

## Section: Theoretical reviews and research in PPT

### PRIMARY CAPACITIES OF CONTACT AND PLEASURE



#### Ivan Kirillov

MD, PhD, psychiatrist, psychotherapist,  
Master trainer of PPT,  
private practice (Istanbul, Türkiye)

Email: [surfstress@gmail.com](mailto:surfstress@gmail.com)

ORCID: [0009-0005-1701-8367](https://orcid.org/0009-0005-1701-8367)

Received 30.04.2024

Accepted for publication 15.06.2024

Published 08.07.2024

DOI: [10.52982/lkj235](https://doi.org/10.52982/lkj235)

#### Abstract

This article opens a series of four publications designed to initiate a discussion of the author's proposed refinement of the list, definitions, and diagnostic criteria of primary actual capacities postulated by Nossrat Peseschkian, in accordance with recent developments in psychodynamic theory and practice. This first article addresses capacities of contact and pleasure, offering a deeper integrative understanding of related psychodynamics of motivations, cognitions, behaviours, and relationships.

Specification of diagnostic criteria provides therapists with a practical tool for more accurate and objective clinical assessment, personalised interventions, development of self-help tools, and further research.

**Keywords:** Positive Psychotherapy, operationalisation, primary capacities, contact, pleasure

#### Introduction

Nossrat Peseschkian theorised *primary actual capacities* as "basic mental processes" within the emotional domain, influencing the perception of self-worth and other internal aspects (Peseschkian, N., 1977). Based on this, *primary needs* have been hypothesised (Kirillov, 2015) as the "emotional ties" that fuel the subjective meaning of *secondary actual capabilities* shaped by individual and interpersonal experiences (Peseschkian H., Remmers A., 2020).

Originally derived from transcultural studies (Peseschkian 1974, 1977), the primary capacities list has evolved (Peseschkian, N., 1980; Peseschkian, N., Deidenbach, H., 1988) through practice (Table 1.).

Parallel to this, the discussion about the personality structure functions in the psychodynamic tradition (Kernberg 1976, 1977, 1980, 1984; Rudolf 1993) has led to the creation of a reliable and practical structure axis (Freyberger et al., 1998; Rudolf, 1996, 1999, Rudolf et al., 1995, 1997, 2000) in

Operationalized Psychodynamic Diagnostics (OPD). Thus, it has been shown that lower structural integration according to the OPD correlates with:

- Poorer emotional resonance and reliance on others (Rudolf, 1999)
- Reduces therapy outcomes (Strauß, 1997)
- Longer psychogenic illness duration (Rudolf G., 1996)
- Difficulty identifying stable conflict patterns
- ICD-10 personality disorder diagnoses (Nitzgen, Brünger, 2000)

Both primary capacities and personality structure functions:

1) describe ego functions in their relationship with self (reactive mode) and others (active mode);

2) develop in interpersonal relationships, especially with primary caregivers (Peseschkian, 1977; Rudolf, 2002; Rudolf et al., 1995; OPD Task Force 2023);

3) cannot be directly observed and only emotions, look, moves) and subjectively hypothesized by bodily reactions (stress, associated behavior.

**Table 1.**  
**Evolution of Primary capacities**

Peseschkian, 1977	Peseschkian, 1980 (DAI)	Peseschkian, Deidenbach, 1988 (WIPPF)	Kirillov, I., 2015	OPD-3
Contact	Contact	Contact	Contact	ST 1.1; 1.4; 1.3; 1.6; 4.4; 4.3
Sexuality	Sexuality	Sexuality	Pleasure	ST 1.2; 1.5; 2.1; 2.2; 2.4; 2.5; 4.1; 4.2;4.6
Love	Love	Love	Love	ST 4.5; 5.3; 5.4; 5.6
			Care	ST 2.6; 4,3;
Time	Time	Time	Time	
Patience	Patience	Patience		
Trust	Trust/Hope	Trust	Trust	ST 5.5
Hope		Hope		
Confidence				
Doubt				
Certitude				
Unity				
			Meaning	
	Belief/Faith	Faith/meaning	Ideal	ST 2.3; 4.1; 5.1; 5.2
Model				

To address the clinical need for finer differentiation and align primary capacities with the validated OPD structural functions, their list and descriptions were optimised (Kirillov I., 2015) considering the following criteria:

**Activity:** Every Primary Capacity (PC) should reflect an internal mental act.

**Simplicity:** Each PC should be easily operationalized by 2-3 simple aspects (actions), both active (toward others) and reactive (toward self) mode.

**Distinctive Universality:** Each PC should differentiate (from other PPT constructs) fundamental mental processes influencing diverse experiences. *For instance, the capacity to enjoy pleasure underlies not just sexuality but also satisfaction from food, achievement, and various other needs.*

**Comparability:** If possible, it should be comparable with the OPD’s structural dimensions & aspects.

**Disclaimer:** This optimization of the primary capacities is intended to describe and operationalize a minimum, yet sufficient number of primary capacities to describe the significant mental processes needed for practical

diagnostic, clinical reasoning, therapy, and research. Surely, when dealing with a particular patient, the therapist can and should use all richness of language according to the patient’s/client’s understanding.

This optimized list and description of primary capacities were widely discussed in conferences and seminars. It received positive practitioner feedback and preliminarily proved its clinical practicality (Kirillov et al., 2023).

Despite this, the last optimisation of primary capacities remains confusing and calls for further clarification. Given the scope constraints, this article will initiate a four-part series, each delving into a pair of primary capacities governing one of the four areas in the Balance Model: 1) Body (Contact and Pleasure); 2) Relationships (Love and Care); 3) Achievement / Productivity (Time and Trust); 4) Imagination (Meaning and Ideal).

This introductory article will focus on defining and differentiating the needs/capacities for contact and pleasure, operationalizing their diagnosis, and proposing primary therapeutic approaches based on the maturity level of these capacities.

## Methodology

For the sake of brevity and ease of perception, each capacity is described according to a single algorithm:

1. Definition
2. Reactive (self-directed) mode
3. Active (object-oriented) mode

Each of the capacity modes is presented in the following order:

A) sub-capacities and the features of their manifestation specific for each of the three integration levels are summarized in a single table.

The PPT differentiates three integration levels of primary capacities correlated with stages of interaction (*low level - attachment, moderate - differentiation, high - detachment*). In addition to that, OPD identifies the *disintegrated* level. Both assess integration through social interactions and life experiences. The well-integrated structure allows for self-regulation and healthy object relations, even under stress. Conversely, a low integrated structure, whether due to underdevelopment or situational factors, is ineffective.

