

Treatment Planning in Psychotherapy by Use of the Interview for Operationalized Skills Assessment

Evaluation in a Clinical Sample

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Key Words

Clinical assessment · Skills · Interview · Operationalized Skills Assessment Inventory

Summary

Introduction: Behavior therapy makes use of disorder-specific treatment manuals as well as non-disorder-specific interventions for specific skills. The latter are often used to develop specific skills such as social competence or emotion regulation. The 'Operationalized Skills Assessment Inventory' (Operationalisierte Fertigkeitendiagnostik zur Therapieplanung, OFD) has been designed to assess seven specific skills, i.e. problem solving, social competence, stress management, emotion regulation, relaxation ability, self-efficacy, and self-esteem, in four different areas of life. **Patients and Methods:** In this study, the psychometric quality of the OFD was analyzed in a clinical sample (N = 111). **Results:** Previous results of a non-clinical sample could mostly be replicated: The reliability of the scales was good. Confirmatory factor analyses have confirmed the structure of the interview. Correlations with well-established questionnaires mostly support its validity. Furthermore, good inter-rater reliability and sensitivity to change could be demonstrated. **Conclusion:** The OFD is a valid instrument for the multi-dimensional assessment of specific skills. It gives indications for specific interventions in psychotherapy.

Schlüsselwörter

Klinische Diagnostik · Fertigkeiten · Interview · Operationalisierte Fertigkeitendiagnostik

Zusammenfassung

Hintergrund: In der Verhaltenstherapie wird sowohl mit störungsspezifischen als auch mit diagnoseübergreifenden Interventionen gearbeitet. Letztere dienen oft dem Aufbau spezieller Fertigkeiten wie sozialer Kompetenz oder Emotionsregulation. Mit dem Interview «Operationalisierte Fertigkeitendiagnostik zur Therapieplanung» (OFD) lassen sich sieben Fertigkeiten in vier Lebensbereichen erfassen: Problemlösen, soziale Kompetenz, Stressbewältigung, Emotionsregulation, Entspannungsfähigkeit, Selbstwirksamkeit, Selbstwert. **Methoden:** In der vorliegenden Studie wurde die psychometrische Qualität des Interviews an einer klinischen Stichprobe (N = 111) überprüft. **Ergebnisse:** Die Ergebnisse einer früheren, nichtklinischen Studie ließen sich weitgehend bestätigen. Es ergaben sich gute Reliabilitäten. Konfirmatorische Faktorenanalysen bestätigten größtenteils die Struktur des Interviews. Etablierte Fragebögen belegen weitgehend dessen Validität. Zusätzlich erwiesen sich die Beurteilerübereinstimmung und die Änderungssensitivität als gut. **Schlussfolgerung:** Das OFD ist ein valides Instrument zur differenzierten Erfassung von Fertigkeiten, das zur Indikationsstellung eingesetzt werden kann.

Introduction

Although in recent decades there has been a great deal of progress in the development and evaluation of disorder-specific treatments, these are sometimes not as effective as one would wish [Westen and Morrison, 2001]. This may be due in part to the fact that disorder-specific treatment manuals are often designed for patients with isolated disorders. But these occur rather seldom in everyday clinical practice: Thus, for example, Brown et al. found [2001] that 95% of patients who displayed major depression or dysthymia were also suffering from or had previously suffered from an anxiety disorder. In psychotherapy research, therefore, priority is increasingly being given to factors that play a role in various mental disorders – i.e., cross-disorder factors – such as emotion regulation [Berking, 2008].

There are many cross-disorder factors that are considered relevant to mental disorders. In what follows, we shall refer in more detail to the factors that we call ‘skills,’ such as emotion regulation or social competence. They stem from various research traditions, are defined more or less broadly and overlap in their content to varying degrees. What they have in common is that deficits in these skills occur in the context of mental illness and can influence its formation and course of development. For example, some authors view a low social skill level as a vulnerability factor for mental illness [e.g., Burt et al., 2008]. Many symptoms also express a maladaptive way of dealing with negative emotions [e.g., Garnefski et al., 2006]. Deficits in emotion regulation can even precede mental disorders [Berking, 2008]. Fostering such skills can, on the other hand, have a positive effect on the course of mental disorders (e.g., support for emotion regulation [Lynch et al., 2003], self-esteem [Schütz, 2003] or problem solving [D’Zurilla and Nezu, 2007]). Interventions to promote specific competencies are now commonly used in behavioral therapy. They are often included in disorder-specific manuals, but there are also self-standing programs, such as those for training in emotional competencies [Berking, 2008] or social competencies [Hinsch and Pflingsten, 2002].

