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EFICÁCIA EM PSICOTERAPIA: MUDANÇA ESTRUTURAL
ESTUDO EMPIRICO

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RESUMO

A tentativa de validação empírica da eficácia da psicoterapia tem gerado controvérsias, decorrente de diferentes entendimentos epistemológicos e metodológicos sobre a temática. A complexidade associada a esta prática clínica envolve a necessidade de a objetivar e medir, recorrendo a critérios uniformemente aceites, com o objetivo de identificar as variáveis que atuam ao longo do processo terapêutico e que conduzem a mudanças na estrutura psíquica do sujeito. A partir da literatura revista conclui-se que, apesar do reconhecimento da existência de mudança a um nível mais estrutural e da identificação das variáveis deste processo, não se verifica uma visão clara da contribuição das relações entre as variáveis.

Palavras-chave: estrutura psíquica, mudanças estruturais, competências psicológicas

ABSTRACT

The effort regarding the empirical validation of the effectiveness of psychotherapy has caused controversy, due from different epistemological and methodological understanding on the subject. The complexity allied with this clinical practice involves the need to objectify and measure using criteria uniformly accepted, in order to identify the variables that operate throughout the therapeutic process and leading to changes in the intrapsychic structure. This literature review concluded that, despite the recognition of structural change and the identification of variables through the process, it is not clear the contribution of the relationship between the variables.

Keywords: psychic structure, structural change, psychological capacities.

INTRODUÇÃO

Nas últimas décadas os investigadores têm procurado validar a eficácia da psicoterapia empenhando-se na verificação dos processos e comprovação dos seus resultados. Independente da abordagem teórica e/ou técnica adotada tem vindo, igualmente, a constatar-se a necessidade de obter evidências empíricas quanto à validade e a eficácia do processo psicoterapêutico.

Contudo, as dificuldades de observação e mensuração dos constructos psíquicos têm dificultado a aceitação da psicoterapia como tratamento psíquico com validade e eficácia, consequência da falta de estudos que o comprovem, bem como da ausência de critérios objetivos para a sua medição, tanto mais relevante quando se refere a psicoterapias como são as psicanalíticas e a psicanálise.

Howard, Monas, Brill, Martinovich e Lutz (1996) apontam a dificuldade da definição de critérios e a falta de consenso de conceptualização e operacionalização dos temas teóricos e clínicos da psicoterapia como uma dificuldade limitadora de todo o processo de validade.

Ao contrário dos sintomas ou dos comportamentos, que podem ser mensuráveis de forma válida e fiável, os constructos psicodinâmicos não são tangíveis, o que dificulta a sua avaliação em termos empíricos. A dificuldade de operacionalização dos constructos psicodinâmicos continua a ser apresentada como fator principal da falta de estudos sobre eficácia do tratamento analítico (Wallerstein, 1994; Blatt & Auerbach, 2003).

No que se refere ao próprio entendimento de mudança são inúmeros os fatores apontados como catalisadores da mudança psíquica do sujeito e, por isso, agentes fundamentais em psicoterapia.

Motivado por estas dificuldades conceptuais e de operacionalização dos constructos psicodinâmicos, o Projeto de Pesquisa em Psicoterapia (*Psychotherapy Research Project - PRP*) da Fundação Menninger, no início dos anos 50, procurou um entendimento sobre que mudanças ocorrem nos pacientes submetidos a psicanálise e a outras terapias de base psicanalítica, mas também a forma como essas mudanças ocorrem. O ponto de partida do PRP passou por verificar que processo e resultados estão interligados e que ambos devem merecer igual relevância.

Em 1986, este grupo de trabalho formulou um conjunto de conceitos psicológicos teoricamente neutros – 17 competências psicológicas – como sendo atributos que descreveriam o funcionamento da personalidade do sujeito e cujas alterações

reflectiriam uma mudança na estrutura psíquica. O instrumento Scales of Psychological Capacities (SPC), surgiu da dificuldade em encontrar consenso quanto aos conceitos da estrutura psíquica e mudança estrutural (De Witt, Hartley, Rosenberg, Zillberg & Wallerstein, 1991)

Em 1994, Wallerstein referiu que ao longo dos 30 anos em que decorreu o programa de investigação, mais de 20 autores tinham trabalhado este tema fazendo surgir seis livros e mais de setenta artigos. Atualmente, o interesse nesta área mantem-se e continuam a desenvolver-se trabalhos, no sentido de identificar as variáveis que influenciam o processo terapêutico provocando mudanças na estrutura psíquica e a forma como estas variáveis comunicam entre si.

Na revisão realizada, a pesquisa centrou-se nos conceitos de estrutura psíquica, mudança estrutural e competência psicológica. A pesquisa foi efetuada com recurso a vários motores de busca tais como a EBSCO, incluindo as bases de dados *Psyc*INFO, *Psyc*ARTICLES, PEP*Archive*, *Psychology and Behavioral Sciences Collection*, *Academic Search Complete*, bem como a base de dados *Web of Knowledge, Google Scholar* e o sistema de pesquisa Intranet do Centro de Documentação do Instituto Superior de Psicologia SPC

A data de publicação situou-se entre 1992 e 2012, tendo sido utilizadas as palavras-chave "*estrutura psíquica*", "*mudanças estruturais*" e "*competências psicológicas*", igualmente no idioma inglês "*psychic structure*", "*structural changes"* and "*psychological capacities"*.

INVESTIGAÇÃO E EFICÁCIA EM PSICOTERAPIA

Desde o início da Psicanálise que os efeitos da terapia têm sido uma preocupação de clínicos e investigadores. Freud e Breuer questionaram a mudança psíquica provocada pelo trabalho analítico levantado várias questões sobre a eficácia terapêutica da psicanálise (Cooper, 1989).

Diversos autores concluíram que a psicoterapia é mais eficaz quando comparada a situações de não-tratamento ou com grupos de controlo placebo (Lambert & Ogles, 2004; Lambert, Bergin & Garfield, 2004, citado por Sousa, 2006).

Igualmente, é referido na literatura a existência de mudanças clinicamente significativas face a pacientes que com o mesmo tipo de problemática que não realizaram psicoterapia (Lambert & Ogles, 2004; Asay & Lambert, 1999, citado por Sousa, 2006).

Atualmente, as conclusões dos diversos estudos nesta área são categóricas ao afirmar que a psicoterapia é benéfica e eficaz, existindo consenso na comunidade científica (Sousa, 2006).

Posteriormente, foram também levantadas questões sobre o modelo teórico mais eficaz e que quantidade de psicoterapia é necessária para se alcançar resultados mais seguros e a qualidade da manutenção dos ganhos (Maling *et al*., 1995, citado por Howard *et al*, 1996).

A investigação científica em psicoterapia tem encontrado diversos obstáculos metodológicos e epistemológicos, sendo um dos pontos de grande pertinência a separação entre investigação centrada nos resultados (*outcome research*) e investigação centrada nos processos (*process research*). Assim, podemos afirmar que a investigação em psicoterapia se divide em dois grupos de pesquisa: um que assenta em resultados e outro que tem por base os processos, i.e., estudos que avaliam o resultado, como os de eficácia e de efetividade, e estudos que avaliam o processo psicoterapêutico direcionado para o entendimento do percurso até à mudança.

A investigação centrada nos resultados está direcionada para as mudanças durante a terapia ou após a terapia, sendo que na investigação do processo, o foco está no que acontece e como é que acontece (Wallerstein, 1994).

Os processos determinam os resultados sendo por isso necessário um entendimento do material desencadeado no trabalho terapêutico, pois é instigador das mudanças. Para a investigação nesta área é importante existir um entendimento dos resultados, mas

também dos processos envolvidos no processo analítico e que são parte responsável da mudança psíquica, i.e. agentes fundamentais em psicoterapia.

MUDANÇA

De uma forma geral, as várias orientações apontam que a remissão de sintomas é resultado de um tratamento bem-sucedido se acompanhado por mudanças nas estruturas mentais e estados inconscientes do sujeito. A dificuldade em medir alterações de estados mentais inconscientes e de estrutura psíquica tem levado ao pouco envolvimento de clínicos em processos que investiguem a mudança (Blatt & Auerbach, 2003). De acordo com os autores, é essencial que a pesquisa da mudança em psicoterapia, se centre nas mudanças na estrutura e no conteúdo das representações mentais, uma vez que um foco exclusivo na redução dos sintomas revela pouco sobre a mudança terapêutica.

A pesquisa em psicoterapia tem procurado identificar os fatores específicos, envolvidos no processo terapêutico, que contribuem para uma mudança terapêutica.

Após evidências sobre a eficácia da psicoterapia tornou-se então pertinente identificar os fatores que mais contribuem para a mudança terapêutica.

Evidências consensuais, fornecidas por pesquisas de resultados, indicam que as psicoterapias são eficazes e são mais efetivas do que ausência de terapia ou intervenções placebo. Estudos comparativos demonstram que as psicoterapias, independentemente das orientações teóricas que as inspiram, são capazes de produzir mudança, sendo que as diferenças nos resultados estão mais relacionadas com a relação terapêutica do que com técnicas específicas. (Glucksman, 1993)

O contínuo crescimento da complexidade da teoria psicanalítica levou a diversas formulações do conceito de mudança.

No período inicial da Psicanálise, os mecanismos de mudança resumiam-se a trazer à consciência o material inconsciente (Freud, 1916, citado por Cooper, 1989). O êxito de trazer os conteúdos inconscientes à consciência assentava no processo de interpretação das resistências e defesas no contexto da transferência. Nesta fase inicial, o ponto fulcral era dado ao insight, resultado de um trabalho introspetivo do paciente ou da sua intuição, cabendo ao terapeuta transformar o material em situação analítica. Assim, há uma primeira fase de trabalho interpretativo do paciente que dá lugar a uma segunda fase alicerçada na razão (cognição) (Arlow, 1979). Desta forma, considerava-se o insight agente único no trabalho psicanalítico, responsável por uma nova organização psíquica capaz de promover a mudança.

Como referiu Blum (1979), o insight era o agente essencial da mudança, o catalisador do trabalho terapêutico, a condição para a resolução da resistência, no

entanto, a sua profundidade varia de acordo com a fase da terapia, bem como a fase de desenvolvimento e recursos do paciente. Neste âmbito, e como referiu este autor, a psicanálise maximiza o insight minimizando outras influências terapêuticas.

Loewald, em 1960 (citado por Cooper, 1989) refere que a eficiência terapêutica depende da experiência com o analista, no sentido em que este induz o paciente a corrigir o desenvolvimento frustrado, enfatizando o papel do analista como elemento que conduz o material inconsciente ao pré-consciente permitindo assim a sua interação. O mesmo autor refere que é a interação analista-paciente que permite a organização e reorganização do aparelho psíquico, permitindo que o outro se reconheça como ser individual.

Depois de uma abordagem virada para a interpretação e o insight, o foco passou a ser na relação analítica como agente de mudança (Greenson, 1972)

Mais tarde, autores como Fairbairn e Winnicott (citado por Cooper, 1989) introduzem a importância da experiência emocional da terapia como espaço relacional securizante, onde paciente e analista contribuem para uma mudança de representações. O analista como ego-auxiliar, à semelhança da relação primária mãe-bebé, introduz o princípio da realidade. É na relação com o outro que o sujeito se reconhece, sendo que o analista no papel do outro permite que o sujeito se reconheça.

Ferenzi e Rank, em 1956 (citado por Cooper, 1989) referem que uma análise bem-sucedida dos conflitos inconscientes era insuficiente para produzir mudança, se esta não fosse acompanhada por uma experiência afetiva dentro da análise.

Assim, a investigação tem dado atenção à relação analista/paciente. Neste sentido, importa ter em consideração as características do analista e do paciente, uma vez que estas podem favorecer a relação terapêutica e contribuir, então, para a eficácia do tratamento.

Os fatores de relacionamento cliente-terapeuta são os mais significativos para o resultado positivo da terapia. (Lambert & Barley, 2002).

Lambert e Barley (2001) concluíram que 40% da variação dos resultados na terapia assenta em fatores extra-terapêuticos (como a motivação do paciente para mudar, as capacidades cognitivas e interpessoais do paciente, a vontade deste em estabelecer uma relação com o terapeuta, as condições envolventes, o suporte familiar e social ou os acontecimentos de vida), 30% é atribuída a fatores comuns às várias terapias, como são os relacionados com a relação terapeuta/cliente, 15% referem-se às expectativas do paciente de que a terapia será bem-sucedida, e 15% como responsabilidade das técnicas

específicas das linhas teóricas.

