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PSYCHOTHERAPEUTIC WORK FOCUSED ON STRUCTURAL PERSONALITY FUNCTIONING DEFICITS

SYSTEMATIZATION OF TOOLS FOR CLINICAL PRACTICE

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To my life partner, Gustavo.

For your love and your doctorate-proof support, and so much more. Thank you.

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Abstract

Background: Psychotherapists working in institutional contexts, especially in public health centers, must quickly resolve cases of multiple levels of severity due to the high demand for care and multiple obstacles that make long treatments unfeasible. Focal psychotherapy makes it possible to abbreviate treatments, but it is difficult to implement in patients with personality functioning difficulties.

Objective: To propose an operational system of psychotherapeutic tools focused on structural personality functioning deficits, incorporating the perspectives of specialists and the analysis of video-recorded psychotherapy sessions.

Methodology: Two qualitative studies were implemented: first, an open-coding analysis to determine and classify the therapeutic guidelines of the Manual of Structure-Oriented Psychotherapy (Rudolf, 2013) and those obtained from interviews with specialists in the Operationalized Psychodynamic Diagnosis System (OPD-2); second, a study consisting in the observation of 45 psychotherapy sessions to identify and characterize the psychotherapeutic guidelines and interventions categorized earlier and create new interventions not considered in the first study. The results of both studies were integrated to develop an operational system of psychotherapeutic tools.

Results: The operational system of psychotherapeutic tools developed comprises three levels and features the characterization of six Therapeutic Principles, 33 Therapeutic Guidelines, and 59 Therapeutic Interventions with their respective clinical examples. The system is characterized by the presence of common factors for an effective psychotherapy and elements that typify supportive therapies, complemented with specific components for dealing with structural deficits susceptible of modularization.

Conclusions: The system is expected to allow practitioners to work focally with patients with a wide range of structural deficits of multiple levels of severity. The clinical tools proposed are flexible enough and include the necessary components to be well received by professionals from a wide range of clinical training backgrounds and be implemented as an initial approach within a tiered treatment system for personality problems.

Keywords: psychotherapeutic tools, focus, structural deficits, personality, OPD-2

Introduction

One of the challenges of implementing psychotherapy in public and private health care contexts is the ability to address patients' requests for help promptly, given the high demand exerted on health care systems and the difficulties of conducting long psychotherapeutic processes. A focused approach makes it possible to abbreviate the psychotherapy process and helps to tackle this challenge. The present study addresses this issue, proposing an operational system of psychotherapeutic tools focused on structural personality deficits affecting patients with various functioning levels. To achieve this goal, we implemented two qualitative studies: the first, to determine and classify the therapeutic guidelines of the Manual of Structure-Oriented Psychotherapy (Rudolf, 2013) and those provided by practitioners specialized in Operationalized Psychodynamic Diagnosis (OPD-2) (OPD Task Force, 2008); the second, to identify and characterize, based on the observation of psychotherapy sessions, the psychotherapeutic guidelines and interventions categorized earlier. Drawing on the results of both studies, we developed an operational system that incorporates Principles, Guidelines, and Therapeutic Interventions while also presenting clinical examples.

A number of widespread focal therapy models have been developed in the field of psychodynamic psychotherapy (Balint et al., 1972; Davanloo, 1980; Fiorini, 2000; Luborsky, 1977; Malan, 1976; Sifneos, 1979; Strupp & Binder, 1984). These approaches are heterogeneous regarding the level of personality functioning that they target (Dagnino, 2012) and tend to be hard to implement with patients affected by structural functioning deficits. This creates the clinical impression that they cannot be focused, since the predominance of psychological function deficits makes it impossible to target the comprehension of intrapsychic conflicts and their associated narratives (de la Parra et al., 2016; Lanza, 2015; Dagnino, 2012; Braier, 2009). In addition, as personality functioning worsens, managing the process becomes more complex and additional therapeutic tools are needed to obtain satisfactory results (Koelen et al., 2012). This situation has resulted in major progress in the study of interventions aimed at patients with personality problems (Newton-Howes et al., 2014), leading to the consolidation of empirically backed approaches (Bateman & Fonagy, 2016; Caligor et al., 2018; Linehan, 2014). However, since they were originally designed for severe personality disorders, these treatments are highly specialized and thus complex, lengthy, and expensive to implement (Bateman et al., 2015; Zanarini, 2009). This is especially problematic in countries like Chile,

which, despite being classed as a high-income country, is still affected by high levels of multidimensional poverty, unequal access to mental health services, and public health care networks that have neither the funding nor the management systems needed to cover their users' needs, let alone train their professionals or implement treatments of this type (Blukacz et al., 2020; de la Parra et al., 2019; Kohn et al., 2018).

Apart from its treatment relevance, structural functioning has become increasingly important in diagnosis due to evidence of comorbidity between personality functioning deficits and syndromal disorders, which complicates their prognosis and evolution (Luyten & Fonagy, 2021; Newton-Howes et al., 2014). This has made it necessary to complement the usual categorical diagnoses of personality problems with dimensional diagnoses (American Psychiatric Association [APA], 2013; World Health Organization [WHO], 2019) while also encouraging research on the underlying dysfunctions of mental health diseases across multiple experiential domains (National Institute of Mental Health [NIHM], 2009).

The Operationalized Psychodynamic Diagnostic (OPD) System (OPD Task Force, 2001; 2008) developed an interview-based approach that complements syndromal diagnoses (APA, 2000; WHO, 1992) with a psychodynamic diagnosis that considers dysfunctional relational patterns, intrapsychic conflicts, and structural functioning. The OPD system makes it possible to determine focal points for psychotherapy and then plan treatment strategies. One of its most noteworthy ─and novel─ strategies consists in implementing a structure-centric focus; that is, adopting as the object of psychotherapeutic work the patient's specific psychic capability deficits that determine his/her structural functioning, helping him/her to identify and recognize them in his/her daily life to later develop self-regulation and adaptation mechanisms to address structural limitations. This is an alternate path between the psychodynamic approach of understanding and finding the underlying meaning of the patient's problem and the implementation of support strategies (Rudolf, 2013; OPD Task Force, 2008).

The second version of the OPD system (OPD-2), in its diagnosis manual, provides general guidelines for adopting a structure-centered approach to psychotherapeutic work. In parallel, a more detailed Structure-Oriented Psychotherapy manual was produced (Rudolf, 2004; Rudolf, 2013), providing guidelines for implementing strategies and interventions of several levels of complexity aimed at multiple aspects of the psychotherapeutic process.

However, this proposed therapeutic approach is scarcely known in our region and has yet to be empirically studied in depth. Furthermore, the Manual of Structure-Oriented Psychotherapy, despite offering a wealth of high-quality clinical guidelines, presents contents in a way that limits application, training, and research opportunities, mainly because of how instructions are described and due to insufficient operational descriptions. This study tackles this limitation empirically by identifying, characterizing, and complementing ─with a clinical methodology─ the clinical proposals of Structure-Oriented Psychotherapy, which are then systematized as "therapeutic tools".

Conducting an in-depth examination of the Structure-Focused Psychotherapy model is relevant because it can narrow on the clinical gap present in focal psychodynamic psychotherapies with patients displaying lower integration levels who are not affected by severe personality disorders (Dagnino, 2012). Such patients are deemed "difficult" by therapists either due to structural deficits which constitute their main syndrome, or which add complexity to other syndromes (such as depression) (de la Parra, Dagnino et al., 2017), or because they are treated in settings characterized by high demand for care and limited resources (Fischer et al., 2019), which lowers their chances of receiving treatments adapted to their functioning. In this context, the present study advances an operational system composed of therapeutic tools focused on structural functions, thus offering a feasible approach to psychotherapies that must be implemented in public and private institutional settings, which is where most mental health services are delivered in Chile.

This study proposes an operational system of psychotherapeutic tools focused on personality structure deficits, incorporating the perspectives of specialists and the analysis of video-recorded psychotherapy sessions. The study, of a qualitative nature, sought to shed light on a relatively unexplored phenomenon, which it approached from two observational perspectives (expert therapists and session observers). We employed a qualitative method due to its usefulness for discovering "new" things, which is suitable when little is known about the object of study (Krause, 1995). Two studies were implemented. In the first study, we constructed a list of categories of therapeutic guidelines through an open coding analysis of the Manual of Structure-Oriented Psychotherapy and a set of interviews with therapists who specialize in OPD. In the second study, we analyzed 42 psychotherapy sessions using an Observation Manual constructed upon the basis of the categories yielded by the first study,

in order to identify and characterize interventions associated with therapeutic guidelines while also generating new categories whenever necessary. To generate the operational system of psychotherapeutic tools focused on structural deficits, we conducted a result integration process which consisted in arranging the categories yielded by both studies. To do so, we reviewed logical levels, repetitions or instances of overlapping, and the wording of definitions.

In the following sections, we present the key concepts that supported this study. First, we describe the need for therapeutic tools specifically aimed at institutional settings; second, we present the characteristics, contributions, and limitations of focal psychotherapy; third, we describe the Operationalized Psychodynamic Diagnosis System OPD-2, highlighting the dimensional diagnosis of the integration level of the structure on Axis IV as well as the characteristics and therapeutic potential of a therapeutic strategy focused on the patient's deficits; fourth, we address the problems of traditional diagnoses and therapeutic approaches when treating patients with structural limitations. In the following sections, we present the formulation of our objectives, guiding questions, methodology, and results. The latter are also discussed in the final section, along with our conclusions.

Theoretical and Empirical Background of the Research Problem

Treatment Settings and Clinical Tools in Psychotherapy

Chile has a mixed health care system in which approximately 75% of the population receive health services at public centers belonging to a network of municipally administered primary and secondary health care centers and at sector-specific hospitals. The rest of the population[1], people with a higher income, receive health care services in the private sector, especially in urban centers (Becerril-Montekio et al., 2011; Minoletti, 2016; Minoletti & Zaccaria, 2005; Minoletti et al., 2012; Ministerio de Salud (MINSAL), 2018). Regarding mental health, Chile has a National Mental Health Plan that emphasizes a community-based approach (MINSAL, 2017b), given the evidence showing that psychosocial factors influence the appearance and duration of psychiatric disorders. Even though this model strongly emphasizes preventive, local, and community-based actions, the system considers individual psychotherapy for people diagnosed with mental diseases, conducted by clinical psychologists at all levels of care (MINSAL, 2017a, 2017b, 2021, 2022). It is difficult to find information about the specific situation of the psychotherapy services offered. The limited information available mostly concerns the treatment of syndromal diagnoses, especially depression, given its inclusion in the Explicit Health Care Guarantees Program (*Garantías Explícitas en Salud, GES*) (Araya et al., 2018; MINSAL, 2013). Regarding the treatment of patients with personality functioning problems, the available information is also scarce and only refers to specialized treatments for severe personality problems, such as Dialectical Behavior Therapy (Ponce de León et al., 2017), or refers to personality functioning in connection with syndromes like depression (de la Parra, Dagnino et al., 2017; 2021; Dagnino et al., 2017, 2018). With respect to clinical tools for treating patients of medium to high complexity, research indicates that psychologists have few clinical options useful in high pressure contexts and brief interventions (Bedregal, 2017). This is a relevant shortcoming, since these treatment settings are inherent to the public health care system and many private mental health centers, such as university clinics (de la Parra et al., 2018; Hansen et al., 2002; Harnett, et al., 2010;

1 The Armed Forces Health Services cover a small percentage of the population.

Lambert, 2013; Robinson et al., 2019). In addition, patients with personality functioning difficulties are perceived as "difficult" and are thus easily stigmatized (Fischer et al., 2019). These difficulties spring from the fact that university curricula and clinical specialization programs are not well adapted to real institutional treatment settings; furthermore, the National Mental Health and Psychiatry Plan, despite offering mental health training to health professionals, does not consider the development of psychotherapists' clinical competences (Minoletti & Zaccaria, 2005; Minoletti et al., 2018; MINSAL, 2022; Scharager & Molina, 2007). All this is especially relevant because psychology is one of the clinical professions with the largest number of graduates and the highest rate of incorporation into public mental health services (Minoletti, 2014; Minoletti et al., 2014) and because psychotherapy is the recommended therapeutic approach for a wide range of patients who exhibit moderate to severe personality symptomatology, generally in connection with other syndromes, and who must be treated in the public system, either in primary care or in referral centers such as Community Mental Health Centers (Centros de Comunitarios de Salud Mental, COSAM) (Crempien et al., 2017; de la Parra et al., 2019).

Focal Psychotherapy and Structural Functioning

Focal psychotherapy strategies were developed in response to the need to abbreviate psychodynamic treatments and thus increase their availability for larger population groups. Focal therapy is a procedure with limited objectives, which may or may not have a limited duration. When it is brief, it lasts for weeks or months, and not years like psychoanalysis (Braier, 2009). In broad terms, this focal approach refers to the degree to which a problem addressed in psychotherapy can be delimited or “cut” to facilitate the implementation of the therapy. A focal approach makes it possible to guide interventions from the start of the treatment and hierarchize the materials of the session (Braier, 2009; De la Cour, 1986; Poch & Maestre, 1994; Scaturo, 2002). A variety of methods for conducting brief focal psychotherapeutic work have been proposed (Messer, 2001). The first systematic proposals of psychodynamic theory, based on classical principles of drive theory and intrapsychic conflicts (Balint et al., 1972; Davanloo, 1980; Malan, 1976; Sifneos, 1967, 1979) or object relations (Mann, 1973), were made in the 1960s and 1970s. In the 1980s, researchers developed psychodynamic models with a relational focus (Luborsky, 1984; Strupp & Binder, 1984) and others

which incorporated empirical evidence. In our region, a well known approach was devised by Fiorini (2000)[2]. These therapies can be differentiated according to their emphasis on an intrapsychic conflict, or the interpersonal patterns derived from it, their level of operationalization, or the usage of a single or multiple focus (Dagnino, 2012). Nevertheless, they share a dynamic notion of the symptom and work on the assumption that certain unconscious, emotion-laden topics of the past become active in the present and in transferential relationships, resulting in psychic pain. The therapist mainly uses clarifications, confrontations, and interpretations and pays attention to transference and countertransference (Crits-Christoph, 1991; Messer, 2001). These traditional focal strategies are widely known and continue to be extensively implemented due to their clinical usefulness (Messer & Warren, 1998). However, they are hard to apply in patients with low structural functioning integration, because their psychological functioning deficits predominate during the sessions, making it difficult to focus on understanding intrapsychic conflicts and their related narratives (Braier, 2009; Dagnino, 2012; de la Parra et al., 2016; Lanza, 2015, 2016). Therapists commonly encounter such patients in everyday clinical practice and consider that focal work is impossible with them; due to this, therapists rule out brief focal strategies due to the absence of ego functions, which allow people to self-regulate and take the distance needed to reflect on their conflicts. In such cases, clinicians must address conflict themes which are highly diverse and weakly defined, and which change both within and between sessions. The Operationalized Psychodynamic Diagnosis System (OPD-2) (OPD Task Force, 2008) proposes a novel approach to planning the psychotherapy, as it considers structural functioning vulnerabilities as the focus of the therapeutic work, either in combination with interpersonal and conflict foci or by themselves The OPD regards focus as the problematic area(s) that underlie the preservation of psychic symptoms and interpersonal difficulties; therefore, focus is idiosyncratic to each patient. This perspective increases participants' chances for working focally and makes it possible to plan brief treatment strategies for patients with issues that cannot be tackled considering conflict dynamics only.

2 Detailed reviews of brief focal models can be found in Budman (1981), Crits-Cristoph and Barber (1991), and Messer and Warren (1998).

The Operationalized Psychodynamic Diagnostic (OPD) System

The OPD was developed in Germany (Arbeitskreis OPD, 1996) to provide a valid and reliable psychodynamic diagnosis system by operationalizing psychoanalytic constructs at an intermediate level of abstraction. The system makes it possible to assess psychodynamic processes by examining their observable traits as closely as possible and considering multiple aspects of the patient. Thus, the OPD system complements and expands descriptive syndromal diagnostic classifications. The OPD-2 (Arbeitskreis OPD, 2006), a second version produced after ten years of administration and training experience, incorporates slight changes in the diagnosis area and includes guidelines for making decisions about psychotherapeutic focus and strategy, thereby becoming a diagnosis and planning tool in psychotherapy. The information obtained from the OPD's diagnostic interview yields a complex, four-axis functioning profile: experience of illness and prerequisites for treatment (Axis I), dysfunctional relational pattern (Axis II), conflict (Axis III), and level of structural integration (Axis IV). Based on this information, up to five treatment foci are selected and a therapeutic strategy is planned, oriented towards either conflict or structure; alternatively, a mixed approach can be adopted. Thus, the OPD system personalizes diagnosis and provides clinicians with tools for making decisions regarding their psychotherapeutic approach (OPD Task Force, 2008). The OPD system can also be used in research, both in diagnosis and process-outcome assessment (Cierpka et al., 2006). As previously noted, the OPD-2 system offers a conceptualization that is greatly useful in clinical practice because it makes it possible to plan a structure-focused strategy. The Structure Assessment Axis is mainly based on the conceptual developments of Ego Psychology (Rapaport, 1967), Self Psychology (Kohut, 1999), and Object Relations Theory (Kernberg, 1995). OPD Structural diagnosis includes an estimation of the individual's overall level of structural functioning and a detailed functioning profile constructed upon the basis of an estimate of the specific functions or capabilities available to him/her. These functions are organized around two poles ─Relationship toward the Self and Relationship toward the Object (others)─ and are grouped into four dimensions: Cognitive Capabilities, Regulation Capabilities, Affective Capabilities, and Attachment Capabilities. All of them contain subcategories, for a total of twenty-four functions (Table 1). In order to identify these capabilities as either deficits or resources and generate a diagnosis, they are described prototypically in each integration level (high, medium, low, disintegrated), which yields 94 descriptors

of structural functions. Integration levels reflect differences in the functioning of each capability, indicating greater or lesser availability of the function (available, interfered, or very fragile) or specifying changes in its mode of operation (being noticeably distorted). Any of these functions can become a therapeutic focus (Ehrenthal et al., 2012).

Table 1

Structural capacities Axis IV OPD-2

Oriented to the self	Oriented to others
1. Cognitive capacities	
1.1. Reflect and differenciate self-image	1.4. Self-object differentiation: distinguish one´s own thoughts, needs, impulses from those of others
1.2. Differentiate one´s own affects	1.5. Peceive others in their various aspects that is, whole persons
1.3. Design and further develop one´s own identity	1.6. Ability to design a realistic picture of others
2. Regulation capacities	
2.1. Distance oneself from impulses, controlling and integrating impulses	2.4. Protect the relationship from one´s own disturbing impulses intrapsychic instead of interpersonal defence
2.2. Distance oneself from affects, regulate affects	2.5. In relationships, maintain one´s own interests and take due account of the interests of others
2.3. Distance oneself from emotional hurts, regulate self-worth	2.6. Anticipate the reaction of others
3. Affective capacities	
3.1. Generate and experience one´s own affects	3.4. Make emotional contact: allow feelings towards others, dare to make emotional investments, achieve “we” feeling (reciprocity)
3.2. Create and use of fantasies	3.5. Express one´s own affects, let oneself be reached by the affects of others
3.3. Emotionally animate perception of one´s own body, or bodily self	3.6. Experience empathy
4. Attachment Capacities	
4.1. Internalization: positive self-representations, positive object representations, ability to build and mantain positive object-related affects	4.4. Ability to form attachments: attach to others emotionally (gratitude, loving care, guilt, sadness)
4.2. Positive introjects: ability to care for oneself, to calm. Console, help, protect oneself, to stand in for oneself	4.5. Acceptance help: ability to accept support, care, concern, guidance, apologies from others
4.3. Variable and triangular attachments: different internal object qualities; attachment to one does not mean turning away from another	4.6. Ability to sever attachments and tolerate farewells

(OPD Task-Force, 2008)

This type of structural diagnosis profile —aimed at establishing a therapeutic focus— is greatly important because it makes it possible to generate a focal approach for patients with personality problems. These patients display deficits in several structural functions, and the therapeutic approach adopted must focus on these difficulties, because it is difficult to examine the patient's underlying psychological conflicts due to the unavailability of the psychological functions that allow individuals to self-regulate and take the distance necessary to reflect on their conflicts. Therefore, clinicians must deal with highly varied, weakly defined, and changing conflict topics (within and between sessions) while also addressing the expression of functioning deficits (e.g., affectively overwhelmed, angry, silent, or distrustful patients during the session). The OPD system makes it possible to identify these insufficient functions and differentiate them from better-preserved ones, thus providing a precise diagnostic profile that can be used to define an approach that considers each patient's characteristics and focuses on them when planning the psychotherapy (OPD Task Force, 2008). The main advantage of the OPD system's dimensional approach is that, by describing each structural function operationally at several levels of integration, it yields a clearer picture of the complexity of the patient's functioning and allows clinicians to plan the psychotherapy considering the patient's deficits to be addressed.

Structure, Functions, and Structural Deficits

Structure and Functions

The word *structure* derives from the Latin *structura*, from the verb *struere*, to construct. In Spanish, the word *estructura* refers to the configuration or relation between the multiple parts of a group, such as the main parts of a building; in addition, it refers to a framework, generally made from iron or concrete, which fixes a building to the ground and supports it (Real Academia Española, 2022). The term is also common in the social sciences (Apostel et al., 1957). In psychology, it has been used to convey the notion that the parts that can be distinguished in a mental set are engaged in defined relationships, being applied to various psychological objects, including personality (Lagache, 1971). In the psychoanalytical tradition, it has been used to understand the functioning of the psyche and possible psy-

chopathological mechanisms, considering the psychic apparatus as a structure that hosts substructures. Originally, Freud developed a structural model, the second topic, in which he describes three elements: Ego, Id, and Superego (Freud, 1923; Laplanche & Pontalis, 1996). In general terms, each of them can be regarded as a representative of an aspect of mental functioning: the ego represents the interests of the whole person, the id the drive-related pole, and the superego the internalization of parental and social prohibitions and demands. The Freudian concept of physic structure denotes a stable organization of psychological functions (Nos, 1995). Later on, based on this structural model, Ego Psychology (Bellak & Hurvich, 1969; Freud, 1980; Hartmann & Rapaport, 1958) discussed and highlighted the relevance of the functioning of this substructure and systematized its functions, even seeking to assess and operationalize them in order to infer the structural functioning of the Ego based on them. At present, the notions of ego, id, and superego have been gradually superseded by a structure model that involves repetitive processes and interactions that are activated to perform adaptive functions; when these fail, psychopathology appears (Westen et al., 2006). Thus, definitions of structure all refer to a set of psychological substructures, mainly unconscious, which dynamically organize mental processing and contents into a coherent whole (Koelen et al., 2012). For their part, the constructs *personality organization*, *character structure*, and *personality structure*, used in the psychoanalytical tradition, are regarded as equivalent, since they refer to organized patterns of personality processes (Westen et al., 2006). In the same vein, the construct *personality functioning* represents the observable aspects of structural conditions; therefore, all these constructs are closely interrelated, which makes it possible to refer to all of them in general as Structure (Doering et al., 2014; Zimmermann et al., 2012). The OPD system defines Structure as "a network of psychic attitudes that comprises all that which, in the experiencing and behaviour of the individual, runs a regular, repetitive course (consciously or remote from consciousness). Structure forms the basis of the ongoing, personal style in which the individual time and time again reestablishes his intrapsychic and interpersonal balance. An undamaged structure grants a flexible and creative availability of functions which have a regulating, adaptive, intrapsychic, and interpersonal effect." (OPD Task Force, 2008, p. 135). From this perspective, structures change through the integration of new information, allowing new regulation rules to be established.

Structural Deficits

The study of deficits in the structural functioning of personality has generally focused on severe disorders such as Borderline Personality Disorder, regarded as a diagnostic entity, and on Severe Personality Organizations. Research has shown that these are complex multi-level phenomena, with interactions between genetic and neurobiological factors and adverse environmental variables present during development (Ensink et al., 2015; Doering et al., 2014). The traditional approach to personality psychopathology as a syndromal model that categorically organizes diagnosis into personality disorders, has been widely adopted and informs the diagnostic manuals of the APA (1980, 1987, 1994, 2000, 2013) WHO (1948, 1977, 1992). However, the categorical view of personality problems has been shown to be limited. Research has revealed that this diagnostic approach is grounded in a conceptual in-accuracy, as there are no defined boundaries for abnormality, but a continuum from normality to personality pathology with rather arbitrary diagnostic thresholds (Bach & First, 2018; Herpertz, 2018). In addition, given the multiple criteria used when defining disorders, diagnoses may overlap, generating high comorbidity among various personality disorders as well as with other syndromes. Likewise, diagnostic categories have been found to lack validity, since they do not represent central and distinctive components of disorders, resulting in highly heterogeneous clinical presentations (Tyrer et al., 2015). All this has clinical implications, since the multiple possible combinations generated by diagnostic criteria make personality pathology more difficult to identify than other mental health disorders, produce artificial comorbidity, and cause the residual category of unspecified personality disorder to increase arbitrarily (Bach & First, 2018; Herpertz, 2018; Tyrer et al., 2015). For these reasons, the latest APA and WHO diagnostic manuals incorporate, each in its own manner, dimensional diagnostic approaches to classify personality psychopathology. The ICD-11 (WHO, 2013) eliminates the disease type categories and focuses on overall severity (personality difficulty and mild, moderate, and severe personality disorder), which can be further specified with one or more traits from five domains (negative affective features, dissocial features, features of disinhibition, anankastic features, and features of detachment) that represent a set of dimensions associated with the patient's underlying personality structure (Tyrer et al., 2015). The

DSM-5 (APA, 2013) maintains its categorical classification, but incorporates a hybrid diagnostic proposal to be empirically studied (Section III: Emerging measures and models). DSM-5 evaluation includes a five-level dimensional assessment of the level of deterioration of personality functioning in terms of the relationship with the self (identity and self-orientation) and interpersonal relationships (empathy and intimacy). This assessment is aimed at differentiating personalities with psychopathology from healthy people or from individuals with other disorders. In addition, it includes an assessment of five dimensions or general domains (negative affectivity, detachment, antagonism, disinhibition, and psychoticism) and 25 subdomains of pathological personality facets-traits, which comprise six defined categories of personality disorders (antisocial, borderline, narcissistic, avoidant, obsessive-compulsive, and schizotypal). These diagnostic proposals still require further empirical validation and have drawn criticism (Herpertz et al., 2017; Meehan et al., 2018; Mulay et al., 2019; Zimmermann et al., 2019); therefore, the traditional perspective based on categorical personality diagnoses continues to be used. However, it has become increasingly relevant to offer diagnoses capable of focusing beyond symptoms, since the available evidence suggests that personality pathologies and other mental disorders share underlying difficulties in latent structures of functioning (Clarkin, Lenzenweger et al., 2007; Luyten & Fonagy, 2021) and that there is a connection between symptom severity and personality functioning (Bender et al., 2011; Köhling et al., 2015; Tyrer et al., 2019). In this regard, the estimation of structural functioning profiles is not only relevant for tackling personality problems; also, their assessment has become increasingly important because they have been proven to be linked to overall psychopathology severity and therefore to therapeutic outcomes. This has made it necessary to consider such profiles in the indication and planning of treatment in other syndromes, such as mood and anxiety disorders (Caligor & Clarkin, 2010; Magnavita, 2004; Doering, et al., 2014; Köhling et al., 2015). This is especially important in clinical practice in institutional settings, since many of the patients who seek help tend to display deficits and vulnerabilities that hinder the efficient treatment of syndromal disorders such as complex depression (Behn, 2019; Behn et al., 2018; Dagnino et al., 2017; Dagnino et al., 2020; de la Parra et al., 2017, 2021).

The assessment of structural functioning with the OPD system takes this limitation into account and works independently from categorical syndromal diagnosis, yielding an estimate of the patient's overall functioning level and identifying specific deficits and vulnerabilities, regarded as a lack of ego functions or fragility in their development in the patient's regulation, reflection, affective communication, and attachment capabilities. In this way, it is possible to generate a dimensional diagnosis and a functioning profile (OPD Task Force, 2008). The OPD system can provide clinically relevant diagnostic information for multiple structural functioning profiles and has the advantage of allowing clinicians to plan flexible treatment strategies in accordance with said profiles. In this dimensional diagnosis, functioning problems can be defined from the moderate integration level onward (operationally equivalent to level 2), where the patient's capacities are still present but in a weakened form. At this level, his/her main anxieties concern loss or separation from objects and the intensity of his/her own impulses. At a low integration level (equivalent to level 3), functions are clearly less available, either permanently or repeatedly in the presence of stressors; there is limited inner emotional space, the self is highly fragile, impulsive, and needy; and representations are threatening, haunting, or nostalgically idealized. Since dissociation is extensive, conflicts are poorly developed internally and are externalized, thus affecting the person's significant world (e.g., close relationships, job, friends). The main anxiety is the destruction of the self. The disintegrated level constitutes psychotic functioning. Between the high, moderate, low, and disintegrated levels, it is possible to identify intermediate functioning types that are not operationally described in the OPD-2 (2008). These types will be included in the third version of the diagnostic manual, which has yet to be published (H. Schauenburg, personal communication, February 17, 2022).

Therapeutic Approaches Aimed at Structural Deficits

Therapeutic approaches for patients with personality functioning problems have displayed a strong tendency to focus on severe disorders, given their complex course and especially their difficult and challenging management (Magnavita, 2004, 2018). In addition, evidence-based psychotherapy has gained relevance due to the need to ensure outcome standards, which has resulted in manualized therapeutic approaches of proven effectiveness (Simonsen et al., 2019; Stoffers-Winterling et al., 2012). The most widely used and legitimized

psychodynamic approaches are Transference-Focused Psychotherapy (TFP) (Caligor et al., 2018; Clarkin & Kernberg, 2015; Clarkin et al., 1999, 2006; Yeomans et al., 2015), Mentalization-Based Treatment (MBT) (Allen & Fonagy, 2006; Allen et al., 2008; Bateman & Fonagy, 2004, 2016), and, though less empirically researched, Supportive Therapy (ST) (Rockland, 1989)[3]. However, efficacy rates based on randomized controlled trials are controversial (Shedler, 2018; Lilienfeld et al., 2018) because, given their design requirements, they study groups of patients who are more homogeneous than those treated in naturalistic clinical contexts, where contextual conditions differ from those studied originally (lack of external validity). Yet, strictly following psychotherapy manuals can hinder adaptation to the idiosyncratic traits of each patient and to the complexities of those with comorbid disorders or external obstacles, including extra-therapeutic conditions such as poverty or insufficient professional resources. In addition, the adherence required by manualized therapies stands in contrast to the flexibility and adaptation to each patient's characteristics necessary in clinical practice (Binks et al., 2006; Carey & Stiles, 2016; Chambless & Hollon, 1998; Grande et al., 2007; Martin et al., 2018).

TFP (Caligor et al., 2018) operates on the assumption that both experience and behavior are organized by a psychic structure composed of units: dyadic object relations. These include a representation of the self, a representation of the other in relation to the self, and an affect linked to both. They are the basic element of psychic structure and organize motivation and behavior; therefore, they form the basis of intrapsychic conflicts and reactions in the transferential relationship. Psychotherapy focuses on the principle of the systematic interpretation of transference and the establishment of treatment structure, with clear commitment rules in the functioning of the psychotherapy. The main strategy consists in facilitating (re) activation in the treatment of split internalized object relations of an opposite, persecutory, and idealized nature, which are observed and interpreted in transference. TFP, a long-term therapy, is conducted in face-to-face sessions, normally between two and three times per week. The main techniques used are clarification, confrontation, and transferential interpretation, but integrating external reality.

3 Tough outside the sphere of psychodynamic psychotherapy, Dialectical Behavior Therapy (DBT) (Linehan, 1993, 2014) has been extensively developed and is backed by a large body of empirical research; likewise, there is empirical evidence of the efficacy of Schema-Focused Therapy (Young, Klosko, & Weishaar, 2003) and Good Psychiatric Management for Personality Disorder (GMP) (Gunderson & Links, 2014).

MBT (Bateman & Fonagy, 2016) is a structured treatment that lasts between twelve and eighteen months, with a clearly defined course during the whole treatment and within the session. Its aim is to develop, maintain, and recover the patient's mentalization capacity. It starts with a Group for Introduction to MBT lasting between 10 and 12 sessions, which is intended to support the diagnosis process. This is followed by individual or group psychotherapy. Sessions focus on non-mentalizing modes.

ST (Rockland, 1989), based on psychoanalytical theory, is a less structured treatment compared to the previous two and seeks to foster adaptation to intrapsychic and external needs rather than facilitate structural changes. Treatment is structured via clear objectives, defined through extensive participation and guidance by the therapist. It focuses on everyday functioning, uses psychoanalytical techniques such as clarification and confrontation, but not interpretation per se, although it pays close attention to transferential developments in order to understand the patient's everyday dysfunctional interactions. In addition, it incorporates cognitive and emotional support, that is, therapist utterances conveying persuasion, advice, suggestions, reassurance, encouragement, and praise (the suggestion, advice, and education triad), and also uses direct environmental intervention via the therapist, family members, or other services provided by mental health staff.

Structure-Oriented Psychotherapy (SOP) (Rudolf, 2004, 2006, 2013) was developed in Germany to complement the OPD system; unlike the latter, however, little empirical research has been done on it and it lacks a training system. Like TFP and MBT, it is aimed at generating structural functioning changes, and like ST, it uses elements that aid the therapeutic relationship and the vulnerable functions diagnosed. It is close to MBT in terms of its view of the development of the self, which is more focused on attachment theory, and more distant from TFP and its strong emphasis on object relations theory. However, SOP expands and flexibilizes the focus of ST, MBT, and TFP: apart from considering mentalization deficits and the poor integration of aspects split off from the self, it focuses on an idiosyncratic profile of deficits in the other structural functions described (Hörz-Sagstetter & Doering, 2015). This makes it possible to treat a wide-ranging group of patients with structure-related problems without needing to adapt a model devised for people with severe functioning issues.

The SOP Manual incorporates diagnosis guidelines and a wide range of recommendations about strategic decisions for planning therapy, as well as specific therapeutic work

techniques for patients with a low level of structural functioning integration. In diagnostic terms, its ultimate objective is to construct, through a joint and shared effort, an image of the patient that reveals both his/her functioning and way of life (self and objects). In this process, the therapist's attitude and understanding are key, since he/she does not ascribe (either conscious or unconscious) intentionality to the patient's behavior and is aware of the difficulties that may emerge in connection with his/her deficits. In this approach, the therapist accepts the limitation of not being able to conduct sessions with material that configures a coherent narrative to which he/she can attribute motivations, since the patient's deficits affect his/her expression and communication abilities. Also, the therapist accesses the patient's biographical history, especially his/her early life, by exploring the context of his/her development and the fundamental early attachments that prevented him/her from building structural functions, not by having the patient subjectively reconstruct his/her history to find meaning in the motivations that generate his/her current problems. Access to this information is gained via other people's narrations about that moment, either directly through the patient's relatives or through what he/she knows. Treatment planning is oriented towards structural issues, that is, deficits and vulnerabilities, while psychotherapeutic strategies have an emphasis that differs in several aspects from that of a therapeutic process with a high-functioning patient. The manual highlights the relational stance and attitude that the therapist must adopt as the main strategies to be used throughout the process (a stable, parental, and available figure). Therapeutic goals are defined together with the patient and are aimed at overcoming difficulties, so that the patient can take responsibility for his/her behaviors and decisions. The manual indicates that the therapist should be able to tolerate the difficulties that characterize the therapeutic relationship, marked by intense patient needs and demands. The therapist's relational positions for working with the patient are also described: “behind” the patient, offering support, concern, and care; “beside”, to recognize his/her functioning; “in front”, to reflect, to offer responses expressing alterity and confronting certain aspects of reality; and “ahead”, anticipating difficulties. With respect to the types of therapist activity, the manual stresses taking the initiative, drawing attention to the patient's internal and external world, and performing microanalyses of interactional situations. The most relevant therapeutic topics to be addressed concern the patient's affects, interpersonal relationship dynamics, and bonds. The key interventions described are reflexes, encouraging reflection, and support interventions,

while other specific interventions are described for cognitive, affective, regulation, and attachment capacities. In addition, the manual describes characteristics of certain moments of the process and stresses the relevance of incorporating topics aimed at developing the patient's responsibility.

This is a clinical guide that offers tools of great usefulness to practitioners; however, it has certain limitations that must be considered before employing it. This proposal is still relatively unknown in our country ─mainly due to the language barrier─ and was developed in an economic and cultural context different from our own. Both these aspects must be taken into account when "importing" psychotherapy models from other countries (Blukacz et al., 2020; Defey, 2018; Kohn et al., 2018). Furthermore, its contents are not presented in a way that facilitates systematic training or the implementation of empirical studies. Conceptual notions, general strategies, and specific interventions are presented in a confusing and repetitive manner in the manual, and it is difficult to easily identify the operational descriptors of clinical interventions among the more conceptual indications. Despite these limitations, the therapeutic tools contained in the SOP Manual are varied and clinically rich and address the complexity of the treatment of patients with structural functioning deficits. The strategy of focusing on psychic dysfunctions based on the OPD-2 is highly promising, since it opens the door to a clinically valuable transdiagnostic approach when working with patients who are not affected by severe personality disorders but who are still deemed hard to treat (Fischer et al., 2019). This has also been the experience reported by the therapists trained in the Operationalized Psychodynamic Diagnosis System (OPD-2) in Chile[4], who have sought to learn more about structure-focused therapeutic strategies derived from this approach to diagnosis.