The diagnostic evaluation of such interventions is usually done by an individual therapeutic judgment or using several questionnaires. But a unified compilation of several skills seems desirable, as an economical way to gain an overview and be able to provide an indication for specific therapeutic interventions. The ‘Interview for Operationalized Skills Assessment’ (Operationalisierte Fertigkeiten-Diagnostik, OFD), developed by Stenzel and Rief [subm.], includes seven skills (problem solving, social competence, stress management, emotion regulation, relaxation skills, self-efficacy and self-esteem) in four areas of life: primary attachment figure, broader social environment, occupation, independent living. Psychological mechanisms (skills) and their effect on various spheres of life are thus described, in terms of a multiaxial classification, to assess a person’s functional level in his or her environment.

Skills Pertaining to Therapy: The OFD can assess skills that are viewed as significant in mental illness and for therapy. It is assumed that the skills are related by content, but are not identical. The measurements should therefore contain similar information (referring to skills), but each should contribute its own features, which can be integrated into a ‘functional profile’ of a person. There is plenty of evidence of relationships between individual skills, e.g., self-esteem and self-efficacy [Judge et al., 2002], or coping and emotion regulation [Watson and Sinha, 2008]. The individual skills do not only overlap, but may also have a different hierarchical order. Thus stress management programs can also communicate problem-solving and relaxation techniques, as well as social competence [Kaluza, 2006]; in models of stress management [Lazarus, 2007], self-efficacy plays an important role as a personal resource. This, of course, also has clinical implications. Treating the skills in a differentiated manner should facilitate a specific diagnostic evaluation. Stenzel and Rief [subm.] provide a detailed comparison of the individual areas.

The Goal of the Research was to review the psychometric characteristics of the OFD for planning of therapy in a clinical sample.

Sample and Method

Sample

The sample consisted of 111 subjects (49 female, 62 male), who were consecutively recruited from the Grosse Allee Medical-Psychosomatic Clinic, the Bad Arolsen Medical-Psychosomatic Clinic and the Salus-Klinik Lindow. Participation in the study was voluntary. Nobody was excluded. The age range was 18 to 72 years (mean, $M = 47.8$ years). 25.2% of the subjects had a general secondary school degree, 35.1% an intermediate secondary school degree, and 13.5% a baccalaureate, 20.7% were university graduates, and for 5.4%, the level of education was unknown. Participants received an average of 2.06 diagnoses according to the ICD-10. Among the most common were, by the IDCL checklists, depression (65.4%), panic disorder (23.4%) and somatoform disorder (14.9%). Data collection was carried out by three trained project staff members.

Instruments and Data Collection

OFD: The OFD covers the seven above-mentioned skills in four areas of life (table 1). It involves a situational interview, recording the patient’s skills by use of a mixed assessment (self-rating and rating by others). The subject is presented with sample situations that correspond to each of the skill areas, and describes how he would behave in that situation. The interviewer assesses the adequacy of the described behavior for that particular dimension, using behavioral anchoring on a 5-step Likert Scale. The behavioral anchors include concrete examples of steps 1, 3 and 5 on the scale (5 = high, 1 = low skill level). Behavioral anchors and hypothetical situations were devised in preliminary studies, based upon discriminating items from a current questionnaire and theoretical concepts in the respective areas.