Nas últimas décadas, a relação analítica é entendida como um esforço conjunto da díade terapeuta-cliente com o objetivo de ultrapassar a dor do Cliente. Temos vindo a assistir a um crescente empenho por parte dos investigadores, em demonstrar a relevância que é conferida à relação paciente-terapeuta no âmbito da investigação em psicoterapia. É na relação terapêutica que o paciente percebe o terapeuta como um aliado, o que facilita a sua compreensão dos sintomas e padrões vividos, bem como a internalização dos ganhos alcançados com o tratamento, possibilitando ao paciente um maior domínio sobre seus conflitos. (Freud, 1937, citado por Ribeiro, 2009).

A aliança terapêutica é cada vez mais considerada um fator promotor de mudança e não unicamente uma variável facilitadora desse processo.

Malcom, em 1977 (citado por Cooper, 1989), na sua autobiografia permite concluir que o processo analítico está condenado (ou, pelo menos, é bastante dificultado) se a envolvente externa, com a sua dimensão social não promove oportunidade para novos comportamentos, novas relações, ou idealizações para além do terapeuta.

Cooper (1989) alertou, também, para a necessidade de uma *teoria de mudança* assente em causalidades múltiplas, pois uma visão unitária dos agentes de transformação seria, segundo o autor, uma visão redutora condenada à frustração.

É notório o caminho percorrido na tentativa de encontrar um entendimento sobre a origem e eficácia terapêutica a partir de uma visão unitária, em que um único fator explicava o resultado da terapia, para uma visão global que assenta na compreensão do processo e na interação dos vários fatores que o influenciam.

MUDANÇA ESTRUTURAL E ESTRUTURA PSÍQUICA

Diferentes correntes partilham a suposição de que há mudanças mais profundas e, por isso, mais estáveis distintas de mudanças comportamentais ou sintomáticas e, assim, transitórias. As diferentes perspetivas propõem diversas formas de intervenção que influenciam quer os processos, quer os resultados de uma psicoterapia.

As mudanças estruturais pressupõem processos que modificam as funções psíquicas do sujeito, no sentido de uma maior eficácia adaptativa e, consequentemente, uma maior estabilidade da mudança.

São frequentes as distinções entre verdadeira mudança estrutural na organização e funcionamento da personalidade, assente na resolução de conflitos intrapsíquicos, de mudança comportamentais, onde o que prevalece são alterações dos padrões adaptativos.

É necessário, em primeiro lugar, compreender as diferentes conceções de estrutura antes de procurar avaliar a mudança estrutural, i.e., mostra-se necessário identificar a definição de estrutura de entre as várias linhas teóricas, com vista a delinear uma estratégia de avaliação para medir essas possíveis alterações na estrutura.

Partir de um pressuposto que um tratamento eficaz traduz mudança que vai para além de alterações sintomáticas ou comportamentais, e portanto ao nível de alterações na estrutura psicológica do sujeito, implica não só diferenciar padrões de mudança, mas também identificar as variáveis que envolvem todo este processo.

Um dos pontos de vista considerados cruciais para abordar a mudança estrutural é a necessidade de considerar uma teoria da personalidade (Zilberg, Wallerstein, DeWitt, Hartley & Rosenberg, 1991). De acordo com estes autores, não é possível medir a estrutura psicológica ou mudança estrutural quando não existe uma perspetiva universal de estrutura.

A conceptualização de estrutura psicológica envolve uma diversidade de perspetivas e enquadramentos e o facto de não existir uma unanimidade conceptual impede a validade de um método que tenha como objetivo avaliar a estrutura psicológica, até porque, as diferentes perspetivas de estrutura psicológica propõem diversas formas de intervenção, as quais irão influenciar quer os processos, quer os resultados de uma psicoterapia.

Rangell, em 1989 (citado por Zilberg *et al,*1991) considera o conceito de “mudança estrutural” um *cliché,* rejeitando a validade do uso do termo estrutura. De acordo com este autor o conceito de mudança estrutural não deverá ficar pela definição conceptual

de impulso-defesa e configurações entre ego, superego e *id*, mas deverá considerar uma abordagem tripartida que inclua este impulso-defesa em relação com os padrões internalizados de relação de objeto.

Josephs (2011) chama a atenção para a necessidade de diferenciar uma estrutura psicológica que está presente mas inativa temporariamente, e a mudança autêntica nessa estrutura. Um tratamento pode refletir uma mudança estrutural aparente que mais não é do que uma resposta desadaptada ao tratamento, o que torna o sujeito mais vulnerável em caso de recaída. A estabilidade observada em medidas repetidas ao longo do tempo pode representar uma boa evidência de que a estrutura subjacente não é cronicamente ativada.

Nem todas as dimensões de um quadro teórico têm igual impacto na mudança estrutural, sendo importante identificar a estabilidade dessa mudança.

A falta de clareza conceptual dificulta a metodologia de avaliação quer da estrutura psicológica, quer das mudanças operadas a este nível, e revelou-se a preocupação central do grupo de pesquisa do Projeto Menninger.

Apesar destes obstáculos, o problema de diferenciar o grau de mudança, mais ou menos estável, permanece na pesquisa em psicoterapia.

O Projeto PRP acautelou que, a avaliação dos diferentes componentes de mudança estrutural fossem avaliados de acordo com parâmetros de frequência, persistência e intensidade, para que a mudança operada não se confunda com uma simples remoção de sintomas, mas sejam a expressão de mudanças estruturais mais estáveis (Huber, Henrich & Klug, 2005).

COMPETÊNCIAS PSICOLÓGICAS

O Projeto PRP ao invés de procurar conceptualizar e medir estrutura e mudança estrutural desenvolveu um conjunto de constructos psicológicos, teoricamente neutros, (competências psicológicas) que pretendem ser um conjunto de dimensões que se pensa serem os recursos essenciais para um funcionamento adaptativo e satisfatório do individuo. Estas competências psicológicas, consideradas como elementos nucleares do funcionamento da personalidade, permitem, assim, identificar fenómenos de mudança.

Wallerstein (1991) apresenta as competências psicológicas como uma espécie de recursos psicológicos fundamentais para uma funcionalidade saudável. De Witt *et al*. (1999) definem que competências psicológicas são um recurso acessível e indicador de um funcionamento intrapsíquico e interpessoal adaptado.

O conceito de capacidade psicológica pressupõe que uma mudança nas capacidades psicológicas indicaria mudança na estrutura psíquica, este conceito conseguiu obter o consenso dos diferentes pontos de vista psicanalíticos.

Entende-se que as capacidades psicológicas estão presentes em diferentes graus nos vários indivíduos considerando-se em estreita ligação com o desenvolvimento do individuo, sendo que, em dado momento do desenvolvimento se tornam estáveis, o que evidencia a sua diferença do conceito de recursos psicológicos. A estabilidade das competências psicológicas é determinada por várias fatores inatos, como são os genéticos ou determinadas predisposições, ou outros que se vão desenvolvendo com o tempo, que são influenciados pela aprendizagem, fatores que ocorrem em momentos sensíveis do desenvolvimento, ou, ainda, acontecimentos críticos que podem inibir o desenvolvimento de certas competências.

Quando é atingido um dado grau de estabilidade no desenvolvimento de um individuo cada competência psicológica passa a constituir um atributo que se reflete nos traços mais nucleares do sujeito.

Estudos vieram comprovar a relevância destas competências na avaliação da estrutura psíquica e da mudança estrutural, conduzindo ao desenvolvimento, por Robert Wallerstein e a sua equipa, em 1986, de uma escala de competências psicológicas.

CONCLUSÕES

Os investigadores, nas últimas décadas, têm procurado validar a eficácia da psicoterapia, verificando processos e comprovando resultados. As dificuldades ao nível, quer da definição, quer da observação ou mensuração dos constructos psíquicos têm dificultado a produção de estudos empíricos que comprovem a eficácia da psicoterapia, limitando todo o processo de validade. Esta dificuldade de operacionalização dos constructos psíquicos continua a ser apontada como o fator principal da falta de estudos sobre a eficácia do tratamento analítico.

Apesar dos obstáculos associados à investigação nesta área, continuam a ser desenvolvidos trabalhos, no sentido de identificar as variáveis que influenciam o processo terapêutico e que provocam mudanças estruturais, bem como a forma como estas variáveis comunicam entre si.

Na revisão realizada é notório o caminho percorrido na tentativa de encontrar um entendimento sobre a eficácia terapêutica a partir de uma visão unitária, em que um único fator explicava o resultado da terapia, para uma visão global que assenta na compreensão do processo e na interação dos vários fatores que o influenciam.

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PARTE II – ESTUDO EMPIRICO

EFICÁCIA EM PSICOTERAPIA: MUDANÇA ESTRUTURAL

RESUMO

A tentativa de validação empírica da eficácia da psicoterapia tem gerado controvérsias, decorrente de diferentes entendimentos epistemológicos e metodológicos sobre a temática. A complexidade associada a esta prática clínica envolve a necessidade de a objetivar e medir, recorrendo a critérios uniformemente aceites, com o objetivo de identificar as variáveis que atuam ao longo do processo terapêutico e que conduzem a mudanças na estrutura psíquica do sujeito.

O estudo visou avaliar a eficácia da psicoterapia, tendo por base a aplicação da *Scales Psychological Capacities* (SPC). Foram utilizadas gravações de sessões de duas pacientes do mesmo terapeuta, referentes a dois anos de psicoterapia, tendo a SPC sido aplicada no início, fim do primeiro ano e fim do segundo ano.

Os resultados permitem concluir que a psicoterapia tem efeito ao nível da alteração de capacidades psicológicas dos sujeitos, tendo-se comprovado a existência de mudanças estruturais processadas ao longo do trabalho analítico.

Palavras-chave: estrutura psíquica, mudanças estruturais, competências psicológicas.

ABSTRACT

The effort regarding the empirical validation of the effectiveness of psychotherapy has caused controversy, due from different epistemological and methodological understanding on the subject. The complexity allied with this clinical practice involves the need to objectify and measure using criteria uniformly accepted, in order to identify the variables that operate throughout the therapeutic process and leading to changes in the intrapsychic structure.

The study aimed to evaluate the effectiveness of psychotherapy, based on the application of a *Scales of Psychological Capacities* (SPC). Session recordings were used in two patients of the same therapist, referring to two years of psychotherapy, the SPC was applied at the beginning, the end of the first year and the end of the second year.

The results allow to conclude, that psychotherapy has an effect at the level of changing psychological capacities and having proved the existence of a structural change processed along the analytical work.

Keywords: psychic structure, structural change, psychological capacities.

INTRODUÇÃO

Nas últimas décadas, os investigadores têm procurado validar a eficácia da psicoterapia empenhando-se na verificação dos processos e comprovação dos seus resultados. Independente da abordagem teórica e/ou técnica adotada, tem vindo, igualmente, a constatar-se a necessidade de obter evidências empíricas quanto à validade e a eficácia do processo psicoterapêutico.

Contudo, a ausência de critérios objetivos para a sua medição, consequência das dificuldades de observação e mensuração dos constructos psíquicos, criam constrangimentos à aceitação da psicoterapia como tratamento psíquico com validade e eficácia.

Pelo contrário, no caso dos sintomas ou dos comportamentos, que podem ser mensuráveis de forma válida e fiável, os constructos psicodinâmicos não são tangíveis, dificultando a sua avaliação em termos empíricos. A dificuldade de operacionalização dos constructos psicodinâmicos continua a ser apresentada como fator principal da falta de estudos sobre eficácia do tratamento analítico (Wallerstein, 1994; Blatt & Auerbach, 2003).

Paralelamente, verifica-se que a investigação científica em psicoterapia tem encontrado diversos obstáculos metodológicos e epistemológicos, sendo pertinente destacar a separação entre investigação centrada nos resultados (*outcome research*) e investigação centrada nos processos (*process research*).

Com efeito, a investigação centrada nos resultados está direcionada para as mudanças durante a terapia ou após a terapia, sendo que, na investigação do processo, o foco está no que acontece e como é que acontece (Wallerstein, 1994). Os processos determinam os resultados, pelo que se mostra necessário obter um entendimento dos fatores envolvidos no trabalho terapêutico, uma vez que estes são instigadores de mudança.

As mudanças estruturais pressupõem uma modificação das funções psíquicas do sujeito, permitindo uma maior eficácia adaptativa e, consequentemente, uma maior estabilidade da mudança.

De uma forma geral, as várias orientações apontam que a remissão de sintomas é resultado de um tratamento bem-sucedido, desde que acompanhado por mudanças nas estruturas mentais e estados inconscientes do sujeito.