This doctoral thesis targets this clinical gap in psychotherapy approaches suited to high-pressure, high-demand settings with patients who are "difficult" as a result of their personality functioning deficits and who, due to contextual limitations or because they are not affected by a severe personality disorder, cannot access a psychotherapy that effectively deals with their difficulties and symptoms. To address this problem, the present study advances a therapeutic proposal that empirically characterizes and systematizes the SOP Manual, presenting it as a set of clinical tools which can be applied flexibly and which are technically

4 To date, the Diploma Program organized in Chile to train practitioners in the Operationalized Psychodynamic Diagnosis System has been held 11 times, benefiting over 250 therapists from several Latin American countries.

and conceptually consistent; furthermore, this toolkit is enriched through the observation of psychotherapy sessions. The operational features incorporated into this system are expected to facilitate application, training, and evaluation processes, thus enriching psychotherapy offerings in institutional settings, especially in the public health system. To guide the development of this study, we sought to answer the following question: What characterizes the psychotherapeutic guidelines focused on structural deficits according to the conceptual model of the Operationalized Psychodynamic Diagnosis System (OPD-2) and the exercise of psychotherapy centered on structural personality functioning?

Objectives and Guiding Questions

General Objective:

To propose an operational system of psychotherapeutic tools focused on structure personality functioning deficits, incorporating the perspectives of specialists and the analysis of video-recorded psychotherapy sessions.

Specific Objectives:

To determine and classify the guidelines for specialists (manual of structure-oriented psychotherapy and interviews with therapists) in the model of psychotherapeutic work focused on structure integration deficits, distinguishing their levels of abstraction and scopes of action.

To identify and characterize ─in psychotherapy sessions─ therapeutic interventions associated with therapeutic guidelines focused on structural deficits in patients' overall personality functioning and linked to specific cognitive, regulation, affective, and attachment capabilities.

To establish definitions and descriptions of the guidelines and interventions, integrating the two perspectives studied into an operational system aimed at orienting practice and training in psychotherapy.

Guiding Questions

Question That Guided the Study:

What characterizes the psychotherapeutic guidelines focused on structural deficits according to the conceptual model of the Operationalized Psychodynamic Diagnosis System (OPD-2) and the exercise of psychotherapy centered on structural personality functioning?

Questions That Guided Study 1:

How are psychotherapeutic guidelines organized in the psychotherapy model focused on personality structure proposed by specialists, in terms of levels of abstraction, complexity, areas of the process covered, and differences derived from the moment of the process and the type of structural deficit targeted?

Questions that Guided Study 2:

What guidelines and interventions focused on structural deficits can be distinguished through the observation of psychotherapy sessions belonging to different stages of the process?

What interventions not identified in the perspective of the specialists emerge from the observation of psychotherapy sessions?

Questions that Guided the Integration of Studies 1 and 2:

What complementary relationships can be observed between the categories that emerge from the two perspectives studied?

What guidelines and interventions are common to both perspectives and what are present in only one of them?

Methodology

We employed a qualitative **methodology**, oriented toward the discovery of a relatively unexplored phenomenon: psychotherapeutic work focused on structural deficits of personality functioning. Our approach considered two observation perspectives: psychotherapy specialists and external observers of psychotherapy sessions. We employed a qualitative method due to its usefulness for discovering "new" things and generating hypotheses and theories, which is relevant when little is known about the object of study (Krause, 1995).

The **design** comprised two studies (S1 and S2), each of which sought to provide information about the first two specific objectives. Thus, we conducted an in-depth examination of the perspective of specialists in Structure-Oriented Psychotherapy (S1) and the external observation of strategies and interventions focused on personality structure deficits during psychotherapy sessions (S2). Afterward, we integrated the findings derived from each perspective in order to propose an operational system of therapeutic strategies and interventions focused on structure deficits, thus addressing the third specific objective.

Procedure

We will describe the procedure employed in each study separately and then the one used in the result integration stage.

Study 1 (S1)

This study considered the perspective of specialists in Structure-Oriented Psychotherapy. It consisted in an open coding analysis of two complementary sources of information (document analysis and interviews with specialists) and the construction of a categorical list of interventions, strategies, and psychotherapeutic principles based on the data yielded by the open coding.

The document analysis was conducted to classify and describe the strategies and interventions proposed in the “Manual of Structure-Oriented Psychotherapy” (Rudolf, 2013), distinguishing levels of abstraction and spheres of action and application in the psychotherapy process. Our **sampling unit** in this analysis was Chapter 6 of the “Manual zur strukturbezogenen psychodynamischen Therapie: Allgemeine Strategien und spezifische Interven-

tionen”[5] from the book “Strukturbezogene Psychotherapie. Leitfaden zur psychodynamischen Therapie struktureller Störungen. 3. Auflage”[6], (Rudolf, 2013). This manual complements the Diagnostic Manual OPD-2 (OPD Task Force, 2008) and provides guidelines to conduct a "structure-oriented psychotherapy". The chapter was translated from German into Spanish. This translation was reviewed by the principal investigator and a German-speaking therapist specialized in OPD who had previously worked on the translation of the OPD-2 diagnostic manual. The original version of the chapter is 66 pages long (118 to 184) and comprises 20 sections (see Table 2).

To enrich the theoretical contents of the manual, we conducted 4 semistructured interviews with therapists specialized in OPD who belonged to the OPD Task Force in Germany. They were **purposively selected** to ensure that they were experts in Structure-Focused Psychotherapy and were willing to be interviewed for the study. **Sample size** was determined by feasibility factors. The interviewees were three psychiatrists and one psychologist, all German, male, between fort-six and sixty-six years old. They had all been trained as psychotherapists and psychoanalysts and had over twenty years of clinical experience. The four interviewees have academic experience, are part of the group that created the Operationalized Psychodynamic Diagnosis System, are OPD trainers, and are specialists in Structure-Oriented Psychotherapy. The interviews were conducted in Germany, in English, by the principal investigator. A set of guidelines were used to orient the interviews (Appendix A), which were audio-recorded and transcribed.

Table 2

Sections of Chapter 6 of the Manual of Structure-Oriented Psychodynamic Psychotherapy: General Guidelines and Specific Interventions

Section number	Title
1	Clinical presentation and establishment of therapeutic goals.
2	Relational disposition, transferential offer, and countertransference in structural disorders

5 Chapter 6 of the “Manual of Structure-Oriented Psychodynamic Psychotherapy: General Guidelines and Specific Interventions”.
6 Structure-Oriented Psychotherapy: Guidelines for the Psychodynamic Therapy of Structural Disorders.

Sections of Chapter 6 of the Manual of Structure-Oriented Psychodynamic Psychotherapy: General Guidelines and Specific Interventions

3	Generation of a therapeutic attitude
4	Therapeutic positions
5	Therapeutic activity in structure-oriented psychotherapy
6	Therapeutic work focused on the implicit unconscious
7	Therapeutic work focused on the third-party position
8	Therapy as a structural experience of the self
9	Thematic areas of the therapy *(areas, megafoci)*
10	Therapeutic interventions
11	Therapeutic process
12	Sequencing of therapeutic objectives and interventions
13	Therapeutic focus on structure
14	Systematization of structure-oriented interventions
15	Therapeutic promotion of structural capabilities: selected examples
16	Adherence to the guidelines included in the psychotherapy manuals of structure-oriented psychotherapy
17	Case example: a psychotherapy process
18	Therapeutic working-through of conflict and structure
19	Ethical attitude as a therapeutic goal
20	Relationship between structure-oriented psychotherapy and other psychodynamic procedures

(Rudolf, 2013)

We used content analysis with open coding as our **data analysis strategy**. This approach provides depth and analytic richness in data analysis, since it rearranges data into homogeneous groups with a similar meaning using a descriptive rule that justifies their grouping across several levels of abstraction (Cáceres, 2003). We used Atlas-Ti to systematize and store the analysis. The "hermeneutic unit"[7] comprised twenty-four documents: the twenty sections of the manual and the four interviews. We used the paragraph as the unit of analysis for the sections of the manual and speaking turns for interviews.

7 A hermeneutic unit is the work unit or file in Atlas-Ti that contains all the information produced during the analysis, including the documents used for coding (Muñoz & Sahagún, 2017).

The **content analysis with open coding** was conducted according to **Grounded Theory guidelines until the descriptive stage** (Strauss & Corbin, 2002) by two coders (the principal researcher and a researcher experienced in qualitative analysis). The results were triangulated by means of intersubjective agreement.

Open coding made it possible to construct a list of therapeutic interventions associated with therapeutic strategies and principles as our first attempt at categorization. Appendix B includes a detailed list of these categories. This list was then used in Study 2 to develop a guide for observing and coding therapeutic interventions in video-recorded psychotherapy sessions.

Study 2 (S2)

The aim of this study was to identify and characterize ─in psychotherapy sessions─ therapeutic interventions associated with therapeutic guidelines focused on structural deficits in patients' overall personality functioning and linked to specific cognitive, regulation, affective, and attachment capabilities.

To implement this study, based on the listing of categories yielded by Study 1, we constructed a **procedural guide to orient the observation and coding of strategies and interventions focused on structural personality deficits** in video-recorded and transcribed psychotherapy sessions. This guide included a brief description of the Operationalized Psychodynamic Diagnosis System OPD-2, the focus on structure of this diagnosis system, the concepts of Structure, Dimensions, and Structural Capabilities in OPD-2, and a description of the categories that emerged from Study 1 (Appendix C). In addition, we made explicit the procedures and tasks of the coders: 1) to identify interventions at an operational level, assigning a code to them and 2) to create and describe any additional interventions found based on their observations, linked to strategies, that were not included in the listing handed to them. Each coder was given an Observation Guide, the list of categories and their codes, the confidentiality agreement (Appendix D), the video-recorded sessions, the transcripts of the sessions with demarcations identifying the units of analysis (three-minute segments), and a link to an Excel spreadsheet to record the codes found.

Before starting the coding process, a videoconference **training program** lasting twenty-eight hours was conducted, led by the principal investigator and six coders. Two

meetings were held to train the observers in Axis IV of the OPD-2 and the focus on structural deficits proposed by this diagnosis system. In one of these meetings, the coders and the research team reviewed the Observation Guide, which explains the observation and coding procedures and contains the categories to be observed, complemented with definitions and examples. After signing a confidentiality agreement, eleven **group meetings** were held in which the raters and the research team **observed and coded** three psychotherapy sessions to complement, based on their practical experience, the initial indications of the guide, clear any doubts, and calibrate their observations. Apart from training the coders, this process made it possible to fine tune the Guide's indications about the observation and coding process. After completing this training, the six coders worked in dyads to **observe the sessions**. The coders were tasked with identifying the interventions defined in the study and assigning a code to them; also, they were required to describe any additional interventions found in their observations, linked to strategies, that were not included in the listing handed to them. The **dyads** individually coded the session segments and arrived at **intersubjective agreement**. When no agreement was reached, the principal investigator defined the final coding. The dyads were changed every two sessions so that the observers' coding criteria would remain similar. The coders were six psychologists (five women and one man), aged between twenty-four and twenty-seven years, with different levels of clinical and academic experience. The coders' characteristics are presented in Table 3.

Table 3

Characterization of the coders

Rater	Age	Gender	Profession	Years of experience	Academic Experience
coder 1	25	F	psychologist	1	bachelor's degree
coder 2	24	F	psychologist	1	bachelor's degree
coder 3	27	F	psychologist	1	bachelor's degree
coder 4	27	M	psychologist	2	bachelor's degree
coder 5	30	F	psychologist	5	naster's degree
coder 6	30	M	psychologist	5	master's degree

The **sample** was composed of forty-two video-recorded sessions purposively selected from three psychotherapies with the following inclusion criteria: implemented in public or private institutional settings, b) with therapists trained in OPD, c) with patients with low to medium structure integration according to the OPD-SQ and d) who agreed to participate in the study. Both the patients and the therapists signed an informed consent document. Patients who met criteria for borderline or antisocial personality disorder, psychotic disorder, mental retardation, or organic damage were excluded. We employed one psychotherapy previously carried out in a study conducted by the Millennium Institute for Personality and Depression Research (MIDAP) whose informed consent allowed audiovisual material to be used in new analyses. Two psychotherapies were conducted and video recorded as part of this study. Once the informed consents to participate were approved, we evaluated the patients' level of structural integration with the OPD-SQ, adapted and validated in Chile (de la Parra et al., 2017; Lorenzini et al., 2021). This self-report questionnaire (Appendix E) comprises 95 items that asses eight structural dimensions: self-perception, object perception (cognitive capabilities), self-regulation, regulation of relationships (regulation capabilities), internal emotional communication, emotional communication with the external world (affective capabilities), internal attachment, attachment in external relationships (attachment capabilities). Each scale places the patient on a continuum of integration scores for each function, with 1 representing a high level of integration, 2 a medium level, 3 a low level, and 4 a disintegrated level. The average of all the scales constitutes an indicator of overall structural functioning (Ehrenthal et al., 2012). The treating clinicians were one female psychologist, one male psychologist, and one psychiatrist, all experienced psychotherapists (with nineteen to thirty-plus years of professional experience) whose orientations were psychodynamic and systemic. They had received training in the Operationalized Psychodynamic Diagnosis System OPD-2. The patients were between twenty-one and thirty-one years old, with OPD-SQ scores between 2.5 and 2.66. All three had received syndromal diagnoses of depressive disorder. The characteristics of the therapeutic processes and the participants is presented in Table 4.

Table 4

Characterization of the psychotherapies

	Psychotherapy 1	Psychotherapy 2	Psychotherapy 3	
Therapist Information				
age	49	67	46	
gender	F	M	M	
years of experience	22	30+	19	
theoretical orientation	systemic	psychodynamic	psychodynamic	
Patient Information				
age	31	22	21	
gender	F	F	F	
OPD-SQ score	2.66	2.5	2.5	
diagnosis	depressive disorder	depressive disorder	depressive disorder	
Therapy Information				
no. of sessions	11	16	18	
total sessions				45
no. of segments	186	169	300	
total segments				655

For coding, each session was temporally divided into three-minute segments. A total of 655 **units of analysis** were coded. To estimate the agreement of the observer dyads in their identification of Therapeutic Guidelines, we calculated the percentage of concordance over the total number of units of analysis, with a result of 70,16 %.

Integration of S1 and S2

To integrate the results, we **incorporated the transcripts** of the forty-two sessions into the "hermeneutic unit" of Study 1 using Atlas-ti. We created the quotations identified by the coders, assigning existing codes to them as well as the new codes generated through the observation of the sessions. Thus, **each category was linked to quotations from the manual, the interviews, and/or the session transcripts**. In this stage, we made changes to some

categories based on the coders' comments in Study 2 and the intersubjective resolution of their disagreements. This process resulted in a **list of categories** enriched by session observation. Lastly, an expert in qualitative analysis knowledgeable in OPD-2 reviewed this new list of categories to fine-tune their logical levels, repetitions, or overlaps and check the wording of their names and definitions. At the end of this process, she reached intersubjective agreement with the principal investigator. Based on this new arrangement, we developed the Operational System of Principles, Guideliines and Interventions Focused on Structural Personality Functioning Deficits that will be described in the Results section.

This study was approved by the **Institutional Review Board** of Social Sciences, Arts, and Humanities Research of the Pontificia Universidad Católica de Chile (Appendix F).

Results

Results[8] configuring the proposal for an Operational System of Principles, Guidelines, and Interventions Focused on Structural Personality Functioning Deficits stem from integrating Study 1 (the open codification of the Structured Oriented Psychotherapy (SOE) Manual[9] and of the interviews done with specialists) with Study 2 (the identification and creation of intervention categories from observing video-recorded sessions) and the final regrouping of the categories generated in both studies.

Psychotherapeutic Tools in Three Levels of Abstraction: Why do it? What to do? How to do it?

The first distinction for psychotherapeutic orientations was made based on levels of abstraction, thus generating three categories: Therapeutic Principles, Therapeutic Guidelines, and Therapeutic Interventions[10].

Therapeutic Principles

They correspond to higher levels of abstraction categories. The concept "Therapeutic Principle[11]" was coined by the author (Rudolf, 2013) to name those categories which incorporate wide and fundamental definitions, which in turn allow for a framing of the treatment focusing on the structure from the OPD model, while at the same time distinguishing it from other psychoanalytic approaches. Altogether, six Therapeutic Principles were identified. This category can be assimilated to the question *why do it?* The list of Principles can be found in Table 5.

[8] For the purposes of fluency in writing and reading, the terms "the patient" and "the therapist" have been used in the presentation of the results in masculine gender when referring to persons of female, male and non-binary gender.
[9] Chapter 6 Manual zur strukturbezogenen psychodynamischen Therapie: Allgemeine Strategien und spezifische Interventionen"[9] del libro Strukturbezogene Psychotherapie. Leitfaden zur psychodynamischen Therapie struktureller Störungen. 3. Auflage, (Rudolf, 2013).
[10] To make the reading of the results easier, all *Therapeutic Principles* categories will be written in *italics*, *Therapeutic Guidelines categories in italics and underlined*, and ***Therapeutic Interventions categories in italic and bold.***
[11] In Spanish, the word *principio* refers to a "Basis, origin, fundamental reason on which one proceeds in discourse in any matter; fundamental rule or idea governing thought or conduct" (Real Academia Española. *Diccionario de la lengua española, 23ª ed*.)

Table 5

List of Therapeutic Principles

A	A Therapeutic approach requires an understanding based on the deficit model
B	B Psychotherapy goals are different from those of classical psychodynamic approaches
C	C Psychotherapy work requires a therapeutic attitude and an internal disposition fit for deficit development
D	D Psychotherapy work requires developing a cooperative therapeutic relationship
E	E Therapeutic experience has a structuring function itself
F	F Psychotherapeutic work is focused on structural deficits

Therapeutic Guidelines

They are aimed directly at the therapeutic work and constitute an intermediate level of abstraction in relation to Therapeutic Principles. They contain guidelines for psychotherapeutic work, akin to a series of rules with directional character for when it is time to plan interventions. A total of 33 Guidelines were identified, all of which are presented in Table 6. This category can be assimilated to the question *what to do?*

Table 6

List of Therapeutic Guidelines

A1	Do not subscribe to classical psychoanalytic logic
A2	Understand the patient's dysfunctional behavior as an aspect of their interpersonal abandonment
A3	Focus on functions that the patient could not develop on their own
A4	Support the development of missing abilities
A5	Adjust therapeutic methods to the patient's restrictive relational competences
B1	Aim for the development of self-reflection and realistic perception of the patient's self and objects
B2	Aim for the patient to get familiar with their own emotions
B3	Guide the work towards developing the patient's capability for self-regulation
B4	Stimulate the emergence of new emotional experiences and the internalization of new positive relational experiences
B5	Aim for the patient to take responsibility for their own wellbeing and avoid self-harm
B6	Establish with the patient their model of problematic functioning without incorporating a dynamic unconscious understanding of its origin
C1	Be available for the patient as an equal
C2	Ready yourself to respect less effective coping strategies due to their previous adaptive function
C3	Ready yourself to work actively
C4	Ready yourself to assume a parental attitude that promotes development

List of Therapeutic Guidelines

C5	Ready yourself to sustain hope for a primarily positive progression of the patient
C6	Aim strongly for identification and tolerance of countertransference
C7	Be actively prepared to creatively connect with the patient despite their structural deficits
C8	Work with a group of peers that contains you and allows you to sustain an abilitating attitude
D1	Always adjust to the patient's restricted capacities
D2	Work without promoting transference. Investigate with the patient difficult aspects of their life as if they were a third party (triangulation)
D3	*Look for ways to emotionally connect with the patient promoting a weness experience in the therapeutic relationship*
D4	Separate your responses according to the patient relational offers during the different stages of the process (initial-middle-final)
D5	Place the patient in an active role
E1	Pay attention to identification models you offer to the patient
E2	Guide the patient to develop responsibility for themselves
F1	Evaluate deficits and establish the reasons for consultation jointly with the patient
F2	Establish a psychotherapeutic focus with the patient
F3	Establish a clear therapeutic setting
F4	Undertake a general process work focused on the structure
F5	Work focused on specific deficits according to the patient's profile
F6	Track the therapeutic process (S*)
F7	Prepare closure for the process

Note: (S*) =Guidelines created based on observations of sessions

Therapeutic Interventions[12]

The third group describes ***Therapeutic Interventions*** which are at the lowest level of abstraction because of their specificity. They include simple actions as well as more complex procedures. After having analyzed the Manual and interviews, observing sessions and re-grouping, 59 interventions were established, all of which are listed in Table 7.

Table 7

List of Therapeutic Interventions

C1.1	Respond “normally” to the patient’s relational offer
C1.2	Use informal and comprehensible language with the patient
C1.3	Answer the patient’s questions
C1.4	Show doubts, confusions (*S)

[12] Interventions, of any category, are the way in which the psychotherapist proceeds and activates, within the treatment, in their relationship with the patient (Vernengo & Stordeur, 2019).

List of Therapeutic Interventions

C2.1	Empathise with the patient's early relational experiences
C2.2	Show the previous adaptive function of the current maladapted coping (S*)
C3.1	Intervene actively during therapeutic work
C4.1	Intervene in therapeutic parental function of small child or adolescent
C5.1	Make the patient's positive development possibilities clear
C6.1	Identify typical countertransference of patients with structural deficits
C6.2	Try not to get discouraged by the patient's challenging relational offers
C6.3	Get close to the patient by paying attention to differentiation
C6.4	Avoid putting constrictive pressure on the patient
C7.1	Use words, metaphors, designs, drawings, and pictures to promote narrative communication
C8.1	Share thoughts or emotions about the process with peers or supervisors
D1.1	Show the difficulties in carrying out interventions on the patient benevolently
D2.1	Don't look for motivational significance in the patient's relational offer within sessions
D3.1	Suggest an empathic relational offer that facilitates experiencing a benevolent bond with the patient (S*)
D3.2	Evaluate the patient's experience of the session (S*)
D4.1	Use the relational position "behind the patient"
D4.2	Use the relational position "with the patient"
D4.3	Use the relational position "in front of the patient"
D4.4	Use the relational position "ahead of the patient"
D4.5	Contrast and compare the different relational positions' perspectives
D5.1	Include the patient in the characteristic actions of the therapeutic work from the beginning
E1.1	Recreate an early relationship of structuring function
E2.1	Encourage the end of risk behaviours/ promote adaptive activities
E2.2	Provide psychoeducation, advice, make suggestions, answer questions
F1.1	Explore with the patient the problem that motivates consultation (S*)
F1.2	Explore with the patient the current situation and its biographical background
F1.3	Explore with the patient their structural limitations (cognitive, affective, regulatory, bonding)
F1.4	Explore with the patient coping strategies used in negative experiences (symptoms and risk behaviours)
F1.5	Explore with the patient maladaptive relational patterns developed by the patient based on symptomatic behaviour
F1.6	Identify with the patient stagnation of development (partner, family, professional, health, autonomy) and structural deficit associated with them
F2.1	Evaluate the patient's expectations about psychotherapy (S*)
F2.2	Propose and agree with the patient a topic to work on
F2.3	Highlight the patient's resources within the framework of focalization (S*)
F3.1	Establish clear responsibilities for the patient and therapist
F3.2	Provide psychoeducation about the therapeutic process (S*)
F3.3	Establish and agree on protocols for possible risk behaviours
F4.1	Clearly identify patterns with the patient

List of Therapeutic Interventions

F4.2	Perform mirroring interventions
F4.3	Search and highlight resources
F4.4	Pay attention to signs of implicit memory
F5.1	Signify structural limitations in biographical context
F5.2	Intentionally target and intervene in perception deficits
F5.3	Intentionally target and intervene in regulation deficits
F5.4	Intentionally target and intervene in affective deficits
F5.5	Intentionally target and intervene in bonding deficits
F5.6	Intervene in dysfunctional relational patterns determined by deficits
F5.7	Practice functions in therapeutic relation
F6.1	Resume issues relative to the setting during the therapeutic process (S*)
F6.2	Highlight improvements, achievements, and therapeutic changes during the process (S*)
F6.3	Evaluate the psychotherapeutic process with the patient and adjust focus and/or duration (S*)
F7.1	Address the possibilities of closure for the process (S*)
F7.2	Address affections associated with closure of the process (S*)
F7.3	Explore the experience of psychotherapeutic work done with the patient (S*)
F7.4	Explore changes and improvements concerning the focus proposed and complementary topics (S*)
F7.5	Explore strategies with the patient to address difficulties related to ending the psychotherapeutic process (S*)

(S*) = Interventions created based on the observation of sessions

Psychotherapeutic Tools to Be Used at Different Stages and Areas of the Therapeutic Process: When in the process? In what scope of the process?

Within the groupings according to levels of abstraction it was possible to distinguish stages and contexts of application. In their definition, all six Therapeutic Principles encompass every area and stage of the psychotherapeutic process, and therefore they have been defined as transversal to this systematization. By lowering abstraction levels, some of their guidelines and interventions can be set aside and used at specific stages and areas of the therapeutic process. This is the case of Guideline *D4 Separate your responses according to the patient's relational offers during the different stages of the process (initial-middle-final)*, as well as for its associated interventions. As it will be seen, these indicate that the therapist, depending on whether they are at the initial, middle or final stage of the process, will position themselves in a different manner in relation to the patient's relational offer. In the case of Principle F, Guidelines *F1 Evaluate deficits and establish the reasons for consultation jointly with the patient*, *F2 Establish a psychotherapeutic focus with the patient* and *F3 Establish a*

clear therapeutic setting apply to the initial phase of the treatment but refer to different areas of action for this stage of the process (evaluation, defining focuses, and setting). Guidelines *F4 Undertake general process work focused on structure*, *F5 Work focused on specific deficits according to the patient's profile* and *F6 Track the therapeutic process* mainly correspond to work done during the middle stage of psychotherapy, whereas guideline *F7 Prepare closure for the process* to the final stage.

Psychotherapeutic Tools to Be Used for Different Aspects of the Patient: In what Dimensions of the Patient Functioning?

Guideline *F5 Work focused on specific deficits according to the patient's profile* allows for a different distinction to be made from the already mentioned ones, given that it gathers interventions targeting to specific deficits detected in the assessment and agreed as foci with the patient. All the other guidelines address aspects of global functioning of patients with medium to low level of structure integration, although Guideline *F4 Undertake general process work focused on structure* gathers more specific interventions to work considering the clinical material the patient is bringing to sessions. Table 8 shows general characteristics of the groups described.

Contributions to Psychotherapeutic Tools Derived from Perspective of Specialists from Observing Sessions

During the second study, sessions were observed to identify categories from the previously elaborated list, so as to assign them a corresponding code, and also record comments that were relevant to their descriptions. In addition, new strategies or interventions had to be created when necessary. A new Guideline was created, *F6 Track the therapeutic process (S*)*, assigned to Principle *F Phychotherapeutic work is focused on structural deficits*. This category highlights the need for the therapist to pay close attention to any adjustment that the therapeutic process may require and make it the topic for the session. Three new Interventions originated from this: ***F6.1 Resume issues relative to the setting during the therapeutic process (S*), F6.2 Highlight improvements, achievements, and therapeutic changes during the process (S*)*** and ***F6.3 Evaluate the psychotherapeutic process with the patient and***

adjust focus and/or duration (S*). Also, 13 new Interventions were created associated with Guidelines that already existed, all of which are shown in Table 9.

Table 8

Levels of psychotherapeutic work with focus in structural functioning

Category	6 therapeutic principles Why do it?	33 therapeutic guidelines What to do?	59 therapeutic interventions What to do?
Level of abstraction	high	intermediate	low
Description	wide and fundamental definitions that allow to frame the treatment focusing on the structure from OPD model, and simultaneously differentiate it from other psychoanalytic perspectives	rules that have instructional character when planning interventions	more complex concrete actions and procedures done by the therapist
Scopes of application of psychotherapy	transversal	evaluation focalization	evaluation focalization
In which moment in the process?		setting	setting
In what scope of the process?		process development closure of the process	process development closure of process
Scopes of application for the patient	transversal	global functioning	global functioning
In which aspects of the patient's functioning?		specific according to deficit profile	specific according to deficit profile

Table 9

Interventions created based on observing sessions and associated to existing Guidelines

Guideline	Intervention
C1 Be available for the patient as an equal	C1.4 Show doubts, confusions (*S)
D1 Always adjust to the patient's restricted capacities	D1.1. Show the difficulties in carrying out interventions on the patient benevolently (*S)
D3 Look for ways to emotionally connect with the patient promoting a weness experience in the therapeutic relationship	D3.1 Suggest an empathic relational offer that facilitates experiencing a benevolent bond with the patient (S*)
	D3.2 Evaluate the patient's experience of the session (S*)

Interventions created based on observing sessions and associated to existing Guidelines

F1 Evaluate deficits and establish the reasons of consultation jointly with the patient	F1.1 Explore with the patient the problem that motivates consultation (S*)
F2 Establish a psychotherapeutic focus with the patient	F2.1 Evaluate the patient's expectations about psychotherapy (S*) F2.3 Highlight the patient's resources within the framework of focalization (S*)
F3 Establish a clear therapeutic setting	F3.2 Provide psychoeducation about the therapeutic process (S*)
F7 Prepare closure for the process	F7.1 Address the possibilities of closure for the process (S*) F7.2Address affections associated with closure of the process (S*) F7.3 Explore the experience of psychotherapeutic work done with the patient (S*) F7.4 Explore changes and improvements concerning the focus proposed and complementary topics (S*) F7.5 Explore strategies with the patient to address difficulties related to ending the psychotherapeutic process (S*)

Note: Categories (S*) created based on the observation of sessions

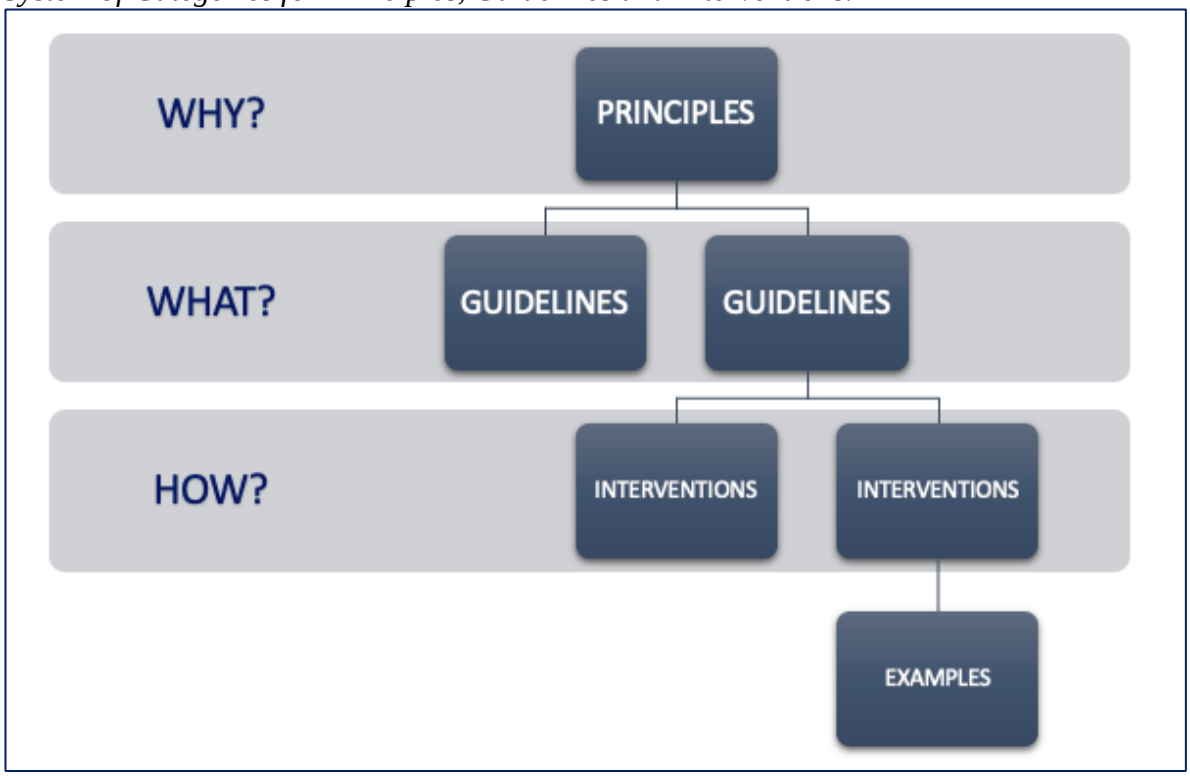
Category System: Relations and Descriptions

All three categories, Principles, Guidelines, and Interventions emerged independently from codification; later, Guidelines were assigned to Principles, and interventions were assigned to Guidelines, seeking to keep levels understandable and to give the contents a coherent organization. The result is a systematized set of Principles that provide meaning ("why do it") to guidelines of work ("what to do"). Working guidelines, in turn, have in most cases corresponding interventions ("how to do it") at concrete levels of action, with clinical examples. Descriptions for the Principles and Guidelines were developed based on quotes from the manual and interviews. Examples from interventions were taken from observed sessions and the manual.

Categories are shown below: Principles, Guidelines and Therapeutic Interventions, organized according to relations established in the analysis, incorporating their descriptions and, in the case of interventions, examples. Within the six Principles, four of them have Guidelines associated, with their corresponding interventions. Because of their conceptual nature, two other principles result in Guidelines and not Interventions (Figure 1).

Figure 1

System of Categories for Principles, Guidelines and Interventions.



Note: The figure shows the order of Principles, Guidelines and Interventions, where some Principles are associated with Guidelines that result in Interventions and clinical examples, and some don't.

The first two Principles are introduced together, *A Therapeutic approach requires an understanding based on the deficit model* and *B Psychotherapy goals are different from those of classical psychodynamic approaches, since* they both share a conceptual character and, as mentioned before, result only in Guidelines. They refer to the understanding that the therapist must have of the patient's problems, and therefore to the adjustments that must be made to the therapy's goals. Guidelines with inferential character are assigned to these two Principles. Principles and their associated guidelines are shown in Table 10.

Table 10
List of Conceptual Therapeutic Principles and associated Guidelines

Therapeutic Principles	Therapeutic Guidelines
A Therapeutic approach requires an understanding based on the deficit model	A1 Do not subscribe to classical psychoanalytic logic
	A2 Understand the patient's dysfunctional behavior as an aspect of their interpersonal abandonment
	A3 Focus on functions that the patient could not develop on their own
	A4 Support the development of missing abilities
	A5 Adjust therapeutic methods to the patient's restrictive relational competences
B Psychotherapy goals are different from those of classical psychodynamic approaches	B1 Aim for the development of self-reflection and realistic perception of the patient's self and objects
	B2 Aim for the patient to get familiar with their own emotions
	B3 Guide the work towards developing the patient's capability for self-regulation
	B4 Stimulate the emergence of new emotional experiences and the internalization of new positive relational experiences
	B5 Aim for the patient to take responsibility for their own wellbeing and avoid self-harm
	B6 Establish with the patient their model of problematic functioning without incorporating a dynamic unconscious understanding of its origin

Principle A Therapeutic approach requires an understanding based on the deficit model establishes that the patient's difficulties will be understood mainly as an expression of their deficit/needs, and not as an expression of unconscious/pulsion motivations. Therefore, interventions must aim to support and strengthen the structure, instead of addressing the conflict, and must adjust to the patient's needs. Unconscious aspects expressed are not considered part of the "explicit" unconscious formed by thoughts, representations, memories or desires kept in a verbal-conceptual way and protected against perception by conscience through defenses, because they are associated with negative emotions (shame, guilt, fear, desperation, pain). In patients with structural deficits, topics deal mainly with expressing implicit memory, manifested in relational and nonverbal ways, not related to words already developed as mechanisms to confront an early deprived environment. Therefore, the processing done by the therapist of these offers from the patient is considered psychodynamic, since they are returned within the therapeutic relationship, and made susceptible of being experienced, perceived and thought-out without necessarily being interpreted. This way the

unconscious implicit experience becomes accessible to the patient's self. Five Therapeutic Guidelines are associated with this Therapeutic Principle:

A1 Do not subscribe to classical psychoanalytic logic which stems from the understanding that what is not available to the psyche is defensively blocked, and therefore has unconscious intentionality. The therapist must understand the patient's deficits as expressions for specific states of the *self* which are the consequence of insufficient early relational experiences. Therefore, it is important for the therapist to keep in mind the adaptational aspects of these limitations/dysfunctionalities, and to signify them positively in terms of resources. The intentional unconscious aspects of the experience will not be developed.

A2 Understand the patient's dysfunctional behavior as an aspect of their interpersonal abandonment, and not as aggressive-destructive expressions, disdainful intentions, or as offers for personal transference. Therefore, the therapist must not question these defensive/compensatory patterns, but rather consider that they have become the best possible way or solution for the patient to confront unbearable or complex situations from the past.

A3 Focus on functions that the patient could not develop on their own because of early emotional support deficiencies. These limitations should be identified by the therapist without being recognized by the patient as something to be ashamed of; on the contrary, they should be experienced as capacities or functions not available because they have not been delivered to them.