B) How to ask about it? Here are some examples of questions that can help the patient and therapist recognise the specifics of sub-capacities and their impact on the patient's life and the therapeutic relationship.

Finally, some tentative ideas for therapeutic interventions according to the level of ability development are presented.

## I. Contact

### I.1. Definition

**Contact** is defined in "Oxford Languages" as "a state of physical touching" or "the action of communicating or meeting."

Nossrat Peseschkian (1977) suggested that contact is "the ability to establish and cultivate social relationships", yet it can be as well "directed towards animals, plants, or things". Later (Peseschkian, 1986) he redefined it as "the ability and willingness to turn to other people, parents, partners, colleagues, and social groups, and also to animals, plants, and objects". It is important to differentiate the PC of Contact from "Contact" as an area of life and "dealing with the conflict" that rather refers to "the ability to

develop and maintain relationships: with oneself, one's mate, family, other people, groups, social classes, and foreign cultural circles, and animals, plants, and things." (Peseschkian, 1980). To avoid confusion in later literature, this area of life is more and more often named a "Relationship" (Peseschkian, H., Remmers, A., 2020)

Here, the primary actual capacity of *contact* is defined in line with the recent N. Peseschkian description as *the ability to focus, shift, and sustain attention, differentiating and naming the characteristics (similarities and differences), states, emotions, feelings, fantasies, thoughts, etc. of oneself and others; to ultimately form integrated and accurate perceptions of self, other people, and external objects.*

A **prerequisite** of the mature contract capacity is an ability to distinguish self from object.

**The instrument** of contact is active attention directed by triggers, associations, thoughts, words, and questions.

The contact can be *reactive* or *active*.

### I.2. Reactive Contact

**Reactive contact** is directed toward the self by self and others. It is described by 3 sub-capacities (aspects)

#### I.2.A. Sub-capacities of reactive contact (Table 2)

- **to perceive self-experiences** – to notice and name one's own states, emotions, feelings, fantasies, thoughts, actions, etc.
- **to integrate self-perception** and describe it as a realistic, consistent, and stable physical, mental and sexual image of self.
- **to accept and appreciate other's attention.**

#### I.2.B. How to ask about reactive contact?

##### Sub-capacity to perceive self-experiences.

How do you feel now?

How did you feel in that situation?

Can you describe this aspect of your character?

Are you always able/willing to describe your feelings?

Questions for the therapist about countertransference

Do you feel emotionally moved by the

patient's story or does it leave you feeling empty and detached?  
 Can you describe the patient's emotional moves?

Can you describe the change in the patient's feelings during the interview?

**Table 2.**  
**3 levels of integration of sub-capacities of reactive contact**

Integration level Characteristics	HIGH	MEDIUM	LOW
	Even in stressful emotional conflict, one:	The ability is limited (especially under stress):	The capacity is little or not available (even with help):
<b>Perception of self-experiences</b>	- notices and names a wide range of sensations, emotions, impulses, and inner processes;	- tends to describe actions instead of experiences.	- almost or totally not able to reflect own sensations, emotions, impulses, and inner processes
<b>Integrated self-perception</b>	- perceives and describes oneself realistically, holistically, and consistently	- experiences oneself as inconsistent and varying across situations.	- experiences fragmented and disconnected aspects of self in different situations.
<b>Acceptance and appreciation of other's attention</b>	- accepts and appreciates the attention of others. - copes with the stress of it and its emotional coloring - accepts and integrates other's feedback regarding one's own body.	- perceives attention to oneself as an intrusion - feels unsatisfied. - takes other's feedback regarding one's own body as an attack or offence.	- impulsively avoids the attention of others that causes intolerable stress, fear, and aggression.
<b>The predominant emotions</b>	- joy, curiosity, pride... - occasionally: fear, contempt, anger, disgust, sadness, guilt, and shame.	- difficult feelings, anxiety, anger, fear, frustration, depression, self-deprecation. - joy, curiosity, pride, etc. are rare and fleeting.	- agitation, irritation, alienation, emptiness, depression, contempt, disgust, anger, or fear.
<b>Coping &amp; defense</b>	- quickly understands and constructively uses own states.	- strives for other's attention to validate own feelings and identity. - ignores/avoids strong feelings, projects them onto others to stabilize oneself.	- impulsively seeks attention to validate own existence. - explains bursting out unbearable affects by external events and other's actions.
<b>EXAMPLES</b>			
<b>Therapist:</b> How do you feel about Anna?	<b>Client:</b> I feel joyful excitement when I think about her or meet her. Sometimes, I get angry at her tardiness, but a minute later, I enjoy her company again.	<b>Client:</b> I do everything for her, but she doesn't care about me—she's always late. Then she just paralyzes me with her gaze, and I can't say anything.	<b>Client:</b> She's driving me crazy! I'll die if she doesn't answer a text. I don't want to see her. We have crazy sex, but she pisses me off. I'm leaving. It starts all over again.
<b>Therapist:</b> Tell me, what kind of person are	<b>Client:</b> I am 40 years old, a healthy man. Still in shape. Agile and move smoothly. I	<b>Client:</b> In my 40s, I look 30 years old, and I am very positive. Thanks to	<b>Client:</b> I'm a great computer guy, but I hate when people ask

you?	<i>am usually calm and happy. Sometimes I am sad about things that didn't work out or angry at myself for making mistakes, but I quickly switch to the joys of life.</i>	<i>HWL and sports, women notice me more than ever. Alas, my relationships are destroying me with violent feelings.</i>	<i>me that. I'm a person, yet everyone is only interested to fix their laptop. <b>Therapist:</b> Okay. Tell me about your personality. <b>Client:</b> I'm good with computers.</i>
------	--	--	--

### Sub-capacity to integrate self-perception.

What kind of person are you?

Do others perceive you the same way you are?

Do you perceive yourself differently in different situations?

Do you present yourself differently in different situations to make the best impression?

Questions for the therapist about

countertransference

Are you captivated by the way the patient describes himself/herself?

Does this description make sense to you?

Does this description seem plausible?

Does the patient's story make you uncomfortable?

### Sub-capacity to accept and appreciate other's attention.

Do you seek the attention of others?

How do you perceive the attention of others?

How do you cope with it?

Questions for the therapist about

countertransference

Do you have a sense that the patient is demanding or avoiding your attention?

