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):

Leigh McCullough, Ph.D.

The Achievement of Therapeutic Objectives 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:

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<th>Objectives in Short Term Dynamic Psychotherapy</th>
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<td>Motivation</td>
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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 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.


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:

**Defense Restructuring:**

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

**Affect Restructuring:**

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

**Anxiety Regulation: Degree of Inhibition:**

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

**Self/Other Restructuring:** (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 once at the end of the entire session. 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 clear and unambiguous behavioral data 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

943 High Street

Dedham, MA 02026-4220  Phone/FAX: (617) 326-6060

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

The Psychotherapy Research Program at HMS

Leigh McCullough Ph.D., Director

AWARENESS OR INSIGHT IN VERBAL DESCRIPTION OF MALADAPTIVE BEHAVIOR PATTERNS
81-100 = Excellent recognition of problem patterns. Excellent links to past origin of behaviors. Excellent awareness/insight.
41-60 = Moderately clear recognition. On Own describes occurrence of maladaptive patterns. No references to past. Moderate awareness/insight.
21-40 = Minimal recognition. Can see problem pattern only when pointed out by therapist. Little/no elaboration. Minimal awareness/insight.
01-20 = No awareness of maladaptive behavior (cognitive or defensive) – even unsure when pointed out. May mention anxieties or feelings. No awareness/insight or resists awareness/insight.

MOTIVATION TO GIVE UP MALADAPTIVE BEHAVIOR (COGNITIVE OR DEFENSIVE) – RESISTANCE TO CHANGE
81-100 = Excellent motivation to give up maladaptive behavior (cognitive or defensive). Great discomfort. Behavior fully undesirable/ego-dystonic.
61-80 = Strong motivation to give up maladaptive behavior (cognitive or defensive); much discomfort, undesirability.
41-60 = Moderate motivation to give up maladaptive behavior (cognitive or defensive)/ moderate wish not to change; moderately undesirable.
21-40 = Low motivation to give up maladaptive behavior (cognitive or defensive)/ Fear of giving them up. Behavior somewhat desirable.
01-20 = No motivation to give up maladaptive behavior (cognitive or defensive). Ego-syntonic/highly desirable. This is who I am.”

PEAK EMOTIONAL AROUSAL OF ADAPTIVE AFFECT: IN-SESSION EXPOSURE & DESENSITIZATION OF PHOBIC AFFECTS
81-100 = Excellent experience of emotion, well-integrated (Over 61%); Full grief, full openness/tenderness/trust, full justifiable outrage, full joy, etc.
61-80 = Strong experience of emotion (61-80%); Very strong affect quickly cut off or strong affect sustained but a little held back.
41-60 = Moderate experience of emotion (41-60%); Some grief, some anger, some openness/tenderness/trust/care, etc. Some holding back.
21-40 = Low experience of emotion (21-40%); e.g., Beginning indications of grief, anger, openness/tenderness/trust/care/joy, etc.
01-20 = Little/no physiological experience of emotion in facial expression, verbal report, tone of voice, body movement; Flat, dull, bland presentation.

NEW LEARNING OF ADAPTIVE EXPRESSION OF THOUGHTS, FEELINGS, WANTS, OR NEEDS: IN FACE TO FACE INTERACTIONS:
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.
01-20 = 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 in to action.

DEGREE OF INHIBITION (ANXIETY, GUILT, SHAME, OR PAIN)
81-100 = Very much inhibition of adaptive thoughts or feelings. Expression entirely blocked, or uncontrolled. (Over 81% inhibition)
61-80 = Much inhibition of adaptive thoughts or feelings. Affect may be expressed but with difficulty. (61-80% inhibition)
41-60 = Moderate inhibition of adaptive thoughts or feelings. Moderate interference with or blocking, toning down of expression. (41-60% inhibition)
21-40 = Low inhibition of adaptive thoughts or feelings. Feeling diminished but not blocked or returned to after brief avoidance. (21-40% inhibition)
01-20 = Little or no maladaptive inhibition of feeling. Excellent containment and guidance of adaptive thoughts & feelings. (Under 20% inhibition)

IMPROVEMENT OF THE IMAGE OF THE SELF
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.
01-20 = 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
01-20 = Highly maladaptive sense of others; Little or no compassion, empathy or acceptance. Very much devaluation, idealization or splitting.
**AWARENESS or INSIGHT of PROBLEM THOUGHTS OR FEELINGS:**

**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 FOR STDP:**

1. Degree of clarity and fullness of VERBAL descriptions of maladaptive behavior (cognitive or defensive). in explicit examples.
2. Ability to state why and how maladaptive/defensive patterns began (the secondary gain, meanings, causes, and with whom.)