A4 Support the development of missing abilities. After identifying those functions that are not available to regulate, understand or structure the patient's current situation, the therapist seeks to develop them within the therapeutic process in order to finally stimulate the patient to use them outside the session.

A5 Adjust therapeutic methods to the patient's restrictive relational competences, without therapeutically taking or reinforcing the patient's transferential offer. If the therapist makes interpretations related to the transference, these should not be aligned to traditional neurosis psychotherapy, oriented at the conflict, but aimed at creating and strengthening the therapeutic alliance.

Principle B Psychotherapy goals are different from those of classical psychodynamic approaches establishes that unlike traditional psychodynamic approach, therapeutic goals

should aim at improving the patient's structural functions, developing new ways for confrontation that improve self-efficiency and responsibility for oneself, improvements that come mainly from the possibility of distancing themselves from overflowing feelings, so as to be able to manage and regulate them, as well as developing and/or strengthening functions of comprehensive perception of the object, differentiating *self* from the object and developing empathy. There are six Therapeutic Guidelines associated with this Principle:

B1 Aim for the development of self-reflection and realistic perception of the patient's self and objects. The therapist guides the work to clear internal states and interpersonal situations and their causes, in order to become familiar with their mental processes, and to distinguish in them aspects that are personal or external (of others) so as to not distort reality with their own projections. This process stimulates the patient to find a language that allows them to acknowledge their functioning patterns.

B2 Aim for the patient to get familiar with their own emotions. Experiencing emotions allows for the patient to get involved with their intrapsychic processes and give meaning to symptomatic behaviors, progressively incorporating autobiographical aspects to deepen self-understanding. Reinvigoration comprehends relating to others, encouraging the patient to get emotionally involved in their interpersonal relationships.

B3 Guide the work towards developing the patient's capability of self-regulation. The structural task of integration is aimed at the patient being able to take an internal distance from overflowing impulses and negative feelings, influencing self-valuation. Additionally, this work aims at tracing and managing limits that allow them to differentiate and define themselves, in contrast to fusion tendencies. Developing this regulation allows the patient to have at their disposal psychic functions to choose how to conduct their actions.

B4 Stimulate the emergence of new emotional experiences and the internalization of new positive relational experiences. The therapist must stimulate in the patient the emergence of new and positive emotional experiences in their interpersonal relations, so that they can learn how to relate to good objects, internal (that help them self-contain and calm themselves down) as well as external (that act as relational resources whenever they need them). The therapist also contributes to unfold these experiences within the therapeutic relationship.

B5 Aim for the patient to take responsibility for their own wellbeing and avoid self-harm. Inasmuch as the therapist is focused on the goals of structural strengthening, the process is gradually oriented towards a more responsible functioning of the patient in regard to themselves and their relationships.

B6 Establish with the patient their model of problematic functioning without incorporating a dynamic unconscious understanding of its origin. The therapist helps the patient make their behavior visible and recognizable to themselves as a pattern of functioning in descriptive terms (acknowledging difficulties) and not in terms of underlying dynamisms (understanding where they come from). Based on this acknowledgement, therapist and patient seek alternative solutions, more adaptive, without entering the unconscious motivational understandings that may be the basis for the identified patterns.

Third Principle *C Psychotherapeutic work requires a therapeutic attitude and an internal disposition fit for deficit development* describes an attitudinal aspect of the therapist that results into Guidelines and Interventions. The relationship between its categories on all three levels is shown on Table 11. This principle refers to the way that the therapist must settle in the process and in the therapeutic relation to be fit for the kind of interventions that are required to be performed. It establishes that the therapist must stay active to support and contain the patient, inspired by the way in which adults lead a child or an adolescent. The therapist must always show an open and unconditional attitude of acceptance from a symmetrical and respectful position that offers stability by sustaining motivation, hope and interest in the therapeutic work, especially when patients are not in condition to sustain these aspects for themselves. The 8 associated Guidelines derive in 15 interventions.

C1 Be available for the patient as an equal. Therapists must consider the patient as a person with rights. Consequently, they must not interpret the psychic process of the patient from a higher position and should be flexible about the rules of abstinence and psychoanalytic neutrality. Therefore, the therapist uses a more spontaneous attitudinal style consistent with the patient's relational offer, although always within the framework of the asymmetry according to the professional therapeutic situation. The therapist must be at the service of the patient to help them stabilize and overcome their difficulties.

Table 11

List of guidelines and interventions associated to Principle C Therapeutic work requires a therapeutic attitude and an internal disposition fit for deficit development

Therapeutic Principle	Therapeutic Guideline	Therapeutic Intervention
C Psychotherapy work requires a therapeutic attitude and an internal disposition fit for deficit development	C1 Be available for the patient as an equal	C1.1 Respond "naturally" to the patient's relational offer
		C1.2 Use informal and comprehensible language with the patient
		C1.3 Answer the patient's questions
		C1.4 Show doubts, confusions (*S)
	C2 Ready yourself to respect less effective coping strategies due to their previous adaptive function	C2.1 Empathise with the patient's early relational experiences
		C2.2 Show the previous adaptive function of the current maladapted coping (S*)
	C3 Ready yourself to work actively	C3.1 Intervene actively during therapeutic work
	C4 Ready yourself to assume a parental attitude that promotes development	C4.1 Intervene in therapeutic parental function of small child or adolescent
	C5 Ready yourself to sustain the hope of a primarily positive progression of the patient	C5.1 Make the patient's positive development possibilities clear
	C6 Aim strongly for the identification and tolerance of countertransference	C6.1. Identify the typical countertransference of patients with structural deficits
		C6.2 Try not to get discouraged by the patient's challenging relational offers
		C6.3 Get close to the patient by paying attention to differentiation
		C6.4 Avoid putting constrictive pressure on the patient
	C7 Be actively prepared to creatively connect with the patient despite their structural deficit	C7.1 Use words, metaphors, designs, drawings and pictures to promote narrative communication
	C8 Work with a group of peers that contains you and allows you to sustain the abilitating attitude	C8.1 Share thoughts or emotions about the process with peers or supervisors

(S*) = Guidelines or Interventions created based on the observation of sessions

Interventions associated to *C1 Be available to the patient as an equal* *are:*

C1.1 Respond "normally" to the patient's relational offer. The therapist reacts in the most spontaneous way possible, within their therapeutic role, to the patient's relational offer.

C1.2 Use informal and comprehensible language with the patient. The therapist strives to translate technical language to make their points of view understandable.

Example:

"T: I, I don't know if my comment on suicidal tendencies is any good… Mmm, it has to dowith this diagnosis, how do you feel about it? What are your thoughts on "borderline" or "borderline personality disorder" diagnosis? … P: I don't feel it fits… T: What doesn't fit?... P: No… T: Yes, I know that in many ways it doesn't fit, and also in which ways it could… Mmm, I'm telling you this because… not of the diagnosis, because I agree with you that in many ways it doesn't, I don't make much sense in it, except that I do think that there are certain dysfunctions in your structure, for example your introspection… That is something in your structure that we can work on, see? To increase it… And part of the structural issue that has to do with lack of meaning [...] I mean, lack of meaning concerning the feeling of "what for?", "what am I living for?" Why is it important to see it this way? Because it's also a symptom, I mean the same symptom that makes me sometimes not remember things, let's say it's a dissociative symptom, right? I dissociate experiences and don't remember, like the situation with the pills that we discussed on another occasion, right? That is a symptom, mmm… and this is another symptom, the lack of meaning… It's… the world is so… let's say, as it is, that it's so easy to blame it on the world, see? Because surely the world's situation is difficult, so is the planet's, but it's also a symptom you have… (36:16 in T2S4)

C1.3 Answer the patient's questions. The therapist takes in consideration the patient's questions and concerns. The therapist offers their own perception at the service of the material seen in sessions to help formulate the patient's ideas, clarifying and organizing aspects of their everyday life.

C1.4 Show doubts, confusions (*S)[13]. The therapist performs small self-disclosures to demonstrate no superior position of knowledge about internal conditions of the patient.

Example:

"I think even you don't understand very well that feeling of obligation to take care of her… P: no, yes, sometimes, that's why I hate it, what distresses me [...] I mean, why am I doing

[13] S*= Guideline created based on observation of sessions

it? or, why am I not? [...] it makes me feel insecure [...] T: Why are you doing or not doing the "stay alert" thing, this necessity of taking care of them? [...] This is something that I ask myself too… (23:13 in T1 S2)

"... explain it to me because you can teach me… P: ok…. (37:11 in T2 S5)
"T: Yes. Let's see, what happened was… exactly, what happened to me was…. You have a point there, right? That there is a generational gap, as you call it, but also what happened was that I rushed into an opinion, I rushed into the question without asking for more details, more background, you see? (38:9 in T2 S6)

C2 Ready yourself to respect less effective coping strategies due to their previous adaptive function, which means to be empathic with the patient's difficult biographical conditions of development and precarious early relationships that caused harm, trying not to assign the patient a victim status. That is why it is very important to respectfully consider their overcoming strategies, even if partially effective, that in some degree allows the patient to achieve some balance in life, or even survive. Interventions associated to Guideline *C2 Ready yourself to respect less effective coping strategies due to their previous adaptive function* are:

C2.1 Empathize with the patient's early relational experiences. The therapist adopts a position in relation to adverse early experiences of the patient, acknowledging the experience of pain, without expressing pity or comfortation.

Examples:

T: How did you feel about this? That little 12-year-old girl… P: Mmm, I didn't like to hear them fight. I remember that I stayed with my sister because I was crying [...] Normally I don't have much time to think about how I feel because I'm always taking care of my mother or sister… [...] T: Ok, let's see, what do I think when I hear you say that? I think, for example, that now that your father passed, and you were daddy's girl, back then when you were 13 or so, under the rule of an adult, right? [...] you were under a violent situation and saw your father disfigured, transformed into a violent being. So, well, what happens with you? Back then and now… (35:8 in T2 S3)

"T: Now, I understand from what you are saying that it was very difficult and painful to experience bullying in school, I can imagine the burden than can be in life, so it´s no surprise that you feel the way you do, to carry some kind of accumulated experience where relations with new people or groups of people are never easy [...] P: I think that I have clear ideas about how to relate with people, how to make conversation, things they could or not say, but it happens to me often that when I have the chance to talk to someone, whatever is the subject, my mind goes blank…" (48:6 in T3 S2)

"P: Well, that was also part of ending communication with my family based on… I mean, apart from the criticism… T: You mean as a way to protect yourself… P: Yes… T: As a way to take care of yourself… P: Yes, I think in that way I felt less… pressured, you know? … T: Sure, and you know what, while you were telling me this [...] I imagined [...] how lonely you must have felt (52:10 in T3 S6)

C2.2 Show the previous adaptive function of the current maladapted coping (S*). The therapist considers with the patient the adaptive effort done by the patient in a devoid and adverse early childhood environment and makes explicit mention of the function that the characteristic confrontation way had in the past and now becomes maladapted.

Example:

"this way to balance emotional demands with stress demands, of work and domestic work, locking yourself up, of work and study, you shut yourself down and stay lonely, has been a way to confront, but it's over now and maybe it is time to start looking for other ways to balance tension, and maybe that could be the best way in which the therapy could help you" (47:18 in T3 S1)

<u>*C3 Ready yourself to work actively,*</u> which means to always keep a verbal, emotional and intellectual initiative, especially not being discouraged by the lack of emotional resonance or rejection of the patient, supporting them actively to become more conscious about their own deficits and resources. Interventions associated to Guideline <u>*C3 Ready yourself to work actively*</u> are:

C3.1 Intervene actively during therapeutic work. The therapist does several interventions from their own initiative to make the most of the therapeutic situation: helps in session´s opening if this is problematic for the patient, asks questions, offers thoughts regarding the topics that the patient brings, evaluates the process and the development of the session, suggests topics to work in therapy and resumes topics that could be left behind or unfinished.

Example:

"T: Tell me, how did you feel last Tuesday after the session?… P: ehm, I kind of left with the idea to keep coming here [...] T: you mean you left motivated [...] T: Was there something about the conversation that kept you thinking?… [...] P: Yes, when you asked me about my parents [...] that kept me thinking, in fact I kept thinking about it on the subway on my way home… T: And you keep thinking of what - what is going to become of you? you told me "what's going to become of me when they are gone?" (22:1in T1 S1)

C4 Ready yourself to assume a parental attitude that promotes development, based on the type of early relationship between parent and child. This kind of benevolent and therapeutic parenting is based on the work of joint affective regulation and mirroring of self done by the therapist, for a limited time. This parental attitude must allow the patient to progressively develop their capacity to set limits, be safe from harm, test reality and practice responsibility with themselves. Interventions associated to Guideline *C4 Ready yourself to assume a parental attitude that promotes development* are:

C4.1 Intervene in therapeutic parental function of small child or adolescent. In order to perform therapeutic parenting, the therapist performs mirroring and joint regulation interventions as a parent would do with a small child or adolescent, reflecting together on reality aspects related to risk situations and responsibility practices in relation to actions and decisions.

Examples:

P: Mmm… I can't think of anything right now... T: You can't?... P: No… T: Perhaps it's difficult to think today? … P: A little… T: Mmm … yes… I can imagine the shock. Maybe it is a hard question for today, don't you think … P: Aha… T: Because… of the death of your father, let's say… that you are not so clear, right? to think… P: Aha… T: Because we are

talking of death. I mean, your family's boat was headed one direction, so to speak, with a dynamic, a way of functioning… P: Yes… T: And suddenly this happens… and you are suddenly lost, let's say. I mean…I can imagine that you're still under shock really…right?...P: (looks down) … Maybe (very low tone)... T: Mmm… you look really tired… P: Yes (laughs)... T: Are you alone here?... P: Today in college? Yes… T: Did someone come with you here? …P: Oh, here at the center, no… T: Mmm… Is there anything we haven't covered? Something you want to talk about? (34:16 in T2 S2)

"Considering that you have been under a lot of stress… Well, while I was listening to you, about your four classes and all… you are super self-demanding. But also there's a lot going on, your father is a big deal, so… P: Yes… T: If you fail a class, it's not so… I don't know, from my point of view, it's not a sin… P: Mmm… T: I know that for you it's hard to understand, let's say, because you are very hard on yourself, but (they both laugh)... P: Yes, it's just that… mmm… (silence) I don 't know… I don't want to stay more time stuck on my career… T: I understand, but you also need to understand that you can do everything you can, and in spite that, it can become very difficult… P: Mmm… T: I mean, we need to consider all this issue that has been a burden, about the abuses and all, and you are starting to confront that, and dad dies, something really important. So I can understand that you're making every effort, but you know… I'm telling you this so you don't get too stressed, right? That you make an effort, but not too much… (silence)…" (38:7 in T2 S6).

C5 Ready yourself to sustain hope for a primarily positive progression of the patient, so they can accept themselves and their lives and be able to overcome their adverse condition, especially when they feel overwhelmed by the difficulties of their current life and their way of experiencing them. Interventions associated to Guideline *C5 Ready yourself to sustain hope for a primarily positive progression of the patient* are:

C5.1 Make the patient's positive development possibilities clear. The therapist strives to stay hopeful for change and incorporates this in the session's narrative, aspiring to the patient's acceptance of themselves as well as the capacity to overcome their current difficulties.

Examples:

"P: I have tried it more than once… [...] and not because I really feel it, and that's why I'm always returning to the starting point… [...] T: Of course, in that case this might be an opportunity, because this is the opportunity, that also therapy provides the help that you didn't have before, which is kind of the support to be independent [...] you've tried this alone before and maybe now you can have therapy as your ally [...] P: [...] personally it's something that I can't identify or can't separate if it's only about me… T: Until now, until now you can't, but maybe, as long as we are progressing step by step, focusing on this, maybe you will, you will be able to make some differences, I think…" (54:11 in T3 S8)

"T: But you… you told me that generally you can realize that it's hard for you, when you meet someone for the first time [...] and you tell me 'I have trouble talking to people for the first time'. But I find here that maybe you were nervous at first…It wasn't easy, but I could get a rather specific picture about what's going on… you expressed yourself well… [...] P: In order to speak well I put pressure on myself, towards myself son I can express… T: Ok, but you achieve it, you can do it, it works. So that says a lot about how you manage things, that maybe you need more tools, we need to work on how it can get easier, but I think you can benefit very much from this process…" (47:17 in T3 S1)

C6 Aim strongly for identification and tolerance of countertransference. Patterns of countertransference in patients with structural deficit can be hard to tolerate, given that they tend to be more intense, hard to describe and frequently make references to past experiences unknown to the therapist, therefore causing confusion. They are blockages or tension estates difficult to differentiate that can even be bodily expressed as muscular tension, dizziness, etc. It is critical that the therapist, supported by their own emotionality, pays special attention to these states in order to identify them, contain them, delineate them and work the patient's experiences so they become tolerable. Additionally, the therapist must make a conscious effort to not get intimidated by negative and depreciative-aggressive attitudes, or their desperate behaviors. Interventions associated to Guideline *C6 Aim strongly for identification and tolerance of countertransference* are:

C6.1 Identify typical countertransference of patients with structural deficits. The therapist must stay alert to unclear physical sensations, muscular tension, even dizziness;

also, to uncommon feelings of their experiential world, emotional blockages or confusions in their therapeutic capacity to think.

Example:

"... you always have to be aware of your countertransferential things, ... because it can easily flow into these kinds of interventions, and you have to be very careful and very clear with what you are doing. Yeah? Is this destructive? Or is this intrusive? ...so, you always must reflect this as a `me term´ layer, yeah? Before anything, I think. It should be clear, and that's my focus always working with teams: what is going on with the team, working with the patient? What are the impulses… so… yeah? Sometimes it is according to the problem of the patient, but sometimes not [...] because then sometimes it is `oh, he has to learn so, and so, and so´ and that's like… the sadistic father… that can't happen, or it would be harmful […] You can't divide it, yeah? Technics are working, but I think from a psychodynamic view you can't divide it from the transferential-countertransferential processes, I think that belongs together" (14:33 in E4)

C6.2 Try not to get discouraged by the patient's challenging relational offers. The therapist must be alert to the feeling of intimidation by the patient's negative or aggressive behavior, or get discouraged by them; after recognizing them, they become part of the therapeutic work and the therapist tries not to get dragged into them.

Examples:

"T: So, I'm thinking that this is going to be our last session before a long holiday. How do you evaluate our meetings? the sessions that we've had? what do you think? what's missing in them?… P: I feel that we are talking about the same things that I could be talking to anybody, like my mom or my partner, or to X, because he's one of my closest friends [...] T: So it hasn't been very helpful… P: No, because talking… T: how could it be more helpful? …P: I really don't know, because I feel that we're still knowing each other, and in this phase we are mostly talking… T: Do you feel that there are topics that we´ve been avoiding so far? …P: Mmm, there's a topic that I have avoided, I explicitly said I wanted to avoid it, but apart from that, no… T: the thing is that it´s some kind of dilemma, because I get the feeling that you, some important part of your discontent, your suicidal ideation, depressions, are related to your abuse experience… P: They started before… T: what started before?... P: the abuse

happpened after the suicidal ideation, mmm, self-injurys, depression… T: Is that so?... P: There's no causal connection, just…another factor in the equation… T: Mmm… T: An important factor, but another… T: Yes, you have the idea of having this kind of experiences […] sure, we have asked ourselves if there hasn't been abuse experiences as a child that you don't remember that have left you wounded, and the current experience is maybe an experience, but it's, it's like being in one end of the thread and if we pulled that thread maybe we could find other experiences. I mean, my point is, that when we leave all this topic out, because it's difficult to talk about it and all, it has been precisely that we're not talking about the most important thing, and this becomes a conversation, as you say. So, in that way we are in a dilemma, because if we go there it turns out to be painful and hard, but if we don't it becomes a relationship of just friends… (39:7in T2 S7)

"T: ¿what else? would you like to tell me, to comment… P: mmm… I was thinking that coming here is not doing me any good, it's just talking about what's going on and updating you… T: aha, and especially after one month… P: yes, but at least I felt the same on the last sessions, it was like talking about what I did the past weeks, and I feel like when in cartoons they say like, show and tell? …T: aha… P: they bring a toy and show it, that's how I feel, and… I don't know, there's been several sessions, more than half of what a standard therapy lasts, from what I understand …T: we said twenty and it's been seven, let's say… P: Yes, by standard I mean that they generally last fourteen, fifteen, I feel that's enough, and I feel that I come for nothing. So I've been thinking of how we could focus and… I can't think of anything, I've been thinking about it a lot and I can't think of anything. I think that my trouble with suicidal ideation has more to do with existentialism, mmm, with the meaning of life and how short it is… T: And, ¿how have you been? In the context of what you're proposing, because a standard therapy doesn't necessarily have fourteen sessions, it depends on the standard, I mean, there are different standards. A crisis intervention comprehends eight sessions more or less, a short standard therapy, or what we call a short standard are twenty, twenty two sessions. A common standard therapy takes like forty sessions… standards… are all different, mmm… I think that you have a point, so to speak, of digging deeper, deeper, to take something out if you want, and we have to approach this in the context of how you feel, how have you been lately… How have you been? (40:3 in T2 S8)

***C6.3* Get close to the patient by paying attention to differentiation.** Intense anguish and feelings of emptiness have an "attraction force" from which the therapist needs to stay out, differentiate and delimit. In order to achieve this, they stay alert and regulate the closeness given by the empathy attitude, alternating with emotional distance moments.

C6.4 Avoid putting pressure on the patient constrictively. The therapist strives to respect the patient in spite of their intensity of demands, rejection or desperate behaviors, and positions themselves as non-pressuring observers without constricting patients with therapeutic interventions.

Example:

"P: I don't want to talk about it so much… [..] T: Do you think we can talk about it at some point?... P: I think we can, but it's hard and I don't feel comfortable… T: Ok. [...] because if this is something that was in your mind at some point causing pain and making you want to stop living, we'll have to, someday, deal with it [...] P: But not today [...] T: I agree, yes, yes, you can take your time… (35:4 in T2 S3)

C7 *Be actively prepared to creatively connect with the patient despite their structural deficits.* Therapists will frequently find that patients with structural deficits can't reflect for themselves, keep a record of their emotional states and seemingly expect little or nothing of the psychotherapeutic process or of the therapist. That is why the therapeutic attitude (to be creatively available to connect, to adjust to their restricted relational competencies, not getting discouraged by their lack of emotional resonance and accepting them as they are) is fundamental to sustain and make progress in the treatment.

Interventions associated to Guideline C*7 Be actively prepared to creatively connect with the patient despite their structural deficits* are:

C7.1 Use words, metaphors, designs, drawings, and pictures to promote narrative communication. The therapist promotes the patient's psychic production, asking them to narrate situations of their everyday life, memories, dreams and reflections about themselves. If the patient can't do this with their own words, the therapist proposes other ways like pictures, drawings, stories, movies, songs, etc., as well as non-verbal aspects perceived in sessions.

Examples:

"Now I see you and see in your face that you are very angry" (12:4 in E2)

"If the patient sees anger in your face […] you can ask him: `What do you think? Which effect is switched on in my face?´; and the patient could say `I can see that you are angry, or disappointed, or sad or whatever…" (12:4 in E2)

"T: Now Silvia, I'll make a comment. You may feel it has nothing to do with what we're talking about, but I get the idea that it might be helpful to us. Because you say, ok, we talked about what happens with expression [...] and you say, "well, for a long time I haven´t been showing what's inside me. No… I don't want to, it's like I forgot how to express myself, so to speak, I can't, I don't know how to talk from inside me, so that others can see what's inside". But [...] there are certain aspects, certain details that give me the idea that you would like to be able to communicate in a different way, mmm [...] they are much simpler details. Because, I don't know, I was thinking that since we've met, I've noticed how you take care of your hair, mmm… It calls to my attention that first you had some kind of hair color that was very, very expressive I think, with beautiful colors [...] and I wondered how there was a desire, a wish to express something, at least in appearance, in how you look… P: mmm, yes, I think it's pretty accurate, but it's not like expressing how I feel, it's more like, maybe, expressing how confident I am with myself. When I dyed my hair a year ago, my self-esteem grew a lot, I felt that I looked better than before, that… I could even achieve a specific style; I could even label myself in some way…" (51:9 in T3 S5)

"T: but for example, with respect to the pressure that might be, right? I don't know, I imagined that your semester, for example, could be like navigating in a boat on a river, and you could say I am conscious that maybe my boat, maybe [...] There's water getting into the boat, then I'll wait until I realize that water is getting in, the boat is starting to sink, and then maybe I can do something. Or is it possible that before that, before that happens, I could do something to take care of it? [...] For example, [...] I know that this boat has a leak, I will take care of it, I'll use a product or caulk inside [...] to control the leaking as much as I can. That's no guarantee that water isn't getting inside, maybe it will, but maybe less, so I'll be

less nervous knowing that leaks are not so bad… P: I think I could compare that with last semester…" (59:3 in T3 S13)

C8 Work with a group of peers that contains you and allows you to sustain an abilitating attitude. This is a Guideline on a different logic level, given that it works outside the session. Nevertheless, it is part of this category for its importance to sustain the abilitating therapeutic attitude. The therapist must count on a group of peers who can provide containment, help understand the therapeutic situation and therefore sustain the abilitating attitude in session. Interventions associated to Guideline *C8 Work with a group of peers that contains you and allows you to sustain an abilitating attitude* are:

C8.1 Share thoughts or emotions about the process with peers or supervisors. Given that they are difficult patients, the therapist must have peers to reflect with and keep a distance from complex therapeutic situations. It must be a trusted group that also contains them emotionally.

Principle D Psychotherapy work requires developing a cooperative therapeutic relationship. This therapeutic principle is about the importance of establishing a cooperative relationship and collaborative work on therapeutic topics between patient and therapist from the beginning. It also establishes that the therapist is the one who must permanently sustain interest in the psychotherapeutic work, regardless of the patient's level of motivation. The development of the collaborative relationship requires that the therapist considers different relational positions during the therapeutic process ("after, with, in front and ahead of the patient") that allows interventions that go beyond the traditional support therapy, in order to promote the patient's knowledge and competencies. Guidelines associated to this Principle are 5 and lead to 10 related interventions, as shown in table 12.

D1 Always adjust to the patient's restricted capacities. The relationship's development requires that the therapist intervenes having always in mind the patient's limitations, without demanding a psychotherapeutic work for which they don't have the psychological resources, and always legitimating their necessities as expressions of vulnerability. The therapist must ask themselves permanently "What does this patient need at this moment? Is more

regression needed to weaken/loosen defenses and achieve more experimentation of hidden or repressed feelings? Does the patient need help to configure an interior reality and outline ideas and abilities to confront difficult situations better?"

Table 12

List of guidelines and interventions associated with Principle D Psychotherapy work requires the development of a cooperative therapeutic relationship

Therapeutic Principle	Therapeutic Guideline	Therapeutic Intervention
D Psychotherapy work requires developing a cooperative therapeutic relationship	D1 Always adjust to the patient's restricted capacities	D1.1. Show the difficulties in carrying out interventions on the patient benevolently (S*)
	D2 Work without promoting transference. Investigate with the patient difficult aspects of their life as if they were a third party (triangulation)	D2.1 Don't look for motivational significance in the patient's relational offer within sessions
	D3 Look for ways to emotionally connect with the patient promoting a weness experience in the therapeutic relationship	D3.1 Suggest an empathic relational offer that facilitates experiencing a benevolent bond with the patient (S*) D3.2 Evaluate the patient's experience of the session (S*)
	D4 Separate your responses according to the patient relational offers during the different stages of the process *(initial-middle-final*)	D4.1 Use the relational position "behind the patient" D4.2 Use the relational position "with the patient" D4.3 Use the relational position "in front of the patient" D4.4 Use the relational position "ahead of the patient" D4.5 Contrast and compare the different relational positions' perspectives
	D5 Place the patient in an active role	D5.1 Include the patient in the characteristic actions of the therapeutic work from the beginning

(S*) = Guidelines or Interventions created based on the observation of sessions

Interventions associated to Guideline *D1 Always adjust to the patient's restricted capacities* are:

D1.1 Show difficulties in carrying out interventions on the patient benevolently (S*)

The therapist shares in session part of the patient's functioning that is unfolding in the therapeutic relation. The therapist expresses their difficulties to intervene benevolently in order to use the therapeutic situation to help the patient observe difficult relational situations.

Example:

P: "So… that same experience makes me want to stay away from people and keep a distance… a formal distance, so to speak [...] T: it makes you set more explicit limits, like, like a barrier between the personal and the public… Yes, you've told me about that, I mean, mmm, you have explained it to me several times [...] I think there's something else happening on another level because, let's see [...] in this process, little by little, a feeling that we are getting close to… look at what's going on, understand things, see their ways… [...] I mean, everything that involves this therapy [...] but, for example, many times I've thought about telling you something and have caught myself saying: 'no, no, I don't know if I'll tell her this, I don't know if… if… how is Claudia going to receive this, maybe she takes it…. maybe she'll think that I'm criticizing her, or maybe if I tell her something … she'll think that I'm laughing at her, so I have found myself several times being very careful about what I say [...] as someone who talks to you, it's difficult to establish… let's see… Claudia… will she feel confident enough with me or will she let me tell her? things that might be useful to her but maybe, to not disturb her, or how is she going to take it, that I might have restricted myself. I don't know if I'm making myself clear… P: Yes, that happens to me a lot… with most people (55:13 in T3 S9)

<u>D2 Work without promoting transference. Investigate with the patient difficult aspects of their life as if they were a third party (triangulation)</u>. Transferential dynamic is registered by the therapist, handled in its regressive processes in order to protect the therapeutic alliance, but not mentioned therapeutically. Therapy must not emphasize a dyadic relation, but a triangulation work: patient and therapist observe and reflect about the internal and external world of the patient as if it was someone else's. Interventions for this Guideline are:

D2.1 Don't look for motivational significance in the patient's relational offer within sessions. The therapist internally registers transferential significances deployed in the therapeutic relationship but doesn't mention them. In this way, they renounce the therapeutic work of asking themselves questions for a transferential interpretation (What is the patient trying

to unconsciously say? What are they defending themselves from? What necessities are they projecting on me? With whom are they identifying me in regard to fears or transferential expectations?) If regressive processes appear, the therapist handles them and does not interpret them.

Example:

"T: Now, talking about your grandfather, sure, you felt misunderstood by your mother because of her comment, and felt misunderstood by me, because of my comment… P: Yes… T: How was that for you? …P: Mmm, I understand so I explain it patiently (smiles)... T: Sure (laughter), I have to be patient with my therapist, ok… I have to be patient with my therapist, ok (they both laugh)... (38:11 in T2 S6)

D3 Look for ways to emotionally connect with the patient promoting a weness experience in the therapeutic relationship. The therapist actively seeks ways of connecting emotionally with the patient's experience, tries to understand their perspective and empathize with their affections. This effort facilitates the development of a weness experience, laying the foundations for collaborative therapeutic work.

Interventions associated to this Guideline are:

D3.1 Suggest an empathic relational offer that facilitates experiencing a benevolent bond with the patient (S*). The therapist seeks permanently that the patient feels their experience understood and accepted despite their functioning deficits. The therapist strives to "see" situations from the patient's point of view so they can experience interest, concern and availability from someone else in an emotionally close relationship.

Examples:

"P: I know it hasn't been too long, but this is my third year as a school teacher, so I've been thinking about finishing college… in fact I don't tell this to anyone because these are kind of plans of my own… T: Your dreams, your plans… P: Sure, they're mine, in fact I'm not going… I will talk about them, but I won't say 'I will do this' so that everyone knows… T: So it's important that you can talk about this here…" (25:8 in T1 S4)

"T: Mmm… ¿Is there anything left unspoken? ¿something you want to talk about?... P: Mmm…mmm…oh, yes. During the weekend I had… social anxiety?… The whole drama of

the funeral and with so many people… I felt like I was allergic to people (laughs)... T: Mmm…what was the manifestation of this? ...P: Mmm… I don't know, at the funeral I kept away from the people's attention… T: Aha… P: Mmm… and stayed close to my friends. Given that basically all my friends came to visit me during the week… T: Aha… P: Mmm…and, I don't know, my sister's birthday was on saturday. My youngest sister, twenty years old. And… during the celebration, a family dinner, I stayed almost the whole time in my room… T: Aha… P: Like…getting away from people (laughs)... T: Ok. Let's say it was too much… P: Yes, too many people. The previous day, a Friday, was the funeral. Mmm, relatives came home for dinner from abroad, we had chinese food and there were like thirty people there… And at my sister's birthday there were like, I don't know, fifteen people.. T: Is this common for you, to get saturated from people? ...P: No, I mean, I'm no good with too many people, but I can stand it… T: aha… But this time it was like, I don't want to be here, I'll go to my room… T: aha, sure, one could take it as a self protection measure, because it was such an intense week, right… P: Aha… T: Right? Aha, with so much going on… Sometimes we need to unplug as a way to take care of ourselves … How do you feel about this meeting here today? (34:13 in T2 S2)

D3.2 Evaluate the patient's experience of the session (S*). To understand the patient's point of view it's necessary to understand their therapeutic experience and relationship.

Examples:

"T: Ok… How did you feel in a shorter session? ...P: Mmm… Fine… T: Fine? Ok, was there something that didn't feel right, that you didn't like? ...P: Mmm… No… T: No?...P: No, it's fine" (33:13 in T2 S1)

"T: How do you feel about this session today?... P: Mmm, It's taking forever… and, I don't know, I'm not paying too much attention, I'm very… tired… T: Aha, yes, yes…" (34:15 in T2 S2)

"T: Does it bother you that I return to the subject like this?... P: A little… T: Yes?... P: Yes…

T: Ok, tell me… P: Huh?... T: Tell me, what's bothering you… P: I don't feel like talking about it today… T: Aha, I understand that perfectly, I mention it because we are kind of evaluating, since we haven't seen each other in several weeks, we are like evaluating how you've been, right? (44:11 in T2 S14)

D4 Separate your responses according to the patient relational offers during the different stages of the process (initial-middle-final). The therapist adapts their therapeutic attitude to the stage of the psychotherapeutic process. At first they have a supporting attitude; once the therapeutic relation is settled, they can use a more confrontational attitude and then return to a stage of help and support towards the closure of the process. The therapist finds support in a relational metaphor for these attitudinal movements: intervene assuming different interpersonal positions.[14] First they start "behind the patient", looking with their own eyes. Later they can use the "with the patient" position, where they invite the patient to an external observation of their experience and conduct, rehearsing a posterior self-reflection. When the therapeutic relationship is established, they can occasionally use a more confrontational attitude, the 'in front of the patient' position, where they adopt the perspective of "others". Another possible position is the "in front of the patient", where the therapist displays the capacity to think ahead of the patient. Additionally, the therapist explores the divergences between these three positions, so the patient is able to consider other people's points of views. Interventions associated to Guideline *D4 Separate your responses according to the patient relational offers during the different stages of the process (initial-middle-final)* are:

D4.1 Use the relational position "behind the patient". The therapist observes from the patient's point of view to share and understand their experience and provide containment. This therapeutic focus is strongly sympathetic and caring. The therapist takes support in their own perception and emotionality, putting them at the patient's service and thus generating a slight newness, sympathetic and benevolent, on the shared view.

Examples:

[14] The 'metaphoric place' notion for intervention is related to the operationalized maladaptive relational pattern diagnosis in the OPD-2 (Axe II Interpersonal Relationship,) which acknowledges two experiential perspectives and four interpersonal positions (OPD Task Force, 2008).

"I can perfectly imagine how this situation offended you, to the extent that…" (M4:5)
"I went to the beach [...] and I broke up with my boyfriend… I decided to break up because of what I told you before, I kind of didn't like that we didn't do the same things… also he used to get upset, not wanting to do anything, so this attitude, that I was leaving him alone, and I never left him alone… T: So being there wasn't easy… P: Right [...] we had a nice time on new year's eve, but on the last night we had a discussion and I told him that if things weren't going well we'd better end it [...] T: How was it going before you went to the beach? How were you feeling? …P: Always like… ehm, his attitude was upsetting me… T: What attitudes? … P: ehm… T: To understand what was upsetting you…" (26:1in T1 S5).

"T: Well, that's a difficult thing, very tough, having to live with that [...] and very discouraging, because it seems that you've tried a lot and it's so difficult [...] this is a very hard thing in a family's harmony, but, how can it be fixed? because it's a kind of, I thought it was a kind of bullying, like not paying attention to someone, because one can bully by annoying someone, like harassing, hitting, but also one can bully by talking to everyone except you or talking about everything except what concerns you… P: ehm, that's why, because of these situations I'd rather step aside or maybe wait a couple more days to give it a try, instead of just sitting at the table, maybe I'll try to start a conversation, or not… but maybe participate and it's still weird… P: Yes…" (60:16 in T3 S15)

D4.2 Use the relational position "with the patient". This "third party" position allows the therapist to objectivate and gain perspective on the patient's experience and behavior. The therapist asks the patient to observe from the outside: together they look at the situation experienced by the patient as if it was a video, a novel, a dream or report. This is about looking at the self like some other, in order that the patient practices objectification, since they look at the situation without being overwhelmed by emotionality. A more distant perception prepares for introspection (looking at the *self*), where collaborative and shared attention reinforces the therapeutic relation by providing a common experience, a "*weness*".

