of this behavioural pattern is the **'He-man'** or the **'She-woman'**, the idealized image of the sexually desirable partner. There are two types of She-woman: the film star model, whose attractions are presented more or less openly and the inhibited type, reserved and shy who is asking to be conquered. Within the culture of Western Europe, the first of these two roles is the only one available to the He-man. The doubt and frustration about one's own sexual identity may also manifest itself in a striving to devalue the other person as a sexual partner. The She-woman then becomes a **'femme fatale'**, the He-man a **'don Juan'** and the relationship a 'liaison dangereuse'.

Examples:
I keep falling in love, but after about six months I lose interest and the relationship just sort of peters out. / For me the important thing was to show everyone that I could get her. After that, I just dropped her, and I have to admit that that gave me a real kick. / I want to be considered attractive and to be admired, but otherwise I keep everyone at a distance.

INDIVIDUATION (60)

The primary goal of the behaviour one sees on this level is **'self-realization'**, i.e. leading 'one's own life', taking into account both the existing possibilities and the interests of others. The 'patient' is capable of socially relevant accomplishments (Productivity 61). In his contacts he respects the rights of others (Equal 62). The significance or value the 'patient' attributes to himself is related to his sense of being a 'real' person and acting according to his own insights (Authentic Self-Image - individual 63). His judgements are also based on personal choices, which may deviate from the collective norms (Fundamental Norms - individual 64). The patient experiences important decisions, such as the choice of a partner and whether or not to have children, as well as choices related to schooling, work and important religious, political and other social activities, as appropriate for him (Identity 65). His attribution of meaning is personal, reflective, but not yet explanatory (Self-Confrontation 66). The patient is capable of enduring frustration and finding an acceptable solution for desires he cannot fulfil (Self-Control 67). He is also capable of standing up for himself in an adequate manner (Assertivity 68). And finally, he is convinced of his value as a human being (Self-Respect 69).

PRODUCTIVITY (61) Social attitudes

Operational definition: The 'patient' has shown that he is willing and capable of socially relevant achievements.

The achievements (in the last ten years) involved here are:
(a) Completion of schooling leading to a profession. If the patient freely chose not to enter the profession in question, then the completion of the schooling is not considered productive.
(b) A payed job for a period of at least one year.
(c) Housework or volunteer work carried out at least in part for the benefit of others.
The qualification 'willing' implies a personal commitment. Thus work one is forced to do does not meet the definition. The term 'socially relevant' refers to activities generally considered of importance for society, on condition the execution of these activities meets certain criteria with respect to quality, quantity and duration. In assessing productivity it is important to take into account the capabilities of the patient and the possibilities open to him. Productivity cannot be assessed in the case of illness, disability or involuntary unemployment. The same is true of the work of artists, philosophers or scientists, whose significance for society is difficult to measure. The definition does not include hobbies. Obviously, the notion of social relevance is strongly influenced by the specific culture and historical period.

The assessment of productivity is the truncated average of the assessments (if relevant) of (a) schooling, (b) work and (c) volunteer activities. The amount of time and the personal commitment involved in such activities is taken into account. Thus the patient who keeps house for herself (no Productivity) and works half a day per week as a volunteer in a hospital or the patient who works, but who does not actually do his best at work are considered productive to a limited extent.

Examples:
***(a)** Completed studies without any great difficulty **(b)** Functions well in his profession **(c)** Is an elder of his church, member of the volunteer fire department, treasurer of his sports club. /Works as a volunteer at a youth centre.*

EQUAL (62) Object relationships

Operational definition: The 'patient' actually demonstrates respect for the person of others.

The patient unconditionally acknowledges the interests, convictions, desires or rights of others. This does not necessarily mean the patient shares the views of another person or fulfils all the others desires. The qualification 'actually' indicates this respect is not confined to stating principles, but is translated into action. Being of equal value is not the same thing as being equal. Persons in unequal relationships, such as those between client and therapist or between employer and employee, may be of equal value in the sense intended above.

Examples:
I don't like being alone when my husband goes out to play cards every wednesday. But he likes it so much I don't complain. / I may not like it when my wife says she doesn't feel like making love, but I accept it. 'It takes two to tango'. / When we make love, I always wait so

that we come together. / If we can't agree, we draw straws or take turns. / We always vote on what to watch on TV. / When we had our child, I took a part-time job, so my wife could continue her work.

AUTHENTIC SELF-IMAGE - individual (63) Self-images

Operational definition: The significance or value the 'patient' attributes to himself is derived from undertaking action within his own frame of reference.

'Being' means 'being myself'. The 'patient's' behaviour is 'genuine' or 'true' and 'consistent', i.e. to a large degree predictable. An Authentic Self-Image is 'obvious'. As a rule, the 'patient' has no need to talk about himself and he only does so when asked to explain why he is or is not satisfied with himself.

Examples:
I made it clear I didn't agree. That made me feel better about myself.

FUNDAMENTAL NORMS - individual (64) Norms

Operational definition: In making value judgements the 'patient' uses his own choice of goals and means as criteria, taking into account both his own interests and those of his environment.