### 1.3. Active Contact

**Active contact** is directed toward objects and other people. It is described by 3 sub-capacities (aspects)

#### 1.3.A. Sub-capacities of active contact (Table 3)

**to perceive an object's characteristics:** to differentiate and name physical features, states and emotions, behaviour and speech of other people and objects from the outside, apart from oneself, one's own experiences, emotions, and impulses.

**to integrate object perception** and describe it vividly, realistically, and consistently as a stable physical and psycho-

sexual image, separate from oneself.

**to contact with an object.**

#### 1.3.B. How to ask about active contact?

##### Sub-capacity to perceive object's characteristics.

Do you understand how N feels in this situation?

What else can you tell about this character trait of N?

Is it easy for you to adjust quickly to others?

Does your perception of N depend on your emotional state?

Questions for the therapist about

countertransference

How well do you understand the patient's descriptions of other people's traits, feelings, and mannerisms?

Do you always understand whether the patient is talking about him/herself or others?

##### Sub-capacity to integrate object perception.

What kind of person is N?

Is it true that when you see this trait in someone, you expect the worst/best from that person and cannot change this attitude, regardless of reality?

Do you perceive N differently in different situations?

Questions for the therapist about

countertransference

Does it seem to you that the patient mixes up his/her description of self and others?

Is the patient's account of other people interesting to you?

Do you find the patient's accounts believable?

Can you imagine the people the patient describes easily? Do they evoke a clear emotional response?

##### Sub-capacity to accept and appreciate other's attention.

How do you feel when you need to address someone?

Is it easy for you to maintain contact with other people?  
 Is it easy for you to maintain interest and attention to other people and what they say?  
 How do you cope with it?  
 Questions for the therapist about

countertransference  
 Do you have a sense that the patient is intruding too much into your space or pushing you away?

**Characteristics**

**Table 3.**  
**3 levels of integration of sub-capacities of active contact**

<b>Integration level</b> <b>Characteristics</b>	<b>HIGH</b> Even in stressful emotional conflict, one:	<b>MEDIUM</b> The ability is limited (especially under stress):	<b>LOW</b> The capacity is little or not available (even with help):
<b>Perception of an object's characteristics</b>	- notices, distinguishes, names a wide range of physical features, states and emotions, impulses, behaviors, and speech of other people and objects, separately from one's own.	- perceives other people's affects, impulses, and thoughts only partially separated from one's own without violating his/her sense of security.	- attributes his/her own affects unbearable for the Ego to the object.
<b>Integrated object perception</b>	- describes a coherent and stable image of other people and objects realistically, consistently, and separate from self, without the distortions of romance and prejudice.	- perceives and describes the image of the object simplistically, through the prism of his/her own needs, reducing it to actions often exaggeratedly good or bad.	- perceives and describes objects depending on one's own needs and fears as too good or bad - insolubly contradictory.
<b>Contact with an object</b>	- vividly interested, - mutually comfortable. - with clear boundaries.	- separation anxiety. - patient tends to invade another's space.	- experiences ambivalent overwhelming impulses: to invade and repel.
<b>The predominant emotions</b>	- inspiration, engagement, curiosity happiness. - occasionally sadness fear and irritation.	- anxiety, fear, anger, contempt, loneliness. - occasionally, happiness and tenderness.	- agitation, emptiness, depression, contempt, disgust, anger, or fear.
<b>Coping &amp; defense</b>	- quickly understands and utilizes own emotions.	- intrudes another's space or avoids/push it away.	- impulsively invades and repels; projects.
<b>EXAMPLES</b>			
<i>Therapist: How do you think Anna feels about you?</i>	<i>Client: She has warm feelings for me, but my declaration of love surprised her. She has taken a pause to sort out her feelings and has been careful not to</i>	<i>Client: Since I confessed my love to her, I have no idea. I ask her</i>	<i>Client: She's obsessively in love with me. I confessed my love</i>

	<i>give me too much hope since then.</i>	<i>again and again. She avoids answering. I snap and run away. But I need clarity, which is why I called her at 2:30 this morning.</i>	<i>to her. Now she is going crazy: she avoids me to make me long to see her. I call and text every ten minutes. If she replies I scream and push her away.</i>
<b>Therapist:</b> Can you describe Anna? What do you like about her?	<b>Client:</b> She is enchanting: slender, graceful, and delicate, with sky-blue eyes and a captivating smile. Her smile persists even when she feels down, a selfless act to spare my feelings. Yet, I sense her hidden struggles. At times, tension betrays her fatigue.	<b>Client:</b> Anna is so beautiful. She drives me crazy with her eyes. That's why I hardly ever talk to her. <b>Therapist:</b> Can you tell me more about her? <b>Client:</b> She's just great! I have no doubt that she is the One, the Perfect One.	<b>Client:</b> I don't know. I'm just crazy about her. I need her presence. There's such electricity between us that we start yelling at each other as soon as we meet. She drives me crazy, and I push her away.

## II. Pleasure

*Pleasure is the first good. It is the beginning of every choice and every aversion.*

*Epicurus*

### II.1. Definition

Nossrat Peseschkian identified the primary capacity/need of sexuality. Yet, while sexuality is indeed one of the basic instincts, it's not the only one in the range of other libidinous drives such as hunger, thirst, elimination, aggression, etc. (APA Dictionary of Psychology). Therefore, postulating sexuality as the primary capacity, one would have to consider capacities of eating, drinking, excretions, aggression, etc. Instead, it is suggested (Kirillov, I, 2021) to focus on pleasure as the universal principle of self-regulation driving, rewarding and priming satisfaction of any need.

**Pleasure** is “a state of feeling or being happy or satisfied” (Oxford Learners Dictionaries); “the emotion or sensation induced by the enjoyment or anticipation of what is felt or viewed as good or desirable.” (APA Dictionary of Psychology).

In this article, pleasure is defined by clinically distinctive criteria correlated with the structural functions of perception of self and objects and regulation of self and relations in the OPD-3.

**Pleasure/ enjoyment** - capacity to distinguish one's emotions from those of others; to connect one's own and other's emotions to their triggers and outcomes; to regulate (replay, predict and discontinue) emotions; to enjoy what is pleasant and consider/avoid what is unpleasant or painful; to make others pleasant and share enjoyment with them.

A **prerequisite** of the mature capacity of pleasure is a sufficiently developed capacity to contact experience and recognize the full range of emotions, including hate, fear, and other uneasy affects.

**The instruments** of pleasure are abilities:

- to notice and name one's own and others' emotions,
- to differentiate emotions, their triggers and outcomes,
- to prolong, discontinue, amplify and predict emotions
- integrate emotions into one's concepts, and identities.