A study using a nonclinical sample [Stenzel and Rief, subm.] yielded satisfactory to good reliability (internal consistency $r = 0.66-0.86$). Confirmatory factor analyses supported the theoretically devised structure of the interview. The validity of the questionnaires was largely confirmed: For five of the seven skills, there were moderate convergent ($r = 0.52-0.54$) and lower divergent validities in each case (0.28–0.38; SCL-9 [Klaghofer and Brähler, 2001]). The areas of problem solving and stress

Table 1. Structure of the OFD and sample items

Skill Areas and Scales	Examples of Items
<i>Problem solving</i> Definition of the problem Generation of possible solutions Decision of what to do Implementation and evaluation	
<i>Social competence</i> Initiation of interactions and relationships Assertion of personal rights Disclosure of personal information Emotional support from another Effective handling of interpersonal conflicts	<i>Scale 5, Area of Primary Attachment Figures*</i> Please imagine that you and your partner planned a joint undertaking some time ago and that you are looking forward to spending time with him alone. Shortly beforehand, he tells you that he has invited a friendly couple to come along. How would you act to resolve the conflict?
<i>Stress management</i> Stress management under time pressure Stress management when feeling overwhelmed Stress management when exhausted	<i>Scale 1, Area of Training/Independent Living*</i> Please imagine that you want to submit a job application. For this you need to fill out several forms and assemble documents. You also want to write a cover letter to explain your situation. But you realize that you have miscalculated by one day and the deadline is tomorrow. You do not have enough time to do it all. How would you behave in this situation?
<i>Emotion regulation</i> Acceptance of one's own emotions Impulse control and purposeful behavior Identification and naming of emotions Access to strategies for emotion regulation	
<i>Relaxation skills</i> Physical and mental exhaustion Nervousness and inner tension Psychophysiological dysregulation	
<i>Self-efficacy</i> Dealing with difficulties or problems Achieving one's own goals and intentions Adjusting to new situations	
<i>Self-esteem</i> Emotional self-esteem Social self-esteem Performance-based self-esteem	
*Subscales are each assessed in four areas of life: 1. primary attachment figure, 2. broader social environment, 3. training/ occupation, 4. independent living.	

management, for which there were more divergent than convergent validities, were revised and are now being reviewed again.

Validating Instruments: In two out of the three participating clinics (Grosse Allee and Bad Arolsen), the participants (N = 60) filled out additional validating questionnaires. Seven different questionnaires were used to depict the seven skills that are covered by the OFD. To check whether the skills in the OFD only depicted a general psychopathology, a divergent instrument was also used, the SCL-90-R [Franke, 2002]. Thus, for the eight different questionnaires for each interview scale, one convergent and seven divergent self-rating instruments were available. These instruments are published and established procedures and can be found in table 3.

Procedure for Data Collection: This study used a survey method comparable to the legally mandated quality assurance measures. Therefore no vote of the Ethics Committee was taken. Nevertheless, the patients were informed, in accordance with the rules of good scientific practice, and their data were included only on a voluntary basis. Patients were duly in-

formed that their non-participation would not be detrimental to them in any way. First of all, we conducted the structured interview as well as a diagnostic survey using IDCL checklists [Hiller et al., 1997]. The interview was also recorded; it lasted about 75 minutes, and the entire investigation (briefing the participants, interview, diagnostic survey) took approximately 2 hours. At two of the three clinics, the participants then filled out various validating questionnaires (sub-sample: N = 60).

Statistical Analysis

Item Analysis, Reliability, Inter-Rater Reliability: First we considered the distribution of the items. Then we performed a Kolmogorov-Smirnov test to check for normal distribution. Difficulty indices and discriminative power were calculated, as well as internal consistencies of the interview scales. To determine inter-rater reliability, 30 randomly selected audio recordings of the interviews were assessed by a second rater. Dimensional intra-class correlation values (ICC) were calculated to assess inter-rater

Table 2. Distributions, Discriminative Power and Reliability

Interview Scales	M (SD)	P	Skewness	Kurtosis	r_{itc}	α	r_{icc}	SRM
<i>Skills</i>								
Problem solving	3.33 (0.80)	0.67	-0.03	-0.52	0.50–0.76	0.92	0.88	0.61
Social competence	3.74 (0.70)	0.75	-0.42	-0.20	0.25–0.71	0.90	0.93	0.69
Stress management	3.27 (0.96)	0.65	-0.48	-0.34	0.57–0.72	0.91	0.86	1.53
Emotion regulation	3.35 (0.77)	0.67	-0.38	0.04	0.34–0.67	0.86	0.93	1.10
Relaxation	3.15 (0.86)	0.63	-0.10	-0.03	0.50–0.68	0.88	0.94	1.32
Self-efficacy	3.58 (0.68)	0.72	-0.68	1.47	0.40–0.68	0.86	0.98	1.21
Self-esteem	3.72 (0.75)	0.74	-0.46	-0.28	0.47–0.74	0.91	0.98	1.24