Motivado por estas dificuldades conceptuais e de operacionalização dos constructos

psicodinâmicos, o Projeto de Pesquisa em Psicoterapia (*Psychotherapy Research Project - PRP*) da Fundação Menninger, no início dos anos 50, procurou um entendimento sobre as mudanças que ocorrem nos pacientes submetidos a psicanálise e a outras terapias de base psicanalítica, mas também a forma como essas mudanças sucedem. Assim, o ponto de partida do PRP passou por verificar que processo e resultados estão interligados e que ambos devem merecer igual relevância. O Projeto PRP acautelou que a avaliação dos diferentes componentes de mudança estrutural fosse avaliada de acordo com parâmetros de frequência, persistência e intensidade, para que a mudança operada não se confunda com uma simples remoção de sintomas, mas sejam a expressão de mudanças estruturais mais estáveis (Huber, Henrich & Klug, 2005). Em 1986, este grupo de trabalho formulou um conjunto de conceitos psicológicos teoricamente neutros, como sendo atributos que descreveriam o funcionamento da personalidade do sujeito e cujas alterações refletiriam uma mudança na estrutura psíquica. O instrumento *Scales of Psychological Capacities* (SPC) surgiu da dificuldade em encontrar consenso quanto aos conceitos da estrutura psíquica e mudança estrutural (De Witt, Hartley, Rosenberg, Zillberg, & Wallerstein, 1991).

O presente estudo visa avaliar a eficácia da psicoterapia, com recurso à aplicação da SPC, a gravações de sessões de psicoterapia de dois pacientes. Esta análise, que decorreu em três períodos intervalados no tempo, permitiu avaliar a evolução das competências psicológicas do sujeito ao longo do trabalho analítico e inferir relativamente à existência de mudanças na estrutura psíquica dos sujeitos.

MÉTODO

PARTICIPANTES

Participante A

A Paciente A tem 57 anos, é casada, vive com o marido e um filho mais novo, de 31 anos. Tem uma filha casada e um neto que vivem nos arredores da cidade onde habita. O filho do meio faleceu quando a A tinha 42 anos.

A Paciente casou com 17 anos e foi viver para casa da sogra, onde se manteve até ao final da terapia. Como relatou a Paciente, a relação estabelecida com a sogra, uma mulher que a feriu e magoou durante a convivência em comum, foi dolorosa. A relação que mantem com o marido é funcional, conflituosa e quase sem diálogo. Refere que suportou a dureza do casamento pela obrigação de proteger os filhos.

Filha de uma mãe abusadora do álcool e de um pai ausente, conviveu com um ambiente familiar desorganizador. A segurança familiar foi precária com dificuldades ao nível da sobrevivência.

Ao longo da terapia demonstrou dificuldade inicial em recordar-se de factos da sua infância, e quando o conseguiu, todos os eventos recordados remetiam para referências a trabalhos realizados neste período, mais acentuadas quando as recordações incentivadas eram os afetos.

O papel de cuidadora e as responsabilidades inerentes a esse papel foram uma constante em toda a sua vida, tendo assumido os seus compromissos e os compromissos de quem cuidou.

Durante a terapia, a paciente revela uma submissão, assumida na forma de cuidar do outro, antecipando as necessidades do outro, na expectativa inconsciente de receber, culpabilizando-se por não receber. A relação que estabelece com a sogra e com o sogro foi uma tentativa falhada de reviver a situação primária, mas cuja rigidez e falta de afetividade acentuou a vivência de culpabilização.

A relação que a Paciente manteve com os filhos (especialmente a filha) foi de rigidez, repetindo o padrão de funcionamento que conhece. No espaço da terapia reconheceu esse padrão e demonstrou uma capacidade de reparação espontânea. Com o filho, relata uma relação mais conturbada acusando-o de irresponsabilidade,

consequência da sua própria incapacidade de dar espaço ao filho, antecipando as suas necessidades, como mais tarde veio efetivamente a reconhecer.

As referências que faz ao filho falecido parecem evidenciar uma idealização quer do filho, quer da relação que com ele manteve.

No decurso das sessões de psicoterapia, a paciente demonstra uma elevada capacidade de reação, reagindo por si e pelos que dela dependiam, acentuando o ciclo de dependências que a sobrecarregam.

Está omisso o motivo que a terá levado a iniciar a psicoterapia, pelo que não temos presente o problema que a levou a recorrer a ajuda.

No início da terapia, recorre frequentemente ao sentimento de cansaço, e refere dificuldades em dormir, que atribui ao muito trabalho que tem diariamente. Demonstra uma ansiedade e preocupação que tem dificuldade em controlar e que imputa sempre a ocorrências do quotidiano. Ao longo da terapia, demonstrou cooperação com o trabalho analítico, apresentando uma capacidade de elaboração do material devolvido satisfatória.

A terapia teve a duração de 18 meses, com frequência semanal, em sessões de 50 minutos.

Tendo em conta os dados da análise, reconhecemos que a paciente procura satisfazer as próprias necessidades de dependência, tomando conta de outros, identificando-se, assim, inconscientemente com a gratificação desses outros em ser cuidados (inversão).

Ao longo da terapia verificou-se que a paciente foi alterando o seu papel, de forma construtiva, de quem responde para quem toma a iniciativa.

A paciente ao considerar o problema como falta sua e virando-se contra o *self,* resiste assim à tentação de negar ou de fazer projeções, revelando uma estrutura saudável.

Participante B

A paciente tem 36 anos, é solteira, e encontra-se atualmente desempregada. Vive sozinha, devido a uma separação recente do namorado com quem vivia. Filha mais velha de uma fratria de três, mencionou que teve uma infância feliz, com pais presentes e boa relação entre irmãos. No entanto, deixa o registo de que a mãe não era uma pessoa de afetos, ao contrário do pai, e que o irmão era o preferido da mãe, e a irmã a preferida

do pai, restando-lhe, pois, a preferência de uma ama.

Recorre à psicoterapia por sentir-se deprimida e sem motivação para atividades pessoais ou sociais, mas revela um quotidiano marcado por eventos sociais que procura ativamente para não estar só. O facto de estar desempregada obriga-a a passar o dia sozinha, o que lhe provoca um forte sentimento de abandono. Refere que é muito carente, no que respeita aos afetos, e que quer perceber a origem dessa necessidade afetiva.

A paciente evidencia sintomas depressivos proeminentes em resposta ao abandono por parte do namorado, tendo o término da relação o que motivou o recurso à terapia.

Refere, ainda, perturbações no sono, que não foram suficientemente graves para serem um foco de atenção médica independente, consequência provável de um estado de ansiedade generalizado, bem como de uma dependência adaptativa.

Apresenta, igualmente, uma dependência dominadora, uma vez que espera do outro realizações e decisões que sejam consequência de diretrizes e ordens suas ao sujeito de quem depende.

É notória uma necessidade excessiva de admiração do outro que a leva à submissão. Muito embora revele uma forte necessidade em obter a atenção dos outros, a paciente necessita que essa atenção seja um reconhecimento ilimitado da sua superioridade.

Demonstra, ao longo de toda a terapia, como preocupação central, a aceitação e admiração masculina, e deseja um homem para manter uma relação afetiva. Contudo, idealiza este sujeito como detendo um estatuto superior, sustentando a sua crença de que é especial e única.

A paciente revela sempre alguma dificuldade no reconhecimento espontâneo das suas fragilidades perante o outro, no entanto, adere às sugestões do terapeuta no planeamento de atitudes, referindo com frequência “segui o seu conselho”.

No decorrer da terapia assiste-se a acessos de voracidade alimentar que alterna com episódios de dieta, faz a sua autoavaliação associada ao peso e formas corporais, no entanto, não parece haver enquadramento numa perturbação do comportamento alimentar.

INSTRUMENTO

O instrumento utilizado para a avaliar a eficácia da psicoterapia neste estudo foi a *Scales of Psychological Capacites* (SPC), junto como anexo I.

De acordo com alguns autores, a SPC representou a primeira forma de avaliar o constructo psicanalítico de mudança estrutural, segundo uma base empírica (Huber, Henrich & Klug, 2005).

A SPC procura a operacionalização dos conceitos de estrutura psíquica e de mudança estrutural, tendo como principal preocupação a independência das diferentes perspetivas teóricas da psicanálise (Huber, Brandl & Klug, 2004). Este instrumento procurou estabelecer uma linguagem comum entre clínicos e investigadores de diferentes escolas e modelos terapêuticos estimulando o diálogo entre estes profissionais.

A SPC foi desenvolvida para aceder a atributos relevantes quer para a psicopatologia, quer para o funcionamento dito normal, não tendo sido criada no sentido de detetar a presença de condições psicopatológicas, pelo que só deverá ser usada quando a realidade do sujeito não está comprometida.

No que diz respeito à estrutura da SPC, estão definidas dezassete competências psicológicas que se dividem, cada uma, em três subescalas. As competências psicológicas foram produzidas tendo por base elementos fundamentais do funcionamento psicológico, de acordo com a teoria psicanalítica. As três subescalas são *i)* atributos do *self*, no que se refere a características internas do sujeito como a autoestima, o entusiasmo pela vida, esperança, flexibilidade, atribuição de responsabilidade, persistência e compromisso com os padrões e valores; *ii*) regulação do *self*, no que diz respeito à regulação que o sujeito faz dos seus comportamentos e experiências e que envolvem competências ao nível da regulação do afeto e dos impulsos ou afirmação pessoal, e *iii*) subescala que remete para as capacidades do sujeito de se relacionar, e que envolve competências como empatia confiança, autoconfiança e compromisso.

As 17 competências dão acesso a 35 sub-dimensões, uma vez que 14 competências se dividem em outras duas sub-dimensões, duas competências dividem-se em três sub-dimensões e uma não está dividida.

As cotações de cada sub-dimensão são realizadas de acordo com uma escala de quatro pontos, em que o valor 0 corresponde ao funcionamento normal ou

completamente adaptativo e o valor 3 ao funcionamento claramente perturbado.

As dimensões estão construídas para que uma sub-dimensão cubra vários graus de funcionamento, o inibido e exagerado ou desadaptado. Das 17 competências psicológicas, 13 consideram duas sub-dimensões relativas ao funcionamento exagerado ou inibido. Por exemplo, na capacidade psicológica de auto-estima, podem coexistir a exibição de uma grandiosidade exagerada, ao mesmo tempo que o sentimento é o de intensa auto-depreciação. Em 3 das 17 competências psicológicas são definidas três sub-dimensões de funcionamento desadaptado

Por último, a competência coerência ou a inconsistência do eu em relação a comportamentos e experiências, em que o funcionamento problemático aumenta apenas num sentido.

PROCEDIMENTO

Para este estudo, foram utilizadas gravações de sessões de psicoterapia de dois participantes. A Psicoterapia, de Inspiração Psicanalítica, foi conduzida na Clinica Psicológica do ISPA-IU, durante 2 anos, com uma frequência semanal e duração média de 50 minutos.

No caso da participante A, foram disponibilizadas as primeiras quatro sessões do início da terapia, duas sessões ao final do primeiro ano de acompanhamento e as quatro sessões finais. No caso da participante B, foram disponibilizadas as primeiras quatro sessões do início da terapia, quatro sessões ao final do primeiro ano de acompanhamento e as três últimas sessões.

As audições das sessões de psicoterapia, das duas pacientes selecionadas, e a respetiva avaliação cumpriram procedimentos rigorosos em todas as fases do processo. Inicialmente, foi realizado um estudo aprofundado do instrumento, com o objetivo de alcançar uma maior compreensão sobre o seu funcionamento e aplicação, seguindo-se uma fase de treino, como forma de preparação para as futuras aplicações utilizadas no estudo empírico final. Este treino consistiu na aplicação do instrumento a notas de sessões de três pacientes distintos dos apresentados no estudo. Foi, igualmente, determinado um intervalo de tempo de vinte e quatro horas entre a cotação dos diferentes momentos.

Cada momento iniciou-se com a audição das sessões, tendo em vista um levantamento dos aspetos que pareciam remeter para as competências psicológicas em estudo, a que se seguiu a cotação do material com recurso à SPC.

Foram respondidas todas as dimensões e respetivas sub-dimensões, em conformidade com a ordem recomendada. Cada sub-dimensão foi cotada com uma pontuação de 0 (funcionamento normal ou completamente adaptativo) a 3 (funcionamento seriamente e claramente perturbado). Utilizou-se o mesmo procedimento para os outros dois momentos respeitando-se vinte e quatro horas entre a cotação de um momento e a audição do momento seguinte para evitar o efeito de *halo,* e assim minimizar a possibilidade de interferência que contamine resultados.

Verificámos que algumas sub-dimensões não eram aplicáveis ao sujeito por indisponibilidade ou limitação de informação no material clínico, e nessas condições atribuiu-se a pontuação relativa a um tipo de funcionamento saudável.

RESULTADOS

De seguida, são apresentados os resultados das varáveis em análise ao logo da terapia nos três momentos analisados, por participante.

As cotações de cada sub-dimensão (A, B, C) são realizadas de acordo com uma escala de quatro pontos, em que o valor 0 corresponde ao funcionamento normal ou completamente adaptativo e o valor 3 ao funcionamento claramente perturbado.

