Assessment of Change in Dynamic Psychotherapy

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Five scales have been developed to assess changes that are consistent with the therapeutic rationales and procedures of dynamic psychotherapy. Seven raters evaluated 50 patients before and 36 patients again after brief dynamic psychotherapy. A factor analysis indicated that the scales represent a dimension that is discriminable from general symptoms. A summary measure, Dynamic Capacity, was rated with acceptable reliability by a single rater. However, average scores of three raters were needed for good reliability of change ratings. The scales seem to be sufficiently fine-grained to capture statistically and clinically significant changes during brief dynamic psychotherapy.

Some researchers have claimed that symptom measures or measures of global change after psychotherapy account for almost all of the variance found in specific outcome measures. Others emphasize the need for mode-specific outcome scales measuring factors such as quality of interpersonal relationships, insight, or self-esteem. It is a common clinical observation that some patients may achieve symptom relief by life restrictions, with little or no improvement in areas such as interpersonal functioning, insight, or tolerance for affects. Conversely, patients may sometimes tolerate increased levels of symptoms as their aspirations increase and new problem-solving strategies are tried out. Instruments for measuring symptoms or global functioning may therefore offer limited information about the complex composition of changes that potentially can occur.

Theory-related, or so called mode-specific, instru-
ments for measuring dynamic changes, developed by pioneers such as Karush et al., May and Dixon, Kernberg et al., Bellak et al., and Semrad et al., have been criticized for being too abstract, cumbersome, or unreliable or too highly correlated with symptom measures.

Idiographic (individualized) methods developed by Malan, Luborsky, Horowitz, and Perry provide important clinical information with regard to limited areas of psychological functioning. However, individualized measures have weak psychometric properties for group designs. Methods for post-treatment change ratings have been developed by Sifneos and Sandell. Change estimates from ratings made after therapy tend to be too highly correlated with post-treatment status, and such ratings may also be difficult to compare across cases.

Later developments of batteries of dynamic scales such as the Patterns of Individual Change Scales (PICS), Scales of Psychological Capacities (SPC), and Karolinska Psychodynamic Profile (KAPP) have scales with poor to excellent reliability, and some aspects of their validity have been tested. These batteries are quite comprehensive and have many scales. The scales have only three to seven descriptive levels, which may impair their sensitivity for changes. The PICS scales, which have seven descriptive levels, could not capture statistically significant changes during brief psychotherapy with ordinary neurotic patients.

On the basis of 20 years of clinical and research experience with brief dynamic psychotherapy, we have developed a new set of dynamic scales. We have been influenced by the work of several of the above-mentioned research groups. Thus, resemblances are intentional.

Like most other batteries of dynamic scales, our scales do not measure personality traits or typologies. They describe internal predispositions, psychological resources, capacities, or aptitudes that can be mobilized by the individual in order to achieve adaptive functioning and life satisfaction. Unlike most other batteries, our rating scales cover the entire range of functioning, from superior to extremely poor. Our intention has been to make the scales “fine-grained” enough to capture reliable changes during brief dynamic psychotherapy.

The scale format has been modeled after the Global Assessment Scale (GAS), with ten descriptive levels and scale points ranging from 1 to 100. The use of a well-known scale format should make the scales easier to learn. The descriptive levels are linked as closely as possible to the way mainstream psychodynamically oriented clinicians interpret and work with clinically observable phenomena.

Value judgments, especially with regard to higher levels of functioning, are unavoidable with scales of this type. The decision to select five dimensions is based on clinical experience and literature. Psychoanalytic theories give limited assistance in the task of choosing dimensions. Our ambition has been to construct as few scales as possible and still maintain a reasonable comprehensiveness. Several related psychological resources have therefore been incorporated within the same scale.

The content validity and Guttman scale structure have been tested with Q-sort methodology performed by a large number of psychotherapists from Norway, Finland, and Germany. A few global scales with many descriptive anchor points are easy to use, and such scales have been demonstrated to be among the most powerful in detecting change. Several studies have indicated that global scales rated by experts may be equal and sometimes superior to test batteries with many subscales. However, reliability and predictive validity depend on the issue under study.

Current functioning within the last 3 to 4 months should be rated on the basis of a semistructured dynamic interview that includes interpersonal functioning, tolerance for affects, insight, and the capacity to handle both the ordinary vicissitudes of life and more challenging psychosocial stressors (problem-solving capacity). The five scales are described in Appendix A.