M = mean; SD = standard deviation, P = average item difficulty; r_{itc} = corrected item total correlation; α = Cronbach's alpha, r_{icc} = intra-class correlation; SRM = standard response mean.

reliabilities. Interval rating scales showed these to be a suitable measure of inter-rater consistency [Wirtz and Caspar, 2002].

Structural Validity (Factor Analyses): Given the theory-based approach to the interview design and the results achieved by Stenzel and Rief [subm.] in a nonclinical sample, reasonable assumptions can be made about the factor structure of the interview. These assumptions had to be validated by confirmatory factor analyses (CFAs). The theoretical model of the interview was confirmed, on the basis of CFAs, by Stenzel and Rief [subm.]. This model and possible modifications are described, along with the relevant results. As in Stenzel and Rief [subm.], parcels were formed to reduce the number of detailed indicators required for the analysis. Because each sub-scale (e.g., handling of interpersonal conflicts) covers the four areas of life, an average of the four areas was used to form the parcels for each sub-scale. This resulted in a total of 25 parcels.

Pursuant to Beauducél and Wittmann [2005], the following CFA indices and cutoffs were used: root mean squared error of approximation (RMSEA, cutoff ≤ 0.08), standardized root mean square residual (SRMR; cutoff ≤ 0.11), comparative fit index (CFI; cutoff ≥ 0.95), as well as the chi-squared test. We also examined the multivariate normal distribution.

Construct Validity: To assess the validity of the interview scales, bivariate correlations with the questionnaires were used. We expected that the interview scales would each show higher correlations with the convergent than with the divergent questionnaires.

Sensitivity to Change: To verify the OFD's sensitivity to change, the interviews were given again at the end of therapy, to a sample of $N = 30$ people. Approximately 8 weeks elapsed between the first and second test, with the second test always occurring one week before the end of therapy. To calculate sensitivity to change, we used the standardized response mean (SRM) as a measure of the effect size. The SRM places the mean difference $M_{i2} - M_{i1}$ in relation to the standard deviation of the change scores (SD_{i2-i1}).

Results

Distributions and Descriptive Statistics

Examination of the distributions showed that some items are not distributed normally and are somewhat positively skewed. But the average values for individual scales as well as the combined parcels were all distributed normally. Means and standard deviations of the scales and item difficulties are given in table 2.

Discriminative Power, Reliability and Inter-Rater Reliability

As table 2 clearly shows, the internal consistency (Cronbach's alpha) of the scales ranged from 0.86 to 0.92. The discrimina-

tive power [r_{itc}] of the items was between 0.25 and 0.76. According to Fisseni [2004], discriminative powers <0.3 are regarded as low, between 0.3 and 0.5 as medium, and >0.5 as high. Accordingly, 1 item had low discriminative power (0.27) and 6 items medium discriminative power. The others had high discriminative power. The consistency of the raters with respect to the individual scales of the interview [r_{icc}] was between 0.86 and 0.98. Detailed results are shown in table 2.

Validity

Factorial Validity: The CFAs were calculated with aggregate data (parcels). It was not possible to confirm a multivariate normal distribution [Kurtosis = 58.46; c.r. = 7.96]. Therefore, for correction of the p-value for the χ^2 test, we conducted a Bollen-Stine Bootstrap with 200 random samples. When interpreting the CFI value, it should further be noted that for non-multivariate data with a normal distribution, the CFI value is too conservative an indicator of the model fit [Beauducél and Wittmann, 2005].