Participante A

A Paciente A assinala mudança em 11 das 17 competências psicológicas abrangidas pela escala SPC, a saber, Esperança, Entusiasmo pela vida, Atribuição de responsabilidade, Flexibilidade, Persistência, Compromisso nas relações, Reciprocidade, Empatia, Regulação de impulsos, Auto-estima e Auto-coerência.

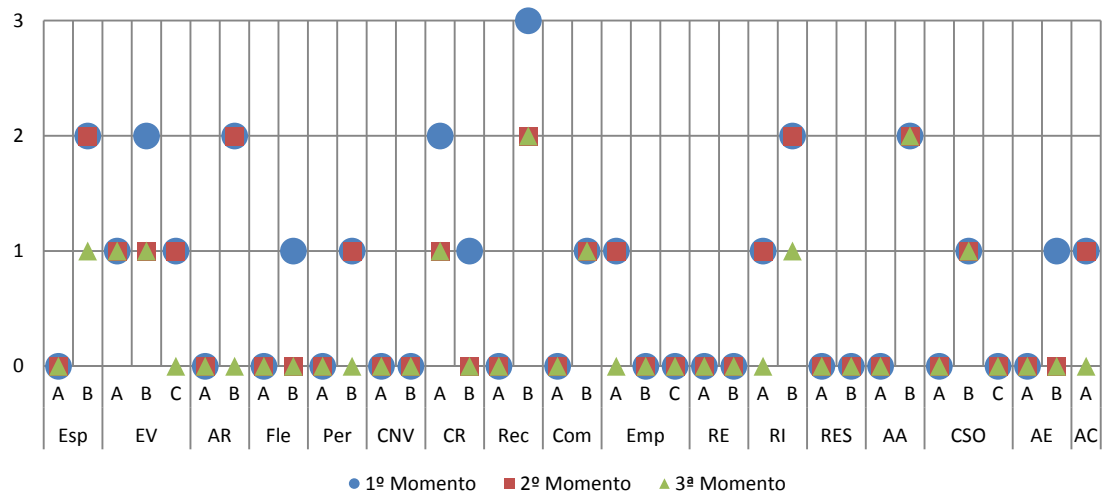

Gráfico 1:Apresentação dos resultados das dezassete variáveis da SPC, nos três períodos analisados.

As competências psicológicas (dimensões da SPC) que apresentam resultados enquadrados num padrão de funcionamento adaptado e que se mantiveram nesse registo ao longo de toda a terapia são: compromisso com normas e valores (CNV), regulação das emoções (RE) e regulação da experiencia sexual (RES). A dimensão CNV remete para uma conduta de compreensão e tolerância e nesta dimensão a paciente revela um comportamento adaptativo. Na dimensão RE, a participante apresenta um expressar e experienciar de emoções de forma adequada. A cotação da dimensão RES considerou-se

um registo saudável por indisponibilidade de informação no material clínico.

As dimensões que, embora tenham registado uma mudança evolutiva, se mantiveram, no final da terapia, em registos desajustados foram: Esperança (Esp) na sub-dimensão B, Entusiasmo pela vida (EV) na sub-dimensão B, Compromisso nas relações (CR) na sub-dimensão A, Reciprocidade (Rec) na sub-dimensão B, e Regulação de impulsos (RI) na sub-dimensão B. Na dimensão Esp, que remete para conteúdos sobre o otimismo e o pessimismo, verifica-se que a participante evoluiu de um funcionamento comprometido por uma perspetiva pessimista, onde imperava uma preocupação excessiva com o futuro, mesmo na presença de eventos neutros, para um registo capaz de controlar as expectativas pessimistas, i.e., embora mantendo esse pessimismo perante uma dificuldade, tem capacidade de prosseguir. Na dimensão EV, que remete para a capacidade do sujeito em transmitir e experienciar entusiasmo, a participante no início da terapia apresenta uma clara limitação a este nível, tendo recuperado para um registo em que o entusiasmo está presente, muito embora não esteja facilmente disponível. A dimensão CR demonstra que a paciente evolui de uma situação de incapacidade para se libertar de situações e relacionamentos difíceis, para um registo em que não só valoriza a liberdade de escolha, como se permite escolher, muito embora mantenha uma tendência para se deixar enredar para além dos limites da sensatez. Na dimensão Rec, a participante revela no momento inicial uma posição de autossacrifício, mostrando-se altamente vulnerável à exploração de terceiros, mantendo relacionamentos em que dá em detrimento de receber, sendo que, a partir do segundo momento, modera esta tendência, mas continua vulnerável à exploração, pois está sempre pronta a dar, mesmo que isso signifique negligenciar-se. Na dimensão RI, o primeiro e segundo momento de avaliação são marcados por uma expressão inibida dos impulsos, em que só consegue ceder a impulsos em ocasiões especiais ou com certas pessoas, sendo que, no final da terapia, apresenta já uma ligeira recuperação, muito embora ainda se sinta constrangida.

As dimensões cujos registos desadaptados se mantiveram ao longo da terapia, não sofrendo qualquer alteração: A dimensão Entusiasmo pela vida (EV) na sub-dimensão A, Confiança (Conf) na sub-dimensão B, Auto-afirmação (AA) na sub-dimensão B, Confiança em si e nos outros (CSO) na sub-dimensão B. Na dimensão EV, a paciente revela pouco entusiasmo pela vida ao longo de toda a terapia. Na dimensão Conf a paciente mantém ao longo de toda a terapia uma tendência para confiar excessivamente dos outros, muito embora avalie situações e pessoas de forma realista e tenha

capacidade para se proteger e defender os seus interesses. Na dimensão AA, a paciente mantém o registo de limitação na expressão das suas necessidades e interesses, sendo que esta inibição tem como objetivo evitar o confronto. Se incentivada revela um comportamento mais assertivo, ainda que se sinta desconfortável. Na dimensão CSO, verifica-se que a paciente embora demonstre autoconfiança e capacidade para funcionar adaptadamente, manifesta algumas dificuldades a este nível quando sente ansiedade ou solidão.

As dimensões cujos registos demonstram uma mudança positiva mais significativa (são apenas consideradas as alterações superiores a dois pontos na escala): Na dimensão Atribuição de responsabilidade (AR) na sub-dimensão B, os primeiros dois momentos da terapia caracterizaram-se por uma culpabilização excessiva, com tendência notável para se culpar incorretamente por acontecimentos negativos e dificuldade em moderar este sentimento, mesmo quando confrontada com provas e argumentos contrários. No último momento da terapia, verifica-se o reconhecimento do impacto externo nos seus próprios sentimentos, pensamentos e comportamentos.

Assim, e de acordo com o Gráfico 1, observa-se que a Paciente A, ao final do 1º momento, evoluiu para um registo saudável nas competências Entusiamo pela vida, Flexibilidade, Compromisso nas relações e Auto-estima.

As competências onde apenas se verifica uma mudança no final da terapia são Esperança, Atribuição de responsabilidade, Persistência, Empatia, Regulação de Impulsos e Auto-coerência.

Participante B

A paciente B não apresenta em nenhuma dimensão um padrão de funcionamento totalmente adaptado, embora algumas sub-dimensões registem valores saudáveis que se mantiveram ao longo de toda a terapia.

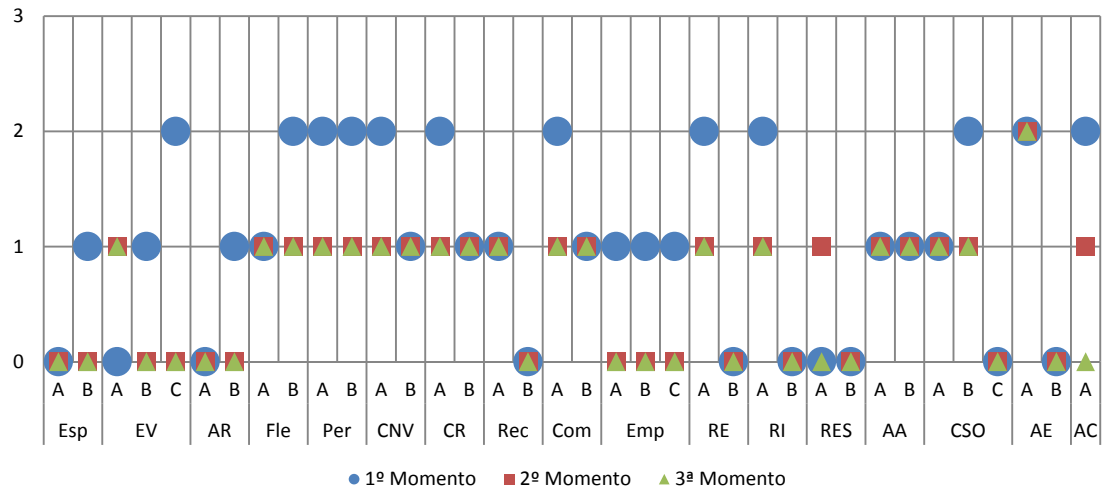

Gráfico 2: Apresentação dos resultados das dezassete variáveis da SPC nos três períodos analisados

Na dimensão Esperança (Esp), sub-dimensão A, a cotação revela que a paciente possui um nível de otimismo saudável que se mantém ao longo da terapia.

Na dimensão Atribuição de responsabilidade (AR), sub-dimensão A, verifica-se um funcionamento responsável, sendo a paciente capaz de perceber a sua contribuição e assumir a sua responsabilidade pelas consequências indesejáveis do seu comportamento.

Também na Dimensão Reciprocidade (Rec), a sub-dimensão B, demonstra uma capacidade saudável para gerir o que dá aos outros.

Na Regulação das emoções (RE), sub-dimensão B, a paciente demonstra um equilíbrio no controlo das emoções.

Na dimensão Regulação de impulsos (RI), na sub-dimensão B, verifica-se capacidade para satisfazer os seus impulsos sem ser de forma rígida ou controladora.

Na dimensão Regulação das emoções (RES), sub-dimensão B, não há sinais de inibição sexual, a sub-dimensão A, ainda que se encontre num registo em que não existe disposição à sexualidade impulsiva, no segundo momento da terapia, acabou por demonstrar uma excessiva preocupação com o sexo.

Na dimensão Confiança em si e nos outros (CSO), subdimensão C, a paciente permite que os outros confiem em si, oferecendo espontaneamente apoio emocional,

conforto ou outro tipo de ajuda sem ambivalência percetível.

Na dimensão Auto-estima, sub dimensão B, o nível normal de autoestima global é alto, com uma perspetiva e juízo de si seguros.

As dimensões que, embora tenham registado uma mudança evolutiva, se mantiveram, no final da terapia, em registos desajustados foram:

Na dimensão Flexibilidade (Flex), subdimensão B, no primeiro momento de avaliação a paciente revela um funcionamento com tendência a insegurança, duvidando das suas próprias opiniões, face a ideias e opiniões contrárias. Regista, contudo, uma ligeira recuperação ao fim de 12 meses de terapia, ainda que mantenha insegurança até ao final da terapia.

Na dimensão Persistência (Per), a paciente apresenta, no primeiro momento da terapia, dificuldade em aceitar os seus próprios limites, sendo que a partir do segundo momento mantém a vontade em ir para além das suas limitações, muito embora tenha a capacidade de recuperar quando é encorajada ou confrontada por outros. No que respeita à sub-dimensão B, no primeiro momento da terapia manifesta tendência para desistir perante obstáculos, com episódios de retirada que prejudicam o funcionamento, no entanto, a partir do segundo momento da terapia evolui tendo episódios em que tem vontade de desistir perante obstáculos mas recupera facilmente o seu funcionamento normal.

Na dimensão Compromisso nas relações (CR), a sub-dimensão A, no início da terapia demonstra incapacidade em se libertar das relações recuperando para um registo em que já consegue fazer escolhas sobre o seu envolvimento nos relacionamentos.

Na dimensão Confiança (Conf), na sub-dimensão A, a paciente, no início da terapia, mostra tendência para suspeitas irrealistas, que a levam a questionar a confiança e honestidade dos outros recuperando para um registo de maior confiança.

Na dimensão Regulação das emoções (RE), Sub-dimensão A, a paciente recupera no segundo momento da terapia de um estado frequente de surtos de emoções fortes para um registo de maior controlo.

Na dimensão Regulação de impulsos (RI), sub-dimensão A, a paciente passa de um registo de cometer excessos para um registo de maior controlo, em que os exageros são cometidos apenas em determinadas circunstancias.

Na dimensão Confiança em si e nos outros, sub-dimensão B, a paciente revela, no início da terapia, dificuldade em confiar nos outros para um registo de confiança muito embora com algumas reservas e exceções circunscritas.

Na dimensão Auto-coerência (AC), sub-escala A, revelando uma rutura moderada de si próprio, recuperando para uma rutura circunscrita.