The present study tests the interrater reliability of the five scales, the reliability of change ratings, the discriminability from global functioning (Global Assessment of Functioning [GAF]) and subjective distress (Global Severity Index [GSI] from the Symptom Checklist-90), and the scales’ sensitivity for change during brief dynamic psychotherapy.

METHODS

Patients

The patients are the first 50 cases included in a large-scale experimental study of patient–therapist interaction (transference) in brief dynamic psychotherapy. There were 24 men and 26 women. Their ages ranged from 26 to 58 (median 35) years. Twenty-six
Change in Dynamic Psychotherapy

were married, 17 never married, and 7 divorced. The
majority were professional, middle-class individuals
with an average formal education of about 15 years.
DSM-IV Axis I diagnoses27 were mostly adjustment dis-
orders, anxiety and affective disorders, and problems
not due to a mental disorder. Twenty-four patients (48%)
had one or more Axis II disorders—primarily depend-
ent, avoidant, obsessive-compulsive, or depressive
personality disorder. The patient sample had, on the
average, mild to moderate symptoms and dysfunctions.
The mean GAF score at the initial dynamic evaluation
was 60 (SD = 7.4, range 44–79). The mean GSI score
was 1.02 (SD = 0.61, range 0.04–3.13). The distribution
of mean pre-treatment scores indicated that the sample
of 50 patients was a group of mildly to moderately dis-
turbed individuals representative of typical outpatients
offered psychotherapy. The range of the pre-treatment
scores of the five dynamic scales covered the area of
functioning from relatively severe and chronic distur-
bances to mild and intermittent problems of living
(range 41–81). Informed consent was obtained for all
subjects in this study.

Therapists

The therapists were 6 psychiatrists and 1 clinical
psychologist. They all had long experience in practicing
dynamic psychotherapy (range 10–25 years). Each
therapist worked in a different institution. They had
received formal education in psychoanalytic psycho-
therapy from four different training institutes. All of the
therapists were also clinical evaluators. Because the
group of raters had such long experience, no pilot train-
ing using the dynamic scales was offered, only didactic
lessons.

Evaluation

After history-taking and assessment of background
variables, each patient was interviewed by one clinician
in the presence of two or three other clinicians. When
necessary, several of the clinicians posed additional
questions after the interview to ensure adequate cover-
age of the patient’s level of functioning in all areas. The
group interviews lasted 60 to 100 minutes and included
some trial interpretations. Ratings on the five dynamic
scales and GAF were done independently by each cli-
nician, before any discussion of the case. Half of the
assessments were done by clinicians who had not been
present at the dynamic interview. Their assessments
were based on the audiotapes from the interviews. The
patients filled out the SCL-90-R along with many other
self-reports. At present, 36 patients have been reevalu-
ated one year after the start of therapy. Most of them
were in treatment for about one year and had recently
ended therapy. The therapies were manualized (P. Høg-
lend, unpublished manuscript). Adherence checks were
done on several occasions for each case (sessions 7 and
16 plus randomly drawn sessions) in order to secure
treatment integrity; details have been published else-
where.29 The patient and therapist could agree jointly
to end therapy before one year if sufficient progress was
achieved. The number of treatment sessions ranged
from 28 to 40 (median = 36).

Data Analysis

The seven raters assessed 50 patients before ther-
apy and 36 of the same patients after therapy. Three of
the raters have assessed all of the interviews, and four
others have assessed varying numbers of interviews.
This design allows several versions of intraclass reli-
ability estimates to be calculated.30 Intraclass correla-
tion coefficients (ICC) are derived from analysis of
variance components. Because our design is unbal-
anced (i.e., all raters did not assess all subjects), we used
restricted maximum likelihood approaches. And be-
cause we did not assume lack of rater bias, we chose a
two-way analysis of variance, random model (random
effect of rater, random effect of subject). Average pre-
treatment scores on each scale were compared with av-
erage post-treatment scores, by use of paired t-tests, on
the subsample of 36 patients evaluated before and after
therapy. Rating of change is generally more unreliable
than status ratings.30 Therefore, repeated-measures
analysis of variance with time (pre- and post-treatment)
and raters (the three raters with full data sets) as factors
were performed on the same subsample in order to an-
alyze in greater detail the differences between raters in
assessing change. The interrater reliability of raw
change and residual gain scores is also reported for a
summary measure of the dynamic scales.

