Short-Term Psychotherapy Research Program at Harvard Medical School

Leigh McCullough Ph.D., Director

ACHIEVEMENT OF THERAPEUTIC OBJECTIVES SCALE: ATOS Scale

(REPRESENTING WELL-ESTABLISHED COMMON FACTORS IN PSYCHOTHERAPY)

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This manual includes:

A One Page Brief Overview of treatment objectives in 20-point objectives

And more detailed 1-100 Scales for the 7 Treatment Objectives

(A catalog of specific examples is currently being developed)

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Description and Brief Directions for the

Achievement of Therapeutic Objectives Scale (ATOS):

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The Achievement of Therapeutic Objective Scale (ATOS) is a research tool that has grown directly out of our clinical work to evaluate the extent of beneficial or therapeutic effects of therapy that the patient is absorbing or assimilating.

Much psychotherapy process research to date has focused on the interventions that the therapist is offering or the amount of therapy the patient has received; (e.g., number of sessions, or number of specific interventions). In contrast, the ATOS Scale is not a measure of the dosage of treatment, but more analogous to a blood level - the absorption or 'receipt' of the therapy/techniques given.

To use a metaphor from the field of medicine, when a physician gives a patient a pill, it is important to know the type and dose, as well as whether the patient spits out the pill. Furthermore, if the patient swallows a particular pill, the physician still needs to know to what degree the pill is absorbed into the blood.

In the same way, to evaluate the effects of psychotherapy, we need to know not only whether the therapist made an interpretation or a confrontation, but also whether the patient heard the intervention, felt the emotional implications, and then behaved in some way to indicate that the intervention had an impact. The ATOS scale is designed to measure this impact on the patient from several perspectives. For example, if the therapist confronted the patient's defenses against grief and helped the patient grieve a loss, The ATOS scale would assess (in part) the length and intensity of crying in the session, and if relief was reported afterwards. In this manner, the ATOS Scale attempts to identify the adaptive shifts in behavior that occur as a result of treatment. These behaviors are the 'micro-outcomes' that we hypothesize to predict or correlate with outcome of treatment.

Content of the ATOS-R scales

The ATOS Scale contains seven subscales that represent the main objectives of Short Term Dynamic Psychotherapy. These subscales also represent common factors in psychotherapy:

Common Factors	**Objectives in Short Term Dynamic Psychotherapy**
Insight	Defense Recognition – noting maladaptive defensive patterns
Motivation	Defense Relinquishing – wanting to give up the maladaptive pattern
Exposure	Affect Experiencing – degree of affective bodily arousal during the session
New Learning	Affect Expression – the ability to appropriately express feelings, wishes & needs
Inhibition	Degree of Anxiety, Guilt, Shame, or Pain evident in the session
Self Perception	Sense of Self – Degree of self care, self compassion, self interest, self regard, etc.
Alliance & Relations	Sense of Others – Degree of relatedness to others

In STDP, these common factors are discussed in terms of defenses and affects, as follows:

The first scale, *Defense Recognition*, measures insight or how much patients recognize and understand their own pattern of defensive behavior or defensiveness (the D pole of the Two Triangles) as described in the Core Conflict. This could also be stated in terms of how clearly the patient can recognize their own maladaptive cognitive schemas or maladaptive automatic thoughts?

The second scale, *Defense Relinquishing*, measures how much the patient is motivated to change or to give up the defensive behavior. In theory-neutral language, how much does the patient want to give up the maladaptive cognitions or schemas?

The third scale, *Affect Experiencing*, measures the degree of the patients emotional arousal, (either consciously experienced by the patient, based on the visible physiological or bodily signs of arousal of the adaptive affect); i.e, how much affect does the patient actually experience during the session? The degree of arousal can also be thought of as a measure of the degree of desensitization of conflicted ("phobic") affects.

The fourth scale, *Affect Expression*, measures to what degree the patient had learned to express feelings, wants, or needs to others, in face-to-face interactions outside of therapy or, (if relevant) face-to–face with the therapist. In other words, to what extent is the patient able to express adaptive thoughts and feelings interpersonally?

The fifth scale measures the degree of inhibition (i.e., inhibitory affects such as anxiety, guilt, shame, emotional pain or anguish) that are present in the session – and interfering with affect experiencing.

Scales six and seven focus on the degree of positive or constructive sense of the self or others. In other words, how adaptive is the patient's view of self - in terms of pride in positive qualities and acceptance of own realistic limitations, care for self, self confidence, interest in self needs, healthy pride in self (i.e, self-esteem), etc.? Also, to what degree is the patient able to acknowledge and respond to others positive ways or (if there is conflict or abuse) to what degree is the patient able to respond adaptively to negative or destructive qualities in others?

The ATOS scale has been written in language as theory neutral as possible to permit the assessment of factors that are common to many forms of therapy. Examples from both cognitive and psychodynamic orientations are provided to illustrate the flexibility of the ATOS scale for measuring these common factors. By using theory-neutral terminology, grounded in specific behaviors, this rating system may also be used for cognitive therapy, interpersonal therapy, or dialectical behavior therapy, - or any non-psychodynamic therapy - by using the major maladaptive behavioral or cognitive pattern that is being focused on. Instead of rating defenses, one would rate the patient's ability to recognize the maladaptive behaviors or cognitions, their motivation to give up such maladaptive responses, the degree to which the patient could feel an alternative, adaptive response, (in lieu of a specific feeling) and the degree to which the patient could express him or herself in face to face interactions in their social environment.

The ATOS scales incorporates the same 1-100 format as the Global Assessment of Functioning Scale, so that the rater can easily grasp the logic, and can compare scores on the ATOS-R with the GAF.

Identifying objectives, and then rating to what degree the therapist assists the patient in achieving those objectives, offers a new and potentially useful method for assessing therapist competence in applying the model. It also provides a measure of patient in-session response to treatment. The impact of therapist intervention is assessed by evaluating the effectiveness of treatment.

General Directions and Procedures for ATOS Ratings

Raters who are coding videotapes of STDP should be familiar both with the books below and this rating manual.

Changing Character: Short-term Anxiety-Regulating Psychotherapy for Restructuring Defenses, Affects, and Attachments, by Leigh McCullough Vaillant, Basic Books, 1997.

Treating Affect Phobia: A Therapist's Guide to Short Term Dynamic Psychotherapy. Leigh McCullough, Nat Kuhn, Stuart Andrews, Amelia Kaplan, Jonathan Wolf, and Cara Lanza Hurley. Guilford Publications, 2003.

Raters from other theoretical perspectives may adapt the ATOS scale to their specific treatment objectives.

Overview of Procedures:

Videotapes, audiotapes or transcripts of psychotherapy sessions are reviewed in 10-minute segments and ratings are -made at the end of each segment for the main treatment objectives. Each major objective is rated on a 1 to 100 scale. In STDP, the rating of each objective must be based on the predominant affect in the segment being rated.(e.g., anger, sadness, tenderness, positive sense of self, etc.). However, linking of the ratings to a specific affect may not be necessary for rating the ATOS in other forms of therapy, such as cognitive or interpersonal treatments. However, focusing on a core affect is essential in a psychodynamic therapy because the defenses that are being rated will vary depending on what feeling is being defended against. For example, a patient may use very different defenses to avoid grief (e.g., smiling, lightening up) than to avoid closeness (e.g., being irritable and distant). Therefore, it is crucial in a psychodynamically based treatment to link the defense with the affect it is blocking.