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

| 81-100 | Excellent recognition of maladaptive behavior (cognitive or defensive). | Clear, comprehensive descriptions of maladaptive behavior (cognitive or defensive). Can describe clearly and fully how pattern is transferred from past to present. (learning history/TCP). Also, excellent descriptions of why maladaptive responses occur, including meanings & secondary gain. Excellent and full awareness/insight. |
| 61-80 | Good recognition of maladaptive behavior. | Some reference to origins in past. Good awareness/insight |
| 41-60 | Moderately clear recognition. | ON OWN describes occurrence of maladaptive patterns. No references to past. Moderate awareness/insight. |
| 01-20 | No awareness of maladaptive behavior (cognitive or defensive) – even unsure when pointed out. May mention anxieties or feelings. No awareness/insight or resists awareness/insight. |

**BRIEF OVERVIEW FOR AWARENESS OR INSIGHT**

**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 reference to origins in past. Good awareness/insight

**41-60** = Moderately clear recognition. ON OWN describes occurrence of maladaptive patterns. No references to past. Moderate awareness/insight.

**21-40** = Minimal recognition. Can see problem pattern ONLY when pointed out by therapist. Little/no elaboration. Minimal awareness/insight.

**01-20** = No awareness of maladaptive behavior (cognitive or defensive) – even unsure when pointed out. May mention anxieties or feelings. No awareness/insight or resists awareness/insight.

**91-100**

**Excellent recognition of maladaptive behavior (cognitive or defensive):**

Clear, comprehensive descriptions of maladaptive behavior (cognitive or defensive). Can describe clearly and fully how pattern is transferred from past to present. (learning history/TCP). Also, excellent descriptions of why maladaptive responses occur, including meanings & secondary gain. Excellent and full awareness/insight.

**81-90**

**Very good, recognition of maladaptive behavior:**

Clear, somewhat detailed descriptions of patterns. Very good understanding of origins of maladaptive responses, secondary gain functions or meanings – but not all aspects mentioned. Very good awareness/insight.

**71-80**

**Good recognition of maladaptive behavior:**

Good but not detailed descriptions of maladaptive cognitive or defensive patterns. Some recognition of origins in past-present links. Good understanding of why maladaptive responses occur or secondary gain. Good awareness/insight.

**61-70**

**High-moderate recognition of maladaptive behavior:**

Fairly good, general descriptions of maladaptive behavior patterns (cognitive or defensive). Minimal understanding of past-present links. Beginning understanding of why maladaptive behaviors occur or secondary gain. Fairly good awareness/insight.

**51-60**

**Moderate recognition of maladaptive behavior:**

Partial descriptions of maladaptive behavior patterns (cognitive or defensive). No link between past and present. No mention why maladaptive behaviors occur or secondary gain. Moderate awareness/insight.

**41-50**

**Low-moderate recognition of maladaptive behavior:**

ON OWN begins to describe maladaptive patterns (cognitive or defensive) but gives only a vague or general description (not a clear examples of how this occurs). No past-present links. No mention of why maladaptive behaviors occur or understanding of secondary gain. Some awareness/insight.

**31-40**

**Low recognition of maladaptive behavior:**

Can acknowledge maladaptive patterns (cognitive or defensive) ONLY when pointed out, but READILY agrees when therapist points it out – with only a little elaboration. Lower level: Agrees without reluctance but does not elaborate further on own. Beginning awareness/insight.

**21-30**

**Minimal recognition of maladaptive behavior:**

Can acknowledge maladaptive cognitive or defensive 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:**

Does not recognize maladaptive cognitive or defensive responses on own and does not agree or questions/doubts when therapist points it out, but mentions anxieties or warded-off feelings. Seems to lack interest in identifying maladaptive behavior (cognitive or defensive). No awareness/insight.