After the intercorrelation matrix of average scores
on all pre-treatment variables had been examined, a
factor analysis of the variables, with maximum likeli-
hood extraction, was computed.31
RESULTS

Out of the whole group of seven clinicians, the interrater reliability estimates for single raters—who rated a variable number of the 50 patients at pre-treatment and of the 36 patients at post-treatment—are shown in Table 1.

The lower bounds of the confidence intervals were unsatisfactory (<0.50) for three of the single scales at pre-treatment: tolerance for affects, insight, and problem-solving capacity. In scientific studies, such results of reliability estimates for single scales are unsatisfactory. Ideally, the lower bounds of the confidence intervals should be >0.70. With average scores of the three raters who rated all subjects, the intraclass reliability estimates (average measure ICC, two-way, mixed model [fixed effect of rater, random effect of subject]), we achieved ideal results for all single scales, at pre-treatment as well as post-treatment.

Table 2 presents mean scores on all measures at pre-treatment and post-treatment for the 36 patients evaluated on both occasions.

The largest amount of change during individual psychotherapy, and the highest ratios of patients with reliable changes according to the Reliable Change Index criteria by Jacobson and Truax, tended to be in the areas of insight and tolerance for affects.

Repeated-measures analysis of variance, with the dynamic scales as dependent variables and time and raters as factors, showed five significant main effects for Time and one significant main effect for Raters, as shown in Table 3.

These findings indicated that there were no significant differences among the raters in their assessment of pre- to post-treatment changes on the dynamic scales, except for insight. On this scale one rater (K.P.B.) tended to rate patients higher than one of the other raters (O.S.) both before and after treatment. Three significant interaction effects (Time × Raters) were found, with tolerance for affects, insight, and problem-solving capacity as the dependent variables. With regard to insight, one rater (P.H.) tended to rate the patients lower at pre-treatment, but not post-treatment, compared with one other rater (K.P.B.). The pattern was similar for the two other scales.

For four of the dynamic scales, 21% to 43% percent of the variance of average scores ($R^2$) was shared variance with GAF. There was, however, a very high overlap between problem-solving capacity and GAF. The two variables shared 64% of the variance. Given the reliabilities of the two variables (>0.80), our findings may indicate that they measure nondiscriminable constructs. The two variables shared more than 71% of the reliable variance in this study. All other scales shared less than 48% of the reliable variance with GAF (and GSI). A factor analysis was computed to evaluate whether or not the dynamic scales can be differentiated from global functioning and subjective distress. The number of factors was determined by the eigenvalues-greater-than-unity rule. Table 4 shows the results of the factor analysis.

The results were easy to interpret. However, because of the small sample size these results may be unstable and should be considered preliminary. Problem-solving capacity loads on both factors, but it is higher on the dynamic factor. The five dynamic scales constitute a dimension that is probably discriminable from a general symptoms-and-dysfunction dimension. We have decided to name this dimension Dynamic Capacity. Cronbach’s alpha was 0.89. A simple weighted sum-score of the five scales represents this dimension well. Dynamic Capacity shared 42% of overall variance and 47% of the reliable variance with GAF in this study. The reliability estimates for single raters on Dynamic Capacity were 0.71 and 0.80 at pre- and post-treatment, respectively. The lower bounds of the confidence intervals of the reliability estimates for Dynamic Capacity were 0.60 (pre-treatment sample) and

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TABLE 1. Interrater reliability estimates (intraclass correlations; ICC), with 95% confidence intervals (CI), for single raters randomly drawn from a group of seven raters

<table>
<thead>
<tr>
<th>Scale</th>
<th>ICC</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-treatment evaluation (n = 50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friendships and family</td>
<td>0.65</td>
<td>0.53–0.77</td>
</tr>
<tr>
<td>Romantic/sexual</td>
<td>0.74</td>
<td>0.64–0.84</td>
</tr>
<tr>
<td>Tolerance for affects</td>
<td>0.59</td>
<td>0.46–0.72</td>
</tr>
<tr>
<td>Insight</td>
<td>0.49</td>
<td>0.35–0.63</td>
</tr>
<tr>
<td>Problem-solving capacity</td>
<td>0.57</td>
<td>0.43–0.70</td>
</tr>
<tr>
<td>GAF</td>
<td>0.69</td>
<td>0.58–0.80</td>
</tr>
<tr>
<td>Post-treatment evaluation (n = 36)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friendships and family</td>
<td>0.69</td>
<td>0.56–0.81</td>
</tr>
<tr>
<td>Romantic/sexual</td>
<td>0.77</td>
<td>0.67–0.87</td>
</tr>
<tr>
<td>Tolerance for affects</td>
<td>0.69</td>
<td>0.57–0.81</td>
</tr>
<tr>
<td>Insight</td>
<td>0.69</td>
<td>0.57–0.81</td>
</tr>
<tr>
<td>Problem-solving capacity</td>
<td>0.75</td>
<td>0.62–0.85</td>
</tr>
<tr>
<td>GAF</td>
<td>0.78</td>
<td>0.69–0.87</td>
</tr>
</tbody>
</table>