The 'patient' refers to inner standards. Motives and the 'spirit' of the law are more important than the rules themselves. So exceptions to rules are possible. When necessary, the patient follows his own objectives, which may deviate from the collective norms. 'Bad' behaviour is accompanied by a feeling of having 'renounced' or 'betrayed' oneself. Self-reproach, if present, is realistic and related to the consequences of one's deeds. Being able to indicate why one employs certain criteria distinguishes Fundamental Norms from behaviour that is only legitimized by referring to underlying needs. The fact that the views and convictions are those of the 'patient' himself, distinguishes Fundamental- from Conventional Norms (44, 54). Fundamental Norms differs from Authentic Self-Image (63) in that the judgement refers to the actions rather than to the person. Acting in accordance with Fundamental norms is a well considered decision.

Examples:
I'd rather risk having words with someone than pretend. I'd feel like a hypocrite. / If I don't feel like having sex, then I can't force myself. / If I've done what I can, in my eyes that's enough.

IDENTITY (65) Needs

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Operational definition: The 'patient' sees his major activities as appropriate to him.

The 'patient' chooses a life-style and activities meet his needs and his potential. Here, too, the essential thing is not the intentions, but their fulfilment.
These choices involve the:
(a) Partner,
(b) Parenthood,
(c) Schooling,
(d) Work,
(e) Activities related to religion, politics; sport and hobbies.
The determining factor is one's judgement during the activity. If someone played soccer for several years and considered this a 'suitable' sport for him, this meets the definition, even though he no longer plays the game. The same is true of someone who opted for a course of schooling he considered suitable to him, but who is now following a different course, because he wants to go into another type of work. The definition does not include activities the patient does not consider important or choices not concerned primarily with the nature of the activity. For example, 'I enjoy going to work every day, at least it gets me out of the house' or 'Living with someone suits me. I could never live alone'. The definition does include criteria such as: 'enjoying working with other people' or 'the chance to deal with customers'. A well-considered decision not to take part in certain activities, even when this is an unconventional choice, is in accordance with the definition of Identity as long as this choice is experienced as fitting. If the patient is prevented from making a suitable choice by forces beyond his control, then Identity cannot be assessed. These forces may be 'internal', as when a patient decides against entering into a relationship because he does not dare to commit himself or does not want children as long as he is incapacitated by his complaint. External forces would include a situation where the environment does not allow the patient to do what he would like to do, for example going to college.

The assessment of identity is the truncated average of the 'suitability' of the choice (where relevant) of a (a) partner and (b) children, (c) schooling, (d) work and (e) activities related to religion, politics, sport and hobbies. It will be clear the subculture of the patient must be taken into account.

Examples:
***(a)** The relationship with the partner is 'suitable'. **(b)** Always wanted children. **(c)** That's just the course for me. **(d)** I'm a born nurse. **(e)** I consider my volunteer work very important.*

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SELF-CONFRONTATION (66) Cognitions

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Operational definition: The attribution of meaning by the 'patient' is personal and reflective, but not explanatory.

Self-Confrontation answers the question 'How do I do?' The reflection refers to the interactions within oneself or with the environment. Here it is a question of recognizing cohesions, similarities or contradictions in one's own behaviour, without offering an

explanation of that behaviour. This type of reflection implies that these relations are not 'given' or obvious, but that a certain amount of 'detective work' is required to identify them. Thus a factual description such as 'I always feel afraid on a bus' does not meet this definition. Here the patient adopts a '**third-person-perspective**' with respect to himself. This implies a certain '**context-independence**' whereby one does not enter completely into the action. Thus the patient is not only actor, but also observer. However, he does not experience himself as the 'maker' of his behaviour. He is aware of what he is doing, but he cannot explain his behaviour and does not know why he behaves as he does. Patients who function on this level are capable of recognizing various aspects of their behaviour and the contradictions it displays, as well as similarities with their behaviour in the past. Self-Confrontation differs from Classifying Cognitions (46) in the personal nature of the statements. These statements characterize the 'describer' and not - or not exclusively - what is being 'described'. A detailed Self-Confrontation is often difficult to distinguish from Self-Clarification (76). Characteristic of the former is the absence or presence of a logical explanation. If a statement could involve both a reflection or an explanation, then extra details will be needed to provide clarity. For example, 'He is very important to me, because he thinks I'm sweet and he likes my looks.' (Why?) 'It makes me feel good'. (= reflection = Self-Confrontation) or 'Then I feel that I'm worthwhile after all' (= explanation = Self Clarification 76).

The quantification concerns the complexity of the behaviour described:

X **'Correlations':** combinations of behaviours or indications of situational factors, even though the behaviour is not actually explained
XX **'Contradictions'**: inconsistencies in one's own conduct, even though the behaviour is not actually explained
XXX **'Analogies'**: similarities with the past, even though the behaviour is not actually explained

In quantifying behaviour, the highest demonstrable level is registered. As a rule this requires two or more examples.

Examples:
(x) When I feel insecure, I become aggressive./When my boss comes by my department, I'm all stressed out./I always fall for father figures./ (xx) I say to myself that next time I'm going to tell my parents that I don't agree with them. But when I'm sitting there opposite them, I just don't have the courage./I really do my best, but as soon as the relationship is a fact, I'm not that interested any more./I'm terribly afraid of criticism. But I went into a line of work where I have to get up in front of an audience./I have this desire to look sexy, but then I'm ashamed of myself when I do./He's nasty. He beats me. And still I don't want to lose him./(xxx) When I got transferred, I had the same feeling as when I was little. As if you were being punished even though you hadn't done anything wrong./I can't stand being alone. I was like that even as a child.