As dimensões cujos registos desadaptados se mantiveram ao longo da terapia, não sofrendo qualquer alteração:

Na Dimensão Flexiblidade (Flex), sub-dimensão B, a paciente manteve ao longo de toda a terapia tendência para subestimar novas ideias e novas informações, não alterando o seu ponto de vista e opiniões

Na dimensão Compromisso normas e valores (CNV), sub-dimensão B, mantem, ao longo da terapia, um registo de entendimento e ação em conformidade com as normas e valores sociais, muito embora registe alguns comportamentos contrários aos padrões morais normalmente aceites.

Na dimensão Compromisso nas relações (CR), sub-dimensão B, apresenta um registo de vulnerabilidade ao compromisso, em períodos de maior dificuldade

Na dimensão Regulação da experiência sexual (REC), sub-dimensão A, muito embora tenha em conta as necessidades do outro, poderá aproveitar-se dos outros

Na dimensão Confiança, sub-dimensão B, verifica-se uma tendência para agir em função da opinião dos outros, sem reflexão adequada.

Na dimensão Auto-afirmação (AA), ao longo de toda a terapia, a paciente experiencia desconforto em ceder, o que conduz a exigências pouco razoáveis.

Na dimensão Confiança em si e nos outros (CSO) a paciente mantem a dificuldade em confiar no outro, salvo exceções circunscritas que lhe provocam sentimentos como ansiedade ou humilhação.

Na dimensão Auto-estima (AE), sub-dimensão A, constam-se áreas de auto avaliação do *self* circunscritas, mas não danificadas.

As dimensões cujos registos demonstram uma mudança positiva mais significativa (são apenas consideradas as alterações superiores a dois pontos na escala):

Na dimensão Entusiasmo pela vida (EV), sub-dimensão C, a paciente passa de um registo de incerteza sobre o significado das atividades quotidianas e dificuldade em mante-las revelando desinvestimento em algumas áreas, para um registo em que mantém o sentido de investimento nas atividades.

Assim, e de acordo com o Gráfico 2, observa-se que a Paciente B, ao final do 1º momento, evoluiu para um registo mais saudável em 14 das 17 competências. As três competências onde não se verificou qualquer alteração ao estado inicial foram: a Auto-afirmação, mantendo dificuldades em "ceder", e a Auto-estima, em que na sub-

dimensão A manteve o registo pouco saudável, onde se denota uma autoavaliação excessiva em diversas áreas, e na sub-dimensão B mantém um nível de auto estima global alto.

As competências onde apenas se verifica uma mudança no final da terapia são: a Regulação da experiência sexual, na sub dimensão A, onde evolui para um registo saudável, e a Auto-coerência, onde claramente se demonstra a passagem para um funcionamento adaptado.

DISCUSSÃO

O estudo teve como objetivo principal avaliar a eficácia da psicoterapia, no sentido da mudança estrutural do sujeito submetido a terapia.

Para avaliar esta mudança estrutural, recorreu-se à aplicação da escala SPC a gravações de sessões de psicoterapia realizada em dois pacientes, em três períodos de análise, espaçados por, aproximadamente, doze meses.

Considerando os resultados apresentados anteriormente, podemos, pois, concluir que as pacientes registam uma evolução de um funcionamento mais desadaptado para um registo mais saudável, indiciando a ocorrência de mudança na sua estrutura psíquica.

Assim, atendendo ao objetivo do estudo, pode afirmar-se que a psicoterapia foi eficaz, tendo produzido mudanças estruturais na estrutura mental das pacientes em análise.

A Paciente A assinala mudança em 11 das 17 competências psicológicas abrangidas pela escala SPC, verificando-se uma atitude mais positiva e entusiasta pela vida, uma diminuição do registo de culpabilização, uma maior confiança em si própria, com consequente capacidade de assumir as suas escolhas. Verifica-se, ainda, um maior equilíbrio na capacidade de dar e receber e na forma como se relaciona emocionalmente com os outros e consigo própria. A Paciente A evolui, ainda, de um registo inicial de submissão e incapacidade para afirmar os seus próprios interesses, para uma posição de maior liderança e recuperação da auto-estima e um maior sentimento de harmonia interior.

O momento de maior mudança ocorreu nos últimos 12 meses de terapia, denotando uma evolução gradual positiva até uma situação de maior adaptabilidade. Tal verificação, parece ir ao encontro dos estudos que afirmam a pouca probabilidade de ocorrerem mudanças estruturais, nomeadamente ao nível dos traços característicos da personalidade, antes do primeiro ano de tratamento, por ocorrerem de forma mais lenta e subtil.

Ainda como denota Kopta, os estados subjetivos do paciente podem mudar em poucas sessões, sendo expectável que os traços de caráter e autoconceitos não começam a mudar antes de um ano. Deste facto, será exemplo, no caso da paciente em análise, a evolução da competência auto-coerência e auto-estima (Kopta *et al.*, 1994, citado por Gunderson & Gabbard, 1999).

No que respeita ao Paciente B, é de salientar, desde logo, que os resultados apontam uma evolução para um registo mais saudável em 15 das 17 competências psicológicas. A mudança ocorrida na grande maioria das competências psicológicas da escala SPC, logo após o primeiro momento de terapia, poderá ser explicada pela idade jovem da paciente, capacidades cognitivas e interpessoais, as condições envolventes e o suporte familiar e social, i.e. fatores extra extra-terapêuticos que, como referem Lambert & Barley (2001), são responsáveis por 40% da mudança em psicoterapia.

Esta evolução pode, contudo, refletir um comportamento adaptativo e não uma mudança estrutural. Neste contexto, ressalva-se que os resultados apurados na Paciente B podem estar enviesados, em virtude da escala SPC apenas poder ser utilizada quando a realidade do sujeito não está comprometida.

Destaca-se, ainda, que na dimensão Auto-afirmação manteve-se o *status quo* em que a paciente mantem um registo pouco flexível, onde evidencia pouca capacidade de ceder e de estabelecer limite razoáveis, racionalizando em vez de agir de forma a evitar confrontos.

Em termos de limitações do estudo podemos afirmar que não estando prevista a realização de um diagnóstico psicopatológico, e sendo condição da aplicação da escala a inexistência de uma realidade comprometida do sujeito, é difícil apurar a validade da eficácia da psicoterapia uma vez que os resultados da Participante B podem estar comprometidos.

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ANEXOS

ANEXO I

Scales Psychological Capacities (SPC)

(Versão Original)

THE SCALES OF PSYCHOLOGICAL CAPACITIES

Version 1

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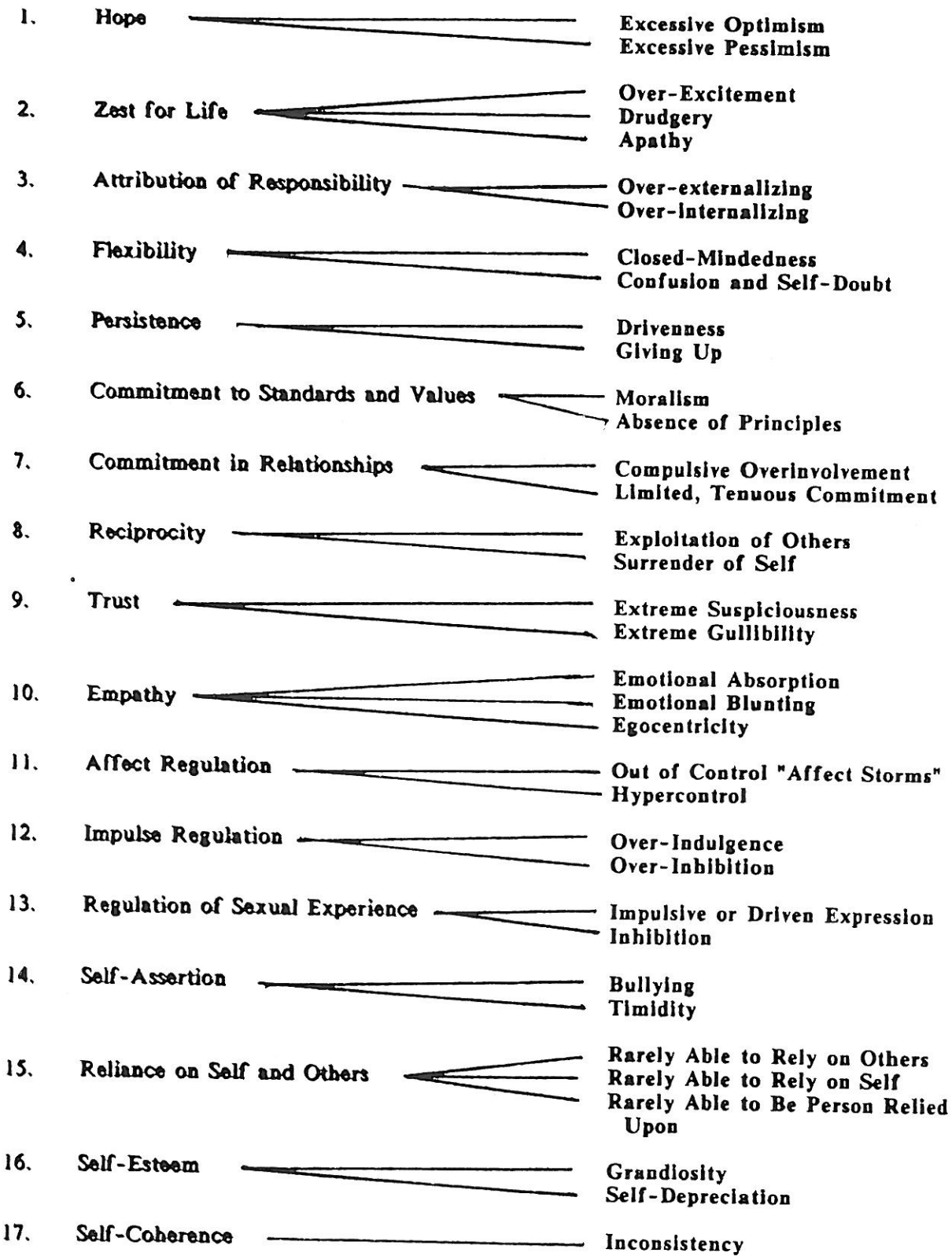
Scales of Psychological Capacities



Scales of Psychological Capacities: Introduction

Our inquiry began with the problem of intrapsychic structure. This concept is central to all the various psychoanalytic (psychodynamic) theories of personality organization and functioning, and the related concept of structural change is integral to our understanding of personality change that comes about in psychoanalysis and other psychoanalytically-based or oriented psychotherapies. The theoretical (and for research purposes, the empirical) problem exists however, that each of the different theoretical perspectives in psychoanalysis (the ego-psychological, the object relational, the self-psychological, the Kleinian, the Bionian, the Lacanian, etc.) has different understandings of what we mean by intrapsychic structure, what its significant dimensions and units are, and how one can assess change in structure. At this point in the development of psychoanalytic (psychodynamic) theory, consensus on these concepts of structure and structural change is not possible at that conceptual level. (See in this connection: Wallerstein, One Psychoanalysis or Many? *Int. J. Psycho-Anal.*, 69:5-21, 1988; Wallerstein, Assessment of Structural Change in Psychoanalytic Therapy and Research, *J. Amer. Psychoanal. Assn.*, 36 (suppl.):241-261, 1988; Zilberg, et al., A Conceptual Analysis and Strategy for Assessing Structural Change, *Psychoanal. & Cont. Thought*, 14:317-342, 1991; De Witt, et al., Scales of Psychological Capacities: Development of an Assessment Approach, *Psychoanal. & Cont. Thought*, 14:343-361, 1991.

Rather, therefore, than trying to track the change process in psychoanalytic therapies through efforts at specifying dimensions and units of intrapsychic structure and of structural change which we think is in principle not possible at this stage of psychodynamic theory development, we have sought to formulate what we call Psychological Capacities that are theoretically-informed but not theory-specific, that adherents of all psychoanalytic theoretical perspectives (as well, hopefully, adherents of other personality theories that try to account for personality organization and therapy-induced changes in personality organization) can agree to be functional attributes that comprehensively describe the range of personality functioning and its potential for change. These capacities should then necessarily change if there is change in underlying intrapsychic structures, however those intrapsychic structures or that structural change are differently conceptualized within the differing theoretical perspectives. That is, sustained changes in these Psychological Capacities should be consensually accepted as reflecting underlying structural change in personality organization and functioning. Within psychoanalysis such structural change might then be formulated differently by adherents of different theoretical perspectives (for example, as changes in the relations of id, ego, and superego by ego psychologists, as changes in self and object representations by object relations theorists, as changes in the coherence and the vulnerability of the self by self-psychologists, as changes in fixations in the schizoid and the depressive positions by Kleinian analysts, etc.).