*Note:* GAF = Global Assessment of Functioning.
0.72 (post-treatment sample). This was comparable to the lower-bound estimates obtained for GAF, 0.58 and 0.69 (see Table 1). Average scores of two raters are needed to secure lower-bound reliability estimates above 0.70. Average scores of three raters are needed to secure lower-bound reliability estimates above 0.80. Repeated-measures analysis of variance with Dynamic Capacity as the dependent variable and time and single raters as factors showed a significant main effect for time \( (F=77.48, \text{df}=1,35, P<0.000) \), no significant main effect for raters \( (F=0.90, \text{df}=2,34, P<0.90, \text{not significant}) \), but a significant interaction effect \( (F=11.10, \text{df}=2,34, P<0.000) \). Average scores of three raters are needed in order to secure adequate reliability of raw change scores \( ( ICC = 0.75, \text{lower bound of the confidence interval 0.56}) \) and residual gain scores \( ( ICC = 0.81, \text{lower bound of the confidence interval 0.67}) \).

**DISCUSSION**

The dynamic scales seem to measure a construct that may prove discriminable from general symptoms and dysfunction. This is consistent with findings reported by Weiss et al., Sundin and Armelius, and Perry et al. The reliability estimates for Dynamic Capacity were equal to those for the well-established GAF scale. In a different psychotherapy study, three pairs of raters, after pilot training on three cases, have so far rated 10 patients at pre-treatment. Their interrater reliability was comparable to the results from this study. The single-rater reliability estimate for Dynamic Capacity was 0.79 (A. G. Hersoug, personal communication, 1997).

The reliability estimates for individual scales reported in this study tend to be similar to or higher than reliability estimates for individual scales from other studies using new batteries of dynamic scales. The cited studies report that a number of individual scales had reliability coefficients below 0.50. We believe that our favorable results for individual scales are at least partly due to our scale format, which includes more descriptive levels and considerably more rating options than other dynamic scales. It is also possible that the comprehensive evaluation interviews secured more complete data for reliable assessments. Our scales

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean ± SD</th>
<th>Reliable Change Index* (% of all cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-treatment</td>
<td>Post-treatment</td>
<td></td>
</tr>
<tr>
<td>Friendships and family</td>
<td>65.7 ± 7.4</td>
<td>71.6 ± 8.3</td>
</tr>
<tr>
<td>Romantic/sexual</td>
<td>59.9 ± 9.9</td>
<td>65.9 ± 9.7</td>
</tr>
<tr>
<td>Tolerance for affects</td>
<td>58.0 ± 6.2</td>
<td>66.6 ± 8.0</td>
</tr>
<tr>
<td>Insight</td>
<td>62.6 ± 6.2</td>
<td>71.5 ± 8.1</td>
</tr>
<tr>
<td>Problem-solving capacity</td>
<td>60.5 ± 6.2</td>
<td>68.3 ± 7.7</td>
</tr>
<tr>
<td>GAF</td>
<td>60.7 ± 7.0</td>
<td>68.4 ± 8.6</td>
</tr>
<tr>
<td>GSI</td>
<td>1.0 ± 0.6</td>
<td>0.66 ± 0.6</td>
</tr>
</tbody>
</table>

*Note: All changes were statistically significant at \( P<0.0005 \), paired \( \text{t}- \)tests (two-tailed). GAF = Global Assessment of Functioning; GSI = Global Severity Index.

*Proportion of cases with reliable change was significantly higher \( (\text{chi-square tests}) \) for tolerance for affect and insight compared with friendships and family, romantic/sexual, and subjective distress (GSI).

