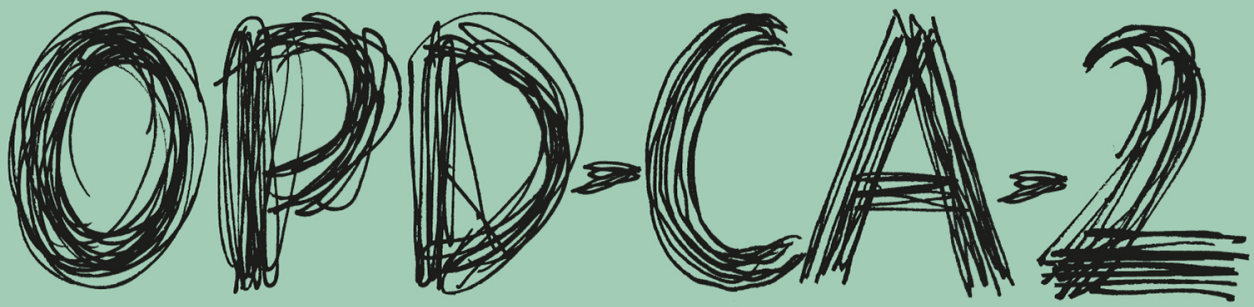

OPD-CA-2
Task Force
(Editors)

Operationalized Psychodynamic Diagnosis in Childhood and Adolescence

Theoretical Basis and User Manual

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OPD-CA-2

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Edited by
OPD-CA-2 Task Force, Franz Resch, Georg Romer,
Klaus Schmeck, and Inge Seiffge-Krenke

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EUROPE: Hogrefe Publishing, Merkelstr. 3, 37085 Göttingen, Germany
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The OPD-CA-2 Task Force

Steering Committee of the OPD-CA-2 Task Force

Franz Resch, Georg Romer, Klaus Schmeck, Inge Seiffge-Krenke

Coauthors of the Manual

Petra Adler-Corman, Cord Benecke, Oliver Bilke-Hentsch, Carola Cropp, Veronika Diederichs-Paeschke, Heiko Dietrich, Rainer Fliedl, Christine Forkel, Tanja Göttken, Ulrike Held, Cordula Jaletzke, Florian Juen, Eginhard Koch, Franz Resch, Christine Röpke, Georg Romer, Susanne Schlüter-Müller, Klaus Schmeck, Inge Seiffge-Krenke, Bruno Stafski, Annette Streeck-Fischer, Helene Timmermann, Matthias Weber, Ruth Weissensteiner, Katharina Weitkamp, Kerstin Westhoff, Klaus Winkelmann, Sibylle Winter

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Interpersonal Relations Axis

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Rainer Fliedl, Tanja Göttken, Brigitte Seifert, Matthias Weber, Ruth Weissensteiner

Structure Axis

Spokesperson: Eginhard Koch
Cord Benecke, Carola Cropp, Florian Juen, Eginhard Koch, Franz Resch, Susanne Schlüter-Müller, Klaus Schmeck, Annette Streeck-Fischer, Klaus Winkelmann

Conflict Axis
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Prerequisites for Treatment Axis
Spokesperson: Oliver Bilke-Hentsch
Oliver Bilke-Hentsch, Georg Romer, Katharina Weitkamp, Kerstin Westhoff

Scientific Editor: Katharina Weitkamp

Members of the original OPD-CA Task Force (1996–2007) who are also coauthors of the first Manual (2003) and its revised 2nd edition (2007): Birgit Atzwanger, Walter Bauers, Alfred Behnisch, Oliver Bilke, Gertrude Bogyi, Karl Heinz Brisch, Dieter Bürgin, Manfred Cierpka, Barbara Diepold, Heiko Dietrich, Reinmar du Bois, Michael Karle, Kai von Klitzing, Ulrich Knölker, Eginhard Koch, Franz Resch, Rainer Richter, Georg Romer, Gerd Rudolf, Susanne Schlüter-Müller, Klaus Schmeck, Michael Schulte-Markwort, Gerhard Schüßler, Inge Seiffge-Krenke, Rainer Georg Siefen, Georg Spiel, Anette Streeck-Fischer, Margot Völger, Matthias Weber, Klaus Winkelmann, Gisela Zeller-Steinbrich, Renate Zimmermann

Foreword

The entire OPD Task Force is pleased to congratulate the group members of the Child and Adolescent OPD Task Force on the second edition of *Operationalized Psychodynamic Diagnosis in Childhood and Adolescence* (OPD-CA). The work has been a great success and we congratulate the group members on this enormous achievement!