Let us state clearly what we mean by Psychological Capacities and how we distinguish them from the varieties of existing personality inventories or typologies, like the polarities of introversion-extraversion, dominance-submission, love-hate; or the various trait categorizations of academic, clinical or personality psychology; or like the character styles, hysterical, obsessive-compulsive, narcissistic, paranoid, etc. of clinical (psychodynamic) psychiatry; or like the congenital activity (and passivity) types of developmental psychology. Our Psychological Capacities are constructs to describe the psychological resources needed to achieve adaptive functioning and life satisfaction. Inherent in this is the conception of developmental unfolding or maturation out of the interplay of biological endowment and experiential vicissitude until some level of stability has been

achieved in each capacity, an enduring essence or disposition that is not simply reflected in average or particular behavior. Our Psychological Capacities are thus more enduring and central to character organization and functioning than just skills and abilities; they consist rather of maturationally and developmentally established capacities, whether optimally unfolded or varyingly impaired, that have an enduring influence upon the acquisition of skills and abilities. Also inherent is the conception of interrelatedness and interaction so that these Psychological Capacities, taken together, can describe the degree of adaptive or maladaptive overall personality integration and functioning. Specifically our focus is on developed functional personality capacities, not on isolatable traits, or on psychopathological character or symptom-formations, or on a typology per se.

In terms of our empirical research purposes, our Psychological Capacities are designed to be as low-level (experience-near) constructs as possible, with as clear and reliable definitions as possible, and readily inferable from observable behaviors (in the widest sense of the word behavior, to include reportable mental states and feelings). We have defined a total of 17 such functional Psychological Capacities and constructed diverging four-point scales for each, indicating differing degrees and differing directions of departure from the optimal functioning of that capacity, i.e. each capacity or personality dimension has relevant subdimensions of blocked, deformed, or exaggerated functioning. Examples of such functional capacities are the capacity for trust in relationships, or the capacity to regulate affects; subdimensions of inhibition or of exaggeration of such capacities come readily to mind.

Our Scales of Psychological Capacities are of course intended to reflect underlying "deep" or "hidden" intrapsychic structures as these are varyingly conceptualized by differing psychoanalytic theoretical perspectives, and movement along the different subdimensions of the scales, from before to after therapy, is intended to reflect structural changes, however we presently, or come later to, conceptualize intrapsychic structure and structural change. Since the scales are however expressed as these reasonably low-level and experience-near capacities, reliably inferable from readily observable behaviors, dispositions, interactions, attitudes, verbalizations, etc., they may seem to be too behavioral or too simplistic or too interpersonal in orientation. It is however from the configuration and valences of just these kinds of observables that those who do conceptualize intrapsychic structures customarily do make the inferences to those "underlying" intrapsychic structures that (to them) define and characterize personality organization (in terms of our theoretical perspectives--and languages--within psychodynamic, psychoanalytic, personality theory).

Each of the scale points on each of these Psychological Capacities is anchored with one or more descriptive clinical vignettes that demonstrate just what we mean when we designate someone as functioning at that scale level. These vignettes or examples are intended to be illustrative, but in no way comprehensive or exhaustive.

These Psychological Capacities scales have been formulated in accord with the following general principles:

1) There is a general notion of a zero point or center point of "normal" or optimal or fully adaptive functioning. This is subdivided into those aspects relevant to each of our designated subdimensions of departure from this optimal functioning or from the optimal presence of this capacity. For the most part (13 of the 17) there are two such subdimensions, basically of exaggerated or inhibited functioning. For example, in regard to affect regulation, one can experience affects explosively, in "affect storms", or, conversely, be rigidly inhibited in regard to affective experience or expression. For other of the psychological capacities (3 of the 17) we have defined three subdimensions of aberrant functioning. For example, in regard to reliance on self and

others, one can be unduly reliant on others, one can be unduly reliant on oneself (and suspicious or fearful of relying on others), and one can be secure or apprehensive when relied on by others. Lastly, with one dimension, the coherence or the inconsistency of the self in relation to behaviors and experiences, we have but one direction of increasingly problematic functioning.

2) There are four scale points on each subdimension along parameters of frequency, pervasiveness or intensity, and accompaniment of dysphoric affect. Though a scale with more points would give more discrimination and presumably make it easier to capture lesser degrees of movement on the scale, we found it too difficult to try to actually conceptualize additional degrees of severity or intensity (and devise discriminable examples of each) for each of the scales. We are, therefore, handling the problem of trying to capture finer degrees of movement on the scales by arranging our four scale points as nodal points along a continuum that will allow markings to be made at an intermediate half-way point.

   a) Scale point zero has been defined under the previous heading.

   b) Scale point one: Difficulties sometime, or to some extent. The difficulties can be overcome without external support, and adaptive functioning can be restored at least over the near time span, though with varying degrees of discomfort. Overall functioning is hardly compromised.

   c) Scale point two: Difficulties often, and/or to a significantly greater extent. The difficulties can be frequent and/or quite pervasive but can be overcome (at least temporarily) with external support, albeit with dysphoric affect, or by strongly motivated effort of one's own, also with significant dysphoric affect. Overall functioning is compromised in some definite way.

   d) Scale point three: Difficulties occur almost all the time or are very pervasive, with severe dysphoria attendant upon any effort at adequate functioning. Functioning is consistently maladaptive with significant manifest dysphoria and/or substantially impaired relationships. Overall functioning is thus seriously and obviously compromised.

3) Additional guidelines in the formulation and use of these scales.

   a) Each subdimension in each direction of the scales is intended to be unitary in character.

   b) The dimensional descriptions are intended to be general, encompassing, and brief. They are followed by brief clinical vignettes (at times more than one) in order to give raters a standard against which to assess the characteristics of the clinical material being rated.

   c) The dimensional descriptions are as free as possible of special technical vocabulary, especially that relating to psychopathological syndromes. The intent is to cast them in "ordinary" English.

   d) It is important to bear in mind that it is not just possible, but quite common, to deviate from optimal functioning of a psychological capacity in more than one direction at the same time. For example, on the psychological capacity self-

esteem, one can display an overblown grandiosity while also feeling an intense self-depreciation and abasement. This can be simultaneous or alternating, with one attribute "defending" against the other or vice versa. Both may be in consciousness at the same time, or only one may be, with the other being "warded off".

e) In evaluating placement on any of the scales where there is a discrepancy between the usual (chronic, longitudinal) status and the more immediate (acute, cross-sectional) status, it is the more usual or characteristic level and kind of functioning that is being assessed. We are trying, that is, to assess usual or characteristic functioning, not acute symptomatic or decompensated states, i.e. an acute depression, or an acute traumatic shock, etc.

f) In evaluating scale placement, issues of situation or <u>context</u> may be involved. That is, different characteristic behaviors, attitudes, ideas, feelings may be evoked under different circumstances. Again, we want the assessment of some overall most characteristic and pervasive level and kind of functioning.

g) These Scales of Psychological Capacities are inevitably infiltrated and underpinned, each perhaps to a different (and undetermined but never perhaps insignificant) degree by the prevailing or majority values of that (Western) culture within which they were devised. This emerges most clearly in the delineation of zero points of "normal" or optimal or fully adaptive functioning. This necessarily places the scales within a particular socio-historical context of time and place, even with full awareness that consensus on values is a constantly shifting and evolving process and that at any time a significant portion of any culture group can espouse and advocate one or more differing value positions on any single value or constellation of values (e.g. the specific "counter-culture" in America which peaked in the late 60's and early 70's). As much as possible, we have tried to take this into account in fashioning the scales, in trying to avoid a coercive pressure towards a particular value position through stressing the concept of available and flexible choice as a desideratum. The individual decision about what is appropriate to a given context is where value commitments necessarily operate. This whole issue is of course confounded if one considers applying these scales within other (non-industrial, third world, or Eastern) cultures that may have significantly different consensus value commitments in a variety of areas of psychological functioning. To what extent this application to these other settings would be even possible and useful is of course an empirical question, as yet untested.

4) This entire array of Psychological Capacities is intended to be comprehensively descriptive of the psychological characteristics of people with a range of functioning within the broad categories of normal, neurotic, character difficulties, impulse disorders, narcissistic, and borderline. It is not intended to cover the functioning of the overtly psychotic (whether institutionalized or not); the openly psychotic exhibit dimensions of personality disorganization and malfunctioning that are beyond the parameters of our described Psychological Capacities.

5) These scales are intended to be used as cross-sectional or "outcome" measures reflecting intrapsychic structural change. They are intended for "before and after" comparison and contrast between any two points in time which can then be correlated with "process" measures of intervening processes, mechanisms, circumstances, etc.

THE SCALES OF PSYCHOLOGICAL CAPACITIES

TABLE OF CONTENTS

1. HOPE

A. FROM ABSENCE OF, TO PRESENCE OF, EXCESSIVE OPTIMISM

0. **Can assess potential problems that may arise from a future course of action without becoming unduly optimistic.**

For example: A college student applying to graduate school has realistic expectations about being accepted to one of the schools he applied to, but does not assume that he will necessarily get his first choice.

For example: Upon receiving a diagnosis of diabetes, a young man realizes that he will have to adjust some aspects of his plans but remains realistically hopeful about following through with his career.

1. **In some situations, may be overly optimistic about the chances for future success and underestimate the potential for disappointment. Occasionally denies or ignores the possibility of future disappointment, but is usually able to regain a more realistic perspective by own efforts.**

For example: A college student initially overestimates the chances of getting accepted to her first-choice graduate school. However, as she learns more about the nature of the competition she faces, she brings her expectations more in line with reality.

2. **Person has tendency to be overly optimistic, often insisting that "everything will turn out for the best." Demonstrates unrealistic expectations and often denies or ignores the possibility for disappointment. As a consequence of ignoring unpleasant realities, functioning is compromised. Is able to regain some perspective, but with difficulty, when others point out the overly optimistic attitude.**

For example: A college student is overly optimistic about getting accepted to first-ranked graduate schools and only moderates his expectations after he has been rejected and disappointed, by then applying to a lower-ranked school. He displays a similar pattern in asking out women, starting with the one he is the most interested in, even though he knows she is committed to someone else. When she is unresponsive to his overtures, he pursues someone who is more available or responsive.

For example: A mother is unable to recognize the serious difficulties her daughter is having in school, assuming it is a phase she will grow out of, despite evidence that the child has serious learning disabilities. But after confrontation by school officials, she accepts the recommendations for remedial work.

3. **Always insists that "everything will turn out for the best," and maintains a cheerful "Pollyanna" attitude despite overwhelming evidence to the contrary. Flatly denies any uncomfortable realities that are contrary to an optimistic appraisal and may become hypomanic. As a consequence, constantly makes gross errors in judgment.**

For example: A man consistently denies any of the unpleasant or painful realities that face him. He dismisses gross problems in his work life or his relationships, insisting that he will be readily able to work them out satisfactorily. As a result, he doesn't notice obvious warning signs from his employer and is very surprised when he gets fired from his job.

B. FROM ABILITY TO BE HOPEFUL, TO EXCESSIVE PESSIMISM

0. **Can assess potential problems that may arise from a future course of action without being unduly pessimistic.**

   For example: A young college graduate of average ability applying for jobs in a highly competitive field, submits a large number of applications assuming that he is likely to get a lot of rejections.

   For example: An office manager is sought out by her colleagues for her ability to anticipate the risks and problems associated with a future course of action without dampening enthusiasm for uncertain ventures.

1. **In certain situations worries excessively after encountering an obstacle, and is unduly pessimistic about overcoming future problems. However, with some reflection, is often able to control pessimistic expectations and proceed.**

   For example: After suffering rejection from a woman, a young man doubts that he will ever find someone who will accept him, but after a time regains his perspective and pursues other women.

2. **Definitely pessimistic, worries excessively about the future, and emphasizes potential negative consequences for many neutral events. Functioning gets compromised by such an outlook. However, can respond to the reassurance of friends and regain some perspective.**

   For example: Upon receiving any bad news, a student reacts with a general attitude of gloom. If she gets a bad grade she finds it difficult to mobilize herself to study for her next exam, convinced that she will fail again. If her male friend is the least bit angry she worries that he will reject her. She reacts even to minor illness in her parents with the fear that they are dying. However, after she talks these things over with others she is able to regain her equilibrium.

   For example: A young college graduate, after being rejected for a few jobs in the field for which he prepared, gets overly pessimistic, thinking he will never find appropriate work and finally settles for work somewhat below his capabilities.

3. **Constant and pervasive, intensely pessimistic attitude about the future. Only attends to the negative side of any future situation and denies that anything positive could ever happen. Lives at all times under the cloud of "Murphy's Law" (Whatever can go wrong, will).**

   For example: A woman greatly exaggerates the negative impact of any negative occurrence and cannot maintain any realistic perspective about the future. If her child gets a poor report card, she is sure he will never amount to anything; if her husband is reprimanded at work she envisions him getting fired and the family on welfare; if anyone is late she is sure they were in an accident; if anyone is sick she imagines the worst possible illness.