<table>
<thead>
<tr>
<th>Scale</th>
<th>Time</th>
<th>Rater</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( F )</td>
<td>( \text{df} )</td>
</tr>
<tr>
<td>Friendships and family</td>
<td>31.82</td>
<td>1,35</td>
</tr>
<tr>
<td>Romantic/sexual</td>
<td>28.96</td>
<td>1,35</td>
</tr>
<tr>
<td>Tolerance for affects</td>
<td>65.80</td>
<td>1,35</td>
</tr>
<tr>
<td>Insight</td>
<td>75.44</td>
<td>1,35</td>
</tr>
<tr>
<td>Problem-solving capacity</td>
<td>52.64</td>
<td>1,35</td>
</tr>
</tbody>
</table>

*Note: Three significant interaction effects \( \text{[Time by Rater]} \) were found: tolerance of affects \( (F=7.78, \text{df}=2,34, P<0.005) \); insight \( (F=14.46, \text{df}=2,34, P<0.005) \); and problem-solving capacity \( (F=3.53, \text{df}=2,34, P<0.05) \); NS = not significant.
TABLE 4. Factor analyses of dynamic scales and symptom scales (N=50)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendships and family</td>
<td>0.64</td>
<td>0.23</td>
</tr>
<tr>
<td>Romantic/sexual</td>
<td>0.77</td>
<td>0.14</td>
</tr>
<tr>
<td>Tolerance for affects</td>
<td>0.82</td>
<td>0.41</td>
</tr>
<tr>
<td>Insight</td>
<td>0.75</td>
<td>0.25</td>
</tr>
<tr>
<td>Problem-solving capacity</td>
<td>0.78</td>
<td>0.56</td>
</tr>
<tr>
<td>GAF</td>
<td>0.44</td>
<td>0.82</td>
</tr>
<tr>
<td>GSI</td>
<td>−0.13</td>
<td>−0.64</td>
</tr>
<tr>
<td>Eigenvalue</td>
<td>4.40</td>
<td>1.03</td>
</tr>
<tr>
<td>Percentage of variance explained</td>
<td>43.5</td>
<td>24.2</td>
</tr>
</tbody>
</table>

Note: Mean scores of all raters. Maximum likelihood extraction, varimax rotation. GAF = Global Assessment of Functioning; GSI = Global Severity Index.

Our findings are preliminary. The interrater reliability of five dynamic scales for assessment of changes beyond symptoms during and after psychotherapy was satisfactory. This is the first study that also analyzes in greater detail the reliability of change ratings with dynamic scales. The scales may prove to be discriminable from general symptom measures, and they are fine-grained enough to capture statistically significant changes during brief dynamic psychotherapy. A summary measure of the five scales can be rated with adequate reliability by a single evaluator, but average scores of three raters are needed for reliable change ratings such as those used in many treatment studies.

CONCLUSIONS

Our findings are preliminary. The interrater reliability of five dynamic scales for assessment of changes beyond symptoms during and after psychotherapy was satisfactory. This is the first study that also analyzes in greater detail the reliability of change ratings with dynamic scales. The scales may prove to be discriminable from general symptom measures, and they are fine-grained enough to capture statistically significant changes during brief dynamic psychotherapy. A summary measure of the five scales can be rated with adequate reliability by a single evaluator, but average scores of three raters are needed for reliable change ratings such as those used in many treatment studies.

REFERENCES


34. Sundin E, Armelius B-C: Mental health and psychic structure: an empirical study (DAPS report 67). Sweden, Umeå University, 1996
### APPENDIX A. Scales developed to assess change in dynamic psychotherapy

#### QUALITY OF FRIENDSHIPS/FAMILY RELATIONS

Quality of nonsexual interpersonal relationships involves appropriate mutuality such as ability to give to and take from others, adequate commitment, ability to trust and be trustworthy, emotional responsiveness, ability to take the other’s perspective, ability to vividly describe others across external and internal dimensions. Involves a feeling of being needed and a sense of belonging.