The second edition of OPD-CA has not only been revised but has been redesigned in many areas. The experiences gathered in training seminars over the past several years have contributed significantly to OPD-CA-2 being more user-friendly and more theoretically sound than its predecessor.

The revised version presents a diagnostic system for children and adolescents which, among other things, allows the determination of therapeutic goals. It is possible to use the tool to formulate points of focus in therapy and to develop therapy plans.

For a child who seeks and requires therapeutic help psychodynamic formulations can be developed which not only determine the symptoms but explain them as well. Such formulations are the core of a case report that must be able to record and describe the currently active psychological dimensions. OPD does exactly that by evaluating these dimensions on 4 axes. In addition, OPD can help to explain why a patient developed a specific problem at a given time and why he or she maintains it. This is clinically relevant because the psychological factors involved in the development of the problem or the onset of symptoms are often the same factors on which therapy should focus.

OPD can also capture the attachment and relationship representations a child has acquired in the family or in other developmental contexts, his or her internal conflicts and mental structure. OPD describes these aspects as psychodynamic case formulations in relation not only to the present but also to past and future circumstances. Based on the biography of the patient, key psychodynamic concepts that shape current relationships can be understood; wishes and desires for the future can be explained. Formulations developed with the help of this manual prove their clinical validity by allowing practitioners to make predictions about the individual's mental functioning in future situations. This

makes it possible to develop hypotheses as to how a child or adolescent will react in certain situations and which therapeutic approaches will be effective.

This new manual is now used for OPD-CA training seminars and will be used in a number of research projects. We hope that many researchers and practitioners in the field of child and adolescent psychiatry and psychotherapy will make use of this manual. We look forward to the results! On behalf of the entire OPD group, I hope that OPD-CA-2 will play an integral role in psychotherapeutic practice, continuing education, and research.

Manfred Cierpka, OPD Spokesperson

Foreword

The diagnostic categories of the DSM and the ICD systems provide important information geared to formulate therapeutic intervention for psychopathological syndromes. However, only an enriched psychodynamic diagnostic formulation permits to institute a highly personalized, individually tailored therapeutic program for these conditions. The problem is the often imprecise, impressionistic quality of psychodynamic formulations. This problem becomes greater in the diagnostic evaluation of children and adolescents, where a developmental perspective and an assessment of environmental constraints and resources are crucial contributors to the formulation of a comprehensive and practical therapeutic approach.

The OPD-CA-2 diagnostic approach responds effectively to these challenges. The present, English version of that approach presents a clear and comprehensive diagnostic approach that includes both the categorical, descriptive phenomenology of standard psychiatric classification and a clear, updated system of psychodynamic inquiry that enriches psychiatric diagnosis with the formulation of four psychodynamic axes. These axes integrate a developmental perceptive with specific assessment of interpersonal relations, dominant conflicts, intrapsychic structure, and prerequisites for treatment. It is a comprehensive, empirically based and clinically tested approach to the diagnosis and treatment indications for the entire field of child and adolescent psychopathology. I warmly recommend it to all child and adolescent psychiatrists, psychologists, and social workers as an essential contribution to clinical practice.

Otto F. Kernberg, Professor Emeritus of Psychiatry

Preface

Diagnostics for children and adolescents have multiple functions. Disentangling between normative development and psychopathology, and clarifying the indication for psychotherapy are essential elements of the diagnostic process, after which practitioners also have to decide about which specific therapeutic technique is most appropriate for a child or adolescent patient. Given the recent development towards evidence-based medicine, the appropriate assignment to specific therapeutic techniques has become more and more important and is one of the corner stones of therapeutic success.