First of all, we tested the model that depicted the theoretically adopted structure of the interview: Parcels of one skill type were loaded on the corresponding latent variables; correlations between the latent variables were permitted (fig. 1). There was no acceptable model fit ($\chi^2 = 445.93$ (253) $p < 0.05$, SRMR = 0.07, RMSEA = 0.088 (0.074–0.101), CFI = 0.88). Therefore, the model was modified in the following way: Due to high intercorrelation ($r = 0.84$) between the mean values for the skills of self-esteem and self-efficacy, another model was tested, in which the parcels of both skill areas were loaded on a common factor. This gave an acceptable model fit, such that this model can better represent the data ($\chi^2 = 411.01$ (257), n.s., SRMR = 0.08, RMSEA = 0.078 (0.064–0.092), CFI = 0.90).

Scale Intercorrelations: There were moderate to high correlation coefficients among the various interview scales (table 3). The scale of relaxation skills showed the lowest intercorrelations; the highest individual correlation was between the scales of self-esteem and self-efficacy. Moderate to high intercorrelations were also common between the questionnaires (mean interview intercorrelation $r = 0.50$; questionnaire $r = 0.47$)

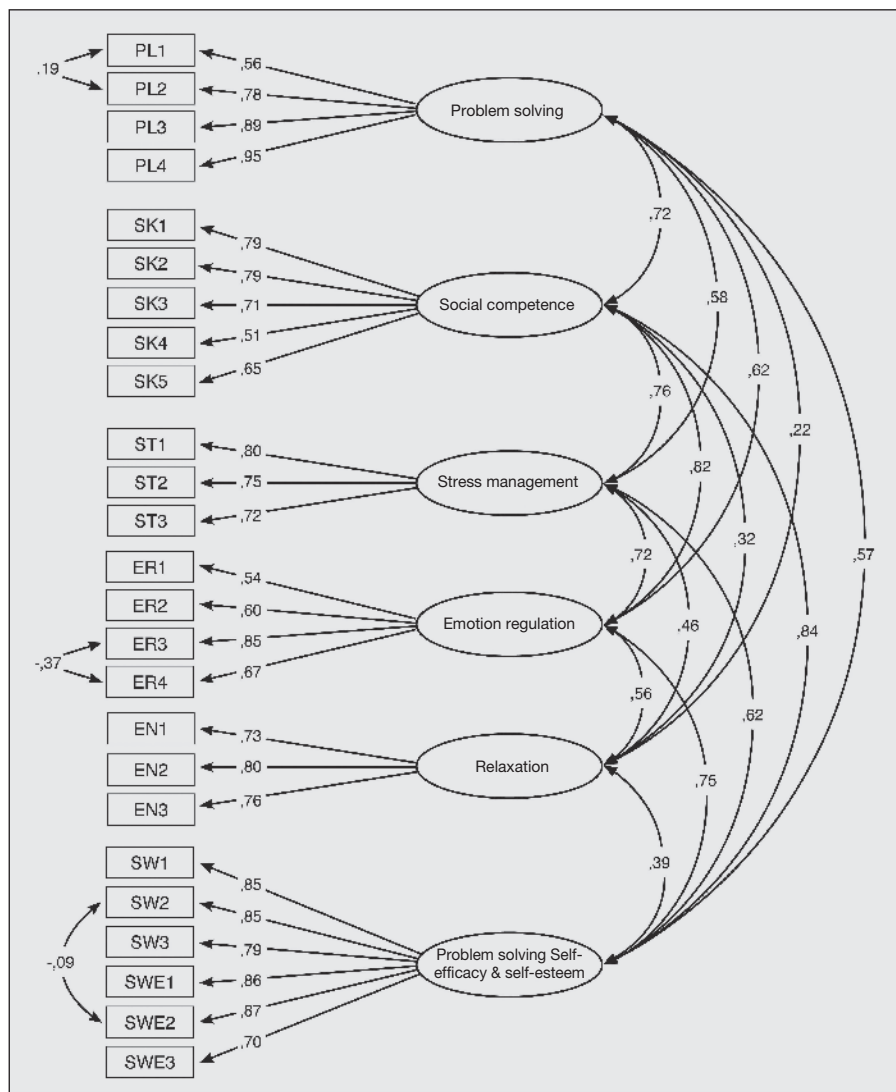


Fig. 1. Confirmatory factor analysis.