**1-10**

**No awareness of maladaptive behavior, anxieties or feelings:**

Does not see maladaptive behavior patterns on own nor when therapist points it out. Upper level: No apparent interest in recognizing maladaptive behavior (cognitive or defensive). Lower level: Disagrees or becomes angry/belligerent when maladaptive behavior (cognitive or defensive) are pointed out. No awareness/insight or resists awareness/insight.
MOTIVATION TO GIVE UP MALADAPTIVE BEHAVIOR (COGNITIVE OR DEFENSIVE) 10/25/02

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 FOR STDP:
1. Degree of motivation to give up maladaptive behavior (cognitive or defensive). RATE the MODE over the 10 minute segment.
2. Degree of dislike, undesirability or sorrow specifically about the costs of defenses or maladaptive behavior. Not sorrow about losses of loved ones. (Base ratings on nonverbal or affective display of motivation; e.g. sorrow/grief expressed about having the maladaptive behavior patterns.)

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

BRIEF OVERVIEW FOR MOTIVATION TO GIVE UP MALADAPTIVE BEHAVIOR (COGNITIVE OR DEFENSIVE)

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>91-100</td>
<td>Full and unconditional motivation to give up maladaptive behavior. Expresses extreme discomfort or grief and/or great wish to change, said with great emotional intensity in voice or non-verbal behavior. Great desire to express self in adaptive ways. (cognitively or emotionally). Fully open to change. Almost no resistance or defensiveness.</td>
</tr>
<tr>
<td>81-90</td>
<td>Very strong motivation to give up maladaptive behavior. Expresses very strong discomfort, very deep grief over losses and/or very strong wish to change with much intensity in voice or non-verbal behavior. Very strong wish to express self adaptively. Very strong openness to change and very little resistance, if any.</td>
</tr>
<tr>
<td>71-80</td>
<td>Strong motivation to give up maladaptive behavior. Expresses strong discomfort, strong sorrow about defenses/maladaptive behavior and/or strong wish to change, with strong intensity in voice or non-verbal behavior. Strong openness to change. Little resistance to change/defensiveness.</td>
</tr>
<tr>
<td>61-70</td>
<td>High moderate motivation to give up maladaptive behavior. Expresses much discomfort and/or much wish to change, said with emotional intensity in voice or non-verbal behavior. Much openness to change. Some sorrow specifically about the costs or losses due to defenses or maladaptive behavior.</td>
</tr>
<tr>
<td>51-60</td>
<td>Moderate motivation to give up maladaptive behavior. Expresses moderate discomfort or moderate wish to change. May express worry whether this is possible or if there will be negative consequences. Moderate resistance or defensiveness and moderate openness to change. Sorrow about costs of defenses/maladaptive behaviors may or may not be present.</td>
</tr>
<tr>
<td>41-50</td>
<td>Low-moderate motivation to give up maladaptive behavior. Expresses some discomfort and some wish to give up maladaptive behavior. No sorrow about costs of defenses. More than moderate resistance and some openness to change.</td>
</tr>
<tr>
<td>31-40</td>
<td>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 and little openness to change.</td>
</tr>
<tr>
<td>21-30</td>
<td>Very low or ambivalent motivation to give up maladaptive behavior. Acknowledges maladaptive behavior (cognitive or defensive) compliantly or passively, but also describes benefits of maladaptive behavior (secondary gains). Very much resistance, defensiveness or ambivalence and very little openness to change.</td>
</tr>
<tr>
<td>11-20</td>
<td>Unclear or barely evident motivation to give up maladaptive behavior. Dislikes symptoms and agrees that maladaptive behavior is problematic, but expresses no desire to change. Either fears expression of adaptive feeling or feels too hopeless to try. Very much resistance and almost no openness to change.</td>
</tr>
<tr>
<td>1-10</td>
<td>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.</td>
</tr>
</tbody>
</table>
DEGREE OF EXPOSURE (DESENSITIZATION) TO ADAPTIVE EMOTIONS 10/25/02

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 FOR STDP:
1. Intensity of arousal of ADAPTIVE AFFECT (rate PEAK degree of arousal) in 10-min. segment. Base rating on intensity of intrapersonal feeling as shown in vocal tone, facial expression, non-verbal behavior/movement or charged verbal statements.
2. Duration of the affective response. (a few seconds to many minutes)
3. Relief in the experience of the feeling (Just put backin on 10/25/02, Leigh thinks this is crucial)

NOTE: Higher scores when affects are well-integrated and balanced by other affects. Lower scores for black and white responses.