However, current diagnostic systems are too limited to answer all these clinically and empirically relevant questions. Nosological classification via DSM-5 or ICD-10 is important, but not sufficient for therapeutic work. Furthermore, we need specific indices to measure therapeutic progress. With this book, we present the first empirically based assessment tool for psychodynamically relevant dimensions in child and adolescent psychotherapy.

The OPD-CA-2 provides helpful tools for the indication of treatment, the planning of treatment and its evaluation. Important dimensions such as the quality of relationships to significant others (including the therapist), structural functioning of the patient (such as his or her capacity for emotion regulation), prevailing intrapsychic conflict issues which hinder functional development as well as treatment requirements (such as treatment motivation) can be assessed. The instruments presented cover a wide range of assessment which can be applied to the child and his or her parents. They relate diagnostic questions to the main developmental areas in childhood or adolescence, such as school, family, peers, and health. Starting from the diagnostic interview, these tools allow all relevant diagnostic categories to be coded. Correspondingly they can also be used for the evaluation of treatment.

This book presents the results of 30 years of collaborative work of practitioners and researchers from different fields such as child and adolescent psychiatry, child and adolescent psychotherapy, and developmental psychology. The OPD-CA Task Force has, over the decades, refined the conceptual work in all diagnostically relevant dimensions, improved the reliability and validity of the instruments, documented

its empirical significance in a number of studies with various clinical samples, and provided helpful clinical tools and case studies for practical application. After several revisions of the instrument and extensive usage in Germany, we now want to make the instrument available to colleagues in research and practice in other countries. On behalf of the Task Force OPD-CA-2, we wish you every success with the implementation of the instrument and we are eager to learn about your experiences and results with the instrument. Feel free to contact us whenever questions or suggestions arise from your work with the instrument, be it in clinical practice or research. This will help us to make the future OPD-CA even more applicable in different cultural contexts.

Franz Resch
Georg Romer
Klaus Schmeck
Inge Seiffge-Krenke

Part 1: The OPD-CA-2

1. Introduction

Beginning in 1992, the *Operationalisierte Psychodynamische Diagnostik* (in English *Operationalized Psychodynamic Diagnostics,* OPD) for adults was developed for German-speaking countries (Arbeitskreis OPD, 1996) and then later revised (Arbeitskreis OPD, 2006). The English versions of the Manual were published a bit later (OPD Task Force, 2001, 2008). The OPD is a system with psychodynamically based diagnostic axes for supplementing and expanding nosological classification schemes (such as DSM-5 in the USA, American Psychiatric Association, 2015; ICD-10 in Europe, World Health Organisation, 1992).

The result is an instrument that both takes into account psychodynamic theory and attempts to improve interrater reliability in the psychodynamic assessment of mental states. This instrument is intended to remedy the fuzziness of psychoanalytic concepts – often criticised by other therapy approaches – through definitional principles. Of course, the reduction of fuzziness and ambiguity necessarily entails a curtailment of some theoretical models, which is appropriate given the practical diagnostic and therapeutic considerations.

From the outset, the OPD and the *Operationalized Psychodynamic Diagnosis in Childhood and Adolescence* (OPD-CA; in German *Operationalisierte Psychodynamische Diagnostik im Kindes- und Jugendalter* [OPD-KJ]; Arbeitskreis OPD-KJ, 2007) aimed at complementing the categorical approach (in terms of diagnoses) with a dimensional view of mental disorders in terms of ratings of severity along different axes (or dimensions). This approach to the classification of mental disorders has proven to be forward-thinking and ground-breaking, as the current developments in the new DSM-5 show, in which dimensional perspectives and assessments of severity have now been integrated into the categorical system of psychiatric diagnoses (APA, 2015).