Examples:

"T: Ehm, so you say: 'now that heading somewhere, I'm afraid that somehow - that somehow the anguish or the pain will stand in my way'… P: Refrain me… T: Refrain you - - distress

you… P: In fact I had a very bad time (sobs)... I've had a very bad time when I've wanted to do things and all, and I don't want to feel that again [...] I've always thought about doing something to myself but I never did anything, like disappearing [...] and when I was a kid it was the same thing, I would say 'and if I'm not here?' [...] T: And why do you think that is? Now, looking in your thirty year old perspective, what do you think was the matter? How, how could we understand?" (22:19 in T1 S1)

"T: ... experiencing a violent situation [...] so, sure, well, what's going on with you? Back then and now... P: Mmm… I kind of felt bad, but I didn't have time to think about it [...] T: What does it mean to feel bad?... I can understand that it's not easy to connect like that… P: I don't know…T: With the past and that situation, but if we try to look at the situation, what would feel bad be like?...P: Mmm also start crying, for example? ….T: Sure, maye to be anxious? ...P: Yes…" (35:10 in T2 S3)

D4.3 Use the relational position "in front of the patient". In this position, the therapist perceives the patient "with their own eyes". If the therapeutic alliance and the patient's stability allows it, the therapist performs interventions that emphasize alterity, de "otherness" in an interpersonal relationship, through reflexes and answers that incorporate their own perception and emotional response.

Examples:

"T: That's why it calls my attention that every time you mention the continuity about this relationship, sometimes you say 'maybe he's not comfortable' - 'maybe it's too demanding for him' [...] but on the other hand I was thinking that maybe you are not comfortable in this relationship as well because of what you're telling me, because you find him a little passive…P: Right… T: Not to focus on him, but rather focus a bit on how satisfied you are, how happy you are in this relationship…" (*23:5 in T1 S2)*

"P: It's the end of the semester, I have several courses in danger because I have skipped evaluations. So I have to do everything now, at the end of the semester…T: Why did you skip them? Because of your father?… why?... P: Mmm, the first delay was because of my dad, and after that like… because I didn't feel well [...] T: And on Monday, why did you skip it?

It can be obvious but, why did you? P: Mmm, because I didn't feel in the minimum conditions to take a test… It was like… this test is not going to show everything I know… T: Because you weren't in conditions? How did you feel? …P: Mmm…very tired and stressed (smiles), these are two concepts that synthesize this last two weeks (silence)...T: Yes, I wonder if perfectionism wasn't negative for you, maybe you could have taken the test and not necessarily get a very good grade, but…" (38:5 in T2 S6).

D4.4 Use the relational position "ahead of the patient". This is an anticipatory position, where the therapist thinks about a possible future situation in the patient's development and anticipates what could be important to be considered by the patient to cope better. By preventing and communicating difficulties that may appear, the therapist helps patients prepare for new challenges and reduces the chances of new experiences of failure.

Examples:

"T: you know him well - what are the chances or how realistic are these expectations of change? (...) P: I think a hundred percent, these probabilities are realistic, for example like half of it in percentage, I think he can do things and commit… T: Ok… P: But I can't pressure him, because if he doesn't want to, everything is up to him…" (26:15 in T1 S5)

T: Let's see, let's go bit by bit, tell me, about next year, do you think it'll be harder than last year? … P: Yes, I think it will, because I want to finish already, I won't get delayed by one class, so I want to finish it this year … T: Does this imply more classes at the university than last year? …P: Yes… T: And implies more work? (...) T: Do you have more classes or is it because of the dissertation? …P: No, it's the dissertation - I do have the same number of classes but there is also the dissertation… and what comes with it, if I have to amend something, the presentation day at the end of september, then I have to submit a draft in april or may… T: Now, if you think about it, maybe it's a theory that I have, before starting, everything seems harder, doesn't it? …P: Yes… T: And when you start walking, - - slowly, you start to progress. Have you felt this way before? …P: Yes, for example on my first day at the university I felt like this… T: And have you felt that, in the way, sometimes the expectations that come with anxiety are bigger than reality? …P: Sure, sometimes when it's too hard, on the way you find it easier, I've felt that…" (27:13 in T1 S6)

"P: But it's not always going to be a real alternative, because at work I have to let them know one month and a half in advance if I want to plan a holiday…T: Mmm… P: And I don't know how everything is going to be a month and a half from now… T: Wait, I'm sorry, of course that we don't know the conditions of a month and a half from now, but maybe you do know when the semester ends, because, weren't the dates changed? … P: Mmm, no… T: Then you know more or less, apparently, that classes will end and all grades have to be ready the last week of november, you could say 'maybe what could be best for me is not working on those two last weekends of november, and I can foresee that knowing that the end of the semester is always a very demanding time because classes end [...] with no need to react to the emergency, when you'll see danger face to face…" (59:14 in T3 S13)

D4.5 Contrast and compare the different relational positions' perspectives. After the therapist has been able to share the patient's experience ("behind the patient"), to see them from the outside ("with the patient") and eventually to include a third party view ("in front of the patient"), they try to explore the differences between these three positions. This therapeutic exercise aims to replace the fusion fantasy, where there is only one truth, for a multiple perspective reality.

Example:

"T: …how difficult it can be to match, or feel that you connect, or that others connect with you. For example I've tried to get close to some of your experiences, right?, and sometimes I feel like I succeed, but sometimes I don't. So I wondered if that difficulty to connect can have something to do with that necessity of yours that in order to feel understood, you have to be completely understood. I mean, if I want to help you I need to provide the key that you need for a locked door, and if that key doesn't work immediately, then you don't want it at all. Right? …P: Yes, I think I tend to do that, like if something doesn't work for me, I won't take it, I tried and I will not try again, that happens to me… T: Right, and then it's hard to get into a collaborative conversation if what I'm expecting is to receive exactly what I think I need, because sometimes someone can help me, I can help you, other people can help you according to their own possibilities. But of course, if it's not what I'm expecting, it's difficult

that I can use it, and that can be something that we're going to be careful about, of how to receive beyond my own truth…" (48:19 in T3 S2)

D5 TP Place the patient in an active role. According to this Guideline, the fact that the therapist should stay active during the process must not stand in the way of encouraging the patient to have an active role in sessions, in order to have the experience of a collaborative work that requires their effort and commitment from the beginning, therefore incorporating the development of responsibility. The intervention associated to this Guideline is:

D5.1 Include the patient in the characteristic actions of the therapeutic work from the beginning. Since the beginning, the therapist incorporates the patient as an active agent of the process, jointly defining main topics and promoting their discussion in session. Furthermore, the therapist encourages the patient to communicate by asking questions and inviting them to think collaboratively.

Examples:

"T: Ok Daniela, the idea for this second session is that you can use this space to talk about what you've been thinking this past week, start with what you feel is necessary" (23:1 in T1 S2)

"T: … Ok, but, where do you think we should focus the therapy in this case? Some tool, like you said last week? How can we help? How can I help you? … P: What are the options? … T: The options? … P: Yes (smiles) … T: I don't know, it can be anything (laughs), where… P: Mmm… T: I'm telling you because, when I hear you and see you, because last time you said that in several aspects, right? this specific situations of yours… you cut yourself for the last time two years ago, and now it happened again two weeks ago. But you were telling me that in general you function well, you are a leader, you have lots of activities where you do well, you have a boyfriend, a friend that you can count on … P: Aha… T: So… the question now is, from your point of view, where do you need help? …P: Aha, mmm… T: It says here that you've been depressed, that you have chronical suicidal tendencies, but that doesn't seem so clear today. So then, the question now is, from your point of view, from Andrea's point of view, what is it that Andrea needs? How can we help her? (34:10 in T2 S2)

Principle E Therapeutic experience has a structuring function itself. This Principle establishes that the therapist's way of being and doing should be a therapeutic experience itself for the patient, with a structuring function. This way of being relates to the bond and identification between therapist and patient, while the way of doing relates to the kind of guidance that the therapist offers to help the patient develop responsibility with themselves and others, with the systematic support on regulation of affections, impulses and self-esteem they give, and with differentiated, benevolent and reality-based perception. In addition, the therapist must perform a modeling function of new abilities and strategies. Two Guidelines and three interventions are associated with this principle, as shown in Table 13.

E1 Pay attention to identification models you offer to the patient. The therapist's way of being during the therapeutic situation has a modeling function for the patient. Therefore, it is necessary that they stay alert to possible identifications and internalizations by the patient in order to help create an internal space not controlled by partial objects. As long as the therapist acts in a stable, accepting, concerned and available way, and offers a differentiated, benevolent and reality-based perception, the patient experiments the therapeutic relation as a place where they can display new psychological functions. Interventions associated to Guideline *E1 Pay attention to identification models you offered to the patient* are:

Table 13

List of Guidelines and interventions associated with principal E The therapeutic experience has a structuring function itself

Therapeutic principle	Therapeutic Guideline	Therapeutic intervention
E The therapeutic experience has a structuring function itself	E1 Pay attention to identification models you offer to the patient	E1.1 Recreate an early relationship of structuring function
	E2 Guide the patient towards developing responsibility with themselves	E2.1 Encourage the end of risk behaviours/ promote adaptive activities E2.2 Provide psychoeducation, advice, make suggestions, answer questions

E1.1 Recreate an early relationship of structuring function. The therapist relates with the patient generating "creative" structuring experiences just like early relationships described in developmental psychology reflects and responds to stimulate cognitive capacities,

supports affection regulation and impulses, seeks emotional connection, expresses affections and aims for understanding. This therapist's way of being and doing is itself a way of modeling relations towards the *self* and others.

E2 Guide the patient to develop responsibility for themselves. Structural deficit leads to regressive functioning, where childish ways of living and behaving can predominate. This prevents them from achieving expected tasks for the corresponding development stage and is frequently coupled with risk behaviors. Therefore, the therapist doesn't promote transitory regression in the therapeutic process, but rather promotes progression so the patient can achieve better self-efficacy and progressively take responsibility for handling their structural problems. The therapist helps achieve this mainly by systematically supporting regulation functions to take distance from overwhelming affections, impulses and perceptions, showing the patient a differentiated, comprehensive and reality-based perspective. Additionally, the therapist guides the patient in the structuring of their daily activities. Interventions associated to Guideline *E2 Guide the patient to develop responsibility for themselves* are:

E2.1 Encourage the end of risk behaviors/ promote adaptive activities. During the session, the therapist explores with the patient the anxiety coping management and usual impulses that are risky to them or other people, in order to explore adaptive alternatives. Once they are identified, they encourage patients to practice them. Additionally, they support the patient in their daily life activities organization.

Examples:

"… so, what can you do instead of cutting yourself?" (E11:26)

"T: you were telling me about some difficulties that you were having to meet some… meet some requirements, let's say, of your career… the morning classes, right? You had trouble waking up, getting out of the house [...] P: I'm still having trouble falling asleep at night… the earliest that I have fallen asleep was maybe at two, last night I fell asleep past three [...] T: Because when you have classes in the morning, you have to set your alarm at six… P: Yep [...] I have to… organize my sleeping habits [...] T: But you had managed to, what you're telling me… you had managed to organize them, you had managed to go to sleep earlier?... P: Ehm… No, I was still staying up late, but I was sleeping what I needed…" (55:1 in T3 S9)

"T: What you're telling me, that a lot of times anxiety has controlled you, that instead of your intellectual or academic… capacities, it's anxiety that has hindered you… P: Yes… T: It doesn't allow you to think well, to be organized. Now, if you tell me that right now you are tightly following your pharmacologic treatment, it's not the only thing, but surely it will help to keep the anxiety out…P: mmm… T: Because anxiety also troubles you everyday like it was three in the morning…P: Right… T: Have you noticed that at three in the morning problems have an extraordinary weight? [...] "P: I study better at night [...] Time flashes by studying and my whole schedule falls apart, and then it's so hard to wake up… T: Mmm. And with your medication, ¿how do you do it? [...] P: It's all messed up. I take them when I remember, before going to bed or when it's like 'oh, I've been studying for so long, it's late, ok, I can't take them anymore, because they're bad for me [...] T: Ok, and how are you managing to come to class? ...P: I come if I wake up…T: Not always… P: Not always… T: Ok. So you're a little disorganized then… P: Yes… T: And what can you do about it? ... P: Ehm… I'm trying to go to bed earlier and study more in the afternoons… T: Ok… and what about the medication? Because you're telling me that sometimes you remember, sometimes you don't… [...] Have you set a phone alarm? [...] P: Mmm, no… T: (laughs) ¿Why not? ... P: Because I don't like alarms…T: You don't like alarms? ... P: No… T: The doctor was telling me that he talked to your mother so that she could help you, she could help you remember… P: Yes… T: But I don't know how your mother is with all this happening in your family… P: Mmm, she remembered the first two or three days, but I didn't want to bother her anymore… T: Ok, I think we should evaluate that, don't you think? I think it's important that you organize yourself… P: Yes… T: Don't you think? For your mental health. It's important to be organized. Then we should evaluate what you're saying about 'I don't like alarms', right?, evaluate your priorities [...] Does it make sense to you? Because I think, I think it's important to put some structure, not only for your performance, but for your sleep, your mental health" (35:1 in T2 S3)

E2.2 Provide psychoeducation, advice, make suggestions, answer questions. The therapist points out views about the patient's vital situations, responds to doubts and concerns and adds relevant scientific information about socio-emotional development, psychological

functioning, and interpersonal relationships when necessary. All these interventions must be at the service of the patient's needs for the therapeutic work of identifying and understanding confrontational mechanisms, experiences, and ways of establishing relations.

Examples:

"... One can get angry at someone one loves, right?... P: Yes, but it's not fair to be angry at someone if there's nothing more to do about it and you can't communicate… T: Sure, but in your heart you still have a relationship with your dad. And you can have mixed feelings with your loved ones. There's a saying that in cases of mourning, like with your dad, it goes like 'a life ends, but not the relationship'. I mean, the life of your dad ended, but you're still in a relationship with him internally…" (36:5 in T2 S4)

"T: Mmm sure, but you could consider that these burdens won't necessarily be there forever [...] what happens when they appear is that your performance or functioning starts going down, your daily life starts to deteriorate and begins to worsen. You don't feel like going to class, you don't feel like doing your assignments, and that directly affects your personal life project, so you could consider that in extreme situations [...], ehm, I mean in some eventuality [...] your dad could support you, but I insist, what's difficult to see is that you can consider it an alternative…" (59:18 in T3 S13)

"P:... it's my mood and I think it's directly related to it [...] T: when your mood decreases, that mood is a response to the overload that you experience, that's what we've been able to understand, that when you're too overwhelmed it looks like your need to 'sleep more, get up late, don't show up at class, not have to look at my classmates eyes and see what they think about me not submitting my assignment'…" (59:15 in T3 S13)

Principle F Psychotherapeutic work is focused on structural deficits. This principle establishes that psychotherapeutic work is focal, understanding 'focal' as specific findings that play a determinant role in the origin and persistence of the problem, symptom or disorder. The therapist must identify the structural deficits according to OPD-2 guidelines of diagnosis (cognitive, regulatory, affective, and bonding), for these will become the therapeutic process focuses and guide the planification of the treatment and therapeutic actions. This

doesn't mean to focus only on a specific deficit, but to consider the functioning characteristics of a global structure of low integration This implies performing "general" (or generic) Interventions, characteristic of every work done with low integration level patients, and "specific" Interventions, according to each patient's deficit profile. This last Principle considers the biggest number of Guidelines and Interventions, and configures the central body of psychotherapeutic tools, distinguishing between those transversals to every patient with low level of integration, and those aimed at specific deficits. Scopes of application can also be distinguished in this category, specifically in the level of associated Guidelines, according to the stage of the process. Guidelines associated with this principle are seven and Interventions 34, as shown in table 14. Guidelines for F Principle are:

F1 Evaluate deficits and establish the reasons for consultation jointly with the patient.

The focalized work on deficits starts with the delimitation of the current consultation motif, and promptly estimating the patient's global functioning level, since this determines the strategy and therapeutic attitude in the beginning of the process (prevalence of conflict or structure orientation). Along with this global estimation, the therapist identifies with the patient the main deficits based on structural capacities list of OPD-2 (cognitive capacities, affective, regulatory and bonding), and determines the specific profile that will guide the focalization proposal. Along with the structural limitation evaluation, the therapist considers maladaptive confrontation (coping) as an attempt of solution. The symptom results from the attempt of coping with the structural limitation, which, although damaging, turns out more tolerable than the limitation itself. The initial evaluation includes the comprehension of how the biographic situation determined the patient's development and relates to the maladaptive confrontational styles. Along with deficit identification, the therapist must also identify resources that have allowed the patient to cope with problems until now.

Table 14

List of guidelines and interventions associated to Principle F Psychotherapeutic work is focused on structural deficits

Therapeutic Principle	Therapeutic Guideline	Therapeutic Intervention
F Psychotherapeutic work is focused on structural deficits	F1 Evaluate deficits and establish the reason for consultation jointly with the patient	F1.1 Explore with the patient the problem that motivates consultation (S*)
		F1.2 Explore with the patient the current situation and its biographical background
		F1.3 Explore with the patient their structural limitations (cognitive, affective, regulatory, bonding)
		F1.4 Explore with the patient coping strategies used in negative experiences (symptoms and risk behaviours)
		F1.5 Explore with the patient maladaptive relational patterns developed by the patient based on symptomatic behaviour
		F1.6 Identify with the patient stagnation of development (partner, family, professional, health, autonomy) and structural deficit associated with them
	F2 Establish a psychotherapeutic focus with the patient	F2.1 Evaluate the patient's expectations about psychotherapy (S*)
		F2.2 Propose and agree with the patiente a topic to work on
		F2.3 Highlight the patient's resources within the framework of focalization (S*)
	F3 Establish a clear therapeutic setting	F3.1. Establish clear responsibilities for the patient and therapist
		F3.2 Provide psychoeducation about the therapeutic process (S*)
		F3.3 Establish and agree protocols for possible risk behaviours
	F4 Undertake general process work focused on structure	F4.1 Clearly identify patterns with the patient
		F4.2 Perform mirroring interventions
		F4.3 Search and highlight resources
		F4.4 Pay attention to signs of implicit memory
	F5 Work focused on specific deficits according to the patient's profile	F5.1 Signify structural limitations in biographical context
		F5.2 Intentionally target and intervene in perception deficits
		F5.3 Intentionally target and intervene in regulation deficits
		F5.4 Intentionally target and intervene in affective deficits
		F5.5 Intentionally target and intervene in bonding deficits
		F5.6 Intervene in dysfunctional relational patterns determined by deficits
		F5.7 Practice functions in therapeutic relation
	F6 Track the therapeutic process (S*)	F6.1 Resume issues relative to the setting during the therapeutic process (S*)
		F6.2 Highlight improvements, achievements and therapeutic changes during the process (S*)
		F6.3 Evaluate the psychotherapeutic process with the patient and adjust focus and/or duration (S*)

List of guidelines and interventions associated to Principle F Psychotherapeutic work is focused on structural deficits

	F7 Prepare a closure for the process	F7.1 Address the possibilities of closure for the process (S*) F7.2 Address affections associated with closure of the process (S*) F7.3 Explore the experience of psychotherapeutic work done with the patient (S*) F7.4 Explore changes and improvements concerning the focus proposed and complementary topics (S*) (S*) F7.5 Explore strategies with the patient to address difficulties related to ending the psychotherapeutic process (S*)

(S*)= Guideline or Intervention created based on observation of sessions

Interventions to be done by the therapist associated to Guideline *F1 Evaluate deficits and establish the reasons for consultation jointly with the patient* are:

F1.1 Explore with the patient the problem that motivates consultation (S*). The therapist explores with the patient the situation that pushed them to look for help this time. Delimitation is especially important when there is chronicity or multiple problems. In this case, to look for the triggering of the decision to ask for professional help contributes to delimit the current motif of consultation.

Examples:

"T: Ok… Tell me, what brings you here?... P: Mmm… lots of things… T: Mmm… P: Mmm, since they just called me yesterday, I didn't have enough time to organize my ideas, which are many, or I think there are many. Mmm, one of them is an abuse and possible violation experiencethat I had with an ex-partner, five years ago… T: Aha… P: Mmm… another is suicidal ideation, and… another are troubles with my body and eating. More like… I don't know, I tend to be restrictive… Those things… […] those three things I think [...] T: The consultation said self-injury, that as well?... P: Yes, that too. That goes together with suicidal ideation. […] Aha… at present?… P: Yes, this year I've had like… three times? I've thought about it a lot, a lot. I haven't done anything, anyway… T: Aha… Have you managed to make a plan at the moment?... P: Yes, two or three weeks ago, a couple of days after the situation… Mmm… T: The situation of hearing this song?... P: Yes…" (33:14 in T2 S1)

"T: I'd like you to explain to me what drove you to ask for this help, what is it that you've been experiencing, and as you explain it to me, I will probably ask you to clarify questions and see if there's any way I can help you… P: Ehh…. I think that I've been having some anxiety episodes, like, I don't know what to call them or if they are anxiety attacks or something, for several years, several years. And this year I returned to the university, the same career but a different university [...] I'm also working [...] I feel that I'm performing very poorly in both, but yes, what worries me most are my studies. I've lowered my grades a lot because of this and… I feel tired all the time. Maybe I could do better and get better grades… P: … that's all, basically… T: Ok, and are you worried that maybe this weariness or this need you have to work and study can ruin your performance?... P: Yes… (47:19 in T3 S1)

"P:... I want to reach the goal that I have set for myself, but on the way, maybe, it happened so many times before, I've had failures and I don't want to go through the same again, that's the fear I have, that I don't want to [...] T: It's becoming clear to me, Daniela, that right now you're saying 'for me, coming here today', I will tell you in my own words so you can see, 'has to do with taking care of myself so I can keep going'... [...] P: Yes… T: …'and the things that have affected me or couldn't handle before, and somehow have made me drop out of a project, won't happen to me again'... P: Yes, because it's so distressing, I remember locking myself up and crying, crying, crying…" (22:20 in T1 S1)

F1.2 Explore with the patient the current situation and its biographical background. The therapist asks the necessary questions to get a clear image of the current life situation and how the patient is experiencing it. At the same time, the therapist seeks to know the biographical aspects to understand the conditions that limited the patient's possibilities of development. In this exploration, the therapist must pay special attention to achievements and resources developed in spite of adverse conditions. All this initial therapeutic work can require the therapist's effort to stimulate the narratives and obtain relevant and complete biographical episodes from rather fragmentary experiences brought up by the patient.

Examples:

"T: … this suicidal ideation [...], why do you think…? Because when you were a child, in eighth grade… right? P: I was twelve more or less… Mmm yes, without any cause…T: Ok,

so why do you think you have these difficulties? Why did I get depressed? Why I wanted to kill myself at the age of twelve?... P: Mmm… (silence). It's like a mix between, mmm… a nihilist vision of the world and a more hopeful one. Mmm… My daily life and my relations and everything really, I try to act as if the world had some hope to be better… T: Aha… P: In terms of climate change, earth, problems between people, everything. And… on the other hand, the more nihilist version, it's like there's nothing much to do about it… it's senseless to try to make things better if everything is wrong… It's meaningless. That's a very fixed statement… T: And the lack of meaning is something that overwhelms you sometimes? P: Yes… T: Yes? Since you were a child? since you were twelve years old?... P: Yes, more or less… T: Like a feeling of void? … P: Aha… and why do you think that is? how did you arrive at this nihilist idea when you were only a girl?... P: Mmm, I don't know… T: Because of your history? Your home? Your family?... P: (nods with the head). Just thinking about what's wrong in the world and between people, and thinking of how it could be better and realizing that as an individual there's not much you can do… T: Aha… in the sense of hopelessness …P: Aha… (33:19 en T2 S1)

"T: Ok… How elaborate are these situations? How much did they affect you? Tell me a little about that… P: Mmm… I don't know, like twice a month, once, more or less… T: Aha… Did you experience two… abuse situations? P: Mmm… It was a partner… So it happened several times, but I didn't realice untill now, because of the feminist movement… Lot's of abuse situations are so normalized … T: Aha… P: This movement has helped me realize that this experience I had, that made me feel so bad, was in fact abuse… (33:16 in T2 S)

"T:... Do you have any memories about your childhood, your school time?... P: Yes… T: Tell me about it a little. How was your family when you were little? What are your first memories… P: Mmm… the first significant memories? They must be from the age of six… because before that I only have memories of objects and situations… T: For example? … P: I don't know, I remember a coffee table that was in (another city) when I was three years old… T: When? Did you live in (another city) first?... P: When I was born, yes… T: Until what age? P: Until I was three [...] T: Why were you in (another city)?... P: Because of my father's

job… T: Does your mother have a job? P: No, she didn't have a job until now… P: I remember, I don't know, mmm that from three to six I went to a language school… T: Really? And why?... P: Because I didn't speak well (laughs)... I didn't go to the nursery… always to this language school and after that, to school [...] I remember I had a best friend in pre-school [...] until second grade when he left for another school… In third grade he wasn't there anymore… T: And you remember him still… [...] P: When you were little, who were you most close to, you're mom, your dad?... P: My dad, I was daddy's girl (smiles) T: Really? P: When I was a girl, my dad had trouble with alcohol… T: Oh really?... ?P: Yes. And I had the impression that my dad needed a lot of love. So I became very close to him… T: And how did you know that your dad had alcohol problems?... P: Mmm he used to drink a lot and came home drunk, had fights with my mom… T: Were they violent fights?... P: Mmm no… T: Was there physical violence?... P: Mmm, no. Just yelling and talking loud. Usually it ended with one of them in the bedroom and the other in the living room, upset… T: And you felt sorry for him?... P: A little… T: Ok. Weren't you scared to see your dad?... P: Mmm, I'm not sure I ever saw him… It was like, I heard him or I was somewhere else… T: Ok. P: When I was older I saw my dad drunk… T: Older? How much?... P: Probably twelve or thirteen years old… Those were the last times he drank so much… T: Ok, and how was he at that time?... P: Mmm… the last time I remember he must arrived home, and was not really violent, but upset… No, he was violent that time, he broke a camera… But he was never violent with my mom, he was violent with things around… He had come home from a meeting, drunk too much and was really upset, I don't know why. So my mom said: 'ok, I will record this so you can see how drunk you are this time". My dad got really angry and broke the camera…[...] It was horrible to see them fight. I remember staying close to my sister because she was crying… [...] T: Then she was disturbed, and you? P: I stayed with her… T: Speaking of introspection (laughs)... P: Yes, in general I don't have much time to think about how I feel because I'm always taking care of my mother or sister…" (35:7 in T2 S3)

F1.3 Explore with the patient their structural limitations (cognitive, affective, regulatory, bonding)[15]. During the initial evaluation, therapist and patient identify less available

[15] Orientations for the evaluation of functions correspond to the Evaluation of Axe IV in the OPD-2, and the interview tools are found in Chapter 12 of the Manual (OPD Task Force, 2008).

structural capacities that make the handling of the situation related to the consultation's motif difficult. To perform this exploration, the therapist aims to answer, jointly with the patient, certain questions to have a panoramic view of the most relevant deficits. Regarding cognitive capacities: how does the patient experience and perceive? Does the patient have self-reflective access to their internal world? Do they have a language for internal processes? How do they understand, respond and fulfill themselves? Does the patient lack perceptions about their emotional state? Can they differentiate affections? Who are the most significant others? How is the other defined? How well can they perceive others with their own interests, convictions, points of view? How well can they perceive others as separated from themselves? About the capacities of regulation, how are the impulses and affections regulated and tolerated? How are relationships configured, protected, and regulated? When evaluating affective capacities: how are affections experienced and expressed? How well can they express themselves and make themselves clear? How well can they understand what is happening to the other? How well can they put themselves in someone else's place? To explore the bonding capacities: Can the patient relate emotionally to another? Can they retain positive relational experiences inwardly? Can they have differentiated relationships with different people? Are intimate (dyadic) relations possible? How are negative relational experiences overcomed? Are punishing, hunting, despising internal objects significant? Can they control and calm themselves internally by appealing to positive internalized experiences? Are they capable of having sociable feelings like gratefulness, concern and responsibility? Can they feel guilt before people that were willingly damaged? Can they directly ask for help and support in others, and accept it? Can they say goodbye and live through the experience of loss?

F1.4 Explore with the patient coping strategies used in negative experiences (symptoms and risk behaviors). The estimation of symptoms and risk behaviors towards themselves and others are explored within (presence, frequency, and intensity) as well as in their function, considering them management strategies before anguish and feelings of emptiness: What does the patient do to process or avoid negative experience? Do they retire in solitude and fantasy? Do they calm themselves with food, alcohol, online sex? Do they release tension with self-injuries? This way, the therapist begins to relate, through evaluation, the confronting conduct that constitutes symptoms along with structural limitations.

Examples:

"P: I start to like, get overwhelmed, and what I was telling you before, every psychological experience I express in - - in my body - - I used to associate it with muscular soreness, like sleeping in a bad neck position, but one day I couldn't get up from my bed… T: Ok, so you have a - you have a clear idea that when you are more stressed your body reacts somehow…" (22:22 in T1 S1)

"T: Ok, what about the idea of taking your own life…? P: These last two weeks I don't remember having them… T: Ok, ok. Because what drived you to this idea of taking your own life, what drove you to a crisis were, this topics of, of sexual abuse… mmm… can you tell me a little about that…? (35:4 in T2 S3)

"T: So, when you're overwhelmed emotionally by something you tend to cut yourself? Maybe?... P: Mmm… no… It was like… mmm…it was an unusual situation, really. I haven't cut myself for many years… T: Aha… and what happened in this ocassion?... P: Mmm… I felt really bad… T: Aha… Can you tell me a little bit about it?... P: Mmm… I felt overwhelmed, but like… too much!... T: Aha… You wanted to take you'r own life?... P: No… T: No… was it because of the overwhelming feeling?... P: Yes… T: Ok, so you are telling me, explaining to me that it's not a pattern, because "I haven't done it for a long time"... P: Aha… T: But this was a rare occasion, like "when I remembered something I haven't realized before, I felt overwhelmed and"... P: Yes… T: "And I began to cut myself"... P: Yes… T: And how did you cut yourself?... P: Mmm, here, this (points to the arm), inside, I scratched myself and used a cardboard cutter… T: And about your suicidial ideation, have you made attempts to kill yourself?... P: Yes, a few years ago, with pills… T: Tell me about it… P: Mmm, I took a lot of mixed pills that I found and hoped they would react somehow… I didn't plan it much, really, I mean… T: It wasn't planned… P: It wasn't planned, I mean, I didn't know about the efficacy of the pills… P: I mean, I was collecting them for a while… T: Then there was a planification if you were gathering them… P: Yes. It was in eight grade… T: Aha… and in relation to what?... P: Mmm…there wasn't a trigger… T: And why did you wanted to take your own life?... P: I was tired… T: Aha, and what happened that time?... P: I ended up with a slight intoxication. I was very dizzy, nauseous… and in my family they thought it was a stomachache… T: Aha, so they didn't realize what was happening?... P: No… T: Ok… But

it's a recurring thought… P: Mmm… yes, once in a while… T: Aha… and now?... P: Currently, this year, yes [...] I couldn't focus on my studies, so I said "ok, I'll call a few people and if they pick up the phone, I won't take the pills", the ones I had. And… they picked up the phone, so I didn't take them… T: Tell me, I'm missing something, what do you mean with "if they pick up, I won't take them"? [...] T: And these people, could you share with them how you felt?... P: Yes…" (33:2 en T2 S1)

F1.5 Explore with the patient maladaptive relational patterns developed by the patient based on symptomatic behavior. The reason for consultation frequently contains interpersonal difficulties, especially in patients with structural limitations. Therefore, the evaluation must address the explicitly maladaptive relational pattern.

F1.6 Identify with the patient stagnation of development (partner, family, professional, health, autonomy) and structural deficit associated with them. The therapist explores the degree in which deficits have affected the development in tasks expected for the patient's age and gender, causing stagnation in their development: what is it that the patient can't handle? Does the patient know how to structure their daily life? Do they have goals to pursue? This exploration comprehends functions that are not available for the patient to structure their social, educational, professional, partner and family situations, as well as in the relationship with themselves or with their own body, for example. Is the patient independent from their parents? Have they been able to commit in a partner's relationship? Have they been able to professionally qualify according to their possibilities? Have they been able to enter the professional world? Build relationships? Assume responsibilities? Adaptively face getting old?

Example:

"T: And do you picture yourself living somewhere, for example?... P: Yes, I do. I do picture myself, but I think it will be so hard to be apart from… T: What would be the most difficult part?... P: Maybe… it would be difficult, well, the fact of being alone or not having someone there, and having a crisis, that I could cry and have the advice of my mother beside me, to have her constantly beside me, maybe that would be hard for me, to separate, I think that would be hard… T: How to confront anxiety without her by your side… P: Without someone by my side, I don't know…" (22:24 in T1 S1)

F2 Establish a psychotherapeutic focus with the patient. This guideline suggests that therapist and patient must establish which deficient aspect or aspects of the structural functioning will be addressed in psychotherapy. It's important that the therapist offers the patient the possibility to work on important aspects together, emphasizing cooperation and mutual responsibility in the therapeutic way of proceeding. The therapist also establishes a focus in the maladaptive relational pattern that will be related to the deficits identified as important topics to work on. Interventions to be performed by the therapist associated to Guideline *F2 Establish a psychotherapeutic focus with the patient* are:

F2.1 Evaluate the patient's expectations about psychotherapy (S*). The therapist explores what does the patient expect of them and the treatment and uses this exploration to ask how much does the patient know about psychotherapeutic treatments.

Examples:

"T: what are you looking for in therapy? How can we help you?... P: Mmm… tools for when I don't feel well?... T: Aha… P: Mmm… and…I think that would be the main thing… T: And, I understand that an example of not feeling well is when you remembered… P: Yes…" (33:8 in T2 S1)

"T: Now, I'm telling you this as a practical exercise, because if I listened to you, If I had an interview with you now and listened to you and went through some areas of your experience, of how you are, I would say you're fine, that VV (name of the patient) is fine. What does she need today? I'm a therapist and I want to help her. What does she need?... P: Mmm… T: I would ask a question like that, how can I help her?... P: Mmm, I can't think of anything… T: So if I did a quick internal scan, what you're telling me is that everything is relatively ok…" (37:9 in T2 S5)

"T: XX. How do you want this psychological therapy - if we start a psychological therapy- ...how do you want this therapy to help you? What would you like to achieve by coming here?... P: I think that feeling good about myself. Ehm… I would like to maybe change the perception I have for my future and for myself, feel that I'm capable of doing things, be able

to do the things I'm postponing and without having them as mental burdens on me… T: How… How could we know that you're starting to feel better about yourself? Because to feel well can vary from person to person… (47:12 in T3 S1)

F2.2 Propose and agree with the patient on a topic to work on. The therapist makes an offer to the patient of what to work on together, some subject that is important to them. It's an agreement about what are the main difficulties according to the conversations on this evaluation stage, and what are the therapeutic goals.

Examples:

"But there are other aspects where you have more difficulties, right?... P: Aha… T: That have to do with suicidal ideation, that have to do with, of course, that you've had behaviors, risk behaviors. That sometimes it's hard for you to know the 'why', let's say, that you can't think of anything to say when I ask you: How a little girl…? And then you say "I don't really know why", or what do you associate with this, because, sure, there's a self-knowledge road to go through, really" (33:20 in T2 S1)

"T: Look, I was thinking XX of, of the other time when we were talking, and you were saying that before your dad passed, right?, you were telling me that you didn't feel anguished, you weren't sad, that you felt good. So I was wondering, well, in what area does XX need help?And now that I see you more calm right now, right?, taking a picture, right now that I see you well, and you say "when I sleep well I'm in a good mood". So I say, ok, where do you need help? [...] P: It's that I'm no good with introspection… T: Well, that's something, right? Because take a look at what you're saying. You were telling me the other time that you had taken some pills in the meantime, after your dad passed. Do you remember that you told me?... P: Yes… T: And later the doctor told me that, that of course you had taken some pills and he told your mother, I don't know if your mother was there, but you, you had gotten up, let's say, like… P: In automatic… T: You stood up upset [...] P: I don't remember… T: Right, that, about that, you see?... P: Yes… T: And that has to do with what you're telling me. Like there's a long way to go through regarding introspection… T: That there's a part of XX of which you don't have much conscience, and that expresses itself somewhere else. Then it's

quite a work to do, right? Introspection would be a topic, don't you think?... P: Maybe… (35:3 en T2 S3)

F2.3 Highlight the patient's resources within the framework of focalization (S*). In this stage, where the agreed working focus is associated with the main deficits, the therapist highlights achievements in spite of early adversity experiences and spite of deficits. It's important that the therapist actively searches for achievements and resources in the patient's context, even though they seem less important.