SELF-CONTROL (67) Problem-solving (thoughts & feelings)

Operational definition: The 'patient' responds to internal or external stress factors by consciously postponing or changing his reaction.

Self-control implies 'mastery' over oneself. The patient is able to endure setbacks. This implies an adequate **'frustration tolerance'**. In contrast to Repression or Denial (both Reversal 57), affects or cognitions are not eliminated. The patient does not avoid confrontation (Defensiveness 48) while, in contrast to Control (Defensiveness 48), there is no stalemate; nor is the original goal relinquished (Giving Up 38). When successful, **'active stress reduction'** decreasing one's symptoms by doing something else (work, sport, etc.) belongs to this category, as does finding a socially acceptable way to decrease frustration or stress. This is also referred to as **'sublimation'**.

Examples:
His remark made me really mad. But that was not the right moment to let him know I was angry. Later I discussed it with him. / At the moment, the plan is not feasible. I'll have to wait until the time is ripe. / When I get tense, I take a long walk. Then I can go on.

ASSERTIVITY (68) Problem-solving (actions)

Operational definition: The 'patient' is capable of promoting his own interests in an appropriate manner.

'His own interests' refers, in general, to the freedom to think, feel and act and, in particular, to the satisfaction of ones own desires. The behaviour is 'appropriate' if it takes into account existing possibilities and limitations and if the methods or means used are suitable to the aims involved. Being assertive is not the same thing as getting your way. The ability to stand up for yourself is no guarantee for success; nor is being assertive the same thing as being aggressive or negative. The patient who fumes and curses in helpless rage or says no to everything, is not being assertive. Assertivity is not only defensive. Making known positive feelings, such as appreciation, love or even fear or uncertainty, is also important in promoting one's own interests.

Examples:
When I'm against something, I say so. / I knew that he wanted to do it the other way, but I felt the least he could do was listen to my arguments. / My playing was good enough for the first team, but they wanted to keep me on the second team, because I helped to raise the level of play. I finally decided to leave. / I was unfairly passed over for the appointment. I went to the Board and they admitted I was right.

SELF-RESPECT (69) Miscellaneous themes

Operational definition: The patient is convinced of his own value as a human being.

Self-respect is obvious in the way the patient acts. An important manifestation is the ability to differentiate between one's actions and one's person. The patient may act stupidly or badly without being stupid or bad. Another manifestation of Self-Respect is the ability to accept criticism and to acknowledge one's own shortcomings without suffering a loss of **'self-esteem'.**

Examples:
I tried my best. That's all I could do. / I failed, so next time I must try harder.

SOLIDARITY (70)

The central theme on this level is **'interdependence'**, functioning in relationships in a mutually satisfying manner. The 'patient' is part of a larger entity without giving up his own personality. He shares the life of a partner on a daily basis (Living Together 71) and he is a significant other for his significant others (Mate 72). The significance or value which the 'patient' attributes to himself is derived from the 'authenticity' of his relationship with others (Authentic Self-Image - relational 73). He bases his value judgements on his own choices, especially with respect to his dealings with others (Fundamental Norms - relational 74). The 'patient' derives satisfaction from joint activities with a partner, such as talking about topics that interest them, leisure activities and making love (Intimacy 75). In his attribution of meaning the 'patient' is personal and causal relationships in his behaviour are recognized (Self-Clarification 76). The 'patient' is capable of integrating contradictory meanings people or situations may have for him (Ambivalence 77). In resolving difficult situations, he asks others for help without relinquishing his own responsibility (Affiliation 78). And finally, the 'patient' is capable of placing himself in the experiential world of others (Empathy 79).

LIVING TOGETHER (71)

Social attitude

Operational definition: The 'patient' shares his daily life with a partner in a mutually satisfactory way and over a considerable period of time.

Functioning together on a daily basis involves:
(a) housekeeping: running a household together.
(b) finances: earning and spending income.
(c) parenthood: raising children (if applicable).
A partner implies a sexual relationship. This excludes friends or relatives living together. The term 'satisfactory' refers to the activities mentioned under (a), (b) and (c). This description does not include the quality of the sexual relationship, which is covered by Intimacy (75). The term 'over a considerable period of time' refers to a time span of at least one year.

The assessment of Living Together is the truncated average of the assessment of the joint fulfilment of the duties of (a) housekeeping, (b) finances and (c) parenthood.

Examples:
Married three years ago. No children. Division of tasks. Both in paid jobs.

MATE (72)

Object relationships

Operational definition: The 'patient' is himself a significant other for a significant other he acquired.

We are referring here to relationships of a certain duration (at least one year) and a certain intensity, (at least six contacts per year). Parental family members are excluded. To distinguish 'socially appropriate' answers the meaning of the relationship should manifest itself in the way the 'patient' and the Mate actually behave towards each other. Being a Mate does not necessarily have the same significance for both partners. The mutual nature of this kind of partnership excludes a one-sided involvement, i.e. being important for someone who is not important to you. Being important 'as a person' distinguishes this relationship from a 'trade-off' where the transaction rather than the relationship is important. Often it is very difficult to differentiate a mature, adaptive relation of the Mate type from a **'collusion'** where people stick together because they compensate for each other's psychological problems. This is also a long-lasting relationship in which the partners are important for each other. But as a rule this relationship is not quite satisfactory. It is appropriate 'for the time being' or 'because there is no other possibility'.