In the case of children and adolescents, the continued development of the ICD-8 and ICD-9 very early on led to a multiaxial nosological

framework (Remschmidt & Mattejat, 1994; Remschmidt, Schmidt & Poustka, 2008; Rutter, Shaffer, & Sturge, 1975). This allowed diagnostics on several levels: Along the first axis the clinical-psychiatric syndrome is described, while the second axis allows coding of developmental disorders, the third records intelligence, and the fourth diagnostically classifies physical illnesses as well as disabilities. The fifth axis captures associated abnormal psychosocial circumstances, and a sixth axis ascertains the level of psychosocial functioning. A task force was established in 1996 with the aim of developing a German instrument for the Operationalisierte Psychodynamische Diagnostik im Kindes- und Jugendalter (OPD-KJ; Arbeitskreis OPD-KJ, 2003, 2007; Operationalized Psychodynamic Diagnostics in Childhood and Adolescence [OPD-CA] in English). The aim was to capture, similar to the adult version, psychodynamic aspects of childhood and adolescence, extending beyond the multiaxial classification system, as an aid to appropriate treatment planning.

Based on the OPD instrument for adults, profound modifications were necessary for childhood and adolescence. The central issue was the influence of developmental processes on the psychodynamics. The second edition of the German classification system OPD-KJ-2 combines psychodynamic, developmental, and clinical psychiatric perspectives (Resch & Koch, 2012; Resch, Schulte-Markwort, & Bürgin, 1998; Windaus, 2012). Multidimensional models of the origins of mental disorders are included (Herpertz-Dahlmann, Resch, Schulte-Markwort, & Warnke, 2008) and integrated in an overall biopsychosocial model open to dynamic perspectives (see Chapter 2 *Developmental Concepts and Ages*). The OPD-CA-2 should accordingly take into account the following special therapeutic considerations: It should allow a good differential indication for therapy and treatment planning given psychodynamic considerations, as well as provide information for a relationship-based foundation for parental work, and, for practical purposes, maintain a sufficiently high level of differentiation and comprehensibility despite the high level of complexity. The psychodynamic approach to the child indeed requires correspondingly complex, multidimensional, and development-oriented diagnostics, and may not remain at the level of nosological assessment.

The identification of specific psychiatric disorders through questionnaires and interviews has a long clinical tradition, with increasing

attention in recent years to developmental aspects and resources in childhood and adolescence. The diagnostic approach in the OPD-CA goes beyond an integration of developmental diagnostics on the one hand and psychiatric classification on the other hand. The OPD-CA aims at a complex identification of psychodynamic processes that takes into account the child's or adolescent's subjectivity and attempts to render the symptoms also hermeneutically accessible and understandable in a developmental context. The developmental perspective is central to all aspects of the diagnostic process, from the type of assessment and selection of relevant diagnostic categories to the process of assessment along various substantive dimensions – where, at the end of the process, a recommendation for treatment can be made integrating psychiatric symptomatology, level of development, and psychodynamic aspects.

In the OPD-CA too we specify, as an orientation aid, certain age groups in which developmental adjustment or maladjustment as well as structural resources become visible. Although compared with adults, children still seem incompletely structured, since at certain ages they cannot fully perceive the causal relationships in the world, some insights and background information remain hidden to them, and their affect regulation depends on significant attachment figures, each child at any given age will possess an optimal structure. At each age, a person has available to him or her a repertoire of experiential and behavioral capacities that also takes into account internal conflicts and allows the active formation of relationships. The view of children as generally not optimally adjusted to their environment or as immature according to some adult ideal is inappropriate. Dysfunctional types of behavior and fantasies always need to be compared against age-appropriate requirements. A child is not an incomplete adult. In order to identify psychodynamic disorders in children of different ages, mentally impaired children have to be compared with healthy children of the same age (Resch & Koch, 2012).

The developmental aspect is relevant at all levels of the diagnostic process. The collection itself of diagnostically relevant information, i.e., the settings the persons are interviewed in as well as the different levels at which information is obtained (play, observation, dialog, scenic understanding) was adapted to the different developmental stages. The collection of relevant psychodynamic information along the axes of *in-*

terpersonal relations, conflict, structure, and *prerequisites for treatment* is differentiated according to the levels of development. As development is always considered contextually, developmentally relevant areas such as family, play, school, peer group, etc., need to be included as well.