In STDP, the most frequently seen affects involve the following *adaptive forms of these feelings (*which are rated in the Defense and Affect Objectives);

- Anger/assertion
- Grief
- Feelings of closeness or attachment to others,
- Care or compassion for self, (referring to positive feelings associated with the self)

These feelings are not the only core affective issues dealt with in STDP, but they are the ones most commonly seen in treatment, and the most basic. Patients also have conflicts about sexual feelings, interest in things, enjoyment, etc., that later may become the focus of treatment, but we have found that work on these 'positive' emotional responses should follow the more fundamental issues of grieving losses, being able to protect and defend oneself, being close to others, and having an adaptive sense of self and others. This brief list of the four affects most frequently dealt with greatly simplifies the selection of the target affects in each segment.

Again, the following objectives represent the main STDP treatment foci and are as follows:

<u>Defense Restructuring</u>;

Defense Recognition – (Insight) How much the patient sees the defensive behavior patterns

Defense Relinquishing – (Motivation) How much the patient wants to give up the defensive patterns

<u>Affect Restructuring</u>:

Affect Experiencing – (Exposure to feeling) How much the patient experiences the underlying feeling in the session

Affect Expression – (New Learning) How adaptively can the patient express what is felt inside in interpersonal relationships outside of therapy

<u>Anxiety Regulation: Degree of Inhibition:</u>

The degree of anxiety, guilt shame or pain inhibiting the predominant affect in the ten minute segment.

<u>Self/Other Restructuring</u>: (Only one rating given per session – Not rated every ten minutes because little change occurs)

Alteration of Inner Representation of Self - How adaptive is the patient's sense of self

Alteration of Inner Representation of Others - How adaptive is the patient's sense of others

The restructuring of sense of self or others are rated only <u>once at the end of the entire session</u>. Often there is too little data to rate these last two objectives every ten minutes. Also, self/other issues do not need to be linked to specific core conflicted affects.

Procedure for Rating Videotapes

The rater must first read this manual and thoroughly understand the levels to be rated for each objective.

1. Psychotherapy sessions are viewed on videotape, and the tape is stopped every ten minutes.
   a. Ideally, the time in minutes should be on the videotape to guide the raters when to start and stop. (It is essential to have the date on the tape with the time – simultaneously, so that specific sessions can be easily located.) Rating is begun at the beginning of a minute (e.g., the beginning of 8:10) and rating ends exactly ten minutes later (at the very beginning of 8:20). The exception to this is the beginning minute of the session, which often starts in the middle of a minute – or is unclear whether the first minute is a full minute. Therefore, we rate from the exact time the session begins (e.g., 8:13 and 30 seconds) but only begin to count the time for the 10-minute segment at the beginning of the next full minute (i.e., 8:14) and continue rating for ten minutes (until the very beginning of 8:24 for the first segment). Therefore, the first segment may be ten minutes plus 1-59 seconds in length. Likewise, the last segment of a session often does not run for the full ten minutes, but it is rated the same as the others as long as there is enough material to be worth coding. If the final segment is very short, it could be included with the previous segment for rating.
   b. If there is not time recorded on the videotape, then the ten-minute segments can be based on the digital counter on the VCR.

It is possible to make ratings from audiotapes, or from reading a transcript - if some reliable method is used to separate the audiotaped sessions into 10-minute segments (i.e., stop watch or line count). However, it is much harder to hold one's attention on an audiotape and we have not rated audiotapes with the ATOS

scale as yet. Videotape is much more interesting and compelling. Transcripts are not difficult to rate, but much is lost in not being able to see or hear the patient. For these reasons we strongly recommend videotape for ratings with data and time on the tape. Research is needed to compare the efficacy of each method.

2. Following the viewing of each 10-minute segment, the rater of STDP must decide upon the predominant affect. We initially thought that a formal process for determining the core conflicted affect would be necessary – as in done in our research studies. However, over time we have found that it is necessary only to identify the predominant adaptive affect that is being focused on (not defensive affects or inhibitory affects), but the adaptive underlying affect that would resolve the patients problems, as described in the above books). As noted above, there are generally only a very few basic affects that are focused on in Short Term treatment, which make the selection of a focal affect fairly simple and straightforward. Remember that when ratings are not linked to major maladaptive patterns of conflicted affect, the ratings are often not specific enough, and thus quite misleading or confusing to interpret.

   Generally, one specific affect is rated per 10 minute segment (the most prominent affect in the segment being rated). However, when two affects are equally prominent in one ten-minute segment, defenses and anxieties may be rated for each affect. But as a general rule, we try to limit it to one affect per ten-minute segment whenever possible.

3. 1-100 ratings are made for each of the main objectives (In theory-neutral language; insight, motivation, affect exposure, new learning and degree of inhibition) for each 10-minute segment (except for Self/other ratings which follow the entire session.)

   a. An objective should not be rated unless there are <u>clear and unambiguous behavioral data</u> to support the rating; i.e., patient verbal or observable non-verbal behavior.

   b. A rating of NO DATA or ND should be given when there is no clear example during the ten minute segment. Trainees often confuse 'no data' ratings with low scores. For example, if there is no mention of new learning in a segment, the rating should be 'no data' rather than " No awareness of defenses…"

or "No motivation…" or "No expression of adaptive feelings…". To give a low score the patient has to provide a behavioral example in which there was no awareness ("I'm not avoiding anything, that's just the way I am"), or motivation (e.g. I don't want to change!!), or new learning ("I can't even imagine doing that!"). "No data" means the issue did not come up during that segment.

The one exception is Affect Experiencing. There is always data for the bodily experiencing of feeling, because that can be observed (or not observed) on the screen. Thus, no sign of bodily arousal gets a 1-10 rating rather than a rating of No Data. It is rare to ever rate Affect experiencing as NO DATA

b. A descriptive example upon which the rating is based (either quoting the patient's statements or describing the patient's observable non-verbal behavior) should be written down next to the rating. . Providing behavioral descriptions will improve the reliability of the rating and it will allow for validity checks.

When raters are first learning the ATOS scale, it can be helpful to do the following:

- First, on the brief guides at the top of each page, find the ' 20-point level that best fits the behavior that you are rating (i.e., little or none … 1 to 20; low, 21-40, moderate, 41-60, etc)
- Then, within that 20-point level, find the specific numerical rating by using the more detailed 10-point rating levels and evaluating where the patient behavior best falls.

4. **Sessions should be rated in their entirety (i. e., five or six ten-minute segments per session).**

Individual ten-minute segments of sessions by themselves are not representative of the whole session because of the variation of patient responses within sessions. Similarly, ratings from individual sessions are not representative of an entire treatment. Often ratings vary widely from one segment to another or from one session to another. Therefore ratings need to be done for whole sessions as well as for a high percentage of sessions (we have done 75%) in a treatment in order to obtain an accurate representation of the degree the entire treatment had achieved the therapeutic objectives. We have not yet determined what percentage of sessions will be adequate to constitute a reliable indication of treatment as a whole.