<table>
<thead>
<tr>
<th>Scale Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100–91</td>
<td>Superior quality of relations to close friends and all close family members. Relationships are secure, warm, open, with respect and concern. Several long-term relationships and also openness towards new friends. Subject admired for ability to be emotionally responsive and understand the perspective of others. Others are described clearly and vividly as unique individuals across a wide range of internal and external dimensions. Transient episodes of conflict or frustration justified by circumstances and easily resolved.</td>
</tr>
<tr>
<td>90–81</td>
<td>Warm, open, and reciprocally rewarding relationships with friends and family. Other people are generally seen as accepting, trustworthy, and responsive. Conflicts or frustrations justified by circumstance and easily resolved.</td>
</tr>
<tr>
<td>80–71</td>
<td>Good, stable, reciprocally rewarding relationships. Problems of short duration or limited to one significant person (sibling/parent/child/friend). Conflicts with others may be painful without compromising basic commitment and security.</td>
</tr>
<tr>
<td>70–61</td>
<td>Some relationships experienced as problematic by subject but may seem normal to others. Can describe significant others as separate beings in terms of functions and also their feelings, attitudes, and values. A tendency to be mildly self-sacrificing or exploitative, overinvolved or underinvolved, mildly suspicious or gullible, dependent or counterdependent in problematic situations. May be preoccupied with gaining acceptance from others.</td>
</tr>
<tr>
<td>60–51</td>
<td>Have one or more long-term friendships. A tendency to take controlling and/or submissive roles. Limited experience of warmth, openness, gratification, and trust. Avoids dramatic conflict or personal pain by keeping distance, or by passive or self-sacrificing behavior. Describes significant others such that it is difficult to visualize and recall the person being described.</td>
</tr>
<tr>
<td>50–41</td>
<td>Mostly short-term intermittent or distant friendships. Self-sacrificing or exploitative, markedly suspicious or gullible, very easily upset by demands, or emotionally detached. Severe difficulty understanding others. Describes others superficially, stereotypically, or inconsistently.</td>
</tr>
<tr>
<td>40–31</td>
<td>Minimal contact with family/friends. No mutual gratification; exploitation, emotional detachment, severe suspicion. Others described globally and concretely or from a highly egocentric perspective. May have long-term severely dependent relationship to parental figures.</td>
</tr>
<tr>
<td>30–21</td>
<td>Strong fear of contact. Very isolated. Some contact with family or social service if they are tolerant of subject.</td>
</tr>
<tr>
<td>20–11</td>
<td>Total social withdrawal. Extreme suspicion or delusional influence on others. Cannot live with family.</td>
</tr>
<tr>
<td>10–1</td>
<td>Disorganized mental functioning makes communication impossible.</td>
</tr>
</tbody>
</table>

#### ROMANTIC/SEXUAL RELATIONSHIPS

If no current romantic relationship due to death or divorce, the patient’s capacity to establish relationships as judged from earlier experiences should be evaluated. Quality of romantic relationships involves sexual interest, arousal, pleasure, initiative, and flexibility. A basic sense of security and emotional significance and trust. Mature dependency involves ability to become emotionally dependent upon partner, but also ability to come to terms with losses. To see the partner as a unique personality involves ability to describe the other across a wide range of internal and external dimensions and development over time.

<table>
<thead>
<tr>
<th>Scale Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100–91</td>
<td>Able to establish a long-term relationship characterized by deep mutual exchange of love, trust, and mature dependency. Willing to allow emotional vulnerability. Active sexual interest, initiative, and surrender to pleasure. The other's unique personality essential and described well by subject. A sense of development and deepening of the relationship over time. Problems and conflicts easily resolved. The quality of the relationship inspires subject in other life areas as well. May involve unusual ability for mutual support in times of crisis.</td>
</tr>
<tr>
<td>90–81</td>
<td>Able to establish long-term relationship characterized by love, trust, and reciprocal mature dependency and active, flexible sexual pleasure. Transient episodes of frustration and doubt justified by circumstances and easily overcome. Good ability for mutual support in times of crisis.</td>
</tr>
<tr>
<td>80–71</td>
<td>Basically stable, mutual relationship with sexual pleasure. Emotional responsiveness and reciprocal understanding in most areas. Circumscribed area of inhibition or conflict may exist. Outside stress can lead to periods of conflict, doubt, or minor dysfunctions.</td>
</tr>
<tr>
<td>70–61</td>
<td>Can establish romantic relationship with reasonable stability, trust, and mutual support and understanding, but ambivalence and fluctuations in the emotional climate exist. May fantasize about or even occasionally seek out another partner, or apprehensive that partner will prefer someone else. Sexual inhibitions/dysfunctions in times of stress. Generally not shaken in basic commitment to partner despite some limitations in quality of relationship.</td>
</tr>
</tbody>
</table>
Can establish long-term relationships, but characterized by less mutuality and gratification. Prone to devaluation or overinvolvement in relationship in times of moderate difficulty. Fears being trapped or rejected by partner. Inhibited sexual desire, function, or initiative. Partner described as separate being, but less may be conveyed of him/her as unique individual. Tendency to split romantic and sexual relationships. Patterns of submission, dominance/control.