The numerous experiences from trainings and information from empirical studies of the German instrument informed the development of the OPD-KJ into the OPD-KJ-2. An English version of the first edition of the Manual was not published so we shall henceforth refer to the second edition as the OPD-CA-2 but use the abbreviation OPD-CA to refer to the the original German version or to the instrument generally. Items and definitions that had proven to be insufficiently clear and selective were revised or even removed. The thorough revision of the axes and their dimensions also incorporated factor-analytic findings, so that significantly improved reliability and construct validity can be expected compared with the original OPD-KJ Manual. The partially new nomenclature of the conflicts is intended to increase comprehensibility of the key conflict themes. The structure axis now shows similarities with the alternative model for personality disorders in Section III of the DSM-5 (American Psychiatric Association, 2015), which incorporates a scale for the level of personality functioning on four dimensions: *identity*, *self-direction*, *empathy,* and *intimacy*. This has significant similarities with the four dimensions of the *structure* axis of the OPD-CA-2: *identity*, *control, interpersonality,* and *attachment*.

The basic concern of the OPD to reduce the fuzziness and ambiguity of some psychoanalytic concepts and constructs through operationalization is also a central concern for the child and adolescent version. It is vital that the operationalization of theoretical constructs is based on practical experience. The reduction of fuzziness and ambiguity within the OPD-CA was therefore necessary to meet the needs of diagnostic practice and psychotherapeutic activities. The revised OPD-CA-2 also does not attempt any reformulation of psychodynamic constructs, but refers, for the most part, to concepts largely accepted as clinical theory within psychodynamic discourse. Users identifying with a particular psychoanalytic approach may then have the impression of a lack of theoretical clarity due to the emphasis on pragmatics. However, the aim of the OPD-CA is to serve psychoanalytic discourse independently of any approach and to be applicable across approaches

in order to have an empirically verifiable operationalization of psychodynamic constructs.

Even if a more operationalized diagnosis cannot capture the overall form of a mental disorder in a specific instance and in the context of a individual's life with all the varied aspects of that disorder, we assume that the operationalization of psychodynamic diagnostics will allow an improvement in communication between different therapists as well as, in particular, an optimization of contact between psychodynamic perspectives and other therapy approaches. On top of this, the clarity and transparency of diagnostic and psychotherapeutic processes should be increased and therefore be beneficial when applied to clinical work and research. The OPD-CA-2 could only disappoint those therapists who believe that psychodynamic processes as dyadic communication phenomena are fundamentally not amenable to empirical approaches or methods of verification and not subject to agreement between different therapists. On the other hand, therapists concerned with the empirical testing of their own thoughts and actions and who advocate operationalization and manualization in the interest of greater transparency towards the patient will welcome the further development in the OPD-CA-2.

The psychiatric and psychological study of children and adolescents generally includes their most important attachment figures. Besides the specific diagnosis, the diagnostic assessment of the relationship dynamics between parents and children is also clinically relevant. The younger the patient, the more interlaced are the intrapsychic and interpersonal levels. For this reason, the OPD-CA-2 also includes an *interpersonal relations axis* for assessing the child's or adolescent's relationships to the examiner and to the relevant familial attachment figures, as well as for assessing the family dynamics.

The *mental structure* construct embodies two ideas in particular: on the one hand, capturing lived functions in experiential schemata and, on the other hand, making available this experience through actualization, which allows the transfer of the experience to new and meaningful functions. Accordingly, *mental structure* is an individually typical disposition to experience and behavior that is available to the individual when faced with making a decision about different interactional options. The OPD-CA-2 describes four dimensions within this structure: reflective

(self) functions form the *identity* axis, communicative qualities form the *interpersonality* axis, internalized attachment experiences form the *attachment* axis, and finally there is the *control* axis (Goth et al., 2012; Resch & Koch, 2012).