The pleasure, as well, can be *reactive* or *active*.

### II.2. Reactive Pleasure

**Reactive pleasure** is directed toward the self by self and others. It is described by 3 sub-capacities (aspects)

**II.2.A. Sub-capacities of reactive pleasure**  
(Table 4)

**to differentiate one’s own emotions**, allowing and experiencing the full range of them, distinguishing them from those of others, from triggers causing them, and from resulting behaviours.

**to enjoy one’s own physical self**, feeling alive in one’s realistically perceived own body.

**to regulate one’s own emotions**: to replay and discontinue, predict and consider them; to integrate and ambivalent affects.

**II.2.B. How to ask about reactive pleasure?**

**Sub-capacity to differentiate one’s own emotions.**

To what do you usually respond with pleasure? (sadness, anger, fear, etc.)?

What emotions do you feel in this situation?

What exactly triggers this emotion? Why?

Can you always describe your emotions, their causes and outcomes?

Questions for the therapist about countertransference

Can you understand the patient’s emotions in different situations and during the session?

Are you experiencing while with the patient understandable (or not) emotions related (or not) to the events being described or to the course of therapy?

Can you easily (or not) distinguish the patient’s emotions from your own and/or other’s?

**Table 4.**  
**3 levels of integration of sub-capacities of reactive pleasure**

<b>Integration level</b> <b>Characteristics</b>	<b>HIGH</b> Even in stressful emotional conflict, when strong emotions driving behavior, one:	<b>MEDIUM</b> The ability is limited (especially under stress):	<b>LOW</b> The capacity is little or not available (even with help):
<b>Differentiation of one’s own emotions</b>	<ul style="list-style-type: none"> <li>- experiences, notice and names the full range of emotions.</li> <li>- distinguishes own emotions from those of others.</li> <li>- distinguishes own emotions from their triggers and resulting behaviors.</li> </ul>	<ul style="list-style-type: none"> <li>- perceives and describes emotions in a limited way.</li> <li>- ascribes responsibility for one’s own emotions to other people and external circumstances.</li> <li>- takes emotions as a "moral compass" for expectations and actions.</li> </ul>	<ul style="list-style-type: none"> <li>- experiences painful overwhelming undifferentiated states and anxiety.</li> <li>- unable to distinguish the ownership of emotions and their triggers.</li> <li>- explain emotions only in a formulaic way.</li> </ul>
<b>Enjoyment of one’s own physical self</b>	<ul style="list-style-type: none"> <li>- enjoys a realistic sense of being alive in one’s own body.</li> </ul>	<ul style="list-style-type: none"> <li>- often not notices unstable pleasures.</li> <li>- greedily craves and seeks for, protects, and consumes external pleasures.</li> </ul>	<ul style="list-style-type: none"> <li>- own body and it’s senses are often experienced as unpleasant and strange.</li> <li>- compulsively seeks for objects of pleasure but can only enjoy them at the moment of direct contact.</li> </ul>
<b>Regulation of one’s own emotions</b>	<ul style="list-style-type: none"> <li>- replays and discontinues own emotional states.</li> <li>- integrates ambivalent affects.</li> <li>- predicts and considers own emotional reactions.</li> </ul>	<ul style="list-style-type: none"> <li>- perceives own emotions as abnormal, disturbing, and uncontrollable (natural) reactions for which one cannot be responsible.</li> </ul>	<ul style="list-style-type: none"> <li>- unable to bare out bursting or fading affects.</li> </ul>
<b>The predominant emotions</b>	<ul style="list-style-type: none"> <li>- pleasant physical sensations, finely discernible states, and</li> </ul>	<ul style="list-style-type: none"> <li>- predominating discomfort, pain, unhappy emotions (fear,</li> </ul>	<ul style="list-style-type: none"> <li>- overpowering threatening uncomfortable, and</li> </ul>

	emotions (joy, curiosity, pride, etc.).	anger) and states (anxiety, depression).	painful affects.
<b>Coping &amp; defense</b>	- takes responsibility for one's own emotions and restores the comfort.	- represses, controls, and avoids emotions.	- avoids any experience as a potential source of affects. - fading affectivity.
<b>EXAMPLES</b>			
<b>Therapist:</b> What emotions does Andrei evoke in you?	<b>Client:</b> I feel good with him: I laugh a lot, I enjoy his care, I get excited by his body and brains. Sometimes I get freaked out by his flirting with other women, I have a hard time trusting people in general, but he wouldn't be himself without it, and I don't know if I'd like it.	<b>Client:</b> He turns me on, sometimes pleases me with his care. He pisses me off by flirting with other women. How can that be? He needs to realize it's inappropriate and stop.	<b>Client:</b> My whole life is love for him. He tears my heart to pieces with his flirting with other women. It hurts! It's my cross to bear.
<b>Therapist:</b> How do you feel physically?	<b>Client:</b> Most of the time, I feel good, strong, energetic, and happy in my body. Of course, I sometimes get tired or sick and experience discomfort, pain, strong emotions or unpleasant sensations. But even then, I am somehow able to stay content in my body.	<b>Client:</b> When he's not around, I feel sad. I can't get my mind off the fact that he's flirting with someone else. I call or text him. If he doesn't answer, I'm afraid he's dumped me. I try to be with him all the time and revel in every moment of intimacy.	<b>Client:</b> All my time is spent in painfully anxious anticipation of seeing him, calling or texting him. I would do anything just to hear his voice or look at him. Only in these moments do I feel calm for a few minutes, and then I am filled with fear that everything will end.

### Sub-capacity to enjoy one's own physical self

How do you usually feel yourself?

Do you always feel the same way?

Do you usually enjoy your physical sensations?

Questions for the therapist about countertransference

How do you feel physically in the patient's presence?

What do you feel about the patient's appearance and physical appearance/condition?

### Sub-capacity to regulate one's own emotions

Can you control (replay, amplify or discontinue) your emotions?

Questions for the therapist about countertransference

Do you feel secure with the patient?

Do you feel that the patient is inhibited and suppresses his/her emotions?

Do you feel that the patient is not coping well

with his/her emotions?

### II.3. Active Pleasure

**Reactive pleasure** is directed toward objects and other people. It is described by 3 sub-capacities (aspects)

#### II.3.A. Sub-capacities of active pleasure (Table 5)

- **to empathize** with the full range of other people's emotions, temporarily engaging in their inner experiences, not confusing them with one's own mental life, and to communicate one's own empathy to those he/she empathizes with.
- **to differentiate others' emotional experiences**, their triggers, and resulting behaviours; to forecast other's emotional reactions to one's own actions.
- **to mutually enjoy** lively and stimulating

experiences (tenderness, sex, conversation, aesthetic pleasure, food, etc.),

– **II.3.B. How to ask about active pleasure?**

**Sub-capacity to empathize.**

Can you empathise with N?