Training

Ideally, for training, raters should practice using tapes or transcripts that have been previously rated by the developers of the method. But because of patient confidentiality issues, we are not able to send out videotapes. We are currently working to prepare transcripts for practice in other locations or over the internet. As an alternative, researchers wishing to use this method may establish reliability on their own clinical material, and may consult with the authors to obtain verification of ratings (e.g., we could provide direct training, or code tapes that are sent to us and provide feedback). For information on training, please call:

The Short Term Psychotherapy Research Program

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A website is being developed that will provide transcripts and 'gold standard' comparisons so that trainees can test themselves. [www.jakobsladder.com]. Reliability coefficients (ICC: Intraclass Correlation Coefficient) are generated for every 20 sets of ratings and can be printed out by the trainees.

When inter-rater reliability is established, then independent rating of sessions can begin. However, we have found that the most accurate rating profile results when multiple raters score each session, and ratings are either averaged or discussed and a consensus score reached.

Additional Notes: When we first developed this rating procedure, the objectives were given a single rating at the end of the entire session. However, there was great variation in patient responding throughout a session. One rater might derive ratings from the early part of the session, and another rater might derive ratings from the end of the session. We tried dividing sessions into quarter, thirds and 5-minute segments. We settled on 10 minute segments as the best compromise of enough time for development of a theme, but not too long to have too much going on to rate. We found that reliabilities were greatly improved by giving ratings on the major affect focus within these sequential ten minute segment of each session. (Thus a 50 - 60 minute session would have 5 to 6 segments each).

We also found it a problem rating Self/Other Restructuring in relation to specific core conflicts. The sense of self and others seems to reflect a more global quality than the defense and affect objectives. Therefore it is sometimes harder to link the sense of self or others to specific core issues. For example, self image can show overall improvement due to resolutions of the dynamic conflict about ability to be assertive, even when the core conflict about intimacy is not resolved. **Therefore we make one global session rating for both Self and Other Restructuring, rather than ratings for 10-minute segments or for a specific core conflict.**

Ratings need to be made while taking into consideration the culture or affective style of the individual. The stoic Scandinavian will have a very different presentation of the experience of intense affect than the individual from South America. Such cultural or gender differences obviously need to be taken into account in the rating process.

Rater Reliability:

Preliminary analyses on 45 cases among 6 raters has been acceptable to very good. Reliabilities further improved for the next 45 cases rated in ten-minute segments. An article is presently in preparation describing these reliability studies. Contact Dr. McCullough for more information (leigh@hms.harvard.edu)

ATOS 1-PAGE BRIEF OVERVIEW – 20 POINT BRIEF RATING GUIDES 27 Aug 08

The Psychotherapy Research Program at HMS

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AWARENESS OR INSIGHT INTO MALADAPTIVE PATTERNS OF THOUGHTS, FEELINGS, AND/OR BEHAVIORS

81-100 - Excellent recognition of problem patterns. Excellent links to past origin of behaviors. Excellent awareness/insight.
61-80 - Good recognition of problem patterns. Some description of origins in past, linked to present. Good awareness/insight.
41-60 - Moderately clear recognition. On own describes occurrence of maladaptive patterns. No references to past. Moderate awareness/insight.
21-40 - Low recognition. Can see problem pattern **only** when pointed out by therapist. Little/no elaboration. Minimal awareness/insight.
1-20 - No recognition of maladaptive behavior patterns, or unsure when pointed out. May mention anxiety without reference to pattern. No awareness/insight or resists awareness/insight.

MOTIVATION TO GIVE UP MALADAPTIVE PATTERNS OF THOUGHTS, FEELINGS, AND/OR BEHAVIORS

81-100 - Excellent motivation to give up maladaptive patterns. Very strong discomfort, sorrow, openness to change. Litte/no resistance.
61-80 - Strong motivation to give up maladaptive patterns. Strong discomfort, sorrow, openness to change. Low resistance.
41-60 - Moderate motivation to give up maladaptive patterns. Moderate discomfort, sorrow, openness to change. Moderate resistance.
21-40 - Low motivation to give up maladaptive patterns. Low discomfort, sorrow, openness to change. Much resistance.
1-20 - No motivation to give up maladaptive patterns. Ego-syntonic/desirable. "This is who I am." Almost total resistance.

DEGREE OF INTENSITY OF AFFECTIVE AROUSAL (IN-SESSION EXPOSURE TO PHOBIC AFFECTS)

81-100 - Full experience of emotion, well-integrated. Full grief, full openness/tenderness/trust, full justifiable outrage, full joy, etc.
61-80 - Strong experience of emotion. Strong affect quickly cut off **or** sustained but a little held back.
41-60 - Moderate experience of emotion. Some grief, some anger, some openness/tenderness/trust/care, etc. Some holding back.
21-40 - Low experience of emotion. Beginning indications of grief, anger, openness/tenderness/trust/care/joy, etc. Much holding back.
1-20 - Little/no physiological experience of emotion in facial expression, verbal report, tone of voice, body movement. Flat, dull, bland presentation.

NEW LEARNING: ADAPTIVE EXPRESSION OF THOUGHTS, FEELINGS, WISHES, OR NEEDS

81-100 - Excellent expression of thoughts/feelings; sense of completeness, balance and excellent results. Great relief and satisfaction experienced.
61-80 - Good expression of thoughts/feelings; slight holding back. Not all expressed, but good sense of relief in speaking up. Good satisfaction.
41-60 - Moderate expression of thoughts or feelings; moderate holding back, but moderate effectiveness. Moderate relief. Moderate satisfaction.
21-40 - Beginning attempt to express thoughts or feelings. Much holding back. A little relief in expression. A little satisfaction.
1-20 - No expression of adaptive thoughts or feelings. Total holding back. No relief. No satisfaction. High end of this rating level: can begin to imagine expressing adaptive thoughts or feelings, wants and needs, but is as yet unable put it into action.

INHIBITORY FEELING: VERBAL OR NONVERBAL EVIDENCE OF THE OBSERVABLE PRESENCE OF ANXIETY, GUILT, SHAME, OR PAIN

81-100 - Extreme inhibitory affect: e.g., extreme shakiness, hesitancy, vigilance, trembling, anxiety or shame. Extreme uneasiness.
61-80 - High inhibitory affect: e.g., high levels of shakiness, hesitancy, vigilance, trembling, anxiety or shame. Great uneasiness.
41-60 - Moderate inhibitory affect: e.g., moderate shakiness, hesitancy, vigilance, trembling, anxiety or shame. Moderate uneasiness.
21-40 - Low inhibitory affect: e.g., low shakiness, hesitancy, vigilance, trembling, anxiety or shame. Low level of uneasiness.
1-20 - Little or no inhibitory affect. Little or no shakiness, guardedness, hesitancy, vigilance, trembling, anxiety, etc. Comfortable, at ease.