In selecting the construct *conflict* our idea was that, besides interactional aspects and individual experience, essential aspects of the unconscious also play a role in coping with the environment. In particular, in work with children and adolescents, the combination of internal and external mental conditional factors (that is, of conflict and interaction) becomes especially important (Seiffge-Krenke, 2012a).

Finally, the *prerequisites for treatment* axis represents the areas that, in addition to psychodynamic constructs, are of great importance for treatment planning. They include subjective dimensions of the children and adolescents as well as their resources. The incorporation of these items was a particular concern as the diagnostic view all too quickly focusses on the pathological in the sense of deficiency.

The OPD-CA-2 makes no claim to completeness regarding the dynamic constructs. The reliability of individual items was examined on the basis of practice as well as empirical studies. The corresponding modifications to definitions and anchor-point descriptions result from the experiences of recent years. The psychometric quality of the OPD-CA instrument proved altogether empirically satisfactory; single weaknesses were remedied through specific changes in the OPD-CA-2. The OPD-CA has thus become established in the research world, despite the focus on clinical applications.

In fact, the OPD-CA has established itself over the years as a very successful concept, as evidenced by the great interest both in the Manual and in trainings. We hope that the revised OPD-CA-2 will stir great interest and offer an exciting expansion of diagnostic potential to people already familiar with the first version of the OPD-CA. We would be greatly pleased if this new instrument also proved useful in your everyday diagnostic and therapeutic work.

2. Developmental Concepts and Ages

Which developmental concept forms the basis for the attempt by the OPD-CA-2 to bring together psychodynamic concepts with ontological developmental phenomena?

Only a working definition can come into question that clarifies the scope while at the same time allowing for sufficient openness to the varieties of experience and behavior of the child. According to Montada (1987), the temporal aspect of development is especially important. All changes that can be meaningfully related to the temporal dimension of the different age groups thus become the subject of development. Whereas development was primarily viewed as a process of maturation in the early 20th century, with, for example, Karl Bühler (1918) stating that the concept of development includes both predisposition as well as a plan or objective of growth, nowadays the following characteristics are thought to govern the developmental process: The emphasis lies on aspects of differentiation, namely subtle formation and refinement, and the emergence of more and more degrees of freedom in decision-making. Integration that over time compiles increasingly more details into a new whole also forms a crucial facet of development. Environmental stimuli are perceived with increasing selectivity, and the interaction between rapid, holistic responses and search responses down to the last detail becomes increasingly complex. In the course of development, function and structure enter into close interplay, with structural consolidation of experiential content being an essential feature of development.

2.1 Theoretical Foundations of the Developmental Concept in the OPD-CA-2

The developmental concept underlying the OPD-CA-2 is based on an interactionist model of development (Oerter, 1995). The concept

is further based on the stages of cognitive development according to Piaget (1952), and integrates the concept of developmental lines from psychoanalytic theory (A. Freud, 1965) and the developmental tasks from empirical developmental psychology (Havighurst, 1972), while incorporating more recent advances. As the OPD-CA-2 is intended for clinical use, a developmental-psychopathological approach is also urgently needed. The following sections present in detail these theoretical elements underlying our view of development.

The Interactionist Model of Development

Early conceptions of development were governed by stage models nowadays largely considered as outdated. The psychodynamic developmental idea of the OPD-CA-2 is based on an interactionist model of development (Oerter, 1995). This model ties an active, self-motivated subject advancing his or her own development to an equally demanding and influential object world. Cultural techniques, standards, attachment figures' expectations, and physical environmental conditions serve as developmental incentives or challenges that must be dealt with by the individual in a process of adaptation. The interactionist theory thus concedes to the individual an active role in the shaping of his or her environment – the individual looks for and shapes the environmental conditions– in the same way as he himself or she herself is shaped by these environmental conditions (Resch, 1999a).