Construct Validity: The testing of convergent and divergent validity gave good convergent validities (marked in gray). The skills corresponded each time to the construct-near questionnaires and were differentiated from generalized stress (SCL-90-R [Franke, 2002], in boldface) (substantially, but with lower correlations). The additional divergent correlations, however, showed a mixed picture: There were high overall correlations of the self-esteem and self-efficacy questionnaires for all the interview scales. Some of these were higher than the correlation of the respective scale with the convergent interview questionnaire. But these two questionnaires also showed similarly high correlations with the other questionnaires. If these are omitted at first, the result is a correlation pattern for the validation of the interview scales that largely conforms to expectations. But the divergent correlations between stress management in the interview and the emotion regulation questionnaire, as well as between relaxation skills in the interview and the stress management questionnaire, did not conform to expectations.

Sensitivity to Change: The sensitivity to change (SRM) of the interview varied in the range of 0.61–1.53 and can be considered good (table 2).

Discussion

The goal of the study was to review psychometric parameters of the OFD in a clinical sample. In this interview, psychological mechanisms (here, 7 skills) and their effect on four spheres of life are described, by a multi-axial classification, but to get an idea of a person's functional level in his or her environment.

There were good values for internal consistency of the scales (Cronbach's $\alpha > 0.70$). Examination of inter-rater reliability also showed good intra-class coefficients ($I_{cc} = 0.86–0.98$) for the individual skills. Since the OFD involves a structured interview, the reliability of the coding is of particular importance. This pertains to areas that have also been reported for other structured interviews [e.g., Y-BOCS; Jacob-

Table 3. Intercorrelations of the Interview Areas, as Well as Convergent and Discriminant Validity^a

	Interview							Questionnaire							
	1	2	3	4	5	6	7	A	B	C	D	E	F	G	
Interview	1														
1) Problem solving	0.61**	1													
2) Social competence	0.49**	0.61**	1												
3) Stress management	0.43**	0.63**	0.59**	1											
4) Emotion regulation	0.11	0.20*	0.35**	0.45**	1										
5) Relaxation	0.43**	0.68**	0.53**	0.61**	0.33**	1									
6) Self-efficacy	0.41**	0.67**	0.49**	0.63**	0.34**	0.84**	1								
7) Self-esteem	0.43**	0.36**	0.36**	0.35**	0.15	0.29*	0.29*	1							
A) PSI	0.28*	0.51**	0.49**	0.43**	0.36**	0.58**	0.54**	0.21	1						
B) ICQ	0.40**	0.40**	0.51**	0.54**	0.55**	0.36**	0.39**	0.13	0.36**	1					
C) FABAs	0.36**	0.45**	0.57**	0.62**	0.57**	0.55**	0.60**	0.10	0.50**	0.65**	1				
D) DERS	0.35**	0.46**	0.50**	0.55**	0.51**	0.50**	0.60**	0.10	0.48**	0.56**	0.74**	1			
E) ASS-SYM	0.42**	0.55**	0.71**	0.62**	0.48**	0.81**	0.81**	0.28*	0.65**	0.40**	0.69**	0.61**	1		
F) SWE	0.42**	0.57**	0.65**	0.61**	0.45**	0.66**	0.73**	0.12	0.56**	0.53**	0.78**	0.74**	0.73**	1	
G) RSE	0.34**	0.41**	0.42**	0.51**	0.49**	0.44**	0.48**	0.13	0.49**	0.49**	0.64**	0.67**	0.65**	0.70**	1
H) SCL-90-R															

Product-moment correlations. Shown are the correlation coefficients whose values are in the theoretically predicted direction.