IMPROVEMENT IN SELF-IMAGE

81-100 - Highly adaptive sense of self; compassionate and accepting of strengths and vulnerabilities.
61-80 - Very adaptive sense of self; much compassion and acceptance, but some self-blame or shame present.
41-60 - Moderately adaptive/maladaptive aspects of self-image in approximately equal amounts.
21-40 - Very maladaptive sense of self, but a little compassion, and a little ability for acceptance.
1-20 - Highly maladaptive sense of self; little or no compassion, awareness, or self acceptance—or excessive grandiosity.

IMPROVEMENT IN IMAGE OF OTHERS

81-100 - Highly adaptive sense of others. Very much compassion/acceptance/trust in others; little or no idealization or devaluation.
61-80 - Very adaptive sense of others. Much compassion/acceptance/trust, but some devaluation or idealization.
41-60 - Moderately adaptive as well as maladaptive aspects; moderate compassion/acceptance/trust, moderate devaluation/idealization.
21-40 - Very maladaptive sense of others, but some compassion, empathy or ability for acceptance; much devaluation or idealization.
1-20 - Highly maladaptive sense of others; Little or no compassion, empathy or acceptance. Very much devaluation, idealization or splitting.

AWARENESS OR INSIGHT INTO MALADAPTIVE PATTERNS 20 Aug08

STDP: Defense Recognition (Noting Patterns of Maladaptive Defenses, Anxieties, and Feelings)
CBT: Recognition of Maladaptive Cognitions or Maladaptive Cognitive Schemas
DBT: Mindfulness of self-destructive pattern. Degree of dialectical thinking/ behavior observation.

MAIN COMPONENTS:

1. Degree of clarity and fullness of **verbal** descriptions of maladaptive patterns of thoughts, feelings, and/or behaviors, with explicit examples.
2. Degree of ability to state why and how maladaptive/defensive patterns began and are maintained (secondary gain, meanings, causes, and with whom.).

NOTE: Rate higher within each 10-point category for multiple examples, and lower for fewer examples.

BRIEF OVERVIEW OF AWARENESS OR INSIGHT INTO MALADAPTIVE PATTERNS OF THOUGHTS, FEELINGS, AND/OR BEHAVIORS

81-100 - Excellent recognition of problem patterns. Excellent links to past origin of behaviors. Excellent awareness/insight.
61-80 - Good recognition of problem patterns. Some description of origins in past, linked to present. Good awareness/insight.
41-60 - Moderately clear recognition. On own describes occurrence of maladaptive patterns. No references to past. Moderate awareness/insight.
21-40 - Low recognition. Can see problem pattern **only** when pointed out by therapist. Little/no elaboration. Minimal awareness/insight.
1-20 - No recognition of maladaptive behavior patterns, or unsure when pointed out. May mention anxiety without reference to pattern. No awareness/insight or resists awareness/insight.

91-100 **Excellent recognition of maladaptive behavior patterns**. Clear, comprehensive descriptions of maladaptive patterns. Describes clearly and fully how pattern is transferred from past to present. (e.g.; learning history or T-C-P links). Also, excellent descriptions of reasons for maladaptive responses, including meanings and secondary gain. Excellent and full awareness/insight.

81-90 **Very good recognition of maladaptive behavior patterns.** Clear, somewhat detailed descriptions of maladaptive patterns. Very good description of origins in past, linked to present. Very good understanding of reasons for maladaptive responses, meanings and secondary gain—but not all aspects mentioned. Very good awareness/insight.

71-80 **Good recognition of maladaptive behavior patterns**. Good but not detailed descriptions of maladaptive patterns. Some description of origins in past, linked to present. Good understanding of reason for maladaptive responses or secondary gain. Good awareness/insight.

61-70 **High-moderate recognition of maladaptive behavior patterns**. Fairly good, general descriptions of maladaptive patterns. Minimal description of origins in past, or links to present. Some understanding of reasons for maladaptive responses or secondary gain. Fairly good awareness/insight.

51-60 **Moderate recognition of maladaptive behavior patterns**. Partial descriptions of maladaptive patterns. No past-present links. No mention why maladaptive behaviors occur or secondary gain. Moderate awareness/insight.

41-50 **Low-moderate recognition of maladaptive behavior patterns**. **On own** begins to describe maladaptive patterns but only vague or general description without clear examples. No past-present links. No mention of why maladaptive behaviors occur nor understanding of secondary gain. Some awareness/insight.

31-40 **Low recognition of maladaptive behavior patterns**. Can acknowledge maladaptive patterns **only** when pointed out, but readily agrees when pointed out by therapist—with little elaboration. Lower level: Agrees without reluctance but does not elaborate further. Beginning awareness/insight.

21-30 **Minimal recognition of maladaptive behavior patterns**. Can acknowledge maladaptive behavior **only** when pointed out, but reluctantly agrees and does not elaborate further. Upper level: Agrees with a little reluctance. Lower level: Agrees with much reluctance/or unclear whether the patient agrees or not. The barest evidence of beginning awareness/insight.

11-20 **No recognition of maladaptive behavior patterns**. Does not recognize maladaptive patterns and questions, doubts or does not agree when pointed out by therapist. Seems to lack interest in identifying maladaptive patterns. No awareness/insight. Mention of anxiety or inhibition without understanding of maladaptive pattern is rated here.

1-10 **No awareness of maladaptive behavior patterns, anxieties or feelings**. Does not see maladaptive patterns on own nor when therapist points it out. Upper level: No apparent interest in recognizing maladaptive responses. Lower level: Disagrees or becomes angry/belligerent when maladaptive responses are pointed out. No awareness/insight or resists awareness/insight. No mention of anxiety or inhibition.

MOTIVATION TO GIVE UP MALADAPTIVE PATTERNS 27 Aug 08

STDP: Defense Relinquishing: Motivation to give up defensive patterns
CBT: Motivation to give up maladaptive cognitive schemas
DBT: Motivation to change maladaptive behaviors. Commitment

MAIN COMPONENTS: RATE the MODE over the 10 minute segment.

1. Degree of motivation to give up maladaptive patterns of thoughts, feelings, and/or behaviors.
2. Degree of dislike, undesirability or sorrow **specifically** about the costs of defenses or maladaptive behavior. (Base ratings on nonverbal or affective display of motivation; e.g. sorrow/grief expressed about having the maladaptive behavior patterns.) NOTE: This is not grief over losses of loved ones, which would be rated as Affect Experiencing if the focus of the segment is grief.

NOTE: The lower the score, the greater the degree of overall resistance to change or the greater the defensiveness to warded-off feeling.

BRIEF OVERVIEW OF MOTIVATION TO GIVE UP MALADAPTIVE PATTERNS OF THOUGHTS, FEELINGS, AND/OR BEHAVIORS

81-100 - Excellent motivation to give up maladaptive patterns. Very strong discomfort, sorrow, openness to change. Litte/no resistance.
61-80 - Strong motivation to give up maladaptive patterns. Strong discomfort, sorrow, openness to change. Low resistance.
41-60 - Moderate motivation to give up maladaptive patterns. Moderate discomfort, sorrow, openness to change. Moderate resistance.
21-40 - Low motivation to give up maladaptive patterns. Low discomfort, sorrow, openness to change. Much resistance.
1-20 - No motivation to give up maladaptive patterns. Ego-syntonic/desirable. "This is who I am." Almost total resistance.