Example:

"T: Ok. Ok, look, what I could tell you today… I mean, I'm taking a clear picture of a moment, really… P: Aha… T: It's like you're getting better. I think that this topic of personality functioning is something that has to be worked on therapy. But according to some vulnerabilities you have, because you have some aspects of your personality that work rather well, don't you think? I mean, you have the capacity to be on other's shoes, the capacity to establish bonds, to love, to be loved, to make yourself loved, the capacity to help people. You have all these competencies, let's say, of your personality. But there are other aspects where you have more difficulties, don't you?" (33:21 in T2 S1)

"T:... to focus on what I'm understanding [...] but the good - the good news is that you've been building a personal project that you like… P: Yes… T: Right? And you feel you have a direction - some have it sooner, some later, and you are not late and - and your purpose of being here is to make sure that this doesn't fall apart, like maybe some other project did… P: Yes… T: And what you fear, by what I gather, is your own anxiety…" (22:30 in T1 S1)

<u>*F3 Establish a clear therapeutic setting.*</u> The therapist establishes clearly and explicitly the setting in which psychotherapy will take place, addressing topics like frequency, face to face interactions, fees and form of payment. Mutual expectations about the duration of the therapy and shared responsibilities during the process are also explicit. In this stage, the therapist must anticipate problematic functioning areas to arrive at certain agreements with the patient, given that small triggers from external reality, or within the therapeutic process, can cause overwhelming situations for the patient and lead to threats on the process continuity or

to the patient itself. When there are precedents, the pact related to possible suicidal conducts has a fundamental place in the therapeutic setting. Nevertheless, it also applies to other threatening relational patterns. In this way, the goal is to break internal functioning structures that can express dysfunctional behavior patterns when activated. Interventions to be performed by the therapist associated to Guideline *F3 Establish a clear therapeutic setting* are:

F3.1. Establish clear responsibilities for the patient and therapist. The therapist saves some time to agree with the patient on the formal aspects of the process. The schedule and timing of the session and process is made explicit, also agreeing on the payment procedure, non-attendances and cancellations, as well as conditions that will be considered as treatment drop-outs. Additionally, patients must be clear about their responsibilities (arrive on time to sessions, focus on the topic agreed during sessions and think about it in between sessions) and of what they can expect from their therapist (give support on the focal subject agreed on sessions and in between sessions according to the agreed established availability).

Examples:

"T: With regard to medication, I'd ask for more active homework. The other thing is, mmm, do you have any comments or questions? Something that I can… P: No, not for now…? T: Ok. Have you given any thought to how many sessions would be reasonable for you?... P: I don't know… T: Ok, let's think about twenty, because we'll have lots of interruptions during the year, so twenty will last through the year. I will be out of the country in July, so there will be an interruption. So twenty are not so few, not so many either, twenty sessions will take about six months, more or less. How does that sound? Too many? Too few?... P: I think it's all right…" (36:15 in T2 S4)

"T: So, I would propose to meet again next Thursday, then start making decisions about what we are going to focus on. According to the topics we have discussed, there are some other topics that I would like to discuss further [...] from there, start making decisions about the focus of this therapy, goals and timelines. I would like that maybe you can think during this week on how long this therapy will last, so then we can negotiate and see how much time we should work to see some improvements…" (48:21 in T3 S2)

"T: Ok… Are you attending classes right now?... P: Yes… T: Mmm… And is it possible for you to come here if we keep this same schedule?...P: Oh, in this same schedule? Yes, it's fine [...] T: Ok. So i f we do therapy together it would be at this same time, here, three times a month because I work somewhere else one tuesday …"(33:12 in T2 S1)

"T: Now, to do therapy means that we can identify a focus among these things that we have discussed, that we can agree on goals and define them for a limited amount of time. Even though we have a general idea with the elements that we discussed today, we still don't have enough. I would propose, and the team would also like to propose, to meet again and go deeper in some topics that we didn't discuss enough today and get to know other aspects of your life. Then we can start talking about what will be our focus, our priorities and for how long we are going to work together. Ok? We think that psychotherapy can be very beneficial for you. Is it true that you can pay for these therapy yourself? P: (nods)... T: Ok. Do you know how much this therapy could cost you?... P: Yes, they told me that it could cost up to $XXX… T: Ok. We wanted to propose that you pay $XXX per session, but also, since you are participating in this study [...] we would like to propose that you pay half of the sessions [...] as a way to pay you back for the availability you have for the use of cameras, question-naires…[...] but it would have to be in this schedule…"(47:15 in T3 S1)

"T: Ok. So next week we would begin with psychotherapy sessions, because we were in an interview stage really, to get to know each other… understand what you, what is your need, [...] so we would begin the sessions… and the only difference with these conversations is that from next session I'll wait for you to start talking about whatever you want to talk about. I won't ask you at the beginning of the session about some specific topic, I'll wait for you to set the tone and I will be there supporting you…P: Ok… T: …on the topics that may appear. That you start the conversation doesn't mean that I will be in silence the whole session, no. You will set the tone, and the idea is that we talk here, that you can begin with whatever you want, something that happened, that you experienced, something you thought about during the week, something you felt… even something you dreamed about, the idea is that everything has value here, everything is good material. And then, and then my job as your therapist will be to discover in what way we can go deep in this focus: to take shelter from self-demand,

incorporate the subjective, equilibrate logic with emotion, so you can have better tools for your everyday life. Do you think what I'm proposing is reasonable?... P: Yes, I understand, I understand completely and I think it will work… T: Mmm, yes, I think so too. About the payments [...] I propose that after we complete one month's sessions, at the end of the month you pay me for all of them… P: Yes, no problem…" (49:13 in T3 S3)

F3.2 Provide psychoeducation about the therapeutic process (S*). The therapist must not take the patient's "psychotherapy culture" for granted. Therefore, they must explain what psychotherapy is in general and what they will do specifically during the process they will start together.

Example:

"T: Then, therapy, the introspection part of therapy has to do with questioning yourself [...] and to question yourself can be painful, but you have seen for yourself in your mother that personal growth through questioning, right?..." (36:14 in T2 S4)

F3.3 Establish and agree on protocols for possible risk behaviors. In this stage the damaging or antisocial ways of coping are addressed to agree on procedures that will help the patient whenever they appear. It's about finding, jointly with the patient, alternative behaviors that help them keep away from harm. For example, an external structure such as a suicidal protocol, a contract for the avoidance of self-aggression or a daily registration of food intake can be helpful. Also, the possibility of being externally protected and guided by someone like the patient's parents or the therapist itself is evaluated.

Example:

"P: … My best friend didn't answer the phone, so I called my partner. And…I spoke of how I felt, we talked and then we got distracted talking about different stuff. And that lowered my anxiety… T: I think that is very important… P: Why?... T: Because, there you find a way out, see? I mean, this is something you will have to be very clear about, you need to make a plan. Because it's a very good experience to feel that you were in a desperate state, you wanted to take the pills, an idea came to your mind and you said: "ok, I'll call these two or three people" that are on the other edge of the river, that eventually are at the other end… And

you realized that your partner was there indeed and fulfilled your needs. Very important. You shouldn't forget this. That is the idea, to emphasize it, be very clear about it and use it… P: Ok… T: To know that in the future, if you feel like taking your own life, this is what to do! Emergency measure number one. And we can also think about number two and three. Do you agree?... P: Mmm… sounds good… T: Maybe we could do the same thing about the cuts, what to do about them, what can you do, like a backup plan. Because you have an intuitive back up plan [...] so that's a backup plan that we can reinforce… Does it make sense to you?... P: Yes, a lot…" (33:3 in T2 S1)

F4 Undertake general process work focused on structure. Part of the psychotherapeutic work process with focus on the structure is oriented towards a deficient functioning of the global structure, beyond the idiosyncratic profile of the patient's deficit. This functioning can be described by a lack of internal psychic space for the conflicts to unfold and be considered; therefore, psychodynamic is more interpersonal than intrapsychic. The core of the patient's painful experience is related to anxieties, tensions and frustrations that are activated in the world of their interpersonal relations. When they try to back out, they face a highly problematic internal world with an unbearable feeling of emptiness that leads to self-harming conducts toward themselves. This is why the therapist must not prioritize the interpretation of unresolved conflicts but aim to address mainly the resolution of interpersonal situations and the development of a psychic structure that allows the patient to understand what is going on, control themselves, calm down and develop more adaptive coping mechanisms in order to resume adult responsibility in their lives, their behavior and overcome their difficulties. The Guideline here is parenting, not by providing support and affection permanently, but by promoting the understanding of themselves and their competencies, identification of patterns and reflective interventions. The work incorporates the elaboration of the biography and the acceptance of the caretaker's failures as a mourning process.

Interventions to be performed by the therapist associated to Guideline *F4 Undertake general process work focused on structure* are:

F4.1 Clearly identify patterns with the patient. An important part of the therapeutic work between therapist and patient is to identify functioning patterns related to structural deficits. There are different stages in the process: a) the therapist offers the patient their perception about some behavior or experience so the patient learns to see their behavior and experience as a pattern, b) the therapist offers the patient their perception and emotional experience and reflects to the patient an image of their emotional situation so the patient learns to see the behavioral pattern as an emotional response to an specific external or internal situation, c) the therapist outlines how the external and internal events are developed to elaborate together a functional model, d) the therapist offers their thoughts or delivers information about what children, adolescents or adults can tolerate in adverse life situations, or what would have been necessary in the situation discussed, so the patient understands and accepts that the functioning model has been biographically mediated and therefore contains adaptation and overcome attempts, e) the therapist proposes to do a balance of what could be the best possible scenario if the pattern persists (what is it for?), versus the self-damage and/or the pathogenic beliefs that it contains (what is the damage?), as to explore together the present functionality/dysfunctionality of the behavioral pattern, f) the therapist offers relief interventions over excessive self-demanding that can be avoided to help the patient accept the pattern as their own; additionally, the therapist mentions the inevitable demands of reality, like pending development tasks, to help the patient be responsible about their pattern, g) the therapist actively supports the patient in the search and rehearsal of new alternative possibilities; the therapist presents themselves as a mentor, acknowledging made attempts, giving support when attempts fail and celebrating the patient's success so they can rehearse alternative possibilities inside as well as outside of the therapeutic situation.

Example:

a) "I perceive that you are always doing/experiencing this and that…" (M16:33)

b) "I perceive you have a specific attachment in a determined situation or you don't have the expected attachment in that situation… if I were in a similar situation I would surely feel like… when I hear you, I feel like…" (M16:33)

c) "It appears that everytime you feel dragged to this situation, something overwhelms you completely, you feel upset, paralized, your thoughts go only in one direction…" (M16:33)

d) "When someone that age has to face a family catastrophe like the one you just told me about, obviously that person will feel completely overwhelmed in spite of attempts to tolerate or manage the situation… you probably didn't have any other way to react…" (M16:33)
e) "Maybe you could evaluate the costs and benefits of this behavior; my impression is that you pay a high price for it and you're not being loving with yourself…" (M16:33)
f) "Maybe you wouldn't necessarily have to do this in your situation… Apparently it's inevitable that you, as a man/woman of your age in your situation, have to…" (M16:33)
g) "That didn't turn out well, but it doesn't have to be your last try… some people your age might think of doing… I find it amazing that you took such a risk. Maybe we could think together about how you could overcome this situation…" (M16:33)

F4.2 Perform mirroring interventions. The main psychotherapeutic intervention in patients with structural functioning problems is to reflect. Mirroring interventions are specific to the "in front of the patient" (D4.3) relational position. In a reflexive intervention, the first step of the therapist is to clear the patient's image through comments or concrete questions. Reflex includes simple interventions, like repeating sentences or words said by the patient (paraphrases) to highlight what's been said, and at the same time strengthens the therapeutic relationship by indicating an active listening by the therapist. Other reflexive interventions are more elaborate and include interventions where the therapist offers the patient their own perception: delivers the image they have of the patient, describing and summarizing their conscious experience and behavior. Interventions can also be the therapist's statements that carefully contain a new and implicit element about some aspect of the patient's functioning, especially affective, or about an affective reaction of the therapist themselves. In this last case, the most frequent shared affection is the concern about the behavior in which the patient puts themselves in danger or harms themselves. The reflex aspects of external reality are also included in this category, given that the therapist's interest doesn't limit itself to the exploration of the internal world, and therefore permanently explores the patient's functioning outside the session.

Examples:

"T: Why do I suddenly get the feeling that you need some authorization or endorsement of your mother?... P: That's right, maybe I want other's opinions, what they think about my current situation, what do I do, should I stay or should I go? (29:2 in T1 S8)

"T: That must have been very hard for you… P: Yes… T: It must have been a very distressing period, I imagine it very anguishing… P: Yes, especially because during the summer he had gone out with her, he had invited her to places that were like our places… (41:6 in T2 S10)

"P:... my concern for this year, if you ask me to prioritize, would be my thesis, then my affective life [...], then the dating. I've always - always left my affective life at second place. I've never been - that's why I tell you, to put it in first place… T: But it seems that this last month the dating part has been more important… because of the conflicts… [...] P: That's right, because of conflicts [...] like in the part where I suffer, I get confused at night, I go to bed and I say this and that is happening…" (27:21 in T1 S6)

"But you could also say 'if I put myself in your position, I could imagine that I would feel like this, and I would have the impulse to do that…'" (11:13 in E1)

"I get the impression that these criticisms, as you're saying in the example of your story, are intensely affecting you in a personal way, like you didn't have any defense against these hurtful aggressions; and the only thing left for you is to abruptly end the relationship and back off… We should think together about how you can manage differently to diminish the risk of being hurt and having to leave…" (5:8 in M5)

"T: Mmm… Sure, if I say what you're saying in my own words, as I understand it, it's like saying 'let's see, I need help, right?' Mmm… and if you didn't need help you wouldn't systematically come here every time you need to be here, right?... P: Aha… T: 'And it hasn't been easy to open up, and a reason why it hasn't been easy is that if I truly open up, much more would be needed, right? More time, more space… P: More or less (nods)... T: Mmm… 'and also the fact is that if I don't have enough time and space, how do I recover afterwards? I mean, in that sense, forty five minutes a week is very little time to contain and sustain myself,

until the next session… P: Aha… T: Apparently that has been our dilemma.. So, you feel that, on balance, with forty five minutes once a week you cannot develop the topic… P: Aha (nods)...T: Because you wouldn't be able to recover, right?... P: Yes, we could synthesize it like that… (39:10 in T2 S7)

"So it has been a week with very important events, right? Your sister going to the hospital, lot's of events. What about you internally, if we could measure it, how have you been, I feel… I put it forward because I'm worried that, for example, last week I had to ask you about the suicide topic, and you told me 'oh, yes, well, I thought about doing something to myself and I called my boyfriend', so there are things that wer're not talking about, some things left aside…" (37:7 in T2 S5)

F4.3 Search and highlight resources. The therapist stays constantly alert to identify and highlight capacities, talents and interests that haven't been communicated enough by the patient and are not recognized enough in their environment. The importance of this activity lies in the fact that the development of new functioning and more adaptive patterns requires the activation of existing and available resources.

Examples:

"T: Ok, those are the wise moves that I told you about, don't you think? From you. I find these research and confrontation moves very wise. To call JJ and, well, empirically, experience shows you that they work, for example, to ask for help [...]. You have a hard time taking care of yourself, but you do something right with this, right? And something that's good for you, to ask for help…" (36:9 en T2 S4)

"T: … and the rest of the birthday party, how was it?... P: It was fun, I danced a lot… [...] P: The tea party was a success, there were seven different kinds of tea, and I danced a lot (laughs), and I got beautiful presents as well, I didn't expect presents [...] T: Celebrating being born has to do with being connected to life…" (45:13 en T2 S15)

"T:... I was thinking in the reaction of your classmates [...] because, well, you explained to them, you apologized, you explained you had this foot pain, that you decided to go to the

doctor, but [...] if your classmates had felt that you weren't a person to support, that you were a distant person, that you were a neutral person, indifferent, your classmates might easily told you 'you know what, you didn't work, you're out, we're sorry'. But I presume that when your classmates consider you at work, is because they feel a personal commitment, beyond what you did or not for the assignment, and I think that there you can realize that you developed something with them, maybe not a friendship, ehh, maybe not a deep relationship, but developed loyalty [...] an engagement, and I think that maybe without realizing very much how, you've been doing that [...] so it seems that maybe you do more than you think to promote relationships with people…" (62:7 en T3 S17)

F4.4 Pay attention to signs of implicit memory. The therapist doesn't try to elaborate intentional aspects of experience characteristic of "explicit" memory, formed by prints of narrated experiences. Implicit memory has as its content sensory perceptions of atmosphere, bodily manipulations or adverse experiences suffered early on and not linked to words. These contents are expressed in the patient's emotional responses through postures, attitudes, convictions and behaviors, to which the therapist must stay alert. Most of these implicit memory expressions are not conscious, not because there is a defensive self-effort, but because during development there were no conditions for the possibility of reflective attention, which would make it possible to mentalise the experiences, to make them the object of observation and internal evaluation and to find words for them.

F5 Work focused on specific deficits according to the patient's profile. This Guideline indicates that, according to the structural functioning profile defined in the deficit/vulnerabilities evaluation, the therapist will help to reinforce, recover or create specific psychic capacities, adapting the therapeutic proposal in relation to modular interventions with regard to their personal and theoretical preferences, the patient's characteristics and the stage of the process. During this work, the therapist will systematically focus on the psychic functions and provisionally help the patient with efficient structural functions, signifying deficits as confrontation mechanisms developed in adverse biographical context and relating them to a maladaptive relational pattern. Interventions to be performed by the therapist associated to Guideline *F5 Work focused on specific deficits according to the patient's profile* are:

F5.1 Signify structural limitations in biographical context. Regardless of the specific profile of deficits, the therapist uses the material communicated during the evaluation stage about the patient's biographical situation to make sense out of them during the whole therapeutic process. This allows for a more complex and deep understanding of the function that confrontation mechanisms had in an environment that didn't create the conditions for a different development, as well as difficulties to face adult life tasks. The experience of being acknowledged and validated in this biographic reality collaborates in their self-acceptance and the possibility to be responsible about it with the help of the therapist.

Examples:

"P: To be able to say… I don't talk much [...] directly say that, it's like… T: I mean you express it with your face, with your distance. And [...] can you describe how your family works? How do you express when something bothers you or makes you angry or you need to say 'no'?..." (28:9 en T1 S7)

"The only real support that I felt, academically, were my classmates, my, my group of friends at the time because… well, in my house it was always the same, 'you need to get good grades, you have to do well, what place did you get [...] T: Some support, but it looks like it was very difficult to find that at home [...] I'm impressed by how lonely you must have felt and, on the other hand, maybe that is related to [...] with this introversion that you develop. Because it seems you can frequently feel alone inside your family, so you decide to lay down your arms and say 'I can't expect anything from my family so I should isolate, isolate, disconnect [...] P: And not only because of the level of exigency at school, but because, ehm, there was a lot of criticism from… from everyone, it was like… T: From everyone?... P: At home, my parents, my sister also. And it was like.. I felt that I had to think like them or not think at all; that's how I perceived it and… my option at the time was not thinking, not tell them what I think, my opinion about many things and … to… shut down…" (52:10 in T3 S6)

F5.2 Intentionally target and intervene in perception deficits. In general, the perception deficits are transversely present in patients with medium to low global functioning levels and therefore are developed on general interventions (F4). However, in some patients

these also form a more specific focus. In these cases, the therapist's interventions must be especially oriented to support the patient in the realistic perception of themselves and understanding of their situation, as well as in the outline of their identity. This way, the patient has the opportunity to develop some familiarity with their mental processes and also develop a language for them. Additionally, the therapist helps the patient develop a realistic perception of their external world and securely distinguish their *self* from *others*, without distorting the external world (object world) with their own experience. The work on deficit perception is done by pointing out, clarifying questions, reflexes, distinctions, and confrontations. This actions are combined to perform the following interventions:

-Be interested about the *self* of the patient and reflect the perceived image: the therapist points out to the patient the importance and uniqueness of their internal world; they gather together information (current narrative episodes, dreams, creative productions) and shares the formed image to the patient. This is an active exercise for the therapist: to ask questions to obtain a detailed account of interactions in narrated situations. This "micro-analytical" kind of observation is about seeing and hearing in the most exact way; stimulate detailed descriptions of significant people; intervene to give continuity to narrated aspects in different moments of the process; and gather episodes of the patient's biografic experience as a chronicler (a "good listener" that retains memories and makes them available for the other).

-The observation practice of the patient's experience is mainly done on the "third part position", where the third is the behavior and the experience observed from the outside (related to *D4.2 Use the relational position "with the patient"*) and the focus is to promote organized and coherent narratives and not aiming to understand them.

Examples:

"What did you do at the time?What did others do?Who behaved this way and with whom? Who felt what you're describing? Who had this intention you're describing?" (M5:6)

"Looking from the outside, what would you say is your typical behavior? how do you do it?"

"How could you describe another person's typical reaction?... How do you think that feels? What do you think is going on inside you when you do that? Why do you think you have this behavior? What feelings provoke them? (M7:2)

-Separately reflect affections perceived in the patient: the therapist searches for possible affective significations of external situations related by the patient in session. If necessary, the therapist suggest options of possible affections using other people's examples or their own, in similar situations; shares with the patient affections perceived in them; validates and puts in context identified affections expressed by the patient, comparing them with other possibilities. This way, the therapist supports the patient in the exercise of observing their feelings and that way differentiate emotional qualities of their internal world. The implicit message for the patient is that there are very different kinds of affections, that it's possible to draw attention to them and let them be clearly perceived inside them; the more they perceive them, the better they know what's going on inside them.

Examples:

"I can imagine something like that could worry/ upset/ humiliate/ depress, etc. someone else" (M19:4)

"When I hear that, I feel… (some specific feeling)" (M19:4)

"I remember someone in the same situation reacted very sadly" (M19:4)

-Search with the patient drafts of identity to structure a more continuous and coherent *self*: the therapist looks for identity aspects according to age, gender, cultural context, professional life, family and biography to develop identity (and not *unveil* some hidden and existing identity): who or what can the patient be? Is there a direction and orientation feeling in the world? What kind of personality is familiar to them and could be developed? What capacities, resources and interests are available to them? What kinds of life (professional, social or familiar) can they imagine? Are corporality, movement or sports of any interest to them? Are there any scientific, philosophical or religious topics of interest? Do they have contact with animals, small children, emotionally relieving or interesting elderly people? Are political topics of any interest?

-Verify with the patient what is characteristic of their *self* and what is rather an intention of attribution of others: the therapist asks about what the patient wants, thinks, fears, aspires, contrasting these with intentions that other presumably have of them (projection) and verifies what aspects of their own feelings and intentions belong rather to others and the

patient experiences as their own (identification). Especially important are descriptions that look like some *think from another* or *feel from another*. In other words, confusing attributions where it is difficult to distinguish the correspondence of feelings and intentions.

Example:

"T: But why - why do you think you need him? Because he needs you and you feel guilty about leaving him, but maybe there's a part of you in which you, by yourself, it's hard to… P: I don't know why it is, maybe because I might miss him, or because of how he feels… T: But you're thinking of him again… P: Sure… T: But I have the impression that maybe because it's sad, it's normal that you empathize with his suffering. But is it just because of empathy or is it guilt?... P: Sometimes I've thought about that, I say to myself 'maybe I'm thinking more about him than me'. But yes, I like being with him and all, but sometimes I feel that I'm not that engaged or maybe I need some time, I'm really confused…" (27:3 en T1 S6)

-Contrast the patient's idealized and devalued perceptions about situations and people: the therapist stimulates the patient to make an effort to see others as they really are and accept that they are someone else, someone who's experiences, interests and convictions can be the same in some regards, but different in others, an even, against their own. This can also be worked in the therapeutic relation, contrasting the patient's perceptions about the therapist with their own experiences, and vice versa.

Example:

"P: He didn't take care of himself too much, he didn't take his medication, things like that… T: What medication? Why?... P: Hypertension… T: Oh, he had hypertension and didn't take his medication… P: And he didn't care about sugar either, he had pre-diabetes, and he used too much salt… T: Are you relating this with his death?... P: I try not to… T: Because he had a vascular accident, didn't he?... P: Yes, and he wasn't taking his medication correctly… T: Right, and you as a nurse… P: Yes, I try not to because it would be like blaming him and I don't think that would be fair with him… T: What do you think is the truth?... P: What?... T: I mean, I understand because you love your father, right? You don't want to blame him, but maybe, scientifically, he had some responsibility… P: Yes, probably… T: Right? I understand the internal dilemma, right? I love him, I don't want to make him responsible, but if I think as a nurse, he had some responsibility, didn't he? (35:15 en T2 S3)

-Clarify concrete situations and check the perception adjustment of shared realities: the therapist stays alert to the reality adjustment of the patient's stories. They intervene asking questions about contradictions, inconsistencies, not credible or unclear descriptions. If necessary, and with the patient's consent, they confirm situations discussed in session with close people like family members, friends or colleagues.

F5.3 Intentionally target and intervene in deficit regulation. When deficit regulation becomes the main target, the therapist has to show the patient the importance of renouncing to immediate satisfaction of their needs and help develop strategies to internally distance themselves from impulses, affections and self-esteem in situations that normally cause deregulation. The achievement of a distanced internal position allows the patient to be oriented, delimited and make decisions. Additionally, the work must target the accomplishment of an effective regulation in relationships, that is to say, to be able to step back from fusioned or absorbing situations. The patient should be able to protect their relations, sustaining their own interests, but also considering others. The following interventions are performed in this therapeutic work:

-Actively stimulate the exercise of impulse control strategies. The therapist is temporarily at the patient's disposal to support in regulation control until they can take over for themselves and can learn to not insist on the immediate satisfaction of their needs. The therapist helps the patient to progressively perceive their own intentions, accept internal and external contradictions, judge situations and make decisions, commitments and solutions with flexibility. In this way, the patient can progressively incorporate responsibility, values and norms. When aggressive impulses appear (towards themselves or others) the therapist addresses them performing confrontations accompanied by alternative regulation proposals, searching for a better integration of them.

-Promote the capacity to be responsible for intense unpleasant affections. On one hand, this means to learn how to tolerate unpleasant emotions when they appear in the experience, and regulate their expression in an adaptive relational way. On the other hand, it means to discourage the permanent avoidance of unpleasantness. The therapist supports the patient in the regulation efforts with reflexive interventions (*top-down*): learn to identify

emotions and the level of intensity that blocks reflection, and find an explanation for the intensity of that experienced emotion; reevaluate the situations that generated emotional overflows; promote caution and affection inhibition in specific situations, specially social, warning about the risks of letting themselves go by intense emotions, like anger. In addition to these cognitive interventions, the therapist teaches regulation techniques (*bottom-up*) for overflowing emotions: relaxation, breathing, meditation; and imagery to address the negative representation moments with emotional flooding (*flashbacks*) and dissociations. If the emotional flooding happens during the session, the therapist first contains emotional excitement (arousal) and once the patient is recovered uses cognitive interventions.

Supports the patient in tolerating insecurity and shame. The therapist works on high sensibility to humiliating feelings and high self-demand, promoting a realistic *self* perception so the patient can be free from exaggerated and idealized expectations of themselves.

Example:

"T:... it's not clear to me how you evaluate yourself at graphic design [...] P: I've done well many times, but it's hard for me to see why I've done well [...] I ended up getting a score of 6.7 on the final exam, and I didn't expect more than a 5.0. In fact I was almost begging for a five in the exam, and I did way better than I expected [...] T: And you're saying something's going on there, that you get lost, right? [...] I was wondering if this difficulty might be related to your self-demand, in the sense that maybe you say 'I'm working to get a score of 5.0, but with a high level of exigency'. Maybe you don't realize how self-demanding you are, how many hours you work, how many times you edit something until it's how you want it, and maybe, at the end, you are so self-demanding that you say "this assignment will get a score of 5.0" [...]. Maybe you are distorting things, isn't this something that you have always done, saying, maybe, 'good is not enough'?... P: Ehm, maybe it's part of it, and it's also the confidence I have in my own work, beyond thinking if it's well conceptualized or not… ehm, I think I've never been confident enough to show my work. If it wasn't because I have to, if it wasn't because I have to go and hang it on the wall of the exhibition for evaluation [...] I think I wouldn't, I would show it privately to the teacher… T: Secretly… but, wouldn't that be your family style? [...] P: Ehm, well, about my grades, when I was a little girl I never felt confident enough to show them my grades, because, because of the answer they always had.

If I got a score of 7.0, it was like "Oh, it's how it should be", and if it was a 6.5, it was like "why isn't it a 7.0". So, if I got a 6.5 I didn't feel confident to show it because I already knew the answer… in this case I think it is, it's the same thing. When they are announcing the final evaluation grades, I could get a 5.0 and it would be like "why didn't I get a 6.5", and I would think to myself "what was wrong with it"...(53:4 in T3 S7)

-Establish strategies to protect relations from harmful impulses and unbalanced interests. It's about finding ways to minimize the risk of impulsive reactions or emotional flooding that may permanently damage interpersonal relations. Additionally, the therapist addresses interpersonal situations where the patient's and other's interests are compromised. The therapist encourages the patient to adequately consider both parties' interests and alerts about the consequences of extreme relational solutions of selfishness or altruism.

-Promote the exercise of anticipating possible reactions of others before one's actions. The therapist helps the patient to see the consequences of their acts and reactions in others, and anticipate possible interpersonal scenarios they can originate. This work is related to the development of the capacity to feel empathy (F5.4.6)

F5.4 Intentionally target and intervene in affective deficits. The therapist promotes the patient's capacity to emotionally experience themselves, including their corporeality, so their experiences become more energetic and dynamic. In order to achieve this, the therapist promotes emotional communication, where the patient is open to emotions and tolerates the discomfort generated by this contact. Additionally, the therapist stimulates the reinvigoration of relations with others, promoting closeness and emotional engagement. This work is the opposite to the one performed on the object's perception and regulation deficit, which is focused on disengagement. The therapist addresses the basic needs of closeness and emotional exchange and points out the problematic emotional contents perceived in this area. Also, they can use countertransference to encourage the patient's contact. Interventions suggested for this deficit work are:

Example:

"P:... I feel sad, it's like my throat is tightening up… T: Now?... P: Now, yes… T: When you talk about the project?... P: Yes, what if it doesn't work? I've failed so many times, I know

how it feels, how many times I've cried about it: 'It didn't work, what will I do with my life'... T: You get sad?... P: Sure, I get sad because I look back, I say: 'oh, I had such a bad time when things didn't turn out well, all the effort' [...] T: Do you feel sad about your experience? P: Yes, I really do, I'm not talking about quitting my studies, sometimes I tell my mother 'no mom, I don't regret it, it's just that maybe my path and projects were different' [...] T: And now that you kept talking, are you still sad? ... P: No, I feel better now. Sometimes I say 'I had a bad time, I chose the wrong career, money, time, mmm // but maybe these are things that had to happen ... [...] and in order to have a job you have to feel fine, you can't work in something you don't like [...] in fact one of my classmates graduated yesterday, she did good, and me: no, I had a different path… T: Now, when you see these things - like this friend that finished and graduated, how do you feel? [...] P: No, it's not what I like… I think I will get enthusiastic at some point, I don't know why, but I feel like, I don't know, but, I'm excited to at least want to start something new… [...] T: Let's see, let's get this straight, because it's important. It's not that there is no fear anymore, it's the enthusiasm that has increased…. P: … there's still fear, more than fear, it's the fear of the unknown, so that…" (25:10 in T1 S4)

Encourage and guide the patient in the use of their imagination and elaboration of their own fantasies. The therapist offers images, descriptions and stimulates internal dialogue in the patient. Together, they also take notice of dreams to observe images, like potential representations of experiences.

Example:

"T: But, maybe a little, it's like the fear, when you are confident that things will work out, or won't, I see that you have some hope… P: What I want to do in the future [...] about my things… just to my boyfriend: I want to do this [...] T: But you are not sure because it's hard for you to trust…P: M-hm… T: But now, internally, you don't tell anyone about it, but you dream about it… P: Yes, I think about it at night and I say 'this can work, and if it doesn't, I can try again, and maybe… I don't know, because I'm scared… a little… Above all, I can't lose the school salary… T: Right… P: So I have to think about that… T: But you are giving space to hope… P: Yes, at least I dream. It's like at least I dream, I imagine it can work … T: Well, that's very good - - I mean, you can say 'at least I dream' [...] T: After the picture

you showed me and what we discussed, it's very important that you're dreaming, believe it or not… (25:14 in T1 S4)

"T: Do you remember your dreams sometimes?... P: Yes, sometimes I do, the last dream I had was not pretty… T: Recently?... P: The day before yesterday. I dreamt I had a multiple pregnancy [...] I was very sad because I had to get an abortion [...] T: And what do you think about the dream?... P: Mmm, it shows my fear of not being able to be a mother [...] T: And, mmm, how did you feel during the dream?... P: I felt sad because… I've been waiting for them since I was nine years old… T: What's that?... P: Mmm… when I was nine or eight years old I decided I wanted to be a mother and adopt children, so I'm waiting for them…" (42:6 in T2)

-Stimulate attention towards experiencing the physical *self*. Situations with emotional content are opportunities to point out basic alternatives about physical experiences: overload, relaxation, need for calm, exhaustion, pleasure in activities, joy of movement, of body games, joy of erotism and sexuality, the pleasure of physically sharing.

-Stimulate the patient to let themselves be emotionally touched in relationships. The therapist helps the patient to emotionally connect in their relationships, searching for contact obstacles and trying to eliminate them (fear of being at someone else's mercy, fear of shame, of recognizing needs, of disapproval, of criticism).

Example:

"P: …of how I relate with others… it's something very complicated for me, ehm… I think about it a lot. I think about… 'what would've happened if I said that instead of this, maybe I shouldn't have said anything, or if I didn't take it so personally I wouldn't feel so bad', so I give that a lot of thought, and maybe it's not necessary, because… I don't know, sometimes I think it's better to let some things pass, instead of… overthink them, but I don't always succeed in that [...] T: For example, that is related to what I was saying: 'sometimes, for example, I find group situations difficult [...] and I see people that are having some conversation and suddenly someone looks at me' [...] I imagine maybe you think: 'they're talking negative things about me' P: Yes, that. Ehm, and maybe [...] It might have been true, or

maybe not, but there is no reason for me to have those things on my mind [...] T: It's very hard to… let go of some… feelings or assumptions you have of others [...] it's difficult to… consider that maybe… there are many chances that it's not like that, I mean, it can be hard to consider that maybe you are not quite right… P: Like I'm wrong when I'm thinking they were… T: Sure, it's hard to consider that, that maybe… P: No, I consider it a lot and that's why I have it frequently on my mind. But what happens if I'm wrong, and they're not really talking about me, I'm exaggerating and overthinking just because, but after thinking that, I think 'ok, but maybe I'm not wrong because I saw this and that' [...] T: Right, but you're always returning to the idea that 'maybe they are talking about me and yes, maybe they are saying negative things', so it's hard for you to let go of that first… impression or feeling [...] P: It's difficult to let go of that situation that might have nothing to do with me and I say 'maybe yes, maybe no', and options are always available… T: Well, and we saw that something like this also happened… at home…" (49:1 in T3 S3)

-Encourage emotional expression in relationships. The therapist helps the patient identify emotions towards others, to read and understand others emotions and to stay in relationships, even though awkward emotions may appear. The therapeutic relation can be useful to exercise these capacities. The therapist can also perceive underlying negative emotions not mentioned by the patient (like anger, disappointment, etc.) and verbalize them.

Example:

"P: So… that same experience makes me stay away from other people and keep a… formal distance, so to speak, that my colleagues are only colleagues [...] T: It, it, it makes you put [...] a wall between your personal life and the group. Mmm, yes, you told me about that. Sure, but I think there's something else going on in another level [...] I started to remember now [...] for example, many times I've thought about telling you something and I've found myself, I've realized, ehm, telling myself: 'I don't know if I'll tell her because I don't know how she will take it [...] she will think I'm too critical [...] and it has to do with, maybe, with something like this: it seems that in this way of… showing yourself, is not clear for the other if they are in a trusting relationship, or not. Because, from another point of view, I think you trust this therapy [...] you have a commitment with this therapy, but maybe something goes

on in this interaction [...] for example, for me, as someone you talk to, it's difficult to establish; let's see… Is Claudia feeling confident enough with me, will she let me tell her things that might be useful to her? But maybe, to not bother you or because… how are you going to feel about what I say, I might have restricted myself… I don't know if I'm making my point clear… P:... Yes, it happens to me frequently with… most people… T: And what are the implications of me telling you this? … that we're talking about this now? P: Ehh.. (long pause) It's not something new to me, that someone tells me something like that, and… (pause) and well, in this context… I don't… I don't really know how… how to take it…" (55:13 in T3 S9)

-Encourage the patient to put themselves in the place of others. The therapist helps the patient to put themselves in the place of others and tolerate fears of closeness they imply. When this capacity to empathize is less available, the patient needs to have the empathic behavior experience of the therapist. Reflections about children's experiences and biographical common aspects help develop the capacity to understand others.

F5.5 Intentionally target and intervene in bonding deficits. The therapist actively promotes the patient's capacity to internalize positive objects, given that, in general, it's not enough to wait until the patient can internalize positive experiences of psychotherapy. Interventions aim to acknowledge experiences and positive relationships in the biography, the external present situation or in future possibilities, and use them to feel accompanied, calm, comforted, protected, defended and responsible for themselves. Also, the therapist helps the patient to elaborate biographic experiences with negative objects. Additionally, the therapist helps the patient to relate with others: ask for and accept help, including the therapeutic situation itself; detach from bonds, providing support in the experience of separation and loss whenever it happens, also including here the therapeutic experience. Interventions for the development of these capacities are:

-Explore positive images of childhood and adolescent experiences to assign them a self-containing function (introjection). The therapist searches jointly with the patient for different kinds of positive experiences, and then practices their function to calm down, like family memories, school memories, nature or even fantasy, literature and religion.