NOT a measure of INAPPROPRIATE or regressive responses. If affect is intellectually described, but physiological arousal is low or not evident, rate below 20.

BRIEF OVERVIEW OF RATING PEAK EMOTIONAL AROUSAL: (IN-SESSION EXPOSURE & DESENSITIZATION OF PHOBIC AFFECTS)

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81-100</td>
<td><strong>Excellent experience</strong> of emotion, well-integrated (Over 81%); Full grief, full openness/tenderness/trust, full justifiable outrage, full joy, etc.</td>
</tr>
<tr>
<td>41-60</td>
<td><strong>Moderate experience</strong> of emotion (41-60%); Very strong affect quickly cut off OR strong affect sustained but a little held back</td>
</tr>
<tr>
<td>21-40</td>
<td><strong>Low experience of emotion</strong> (21-40%); e.g., Beginning indications of grief, anger, openness/tenderness/trust/care/joy, etc.</td>
</tr>
<tr>
<td>01-20</td>
<td><strong>Little/no physiological experience</strong> of emotion in facial expression, verbal report, tone of voice, body movement; Flat, dull, bland presentation</td>
</tr>
</tbody>
</table>

91-100 Full and Complete Affective Arousal. Full and vivid feeling images sustained over several minutes (ebbing & flowing); e.g. full sobbing, with other affects, e.g. murderous but justifiable outrage, openness/care/tenderness/trust deeply felt as shown in face, vocal tone or body. Excellent ability to modulate or control emotion. Affect well-integrated with other affects that balance and enrich the experience. Full relief and resolution.

81-90 Very Strong Affective Arousal. Very strong feeling well sustained (ebbing & 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 entitlement to feeling. Very strong but not full relief.

71-80 Strong affective arousal. Strong feeling either sustained (ebbing & 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 & 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, e.g. rage without much compassion, tenderness without limit-setting. 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. Some 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. Mild 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. A little relief.

21-30 Slight 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 only slightest 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 10/25/02

STDP: Affect Expression: Ability to adaptively express thoughts, feelings, wishes, needs.

CBT: Ability to adaptively express thoughts, wishes, needs.


Main Components:
1. Appropriate, adaptive interpersonal, FACE-TO-FACE behaviors or expression (spirited but well-controlled and well-integrated) of thoughts & feelings
2. Relief/satisfaction versus discomfort in action or expression.

Also Note: FACE-TO-FACE means in-person, REAL-LIFE INTERACTIONS OUTSIDE OF THERAPY OR directly expressed in the real relationship with the therapist (e.g., how spontaneous/authentic is the patient able to be with others?). NOT a measure of regressive or immature responses. VALID EXCEPTIONS TO FACE-TO-FACE expression: Reports of adaptive crying when alone (if not to avoid doing so with others), adaptive masturbatory behavior, adaptive self care or self-talk when alone.

BRIEF OVERVIEW FOR RATING NEW LEARNING OF ADAPTIVE SKILLS OR EXPRESSION:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-20</td>
<td>No expression of adaptive thoughts or feelings; sense of incompleteness, balance and excellent results. Great relief and satisfaction.</td>
</tr>
<tr>
<td>21-40</td>
<td>Moderate expression of thoughts or feelings; Slight holding back but good sense of relief in speaking up. Good satisfaction.</td>
</tr>
<tr>
<td>41-60</td>
<td>Good expression of thoughts/feelings; Slight holding back. Not all expressed, but good sense of relief in speaking up. Good satisfaction.</td>
</tr>
<tr>
<td>61-80</td>
<td>Excellent expression of thoughts/feelings; sense of completeness, balance and excellent results. Great relief and satisfaction.</td>
</tr>
<tr>
<td>81-100</td>
<td>Excellent expression of thoughts/feelings; sense of completeness, balance and excellent results. Great relief and satisfaction.</td>
</tr>
</tbody>
</table>

91-100  Excellent, full, free & un ashamed 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 & very poorly modulated. 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.
DEGREE OF INHIBITION

STDP: Anxiety Regulation. The regulation of inhibitory affects (anxiety, guilt, shame & pain)
CBT: Degree of Anxiety in the segment. Anxiety reduction is a primary focus
DBT: Degree of Anxiety/inhibition. Building appropriate inhibition of behavior (A positive sign in DBT)