91-100 **Excellent motivation to give up maladaptive behavior**. Expresses (verbally and non-verbally) intense wish to change. Extreme discomfort over maladaptive behavior. Intense grief over costs of defenses. No resistance or defensiveness. Fully open to change.

81-90 **Very strong motivation to give up maladaptive behavior**. Expresses very strong wish to change. Very strong discomfort over maladaptive behavior. Very strong grief over costs of defenses. Very little resistance or defensiveness. Very strong openness to change.

71-80 **Strong motivation to give up maladaptive behavior**. Expresses strong wish to change. Strong discomfort over maladaptive behavior. Strong grief over costs of defenses. Low resistance or defensiveness. Strong openness to change.

61-70 **High moderate motivation to give up maladaptive behavior**. Expresses more-than-moderate wish to change. More-than-moderate discomfort over maladaptive behavior. More-than-moderate grief over costs of defenses. Low-moderate resistance or defensiveness. More-than-moderate openness to change.

51-60 **Moderate motivation to give up maladaptive behavior**. Expresses moderate wish to change. Moderate discomfort over maladaptive behavior. Moderate grief over costs of defenses. Moderate resistance or defensiveness. Moderate openness to change.

41-50 **Low-moderate motivation to give up maladaptive behavior**. Expresses some wish to change. Some discomfort over maladaptive behavior. Some grief over costs of defenses. More-than-moderate resistance or defensiveness. Some openness to change.

31-40 **Low motivation to give up maladaptive behavior**. Agrees that change is needed, and that giving up the maladaptive behavior can be beneficial, but no discomfort reported about having the maladaptive behavior. Doubts own ability to change or fears change. Much resistance/defensiveness or ambivalence. Little openness to change.

21-30 **Very low or ambivalent motivation to give up maladaptive behavior**. Very low desire to change. Acknowledges maladaptive behavior as problematic, but also describes its benefits/secondary gain. Very much resistance, defensiveness or ambivalence. Very little openness to change.

11-20 **Barely evident motivation to give up maladaptive behavior**. Expresses almost no desire to change. Dislikes symptoms, but only acknowledges maladaptive behavior as mildly problematic, if at all. Fears expression of adaptive feeling or feels too hopeless to try. Strong resistance/defensiveness. Almost no openness to change.

1-10 **No motivation to give up maladaptive behavior**. Dislikes symptoms, but accepts, values or desires maladaptive behavior. (Fully desirable or ego-syntonic: e.g., "This is the way I am!"). Resists adaptive expression. Indifferent/masochistic attitude towards self. Almost total resistance or defensiveness. No openness to change.

INTENSITY OF AROUSAL OF ADAPTIVE AFFECT: IN-SESSION BODILY EXPOSURE TO PHOBIC AFFECTS 27 Aug 08

STDP: Affect Experiencing: Degree of Bodily Arousal of Adaptive Affects (to desensitize Affect Phobias)
CBT: Affect arousal is not a primary focus – and may or may not be present
DBT: Mindfulness and management of internal reactions. Emotional modulation vs reactivity. Affect tolerance.

MAIN COMPONENTS:

1. Intensity of arousal of **adaptive affect** (rate **peak** degree of arousal for anger, grief, or excitement and the **deepest** arousal for joy, closeness, or self feelings). Base the rating on intensity of inner affective arousal as shown in vocal tone, facial expression, non-verbal behavior/movement or charged verbal statements. This is not a rating of intensity of interpersonal expression, which would be rated as Affect Expression/New Learning.
2. Duration of the affective arousal (a few seconds to many minutes).
3. Relief in the experience of the feeling.

NOTE: This scale does **not** a measure **inappropriate** or regressive affective arousal, which is defensive.

BRIEF OVERVIEW OF DEGREE OF INTENSITY OF AFFECTIVE AROUSAL (IN-SESSION EXPOSURE TO PHOBIC AFFECTS)

81-100 - Full experience of emotion, well-integrated. Full grief, full openness/tenderness/trust, full justifiable outrage, full joy, etc.
61-80 - Strong experience of emotion. Strong affect quickly cut off **or** sustained but a little held back.
41-60 - Moderate experience of emotion. Some grief, some anger, some openness/tenderness/trust/care, etc. Some holding back.
21-40 - Low experience of emotion. Beginning indications of grief, anger, openness/tenderness/trust/care/joy, etc. Much holding back.
1-20 - Little/no physiological experience of emotion in facial expression, verbal report, tone of voice, body movement. Flat, dull, bland presentation.

91-100 **Full and complete affective arousal**. Full and vivid feeling, imagery, and memories sustained over several minutes (ebbing and flowing); e.g. full sobbing, with other affects, e.g. murderous but justifiable outrage, openness/care/tenderness/joy/trust deeply felt as shown in face, vocal tone or body. Excellent ability to modulate or control affect, and integrate it with other affects that balance and enrich the experience, e.g. rage with compassion, tenderness with limit-setting. Full relief and resolution.

81-90 **Very strong affective arousal**. Very strong feeling, imagery, and memories, well sustained (ebbing and flowing) just slightly inhibited or interrupted by other affects as shown in face, vocal tone or body. The affect is partially integrated with other affects, e.g. rage with some compassion; care/trust with limits. Very strong but not full relief.

71-80 **Strong affective arousal**. Strong feeling either sustained (ebbing and flowing) with a little holding back **or** strong feeling that slowly diminishes or is interrupted by another affect; e.g., strong bursts of sobs or anger, strong expressions of caring/tenderness as shown in face, vocal tone or body. Minimal integration with other feelings. Imagery or memories with strong emotional content. Strong relief

61-70 **High-moderate affective arousal**. Much feeling, somewhat sustained (ebbing and flowing) with some holding back **or** quickly cut off. e.g., bursts of crying or anger, much caring/tenderness/warmth/trust as shown in face, vocal tone or body. Only beginning indications of integration with other affects. Imagery or memories with much emotional content. Much relief.

51-60 **Moderate affective arousal**. Moderate feeling; moderate duration/moderate holding back, e.g. tearing up, moderate anger, some tender feelings as shown in face/vocal tone/body. Imagery or memories with moderate emotional content. Moderate relief.

41-50 **Low-moderate affective arousal**. Mild feeling with much holding back shown in face, vocal tone or body, e.g. briefly tears up, raises voice a little in anger, or says a few tender words for short duration, speaks openly. Imagery or memories with some emotional content. Some relief.

31-40 **Low affective arousal**. Low, quickly passing experience of feeling shown in face, vocal tone or body; e.g. clenching fist, sighs, grimaces, choking up, slight sadness/anger/care for self but quickly stopped. Imagery or memories with low emotional content but appears very restrained/held back/constricted. Very little relief.

21-30 **Very low affective arousal**. Minimal or barely visible/audible signs of feeling of short duration shown in face, vocal tone or body. May report slight change in internal bodily state. Imagery/memories have very low expression of feeling. Almost no relief.