-Actively encourage the patient to use positive introjection to calm down and protect themselves. The therapist helps the patient to use containing experiences (father/mother/brother/friend that sets limits/contained/encourage) and to practice them to help calm and protect themselves. Additionally, they exercise the cognitive control of negative introjection.

-Help develop the capacity to establish a variety of bonds. It's necessary to encourage the variety and quality of these internal objects, without provoking dissonance or contraposition.

-Promote interest and capacity to create significant bonds. The therapist also helps the patient develop the capacity to accept the positive image of someone that can become someone significant. This way the patient can emotionally bond, experiment caring and gratitude.

-Positively resignifying the need to ask for help and accept it. This will require that the therapist permanently stimulates the patient's capacity to accept help. The therapist invites the patient to reflect about the relational nature of human beings and aims for the patient to resignify the need for bonding and help as some weakness.

-Help the patient accept losses and tolerate grief. The end stage of the therapy becomes an opportunity to rehearse separation and detach from a significant bond.

F5.6 Intervene in dysfunctional relational patterns determined by deficit (S*). The therapist shows the dysfunctional relational pattern and uses the structurally determined difunctional relational offer to search for new and more adaptive relational behaviors.

Example:

"T: you set a limit for yourself, like a demand too big to respond to what you suppose the other expects from you, so it gives the impression that you are overwhelmed (smiles)... P: Mmm… T: you shut down to possible alternatives [...] sometimes to get by and face challenges you need to ask for help [...] P: Yes, I'm always very radical… T: 'I need to keep going on my own, I need to keep going on my own', as we spoke… you don't have…" (32:16 in T1 S11)

"T:... sure, you are always there supporting, supporting your family, what I was saying on other sessions, supporting your family… P: Mmm… (nods)... T: I've been thinking about your classmate that passed out, and you adopted her and took her home… P: Yes… T: What do you think about that?... P: It's tiring, but… I feel it's what has to be done, that's the expression, like if I was in that situation I would like someone to do that for me. And, I don't know, act differently, treat others like you would like to be treated… T: Sure, but look at this, this is a good example of how you are postponed, because you couldn't study… P: (nods)... T: And that's a pattern… to worry too much about others, but, where are your needs? This is a good example… and how much do you know about your needs, as long as you postpone them… P: But I can manage later, and the other person has a more urgent need…" (37:5 in T2 S5)

F5.7 Practice functions in therapeutic relation. The therapist focuses on the therapeutic relationship when interpersonal topics start to be as clear as in other relationships and describes therapeutic situations that can help to visualize patterns and rehearse missing capacities.

Example:

"T: Maybe you got angry with me when I didn't understand you… P: No… I understand that people do not necessarily get me… T: Let's see, where did your anger go in that moment? I think that you were angry indeed, because you had an angry face, right?, you had an angry face. And afterwards, on Wednesday, we didn't talk about it. When, then? Angry at what, with whom?... P: With my grandfather, yes… T: Yes, but we had an interaction here, like a discussion between us… P: Aha… T: So, I think that you were also angry at me, because I

wasn't understanding… P: Not anger, that's too hard, maybe annoyed… T: Annoyance, anger… P: Irritated, it's between anger and annoyance… T: Ok (laughter), so? P: Irritated… T: What is anger to you, when you feel anger?... P: Anger is… more like an impulsive energy… T: So anger includes a more physical expression in that sense… P: Or… not more physical, but concrete… T: For example? If you had been very angry with me at that moment… P: I think I would not talk to you, but it is hard for me to feel that angry… T: Mmm… sure, because I… on one hand it's good that we can talk, it's good that you can be angry with me. Ehm… now, I think it's a challenge to be able to, ehm, because I was scared that if you felt to angry, you would stop coming here… (39:4 in T2 S7)

F6 Track the therapeutic process (S).* The therapist constantly tracks the process to adequate expectations, resumes early agreed targets, encourages the patient's motivation for self-observance and highlights achievements because of the patient's difficulties to stay motivated with the treatment and therapeutic bond, as well as general functioning characteristics. Interventions in this Guideline are:

F6.1 Resume issues relative to the setting during the therapeutic process (S*).

Whenever the therapist thinks it's necessary or perceives signs of discomfort in the patient, they resume aspects related to the initial agreed setting and check the patient's experience.

Example:

"T: We are about to finish, what is on your mind now?... how do feel?... P: Mmm… I think I need a lot of time, but not time as a pause, but time to talk… T: Mmm, that has to do with what I proposed the other time, it 's been a problem that we have only three sessions a month and have this interruption in July… you were saying it wasn't such a big deal, but it's still a problem, because you get the feeling of discontinuity and that makes hard for you to open up… maybe the camaras and the mirror are also interfering… P: I consciously don't care… T: But maybe these interruptions, in one month [...] and it's hard, it's hard to think about… without a time limit [...]. Let's think about it, maybe… well, let's see, I will think about it, you think about it, and we'll see when we get back… P: Ok… (39:15 in T2 S7)

F6.2 Highlight improvements, achievements and therapeutic changes during the process (S*). The therapist stays alert to the patient's achievements and changes and helps to see them.

Example:

"T:... the topic that was important, that we talked about a lot, and afterwards it hasn't been - it hasn't been a topic that you bring to the session, is the topic of your boyfriend. How are you about that?... P: ehm, fine, I mean, we talked about it the other time, he asked me out and, and we got back together [...] well, we talked about things, the problems we had [...] and we've been fine, little by little, but still, I don't know what will happen…T: and you're more calm about - about the relationship… P: Yes, because I told him, I mean, I told him everything that bothered me about him, that, ehm… that he also told me everything that bothered him about me, that I was indecisive, that I didn't know and all that… T: And what you told him is also on the plan of being able to say everything that bothers you?... P: Yes… T: Do you feel this is something you couldn't do before?... P: Yes [...] He told me 'you are more demanding now, more than before [...] I don't know, it's like you are telling me things now'... T: Ok, so you feel you are able to tell him [...] you're calm… P: yes, yes, I'm fine…" (32:4 in T1 S11)

F6.3 Evaluate the psychotherapeutic process with the patient and adjust focus and/or duration to continue (S*)

Example:

"T: Hey, about the beginning of the year, I was thinking that when we started, ehm, we agreed on a twelve session therapy, we are about two thirds, we have one third left of the treatment… P: M-hm… T: and - and the year is beginning, so I would like us to think a little about, mmm, that we could evaluate together, in what area do you feel you have been able to make progress, or it has been useful, what things do you feel are being left behind or what - what … [...] ok, I mean, this is the progress you see [...] T: thinking about where we are and - and you've been thinking about this, remember? that we agreed until the end of march …P: Yes… T: Is that amount of time enough for you?...P: Yes, I think so…T: and in these, we have two or three weeks left, where - where would you like to go deeper, or what things do you feel are still pending?... " (29:12 in T1 S8)

Guideline *F7 Prepare closure for the process* indicates that the therapist must actively help the patient elaborate the psychotherapy closure topic. This process is highly significant in all kinds of treatments (including short therapies). The work targets feelings on unfulfilled expectations, tolerating disappointment and the aggression this implies. Checking the patient's improvement is also relevant, based on the identified changes in each one of the focal topics agreed at the beginning of the process, the achievement experience associated with change and the personal experience of ending the treatment. Care strategies must also be explored for when the treatment ends. In the case of structural profile patients, where the main deficits are the bonding capacities (toward themselves or others), this stage activates intense anxieties, and the deficits are shown in relation to the therapist. In this way, although highly challenging, this stage must be used as an opportunity for the development of missing functions and must be worked according to the Guidelines that target bonding (F5.5). Interventions associated to this Guideline are:

F7.1 Address the possibilities of closure for the process (S*). In time-limited focal therapy, the therapist stays alert at the number of sessions initially agreed and addresses the specific moment of the process in which they are, especially when the final stage is close. In a focal therapy without a limited number of sessions, the therapist stays alert at the progress on the agreed focus realted with the reason for consultation, and discusses with the patient on the closure possibilities.

Example:

"T: Aha, very good…. we can see in the horizon the end of the therapy then, can you see it?... P: I think I do… T: You do?... P: Yes [...] T: Yes, let's see, this is a proposal to think about, to digest, let's say, ok?... P: Ok… T: I mean, it's not an imposition, ok?... P: Aha" (45:7 in T2 S15)

F7.2 Address affections associated with closure for the process (S*). The intervention aims to help the patient verbalize their experience of the therapy closure and separation from the therapist, in positive aspects as well as negative.

Example:

"T: How are you feeling about this being our last session? … P: ehm, well, in the morning I said to myself 'it's the last one' (smiles), like 'finally', and, and I'm all right, I'm good, finally I did something from beginning to end… T: Yes, it's satisfying [...] Is this the first time you finish a process?...P: Yes - - yes, in fact… T: In that sense, ehm, you were talking about the satisfaction in it… P: aha… T: to - to be able to close it, to have a closure, to say goodby. But we were just talking about how difficult it is for you to talk about certain things, what do you think can be difficult about this therapy closure?... P: What can be…? T: What can be difficult about it now?... P: Mmm… maybe to see each other weekly, or someone telling me 'this is good, this is bad', like, mmm, how other person sees what I'm doing, telling me 'no, this can't be like that', or 'it can be like that', maybe the part of following advices…" (32:13 in T1 S11)

"T: What you're saying now about the therapy also settles a, a key or a very important challenge for the moment we are in, because next week we have our last session, ok? And sure, then, when, when you start feeling, for example, that the therapy is good for you, that it is useful, that it doesn't bother you, the therapy ends, right? And the mixed feelings you can have about that [...] like saying 'well, what's the point of coming' or 'what's the point of keep coming here if this thing is going to end', mmm, I don't know, someone could have those reactions, close the door ahead of time, not closing the door together… P: aha… something like that happened to me last time.. T: Mmm… P: I mean, in my previous therapy… T: Ok… P: of last year, ehm… [...] I forgot to make an appointment, and afterwards I ignored it and stopped going, so that was my last session, and I had that guilty feeling, like 'oh, I didn't finish it', 'I stopped going' [...] T: You closed the door prematurely [...] P: But, mmm, I don't feel like that in this case [...] T: and maybe, these last sessions, the one today and next week, it's a challenge to finish together, close the door together, say goodby [...] maybe we have to tolerate this mixed feelings, ambivalent feelings that, on one side, the achievements are good, but on the other the end is here and we have to say goodby [...] not finish in a way the will leave you with mixed feelings, like 'I should've been there', 'if I need her, how could I call her' [...] if we can close the door together, maybe that can give you freedom for the future, if at some point you need me we can talk… P: Sure, it also gives me confidence [...] T: Right, right, when you don't say goodby properly it's very difficult to get close again afterwards…(62:9 in T3 S17)

F7.3 Explore the experience of psychotherapeutic work done with the patient (S*).
The therapist reflects with the patient on the experience of psychotherapy. As far as possible, the therapist tries to enable the patient to give an account of the positive and negative aspects of the psychotherapy and to identify what facilitated or hindered the change.

Examples:

"T: and - and - and doing this balance, you're telling me you're being more expressive, 'I can say more about what's going on with me, I would like to say it more easily, but I'm saying it, what else do you want?' What else could you add to this balance, now that we are reaching the end of the therapy, what else?… P: ehm… T: From what we've been working, what you've understood…" (31:7 in T1 S10)

"T: Sure, you were telling me last week that - that there were many things you could discuss here… P: that I couldn't talk with anyone before, that for me, for example, talking to you, someone that I've never seen before in my life, talk about intimate things [...] it's weird to have the confidence to tell you things that are important to me, [...] build the conversations. But, about how I feel, at first it was hard to find the words so you could understand what I wanted to say, because I want so say many things, but there are no words to understand what I want to say - - so for me, it's the first time…"(32:19 in T1 S11)

"T: Now, talking about the possibility of asking for support, accepting help [...] I was thinking that we also experienced a moment in the process of this therapy, a few weeks ago, when you had thought about [...] P: What is going on with me is so small compared with what we are experiencing, so how could I come to therapy [...] T: And I think there, in what we talked about in sessions, appeared a P that wanted to give herself an opportunity [...] finding support in the remaining sessions [...] P: Ehm… I think I haven't given it too much thought… T: Aha… P: about therapy, at one point I thought a lot about it, when I wanted to stop coming to sessions, but when I made the decision to come and I decided… T: Aha…P: To finish the… T: The process… P: Right, mmm… it was something more like, ehm, 'well, it's doing me good, I don't have a hard time going, it's not bad for me'… P: Ehm… and I think that was

everything I, I got to think about this therapy, about the sessions, I didn't think very much about it…" (62:6 in T3 S17)

F7.4 Explore changes and improvements concerning the focus proposed and complementary topics (S*). The therapist resumes proposed targets agreed at the beginning of the therapy and recognizes made changes and pending ones jointly with the patient. Additionally, they address improvements that weren't part of the initial agreed targets.

Example:

"P: Ehm… I started to… stop thinking if things were objective or subjective, not all of a sudden… T: mmm… P: and didn't stop a hundred percent, but I am thinking about it, about what I would do, what I would like to do, not because X or Y say it… T: Mmm… P: and… that makes me feel more comfortable with myself and with the places I go, generally, basically work, university and sometimes the group of friends…. ehm…T: Ok, I'm sorry, I think this is very important, it seems to be that now 'I'm open to look for things that I want, what I feel, what's best for me', right? Like 'I have my own way of making progress', right? I think that is very important [...] You had another way of understanding, it was like saying 'I have to do it in a certain way, I have to do it like my classmates do', or 'I have to do it better', or 'I have to work', or 'I can't be tired at work, I have to do things until I finish them, and there wasn't a personal way there…" (63:12 in T3 S18)

"T: Ok, how do you feel about this? I was thinking that we have this session and the next one left and we're finished… P: Ehm, well, from the first session until now [...] I've learned to communicate things that bother me, I feel that I communicate them more, obviously not completely, but little by little [...] T: Ok, and what else? What else are you thinking in relation to the end of the process? P: ehm - - - well,really, I think at first I knew that I wasn't going to be consistent, that I would abandon the sessions (smiles) I myself couldn't have imagined me finishing…T: you didn't imagine it? [...] P: No, because like I was saying, I always, above all, I'm lazy, and I said, oh, I don't feel like it, I'm lazy, what's the point of going if I can (smiles) if I think positive I'll be fine, but really I abandoned many things for the same reason, I would say 'I don't need help'…" (31:6 in T1 S10)

F7.5 Explore strategies with the patient to address difficulties related to ending the psychotherapeutic process (S*). The therapist helps the patient to anticipate what topics are important to stay alert to once psychotherapy ends, and looks for strategies to approach them.

Examples:

"T: You know why I come back to this topic? Because, since this is our last session, we have to think about, ehm, how are you going to continue taking care of yourself, don't you think?... P: yes… T: How are you taking care of yourself in the future, to achieve things that we've talked about here, that are important to you and, well, clearly to be able to follow the pharmacologic treatment is important. You've told me that sometimes, that it happened before in psychotherapy, that 'no, I can do it by myself, I should quit',,, P: mmm… T: so, ehm, you didn't do it this time, you felt better and nevertheless, you continued. - - but you have to be careful about medication, not because you're feeling ok… P: I stop taking them…T: You find it hard to connect or remember how do you feel when you feel bad…P: mm…T: or when you feel bad, sometimes it also can be hard to remember what you can do when you feel better…"(32:8 in T1 S11)

"T: the sessions end, but therapy continues inside you, and probably many of the tools you have found will improve, and will continue to help you [...] and sometimes, life, for example, I think this year you had different experiences that pushed you to be in this therapy, and maybe, in some other time, life will ask you again, probably to solve the unresolved knotts in this therapy, and that can also be a possibility…" (63:11 in T3 S18)

Conclusions and Discussion

This study proposes an Operational System of Psychotherapeutic Tools Focused on Structural Personality Functioning Deficits, incorporating the perspectives of specialists and the analysis of video-recorded psychotherapy sessions. Two studies were implemented to attain this objective. In the first study, we determined and classified guidelines proposed by specialists in the model of psychotherapeutic work focused on structure integration deficits. The study consisted in an open coding analysis of the Manual of Structure-Oriented Psychotherapy[16] (Rudolf, 2013) and a set of interviews with therapists belonging to the OPD Task Force. In the second study, we sought to identify and characterize the interventions associated with this model during psychotherapy sessions. To do this, we constructed an observation guide based on the list of categories and definitions yielded by the first study, which was then used to analyze 45 video-recorded psychotherapy sessions. Lastly, to configure the operational system of clinical tools, we integrated the results of both studies: we regrouped and fine-tuned the categories, created descriptors for all the categories at three levels –Principles, Guidelines, and Therapeutic Interventions–, and selected clinical vignettes of the sessions observed which were illustrative of the therapeutic interventions.

The first study revealed three categories of clinical tools with different therapeutic scopes depending on their level of abstraction. This answered the first guiding question of this study[17], which referred to the organization of the therapeutic guidelines of the structure-focused model in terms of abstraction and complexity. The three groups were Therapeutic Principles, which broadly establish the foundations and basic definitions of the work to be carried out; Therapeutic Guidelines, at an intermediate level of abstraction, which translate the Principles into instructions for planning work during the psychotherapy; and, at the most concrete level, Therapeutic Interventions, which describe the simple actions and the more complex procedures that the psychotherapist performs. Furthermore, the open coding process conducted as part of this study made it possible to answer the guiding question about how

[16] Chapter 6 of the book Manual zur strukturbezogenen psychodynamischen Therapie: Allgemeine Strategien und spezifische Interventionen, in the book "Strukturbezogene Psychotherapie. Leitfaden zur psychodynamischen Therapie struktureller Störungen. 3. Auflage" (Rudolf, 2013).

[17] Guiding question - Study 1: How are psychotherapeutic guidelines organized in the psychotherapy model focused on personality structure proposed by specialists, in terms of levels of abstraction, complexity, areas of the process covered, and differences derived from the moment of the process and the type of structural deficit targeted?

the guidelines are organized according to the moments and contexts of the therapeutic process and by type of deficit. We identified a range of Guidelines and Interventions for the initial (evaluation, definition of foci, and establishment of the therapeutic setting) and the middle phases of the psychotherapy (general psychotherapeutic work and specific work focused on deficits). Only one category was generated for the final phase of the therapeutic process. In the second study, by observing the sessions, we were able to distinguish all the Guidelines categorized previously, which reflected the specialists' perspective (manual and interviews) and most of the Interventions. This study also made it possible to enrich the categorization with new Guidelines and Interventions, which the specialists' perspective had not considered. We identified a new Guideline that indicates that the process must be monitored, and which originated three new Interventions, while existing Guidelines yielded 13 new Interventions. Five of the latter stand out because of their association with the closing stage of the psychotherapy, which has received limited attention in the specialists' perspective. Session observation also made it possible to complement the descriptors with vignettes selected to exemplify most Interventions. These results enable us to answer the questions that guided this study[18]: first, whether categories of therapeutic tools created upon the basis of specialists' perspectives can be identified through session observation; second, whether it is possible to create new emerging categories through the observation of clinical practice.

The integration of both studies yielded a full, three-level system of psychotherapeutic tools of a theoretical and empirical origin that can be used to work focally with patients with different severity profiles and a range of structural deficits. The system comprises 6 Therapeutic Principles, 33 Therapeutic Guidelines, and 59 Therapeutic Interventions with their respective clinical examples. This systematization addresses the guiding questions[19] about the complementary nature of both perspectives, which were successfully integrated into a single grouping of categories, with the contributions of each being identified.

[18] Guiding questions - Study 2: What Guidelines and Interventions focused on structural deficits can be distinguished through the observation of psychotherapy sessions belonging to different stages of the process? and What interventions not identified in the specialists' perspective emerge from the observation of psychotherapy sessions?

[19] Guiding questions for integration: What complementary relationships can be observed between the categories that emerge from the two perspectives studied? and What Guidelines and Interventions are common to both perspectives, and which are present in only one of them?

First, importantly, the results reveal the applicability of the systematization process conducted, given that the Principles, the Guidelines, and most of the Interventions could be identified in session observations, thus enriching the empirical evidence in favor of the structure-focused model. Second, the design of this study, which employs two observational perspectives, confirms the relevance of combining information sources when studying complex phenomena (e.g., psychotherapy) that have received limited research attention (e.g., structure-focused interventions) (Flick, 2004). The observational perspective of the second study made it possible to define the categories more accurately and complement them in areas that were not sufficiently covered by the specialists' perspectives, such as the closing stage and the monitoring of the process.

Characteristics of the System of Therapeutic Tools: Empirical and Theoretical Relevance

As already pointed out in the Results section, the systematization conducted was multi-level, covering Therapeutic Principles, which include intermediate level orientations, and more concrete work tools. This differentiation enables clinicians to have a reference framework that grants meaning and coherence – "a why*"*– to a set of therapeutic tools that concerned with "what to do" and "how to do it" in the psychotherapy process. Possessing a conceptual framework that is sensitive to levels is relevant not only from a theoretical point of view, but also from an empirical one, when studying the relationship between technique and change in psychotherapy (Jiménez, 2005). Fonagy and Luyten (2019), for example, have stressed the importance of having flexible intervention approaches that target the underlying mechanisms of each patient, but which are also part of a coherent, consistent, and continuous organization. This distinction has also been highlighted in the Common Factors Model (CFM) (Frank & Frank, 1993), with authors noting that, for a psychotherapy to be effective regardless of its theoretical orientation, it requires, among other elements, a rationale or "myth" that addresses the disorder and health (Principles) as well as procedures and tasks, or "rituals", which the therapist resorts to as a way of promoting change (Guidelines and Interventions).

In the Manual of Structure-Oriented Psychotherapy, Rudolf (2013) defines therapeutic attitude as the most relevant principle of this approach, since he asserts that it is the source

of all interventions. In the categorization of this study, the most relevant organizing Principle –which determines the rest of the Principles as well as the Guidelines and their Interventions– is conceptual in nature and establishes that the comprehension of the psychopathology of personality dysfunctions must be based on a deficit model[20]. This understanding refers to how the development of psychopathology is impacted by the objective fact, or the subjective experience, of not receiving sufficient care in a coherent and continuous manner in the early stages of life, and how these experiences determine the absence or the limited development of fundamental psychic functions (Coderch, 2007; OPD Task Force, 2008). At a theoretical level, this conception has been developed since the early days of the psychoanalytic model (Ferenczi, 1932; Fairbairn, 1952) and then consolidated with other fundamental theoretical developments such as those advanced by Kohut (1984) and Balint (1968). These psychoanalytic developments focused on deficits and defects (Coderch, 2007), which differ from the classical psychoanalytic psychopathology of conflict and an emphasis on drives (Coderch, 2007), are classical models from a theoretical point of view; however, they are consistent with contemporary studies on patients with severe psychopathology, including personality spectrum disorders, who exhibit a high rate of various early adverse events in their developmental histories. For instance, patients diagnosed with Borderline Personality Disorder (BPD) are 13 times more likely to report events of early adversity than control patients from the non-clinical population, and three times more likely than groups with other diagnoses (Gunderson, Herpertz et al., 2018; Porter et al., 2020). When considering dimensional diagnosis models of personality functioning, recent studies have also confirmed this association with childhood experiences (Back et al., 2021). This evidence highlights the relevance of this Therapeutic Principle that considers adverse aspects of the patient's biography in the treatment.

[20] Principle A. *Therapeutic approach requires an understanding based on the deficit model*

The Guidelines associated with this Principle, which involve considering the patient's dysfunctional behavior as part of his/her deficits[21] and focusing on deficit-related dysfunctions[22] and supporting their development[23], are also consistent with the neurobiological models of personality problems, especially in severe cases, which take into account the interaction of genetic and environmental influences. In this regard, research shows that experiences of abuse and the quality of parental care in early childhood can affect genetic expression and brain development in terms of structure and functions, resulting in behavioral traits that tend to be stable over time (Gunderson, Herpertz et al., 2018).

In the approach adopted in this study, the notion of psychopathology grounded in the deficit model leads to the Guideline of not adhering to the classical psychoanalytic logic[24] of conflict, which is, however, indicated for patients with high levels of functioning integration, as proposed by the OPD-2 (OPD Task Force, 2008). In this regard, it is relevant to note that this distinction is made in order to present the model, since in clinical practice, most psychodynamic psychotherapies combine conflict- and structure-oriented elements (de la Parra et al., 2016; OPD Task Force, 2008), much like Supportive-Expressive Psychotherapy (Luborsky, 1984), which features a continuum of interventions of both types. In the OPD model, the combination of interventions also configures a figure and background game, with the therapist changing his/her therapeutic attitude depending on whether conflict-related or structural aspects predominate in a session or a period of the therapy. This clinical position is also consistent with the dimensional diagnostic approach of personality psychopathology (J. P. Jiménez, personal communication, March 2020).

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[21] Guideline A2. *Understand the patient's dysfunctional behavior as an aspect of their interpersonal abandonment*

[22] Guideline A3. *Focus on functions that the patient could not develop on their own*

[23] Guideline *A4. Support the development of missing abilities*

[24] Guideline *A1 Do not subscribe to classical psychoanalytic logic*

Technical flexibility is associated with the Guideline that encourages therapists to adapt to the patient's relational competences[25]. This Guideline is relevant when working with patients affected by personality functioning deficits and across all therapy types in general, since it is a transdiagnostic and transtheoretical competence as well as a relevant variable in successful therapies (Fonagy & Luyten, 2019). Efforts to adapt to the patient's characteristics have been conducted under the theoretical concept of Adaptive Indication (Thomä & Kächele, 1989), which promotes a therapeutic work setting that changes to adjust to the patient considering both his/her internal characteristic and external conditions; therefore, the therapist must be flexible enough to "meet the patient where he/she is". Flexibility and adaptation to the patient's competences can be likened to the construct of responsiveness (Stiles et al., 1998), empirically studied as a relevant process-outcome variable in psychotherapy. This construct refers to behaviors that are influenced by the emerging context and that, in psychotherapy, have been found to result in the therapeutic competence of having appropriate responsiveness in the emergent context of sessions, that is, the therapist's ability to do, or attempt to do, what is right given the evolution of the session and the process, personalizing treatment to adapt to the patient's needs (Stiles, 2021). The therapist's ability to be flexible has also shown to be a characteristic that patients treated in Chilean primary care centers desire, since they expect their therapists to be able to adapt their theories and intervention techniques, exercising their role as therapists flexibly to address their needs (Zúñiga, 2021).

This Principle about comprehending the patient's problems based on the deficit model is also relevant, because it determines how the therapist will interpret relational demands[26], without questioning them or ascribing any unconscious content to them. This way of understanding the patient's relational offering is consistent with the developments of Attachment Theory (Bowlby, 1969, 1973, 1980; Holmes & Slade 2019) and Infant Research (Beebe & Lachmann, 2013, 2020; Bruschweiler-Stern et al., 2002; Stern, 1998), which indicate that some components of the relationship represent interactional schemas established in pre-verbal periods of development and are thus expressed in the relationship only in a behavioral

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[25] Guideline *A5 Adjust therapeutic methods to the patient's restrictive relational competences*

[26] Guideline A2. *Understand the patient's dysfunctional behavior as an aspect of their interpersonal abandonment*

manner. From a theoretical point of view, this point has been extensively studied by the contemporary currents of Relational and Intersubjective Psychoanalysis (Stolorow, Brandchaft, & Atwood, 1988; Mitchell, 1988) under the concept of Enactment (Jacobs, 1986). To adopt an approach focused on structural deficits, these pre-reflective schemas can configure intense demands which are addressed within the relationship, striving to make it a safe space that can enable both the patient and the therapist to engage in collaborative development, a relevant aspect in the understanding of change processes in psychotherapy (Holmes & Slade, 2019).

The Principles and Guidelines that concern therapeutic attitude and the therapist's internal dispositions[27], the development of a collaborative therapeutic relationship[28], and the structuring function of the therapeutic situation[29] reveal the importance of the therapeutic relationship as a core aspect of a successful treatment. Our results are consistent with the CFM in terms of the importance of the therapeutic relationship as a factor of change in psychotherapy. In the CFM, aspects of the relationship such as the connection between patient and therapist, empathy, joint work, the creation of shared expectations regarding the comprehension of the patient's situation, and the development of tools to help the patient have been found to be components of factors associated with therapeutic outcomes (Wampold, 2015). Therapeutic Alliance (Bordin, 1979) is the common factor that has attracted the most scholarly interest. It has consistently exhibited an association with therapeutic outcomes, with a solid alliance indicating that the patient accepts the treatment and is working together with the therapist (Wampold, 2015). In the systematization proposed in this study, these elements are included in the Guidelines that direct the therapist to adopt a more symmetrical position regarding the patient[30], respect his/her functioning style[31], be hopeful regarding the possibility of change[32], and seek creative ways of maintaining communication[33] and emotional connection with him/her[34]. Complementing the aforementioned Principles and Guidelines, the

[27] Principle C. *Psychotherapy work requires a therapeutic attitude and an internal disposition fit for deficit development*
[28] Principle D. *Psychotherapy work requires developing a cooperative therapeutic relationship*
[29] Principle E. *Therapeutic experience has a structuring function itself*
[30] Guideline C1. *Be available for the patient as an equal*
[31] Guideline C2. *Ready yourself to respect less effective coping strategies due to their previous adaptive function*
[32] Guideline C5. *Ready yourself to sustain hope for a primarily positive progression of the patient*
[33] Guideline C7. *Be actively prepared to creatively connect with the patient despite their structural deficits*
[34] Guideline D3. *Look for ways to emotionally connect with the patient promoting a weness experience in the therapeutic relationship*

Guideline of adopting a parental attitude that promotes development[35] and the Principle regarding the structuring role of the therapeutic experience[36] are clearly aligned with the characteristics common to treatments based on empirical evidence for personality disorders: having actively responsive therapists who validate the patient, show an interest in him/her, make him/her feel that he/she is being listened to, offer support, and do not excessively activate or mobilize emotions (Bateman, et al., 2015).

In addition to complementing common factors in psychotherapy, the Principles, Guidelines, and Interventions of this model have major points of agreement with the perspective of support psychotherapies (Luborsky, 1984; Pinsker, 1997; Rockland, 1989, Werman, 1984), which have targeted the reinforcement of ego functions using interventions beyond interpretation or insight to help the patient. Although these psychotherapies were not originally aimed at achieving structural changes, research has shown that they have the potential to generate them and thus improve the patient's functioning (Clarkin, Levy et al., 2007; Wallerstein, 1989). A look at the history and development of several proposed support psychotherapies (Olivos, 2015) reveals the large degree of overlap between their foundations, strategies, and techniques and the system of clinical tools described in this study. The main strategies described as being common across support psychotherapies concern the formulation of the case, the therapist's function as a good parent, promoting and protecting the Therapeutic Alliance, managing transference, providing patient support, offering psychic structure, strengthening adaptive coping mechanisms, making connections, improving self-esteem, boosting self-esteem, generating hope, focusing on the here and now, fostering activity, educating the patient, and managing the environment. As can be observed, despite being differently organized, these strategies are consistent with the Principles, Guidelines, and Interventions of the system proposed here. The same is true for the techniques indicated in supportive psychotherapies (Olivos, 2015), which include empathetic validation, affective modulation, clarifications, a conversational style, answering questions, using self-disclosure intelligently, and paying attention to language, among others.

The therapeutic tools included in the study and which we have discussed thus far also have major commonalities with the therapeutic principles of Good Psychiatric Management

[35] Guideline C4. *Ready yourself to assume a parental attitude that promotes development*
[36] Principle E *Therapeutic experience has a structuring function itself*

(GPM) (Gunderson & Links, 2014), which assert that the ideal therapist is active, non-reactive, and supportive; that he/she offers support through listening, interest, and selective validation; that he/she focuses on helping the patient to "have a life" (work and interpersonal relationships); that the relationship is real and professional, with selective self-disclosure by the therapist; that the participants expect the psychotherapy to generate changes; and that the patient is expected to take responsibility and collaborate actively (Gunderson, Masland et al., 2018). The fact that the therapeutic tools presented in this study have points in common with GPM is interesting because this approach to BPD treatment is defined as a general-purpose model, which has been shown to have good outcomes in natural settings (effectiveness) compared to DBT while being simpler and less costly in terms of training as well as less intense, complex, and expensive to implement. GPM has been proposed as a primary-level intervention, leaving more intensive evidence-based treatments for cases that do not respond well to this general-purpose approach (Gunderson, Masland et al., 2018).

Taken together, these results indicate that the characteristics of the operational system of clinical tools advanced in this study configure a clinically relevant therapeutic approach, since it is aligned with generic change factors in psychotherapy (CFM), with Supportive Therapy (ST), which improves patient functioning, and with a general-purpose approach that has been shown to be effective in patients with personality psychopathology (GPM). From the point of view of personality psychopathology care, this systematization of clinical tools contains the components described as characteristic of effective BPD treatment: being a treatment conducted by a clinician who develops the plain and aims of the treatment, supervises suicide risk, and monitors the patient's progress; being a treatment with identifiable objectives, which specifies the functions of the patient and the therapist, delimits the latter's availability, and establishes guidelines for managing risk behaviors; being a collaborative effort where the therapist encourages patient participation in goals setting and during the sessions; having an active and receptive therapist who ensures that the patient will feel that someone is listening to and supporting him/her; having groups of colleagues who help the therapist with reactions that could be harmful to the patient (Gunderson, Herpertz et al., 2018).

However, this proposed systematization also stands out due to enriching the aforementioned components with a set of therapeutic tools that make it possible to focus on spe-

cific functioning deficits during the therapy to strengthen or develop them and generate structural changes (OPD Task Force, 2008). In this context, we propose focusing on the patient's deficit profile as a component with specific ingredients intended to promote the development and strengthening of structural functioning, from a dimensional perspective adapted to each patient's needs according to his/her profile of structural deficits. The literature (e.g., Newton-Howes et al., 2015) has recently highlighted the need for treatments to target the personality traits that cause the most functioning difficulties, and the associated deficits at different levels of severity, regardless of the patient's psychopathological diagnosis. Furthermore, the shift to dimensional diagnoses of personality problems may strengthen this trend. For the system of therapeutic tools advanced in this study, these components are defined under Principle *F Psychotherapeutic work is focused on structural deficits*. The Guidelines associated with this principle encompass a number of aspects of the process as well as approaches to patients' deficits, setting out how to delimit problems and work focally, which also makes it possible to abbreviate the psychotherapy in difficult patients.

In the initial stage, the Guidelines for evaluating and delimiting the patient's reason for seeking help[37] were clearly distinguishable based on the specialists' perspective; however, they were described in less detail at the level of Interventions and must therefore be complemented with the indications of Axis I "Experience of illness and prerequisites for treatment" and especially Axis IV "Structure" of the OPD-2 Diagnostic Manual, where these aspects are thoroughly explored (OPD Task-Force, 2008). Having a systematically organized set of tools that include evaluation Guidelines such as those categorized in this study is essential for adequately delimiting the patient's reason for seeking help or his/her current problem, since this is the starting point for constructing a well-defined work focus that will make it possible to abbreviate the psychotherapy and adapt it to the patient's needs (Ehrenthal & Dinger, 2019; Fiorini, 2000). In this first treatment phase, the Guidelines also indicate how to establish foci, highlighting that the process must be collaborative[38]. This emphasis on joint work with the patient, encouraging him/her to become actively involved in therapeutic work from the start, is consistent with the components associated with shared tasks and goals, which require a good Therapeutic Alliance. With respect to Therapeutic Alliance construction, the patient's

[37] Guideline F1. *Evaluate deficits and establish the reasons for consultation jointly with the patient*
[38] Guideline F2. *Establish a psychotherapeutic focus with the patient*

explanation of his/her problem is contrasted with the therapist's explanation, which is more adaptive since it includes ways of addressing the problem. This new perspective allows the patient to believe that it is possible to solve his/her difficulties, encourages him/her to commit to the process, and increases his/her feeling of self-efficacy (Wampold, 2015).

Within the initial treatment phase, the arrangement presented in this study identifies Guidelines for establishing the therapeutic setting, which must be clear to the patient[39] and include agreements about the procedures to be followed in response to possible risk behaviors. Despite the relevance of this component of the setting when treating patients with personality difficulties, none of the stages of the present study (specialists' perspective / session observation) contained categories at the intervention level which described specific ways of reaching agreements on how to deal with risk situations during the setting phase of the therapy. Having tools for recognizing the risk factors of suicidal behavior or self-harm and actively reaching agreements for tackling them is a relevant aspect that must be strengthened in this proposal, since it is common for patients who are at risk of engaging in these behaviors not to expect to receive help with these issues and not to mention them spontaneously (Zúñiga, 2021). Therefore, they may need interventions that are actively led by the therapist, for instance, the evaluation and management of Mental Pain, a transdiagnostic construct that has been shown to be one of the most proximate predictors of suicide risk (Morales & Barros, 2022).