MAIN COMPONENTS FOR STDP:
1. Degree of inhibition (MODE) in the 10-minute segment. The intensity of anxiety, guilt, shame, pain in vocal tone, verbal statements or non-verbal behavior which shut down, hold back, thwart, stifle or decrease adaptive responses. Raters should pay attention to physiological signs of discomfort (e.g., tenseness, squirming, restlessness, twitching, blushing, sighing, low or trembling voice).
2. Duration of the inhibitory feelings (a few seconds to many minutes)
   However, remember that appropriate shame or remorse is considered adaptive when it promotes resolution, growth or change. Note: Acting out, regressive or defensive feeling is a sign of inhibition and should be rated on this scale.

BRIEF OVERVIEW FOR RATING DEGREE OF INHIBITION (ANXIETY, GUILT, SHAME, OR PAIN)

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>91-100</td>
<td><strong>Very much inhibition</strong> of adaptive thoughts or feelings. Expression entirely blocked, or uncontrolled. (Over 90% inhibition)</td>
</tr>
<tr>
<td>61-80</td>
<td><strong>Moderate inhibition</strong> of adaptive thoughts or feelings. Moderate interference with or blocking, toning down of expression. (41-60% inhibition)</td>
</tr>
<tr>
<td>21-40</td>
<td><strong>Low inhibition</strong> of adaptive thoughts or feelings. Feeling diminished but not blocked or returned to after brief avoidance. (21-40% inhibition)</td>
</tr>
<tr>
<td>01-20</td>
<td>Little or no maladaptive inhibition of feeling. Excellent containment and guidance of adaptive thoughts &amp; feelings. (Under 20% inhibition)</td>
</tr>
</tbody>
</table>

91-100 Full and Complete Inhibition. Flooded with inhibitory affect. Bodily movement is extremely tight, withdrawn, tense. Very great discomfort. (Over 90% inhibition.) Adaptive affect is completely blocked.
81-90 Very Strong Inhibition. Very strong inhibitory affects. Very low, hesitant or trembling tone of voice. Very restrained, withdrawn non-verbal behavior. Adaptive affect is almost completely blocked or if accessed at all, it is done only briefly or with great difficulty. Great discomfort. (81-90% inhibition)
71-80 Strong Inhibition. Strong inhibitory affects. Much shakiness, hesitation, sighing or guardedness in tone of voice or non-verbal behavior. Restrained, withdrawn non-verbal behavior. Adaptive affect is very much blocked or patient must struggle to access bodily feeling. Strong affect may be accessed but with much difficulty. Very much discomfort. (About 71-80% inhibition).
61-70 Much Inhibition. Much inhibitory affect. Much shakiness, hesitation, sighing or guardedness in tone of voice. Some restraint or withdrawal in non-verbal behavior. Adaptive affect is very blocked or accessed with difficulty. Much discomfort. (About 61-70% inhibition)
51-60 Moderate Inhibition. Moderate inhibitory affects with moderate weakness in vocal tone; bodily movement vs restraint (moderate shakiness/hesitance/sighing, guardedness, slowness). Inhibition moderately interferes with feeling or moderately blocks or tones down experience in session. Moderate discomfort. (About 51-60% inhibition)
41-50 Low-moderate inhibition. Some inhibitory thoughts or feelings that only slightly blocks experience. More fullness than shakiness/hesitance/sighing or guardedness in vocal tone or behavior. Moderate discomfort. (About 41-50% inhibition)
31-40 Low inhibition. Low inhibition that interferes with feeling or tones down fullness of feeling – but does not block experience. Only slight shakiness/hesitation/sighingguardedness in voice or restraint in bodily movement. Low discomfort. (About 31-40% inhibition.)
21-30 Minimal inhibition. Minimal or fleeting inhibition, but patient is able to return to feeling on own or with minimal assistance. Tone of voice or non-verbal behavior suggests minimal discomfort. (About 21-30% inhibition.)
11-20 Little or no inhibition. Inhibitory thoughts or feelings tone down adaptive affect only slightly, and provide fair to good modulation and maintenance of flow of feeling. Vocal tone and behavior strong/only slightly toned down. Slight discomfort. (About 11-20% inhibition.)
1-10 No inhibition but excellent modulation and guidance of feeling. Inhibitory thoughts or feelings, if present, only help, guide, direct and protect but do not thwart expression at all. Fullness, robustness and easy flow of feeling in behavior and vocal tone. (Less than 10% inhibition.)
IMPROVEMENT IN SELF IMAGE 10/25/02

STDP: Restructuring of the Sense of Self
CBT: Improvement in self-image is often a focus but not a main thrust?
DBT: Degree of self-validation vs self-invalidation.