Can you describe N's emotions in this situation?

Can you talk with N about his/her feelings?

Questions for the therapist about countertransference

Do you understand the emotional reactions of the people described by the patient?

How do you feel about the descriptions of the emotional lives of the people around the patient?

**Sub-capacity to differentiate others' emotional experiences.**

What exactly is causing these emotions of N?

How do N's emotions affect her/his behaviour?

How will N react to your actions?

Questions for the therapist about countertransference

Do you understand the causes and outcomes of the emotional reactions of people described by the patient?

Do you feel that the patient is (in)adequately adjusting to the reactions of other's (including you)?

**Sub-capacity to mutually enjoy.**

How do you react to N's emotions?

Do you like to make N feel good (tenderness, sex, pleasant time together)?

How do you feel being alone with N?

Questions for the therapist about countertransference

What do you feel in contact with the patient?

Do you feel that the patient strives to make others experience pleasure/comfort?

Do you feel that the patient enjoys and shares other's pleasure?

**Discussion**

The operationalization of contact and pleasure capacities enables optimized therapeutic interventions for integrating these primary abilities, fostering resilience and effective coping mechanisms for both internal and external challenges.

Here are some suggestions for differentiated interventions to spark therapeutic creativity:

*1. Ideas for the development of low-integrated capacities for contact and pleasure*

For patients with **low integration** of primary capacities, therapy primarily focuses on transference-based psychodynamic and body-oriented interventions. The therapist acts as a supportive figure compensating for missing mental function, consistently mirroring and validating the patient's states and emotions. This new experience counteracts destructive patterns learned from inadequate attachment and fosters a healthier self-image and emotional regulation.

**Table 5.**  
**3 levels of integration of sub-capacities of active pleasure**

Integration level	HIGH	MEDIUM	LOW
<b>Characteristics</b>	Even in stressful emotional conflict, when strong emotions drive behavior, one:	The ability is limited (especially under stress):	The capacity is little or not available (even with help):
<b>Empathy</b>	<ul style="list-style-type: none"> <li>- empathizes with the full range of other people's emotions.</li> <li>- temporarily engages in other's inner experience without confusing them with one's own mental life.</li> <li>- can communicate one's own empathy to those</li> </ul>	<ul style="list-style-type: none"> <li>- empathizes limitedly or, too much involved.</li> <li>- perceives other people's emotions mixed with his own mental experiences.</li> <li>- poorly communicates one's own emotional understanding to the</li> </ul>	<ul style="list-style-type: none"> <li>- has trouble distinguishing other people's emotions from own once.</li> <li>- afraid of dissolving into other people's emotions.</li> <li>- unable to understand other's emotions.</li> </ul>



	he/she empathizes with.	person he/she tries to empathize with.	
<b>Differentiation of other's emotional experiences</b>	<ul style="list-style-type: none"> <li>- notices other people's emotions, their triggers and resulted behaviours.</li> <li>- forecasts other's emotional reactions to ones' own actions.</li> </ul>	<ul style="list-style-type: none"> <li>- discerns only intense emotions in others.</li> <li>- interprets and anticipate their causes and resulted behaviors through personal experiences or others' attitude to oneself.</li> </ul>	<ul style="list-style-type: none"> <li>- notices not other people's emotions, but one's own impulses that control his/her perception, reasoning, anticipation and behavior.</li> </ul>
<b>Mutual enjoyment</b>	<ul style="list-style-type: none"> <li>- co-experience joy by empathic mirroring.</li> </ul>	<ul style="list-style-type: none"> <li>- competes for pleasure: "one either gives pleasure or takes it"</li> </ul>	<ul style="list-style-type: none"> <li>- perceives another's pleasure as an unspecified threat to his own</li> </ul>
<b>The predominant emotions</b>	<ul style="list-style-type: none"> <li>- joy, own and shared (mirrored) pleasure, satisfaction.</li> </ul>	<ul style="list-style-type: none"> <li>- perceives other people's emotions painfully as difficult experiences; yet absence of strong emotions experiences as indifference</li> </ul>	<ul style="list-style-type: none"> <li>- jealousy, irritation, wariness.</li> </ul>
<b>Coping &amp; defense</b>	<ul style="list-style-type: none"> <li>- joyfully generates pleasure to others.</li> </ul>	<ul style="list-style-type: none"> <li>provokes strong feelings to compensate for lack of emotional feedback;</li> </ul>	<ul style="list-style-type: none"> <li>- avoids emotional interactions</li> </ul>
<b>EXAMPLES</b>			
<b>Therapist:</b> How do you think Andrei feels with you?	<b>Client:</b> He is at ease with me: I don't take offense to his jokes. I can tease him, and I don't "load" him with guilt. Our conversations stimulate him. He gets excited like a child when I get excited about his body or jealous of him. He gets annoyed by my tardiness but quickly forgets about it.	<b>Client:</b> I feel loved at times, and then he insults me with jokes. He also clearly enjoys provoking me with his flirting. But he gets mad when I'm late. I'm sometimes late to punish him for flirting. I like to see the power of his love.	<b>Client:</b> He's head over heels in love and trying to seduce me with his humor. I'm not like that! I see him flirting with everyone. It pisses me off. How dare he question me about my tardiness? I won't talk to him for a week.
<b>Therapist:</b> Do you enjoy pleasing him?	<b>Client:</b> Oh, yeah! I just can't help myself. The more pleasurable it is for him, the more I get aroused and enjoy the process. When he flinches in response to my touch, a wave of bliss sweeps over me.	<b>Client:</b> It's my only weapon. He's always waiting for it. He loves it. What's in it for me, who's going to take care of me?	<b>Client:</b> Why should he enjoy himself at my expense when I am suffering. I often jump up at night and run to the kitchen to get chocolate and eat whatever I can find. It tears me up

To maximize the outcome, interventions should be mainly conducted during sessions, with simple and manageable tasks assigned for intersession practice

## 1.1 Contact

### Psychodynamic interventions

- **Create a Safe Space and Time** for the patient to unfold and explore experiences at his/her own pace.

1 **Be Fully Present and Attentive**, offering genuine eye contact and attunement to his/her emotional states. Respond authentically and flexibly to his/her needs while maintaining healthy boundaries.