In the general process work phase[40], the main Interventions consist in identifying functioning patterns[41] and mirroring interventions[42]. In this systematization, these are essential tools for working with all patients with a middle to low level of structure integration. These interventions are complemented with the Guideline about work specifically focused on deficits according to the patient's profile[43], defined according to the indications of the OPD-2 diagnostic system. This category features several associated Interventions for each group of deficits, integrating techniques inspired by various theoretical approaches that can be flexibly applied and adapted by the clinician according to his/her theoretical and technical

[39] Guideline F3. *Establish a clear therapeutic setting*
[40] Guideline F4. *Undertake a general focus work process on the structure*
[41] Intervention F4.1 ***Clearly identify patterns with the patient***
[42] Intervention F4.2 ***Perform mirroring interventions***
[43] Guideline F5. *Target specific deficits according to the patient's profile*

preferences. Regarding Cognitive Capabilities, the tools highlighted in this systematization are verbal interventions, which are mostly based on questions, clarifications, and mirroring[44], with the latter element being regarded as the core Intervention in the present systematization. Mirroring has been described as the therapist's repetition of parts of the previous conversation (prior talking) which are valuable in some way, such as a word or phrase that is highlighted. Apart from showing that the therapist is paying attention, this response makes it possible to work through elements mentioned previously while allowing the patient to listen to them differently (Ferrara, 1994; Knol et al., 2020). However, in this systematization, the Intervention categories that include mirroring[45] do so broadly, encompassing the simpler actions covered by the above definition as well as more complex ones that combine the therapist's expression of perceptions and affects regarding the patient and his/her context and other types of interventions such as recapitulations and signaling. With respect to regulation deficits[46], specific interventions can include verbal cognitive orientation and the teaching of regulation (bottom-up) techniques, although the latter are only mentioned and not described in detail, so that the clinician may use those of his/her personal or theoretical choice. Affective deficits are also tackled with verbal interventions that can be complemented with non-verbal activities that encourage communication and affective connection, inviting the therapist to be creative in his/her utilization of a variety of techniques, without specifying any in particular. For their part, attachment deficits are worked on actively, without expecting the therapeutic bond to be the only way for the patient to internalize a nurturing experience.

Two Guideline categories –mostly resulting from the session observation stage– are associated with the Principle on focal work and deficits[47]. One of these is the Guideline that

[44] Interventions F5.2.1 ***Show an interest in the patient's self and reflect the image that you perceive***; F5.2.2 ***Reflect the affects perceived in the patient in a differential manner***; F5.2.3 ***Together with the patient, seek glimpses of identity to structure a more continuous and coherent self***; F5.2.4 ***Together with the patient, verify what belongs to the self and what is ascribed to the other***; F5.2.5 ***Contrast idealized and devalued object perceptions***; F5.2.6 ***Clarify situations and check how well adjusted the patient's perception matches shared realities***

[45] Interventions F5.2.1 ***Show an interest in the patient's self and reflect the image that you perceive***; F5.2.2 ***Reflect the affects perceived in the patient in a differential manner***

[46] Interventions F5.3.1 ***Actively encourage the usage of strategies in impulse management***; F5.3.2 ***Promote the patient's ability to cope with intense displeasing affects***; F5.3.3 ***Help the patient to cope with insecurity and shame***; F5.3.4 ***Establish strategies to protect relationships from noxious impulses and unbalanced interests***; F5.3.5 ***Encourage the patient to anticipate the possible reactions of others to his/her actions***

[47] Principle F. *Psychotherapeutic work is focused on structural deficits*

indicates that the process must be monitored[48], stressing the importance of permanently checking with the patient aspects of the setting, the progress made, and the therapeutic experience in order to adjust foci and the duration of the psychotherapy[49]. In line with the notion of responsiveness (Stiles, 2021), these interventions allow the therapist to adapt to the patient's experience, maintain the structure of the treatment, and check progress, all of which are important characteristics in personality treatments (Gunderson, Herpertz et al., 2018). The Interventions associated with the Guideline about monitoring require a therapist who is capable of engaging in metacommunication (Watzlawick et al., 1967), that is, talking directly with the patient about relational dynamics that occur during the session. This is a relevant competence for the development of the therapeutic relationship and the management of impasses in the therapeutic process (Calvert et al., 2020, Mylona et al., 2022). Monitoring Interventions are also relevant for preventing dropout during the psychotherapy process (Busmann et al., 2019; Swift & Greenberg, 2012). In the final stage of the psychotherapy, which received limited attention in the study on the specialists' perspective, the Guideline that indicates therapists to prepare the closure of the process[50] yielded interventions created during session observation. These Interventions highlight the importance of working with the patient to review the overall psychotherapy experience: the affects associated with separation, achievements, unmet goals, and future challenges[51]. The emphasis on collaborative work has mostly been described in the literature as a relevant part of the initial stages of the treatment, however, collaboration is also a critical component of a successful closure. Working together to close the psychotherapy facilitates a symmetrization between therapist and patient while also helping the latter to feel that he/she will be able to deal with problems that may arise after the end of the treatment (Goode et al., 2017).

[48] Guideline F6. *Track the therapeutic process (S*)*

[49] Interventions F6.1 ***Revisit aspects related to the setting during the therapeutic process (S*)***; F6.2 ***Highlight progress, achievements, and therapeutic changes during the process (S*)***; F6.3 ***Together with the patient, evaluate the psychotherapeutic process and adjust foci and/or the duration of the process to continue (S*)***

[50] Guideline F7. *Prepare closure for the process*

[51] Interventions F7.2 ***Address affects linked to the closure of the process (S*)***; F7.3 ***With the patient, explore the psychotherapeutic work experience conducted (S*)***; F7.4 ***With the patient, explore the changes and improvements in each of the foci proposed as well as in complementary foci (S*)***; F7.5 ***With the patient, explore strategies for tackling the difficulties associated with the end of the psychotherapeutic process (S*)***

Finally, the overall result of this study, in terms of a systematization of clinical tools classed as Principles, Guidelines, and Interventions, together with the organization of psychological functions offered by the OPD-2 for evaluating structural capabilities, makes it possible to consider the modularization possibilities of this approach. Modular psychotherapy protocols have been developed as a middle way between the traditional psychotherapeutic interventions proposed by the major theoretical schools and standardized manuals with empirical evidence for clinical diagnosis (Chorpita, Daleiden & Weisz, 2005). In the field of personality disorders, the use of modularization is a response to the search for integration among treatments, in line with the evidence suggesting that certain aspects are common to all personality disorders and that it is more relevant to identify underlying dysfunctions rather than offering categorical diagnoses (Livesley et al., 2016). The grouping of structural capabilities into Cognitive, Regulation, Affective, and Attachment Capabilities, which is the basis of the focal approach adopted in this study (OPD Task Force, 2008), thoroughly covers the baseline symptoms and psychological functions that have been identified as core elements of personality difficulties, either from the point of view of the accentuation of traits or even based on a categorical characterization of personality disorders in the Emotional, Interpersonal, Behavioral, and Cognitive domains (Garland & Miller, 2020). Therefore, this systematization, by differentiating principles from guidelines –especially for the Focal Work principle (F), with guidelines being presented for each stage of the process and for each patient's specific deficit profile–, has great potential for modularization.

Contributions to clinical practice

The clinical work model informed by the results of this doctoral research endeavor has features that make it highly suitable for implementation in a variety of care settings. The original therapeutic proposal on which this study is based is a psychodynamic psychotherapy for patients with severe personality problems susceptible of manualization (Rudolf, 2013), following the tradition of standardization of treatments that can be empirically studied. The originality of the results of this study lies in the proposal of a flexible but coherent model that integrates a set of clinical tools and whose theoretical and applied aspects have been empirically studied. The flexibility of this systematization is in line with the views of Ehrenthal and Dinger (2019), who note that the structure-focused approach is all-encompassing and can be

employed by therapists who have received a variety of training styles. Apart from being flexible in terms of the usage of its clinical tools, it can be utilized with a wide range of patients whose personality problems are underlain by psychological difficulties, in line with recent dimensional diagnostic approaches (APA, 2013; WHO, 2019). These patients, whose personality functioning difficulties are not in the highest severity group, are regarded as "difficult" by clinicians who work in high-pressure settings (Fischer, 20109) and require a treatment tailored to their difficulties without needing to take part in manualized therapies devised for severe disorders such as DBT, TFP, and MBT. These manualized therapies, which are intensive in terms of frequency and involve a combination of intervention modes, are costly to the patient. In addition, these interventions require specialized training and complex clinical devices, which makes them difficult to access (Behn, 2022; Choi-Kain & Gunderson, 2016); furthermore, evidence for the superiority of these treatments compared to their routine counterparts is insufficient, especially considering their high implementation costs (Laska & Wampold, 2014; Laska, Gurman & Wampold, 2014). As previously pointed out, the characteristics of the present systematization make it possible to regard it as a general-purpose approach to the treatment of patients with personality functioning problems rather than as a highly specialized one. The general-purpose approach has gained relevance with second-generation outcome studies and has been recommended as the first intervention in the least severe cases (Gunderson, 2016; Gunderson, Herpertz et al., 2018) within a tiered model, with only the most serious cases being treated by specialists in severe personality disorders (Paris, 2017). The general-purpose approach is characterized by having a case manager –who can be the psychotherapist–, offering a psychotherapeutic treatment with support elements, focusing on the patient's daily life difficulties, being non-intensive in terms of frequency (e.g. weekly), and regarding treatment interruptions as something to be expected. This type of approach can be integrated with pharmacological interventions and can be complemented group and family interventions whenever necessary (Bateman et al., 2015). As can be observed, this approach is compatible with the secondary care settings of Mental Health Clinics (COSAM) in Chile's public health system as well as those of private and university mental health care centers.

The systematization of tools advanced in this study also represents a major contribution to clinical work due to its focus on difficult patients. This type of focus not only helps

the clinician to understand, make sense of, and give continuity to the clinical material that emerges during the session when the expression of the patient's deficits is foregrounded (OPD Task Force, 2008), but also facilitates the abbreviation of treatment, a fundamental requirement in high-pressure treatment contexts. In this regard, dose response studies have stressed the importance of developing models where the therapist works actively and orients the psychotherapy toward concrete objectives (Robinson et al., 2019), as the Guidelines in this systematization suggest. Furthermore, the possibility of abbreviating the psychotherapy by focusing on specific deficits can lay the groundwork for implementing treatment systems with brief but repeated therapies, as sequential phases of a treatment delivered over an extended period instead of single, long, and intensive treatments for a fixed period (Bateman et al., 2015; de la Parra et al., 2019). Such an approach would be well-suited to Chile's community-focused treatment model, taking advantage of the bond that the patient develops with his/her treatment center. In this regard, it is worth stressing that, even though therapists often note that patients with personality functioning problems require long therapies, in routine practice, no clear association has been found between treatment outcomes and personality disorder severity, session frequency, and treatment length. This suggests that treatments adapted to community settings are feasible (Bateman et al., 2015).

Lastly, one element that improves the applicability of such treatments in clinical practice is that this set of clinical tools complements the OPD-2 Diagnostic System, which has already been the topic of training programs in Chile and has been administered in a modified form in public health care centers with encouraging acceptability results[52].

Future directions

Given that the systematization presented here is the first attempt at categorizing structure-focused therapeutic tools, the categories may need to be fine-tuned and enriched. At the Interventions level, future studies should focus on obtaining more illustrative clinical examples and present them in a format aligned with that of the OPD-2 manual. This can be done either by observing new psychotherapy sessions to identify more representative clinical vignettes

[52] "Psychotherapeutic Diagnosis, Indication, and Planning Strategies for Primary Health Care", training workshops organized by the Reloncaví Health Service, Chile. Organized by MIDAP and delivered by OPD-Chile Group.

or by conducting interviews with specialized therapists who can offer examples based on their own experiences. With respect to the Guidelines related to therapeutic attitude[53] presented in this systematization, such as the identification and management of countertransference and having a peer group to support the therapist, they must be studied considering the first-person experiences of clinicians. Holding interviews with therapists to gauge their views on these guidelines could be interesting for generating operational management descriptors of aspects that are invisible to external observers. With respect to the Guidelines and Interventions specific to the patient's deficit profile, it would be interesting to explore the possibility of integrating techniques from other approaches to enrich the pool of therapeutic tools available to clinicians. For instance, for Cognitive deficits, it would be useful to consider integrating mindfulness practices focused on the observation of the mind, which enable practitioners to develop monitoring and focus skills and thus benefit their perception (Delgado, 2009; Simón, 2007; Wielgosz et al., 2019); for Regulation deficits, techniques taken from DBT (Linehan, 2014), which have extensive empirical evidence in this area of dysfunctions; for Affective deficits, techniques consisting in verbal productions beyond therapeutic dialogue, such as narrative techniques (e.g. self-characterizations, autobiographical writings, diaries, letters), which facilitate communication with oneself and can help patients to develop, organize, understand, and shed light on their lives (Martorell, 2019), or analogical resources (e.g. metaphors, photographs, collages, short stories, video games, music, body work, and art as production of material or plastic elements), since they operate on the patient's imagination or sensitivity rather than on his/her reasoning (Sanz, 2008); and for Attachment deficits, techniques from EMDR, such as the installation of resources, which seek to identify and reinforce conscious self-resources for interacting with others and accomplishing daily life tasks, and capacities inaccessible to awareness, to maintain a cohesive sense of self, identity and self-regulation (Leeds, 2009).

Future research should also examine the acceptability of this model among therapists and patients in high-pressure treatment settings, taking into account its scalability potential. Similarly, it is necessary to generate training protocols aimed at professionals who conduct

[53] Principle C. *Psychotherapy work requires a therapeutic attitude and an internal disposition fit for deficit development*

therapeutic work in these contexts and to conduct empirical research on the effectiveness and possibilities of this approach for abbreviating interventions.

Another relevant future development concerns the study of the applicability of these therapeutic tools to other mental health diagnoses (e.g., complex depression) whose complexity increases due to personality functioning difficulties (de la Parra, Crempien et al., 2021; de la Parra, Zuñiga et al., 2021).

Limitations

Since psychotherapeutic practice is a complex phenomenon (Sanabria-González, 2019), organizing therapeutic tools into categories is inescapably a simplification. Likewise, when systematizing models for pedagogical or research purposes, reductions are unavoidable. In the present study, some of the categories resulting from the analysis are not orthogonal and may overlap with others. Interventions were linked to Guidelines, and the latter to Principles, in order to facilitate the systematization; however, this is an arbitrary separation because these are interconnected categories, especially those associated with the Principles considered to be common factors in this study. Regarding the organization of the categories, it is also relevant to consider the impact of observer bias. The limitations derived from the categorization procedure were addressed by triangulating the information through intersubjective agreement.

Another limitation of this study derives from the number of sessions observed. For feasibility reasons, the number of sessions and psychotherapies observed was limited. Observing more sessions from multiple therapeutic processes and led by different therapists would have made it possible to obtain more descriptors of Guidelines and Interventions as well as additional clinical examples for all the Intervention categories. Having observed therapists trained in OPD but not in Structure-Oriented Psychotherapy is both a limitation and an opportunity. It is a limitation because we were unable to include vignettes that clearly resulted from this type of approach. Yet, this is also an opportunity to confirm that therapists from different training backgrounds do conduct interventions suited to the patient's requirements and employ therapeutic tools focused on deficits, even if they may originate in other approaches.

This doctoral thesis was inspired by the need for a set of clinical tools for working with difficult patients in contexts marked by external obstacles that make long and costly psychotherapies unthinkable, where long waiting lists are common, and where health care teams must quickly resolve the cases that they receive. The proposal was informed by the theoretical guidelines developed in Germany by the OPD Task Force. The Operationalized Psychodynamic Diagnostic System (OPD) provides clinical tools for evaluating structural personality functioning deficits which can be easily translated into a focus for planning the psychotherapy, has approached structural diagnosis using a dimensional model for several years, possesses an extensive body of clinical experience and research, and has a high degree of concordance with the current dimensional diagnosis developments of the DSM-5 and CIE11, whose usefulness in clinical practice and treatment planning still needs to be proven (Ehrenthal, 2014; Ehrenthal & Dinger 2019). However, the clinical tools for conducting psychotherapeutic work from this perspective after a diagnosis is reached are practically unknown in Chile. The present study addressed this knowledge gap and proposed an operational system of clinical tools based on Structure Oriented Psychotherapy organizing them in a way that highlights their characteristics and boosts their possibilities of implementation. The results of the categorization and observation of sessions revealed that the therapeutic tools presented contain components that are consistent with the evidence for an effective generic psychotherapy and also for a specialized psychotherapy aimed at personality psychopathology. In addition, this approach includes support components and makes it possible to treat a wide range of patients by considering severity from a dimensional point of view and focusing on each person's specific profile of structural deficits. Another relevant characteristic of this approach is that, by virtue of being focal in nature, it makes it possible to abbreviate treatments. Results also showed that this proposal meets several conditions for implementation as a modular system and may be used as an initial approach within a tiered treatment system). All these characteristics suggest that this toolkit may be well received by professionals from different clinical training backgrounds and may be applied in a variety of high-pressure clinical contexts, where it is particularly important to maximize the efficiency of psychotherapeutic procedures.

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APPENDIX A
INTERVIEW GUIDELINE FOR OPD SPECIALIST INTERVIEWS

Therapist information
Age, gender, profession
Years of experience as psychotherapist
Years of experience with OPD

Introduction
This study is about the psychotherapeutic tools of Structure Oriented Psychotherapy to work with patients with personality structural deficits.

General overview
In general, which is your opinion about using the Structure Oriented focus in psychotherapy?

About the Structure Oriented Psychotherapy
Which are the main characteristics of Structure Oriented Psychotherapy?
How would you describe a psychotherapy focused on structure?
What advantages / disadvantages do you see in this approach in psychotherapy?
What advantages / disadvantages do you see in this approach in psychotherapy, comparing with DBT, MBT, TBP?
Do you see differences between a *Structure Oriented Psychotherapy* and a *psychotherapeutic work with Strategies and Interventions* with focus on structural deficits? If yes, what kind of differences?

Distinctions with other kind of psychotherapeutic work
With generic interventions?
With conflict-oriented actions?

About working with specific deficits
What kind of interventions or strategies could be considered prototypical to address structural deficits of **cognitive capacities?**
Reflect and differentiate self-image
Differentiate one's own affects
Design and further develop one's own identity
Self-object differentiation
Perceive others in their various aspects that is, as whole persons,
Ability to design a realistic picture of other

What kind of interventions or strategies could be considered prototypical to address structural deficits in **regulation** capacities?
Distance oneself from impulses controlling and integrating impulses
Distance oneself from affects, regulate affects
Distance oneself from emotional hurts, regulate self-worth
Protect the relationship from one's own disturbing impulses; intrapsychic instead of interpersonal defence
In relationships, maintain one's own interests and take due account of the interests of others.

Ability to develop a realistic *(anticipated)* picture of *(reactions)* others.

What kind of interventions or strategies could be considered prototypical to address structural deficits of **affective capacities**?

Generate and experience one's own affects
Create and use one's own phantasies.
Emotionally animate the perception of one's own body, or bodily self
Make emotional contact: allow feelings towards others, dare to make emotional investments, achieve "we" feeling (reciprocity)
Express one's own affects, let oneself be reached by the affects of others
Experience empathy.

What kind of interventions or strategies could be considered prototypical to address structural deficits in **bonding-attachment** capacities?

Internalization: positive self-representations, positive object representations, ability to build and maintain positive object-related affects
Positive introjects: ability to care for oneself, to calm, console, help, protect oneself, to stand in for oneself
Variable and triangular attachments: different internal object qualities; attachment to one does not mean turning away from another.
Ability to form attachments: attach to others emotionally (gratitude, loving care, guilt, sadness)
Accepting help: ability to accept support, care, concern, guidance, apologies from others
Ability to sever attachments and tolerate farewells

Personal experience

How has being your experience as a psychotherapist working with the OPD strategy of focusing on structure?

APPENDIX B
LIST OF CATEGORIES STUDY 1

Study 1 - List of Categories: Principles and their associated Guidelines

Therapeutic Principles	Therapeutic Guidelines
A. Conceptual notions associated with the therapeutic approach	A1. TP does not adhere to classical psychoanalytic logic
	A2. TP understands the patient's dysfunctional behavior as an aspect of his/her interpersonal helplessness
	A3. TP focuses on functions that failed to develop
	A4. TP supports the development of the patient's missing skills
	A5. TP adapts interventions to the patient's limited relational competences
B. Therapeutic goals that differ from the classical psychodynamic approach	B1. TP works to develop the patient's self-reflection and a realistic perception of self and objects
	B2. TP works to allow the patient to become familiar with his/her own emotions
	B3. TP works to increase the patient's regulation capabilities
	B4. TP stimulates the emergence of new emotional experiences and the internalization of positive relational experiences
	B5. TP focuses on the achievement of responsibility for one's well-being and the prevention of harm to the self
	B6. TP identifies and establishes functioning
C. Need for a therapeutic attitude and an internal disposition that enable TP to conduct therapeutic work	C1. TP positions him/herself as an equal regarding the patient
	C2. TP is willing to respect ineffective coping strategies and value their prior adaptive function
	C3. TP is willing to work actively
	C4. TP is willing to temporarily adopt a parental attitude to encourage development
	C5. TP is willing to hope that PT development will be largely positive
	C6. TP is strongly focused on identifying and coping with countertransference
	C7. TP is actively open to contacting the patient creatively despite his/her structural deficiencies
	C8. TP requires support from a group of peers to maintain his/her enabling attitude
D. Development of the therapeutic relationship	D1. TP adapts to the patient's limited capabilities
	D2. TP uses triangulation, without encouraging transference
	D3. TP tries to establish an emotional connection with the patient and encourages the experience of a "weness"
	D4. TP responds differentially to the patient's relational offers in each stage of the process
	D5. TP uses a "colloquial" communication style in a therapeutic manner
	D6. TP situates him/herself in metaphorical relational places to intervene ("ahead", "behind", "in front of", or "beside" the patient)
E. Structuring function of the therapeutic experience	E1. Structuring function by experiencing a bond with the therapist
	E2. Structuring function by identifying with the therapist

	E3. Structuring function by guiding the development of responsibility for oneself E4. Structuring function by systematically and jointly supporting the regulation of affects, impulses, and self-esteem E5. Structuring function by offering a differentiated, benevolent, and realistic perception
F. Focus on structural deficits	F1. TP evaluates together with the patient F2. TP establishes foci together with the patient F3. TP establishes the therapeutic setting F4. TP conducts general therapeutic work focused on structure F5. TP conducts specific work focused on deficits F6. TP performs interventions for closing the process

TP= Therapist; PT=Patient

Study 1 - List of Categories: Guidelines and their associated Interventions

Therapeutic Guidelines	Therapeutic Interventions
A1. TP does not adhere to classical psychoanalytic logic	no associated interventions
A2. TP understands the patient's dysfunctional behavior as an aspect of his/her interpersonal helplessness	no associated interventions
A3. TP focuses on functions that failed to develop	no associated interventions
A4. TP supports the development of the patient's missing skills	no associated interventions
A5. TP adapts interventions to the patient's limited relational competences	no associated interventions
B1. TP works to develop the patient's self-reflection and a realistic perception of self and objects	no associated interventions
B2. TP works to allow the patient to become familiar with his/her own emotions	no associated interventions
B3. TP works to increase the patient's regulation capabilities	no associated interventions
B4. TP stimulates the emergence of new emotional experiences and the internalization of positive relational experiences	no associated interventions
B5. TP focuses on the achievement of responsibility for one's well-being and the prevention of harm to the self	no associated interventions
B6. TP identifies and establishes functioning	no associated interventions
C1. TP positions him/herself as an equal regarding the patient	C1.1 TP reacts "normally" to the patient's relational offer C1.2 TP uses a language that the patient is able to understand C1.3 TP answers the patient's questions

C2. TP is willing to respect ineffective coping strategies and value their prior adaptive function	no associated interventions
C3. TP is willing to work actively	C3.1 TP intervenes actively while therapeutic work is underway
C4. TP is willing to temporarily adopt a parental attitude to encourage development	C4.1 TP intervenes therapeutically by fulfilling a parental function for small children or adolescents
C5. TP is willing to hope that PT development will be largely positive	no associated interventions
C6. TP is strongly devoted to identifying and coping with countertransference	C6.1 TP identifies characteristic countertransference (hard to verbalize, hard-to-understand fantasies and reflections, somatization, blockages, tensions) C6.2 TP avoids feeling discouraged by the patient's relational offers (desperate behavior) C6.3 TP pays attention to differentiation (seeing the patient from the outside) and avoids pressuring him/her in a constrictive manner
C7. TP is actively open to contacting the patient creatively despite his/her structural deficiencies	no associated interventions
C8. TP requires support from a group of peers to maintain his/her enabling attitude	no associated interventions
D1. TP adapts to the patient's limited capabilities	no associated interventions
D2. TP uses triangulation, without encouraging transference	no associated interventions
D3. TP tries to establish an emotional connection with the patient and encourages the experience of a "weness"	no associated interventions
D4. TP responds differentially to the patient's relational offers in each stage of the process	no associated interventions
D5. TP uses a "colloquial" communication style in a therapeutic manner	no associated interventions
D6. TP situates him/herself in metaphorical relational places to intervene ("ahead", "behind", "in front of", or "beside" the patient)	no associated interventions
E1. Structuring function by experiencing a bond with the therapist	no associated interventions
E2. Structuring function by identifying with the therapist	no associated interventions
E3. Structuring function by guiding the development of responsibility for oneself	E3.1 TP encourages PT to leave behind maladaptive activities/perform adaptive activities E3.2 TP advises, makes suggestions, answers questions E3.3 TP offers psychoeducation
E4. Structuring function by systematically and jointly supporting the regulation of affects, impulses, and self-esteem	no associated interventions
E5. Structuring function by offering a differentiated, benevolent, and realistic perception	E5.1 TP connects aspects of the patient's experiences

F1. TP evaluates together with the patient	F1.1 TP explores jointly with the patient his/her current situation and biography and proposes a problem to work on together F1.2 TP identifies possible aspects of developmental stagnation (couple, family, work, health, independence) and their associated structural deficits F1.3 TP and PT jointly reflect on and explore the patient's structural limitations (cognitive, affective, regulatory, attachment-related, and behavioral) and their consequences F1. 4 TP and PT, based on his/her symptomatic behavior, jointly explore the dysfunctional relational patterns exhibited by the patient F1.5 TP and PT jointly explore coping strategies adopted in response to negative experiences
F2. TP establishes foci together with the patient	F2.1 TP proposes and agrees on a topic to work on with the patient
F3. TP establishes the therapeutic setting	F3.1 TP explicitly delimits the patient's and the therapist's responsibilities (assistance, focused work) F3.2 TP includes the patient from the start in actions associated with therapeutic work to position him/her in an active role F3.3 TP uses contracts, daily records, and external support to protect PT from possible self-harm and addictive or antisocial behaviors
F4. TP conducts general therapeutic work focused on structure	F4.1 TP performs mirroring interventions F4.2 TP intervenes from relational "positions" ("ahead", "behind", "in front of", or "beside" PT) F4.3 TP identifies functioning patterns F4.4 TP seeks and highlights resources F4.5 TP empathizes with the patient's early relational experiences F4.6 TP pays attention to signs of implicit memory
F5. TP conducts specific work focused on deficits	F5.1 TP attaches meaning to structural limitations within the patient's biographical context F5.2 TP conducts (specific) interventions that target perception deficits (self-reflection, identity, affective differentiation, self-object differentiation) F5.3 TP conducts (specific) interventions that target regulation deficits F5.4 TP conducts (specific) interventions that target affective deficits F5.5 TP conducts (specific) interventions that target attachment deficits F5.6 TP conducts interventions that target the dysfunctional relational pattern associated with the patient's deficits F5.7 TP exercises functions in the therapeutic relationship
F6. TP performs interventions for closing the process	F6.1 TP works through PT losses due to separation from the therapist

APPENDIX C

PROCEDURAL GUIDE FOR OBSERVING AND CODING

MANUAL FOR THE OBSERVATION OF GUIDELINES AND INTERVENTIONS FOCUSED ON STRUCTURAL DEFICITS[54]

Based on the approaches of
Structure-Oriented Psychotherapy (Rudolf, 2013) and
the Operationalized Psychodynamic Diagnosis, OPD-2 (OPD Task Force, 2008)

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Ps. Javiera Martin; Ps. Andrea Molinari, Ps. Natalia Hanckes, MSc. Ps. Catalina Barriga, MSc.
January 2022

[54] Study 2, Doctoral Thesis "Guidelines and therapeutic interventions focused on structural deficits: development of an operational model aimed at integrating the perspectives of specialists and external observers". Doctoral Program in Psychotherapy, PUC. January 2022.
Principal Investigator: Ps. Elyna Gómez-Barris, PhD (c). Research Assistants: Ps. Javiera Martin, Ps. Andrea Molinari, Ps. Natalia Hanckes, MSc. Ps. Catalina Barriga, MSc.

INTRODUCTION

This manual is aimed at orienting the observation of guidelines and interventions focused on personality structure deficits in video-recorded and transcribed psychotherapy sessions, in order to:
1) Identify and describe interventions at an operational level
2) Create observation-based interventions, associated with guidelines
3) Add relevant observationally-collected information to the interventions and guidelines included in the listing.

This procedure is part of Study 2 of the Doctoral Thesis entitled *"Guidelines and therapeutic interventions focused on structural deficits: development of an operational model aimed at integrating the perspectives of specialists and external observers"*. The objective of this thesis is to characterize therapeutic interventions and guidelines focused on personality structure deficits in order to propose an operational model.

CONCEPTUAL CONSIDERATIONS

The Operationalized Psychodynamic Diagnosis (OPD-2) and Structure-Oriented Psychotherapy

The Operationalized Psychodynamic Diagnosis (OPD) (Arbeitskreis OPD, 1996; 2006) developed a diagnostic approach based on an interview that complements syndromatic diagnoses (American Psychiatric Association, 2014; OMS, 2018) with a psychodynamic diagnosis that considers dysfunctional relational patterns, intrapsychic conflicts, and structural capabilities or functions. In addition, the OPD makes it possible to identify foci for psychotherapy and plan treatment strategies.

Among its most remarkable and novel strategies, the OPD enables practitioners to implement a structure-centered focus, that is, to establish as the object of psychotherapeutic work the specific deficits diagnosed on the Structure axis. This is a way to help the patient to identify and recognize these deficits in his/her daily life or him/her to develop self-regulation and adaptation mechanisms in response to his/her structural limitations. This is an alternate path between the psychodynamic approach of understanding and finding the meaning that underlies the problem affecting the patient and the implementation of support strategies (Rudolf, 2013; OPD Task Force, 2008).

Structure-oriented psychotherapy

Structure-Oriented Therapy (SOT) (Rudolf, 2004, 2006, 2013) was developed in Germany as a way to complement the OPD system. It is backed by a Psychotherapy Manual with guidelines for implementing general strategies and specific interventions focused on multiple areas of the psychotherapeutic process. However, this therapeutic approach is scarcely known in Latin America, lacks a training system, and has seen limited empirical research, unlike other therapies developed for people with personality functioning problems such as Mentalization-Based Therapy (MBT) (Bateman & Fonagy, 2016), Transference-Focused

Psychotherapy (TFP) (Clarkin et al., 2007), or Dialectical Behavior Therapy (DBT) (Linehan, 2014).

In this context, it is relevant to characterize interventions and guidelines focused on structural deficits proposed by specialists upon the basis of a conceptual model, incorporating operational qualities systematized in accordance with observations of their implementation in psychotherapy sessions.

Structures, Dimensions, Structural Functions/Capabilities

In the OPD, structure is regarded as "a fabric of psychic dispositions that encompasses everything that develops regularly and repetitively (either consciously or remote from conscience) in the individual's experience and behavior. Structure determines the individual's relatively permanent personal style whereby he/she can recover his/her intrapsychic and interpersonal balance. An undamaged structure grants a flexible and creative availability of functions which have a regulating, adaptive, intrapsychic, and interpersonal effect." (OPD Task Force, 2008, p. 135). From this perspective, structures change through the integration of new information, allowing new regulation rules to be established.

OPD Structural diagnosis includes an estimation of the individual's overall level of structural functioning and a detailed functioning profile constructed upon the basis of an estimate of the specific functions or capabilities available to him/her. These functions are organized around two poles ─Relationship toward the Self and Relationship toward the Object (others)─ and are grouped into four dimensions: Cognitive Capabilities, Regulation Capabilities, Affective Capabilities, and Attachment Capabilities. All of them contain subcategories, for a total of twenty-four functions (Table 1). Any of these functions can become a therapeutic focus (Ehrenthal et al., 2012).

Table 1

Structural Capabilities, Axis IV OPD-2

Oriented toward the Self	Oriented toward the Object
1. Cognitive Capabilities	
1.1. Self-Reflection	1.4. Self-Object Differentiation
1.2. Affective Differentiation	1.5. Overall Object Perception
1.3. Identity	1.6. Realistic Object Perception
2. Regulation Capabilities	
2.1. Impulse Management	2.4. Relationship Protection
2.2. Affective Tolerance	2.5. Interest Regulation
2.3. Self-Esteem Regulation	2.6. Anticipation
3. Affective Capabilities	
3.1. Experiencing Affects	3.4. Establishing Contact
3.2. Using Fantasy	3.5. Communicating Affects
3.3. Bodily Self	3.6. Empathy
4. Attachment Capabilities	
4.1. Internalization	4.4. Bonding Capability

4.2. Using Introjects

4.3. Attachment Variety

4.5. Accepting Help

4.6. Detaching Oneself from Bonds, Separating

OBSERVATION CATEGORIES

The categories to be observed were selected through an open categorization analysis of the Manual of Structure-Oriented Psychotherapy[55] and a set of interviews with OPD specialists. Three major categories exist: Therapeutic Principles, Therapeutic Guidelines, and Therapeutic Interventions

THERAPEUTIC PRINCIPLES[56]:
We adopted the author's concept of "Therapeutic Principle" to label a category that incorporates broad and fundamental definitions that encompass structure-focused psychotherapy based on the OPD model, differentiating it from other psychoanalytic approaches. Therefore, this "major category" is the most abstract one, being placed above 6 subcategories.

Example:
Category C: "Need for a therapeutic attitude and an internal disposition that allow the practitioner to conduct therapeutic work
This is a fundamental principle that defines how the therapist will position him/herself in the process and the therapeutic relationship while also determining the types of interventions to be conducted. It allows the therapist to adopt an active position to support and comfort the patient. This attitude is characterized by openness and unconditional acceptance, adopted in a position of symmetry and respect, which offers stability and hope by supporting the participants' motivation for and interest in the therapeutic work to be carried out".

THERAPEUTIC GUIDELINES[57]:
The Therapeutic Principles yield "Therapeutic Guidelines". This category encompasses therapeutic work guidelines of a lower level of abstraction; in other words, rules. These rules, arranged to form a plan, are expected to enable practitioners to make intervention decisions aimed at achieving the best possible therapeutic outcomes.
Our analysis yielded 36 guidelines.

Example:
"F2. The therapist establishes foci together with the patient:
Together with the patient, the therapist must define which aspect of the patient's functions (regulation, perception, attachment, and/or effective communication) will be worked on.
That is, they must jointly focus on the deficits identified in the evaluation.
In addition, they must flexibly focus on the manipulative relational pattern".

<u>THERAPEUTIC INTERVENTIONS:</u>

[55] Rudolf, G. (2013). Strukturbezogene Psychotherapie: Leitfaden zur psychodynamischen Therapie struktureller Störungen. Schattauer Verlag. Cap.6.
[56] In Spanish, the word *principio* (principle) is defined as "the basis, origin, or fundamental reason used as the starting point in a discourse on any topic; a fundamental norm or idea that guides thought or behavior" (Spanish Language Dictionary, RAE, 2020).
[57] In Spanish, the word *directriz* (guidelines) is defined as an "instruction or norm to be followed when executing a task". Spanish Language Dictionary, RAE, (Diccionario de la lengua española, RAE, 2020).

Therapeutic Interventions are subcategories of Therapeutic Guidelines and constitute the lowest abstraction category. These include concrete and specific interventions implemented during the therapeutic process. Therapeutic interventions are grouped into 25 general interventions (for all patients with a low integration level) and 24 specific interventions (aimed at the patient's specific profile, focused on the structural functions shown to be deficient in the diagnosis).

Example:
"F5.2.3. The therapist collects information to give continuity to the process:
The therapist chronicles the patient's experience: collects the episodes of his/her biographic experience, his/her therapeutic experience, events, affects, dreams, common turning points, operating as a "good listener" who records his/her memories and makes them available to him/her". This intervention belongs to guidelines category F5. "The therapist conducts specific work focused on deficits", which is associated with principle F: "Therapeutic work focused on structural deficits".

PROCEDURES

As previously noted, the coders will fulfill 3 tasks when observing the sessions:
1) Identify interventions at an operational level, assigning a code to them.
2) Create and describe additional interventions based on their observations, associated with guidelines, which were not present in the listing received.
3) Add relevant observationally-collected information to the interventions and guidelines included in the listing.

Therefore, this observation is expected to complement the information present in the psychotherapy manual and the interviews with descriptions that make it possible to construct operational descriptions that clearly show *what to do* with a low-integration patient who exhibits a specific deficit and *how* to do it.

The procedure calls for two coders to observe and code each session individually; then, they must conciliate their findings.