Examples:
My boyfriend is very important to me. And I'm important to him. / My best friend occupies an important place in my life. And she always comes to me when something is bothering her. / My girlfriend and I share all our secrets.

AUTHENTIC SELF-IMAGE - relational (73) Self-image

Operational definition: The significance or value the 'patient' attributes to himself is derived from acting together with others within a common frame of reference.

Being part of a greater entity without losing one's individuality is the central theme here. In contrast to the External Self-Image (33), the important feature is the patient's own opinion.
Examples:
(What enhances your sense of self-esteem?) *The fact that my partner and I have succeeded in building up a good relationship./We form a good team and that's something I'm proud of.*

FUNDAMENTAL NORMS - relational (74) Norms

Operational definition: In making value judgements the 'patient' uses his own choices with respect to his association with others as his criterion .

The 'patient' attaches considerable value to cooperation and other joint activities. In contrast to Selfish Norms (24), the wishes and interests of others are taken into account. Being just and fair towards others is a central criterium. The 'spirit' of the law is more important than the 'letter'. Under certain circumstances, something normally considered wrong, such as stealing, might actually be the lesser of two evils and thus an acceptable solution. Redressing or compensating for the consequences of 'bad' behaviour serves the interests of others and is not used to undo one's own mistakes.

Examples:
Now that we're expecting a baby, we want to be sure we can give it the attention it needs. That's why we're both going to work part-time. / I blame myself for not making more of an effort when I realized that he was drinking so heavily. / When my mother fell ill and needed my support, I wasn't there for her. / My daughter notices that I'm often preoccupied. And that makes me feel guilty. / I get very angry and then later regret what I said. I would never want to hurt him. / I feel guilty about getting so wrapped up in my own problems that I neglect my wife.

INTIMACY (75) Needs

Operational definition: The 'patient' finds satisfaction in joint activities with a partner in a mutually satisfactory way and over a considerable period of time.

Such joint activities include:
(a) Communication: Talking over things that are important to you.
(b) Joint-Actions: Taking part in leisure activities together.
(c) Sex: Making love.
The term 'over a considerable period of time' refers to a time span of at least one year.

The main feature here is the capacity for and the integration into one relationship of love, friendship and sexuality. Intimacy is seen in a context of mutuality. 'Joint activities' imply a free choice and the involvement of both parties. Both parties must experience the activities as satisfying, although not necessarily for the same reasons or to the same degree. The definition does not include giving in to the other just to 'keep the peace' or activities undertaken as a group. The value of a relationship is not measured exclusively by the degree of intimacy. A person can be satisfied with a relationship without joint activities and dissatisfied with a relationship in which these do take place. If one of the parties does not see the importance of talking together, joint activities and making love, then intimacy cannot be assessed. This is also the case if it makes no difference to the patient whom he talks to, engages in joint activities with or makes love to. The assessment must take into account the subcultural norms in the patient's own environment.

The assessment of intimacy is the truncated average of the assessment of the degree of satisfaction with (a) talking, (b) joint activities and (c) making love in the relationship with a partner.

Examples:
Talking together, leisure activities and making love are all satisfactory for both parties.

SELF-CLARIFICATION (76) Cognitions

Operational definition: The attribution of meaning by the 'patient' is personal whereby causal relationships in one's own behaviour are recognized.

Self-Clarification provides a 'superficial' answer to the question: 'Why do I do this?' B. is partially clarified, namely as a logical consequence of A. This relationship must be

comprehensible to the patient as well as to the researcher. But the occurrence of A is not clarified. The explicit formulation of a cause-and-effect relationship distinguishes Self-Clarification from Self-Confrontation (66). If the patient indicates a relationship, but is not capable of making clear why A is a consequence of B, this is not a causal relationship, but a correlation, for example: 'I fell in love with her because she's got these cute little freckles.' (Why does that appeal to you?) 'I don't know'. Questions about the reasons or motives behind one's own maladaptive behaviour are not answered. This distinguishes Self-Clarification from Self-Interpretation (86). In contrast to Rationalization (Elimination 47), the affective significance of events is recognized. If it is not clear whether a connection is a causal relationship or a correlation, is registered at the lower cognitive level, i.e. Self-Confrontation (66).

The quantification concerns the complexity of the causal relationships.

X **Simple causal relationships**: 'A understandably leads to B'.

XX **Complex causal relationships**: 'A understandably leads to B, which leads to C' or 'A and B understandably lead to C' whereby C must be clearly distinguished from A and B.

XXX **Causal relationships between the present and the past**: behaviour B in the present is a consequence of event A in the past.

In quantifying behaviour the highest demonstrable level is registered. As a rule this requires two or more examples.