2. ZEST FOR LIFE

A. FROM ABSENCE OF, TO PRESENCE OF, OVER-EXCITEMENT

0. **No evidence of expression of over-excitement in areas of work, play, or in relationships that irritate or otherwise generate a negative impact on others.**

For example: A person who gets appropriately excited upon winning an award or prize, getting a promotion, or scoring outstandingly on an examination. This is not unduly sustained and the person gets back to a normal emotional equilibrium after an appropriate interval. Others who observe or are aware of this are not put off by it.

1. **Tendency to become somewhat over-excited in a way that may have a negative impact on others, but only a mild one. Can easily become calm or be made aware of any exaggerations and the impact of these on others, and can then control expressing them. Nevertheless, when excitement is not mirrored, is likely to temporarily feel slightly dejected or embarrassed. Functioning is only slightly impaired.**

For example: A woman is excited when anticipating getting together with her friends that evening. She greets people with such enthusiasm that it is experienced by her guests as overdone, and they react with some embarrassment and coolness. It turns out that she also has a reputation at work as "gushing" enthusiasm for projects in a way that co-workers dislike. At times her friends give her feedback about this, and with embarrassment she acknowledges her behavior and makes attempts to keep her demonstrations of enthusiasm in check.

For example: A generally competent and well-liked physics professor has an irritating habit of frequently proclaiming how exciting the field of physics is, in a way that seems somewhat overdone and annoying to his students. One of his favorite students mentions this to him and he blushes in acknowledgement.

2. **Has a distinct tendency to become over-excited to a degree that has a moderately negative impact on others. Able to tone things down only with considerable effort or with persistent input from others. Awareness of out-of-proportion or inappropriate nature of demonstration or feelings is definitely compromised.**

For example: A man consistently demonstrates excitement for his woman friend in such an overdone way that she is turned off, and the relationship is threatened and only tenuously maintained. When she tries to explain, he doesn't quite understand what it is that bothers her. This is a pattern for him only in intimate relationships and does not otherwise occur in work or play settings.

3. **Strong propensity to react with out-of-control over-excitement. Almost no awareness of out-of-proportion or inappropriate nature of demonstrations of feelings. When excitement is not mirrored, person is likely to be oblivious to this or to feel deep dejection or to become rageful and devalue others in a grossly inappropriate manner.**

For example: A man is so prone to nonstop expressions of how "excited" he is about things-- whether it be his "incredibly marvelous friends," the "amazing, incredible 49ers," or his "stupendously interesting" post office work - that people assiduously avoid him, and he has considerable difficulty maintaining relationships and holding down a job.

2. ZEST FOR LIFE

B. FROM READILY AVAILABLE ENTHUSIASM, TO DRUDGERY

0. **Can readily experience and convey enthusiasm.**

For example: A hardworking and productive professor is clearly enthusiastic about her subject and has a reputation for conveying this to students in a way that motivates them to work hard. She is not dejected when a particular student does not respond to this enthusiasm, but instead tries a different tactic to reach that person.

For example: A woman has a sense of excitement and enthusiasm when anticipating getting together with her close friends that evening; upon their arrival she jumps up to greet them and gives everyone a hug, which is well received by warm smiles all around.

1. **Ability to experience and communicate enthusiasm is present, but not so readily available. At times has difficulty feeling enthusiasm when this seems indicated by circumstances. While person may be bothered by this, its effect is only slight.**

For example: A hardworking and productive professor has a reputation for having a teaching style that is reasonably interesting. Periodically he can not maintain his interest and his lecture style becomes more mechanical. He will become aware of this over time and he will re-energize his presentation.

2. **Ability to experience and communicate enthusiasm is distinctly limited. Occasional expressions of enthusiasm are clearly forced and maintained only with effort. This difficulty in being enthusiastic has a definite impact on functioning.**

For example: A person is at a party and is sitting alone. With considerable cajoling, his friends prevail upon him to join in and he does this with some show of enjoyment.

3. **Almost never experiences or expresses enthusiasm about anything. Functions in plodding, joyless manner to an extent that makes it unpleasant. Functioning is seriously affected.**

For example: A hardworking and productive professor who teaches in a consistently perfunctory and monotonous way. Although she knows her subject matter quite well, students try to avoid her classes because she is so dull. This is characteristic of her in almost all areas of life.

C. FROM INVESTMENT IN LIFE ACTIVITIES, TO APATHY

0. **Ability to maintain a sense of investment and meaningfulness in life activities. May occasionally lose interest in one or more of them. Even during these times, however, the person is aware that, in fact, the investment is still maintained and a sense of caring will return.**

   For example: After a period of overinvolvement with a project, a person finds himself saying, "I don't care about this any more," but quickly realizes that, in fact, he does care and just needs a vacation from it.

1. **Basically feels that activities are meaningful and usually cares and is invested in things, but is prone to occasional periods of loss of interest or disengagement that are readily reversible.**

   For example: Young woman notices that she regularly loses interest in just about everything after visiting her parents, but after several days of this she automatically bounces back.

   For example: A lawyer is easily bored while working at her relatively successful law practice, but loves to spend time with her family and play tennis with friends.

2. **Uncertainty about meaningfulness of life activities and some difficulty in maintaining them. Is frequently uninvested in several areas but manages to function, albeit with difficulty. This is likely to be noticed by others. Reversible only with considerable effort, and person may require assistance from others for this.**

   For example: A young woman notices that after every contact with her parents she stops caring about her relationship with her male friend and about her career in a way that threatens both. She can become reinvested after obtaining support from her boyfriend.

3. **Clearly feels lack of meaningfulness in life. Very frequent and pervasive disengagement from most life activities. Functioning seriously and obviously impaired.**

   For example: A war veteran who lives on government compensation checks can't seem to care about anything enough to get involved productively in a job, in relationships, or even in hobbies.

3. ATTRIBUTION OF RESPONSIBILITY

A. FROM TAKING RESPONSIBILITY, TO OVER-EXTERNALIZING

0. **Able to see own contribution to events and to take responsibility for the undesirable consequences of own behavior. Can acknowledge responsibility for mistakes.**

For example: A student breaks a flask in a chemistry class. His first impulse is to call the flask defective, but he immediately realizes that he forgot to tighten a clasp.

1. **Occasional or mild lapses in the experience of self as being responsible for undesirable behaviors, thoughts, or feelings. Some other person or forces beyond own control are initially held to be accountable. Can reflect on this experience and readily acknowledge more responsibility than was first recognized.**

For example: A wife and mother feels that these roles make it impossible for her to pursue a career she previously enjoyed, and she sometimes says, "My husband doesn't want me to work," but on reflection can see that she enjoys the life of running the household, and chose not to take a job.

For example: A man makes inappropriate sexual remarks to a female co-worker at a party. He initially dismisses his behavior by saying, "She behaved seductively," but then apologizes and vows to better control his behavior.

2. **Definite tendency not to take responsibility for undesirable behaviors, thoughts, or feelings. Usually blames other person or forces beyond own control. With external pressure or considerable internal effort, can acknowledge own responsibility.**

For example: A woman rarely takes responsibility for mistakes at work. Instead she blames co-workers, or equipment, or may use her mood or state of health as explanations for what went wrong. When boss suggests how she contributes to the problem and how she might avoid the situation in the future, it takes a while for her to see the point, she eventually takes the advice and changes her behavior.

For example: A veteran often complains that his parents were too poor to send him to college, and he ended up in a blue collar job that he sees as not allowing him to live up to his potential. When a friend reminds him that he could have used his veterans' benefits to attend college but instead chose to get married and start working right away, he grudgingly says, "You're right." He then complains about how his wife and children keep him from doing things he wants to do.

3. **Unwilling to take any responsibility for undesirable behaviors, thoughts, and feelings. Always blames other person or forces beyond own control. Even with confrontation with others, is unwilling to take any responsibility.**

For example: A man consistently describes himself as a victim of circumstance. When speaking of his feelings, starts the sentence by saying someone else "made" him have the feeling. Avoids taking responsibility for mistakes at work and sees self as only following orders from others.

3. ATTRIBUTION OF RESPONSIBILITY

B. FROM DISCLAIMING OF RESPONSIBILITY, TO OVER-INTERNALIZING

0. **Able to acknowledge the impact of other people and of unforeseen events on one's own undesirable thoughts, feelings, and behaviors. Does not take responsibility for events that are beyond one's control.**

For example: A student breaks a flask in chemistry class. First impulse is to berate self for clumsiness, but then notices that the glass was defective.

1. **Occasional or mild lapses in which the person loses sight of the contribution of other people or of external circumstances to undesirable events in own life, so that self is blamed beyond what is warranted by the situation. On reflection, is able to see how external events played a part.**

For example: A woman loses her job due to a merger of her company with a larger corporation. She occasionally has the thought that if she had only performed better or been more likable she would have been kept on. On reflection, however, she realizes that hundreds of people lost jobs in the merger, and that there was nothing she could have done to prevent its happening.

2. **Notable tendency to blame self unduly for negative events. Can moderate this feeling with considerable effort when confronted with evidence and arguments to the contrary.**

For example: In her social groups, a woman apologizes excessively for any behavior she thinks is not pleasant or hurtful, and feels she has to maintain the group's morale. When her friends confront her about blaming herself too much and taking too much responsibility for others, she can come to see that they are right and change her stance.

3. **Major and pervasive sense that self is the primary cause of everything untoward that happens in life, without taking external events into account. Even when confronted or reassured by others, is simply not able to see how other people and external circumstances contributed to what happens.**

For example: A woman who has been diagnosed with breast cancer reads in a magazine that psychological factors contribute to the development of the disease, and to the course of recovery or failure to recover. She reviews her life and tries to remember every occasion when she acted "neurotically" and tries to force herself to adopt the "right" attitude toward her illness. Even though doctors, friends, and family members reassure her that her illness is not her fault and remind her of a strong genetic loading in her family, she is adamant that she could and should have prevented this from happening.

4. FLEXIBILITY

A. FROM OPEN TO CLOSED-MINDEDNESS

0. **Can freely consider and use all external information and ideas. Can change previously held ideas when warranted. Does not show a tendency toward closed-mindedness or rigid, limited thinking.**

For example: A high school mathematics teacher who had been trained in "traditional Mathematics" responded to her department's curriculum change to the "New Math" by exploring all of the details of the new system, considering its advantages and disadvantages when compared to the prior approach, and then generating teaching aids to help her students learn the new concepts.

1. **Generally able to consider and use new information and ideas, but shows some slight feeling of resistance in which the new information is experienced as threatening and greeted with some distrust and anxiety. Can reopen consideration without external pressure or supports. This internal struggle may not be obvious to others.**

For example: Single woman has idea that she is not forming relationships with men because fewer and fewer are available as she grows older. She reads an article that reports new data indicating that contrary to what is commonly believed, there is not a declining supply of men between ages 30 and 60. At first she dismisses the data as "ridiculous, patently false." Later, she is able to reconsider, to reread the article and note that the data were gathered by a reputable source and to consider whether her previous belief was a bias that helped her to dismiss any personal contribution to her social situation.

2. **Is somewhat open to novel information, but shows a definite tendency to undervalue new ideas. Strong external pressure must be present for persons to be able to consider the new point of view in a way that actually alters their previous outlook. Judgment is definitely impaired, and work and relationships suffer as a result.**

For example: Person who is generally "conservative" when it comes to considering any change, but may "come around" eventually, well after most others have integrated the change.

3. **Totally unquestioning correctness of own, rigidly held ideas. Not interested in new information and rejects any contradictory evidence out of hand, to the extent of bending or ignoring reality evidence.**

For example: Person who has reputation for being "close-minded," whose motto is "I already know what I think so don't confuse me with the facts."

B. FROM CONFIDENCE, TO CONFUSION AND SELF-DOUBT

0. **Can sort through available information and ideas with a sense of being able to determine what appears to be valid and what does not without undue doubt. Can discard ideas that don't seem compelling and keep those that do. Has a sense of conviction about own ideas.**

For example: The patient who can respond to a therapist's interpretive comments by considering them, elaborating on what's being suggested, and still be free to disregard or disagree in the face of contradictory internal evidence. For instance, Therapist: "You seem to be acting on the assumption that you shouldn't have needs and that, if you do, you shouldn't mention them." Patient: "You mean like with my friend the other night. I didn't tell him that I needed to get home early. I see what you're getting at. But, actually, it's not that I feel I shouldn't mention it to him; it's that I had told him a number of times and I was seething inside. It's more like I was telling you earlier. I just don't know what to do when I'm angry, so I just keep quiet."