2 **Be Interested, Accepting and Encouraging**, striving to understand the patient's experiences.

### Body oriented interventions

- **Notice and Name** the patient's and your own states, emotions, and impulses: *"You seem excited. Is that so?" "I feel tired. Do you notice that?"*

1 **Facilitate the Patient's Practice of Focusing** on specific sensations of contact with his/her own experiences and external objects: *"Follow your breathing: feel the air entering your nose, filling your lungs, and leaving your body." "Describe the face in this photo."*

### Cognitive interventions

**Foster Mentalization:** Encourage the patient to reflect on his/her state and those of others. As such a request will likely overload the patient's unintegrated capacity, help by offering prompting choices: *"Do you think she looks relaxed or tense?" or "Are you feeling calm or excited? Angry or afraid?"*

**Ask the Patient to Measure** his/her and others' levels of stress, tension, excitement, etc., in different situations.

### Behavioral interventions

Ask the patient to set the 2-3 daily notifications to focus on his/her breathing within a minute.

Ask the patient to examine himself or one inanimate or animate object once a day and to record 3-5 of its specific properties.

If/when the patient is ready, ask him/her to meet other people's eyes for 1-2 sec 2-3 times daily.

## 1.2 Pleasure

### Psychodynamic interventions

**Empathically mirror and validate** patient's states.

**Compassionately smile**, appreciating unfolding patient's transference and unconscious processes.

**Contain your emotions** to not overshadow the patient's experience, and utilize them when appropriate to foster the therapeutic dynamic.

### Body oriented interventions

**Acknowledge the Emotions** of the patient and others (including yourself), and help to express, differentiate, and integrate them constructively.

**Train the Patient to Physically Embody Emotions** one by one in facial expressions, posture, and voice.

### Cognitive interventions

**Educate the Patient About Emotions** by showing one-by-one images of facial expressions for different emotions and discussing their nature and functions.

**Foster Emotion Recognition**, encouraging the patient to identify and articulate his/her and other's emotions. Ask, when appropriate: *"Can you describe the emotion you're (I am) experiencing right now (or felt in that situation)?"*

### Behavioral interventions

Ask the patient to practice emotional facial expressions, using his/her mirror reflection for feedback and adjustment. Encourage the patient to describe the feelings associated with each emotion.

If/when the patient is ready, ask him/her to meet other people's eyes with a smile for 1-2 sec 2-3 times a day.

Ask the patient to notice one's own and other's emotions.

## 2. Ideas for the development of medium-integrated capacities for contact and pleasure

If/when the patient initially demonstrates or progresses in therapy to a **medium level of**

**capacity integration**, the therapist can leverage these established abilities and introduce more challenging (cognitive and behavioural) interventions, fostering the patient's internal processes to further empower him/her towards greater autonomy.

Therapy for these clients focuses on strengthening their ability to differentiate their own experiences and emotions from those of others, exploring the impact of emotions on their sense of self, behavior, and interactions, taking ownership of their reactions, developing self-regulation skills, discovering and dealing with their inner conflicts and destructive patterns of relationships.

## 2.1 Contact

### Psychodynamic interventions

**Navigate the Patient's Curiosity (Attention)** with questions to explore his/her *contact* with self and others, related concepts, conflicts, and their biographical origins.

**Encourage the Patient's Ability to Cope** with overloaded capacity to *contact self and others*, and prompt him/her to optimize those.

**Attribute Any Positive Development to the Patient's Efforts, Capacities, and Recourses** (Asay T, Lambert M, 2001).

### Body oriented interventions

What do you feel now? What is your automatic thought? What do you want to do? What do you do?

When have you experienced a similar state before?

How can you describe yourself (your partner, me, this object, etc.)? Let's unpack your observations.

How can you describe your (your partner's, mine) behaviour?

**Encourage the practice** of self-awareness, conscious movement, progressive relaxation and belly breathing.

### Cognitive interventions

**Use Questions to Encourage the Patient to Recognize Realistic Positive Functions** of physical experiences (especially unpleasant ones), avoidance of contact with self and others, personal boundaries, active listening, and observation.

**Discover and Use the Patient's Symbols, Metaphors, and Narratives** associated with contact with self and others to optimise it.

**Focus on the Patient's Expectations** by verbalizing positive, realistic criteria for desired therapy outcomes and development of the capacity to contact.

### Behavioral interventions

**Engage the Patient in Active Practice and Experimentation** with the contact between sessions, collaboratively defining realistic actions to practice and discussing gained experience at the next session.

**Encourage the Patient to Journal** his/her observations and experiments contacting self and others

## 2.2 Pleasure

### Psychodynamic interventions

**Navigate the Patient's Curiosity (Attention)** with questions to explore his/her and others' *emotions*, their triggers, resulting behaviours, their biographical origins, and prognostic practicality.

**Encourage the Patient's Ability to Cope** with his/her own and others' emotions, and prompt him/her to optimize those.

### Body oriented interventions

What are you feeling in your own body right now? Let's explore the different emotions or sensations present.

What am I feeling right now? What evidence supports your assumptions?

In that situation, how do you think N felt towards you? What led you to that belief?

### Cognitive interventions

**Using Questions Encourage the Patient to Recognize the Realistic Positive Functions** of different emotions, both of self and others, and the different types of use and misuse of them.

**Discover and Use the Patient's Symbols, Metaphors, and Narratives** associated with his/her own and others' emotions to optimise it.

**Focus the Patient's Expectations** by verbalizing positive, realistic criteria for desired therapy outcomes and the development of the capacity of pleasure.

**Prompt the Patient to Take Ownership of**

**his/her Reaction.** For instance, if one claims that another "makes him/her angry", the therapist can challenge him/her: "Who is actually getting angry? What thoughts boost the anger? What do you hope to achieve by anger?".

### Behavioral interventions

**Engage the Patient in Active Practice and Experimentation** with pleasure between sessions, collaboratively defining realistic actions to practice and discussing gained experience at the next session.

**Encourage the Patient to Journal** his/her observations and experiments with his/her own and others' pleasure.

### *3. Ideas for the development of high-integrated capacities for contact and pleasure*

If/when the patient enjoys **high integration of contact and pleasure capacities**, therapy shifts towards empowering the patient through active experimentation and practice in physical, behavioural, mental, and interpersonal dimensions. This cultivates flexible and sustainable health resources to address significant external and internal challenges.

Therapeutic approaches include:

**Active simulation and practice** of states and emotions in diverse scenarios to enhance decision-making and resilience.