Questionnaires: A) problem solving: Problem Solving Inventory [Reininger, 2004], Approach-Avoidance Style subscale; B) social competence: Interpersonal Competence Questionnaire [ICQ, Kanning, 2006], C) stress management: Fragebogen zur Analyse belastungsrelevanter Anforderungen [Questionnaire for Analysis of Stress-Related Demands] [FABA; Richter et al., 1996]; D) emotion regulation: Differences in Emotion Regulation questionnaire [DERS; German: Ehring et al., 2008], E) relaxation skills: Änderungssensitive Symptomliste [Change-Sensitive Symptom List] [ASS-SYM, Krampen, 2006]; F) self-efficacy: Skala zur allgemeinen Selbstwirksamkeitserwartung [General Self-efficacy Scale] [SWE; Schwarzer and Jerusalem, 1999], G) self-esteem: Rosenberg Self-esteem Scale [RSE; Collani and Herzberg, 2003], H) overall stress: Symptom Checklists [SCL-90-R; Franke, 2002]

*p < 0.05; **p < 0.01 (2-sided).

sen et al., 2003]. In summary, it was shown that reliable assessments can be made with the OFD.

The validity of the interview scales yielded a mixed picture. Satisfactory correlations were found within the framework of convergent validation, especially considering the different methods of variance (interview vs. questionnaire). On the other hand, some of the interview scales showed high intercorrelations, although the structural validity was demonstrated for the most part by CFAs. The divergent validation on the basis of the SCL-90-R [Franke, 2002] yielded outcomes that conformed to expectations, whereas some of the divergent skill questionnaires did not conform to the expected high correlations.

Testing the convergent validity of the interview scales yielded correlations which were mostly from 0.51 to 0.82. An exception is the correlation between the scale of problem-solving in the interview and the problem-solving questionnaire (0.43). Correlations from 0.51 to 0.82 are considered medium to high, according to Fisseni [2004]. Considering the present validation's use of two different methods (questionnaire and interview) and two different approaches (evaluation by oneself and by someone else), the validation reported here for the convergent parameters can be considered successful. The scale for problem solving is an exception. The low correlation with the convergent questionnaire could be explained by the use here of only one sub-scale (approach-avoidance style) of the PSI questionnaire [German: Reiningger, 2004]. A more extensive validation (e.g., using external criteria) should be carried out before any conclusions are drawn about revising this interview scale. There were high intercorrelations among the individual interview scales. This initially suggests two explanations. First, the construction of the interview scales could have failed to differentiate among various skills. On the other hand, this finding could be explained by the fact that the skills that are being measured simply overlap substantially in content. The present extensive validation tends to affirm the latter: Almost all the questionnaires that were used show a similar correlation pattern. This means that even using questionnaires designed differently by various authors, the skills are not fully differentiated. Substantive evidence for this explanation can be found in the literature. For instance, intense emotions can affect rational problem solving and decision making [Stäudel, 1983]. Furthermore, it could be shown that emotion regulation is important for effective conflict management [Mischel and DeSmet, 2000]. In clinical practice, the behavioral interactions of borderline patients are described as fluctuating greatly between a high level of competence and difficulty in behaving appropriately [Linehan, 1996]. Thus a patient who has difficulty with emotion regulation and impulse control could also, for that very reason, behave with less social competence, since she is too strongly affected by her emotions (e.g., has angry outbursts). Behavioral skills in a certain mood may be lacking in a different situation. A study by Renneberg et al. [2003] supports these reflections:

Patients with borderline personality disorder exhibited lower non-verbal competence after negative emotion induction. In this case a certain amount of emotion regulation would be a prerequisite for socially competent behavior. Similar considerations can also be raised for other skills.

Subject to further research, therefore, we come to the conclusion that the skills measured by the OFD are related in content, but are not identical. Accordingly, the scales for the interview – even though they were designed to be as independent as possible – included related information. However, each establishes its own features and thus contributes to an overall picture, which can be used to develop therapeutic interventions.

Further evidence of this can be provided by successful replication of the structure of the interview, somewhat modified, with the help of confirmatory factor analyses. A better fit was found for a model in which self-esteem and self-efficacy were combined into one common factor. Consistent with the results of confirmatory factor analysis, self-esteem and self-efficacy showed the highest intercorrelation. By analogy, Judge et al. [2002] reported a high intercorrelation between the two skills ($r = 0.85$). They consider these skills together as an overarching construct ('core self-evaluation'), while stressing, however, the usefulness of a differentiated treatment of the skills. Overall, with the exception of self-esteem and self-efficacy, which should not be interpreted separately, factor analyses provided further proof for the differentiability of the skills assessed in the interview.