Difficulty establishing long-term sexual relationships. Lack of commitment, trust, and reciprocity. Only occasional sexual interest or promiscuous behavior. Seeks out inappropriate partners. Tentative (short-term), nonreciprocal relationships.

Only brief encounters, accompanied by severe ambivalent feelings. Desire/gratification dependent on perversions or erotic props. Describes potential partners in terms of own frustration or gratification.

Cannot initiate sexual relationships. Fantasy rather than real relationships. Fear of engulfment. Experiences no interest in sex, or severe disturbances lead to avoidance of intercourse. Occasional sexual experiences with prostitutes.


Cannot express any coherent feelings, very severe acting out, manic excitement. Needs some outside assistance.


Can account for most important inner conflicts, related problems and repetitive behavior patterns, and personal attitudes. Connections to earlier experience may be partly forgotten. Aware of own vulnerability, stress reactions, and coping abilities. May blame self or others too much in interpersonal disputes, but reflects freely and observes own reactions and learns from them (integration). Generally curious and tolerant. Realistic expectations about the future.

TOLERANCE FOR AFFECTS

This dimension covers the ability to experience, differentiate, and express (verbally and nonverbally) various affects. Includes ability to establish temporal gap between feelings and execution of defenses or automatic behavior. Impulse control and frustration tolerance are part of this dimension. Variables such as alexithymia and inauthenticity are partially related to this dimension.

Unusual ability to experience the richness, differentiate accurately, and express in an adequate and varied way even the strongest affects, such as anger, sadness, contempt, fear, joy, excitement, shame, anguish, and sense of attachment. High tolerance for mixed feelings and ambiguity.

Even strong affects are well differentiated and flexibly expressed. Symptoms almost never develop (anxiety, depression). Some avoidance or restriction of affect occasionally occurs under heavy stress, but generally high access to emotionality.

Can experience strong affects with a reasonable ability to differentiate and express feelings. Transient symptoms or avoidance occurs, or some restriction of goals, or diminished concentration.

Severe disappointments may lead to mild symptoms, some avoidance, restricted experience, and less differentiation (frustration, worrying, uncertainty, indecisive rumination, blunted joy). Inadequate expressions (outbursts, hopelessness) and restriction of ambitions and goals occur.

Disappointments relatively often lead to restriction or denial of affects, outbursts or passive complaining, or symptoms (anxiety, depression, phobias, conversion), and less differentiation of feelings. Avoidance of expression and/or restriction of goals occurs.

Potential disappointments, setbacks, or changes often lead to avoidance, restriction of goals, and more severe and lasting symptoms. Relatively undifferentiated experience of feelings (aloof, devastated, lifeless, frantic, defective, numb) and maladaptive expression such as hopeless complaining, frequent inadequate outbursts, or acting out occur.

Disappointments lead regularly to despair, acting out, or severe symptoms. Lacks ability to differentiate affects.

Even minor or potential disappointments lead to severe reactions of hopelessness and despair. Psychotic symptoms may develop.

Cannot express any coherent feelings, very severe acting out, manic excitement. Needs some outside assistance.

Continuously disorganized psychotic mental functioning. In need of constant assistance.

INSIGHT

This dimension covers cognitive and emotional understanding of the main dynamics of inner conflicts, the related interpersonal patterns and repetitive behaviors, and connection to past experiences. Ability to understand and describe own vulnerability, reactions to stress, and coping abilities.

Unusual ability to describe genuinely personal wishes, fears, defenses, and the related behavior and connections to earlier (childhood) experiences. High awareness of own vulnerability, attitudes, and interpersonal patterns, secondary gains. Open and curious about and reflects on the multiple levels and meanings of experience. Realistic judgment of self and others.

Can account for inner conflicts, the related problems and repetitive behaviors, and connections to earlier experience. Aware of own vulnerability and reactions to stress. A tolerant and realistic sense of self and others in interpersonal disputes. May feel disillusionment, but no bitterness or hopelessness.