**Exercising** mental capacities to recognize, understand, and articulate experiences, fostering self-awareness and emotional regulation, mutually beneficial and satisfying relationships.

Goals of therapeutic collaboration:

**Cultivate mindful awareness** with "evenly hovering attention" (Freud S., 1912) to self, others, objects, and their changing features and states "on the go".

**Empathize, compassionately** engaging with others' experiences, differentiating them from one's own.

**Effectively communicate empathic understanding.**

**Enhance understanding and articulation** of one's own and others' experiences, reactions, and emotions, including their underlying causes and anticipated impacts.

**Take ownership** of one's own reactions.

**Master self-regulation.**

**Identify inner conflicts and relationship patterns.**

**Cultivate integrated, vivid and realistic perception and reflection** of self and others

### 3.1 Contact & Pleasure

#### Psychodynamic practice & experimentation

**Trust the Client's Perception, Reactions, Capacities, and Learning Style.** Strive to objectivize, actualize, and develop their capacities and self-help tools.

**Engage the Client in Informed Decision-making, Active Practice and Experimentation.**

**Encourage the Client to Give You Feedback.**

**Share Your Insights/Feedback** if they are beneficial and relevant to the client.

#### Bodily practice & experimentation

Breathing techniques and dynamic meditation.

Embodiment (physical experience) of new concepts, algorithms and states.

#### Cognitive practice & experimentation

Active simulation by means of focussed imagination of various situations unfolding by different scenarios, states, thoughts, images, emotions, impulses, action algorithms, their outcomes, etc. to facilitate decision-making.

Autogenic training, including "programming" new concepts and resourceful introjects and narratives.

#### Behavioral practice & experimentation

Active practice, exploration, and optimisation of various scenarios, states, thoughts, images and emotions to condition aimed states, behaviours, relationships and outcomes.

### Conclusions

Exploring primary capacities offers nuanced insight into the psychodynamics of human motives and the root causes of inner conflicts, behavioral problems, relationship challenges, and emotional vulnerabilities. Such a differentiated understanding of different levels of capacity integration allows the therapist to

plan and perform focused therapeutic interventions that foster lasting change beyond mere behavioral modifications and symptom management.

The detailed operationalization of primary capacities presented in this article, based on the example of Contact and Pleasure and enriched by the illustrative dialogues, offers an easy-to-use framework for comprehensive assessment, differentiated psycho-socio-biological diagnostic, clinical reasoning, personalized treatment planning, interventions, self-help facilitation and further research.

Suggested principles and ideas for specific psychodynamic, body-oriented, cognitive and behavioral interventions provide an insightful model for further therapeutic creativity and experimentation.

While promising, this model requires further research to solidify its empirical foundation and practical efficiency. Its potential for transforming therapeutic practice and promoting personal growth is intuitively obvious and has already proven helpful in different practices, but systematic scientific validation across diverse populations and exploration of various therapeutic applications are crucial for its future development.

## References

- [1]. **AMERICAN PSYCHOLOGICAL ASSOCIATION.** *APA Dictionary of Psychology.* URL: <https://psycnet.apa.org/record/2006-11044-000> Accessed: 11.06.2024
- [2]. **ARBEITSKREIS OPD (HRSG)** (1996) *Operationalisierte Psychodynamische Diagnostik. Grundlagen und Manual.* Huber, Bern
- [3]. **ARBEITSKREIS OPD** (2023). *OPD-3 – Operationalisierte Psychodynamische Diagnostik: Das Manual für Diagnostik und Therapieplanung.* Bern: Hogrefe.
- [4]. **ASAY, T., LAMBERT, M.** (2001). "Empirische Argumente für die allen Therapien gemeinsamen Faktoren: Quantitative Ergebnisse", in M. Hubble, B. Duncan und S. Miller: "So wirkt Psychotherapie – Empirische Ergebnisse und praktische Folgerungen", Verlag modern lernen
- [5]. **EPICURUS** (1993) Letter to Menoeceus. In *The Essential Epicurus: Letters, Principal Doctrines, Vatican Sayings, and Fragments*, translated by Eugene O'Connor, 26-41. Buffalo, NY: Prometheus Books.
- [6]. **BENEDETTI, F.** (2011) The Patient's Brain. The Neuroscience behind the Doctor-Patient Relationship. Oxford, Oxford University Press.
- [7]. **EGBERT, L.D., BATTIT, G.E., WELCH, C.E., BARTLETT, M.K.** (1964) Reduction of postoperative pain by encouragement and instruction of patients. *N Engl J Med.*
- [8]. **FREUD S.** (1912) Recommendations to physicians practicing psychoanalysis. in *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol. 12*, ed J. Strachey (London: Hogarth Press; ), 109–120.
- [9]. **FREUD, S.** (1895). A Project for a Scientific Psychology (Standard Edition, Vol. 1, pp. 283-397). London: Hogarth.
- [10]. **FREYBERGER, H.J., SCHNEIDER, W., HEUFT, G., SCHAUBURG, H., SEIDLER, G. H.** (1998). Zur Anwendbarkeit, Praktikabilität, Reliabilität und zukünftigen Forschungsfragestellungen der OPD [On the applicability, practicability, reliability and future research questions of the OPD]. In: *Schauburg, H., Freyberger, H. J., Cierpka, M., Buchheim, P., (Hrsg.): OPD in der Praxis. Konzepte, Anwendungen, Ergebnisse der Operationalisierten Psychodynamischen Diagnostik.* Berlin: Huber. [in German]
- [11]. **KERNBERG, O. F.** (1980). *Internal world and external reality. Object relations theory applied.* New York: Jason Aronson.
- [12]. **KERNBERG, O. F.** (1976). *Object relations theory and clinical psychoanalysis.* New York: Jason Aronson.
- [13]. **KERNBERG, O. F.** (1984). *Severe personality disorders. Psychotherapeutic strategies.* New Haven: Yale University Press.
- [14]. **KERNBERG, O. F.** (1977). The structural diagnosis of borderline personality organisation. In; *Hartocollis, P. (Ed.), Borderline personality disorder*
- [15]. **KIRILLOV, I.** (2015). *Positive Psychotherapy in progress. Part 1: The theoretical reflections.* Moscow: Moscow Center of Positive Psychotherapy.
- [16]. **KIRILLOV, I.** (2021). *Basics of Positive Psychotherapy.* Moscow: Academy of Transcultural Psychotherapy, Strana OZ.
- [17]. **KIRILLOV, I., EFREMOVA, P., DOBIALA, E., PLESHAKOV, I.** (2023). Primary Capacities as a Predictor of Perceived Stress, Anxiety, and Depression in the Pandemic Crisis of Covid-19. *The Global Psychotherapist*, Vol. 3, No. 2, pp. 19-29
- [18]. **NITZGEN, D., BRÜNGER, M.** (2000). *Operationalisierte Psychodynamische Diagnostik in der Rehabilitationsklinik Birkenbuck: Einsatz und Befunde [Operationalised Psychodynamic Diagnostics in the Birkenbuck Rehabilitation Clinic: Use and Findings].* In: *Schneider, H. Freyberger (Hrsg.), Was leistet die OPD? Empirische Befunde und*