11-20 **No affective arousal, *but* bland verbal report of feeling**. Almost no expression on face. Flat/dull/bland tone of voice, stiff or barely moving body. Patient may sense a change in internal bodily state, but is unsure whether it is a feeling or not. Only bland, unfeeling report of images or memories with emotional content. No relief.

1-10 **No affective arousal. No report of feeling**. No observable experience of feeling on face. Flat/dull/bland tone of voice. Stiff, unmoving body. No imagery or memories with emotional content. Emotionally numb and/or tense. Self hate/negation. No relief.

NEW LEARNING: ADAPTIVE EXPRESSION OF THOUGHTS, FEELINGS, WISHES, OR NEEDS 8/20/08

STDP : Affect Expression: Ability to adaptively express thoughts, feelings, wishes, needs
CBT: Ability to adaptively express thoughts, wishes, needs.
DBT: Implementation of skills training. Adaptive decision-making/judgment vs. crisis generating behaviors. Accuracy of communication of emotions and competencies. Decreasing mood dependency of behavior.

MAIN COMPONENTS:

1. Appropriate, adaptive interpersonal, **face-to-face** expression (spirited but well-controlled and well-integrated) of thoughts and feelings. As of Aug 2008, if affect is expressed directly in the real relationship with the therapist, this should be noted as 'in session' expression.
2. Degree of relief/satisfaction versus discomfort in action or expression.

NOTE: **Face-to-face** means **in-person, real-life interactions outside of therapy** (i.e., how spontaneous/ authentic is the patient able to be with others?) This is adaptive, **not** regressive or immature expressions. **Valid exceptions** to **face-to-face** expression: reports of adaptive crying when alone (if not to avoid doing so with others); adaptive masturbatory behavior; or adaptive self care or self-talk when alone.

BRIEF OVERVIEW OF NEW LEARNING OF ADAPTIVE EXPRESSION:

81-100 - Excellent expression of thoughts/feelings; sense of completeness, balance, and excellent results. Great relief and satisfaction experienced.
61-80 - Good expression of thoughts/feelings; slight holding back. Not all expressed, but good sense of relief in speaking up. Good satisfaction.
41-60 - Moderate expression of thoughts or feelings; moderate holding back, but moderate effectiveness. Moderate relief. Moderate satisfaction.
21-40 - Beginning attempt to express thoughts or feelings. Much holding back. A little relief in expression. A little satisfaction.
1-20 - No expression of adaptive thoughts or feelings. Total holding back. No relief. No satisfaction. High end of this rating level: can begin to imagine expressing adaptive thoughts or feelings, wants and needs, but is as yet unable put it into action.

91-100 **Excellent, full, free and unashamed expression of thoughts or feelings, wants/ needs**. Excellent, well-modulated and well-articulated communication. Acknowledges other emotions that come up and can integrate them. A sense of full completeness and close interpersonal involvement that invites and encourages connection – but can tolerate conflict when unavoidable. Great relief and satisfaction. No discomfort in expression.

81-90 **Very good expression of thoughts or feelings**. Very good communication of needs in a clear, and direct/effective way, and very good but not full integration of other adaptive thoughts or feelings with most people, but not all. Very well-modulated expression with very much relief and very little if any discomfort.

71-80 **Good expression of thoughts or feelings**. Good, clear and direct expression with some integration of other adaptive thoughts or feelings (e.g., anger with compassion). Well-modulated expression with much relief and some discomfort.

61-70 **High moderate expression of thoughts or feelings**. Much clear expression with beginning attempts to integrate other thoughts or feelings **or** a little indirect but gets the message across. Partially modulated bursts of adaptive feeling. More relief than discomfort.

51-60 **Moderate expression of thoughts or feelings**. Some clarity and elaboration. Expression may be toned down/devalued, **or** indirect/unclear/ambiguous. Thoughts or feelings not yet integrated (black or white presentation). Slightly modulated. Moderate relief and moderate discomfort in expression.

41-50 **Low-moderate expression of feelings or needs**. Very little elaboration and expression may be quickly toned down or devalued. Unintegrated and poorly modulated. Beginning awareness of impact on others. More discomfort than relief.

31-40 **Minimal expression of thoughts or feelings**. Briefly expresses thoughts or feelings, but may do so inappropriately, with difficulty or without elaboration, **or** indirect/unclear/ambiguous. Either very poor modulation (mostly inhibited/holding back)—or too little inhibition with inappropriate acting out with much discomfort in expression.

21-30 **Beginning attempt to express thoughts or feelings. to others**. Expresses some thoughts or feelings maladaptively or with great difficulty, e.g. irritation, frustrated anger or anxious assertion or closeness **or** quickly overwhelmed by inhibitory thoughts or feelings that block expression. Inappropriate expression; e. g. childlike, immature. Very poorly integrated with other thoughts or feelings and very poorly modulated. Very much discomfort in expression.

11-20 **No interpersonal expression of thought or thoughts or feelings, *but* can imagine expressing them**. High end: Can imagine doing so, but has not actually done it yet. Low end: Can barely imagine expressing thoughts or feelings or imagines doing so inappropriately or losing control. Some regressive or inappropriate behaviors instead of appropriate expression.

1-10 **No adaptive expression of thoughts or feelings. and cannot imagine expressing feelings appropriately**. High end: Aware of thoughts or feelings, but can't imagine expressing them. Low end: No idea of how to express own thoughts or feelings/needs. Great discomfort/tension/turmoil or numbness. Much regressive acting out behavior to replace appropriate expression

INHIBITORY FEELING: ANXIETY, GUILT, SHAME, OR PAIN 8/20/08

STDP: Anxiety Regulation: The regulation of Inhibitory Affects (anxiety, guilt, shame, and pain)
CBT: Degree of Anxiety in the segment: Anxiety reduction is a primary focus
DBT: Degree of Anxiety/inhibition

MAIN COMPONENTS: Rate the degree of inhibition (the mode) in the 10-minute segment; i.e., the overall intensity of observable anxiety, guilt, shame, pain as shown in verbal report, vocal tone, and non-verbal behavior. Raters should pay attention to physiological signs of inhibition; Below is a non-exhaustive list of examples:

1. **Anxiety**: trembling, tension, squirming, shifting, restlessness, twitching, nail-biting.
2. **Shame or Guilt**: blushing, looking down, lowering tone of voice, hands over face or covering eyes, head down.
3. **Pain**: wincing, groaning, whimpering.
4. **Common to one or more of the above**: hesitation, looking away, shifting in seat, sweating, vigilance, guardedness. All kinds of displacement activities such as scratching, grooming, rubbing or twisting hair, rubbing hands, squirming or shifting in seat.