The skills were divergent from generalized stress as measured by the SCL-90-R [Franke, 2002] (substantially, but with lower correlations). The interview scales therefore do not constitute global measures for generalized stress, but permit assertions that are more differentiated with respect to content. Regarding the discriminant correlations with other skill questionnaires, the picture was mixed: There were indeed many correlation coefficients between interview scales and convergent questionnaires, conforming to expectations more than the corresponding correlations with discriminant questionnaires. Moreover, there were also some highly discriminant correlations, some of which exceeded the convergent correlations. It is striking that the highly divergent correlations occur almost exclusively in connection with the questionnaires on self-efficacy and self-esteem. This finding did not emerge in the study by Stenzel and Rief [subm.]. One possible explanation for the difference in correlation pattern could be the difference in the samples. The clinical sample examined here displayed a generally lower skill level. Possibly a certain minimum competence in one skill is necessary to be able to demonstrate other skills. Thus persons with severe deficits in certain skills could also exhibit deficits in other skills as a result. In this study, for example, self-efficacy correlated very highly with many other skills. A high expectation of self-efficacy is seen by some authors as a prerequisite for any efforts to demonstrate a certain behavior (e.g., as a per-

sonal resource in models for stress management [Lazarus, 2007]). In this way, the expectation of self-efficacy could influence the expression of other skills (e.g., stress management). On the other hand, it assumed that, for example, a person with little capacity to handle stress on the job and to set priorities, will develop a low sense of self-efficacy with regard to future job requirements. Consistent with these assumptions, there is plenty of evidence of a link among self-efficacy, adaptive coping and stress management [e.g., Luszczyszka et al., 2005]. Overall, the validity of the OFD is confirmed, with limitations. To decide how the scales might be further revised, further research is required on validation (e.g., based on external criteria).

From the above considerations, we can suggest three key features for the present interview. First, deficits in various skills should be treated in a differentiated way. In the example given of the borderline patient, a single diagnosis of a deficit in social skills would be inadequate and also would not result in a successful intervention. Second, the pattern of skill deficits should always be interpreted in light of the prevailing clinical manifestation of the disorder. Disorder-specific models could provide important insights into how an individual pattern of multiple skill deficits is to be interpreted and which deficit should be treated as a priority. Thus the OFD is an aid to therapeutic decision making, but certainly no ‘autopilot.’ Future modifications of the interview should focus on improving the differentiation between the scales in a clinical interview sample. In addition, guidelines for disorder-specific interpretation concerning skill deficits conveyed in the interview could help with effective planning of treatment. Thirdly, it is important to interpret the pattern of skill deficits in the context of the person’s respective areas of life and social structures. Thus it is conceivable that a borderline patient can compensate well for a deficit in social skills in her private en-

vironment, whereas in the workplace she repeatedly gets into conflicts. This approach is of great significance for designing individual therapeutic interventions.

Limitations: The calculations in this study are based on a relatively small sample (N = 111). Replication of the confirmatory factor analyses with a larger sample is therefore desirable. Furthermore, the fact that participation in the study was voluntary could create a selective sample (e.g., less stressed, more motivated patients). On the other hand, it suggests that the subjects showed a higher number of comorbid diagnoses. Also, the time required for the interview (75 min) is not insignificant in daily clinical practice. Perhaps a screening questionnaire prior to the interview (e.g., like the SCID-II questionnaire) could make the use of the procedure more economical.

Nevertheless, the use of a multidimensional interview makes sense: Previously, an overview of individual skill areas could only be achieved through several individual tests. This makes it more difficult to examine the profiles, since the individual questionnaires originate in completely different fields of research. Moreover, none of the questionnaires were explicitly designed with the aim of comparing and delimiting different skills. The OFD has the advantage of being a single instrument, which allows a direct comparison of intra-individual skill levels and provides a uniform basis for design of treatment. Investigation of different symptoms is needed to define more differentiated operating principles and to derive guidelines for therapy.

Acknowledgments and Conflict of Interest

We wish to thank the Bad Arolsen Medical Psychosomatic Clinic, the Grosse Allee Medical Psychosomatic Clinic, and the Salus-Klinik Lindow for their kind support.

The authors declare that they have no conflict of interest.

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