Can account for most important inner conflicts, related problems and repetitive behavior patterns, and personal attitudes. Connections to earlier experience may be partly forgotten. Aware of own vulnerability, stress reactions, and coping abilities. May blame self or others too much in interpersonal disputes, but reflects freely and observes own reactions and learns from them (integration). Generally curious and tolerant. Realistic expectations about the future.
Recognizes but cannot clearly describe the complex association between past experience, inner conflicts, and present problems and repetitive patterns. Reasonably aware of own vulnerability and strength and reactions to stress. Tendency to blame self or others too much in disputes. Occasionally behavior and attitude may be unrecognized, but reflects and observes self in other areas.

Understanding of inner conflicts and associations to past and present experience and behavior is somewhat unclear, or less emotionally integrated, or “learned.” Inadequate judgment of self and others, but ability to observe and reflect with time. Vulnerability and stress reactions sometimes a surprise. Some defensive, unrecognized attitudes and behaviors. Rigid views of rights and wrongs. May look for superficial solutions. Recognizes symptoms as sign of disturbance.

Superficial “learned” or misleading ideas of inner conflicts and past and present experience. Distortions of judgment of self versus others even when no disputes. Painful feelings accompanied by harsh self-blame or incorrectly ascribed to external factors. Little or no reflection on personal motives, unaware of important aspects of attitudes and behaviors (fundamentalism). May deny symptoms as sign of disturbance. Excessive pessimism or optimism.

Does not recognize associations between behavior and internal dynamic components. Severely distorted perceptions/judgment of self or others. Disavows painful personal reactions. Can describe internal experiences but in stereotyped, confusing, or misleading way. Denies signs of mental disturbance.

Great difficulty describing internal experiences. Does not acknowledge associations between internal experiences and own behavior. Severe distortions/delusional ideas may be present.

Disorganized or fragmented mental functioning. Breakdown of reality testing. Needs outside assistance.

Continuously disorganized, in need of constant assistance for days.

**PROBLEM-SOLVING AND ADAPTIVE CAPACITY**

This dimension covers the ability to flexibly handle any difficult situation and assert self without developing symptoms, avoidance, or inadequate actions. Self-observation and planning may or may not be used to enhance performance. Ability to integrate the habitual and also to explore new areas, indulge with pleasure in playful activities and recreation, and pursue meaningful goals.

Unusual ability for resourceful and flexible problem solving in all areas, career, current family, family of origin, friends, leisure time, life goals. Admired for warmth, integrity, wisdom, initiative, and joyfulness.

High adaptive functioning in all areas. May sometimes feel apprehensive or discouraged in difficult situations, but uses self-observation, reflection, affiliation, and planning to solve problems; humor, creativity.

May occasionally feel anxious or tend to avoid critical situations. May back off or be overcompetitive but worried in situations of rivalry. Sometimes curbs own ambitions or is driven towards overachievement. Sense of direction and pursuit of goals sometimes unclear. May stay too much with the habitual or try to explore too many new areas. Engages with pleasure in social and recreational activities.

Sometimes anxious or depressed in critical situations. Occasional inadequate actions in response to stress (aggression or inhibition of appropriate anger). May avoid one or two areas, e.g., fails to apply for promotions or unable to change an unsatisfactory intimate relationship. May have few hobbies or interests or somewhat inhibited pleasure in recreational activities. May confine activities to the habitual and well known, or indulge in too many new areas.

Develops symptoms, avoids or acts inappropriately (aggressively or submissively) in critical and difficult situations, or fails to pursue meaningful goals. Does not dare to initiate desired romantic relationships or fails to pursue realistic career goals. May show rigidity or continue maladaptive habits, or fails to free self from inhibiting or destructive situations. Restricted pleasure or aimless (compensatory) actions, marked selfishness.

Severe symptoms, avoidance, or antisocial behavior/acting out or other highly inappropriate actions in response not only to critical situations but also to more ordinary challenges. Inhibited pleasure, life restrictions in several areas. Lack of sense of direction and self-realization.

Overwhelmed by ordinary life challenges in several areas. Withdraws from most difficult situations and takes on almost no responsibilities. Severe symptoms; passive, dependent, or extremely rigid performance. Unclear communication. Severe disturbance in family life and very restricted leisure activities.

Very limited or no adaptive capacity. Cannot function adequately in almost any area. Overwhelmed by ordinary daily activities, severe disturbances in the ability to communicate.

Needs assistance to solve problems of daily living. Severe self-destructive or dangerous actions.

Continuous disorganized mental functioning.