NOTE: It is very important to distinguish **inhibitory feeling** from **defensive behavior**, which is not coded on the ATOS scale. Confusion sometimes arises because people who are highly defended are often described as 'inhibited.' This scale codes **observable indications of inhibitory affect**. For example, a lowered head can **indicate** shame about grief, and is coded. Defenses, on the other hand, are used to avoid or escape from inhibitory affects, and hence lead to a reduction in inhibitory affect, e.g. changing the subject can **reduce** shame about grief. These defensive avoidance behaviors are not signs of observable inhibition, and thus are not coded. (Defenses can be scored on Perry's DMRS—Defense Mechanism Rating Scale). Keep in mind the following:

- The healthiest individuals score low on inhibitory feeling because they are comfortable with their feelings, and at ease. They also have low defensiveness.
- The most defended patients can seem low on the inhibitory feeling scale because their defenses are effective in blocking 'anxieties,' but if you look for vigilance, tension, or bodily rigidity you will find some. The rating may not be high, but it will not be in the lowest range (1-10), which will only be scored by individuals who are comfortable or at ease with themselves.
- When defenses break down or are only partially effective, inhibitory feelings become more observable and easier to rate.
- Remember that there are **appropriate** versions of anxiety, shame (or remorse), or pain that are **healthy**. For example, **appropriate** shame/remorse is adaptive when it promotes resolution or growth, and it is often accompanied by adaptive grief. Adaptive inhibition is not rated.

BRIEF OVERVIEW OF INHIBITORY FEELING: VERBAL OR NONVERBAL EVIDENCE OF THE OBSERVABLE PRESENCE OF ANXIETY, GUILT, SHAME, OR PAIN

81-100 - Extreme inhibitory affect: e.g., extreme shakiness, hesitancy, vigilance, trembling, anxiety or shame. Extreme uneasiness.
61-80 - High inhibitory affect: e.g., high levels of shakiness, hesitancy, vigilance, trembling, anxiety or shame. Great uneasiness.
41-60 - Moderate inhibitory affect: e.g., moderate shakiness, hesitancy, vigilance, trembling, anxiety or shame. Moderate uneasiness.
21-40 - Low inhibitory affect: e.g., low shakiness, hesitancy, vigilance, trembling, anxiety or shame. Low level of uneasiness.
1-20 - Little or no inhibitory affect. Little or no shakiness, guardedness, hesitancy, vigilance, trembling, anxiety, etc. Comfortable, at ease.

91-100 **Extreme inhibitory affect**. Flooded with anxiety, guilt, shame, or pain as shown by verbal report and/or by signs such as extreme shakiness, hesitation, sighing, or vigilance. Body movement and muscles are extremely tight, tense and rigid. Tone of voice is extremely hesitant, trembling or inaudible. Extreme uneasiness. (Over 90% inhibition.)

81-90 **Very high inhibitory affect**. Very high levels of anxiety, guilt, shame or pain shown by verbal report and/or by signs such as very great shakiness, hesitation, sighing, or vigilance. Body movement and muscles are greatly tight, tense and rigid. Tone of voice is greatly hesitant, trembling or inaudible. Very high uneasiness. (81-90% inhibition.)

71-80 **High Inhibitory Affect**. High levels of anxiety, guilt, shame or pain shown by verbal report and/or by signs such as great shakiness, hesitation, sighing or vigilance. Body movement and muscles are highly tight, tense and rigid. Tone of voice is greatly hesitant, trembling or inaudible. High level of uneasiness. (71-71-80% inhibition.)

61-70 **High-moderate inhibitory affect**. More than moderate levels of anxiety, guilt, shame or pain shown by verbal report and/or by signs such as above moderate levels of shakiness, hesitation, sighing or vigilance. Body movement and muscles are more than moderately tight, tense and rigid. Tone of voice is more than moderately hesitant, trembling or inaudible. Above moderate level of uneasiness. (61-70% inhibition.)

51-60 **Moderate inhibitory affect**. Moderate levels of anxiety, guilt, shame or pain, shown by verbal report and/or by signs such as moderate shakiness, hesitation, sighing, tension or vigilance. Body movement and muscles are moderately tight, tense and rigid. Tone of voice is moderately hesitant, trembling or inaudible. Moderate uneasiness. (51-60% inhibition.)

41-50 **Low-moderate inhibitory affect**. Low-moderate levels of anxiety, guilt, shame or pain shown by verbal report and/or by signs such as shakiness, hesitation, shifting, sighing, tension or vigilance. Body movement and muscles are less than moderately tight, tense and rigid. Tone of voice is less than moderately hesitant, trembling or somewhat difficult to hear. Less than moderate uneasiness. (41-50% inhibition.)

31-40 **Low inhibitory affect**. Low-moderate levels of anxiety, guilt, shame or pain as shown by verbal report and/or by signs such as shakiness, hesitation, shifting, sighing, vigilance. Body movement and muscles show low levels of tightness, tension or rigidity. Tone of voice shows low level of hesitance, trembling or somewhat difficult to hear. Low level of uneasiness. (31-40% inhibition.)

21-30 **Little inhibitory affect**. Little anxiety, guilt, shame or pain as shown by verbal report and/or by such signs as shakiness, hesitation, shifting, sighing, vigilance. Body movement and muscles show little tightness, tension or rigidity. Tone of voice has little hesitance, trembling, and is audible. A little uneasiness. (21-30% inhibition.)

11-20 **Very little inhibitory affect**. Very little anxiety, guilt, shame or pain as shown by verbal report and/or by such signs as shakiness, hesitation, shifting, sighing, or vigilance. Body movement and muscles show very little tightness, tension or rigidity. Tone of voice has very little hesitance, trembling, and is audible. Very little uneasiness. (11-20% inhibition.)

0–10 **No Inhibitory Affect**. No (or almost no) anxiety, guilt, shame or pain as shown by verbal report and/or by signs such as absence of shakiness, hesitation, shifting, sighing, or vigilance. Body movement and muscles are relaxed and movement is smooth and coordinated. Behavior and vocal tone are calm, spontaneous, natural, and very audible. Inhibitory thoughts or feelings, if present, are there to help, guide, direct and protect. No muscle tension is evident. Comfortable and at ease. (10% inhibition or less.)

IMPROVEMENT IN SELF-IMAGE 8/20/08

STDP: Restructuring of the Sense of Self
CBT: Improvement in self-esteem and positive self talk
DBT: Degree of self-validation vs self-invalidation.

MAIN COMPONENTS: The patient's inner experience or verbal report of adaptive self image, in terms of the following:

1. Degree of experience of self compassion, self care, or value as a human being.
2. Degree of adaptive pride in positive qualities (not defensive pridefulness or grandiosity); e.g., self worth, self esteem, competence, etc.
3. Degree of ability to compassionately acknowledge and accept one's limitations or realistic negative qualities of the self.

NOTE: Both grandiosity and devaluation of self should be considered maladaptive.

BRIEF OVERVIEW OF IMPROVEMENT IN SELF-IMAGE

81-100 - Highly adaptive sense of self; compassionate and accepting of strengths and vulnerabilities.
61-80 - Very adaptive sense of self; much compassion and acceptance, but some self-blame or shame present.
41-60 - Moderately adaptive/maladaptive aspects of self-image in approximately equal amounts.
21-40 - Very maladaptive sense of self, but a little compassion, and a little ability for acceptance.
1-20 - Highly maladaptive sense of self; little or no compassion, awareness, or self acceptance—or excessive grandiosity

91-100 **Highly adaptive sense of self**. Great but healthy pride in owns strengths (not grandiose), and highly affirming of own wants and needs, but not demanding. Very realistic but highly compassionate about own weaknesses. Great sense of self-compassion and self-acceptance, with almost no self-blame or shame.