Examples:

(x) I devoted myself entirely to the children. Now that they don't need me anymore, I've fallen into a kind of limbo./Sport is very important to me. It's a way of getting rid of my aggression./It (relationship) didn't last, because I was too tied up with myself and my work./I place such great demands on myself that I'm afraid to do anything./(xx)When I get angry with someone, I feel so guilty afterwards I go out and buy expensive gifts to make it up to them./Those periods of depression have to do with being forced to give up certainties in my life. I just can't do it./I went to bed with every guy I met. But I only did it because I was afraid of not belonging./(xxx) I've never known love. That's why I can't give it./ I just can't believe it when my boyfriend says he loves me. I've never had the feeling I was wanted or that I mattered./When my husband comes home, I start arguing with him until he gets mad. At home with my parents, once you'd had your beating, at least you knew you'd be left in peace for the rest of the evening.

AMBIVALENCE (77) Problem-solving (thoughts & feelings)

Operational definition: The 'patient' recognizes and accepts that a significant other, a significant event or his own behaviour can simultaneously have contradictory meanings for him.

This recognition is not only cognitive but, above all, affective. Acceptance implies one has worked through the negative side of the experiences. Ambivalence must be distinguished from **'ambitendency',** the alternating experience of contradictory emotions, as when the patient comes to hate a partner he was once in love with. Similarly, the definition does not cover contradictory reactions related to themes which do not concern the patient.

Examples:
He can be very sweet to me sometimes. And yet he's very self-centred. / I'd do anything to get that job, but on the other hand, I'm terrified of all the responsibility it would involve. / I'm an egotist. But I'm ashamed of it. / When he (father) died, it was a great loss, but a relief as well. His suffering had been terrible.

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AFFILIATION (78) Problem-solving (actions)

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Operational definition: The 'patient' responds effectively to internal or external stress factors by entering into an alliance in order to combat them.

The main feature of Affiliation is the creation of a **'working alliance'.** The term 'effectively' indicates some permanent change, not only a short-term reduction of symptoms. The 'patient' remains responsible for finding a solution to his problems. This distinguishes Affiliation from Passive Need for Love (35) or Giving Up (38). The help is intended to solve the problem, not to continue the status quo. This differentiates Affiliation from Defensiveness (48). The development of more adaptive behavioural patterns is registrated as Enterprise (88) or Innovation (98).

Examples:
We talked it all over. That helped me to deal with it (loss of a child). / When I got hopelessly bogged down, a colleague helped me to get things straightened out. / When the boss threatened to fire anyone who wouldn't do overtime, we all went to the union.

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EMPATHY (79) Miscellaneous themes

Operational definition: The 'patient' is capable of imagining himself in the experiential world of someone else.

This implies seeing matters from another person's point of view. This is reflected primarily in the ability to understand opinions or actions which differ from one's own. Often this distinction does not emerge until further clarification is requested and the patient makes it clear what his view is actually based on. Empathy must be distinguished from Suggestive Cognitions (36) and Projection (Reversal 57).

Examples:
When my brother starts acting arrogant, that's his way of dealing with insecurity./ He's such a proud man, he must find being unemployed unbearable. / In that situation corruption is inevitable. / In that culture it's quite normal to have children by different partners.

GENERATIVITY (80)

Generative behaviour implies a sense of '**joint accountability**' for the way society functions. This is reflected in the acceptance of Responsibility (81) for the welfare of others in general and in unconditional help for those who need it (Care 82). The significance or value the 'patient' ascribes to himself is derived from life according to one's own life plan (Existential Self-image - personal 83) which also serves as a frame of reference in forming value judgements (Ideological Norms - personal 84). One essential need is acting in accordance with one's own convictions, even if this has adverse consequences for oneself (Integrity 85). In attributing meaning the 'patient' is capable of recognizing his own reasons and motives (Self-Interpretation 86). The 'patient' is able to acknowledge a difficult situation without losing sight of the positive aspects of that situation (or other situations occurring later on in life) and is capable of introducing humour into the situation in the form of mild self-criticism (Perspective 87). Problems are tackled in a systematic manner (Enterprise 88). And finally, the patient is able to work through serious losses (Mourning 89).

RESPONSIBILITY (81) Social attitude

Operational definition: The 'patient' has a realistic acceptance of his accountability for the functioning of society or for the well-being of others in general.

The term 'realistic' excludes taking on more responsibility than is realistic or feasible. 'Acceptance' implies really acting according to this aim, making a contribution to the well-being of others. In contrast to behaviour at the Resistance (40) or Rivalry (50) level, Responsibility is not experienced as the manifestation of one's Power (45) or Potency (55) but as a privilege. Someone who unintentially does something which happens to be helpful to others is not displaying Responsibility. The definition does cover doing something for others which is also in one's own interest as long as the 'patient' considers himself accountable for the well-being of others. This distinguishes Responsibility from **'pseudo-altruism'** (Passive Need for Love 35) where satisfaction of one's own interests is the primary aim.

Examples:
Does volunteer work at a youth centre several evenings a week. / Is a member of an environmental organization and takes special measures in his home designed to protect nature.

CARE (82) Object relationships

Operational definition: The other is someone who needs and receives the 'patient's' unconditional help.

This means actually providing help, not only the intention to do so. The others need determines the interaction, not the 'patient's' urge to help. The qualification 'unconditional' indicates nothing is expected in return. Self-interest, such as the pleasure one takes in caring for others should be of lesser importance. The definition does not include being forced by internal coercion such as feelings of guilt or by external coercion as by means of sanctions. Carrying out a caring profession falls outside this definition, except when it is overly clear one's own interests are of lesser importance.