MAIN COMPONENTS FOR STDP: The degree to which the patient's report of self image is adaptive, in terms of:
1. Degree of adaptive pride in positive qualities. The patient's report of his/her self-image as worthwhile, competent, valuable, etc.
2. Degree of acknowledgement and acceptance of own limitations or realistic negative qualities of the self

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

BRIEF OVERVIEW FOR RATING IMPROVEMENT OF THE IMAGE OF THE SELF

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 & 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 & 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.

51-60 = Mixed adaptive/maladaptive view of self: Slightly more adaptive than maladaptive view of self. Slightly more pride than shame in self. Compassion & 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 & very little pride/or much grandiosity. Devaluation of self and wants and needs. Very little ability to acknowledge & 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 & accept limitations or control impulses. Almost no compassion or self-acceptance, but extremely destructive self-blame or shame.
IMPROVEMENT IN IMAGE OF OTHERS  Draft 10/25/02

STDP: Restructuring Sense of Others
CBT: Improvement in relationships is often a focus but not a main thrust
DBT: Improvement in relationships. Dialectical thinking about others. Adaptive dependence on others.

MAIN COMPONENTS FOR STDP: The degree to which the patient's report of images of other people is adaptive, 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.
But anger at abusive or destructive behavior of others is considered adaptive when it promotes constructive solutions).

<table>
<thead>
<tr>
<th>MAIN COMPONENTS FOR STDP:</th>
<th>BRIEF OVERVIEW FOR RATING IMPROVEMENT IN IMAGE OF OTHERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>91-100 Highly adaptive sense of others:</td>
<td>High compassion/acceptance/trust but realistic about others' weaknesses, admiring of others' strengths, and affirming of others needs and wants. No idealization/devaluation or naivete. Great ability to tolerate and work with conflict or set limits. Excellent ability to integrate positive &amp; negative qualities of others.</td>
</tr>
<tr>
<td>81-90 Very adaptive sense of others:</td>
<td>Very much compassion/acceptance/trust, but occasionally a little devaluation or idealization. Almost no tendency toward naive/compliant or suspicious/projecting. Very good ability to tolerate and work with conflict or set limits with others. Very good ability to integrate positive &amp; negative qualities of others.</td>
</tr>
<tr>
<td>71-80 Moderately adaptive sense of others:</td>
<td>Much compassion/acceptance/trust of others, but occasionally a little devaluation or idealization. Minimally 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 &amp; negative qualities of others.</td>
</tr>
<tr>
<td>61-70 Minimally adaptive view of others:</td>
<td>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 &amp; negative qualities of others.</td>
</tr>
<tr>
<td>51-60 Mixed adaptive/maladaptive view of others:</td>
<td>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.</td>
</tr>
<tr>
<td>41-50 Mixed maladaptive/adaptive view of others:</td>
<td>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 &amp; negative qualities of others.</td>
</tr>
<tr>
<td>31-40 Somewhat maladaptive view of others:</td>
<td>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 &amp; negative qualities of others.</td>
</tr>
<tr>
<td>21-30 Very maladaptive sense of others:</td>
<td>Much devaluation/idealization and little compassion/acceptance/trust. 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 &amp; negative qualities of others.</td>
</tr>
<tr>
<td>11-20 Mostly maladaptive sense of others:</td>
<td>Very much devaluation or idealization, &amp; 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.</td>
</tr>
<tr>
<td>1-10 Extremely maladaptive sense of others:</td>
<td>Extremely negative &amp; devaluing, or over-idealized. Almost no compassion, acceptance or trust. Others split almost totally into all good/all bad. Extreme naivete, projection, paranoia/distrust. Little or no ability to tolerate and work with conflict or set limits – nor to integrate positive and negative qualities.</td>
</tr>
</tbody>
</table>