81-90 **Mostly adaptive sense of self**. Very much pride in own strengths and very much affirming of own wants and needs. Very much ability to acknowledge and accept limitations. Very much compassion and self-acceptance, but a little self-blame or shame.

71-80 **Very adaptive sense of self**. Much pride in own strengths, and quite affirming of own wants and needs in relation to others. Much ability to acknowledge and accept limitations. Much compassion and self-acceptance, but some self-blame or shame.

61-70 **Somewhat adaptive sense of self**. Some pride in own strengths, and some affirming of own wants and needs. Some ability to acknowledge and accept limitations. Some compassion and self acceptance, but moderate self-blame or shame present.

51-60 **Mixed adaptive/maladaptive view of self**. Slightly more adaptive than maladaptive view of self. Slightly more pride than shame in self. Compassion and self-acceptance slightly greater than devaluation or grandiosity. Only moderately affirming of own wants and needs. Only a little more compassion and self-acceptance than self-blame or shame.

41-50 **Mixed maladaptive/adaptive view of self**. Slightly more maladaptive than adaptive view of self. Slightly more shame than pride in self. Devaluation or grandiosity is slightly stronger than self-compassion or acceptance of limitations. Only moderately affirming of own wants and needs. Slightly more self-blame and shame than compassion for self.

31-40 **Somewhat maladaptive sense of self**. Some shame in self. Minimal pride in own strengths. Somewhat affirming of own wants and needs in relation to others. Somewhat able to acknowledge and accept limitations. Some compassion and self-acceptance of self regarding limitations, but more self-blame or shame.

21-30 **Very maladaptive sense of self**. Much shame in self. Little pride/some grandiosity. Almost no affirming of wants and needs. Minimal ability to acknowledge and accept limitations and minimal ability to control impulses. Minimal compassion and self acceptance of self regarding limitations. Much self-blame or shame.

11-20 **Mostly maladaptive sense of self**. Very much shame and very little pride/or much grandiosity. Devaluation of self or wants and needs. Very little ability to acknowledge and accept limitations. Very little ability to control impulses. Very little compassion and self-acceptance, but very much and very destructive self-blame or shame.

1-10 **Highly maladaptive sense of self**. Extremely maladaptive view of self, with little or no pride/or extreme grandiosity. Denying or ignoring wants and needs. Little or no ability to acknowledge and accept limitations or control impulses. Almost no compassion or self-acceptance, but extremely destructive self-blame or shame.

IMPROVEMENT IN IMAGE OF OTHERS 8/20/08

STDP: Restructuring Sense of Others
CBT: Improvement in relationships
DBT: Improvement in relationships. Dialectical thinking about others. Adaptive dependence on others.

MAIN COMPONENTS: The patient's report of adaptive and realistic images of other people, in terms of:
1. Degree patient can acknowledge or respond to others' positive qualities.
2. Degree patient can acknowledge and set limits around destructive or (realistic) negative qualities in others.

NOTE: Over-idealization, naiveté or tolerance of abuse as well as undeserved devaluation of others is considered maladaptive.

BRIEF OVERVIEW OF IMPROVEMENT IN IMAGE OF OTHERS
81-100 - Highly adaptive sense of others. Very much compassion/acceptance/trust in others; little or no idealization or devaluation.
61-80 - Very adaptive sense of others. Much compassion/acceptance/trust, but some devaluation or idealization.
41-60 - Moderately adaptive as well as maladaptive aspects; moderate compassion/acceptance/trust, moderate devaluation/idealization.
21-40 - Very maladaptive sense of others, but some compassion, empathy or ability for acceptance; much devaluation or idealization.
1-20 - Highly maladaptive sense of others; Little or no compassion, empathy or acceptance. Very much devaluation, idealization or splitting.

91-100 **Highly adaptive sense of others**. Highly compassionate/accepting/trusting but realistic about others' weaknesses, admiring of others' strengths, and affirming of others needs and wants. No idealization/devaluation or naïveté. Great ability to tolerate and work with conflict or set limits. Excellent ability to integrate positive and negative qualities of others.

81-90 **Very adaptive sense of others**. Very much compassion/acceptance/trust, but occasionally a little devaluation or idealization. Almost no tendency toward naïve/compliant or suspicious/ projecting. Very good ability to tolerate and work with conflict or set limits with others. Very good ability to integrate positive and negative qualities of others.

71-80 **Moderately adaptive sense of others**. Much compassion/acceptance/trust of others, but occasionally a little devaluation or idealization. Only a little naïve/compliant or suspicious/ distrustful/ projecting Good ability to tolerate and work with conflict, limit-setting or negative qualities in others. Good ability to integrate positive and negative qualities of others.

61-70 **Minimally adaptive view of others**. Somewhat more compassion/ acceptance/trust, than devaluation or idealization. Minimally naïve/compliant or suspicious/ distrustful/ projecting. Above moderate ability to tolerate and work with conflict, limit-setting or negative qualities in others. Above moderate ability to integrate positive and negative qualities of others.

51-60 **Mixed adaptive/maladaptive view of others**. Compassion or acceptance of others is a little stronger than devaluation or idealization. Somewhat naïve/compliant or suspicious/ distrustful/ projecting. Moderate ability to integrate positive and negative qualities of others. Moderate ability to tolerate and work with conflict and set-limits.

41-50 **Mixed maladaptive/adaptive view of others**. Devaluation or idealization is a little stronger than compassion or acceptance. Somewhat naïve/compliant or suspicious/ distrustful/ projecting. Somewhat below average ability to tolerate or work with conflict, or integrate positive and negative qualities of others.

31-40 **Somewhat maladaptive view of others**. Somewhat more devaluation or idealization than compassion or acceptance. A slight tendency toward splitting others into all good or all bad. Somewhat naïve/compliant or suspicious/ distrustful/ projecting. Only fair ability to tolerate and work with conflict or set limits - nor to integrate positive and negative qualities of others.

21-30 **Very maladaptive sense of others**. Much devaluation/idealization and little compassion/acceptance/tru. Others split to moderate degree into all good/all bad. Very naïve/compliant or suspicious/distrustful/ projecting. Poor ability to tolerate and work with conflict or set limits – nor to integrate positive and negative qualities of others.

11-20 **Mostly maladaptive sense of others**. Very much devaluation or idealization, and very little compassion/acceptance/trust. Others split to large degree all good/all bad. Highly naïve/compliant or suspicious/distrustful/projecting. Very poor ability to tolerate or work with conflict or set limits – nor to integrate positive and negative qualities of others.

1-10 **Extremely maladaptive sense of others**. Extremely negative and devaluing, or over-idealized. Almost no compassion, acceptance or trust. Others split almost totally into all good/all bad. Extreme naïveté, projection, paranoia/distrust. Little or no ability to tolerate and work with conflict or set limits – nor to integrate positive and negative qualities.