Examples:
Helps children with their homework or plays games with them. / Helps out neighbours or relatives where necessary. / Regularly visits an acquaintance living in a nursing home. / Is a confidant for friends and colleagues. / Actually, I'm always there for people who need to talk or a shoulder to cry on. / If I know someone's going through a difficult period, I ask if I can help.

EXISTENTIAL SELF-IMAGE - personal (83) Self-images

Operational definition: The significance or value the 'patient' attributes to himself is derived by acting in accordance with his life plan.

A **'life plan'** is a personal vision, often quite vague, of the meaning or aim of one's own life. If a patient was raised in a family with strong religious or political traditions, it is important to ascertain whether or not he really shares those convictions.

Examples:
I consider it an honour to contribute to the education of the next generation. / I'm happy that during the war I was able to give my children the care and understanding they needed. / It is important to me to work on expanding the scientific knowledge in that field.

IDEOLOGICAL NORMS - personal (84) Norms

Operational definition: In value judgements the 'patient' uses his life plan as criterion.

The difference between Ideological Norms and an Existential Self-Image is that in the former it is the behaviour that is assessed and in the latter the person.

Examples:
It's very important to me to work outside the home. Otherwise your world becomes so narrow. / I try to live as a Christian: to be honest, to treat others as you would want them to treat you. / I don't eat meat because factory farming methods don't provide animals with a decent life.

INTEGRITY (85) Needs

Operational definition: The 'patient' actively and realistically subordinates his direct interests to his own fundamental or ideological norms.

The qualification 'actively' implies the 'patient' really acting in line with his principles. A situation in which this occurs often has the nature of an ordeal. The qualification 'realistically' indicates the magnitude of the sacrifice is in accordance with the goals it serves.

Examples:
I'm glad I didn't shoot. Being robbed isn't nearly as bad as killing a human being. / I knew I ran the risk of losing my job. But that was so unfair, I had to speak up. / I could have made a lot of money by not reporting the whole batch was contaminated. But I just couldn't do that to all those people.

SELF-INTERPRETATION (86) Cognitions

Operational definition: The way in which the patient ascribes meaning is personal whereby his own reasons and motives are recognized.

Self-Interpretation refers to one's own share in the occurrence of maladaptive behaviour and ultimately provides an answer to the question 'Why am I doing this?'. The patient is not only the one who executes the behaviour, but also in some measure the creator of that behaviour. This means in principle he is also capable of '**self-determination**'. In other words, through his own action he can alter his maladaptive behaviour. On this level '**circular causality**' is recognized, i.e. the fact that the reaction of the environment is determined in part by one's own actions. Not only 'I can't stand it when people are nasty to me', but also 'I often do things that make people want to be nasty to me'. This realization of one's own reasons or motives and the accompanying '**inner conflicts**' are known as '**insight**'. In the case of 'experienced' patients, it is important to establish whether the motives they give are affectively experienced by them as such and to what extent they may simply be repeating the interpretations of their therapist. The acknowledgement of the 'self-made' nature of the symptoms and problems is realistic. It is an 'existential judgement' and in this it distinguishes itself from the 'value judgements' of the type 'It's all my own fault' (self-accusation 34, self-rejection 39 and self-condemnation 44). The important thing here is not so much the rational as the emotional acknowledgement of one's own reasons and the willingness to change one's behaviour. This distinguishes Self-Interpretation from pronouncements such as 'I know I have to do it myself' and other forms of Rationalization (Elimination 47). It may be difficult to

distinguish making one's reasons explicit (Self-Interpretation) from a consideration of one's conduct (Self-Confrontation 66). The same holds true for the distinction between Self-Interpretation and Self-Clarification (76). The explanation provided by the patient will clarify matters; if uncertain, the therapist will register the lower cognitive level.

The quantification refers to the degree of insight into one's own share in the development of the symptoms or problems.
The patient explicitly acknowledges:

X **His part in the development of his symptoms or problems.**
XX **How he causes his symptoms or problems.**
XXX **The often contradictory reasons** which determine his behaviour.
For quantification the highest level that is clearly demonstrated is registered. As a rule, this requires two or more examples.

Examples:
(x) My mother is so annoying sometimes. But the way I react only makes it worse./It's my fault that my relationships don't work out. I'm doing something wrong somewhere. But I don't know what./I think that the idea that people don't like me has more to do with things in my head than with reality. (xx) I expect people to reject me, because I do it myself./ My girlfriend is always telling me what to do. But I let her do it. Actually I'm the one who allows someone else to dominate me./People are nasty to me so often because I present myself as vulnerable. (xxx) I want to excel over my father. But I don't want to humiliate him. That's why I never get anything done./ People in authority drive me wild. I feel as if I want to destroy them, but actually I'm afraid that they're going to destroy me. In actual fact, I don't want to destroy anyone. Only sometimes maybe. I can't figure it out. That's why I bottle up my anger.
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PERSPECTIVE (87) Problem-solving (thoughts & feelings)

Operational definition: The 'patient' responds to internal or external stress factors by recognizing them as such without losing sight of other, notably positive, developments.