STEP 1: PREPARING THE MATERIAL INDIVIDUALLY

After signing the confidentiality agreement, which includes the obligation to destroy the video recordings and transcripts after observing them, the coder must check the material before starting:
- Video recording of the session.
- Session transcription sheet, which includes space for recording codes and the conciliation agreement.
- Listing of categories to guide observation.
- Manual with category descriptors to guide the identification of guidelines and interventions.

STEP 2: CODING INDIVIDUALLY

The coding unit of the session is a 3-minute period. In each segment, the observed must:
1. Identify the specific guideline(s) and intervention(s) present in the segment.

2. In the session transcription sheet, assign intervention identification codes according to the listing and the category manual.
3. In the session transcription sheet, create and describe all the interventions found which are absent from the listing. The description must avoid inferences and remain at an operational level.
4. And/or, in the transcription sheet, complement and/or detail an intervention present in the listing which might be enriched by said information.

STEP 3: CONCILIATION IN PAIRS

After the individual coding process, the two coders must conciliate their results, reaching an intersubjective agreement on the interventions identified and their descriptions while also agreeing on the creation and description of new categories and/or the modification of previously described ones.

STEP 4: RECORDING THE CODING PROCESS ON THE DIGITAL TRANSCRIPTION SHEET.

After reaching an agreement, both the original coding and the consensus coding must be recorded on the database provided by the principal investigator (on the column identifying the session and the relevant segment).

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APPENDIX D

CODERS CONFIDENCIALITY COMMITMENT

COMPROMISO DE CONFIDENCIALIDAD

Usted ha sido(a) invitado(a) a participar en el estudio titulado "Estrategias e Intervenciones Focalizadas en Déficits Estructurales: Desarrollo de un Modelo Operacional Integrador de las Perspectivas de Especialistas y Observadores externos" a cargo de la investigadora Elyna Gómez-Barris Ch. del Programa de Doctorado en Psicoterapia de la Escuela de Psicología de la Pontificia Universidad Católica de Chile.

En su participación en la presente investigación usted tendrá acceso a información que será considerada confidencial, lo que incluye: todos los antecedentes, conocimientos y/o datos, escritos o verbales, contenidos en documentos, informes, bases de datos, registros, soportes informáticos, telemáticos u otros materiales, y en general, todo soporte y/o vehículo apto para la incorporación, almacenamiento, tratamiento, transmisión y/o comunicación de datos de manera gráfica, sonora, visual, audiovisual, escrita o de cualquier tipo, a los cuales tenga acceso, directa o indirectamente, por cualquier medio, en virtud de su relación con el investigador responsable, señora Elyna Gomez-Barris.

Usted se compromete a guardar absoluta confidencialidad y reserva respecto de toda información o documentación descrita de la cual tenga conocimiento en la ejecución de sus labores en el estudio, cualquiera que sea el soporte en el que ésta se encuentre contenida. Además, se compromete a devolver toda la información recibida o bien destruirla, -especialmente el material audiovisual de las sesiones y sus transcripciones- una vez que haya procesado su información y no podrá conservar copia de ella.

Declaro que he leído el presente acuerdo de confidencialidad, y se me ha entregado un duplicado firmado de este documento.

RUT, Nombre completo Y Firma

FECHA

Ayudante de Investigación Codificador Audiovideos

Firma IR

APPENDIX E OPD-SQ SPANISH VERSION

Cuestionario de Autodescripción OPD-SQ

En las siguientes páginas se encuentran una serie de afirmaciones con las que se describen diferentes características de las personas. Por favor indique cuánto lo representan a usted estas afirmaciones. Marque con una cruz aquella respuesta que, en general, se aplica mejor a usted. No hay respuestas correctas o incorrectas debido a que cada persona es diferente en su forma de ser. Algunas afirmaciones se refieren a relaciones de pareja. En esos casos, por favor también conteste pensando en cómo se siente normalmente en una relación de pareja aunque no la tenga actualmente, o cómo se imaginaría que se sentiría en el caso de no haber tenido nunca una relación de pareja.

		Totalmente en desacuerdo	Levemente en desacuerdo	Ni de acuerdo/ni desacuerdo	Levemente de acuerdo	Totalmente de acuerdo
1.	Me resulta muy difícil describirme a mí mismo(a).	☐	☐	☐	☐	☐
2.	Muchas veces actúo sin pensar cuando estoy enojado(a).	☐	☐	☐	☐	☐
3.	A veces me siento como un extraño(a) conmigo mismo(a).	☐	☐	☐	☐	☐
4.	Me angustian las cosas que imagino o pienso.	☐	☐	☐	☐	☐
5.	Cuando pierdo algo o alguien que yo quiero se me mueve el piso.	☐	☐	☐	☐	☐
6.	Me suelen acusar de ser egoísta en las relaciones.	☐	☐	☐	☐	☐
7.	A menudo los demás perciben mi conducta de forma muy distinta a lo que era mi intención.	☐	☐	☐	☐	☐

8.	Muchas veces tengo emociones que no logro entender.	☐	☐	☐	☐	☐

		Totalmente en desacuerdo	Levemente en desacuerdo	Ni de acuerdo/ni desacuerdo	Levemente de acuerdo	Totalmente de acuerdo
9.	Creo que las pérdidas son más dolorosas para mí que para otras personas.	☐	☐	☐	☐	☐
10.	Muchas veces, sin querer, me meto en situaciones difíciles.	☐	☐	☐	☐	☐
11.	En el contacto con otras personas soy más torpe que los demás.	☐	☐	☐	☐	☐
12.	Me es fácil aceptar la ayuda que otras personas me ofrecen.	☐	☐	☐	☐	☐
13.	Cuando alguien me critica, me resulta difícil superarlo.	☐	☐	☐	☐	☐
14.	Las separaciones y despedidas son muy difíciles para mí.	☐	☐	☐	☐	☐
15.	Percibo a los otros como muy familiares o muy extraños.	☐	☐	☐	☐	☐
16.	Muchas veces no tengo claro lo que estoy sintiendo.	☐	☐	☐	☐	☐
17.	Por ser tan poco crítico a veces me llevo sorpresas con las personas.	☐	☐	☐	☐	☐
18.	A veces me siento como si los otros pudieran ver dentro de mí y reconocer mis pensamientos o	☐	☐	☐	☐	☐

	sentimientos.					
19.	A veces estoy tan furioso que no puedo responder por lo que hago.	☐	☐	☐	☐	☐
20.	Cuando alguien lo está pasando mal, suelo preocuparme.	☐	☐	☐	☐	☐

		Totalmente en desacuerdo	**Levemente en desacuerdo**	**Ni de acuerdo/ni desacuerdo**	**Levemente de acuerdo**	**Total-mente de acuerdo**
21.	A veces dudo si alguien está pensando algo de mí o si sólo es mi imaginación.	☐	☐	☐	☐	☐
22.	Me cuesta percibir mis emociones.	☐	☐	☐	☐	☐
23.	Cuando me enojo, tiendo a hacer daño en mis relacio-nes.	☐	☐	☐	☐	☐
24.	A fin de cuentas, para mí sólo hay amigos o enemigos, entremedio no hay casi nada.	☐	☐	☐	☐	☐
25.	Mis fantasías e ideas me vitalizan y enriquecen.	☐	☐	☐	☐	☐
26.	Muchas veces tengo malos entendidos con otras personas.	☐	☐	☐	☐	☐
27.	Cuando pienso mucho so-bre mí mismo(a), tiendo a confundirme.	☐	☐	☐	☐	☐
28.	Me resulta difícil pedir ayuda a los demás.	☐	☐	☐	☐	☐
29.	Si alguien se acerca					

	demasiado, aunque sea de forma amistosa, me pongo tenso(a) o incluso puedo entrar en pánico.	☐	☐	☐	☐	☐
30.	Yo creo que frecuente-mente me descuido a mi mismo(a).	☐	☐	☐	☐	☐
31.	Me han dicho que muestro muy poco mis sentimien-tos.	☐	☐	☐	☐	☐

		Totalmente en desacuerdo	**Levemente en desacuerdo**	**Ni de acuerdo/ni desacuerdo**	**Levemente de acuerdo**	**Totalmente de acuerdo**
32.	Puede resultar peligroso dejar que los demás se le acerquen a uno demasiado.	☐	☐	☐	☐	☐
33.	A menudo no tengo claro, qué es exactamente lo que estoy sintiendo.	☐	☐	☐	☐	☐
34.	Tiendo a creer que comentarios y actos de otros son sobre mí, aunque posiblemente no tengan que ver conmigo.	☐	☐	☐	☐	☐
35.	Cuando alguien me habla de sus problemas, éstos me quedan dando vueltas por mucho rato.	☐	☐	☐	☐	☐
36.	Normalmente me sé controlar, incluso cuando estoy hirviendo de rabia por dentro.	☐	☐	☐	☐	☐
37.	En el fondo mi cuerpo me resulta ajeno.	☐	☐	☐	☐	☐
38.	En general estoy satisfecho(a) conmigo, tal como soy.	☐	☐	☐	☐	☐

39.	A veces afloran cosas en mí, que no calzan con-migo.	☐	☐	☐	☐	☐
40.	No tengo una buena autoestima.	☐	☐	☐	☐	☐
41.	Muchas veces siento tal caos emocional en mi interior que ni siquiera podría describirlo.	☐	☐	☐	☐	☐
42.	A veces exploto como dinamita.	☐	☐	☐	☐	☐

		Totalmente en desacuerdo	**Levemente en desacuerdo**	**Ni de acuerdo/ni desacuerdo**	**Levemente de acuerdo**	**Totalmente de acuerdo**
43.	A veces, cuando discuto con los demás, lo veo como: “o yo o él /ella“.	☐	☐	☐	☐	☐
44.	A veces lo único que siento es pánico.	☐	☐	☐	☐	☐
45.	En mi vida, no he tenido muchas experiencias buenas con otras personas.	☐	☐	☐	☐	☐
46.	Yo creo que cuando alguien a mi alrededor tiene problemas, me afecta más que a los demás.	☐	☐	☐	☐	☐
47.	Cuando ya no me las puedo arreglar solo(a), pido ayuda a los demás.	☐	☐	☐	☐	☐
48.	Prefiero no pensar en mí, porque si lo hago, sólo veo caos.	☐	☐	☐	☐	☐

49. A veces juzgo mal cómo mi conducta afecta a los demás.	☐	☐	☐	☐	☐
50. A menudo me siento observado y controlado cuando los otros saben mucho de mí.	☐	☐	☐	☐	☐
51. Suelo sufrir una insoportable tensión interna, sin saber el motivo	☐	☐	☐	☐	☐
52. Me angustia sentirme una persona distinta en distintas situaciones.	☐	☐	☐	☐	☐
53. Creo que impresiono más bien como frío(a) e insensible.	☐	☐	☐	☐	☐

	Totalmente en desacuerdo	**Levemente en desacuerdo**	**Ni de acuerdo/ni desacuerdo**	**Levemente de acuerdo**	**Totalmente de acuerdo**
54. Me han dicho repetidas veces que tengo muy poca consideración por las necesidades de los demás.	☐	☐	☐	☐	☐
55. Mis ideas y fantasía me ayudan siempre a recuperar mi equilibrio interno.	☐	☐	☐	☐	☐
56. Frecuentemente me involucro con personas que sólo posteriormente revelan su verdadero carácter.	☐	☐	☐	☐	☐
57. Me resulta difícil hacer algo bueno para mí.	☐	☐	☐	☐	☐
58. A menudo soy incapaz de percibir bien mi cuerpo.	☐	☐	☐	☐	☐

59.	Me llama la atención que, eventos supuestamente importantes, apenas provoquen algún sentimiento dentro de mí.	☐	☐	☐	☐	☐
60.	O la otra persona está en mi misma onda, o no vamos a funcionar.	☐	☐	☐	☐	☐
61.	Una y otra vez me pasa que interpreto de forma completamente equivocada los comentarios de los demás.	☐	☐	☐	☐	☐
62.	A veces disfruto el dejarme llevar por mis pensamientos y fantasías.	☐	☐	☐	☐	☐
63.	Soy bueno(a) para meter la pata en situaciones sociales.	☐	☐	☐	☐	☐

		Totalmente en desacuerdo	**Levemente en desacuerdo**	**Ni de acuerdo/ni desacuerdo**	**Levemente de acuerdo**	**Totalmente de acuerdo**
64.	Muchas veces me siento como un objeto, más que como un ser humano.	☐	☐	☐	☐	☐
65.	Muchas veces los otros me rechazan sin que yo lo pueda entender.	☐	☐	☐	☐	☐
66.	A menudo tiendo a pensar en ciertas personas que podrían dañarme.	☐	☐	☐	☐	☐
67.	Me angustia pensar sobre mi mismo(a).	☐	☐	☐	☐	☐
68.	Parece que muchas veces me paso de ingenuo(a).	☐	☐	☐	☐	☐

69.	Odio mi cuerpo.	☐	☐	☐	☐	☐
70.	Suelo tener fantasías aterradoras.	☐	☐	☐	☐	☐
71.	A veces tengo temor de que el límite entre yo y los demás desaparezca.	☐	☐	☐	☐	☐
72.	Establezco fácilmente contacto con otras personas.	☐	☐	☐	☐	☐
73.	Mis emociones son a veces tan intensas, que me asustan.	☐	☐	☐	☐	☐
74.	Muchas veces me siento como un castillo de naipes, que puede desmoronarse en cualquier momento.	☐	☐	☐	☐	☐
75.	Cuando converso de algo importante, a menudo la conversación se transforma en una pelea.	☐	☐	☐	☐	☐

		Totalmente en desacuerdo	**Levemente en desacuerdo**	**Ni de acuerdo/ni desacuerdo**	**Levemente de acuerdo**	**Totalmente de acuerdo**
76.	Nunca logro quedar contento conmigo mismo(a).	☐	☐	☐	☐	☐
77.	Me tienen que pasar muchas cosas para que yo llegue a pedir ayuda.	☐	☐	☐	☐	☐
78.	Me han dañado mucho por haberme equivocado respecto a una persona.	☐	☐	☐	☐	☐

79.	Me resulta difícil esta-blecer contacto con otras personas.	☐	☐	☐	☐	☐
80.	Muchas veces me siento inútil y que sobro.	☐	☐	☐	☐	☐
81.	Muchas veces me es difícil darme a entender frente a los demás.	☐	☐	☐	☐	☐
82.	Frente a las separaciones o pérdidas siento que se me hunde el piso.	☐	☐	☐	☐	☐
83.	Desearía que me fuera más fácil tomar distancia de los problemas de los demás.	☐	☐	☐	☐	☐
84.	Para mí las personas o son buenas o son malas.	☐	☐	☐	☐	☐
85.	A veces, me es difícil poder predecir cómo los demás van a reaccionar frente a mí.	☐	☐	☐	☐	☐
86.	Me gustaría poder sentir más internamente.	☐	☐	☐	☐	☐
87.	En discusiones me puede pasar que ofendo a personas que son importantes para mí.	☐	☐	☐	☐	☐

		Totalmente en desacuerdo	**Levemente en desacuerdo**	**Ni de acuerdo/ni desacuerdo**	**Levemente de acuerdo**	**Totalmente de acuerdo**
88.	No me trato tan bien a mí mismo(a).	☐	☐	☐	☐	☐
89.	A menudo, cuando mi pareja se me aferra demasiado, siento sin	☐	☐	☐	☐	☐

	querer un intenso rechazo.					
90.	Mi experiencia es que cuando se confía demasiado en las personas, uno puede tener sorpresas desagradables.	☐	☐	☐	☐	☐
91.	Los demás me dicen que siempre vuelvo a elegir a los amigos equivocados.	☐	☐	☐	☐	☐
92.	Mis emociones suelen ser como una montaña rusa.	☐	☐	☐	☐	☐
93.	Me siento incómodo(a) cuando tengo que acercarme a una persona extraña.	☐	☐	☐	☐	☐
94.	Suele pasar mucho tiempo antes de que descubra el lado oscuro de las personas.	☐	☐	☐	☐	☐
95.	Algunas veces, después de una discusión, me ha dado mucha pena porque siento que algo se destruyó.	☐	☐	☐	☐	☐

APPENDIX F ETHICS COMMITTEE APROVAL & INFORMED CONSENTS

PONTIFICIA
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CATÓLICA
DE CHILE

ACTA DE APROBACIÓN ÉTICA DEL COMITÉ ÉTICO CIENTÍFICO DE CIENCIAS SOCIALES, ARTES Y HUMANIDADES

Miembros del Comité

Sra. María Elena Gronemeyer Forni, Presidenta del CEC, Profesora de la Facultad de Comunicaciones UC

Sra. Paulina Ramos Vergara, vicepresidenta del CEC, abogada, profesora de la Facultad de Medicina UC

Sra. Alejandra Santana López, secretaria ejecutiva y ministro de fe del Comité UC

Sra. Inés Contreras Valenzuela, profesora de la Facultad de Educación UC

Sra. Francisca de la Maza, profesora del Campus Villarrica UC

Srta. Javiera Farías Soto, abogada, integrante externo

Sra. Patricia Guerrero Morales, profesora de la Facultad de Educación

Sra. Natalia Hernández Mary, trabajadora social, integrante externo

Sra. Ximena Ortega Fuenzalida, ingeniero agrónomo, representante de la comunidad

Sr. Cristián Simonetti Vicuña, profesor de la Facultad de Ciencias Sociales UC

Sra. Bernardita Vial, profesora de la Facultad de Economía y Ciencias Administrativas de la UC

Sr. Andrew Webb, profesor de la Facultad de Ciencias Sociales UC

Participaron en la aprobación del protocolo titulado: Estrategias e intervenciones focalizadas en déficits estructurales: desarrollo de un modelo operacional integrador de las perspectivas de especialistas, observadores externos y terapeutas

Investigador responsable: Elyna Gómez-Barris Chandía

Institución: Facultad de Ciencias Sociales, Pontificia Universidad Católica de Chile

Categoría: Tesista de Doctorado

Académico responsable: Mariane Krause Jacob

Institución: Facultad de Ciencias Sociales, Pontificia Universidad Católica de Chile

PONTIFICIA UNIVERSIDAD CATÓLICA DE CHILE

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ACTA DE APROBACIÓN ÉTICA DEL COMITÉ ÉTICO CIENTÍFICO DE CIENCIAS SOCIALES, ARTES Y HUMANIDADES

Categoría: Profesor Titular

Financiamiento: Tesis doctoral con financiamiento CONICYT

ID Protocolo: 180112019

Documentos revisados y aprobados por el comité:

- Protocolo de evaluación ética de ciencias sociales, artes y humanidades
- Instrumentos
- Consentimiento informado
- Certificación de capacitación en ética de investigación
- Plan de trabajo
- Documento de contacto con especialistas
- Declaración de responsables
- Proyecto original
- Compromiso del investigador

Considerando:

1.- Que las metodologías, según se describe en el proyecto, aparecen como apropiadas a los objetivos y que en ellas se siguen los estándares internacionales al respecto,

2- Que los investigadores aludidos ya tienen experiencia realizando este tipo de estudios,

3- Que en toda la información entregada al público invitado a participar se evita entrar en detalles que podrían producir un sesgo o predisponer a los entrevistados a responder de una determinada manera (al hacerles explícitos los objetivos de la investigación, por ejemplo) dañando así los objetivos mismos de la investigación,

4.- Que ninguno de los métodos importa un riesgo físico para los participantes y que, garantizada la confidencialidad de las identidades de los informantes en la publicación de

resultados tampoco importa un riesgo de menoscabo de su intimidad.

Y verificado que en el (los) documento(s) de consentimiento informado mencionado(s) se incluye:

1.- Una descripción general de los objetivos de la investigación,

2.- Antecedentes sobre el uso que se dará a la información obtenida por cada uno de los procedimientos de investigación a utilizar,

3.- Un compromiso respecto de que el uso de dicha información sólo se realizará dentro de los marcos de la presente investigación y para el logro de dichos objetivos,

4.- El aseguramiento de la confidencialidad y anonimato de los datos entregados dentro de los marcos propios de cada instrumento,

5.- Información sobre la manera que cada instrumento contempla para recabar la información solicitada,

6.- Antecedentes respecto del costo en tiempo que tiene la participación en el estudio,

7.- La voluntariedad de la participación y la garantía para cada participante de tener la opción hacer abandono del estudio.

Se resuelve respecto de este proyecto:

1.- Que están tomadas las precauciones convencionales para el tratamiento ético de la información entregada por las personas que participen en la investigación,

2.- Y que ellas lo harán adecuadamente informadas de los objetivos generales de la investigación y del uso que se hará de la información que ellos entreguen, en los plazos necesarios para el éxito de la investigación.

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ACTA DE APROBACIÓN ÉTICA DEL COMITÉ ÉTICO CIENTÍFICO DE CIENCIAS SOCIALES, ARTES Y HUMANIDADES

Resolución CEC - Ciencias sociales, artes y humanidades:

Este proyecto ha sido discutido con fecha 13 de junio de 2018 en la sesión n°9 del Comité. Constatados los cambios realizados, la vigencia rige desde el 13 de junio de 2018 hasta el 12 de junio de 2019.

El investigador deberá solicitar la renovación al menos 30 días antes del término del período de vigencia del proyecto. El investigador no puede seguir reclutando o investigando con los participantes si no ha recibido aprobación escrita de su solicitud de renovación. Si no se aprueba la continuación de la investigación, el investigador deberá detener las actividades del proyecto, y no podrá evaluar ni enrolar a ningún nuevo participante y no podrá realizar el análisis de los datos que identifiquen a los participantes.

En la eventualidad de querer incorporar modificaciones, por ejemplo, diseño o rediseño de instrumentos de recolección de datos, cambios en la muestra, el personal a cargo, los procedimientos especificados en el protocolo aprobado u otros, el investigador deberá notificarlo al comité para la evaluación y emisión de una nueva carta de aprobación ética antes de que el investigador ejecute esos cambios.

Los siguientes documentos han sido aprobados y están disponibles para ser descargados:

- EGB Protocolo Versio?n 3_cs_sociales_artes_y_humanidades.pdf
- EGB Compromiso de investigadores .pdf
- Consentimiento informado
- Proyecto de investigación
- Instrumento de evaluación
- Certificado ética
- Plan de trabajo

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ACTA DE APROBACIÓN ÉTICA DEL COMITÉ ÉTICO CIENTÍFICO DE CIENCIAS SOCIALES, ARTES Y HUMANIDADES

- Documento de contacto especialistas
- Declaración responsables proyecto

Alejandra Santana López
Secretaria Ejecutiva

Comité Ético Científico UC Ciencias Sociales Artes y Humanidades

María Elena Gronemeyer Forni
Presidenta

Santiago, 12 de noviembre de 2018

PONTIFICIA UNIVERSIDAD CATÓLICA DE CHILE

Pontificia Universidad Católica de Chile
Escuela de Psicología

CARTA DE CONSENTIMIENTO INFORMADO PACIENTE

TITULO DEL PROYECTO:	Estrategias e Intervenciones Focalizadas en Déficits Estructurales: Desarrollo de un Modelo Operacional Integrador de las Perspectivas de Especialistas, Observadores externos y Terapeutas
NOMBRE INVESTIGADOR RESPONSABLE:	Ps. Elyna Gomez-Barris Ch., RUT 10.243.652-0, egomezbarris@uc.cl
AFILIACIÓN DEL PROYECTO:	Programa de Doctorado en Psicoterapia, Escuela de Psicología, Pontificia Universidad Católica de Chile

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Usted ha sido invitado a participar en la Investigación "Estrategias e Intervenciones Focalizadas en Déficits Estructurales: Desarrollo de un Modelo Operacional Integrador de las Perspectivas de Especialistas, Observadores externos y Terapeutas" a cargo de la investigadora tesista Elyna Gómez-Barris Ch. del Programa de Doctorado de Investigación en Psicoterapia de la Pontificia Universidad Católica de Chile.
El objeto de esta carta es ayudarlo a tomar la decisión de participar en la presente investigación.

¿De qué se trata la investigación científica a la que se lo invita a participar?

Esta investigación busca describir en forma detallada la forma en que pueden ser aplicadas técnicas de psicoterapia para trabajar con dificultades específicas en el funcionamiento de la personalidad. Para esto se estudiarán en profundidad este tipo de estrategias e intervenciones cuando son implementadas por psicoterapeutas durante sesiones de psicoterapia. Los resultados de esta investigación permitirán realizar una propuesta sistematizada para aprender estas estrategias y técnicas de trabajo y probar su efectividad en psicoterapia realizada en instituciones para ayudar a los pacientes en sus dificultades de funcionamiento de personalidad.

¿Cuál es el propósito concretamente de su participación en esta investigación?

Usted ha sido invitado a participar por ser paciente de la Unidad de Salud Mental del Centro Médico San Joaquín y haber sido asignado a un psicólogo que forma parte de esta investigación. Se espera que participe de un proceso de psicoterapia videograbado de modo de poder observar las intervenciones psicoterapéuticas implementadas por su psicoterapeuta.

¿En qué consiste su participación?

Si decide aceptar, su participación consistirá en:

1) permitir ser entrevistado(a) una vez por la investigadora responsable con el fin de identificar potenciales dificultades en su modo de funcionamiento psicológico y contestar 2 cuestionarios sobre su modo de funcionamiento psicólogico y sus síntomas. Esta etapa tiene el objetivo de evaluar si cumple con las características requeridas para participar en el estudio.
2) si la información de la entrevista y cuestionarios indica que usted cumple con las características necesarias para el estudio, permitir el registro en video y audio de sus sesiones de psicoterapia y permitir el posterior análisis de estos registros. Las sesiones de psicoterapia serán videadas, transcritas y analizadas en función de los objetivos del estudio.

Comité Ético Científico UC Ciencias Sociales Artes y Humanidades

CARTA DE CONSENTIMIENTO INFORMADO PACIENTE

TITULO DEL PROYECTO:	Estrategias e Intervenciones Focalizadas en Déficits Estructurales: Desarrollo de un Modelo Operacional Integrador de las Perspectivas de Especialistas, Observadores externos y Terapeutas
NOMBRE INVESTIGADOR RESPONSABLE:	Ps. Elyna Gomez-Barris Ch., RUT 10.243.652-0, egomezbarris@uc.cl
AFILIACIÓN DEL PROYECTO:	Programa de Doctorado en Psicoterapia, Escuela de Psicología, Pontificia Universidad Católica de Chile
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¿Cuánto durará su participación?

La duración de su participación corresponde a:
-1 entrevista de aproximadamente 60 minutos
-2 cuestionarios a completar una vez, que toman en conjunto aproximadamente 30 minutos
-si ingresa al estudio, el número de sesiones que dure su psicoterapia

¿Qué beneficios puede obtener de su participación?

Usted no recibirá beneficios directos por su participación. Sin embargo, los resultados de esta investigación beneficiarán a otros pacientes cuyos terapeutas podrán contar con más herramientas para realizar psicoterapias acordes a las necesidades específicas de pacientes con problemas de funcionamiento de la personalidad. Además, si usted lo desea, puede solicitar que su terapeuta reciba un informe con la información de su entrevista y cuestionarios.

¿Qué riesgos corre al participar?

No existen potenciales riesgos de daño o malestar físico por participar en la investigación. Aunque no es frecuente, podría sentir alguna emocion incómoda durante la entrevista o al responder el cuestionario. Si esto sucediera Ud. puede comunicarlo al entrevistador, quien será un psícólogo clínico y tomará las medidas necesarias para ayudarlo; además de poder solicitar interrumpir su participación. En caso de ingresar a la fase de registro audiovisual de psicoterapia, podría suceder que usted se incomodara con la situación de videograbación. Si esto sucediera, usted **podrá solicitar abandonar el estudio e interrumpir la videograbación en cualquier momento del proceso o de sesión, sin ser perjudicado de ninguna manera en su atención psicoterapéutica.**

CARTA DE CONSENTIMIENTO INFORMADO PACIENTE

TITULO DEL PROYECTO:	Estrategias e Intervenciones Focalizadas en Déficits Estructurales: Desarrollo de un Modelo Operacional Integrador de las Perspectivas de Especialistas, Observadores externos y Terapeutas
NOMBRE INVESTIGADOR RESPONSABLE:	Ps. Elyna Gomez-Barris Ch., RUT 10.243.652-0, egomezbarris@uc.cl
AFILIACIÓN DEL PROYECTO:	Programa de Doctorado en Psicoterapia, Escuela de Psicología, Pontificia Universidad Católica de Chile

¿Cómo se protege la información y datos que usted entregue?

Los investigadores mantendrán CONFIDENCIALIDAD con respecto a cualquier información obtenida en este estudio.

1) La información de las sesiones de psicoterapia, de su entrevista y de sus cuestionarios será tratada confidencialmente, no será publicada en su versión original, ni en forma alguna que permita su identificación.
2) Toda esta información será almacenada y resguardada en la Escuela de Psicología de la Pontificia Universidad Católica de Chile a cargo de la investigadora responsable quién será la única que tendrá llave del lugar donde se mantengan los registros audiovisuales. La información se mantendrá guardada por 5 años y luego será eliminada.
3) La información (videos de sesiones, audios de entrevista y registros escritos asociados) podrá ser compartida con investigadores que participen en esta investigación, previo compromiso escrito de confidencialidad y resguardo de su identificación y la de su paciente.
4) En caso de requerir la información para nuevas investigaciones, se solicitará nuevamente su consentimiento para el uso de los datos.

¿Es obligación participar? ¿Puede arrepentirse después de participar?

Usted NO está obligado(a) de ninguna manera a participar en este estudio. Si accede a participar, puede dejar de hacerlo en cualquier momento sin repercusión alguna y recibirá todas las atenciones regulares que realiza la unidad de psicoterapia a la que está asistiendo.

En cualquier momento usted puede solicitar al investigador que le responda todo tipo de inquietudes respecto al estudio y pedir mayor información sobre las implicancias de su participación.

¿Qué uso se va a dar a la información que yo entregue?

Los resultados de la investigación obtenidos a partir de la información que usted entregue se usarán con fines de investigación, docencia especializada y encuentros científicos.

PONTIFICIA UNIVERSIDAD CATÓLICA DE CHILE
ESCUELA DE PSICOLOGÍA

CARTA DE CONSENTIMIENTO INFORMADO PACIENTE

TITULO DEL PROYECTO:	Estrategias e Intervenciones Focalizadas en Déficits Estructurales: Desarrollo de un Modelo Operacional Integrador de las Perspectivas de Especialistas, Observadores externos y Terapeutas
NOMBRE INVESTIGADOR RESPONSABLE:	Ps. Elyna Gomez-Barris Ch., RUT 10.243.652-0, egomezbarris@uc.cl
AFILIACIÓN DEL PROYECTO:	Programa de Doctorado en Psicoterapia, Escuela de Psicología, Pontificia Universidad Católica de Chile
AFILIACIÓN DEL PROYECTO:	Programa de Doctorado en Psicoterapia, Escuela de Psicología, Pontificia Universidad Católica de Chile

¿A quién puede contactar para saber más de este estudio o si le surgen dudas?

Si tiene cualquier pregunta acerca de esta investigación, puede contactar a la investigadora responsable Elyna Gómez-Barris Ch., Programa de Doctorado en Psicoterapia, Escuela de Psicología Pontifica Universidad Católica de Chile al teléfono +56 223545883 o al email egomezbarris@uc.cl o bien a la profesora tutora de esta investigación Mariane Krause al email mkrause@uc.cl o al teléfono +56 223545883

Si usted tiene alguna consulta o preocupación respecto a sus derechos como participante de este estudio, puede contactar a la Presidenta (I) del Comité de Ética de Ciencias sociales, Artes y Humanidades de la Pontificia Universidad Católica de Chile, profesora Paulina Ramos Vergara, al email: eticadeinvestigacion@uc.cl.

HE TENIDO LA OPORTUNIDAD DE LEER ESTA DECLARACIÓN DE CONSENTIMIENTO INFORMADO, HACER PREGUNTAS ACERCA DEL PROYECTO DE INVESTIGACIÓN, Y ACEPTO PARTICIPAR EN ESTE PROYECTO.

Firma del/la Participante	Fecha
Nombre del/la Participante	
Firma del la Investigador/Investigadora	Fecha
Firma del Director del Centro o delegado	Fecha

(Firmas en duplicado: una copia para el participante y otra para el investigador)

CARTA DE CONSENTIMIENTO INFORMADO TERAPEUTAS

TITULO DEL PROYECTO:	Estrategias e Intervenciones Focalizadas en Déficits Estructurales: Desarrollo de un Modelo Operacional Integrador de las Perspectivas de Especialistas, Observadores externos y Terapeutas
NOMBRE INVESTIGADOR RESPONSABLE:	Ps. Elyna Gomez-Barris Ch., RUT 10.243.652-0, egomezbarris@uc.cl
AFILIACIÓN DEL PROYECTO:	Programa de Doctorado en Psicoterapia, Escuela de Psicología, Pontificia Universidad Católica de Chile

Usted ha sido invitado a participar en la Investigación "Estrategias e Intervenciones Focalizadas en Déficits Estructurales: Desarrollo de un Modelo Operacional Integrador de las Perspectivas de Especialistas, Observadores externos y Terapeutas" a cargo de la investigadora tesista Elyna Gómez-Barris Ch. del Programa de Doctorado de Investigación en Psicoterapia de la Pontificia Universidad Católica de Chile.
El objeto de esta carta es ayudarlo a tomar la decisión de participar o no en la presente investigación.

¿De qué se trata la investigación científica a la que se lo invita a participar?
Esta investigación busca caracterizar intervenciones y estrategias terapéuticas focalizadas en déficits estructurales de la personalidad realizadas con pacientes de mediano a escaso nivel de integración de la personalidad. Para esto se estudiarán las estrategias e intervenciones implementadas en sesiones de psicoterapia y la perspectiva del terapeuta que implementa las estrategias e intervenciones. Se espera que los resultados de esta investigación permitan proponer un modelo operacional de estrategias terápeuticas focalizadas en déficits de la estructura.

¿Cuál es el propósito concretamente de su participación en esta investigación?
Lo estamos invitando a participar por ser psicólogo(a) clínico(a) con formación en el Sistema de Diagnóstico Psicodinámico Operacionalizado (OPD-2) y realizar atención psicoterapéutica en un contexto institucional. El objetivo de su participación es realizar una psicoterapia en su modo de trabajo psicoterapéutico habitual y poder observar en sus sesiones intervenciones psicoterapéuticas.

¿En qué consiste su participación?
Si decide aceptar, su participación consistirá en:
1) permitir el registro en video y audio de sesiones de psicoterapia donde usted realizará su función de terapeuta; y permitir el posterior análisis de estos registros. Las sesiones de psicoterapia serán videadas, transcritas y analizadas en función de los objetivos del estudio.
2) participar de una o más actividades donde observará fragmentos de algunas de sus sesiones videadas y posteriormente ser entrevistado por el investigador responsable para conocer su percepción de la implementación de sus intervenciones en los fragmentos seleccionados.

¿Cuánto durará su participación?

La duración de su participación corresponde

1) al número de sesiones que dure la psicoterapia a registrar y
2) entre 1 a 3 actividades de 60 minutos de observación de fragmentos de psicoterapia y su posterior entrevista.

¿Qué riesgos corre al participar?

No existen potenciales riesgos de daño o malestar físico o psíquico por participar en la investigación.

¿Qué beneficios puede tener su participación?

Usted no recibirá beneficios directos por su participación en el estudio. Sin embargo, los resultados de esta investigación beneficiarán a otros terapeutas quienes podrán contar con más herramientas para el abordaje de pacientes con problemas de funcionamiento de la personalidad. Además, usted puede solicitar una devolución de la información analizada del proceso en el que participó.

¿Qué pasa con la información y datos que usted entregue?

Los investigadores mantendrán CONFIDENCIALIDAD con respecto a cualquier información obtenida en este estudio.

La información de las sesiones de psicoterapia y las entrevistas será tratada confidencialmente, no será publicada en su versión original, ni en forma alguna que permita su identificación, y sólo podrá ser utilizada con fines de investigación, docencia especializada y encuentros científicos.

1) Toda esta información será almacenada y resguardada en la Escuela de Psicología de la Pontificia Universidad Católica de Chile a cargo de la investigadora responsable quién será la única que tenga llave del lugar donde se mantengan los registros audiovisuales. La información se mantendrá guardada por 5 años y luego será eliminada.
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3) En caso de requerir la información para nuevas investigaciones, se solicitará nuevamente su consentimiento para el uso de los datos.

¿Es obligación participar? ¿Puede arrepentirse después de participar?

Usted NO está obligado de ninguna manera a participar en este estudio. Si accede a participar, puede dejar de hacerlo en cualquier momento sin repercusión alguna. Usted puede negarse a la grabación de las sesiones y entrevistas o a partes de ellas.

En cualquier momento usted puede solicitar al investigador que le responda todo tipo de inquietudes respecto al estudio y pedir mayor información sobre las implicancias de su participación.

¿A quién puede contactar para saber más de este estudio o si le surgen dudas?

Si tiene cualquier pregunta acerca de esta investigación, puede contactar a la investigadora responsable Elyna Gómez-Barris Ch., Programa de Doctorado en Psicoterapia, Escuela de Psicología Pontifica Universidad Católica de Chile al teléfono +56 223545883 o al email egomezbarris@uc.cl

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