The Concept of Developmental Lines and its Further Development

Anna Freud worked on the interaction between the ego and the id at different levels of development (A. Freud, 1936). A prototypical developmental line can run from the infant's full emotional dependency through partial object relations to mature object relations. Another further developmental line runs from the baby's body as shared with the mother to bodily self-determination in adolescence. Other developmental lines, such as that running from the young child's egocentric world view to empathy, reciprocity, and camaraderie, have been replaced in the OPD-CA-2 by modern contemporary concepts of mentalization (Fonagy, Gergely, Jurist, & Target, 2006) such that from the outset the child exists in a state of dialectical tension between egocentricity and

reciprocity (see overview in Dornes, 2006). The developmental line running from erotic play with the child's own body or the mother's body through transitional objects to toys, hobbies, and finally to work have been superseded by contemporary activity-theoretical considerations indicating an increasing integration of the inclination towards pleasure and the assumption of responsibility in human actions (Resch, 2012). Fundamental for the concept of psychodynamic developmental lines is the integration of cognitive, social, and emotional learning processes leading to differentiation in the sense of appropriate sequencing.

The Concept of Developmental Tasks

The concept of developmental tasks from Havighurst (1972) shares with Anna Freud's concept the ideas of normative development, continuity, and sequencing. Noteworthy, however, is the emphasis on active achievement on the individual's part during development. Solutions to age-specific developmental tasks can advance the individual's own development. The focus thus lies on individual activity. The mastery of adaptational demands becomes clear in various forms of progression, namely, in successfully continued development on the one hand and in developmental standstill or regression on the other. Solving age-specific developmental tasks necessarily involves the integration of requirements from three areas (physical condition, social norms, and personal skills). Havighurst bases his approach on a division of the course of human life into six segments:

- *Infancy and early childhood*, from birth to 5–6 years
- *Middle childhood*, from 5–6 to 12–13 years
- *Adolescence*, from 12–13 to 18 years
- *Early adulthood*, from 18 to 35 years
- *Middle adulthood*, from 35 to 60 years
- *Later maturity*, 60 years and older

For each of these six stages of development Havighurst defines age-specific developmental tasks connected with one another across the entire lifespan. The eight developmental tasks of adolescence (such as reconceptualization of the self, development of a mature bodily concept, separation from parents and development of mature relationships

with close friends and the beginning of romantic relationships) rest on the accomplished developmental tasks of late childhood (such as learning physical skills, developing a positive attitude towards oneself as a growing organism, learning an appropriate masculine or feminine role, and attaining personal independence). Accomplishment of the developmental tasks is, in turn, the precondition for approaching the stage-specific developmental tasks of the next age group.

Much more clearly than in Anna Freud's work, Havighurst's concept stresses the normative demand of society on development. Many developmental tasks involve normative expectations such as entering school, the transition to a secondary school, graduation, etc. Explicitly operationalized is also the sequencing of the developmental tasks. Compared with developmental lines, developmental tasks have been especially well studied for childhood and adolescence (Seiffge-Krenke, 1998). On the other hand, Anna Freud's consideration of the course of development is more complex and more difficult to operationalize, but then more suitable for the complexity of psychodynamic relationships.

The Developmental-Psychopathological Perspective

Another conceptual element of the OPD-CA-2 is the developmental-psychopathological perspective that attempts to reformulate the aetiopathogenesis of mental symptoms on the basis of developmental aspects. The developmental idea is intended not only to change the view on aetiology, epidemiology, type, and severity of mental disorders, but also to reconceptualize diagnostics, therapy, rehabilitation, and prevention in a flexible and dynamic way. The basic idea is to focus on the influences of normal development on the aetiopathogenesis of psychopathological symptoms in different periods of life, as well as the influence of psychopathological adaptive mechanisms on the normal course of development in the life cycle. Given their somatic, cognitive, and emotional make-up, children in different stages of life possess different resources for responding to different forms of mental irritation. This variety can be reflected in different age-related anxieties, such as separation anxiety and fear of the dark at early ages and social anxieties and existential anxieties in later childhood. If, on the other hand, mental problems have effects modulating development, the job is to determine to what extent psychopathological symptoms in children and