- klinische Erfahrungen mit der Operationalisierten Psychodynamischen Diagnostik*. Bern: Huber.
- [19]. **OPD TASK FORCE (Eds.)** (2008). *Operationalized Psychodynamic Diagnosis OPD-2. Manual of Diagnosis and Treatment Planning*. Cambridge: Hogrefe & Huber Publishers.
- [20]. **OXFORD LEARNERS DICTIONARIES** URL: <https://www.oxfordlearnersdictionaries.com/definition/english/pleasure> Accessed: 11.06.2024
- [21]. **PESECHKIAN H., REMMERS A.** (2020) Positive Psychotherapy: An Introduction. In: *Messias E., Peseschkian H., Cagande C. (eds), Positive Psychiatry, Psychotherapy and Psychology. Clinical Applications*. (pp. 11-32). Springer, Cham.
- [22]. **PESECHKIAN, N.** (1974). Actual capabilities as aspects of connotation and social organization of conflict handling. Fifth international congress of social psychiatry. Athens.
- [23]. **PESECHKIAN, N.** (1977). *Positive Psychotherapie. Theorie und Praxis einer neuen Methode* [Positive Psychotherapy. Theory and practice of a new method]. Frankfurt: Fischer. [in German]
- [24]. **PESECHKIAN, N.** (1980). Positive Familientherapie. Eine Behandlungsmethode der Zukunft. Fischer Verlag GmbH, Frankfurt a. M.
- [25]. **PESECHKIAN, N.** (1986) Psychotherapy of Everyday Life. Training in Partnership and Self-Help. Springer-Verlag Berlin Heidelberg 1986
- [26]. **PESECHKIAN, N., DEIDENBACH, H.,** (1988). *Wiesbadener Inventar zur Positiven Psychotherapie und Familientherapie WIPPF* [Wiesbaden Inventory of Positive Psychotherapy and Family Therapy WIPPF]. Berlin - Heidelberg - New York - Tokyo: Springer-Verlag. [in German]
- [27]. **PESECHKIAN, N.** (1971) Differenzierungsanalyse innerhalb der Gruppe. Vortrag auf der 4. Arbeitstagung des Deutschen Arbeitskreises für Gruppenpsychotherapie und Gruppendynamik (ADGC). Göttingen, 7. bis 10.
- [28]. **RUDOLF, G.** (1993.). Die Struktur der Persönlichkeit. In: Rudolf, G., (Hrsg.), *Psychotherapeutische Medizin*. Stuttgart: Enke
- [29]. **RUDOLF, G.** (1996) Operationalisierte Psychodynamische Diagnostik (OPD): Die Einschätzung des Strukturniveaus [Operationalised Psychodynamic Diagnostic (OPD): The assessment of the structural level]. In: *Buchheim, P., Cierpka, M., Seifert, T. (Hrsg.), Lindauer Texte*. Berlin: Springer. [in German]
- [30]. **RUDOLF, G. G.** (1999). Vergleich und Validierung zweier Instrumente zur Einschätzung von Struktur und struktureller Veränderung. The Scales of Psychological Capacities (RS Wallerstein) und Operationalized Psychodynamic Diagnosis (Arbeitsgruppe OPD). [Comparison and validation of two instruments for the assessment of structure and structural change. The Scales of Psychological Capacities (RS Wallerstein) and Operationalized Psychodynamic Diagnosis (OPD working group)]. *Psychosomatische Medizin und Psychotherapie*, 48 2, pp.163 –173.
- [31]. **RUDOLF, G.** (2002). Konfliktaufdeckende und strukturfördernde Zielsetzungen in der tiefenpsychologisch fundierten Psychotherapie. *Zeitschrift für Psychosomatische Medizin und Psychotherapie*, 48 2, pp.163 –173.
- [32]. **RUDOLF, G., BUCHHEIM, P., EHLERS, W., KÜCHENHOFF, J., MUHS, A., POUGET-SCHORS, D., RÜGER, U., SEIDLER, G. H., SCHWARZ, F.** (1995). Struktur und strukturelle Störung [Structure and structural disorder]. *Zeitschrift für Psychosomatische Medizin und Psychoanalyse*, 41, pp. 197-212. [in German]
- [33]. **RUDOLF, G., CIERPKA, M., FREYBERGER, H. J., HEUFT, G., SCHNEIDER, W.** (1997). Operationalisierte Psychodynamische Diagnostik (OPD) [Operationalised Psychodynamic Diagnostic (OPD)]. In: *Mundt, C., Linden, M., Barnett, W., (Hrsg.), Psychotherapie in der Psychiatrie*. Wien: Springer. [in German] [55]
- [34]. **UDOLF, G., GRANDE, T., OBERBRACHT, C.** (2000). Die Heidelberger Umstrukturierungsskala. Ein Modell der Veränderung in psychoanalytischen Therapien und seine Operationalisierung in einer Schätzsкала [The Heidelberg Restructuring Scale. A Model of Change in Psychoanalytic Therapies and its Operationalisation in an Estimation Scale]. *Psychotherapeut*, 45, pp. 237-246. [in German]
- [35]. **STRAUß, B., HÜTTMANN, B., SCHULZ, N.** (1997). Kategorienhäufigkeit und prognostische Bedeutung einer operationalisierten psychodynamischen Diagnostik. Erste Erfahrungen mit der OPD-1 im stationären Rahmen [Category frequency and prognostic significance of an operationalised psychodynamic diagnosis. First experiences with the OPD-1 in an inpatient setting]. *Psychotherapie, Psychosomatik und Medizinische Psychologie*, 47; 2, pp. 58-63. [in German].

- [36]. WERRINGLOER, R. (2023). Operationalizing and Visualizing Psychodynamics in Positive Psychotherapy (PPT). *The Global Psychotherapist*, 3(2), 76–88. <https://doi.org/10.52982/lkj201>