The 'patient' acknowledges the seriousness and extent of his problems, but also their limits and thus their relative importance. In this way the patient is able of reconciling polarities and seeing a problem in its proper proportions. This is sometimes accompanied by **'humour'**, in the form of mild self-criticism. It is the paradoxical nature of this reaction - the fact the patient describes his own faults or shortcomings without losing his self-esteem - that makes a comical impression. The qualification 'mild' indicates this does not involve ridicule; nor does the definition cover ridiculing yourself in order to prevent others from doing so. Perspective must be distinguished from Rationalization or Intellectualization (Elimination 47) as a means of dealing with disappointment or powerlessness.

Examples:
My ambitions are only exceeded by my fear of failure. / I try so hard that everything I do is almost doomed to fail.

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ENTERPRISE (88) Problem-solving (actions)

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Operational definition: The 'patient' responds to internal or external stress factors by systematically striving to improve the situation.

'Systematically striving' involves considering various possibilities (deliberation); making a choice on the basis of certain criteria (decision); and actually carrying out the intended action (execution). **'Learning from experience'** is another form of Enterprise, as is the **'anticipation'** of possible future developments. As in all problem-solving strategies, intentions, wishes, etc. are disregarded. Deliberation and decision distinguish Enterprise from 'trial-and-error solutions'. Here, in contrast to active tension reduction (Self-Control 67), there is an effort to bring about a structural change in the situation. Enterprise also includes changing one's behaviour to function in a more adaptive way as long as the patient himself remains responsible for his actions.

Examples:
When the radio was stolen from my car in the garage, I immediately wrote to the management and reported the theft to the police. / I'm getting a bit forgetful. That's why I always take a shopping list along when I go to the supermarket. / I've given it a lot of thought and have finally decided to break off the relationship. / Years ago I had a car accident and since then I never exceed the speed limit. / I always used to bottle everything up and then let it all out in an enormous explosion. Now, if I don't agree with something, I usually say so right away. / I'm not afraid any more to say 'no' or to take the initiative if I feel like it.

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MOURNING (89) Miscellaneous themes

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Operational definition: The 'patient' has dealt with major losses.

Major losses include the death of a significant other, illness, being abandoned by a lover, the loss of career opportunities, the loss of physical capabilities or the possibility of ever fulfilling important wishes or ambitions. Dealing with such losses involves coming to terms with the accompanying affects and cognitions so they no longer dominate the patient's world or interfere with his functioning. It is typical that the events preserve their lively character. This differentiates Mourning from Isolation of Affects (Elimination 47).

Examples:
When my father died, I went through a difficult period. I felt empty; sad. But gradually I began to come out of it. / When I became paralysed, I didn't want to live. But I managed to conquer my depression./ I realize my invention won't bring me the fame I expected. It was a beautiful dream. Now life is getting back to normal.

MATURITY (90)

The behaviour on this level is characterized by the ability to '**decentralize**' whereby one no longer considers one's own interests of primary importance. This manifests itself in the voluntary withdrawal from social activities where this is functional (Retirement 91). People in need receive help without any need for gratitude (Altruism 92). The significance of values the patient ascribes to himself are derived from a general philosophy of life (Existential Self-Image - general 93). This philosophy also serves as a criterium in making value judgements (Ideological Norms - general 94) and also helps to place one's own life in a broader, more general context (Significance 95). The 'patient' is capable of reliving his past within his experiential world (Self-Transformation 96). He is also able to relate contrasting and even contradictory themes to one other (Synthesis 97) and to find new solutions to his problems (Innovation 98). And finally, the patient is capable of acknowledging his own mortality (Dying 99).

RETIREMENT (91) Social attitude

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Operational definition: The 'patient' voluntarily turns over social tasks and responsibilities when this is appropriate.

Against the background of a reorientation, the patient relinquishes social responsibilities or otherwise adjusts his life-style. As a rule, this theme gradually becomes relevant from about the age of fifty onward. But someone who is self-employed may want to - or be obliged to - continue working for a longer period than someone with a good pension. And someone involved in top sport will have to withdraw at a relatively early age. The definition does not include enforced withdrawal due to illness, involuntary retirement or other causes. The qualification 'appropriate' refers to general accepted norms. So the assessment must take into account the cultural norms and the specific life-style of the patient.

Examples:
I'm a lot more easy-going than I used to be. I don't have any desire to expand the business. / With my retirement in sight, I decided to work fewer hours.

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ALTRUISM (92) Object relationships

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Operational definition: The 'patient' strives to do something for someone else as a goal in itself.

Doing something for someone else is in itself satisfying. The other person is given help without having to say 'thank-you'. In fact, it is the person who gives the help who is grateful for the opportunity. Identification with the person who benefits from the help is of lesser importance. If this does play an important role, the behaviour is **'pseudo-altruistic'**, satisfying a Passive Need for Love (35) and is registered as such. Exaggerated help combined with 'self-effacement' is a sign of Reaction Formation (Reversal 57) or, if it involves harm to oneself, Self-Punishment (49).

Examples:
Even when they can't be cured, people need care.

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EXISTENTIAL SELF-IMAGE - general (93) Self-image

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Operational definition: The significance or value the 'patient' attributes to himself is derived by acting in accordance with a general philosophy of life.

A general **'philosophy of life'** is a personal view, often fairly vague, of the meaning or aim of life in general.

Examples:
I am content. I can live with the unknowable.

IDEOLOGICAL NORMS - general (94) Norms

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Operational definition: In making value judgements the 'patient' takes as his criterion a general philosophy of life.

Again, what is decisive here is the degree to which the manifest behaviour of the patient is actually determined by this philosophy of life.

Examples:
Violence may only be used as a last resort. In the case of an existential threat or when there is no other way out.

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SIGNIFICANCE (95) Needs

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Operational definition: The 'patient' derives satisfaction from placing his personal life within a broader context.

The aim is reconciliation of one's destiny. Like general Existential Self-Image and general Ideological Norms, Significance involves a philosophy of life worked out to a greater or lesser degree.

Examples:
I am at peace with God.

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SELF-TRANSFORMATION (96) Cognitions

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Operational definition: The 'patient' is capable of reliving the past in the present and of recognizing it as such.

This involves experiences from the past of importance in the patient's perception of and reaction to the reality of the here and now. For example the 'patient' who as a child was abandoned by his mother is often afraid to form a relationship because he fears he will be deserted again. Self-transformation involves adopting the position of the abandoned child again together with all the fear, desperation and anger. Although this transformation will not take place arbitrarily, the 'patient' is capable of deciding whether he wants to make the attempt and when he wants to give it up. Self-Transformation is also referred to as '**reversible regression**' or '**regression in service of the ego**'. In the case of Self-Interpretation (86) the 'patient' is referring to the child in himself. In Self-Transformation he is that child, even though he is aware of the fact he is an adult. This is also known as '**transference**'.

The quantification indicates the degree of insight into this transference.

X **Confrontation with the phenomenon of transference**: The 'patient' recognizes his experience of the here and now is not related to the present persons, events or situations.

XX **Clarification of the transference**: The 'patient' is also capable of recognizing causal relationships.

XXX **Interpretation of the transference**: The 'patient' is also capable of recognizing (contradictory) reasons or motives.

In the quantification, the highest level that is clearly demonstrated is registered. As a rule, this requires two or more examples.

Examples:
(x) Here, too, I have the feeling it's my fault when things don't turn out./I know it's ridiculous, but I'm afraid to look you in the face. I'm afraid you're angry with me; I'm even afraid you're going to send me away./ (xx) (to therapist) I feel guilty when things are going well. Then I need you less and you're less important for me. (xxx) When I leave and I see the next patient sitting in the waiting room, I feel betrayed. As if our relationship is a kind of mass production. Goods 'off the rack' anyone can buy, as long as he has enough money. That's unreasonable. Apparently I want a unique relationship with you. I want to be your favourite patient, in fact your only patient.

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SYNTHESIS (97) Problem-solving (thoughts & feelings)

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Operational definition: The 'patient' is capable of dealing with distressing events or situations by balancing unequal and even contradictory elements.

Synthesis implies the establishment of order, in some cases a new order. One form of synthesis is the ability to deal with **'paradoxes'**, themes which have contradictory meanings in different contexts.

Examples:
It's such a poor country, without any social services. No wonder there's so much corruption and everyone puts himself, his family and his tribe first. / Power is the ability to deal with powerlessness. / It's crazy. I'm a grown man, someone not without talents. And at the same time I'm a little boy who's afraid of what Daddy will say.

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INNOVATION (98) Problem-solving (actions)

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Operational definition: The 'patient' is capable of finding new ways of dealing with internal or external stress factors.

This involves a new way of looking at the problems or a new approach to solving them. The development of truly new, more adaptive behaviour patterns at work or in relationships also belongs to this category. Improvements to existing ways of functioning are registered as Enterprise (88).

Examples:
When I realized the merger was unavoidable, I accepted a post on the Board of the new company: 'If you can't beat them, join them'. /If the patient remains silent, it is this silence that should be discussed.

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DYING (99) Miscellaneous themes

Operational definition: The 'patient' acknowledges his own mortality.

This involves a cognitive and, above all, an affective confrontation with death without relinquishing one's involvement with life. Often this is accompanied by a fear of the unknown. The definition does not include the desire to end an unhappy or useless life.

Examples:
I know that I don't have much time left, but I try to make the most of each day. / I've divided the inheritance among the children. It's better to give things away while you're there to see the pleasure they give. / When I think about death, I'm afraid. But I also realize how valuable life is.

TABLE 27. THE DEVELOPMENTAL LINES
SOCIAL ATTITUDES: The habitual behaviour of the patient in normal social contacts. **OBJECT RELATIONS**: The meaning or role the patient ascribes to his significant others or to other people in general. **SELF-IMAGES**: Criteria determine the sense of self-esteem. **NORMS**: A frame of reference for assessing the correctness or feasibility of the behaviour. **NEEDS**: A general desire for something one lacks, together with the urge to fill that void. **COGNITIONS**: The manner in one attributes meaning to his experiences. **PROBLEM-SOLVING BEHAVIOUR (thoughts and feelings)**: thoughts and feelings as a reaction to internal or external or external stress. **PROBLEM-SOLVING BEHAVIOUR (action)**: action as a reaction to internal or external stress. **MISCELLANEOUS THEMES**: level-specific, largely affective habitual behavioural patterns.