1. **Generally values own opinion but shows some proneness to doubt, rumination, and uncertainty. Checks self and looks for confirmation from some other sources before feeling secure in ideas. Accomplishes these steps without pressure from others, rather with a sense of need for re-orientation.**

For example: Engineer has an idea about how to develop a new product. She writes up a project description but cannot locate any supporting ideas in the professional literature. She begins to doubt her idea and to assume that her reasoning has been faulty, but she can then return to her own idea when she comes back to approach the problem again.

2. **Shows some interest in being able to know and hold ideas with conviction, but shows a moderate tendency to become uncertain and doubt own opinions in the face of contradictory information and ideas. Can only regain own point of view with strong support from others. Ability to know and to hold judgments is definitely impaired, and work and relationships suffer as a consequence.**

For example: The doubting, procrastinating, balancing obsessional who's always checking sources, making lists of pluses and minuses, and weighing alternatives. Can ultimately make a reasoned decision under pressure of time and circumstance.

3. **Unquestioningly dependent on guidance solicited or extracted from others in forming ideas and opinions. Reports doubt or confusion about own ideas, memories, mental content. Pervasive lack of clear, active participation in any decision-making.**

For example: The extreme obsessional is ultimately unable to make a reasoned decision and throws things up to chance with frequent negative consequences.

5. PERSISTENCE

A. FROM ACCEPTANCE OF LIMITATIONS, TO "DRIVENNESS"

0. **Is able to accept limitations on what one can achieve without being driven past own limitations.**

For example: A man is offered a very attractive job opportunity. He turns it down after deciding that it is actually beyond his capabilities.

1. **In some situations is somewhat driven to achieve beyond own limitations. Although may suffer dysphoric affect, can soon enough act in accordance with limits, so that adaptive functioning is hardly compromised.**

For example: A woman agrees to take on an additional commitment because she feels she ought to, even though she knows she will be overextended. After struggling with it for a while, she realizes that it is not feasible and reluctantly withdraws.

For example: A man starts playing tennis for enjoyment, but begins to feel competitive with other much younger and better players. For a while he pushes himself beyond his limits. He realizes that he can no longer perform at that level and settles down with partners at his own level and begins to enjoy the game more again.

2. **Clearly pushes self beyond own limits but can back off; sometimes this requires confrontation or strong encouragement by others. Anger, depression, or other dysphoric affect accompanies recognition of a gap between aspirations and accomplishment.**

For example: A man tries to do everything extremely well and ends up overscheduling his day with work, social, and family activities. When his level of activity and drivenness affect his health and his doctor tells him to take it easy, he pulls back.

3. **Compulsion to achieve beyond any recognition of limitations results in seriously compromised functioning.**

For example: A man has almost no social and recreational activities because he is driven to pursue his occupational success to such an extent that he spends every waking hour at work. His inability to acknowledge his own limitations wreaks havoc with his life.

For example: A woman continually takes on so many activities that she is constantly overextended physically, emotionally, and financially. In spite of repeated instances of failing to come through on commitments and constant urgings from friends and family she is totally unable to put limitations on what she will take on. As a consequence, she ends up achieving little and seriously alienating others.

B. FROM ABILITY TO PERSEVERE, TO GIVING UP

0. **Is able to persevere on goals in the face of internal or external obstacles even when tempted to give up.**

For example: A person sends out several resumes for a job. All are rejected. Despite this he is not deterred and uses the feedback to create an improved version of the resume.

1. **Is generally able to persevere in the face of obstacles whether internal or external. On occasion, becomes discouraged and is tempted to give up. Is, however, able to remobilize and resume, with only minimal impairment of functioning.**

For example: A person sends out several resumes for a job. All are rejected, and the person becomes discouraged and decides to stop the search. After a while, he realizes that he really does want to change jobs, and continues the search.

2. **Tends to give up in the face of obstacles. The retreat does impair functioning. With encouraging input is able, with considerable effort, to resume.**

For example: A woman is known by her friends, family, and co-workers as someone who is easily discouraged and gives up. They all know it takes considerable prodding and encouragement to get her to persevere when the going gets tough. As a result, her accomplishments are substantially limited.

3. **Gives up in the face of obstacles so that functioning is very seriously affected.**

For example: A man has almost no social or recreational activities, and is only marginally employed. This is because any adversity produces paralyzing anxiety.

6. COMMITMENT TO STANDARDS AND VALUES

A. FROM TOLERANCE TO MORALISM

0. **Tolerant of individual variations in the interpretation of rules and standards of the social groups to which one belongs. Does not excessively hold to letter of the law.**

For example: A parent with strong religious convictions has a child who marries someone of a different faith, and is able to accept the spouse into the family.

For example: A therapist makes decisions about self-disclosure based on understanding the principle of neutrality rather than rigidly withholding information because of a "rule" against disclosure.

1. **May be temporarily somewhat self-righteous or intolerant of those who do not conform to norms, or may temporarily hold self to excessively high standards. Recovers with only mild impact on functioning.**

For example: A woman can tolerate sexual freedom in others without being judgmental, but is somewhat rigid about standards for her own conduct.

For example: A usually tolerant man develops a tendency to lecture his adolescent children on issues of propriety of behavior and thought.

2. **Highly attentive to following rules, obeying laws and conforming to a certain set of moral standards. Quite intolerant of those who violate standards. May acknowledge the existence of other value systems, but finds it hard to act on this understanding. Will reluctantly relax rigid stance when confronted by others. Functioning has meanwhile been impaired.**

For example: A woman seen as very "proper" in all aspects of her life refuses to continue a relationship when a friend does something she perceives as against her social code. Over time, when urged by others, she can make overtures to renew the relationship, though the friend has misgivings.

3. **Rigidly adheres to a social, religious or moral code with almost no tolerance for other value systems or for individual variation within own group. Refuses to acknowledge acceptable differences except in very extreme circumstances (e.g., life or death issues).**

For example: A member of a fundamentalist religious group refuses even to gain intellectual knowledge of other viewpoints, including not allowing own children to read such books in public schools.

For example: A woman spends so much time and energy monitoring and trying to "correct" the "morality" of friends, relatives, and co-workers that all her relationships are strained, and people avoid her whenever possible.

6. COMMITMENT TO STANDARDS AND VALUES

B. FROM ADHERENCE TO, TO ABSENCE OF, PRINCIPLED BEHAVIOR

0. **Understands and accepts the need for both informal values and encoded rules for the maintenance of cultural and social groups. Abides by ideals to an acceptable degree, without breaking rules or flouting standards of behavior. Balances needs/wishes of self with those of larger group to guide behavior.**

For example: A man is tempted to have an affair with a married woman he believes would be responsive, but decides not to pursue the relationship because he feels it would be wrong to do so and others could potentially be hurt.

For example: A restaurant owner has many opportunities to cheat on taxes because his business is conducted mostly in cash, but he keeps careful records and pays honestly.

1. **Usually understands and conforms to social standards and values, but may engage in behavior that is slightly counter to generally accepted moral standards. May feel somewhat resentful at being expected to conform, but will also usually feel guilty and alter the behavior and try to make amends to others.**

For example: A woman calls in sick unnecessarily during an especially stressful time at her job, without consideration for the extra load this puts on her co-workers. She feels badly about this all day and works hard to help others when she returns the next day.

For example: A woman does not correct the mistake when she is undercharged at a large department store, justifying her behavior by saying that she grew up poor and besides the stores charge too much for their merchandise. She does not do this in small neighborhood stores, and is honest in other situations.

2. **Definite pursuit of self-interest and willingness to break rules and social conventions and try to get away with things, unless monitored by others, or the negative consequences are clear and unavoidable.**

For example: A man is opportunistic in his business practices and most other relationships with the attitude that he should get his first, then let the others get what they can. At work, he manipulates to get the highest-pay clients, even when they should go to other colleagues whose turn it is. When he sees that this is embittering his relations with his co-workers, he will reluctantly concede their turns to others.

For example: A man has adequate financial resources but resents a court order and is consistently delinquent in paying child support to an ex-wife until she has her lawyer send threatening letters.

3. **Consistently resists the idea of authority, social conventions, or the imposition of standards for conduct. Only abides by blatant self interest, with attitudes and behavior regularly in active opposition to group norms and rules. Will act in ways that harm others without acknowledging their impact.**

For example: A businessman persistently engages in unethical or illegal deals like giving bribes or kickbacks to secure business. When caught, he at first denies it, but when presented with incontrovertible evidence, he claims that everyone would act this way and brazens it out.

7. COMMITMENT IN RELATIONSHIPS

A. FROM BEING ABLE TO DISENGAGE, TO COMPULSIVE OVERINVOLVEMENT

0. **Can disengage from problematic relationships, either wholly or in part, without feeling trapped by guilt, fear, worry, or false pride.**

   For example: Woman supports fellow worker in initial dispute w/boss but when it becomes clear that fellow worker is prone to engage in a series of disputes, the woman pulls back and does not become further embroiled in the ongoing battles.

1. **Generally able to maintain a sense of choice about engagement in relationships, but shows some tendency to become enmeshed beyond "sensible" limits. Can regain distance without external supports, but the process may feel somewhat "wrenching." Freedom of movement is slightly effected as a result.**

   For example: Person has a roommate who is generally inactive and lonely in the evenings. Every independent invitation the person receives is met with sighs and pouting from the roommate. On each occasion, the person feels torn, does choose to go, but feels occasional pangs of guilt when away and always on return.

2. **Values freedom of choice about relationships, but shows a definite tendency to be unable to disengage when this would be the appropriate course of action. Only able to detach or separate by concerted effort or by mobilizing special supports or in the presence of special external pressures.**

   For example: Person who is known in his family as "The Pushover" because of his difficulty in setting limits on problematic relationships. He feels compelled to respond to any emotional appeal and can only wrench himself away from these relationships if his spouse becomes fed up and intervenes.

   For example: Person is particularly sensitive about the issue of abandoning loved ones in need, can only take time off from caring for a severely ill spouse if he works himself into a state of exhaustion, so that his whole family intervenes and insists on some rest.

3. **Compulsively overinvolved, unable to disengage no matter how unrealistic, inappropriate, demanding, or confining the relationship.**

   For example: A dependent battered spouse doesn't consider leaving the relationship out of a mixture of worry that she will not be able to survive on her own, and that her spouse will not be able to survive without her.

B. FROM FIRM TO LIMITED, TENUOUS COMMITMENT

0. **Can maintain positive relationships. Can withstand pressures from adverse external circumstances and from "normal" fluctuations in the emotional climate of the relationship itself. This is not to say that the person does not experience times of frustration, disappointment and doubt about the relationship, but that these episodes are justified by the circumstances, and readily overcome.**

For example: A spouse's commitment to a basically good marriage is unshaken by partner's erratic mood and behavior during period of "mid-life crisis."

For example: Regardless of strong feelings aroused during the treatment, the patient does not doubt the benevolent interest and concern of the therapist and is not shaken in commitment to treatment.

1. **Generally able to form and maintain a sustained positive relationship, but is vulnerable to some doubt and weakening of commitment in times of trouble. These periods of doubt are reversible by the person without external assistance, although with difficulty at times. The relationship suffers only slightly as a result.**

For example: A spouse stays committed to a basically good marriage but talks or fantasizes divorce whenever there is a quarrel.

For example: A patient frequently feels misunderstood, disappointed or angry, and thinks and even talks about quitting treatment, while maintaining a basic sense of engagement with the therapist and the work.

2. **Shows definite proneness to doubt or devalue positive relationships in any time of difficulty. Functioning is moderately impaired and the person will only be able to maintain the relationship by real conscious effort or with situational supports or restraints.**

For example: A patient responds to any emotionally charged issue in treatment by threatening to quit and acting out through lateness and missed sessions. Nonetheless, the patient does stay in treatment.

For example: A person has strong worries about being trapped in a close relationship. He can maintain an enduring commitment to a married lover, or a lover who lives elsewhere and visits periodically, but should the lover divorce the spouse to remarry or move nearby to have more contact, the person breaks off the relationship.

3. **All positive relationships are tenuous and readily disrupted; does not make enduring commitments to positive relationships so that functioning is seriously compromised.**

For example: A bookkeeper loves the detailed work of his job, but will quite whenever he feels criticized or intruded upon.

For example: A person feels that he has always been hurt in relationships, and is ready to withdraw at the slightest sign of hurt.

8. RECIPROCITY

A. FROM ABILITY TO REGULATE TAKING, TO EXPLOITATION OF OTHERS

0. Does not take too much from others nor exploit them.

For example: A project leader receives an award and he does not grab all the credit but shares it with others without diminishing own role.

For example: A bereaved widow receives a great deal of help and support from friends and family and expresses her appreciation. Realizing how much they are putting themselves out for her, when she is feeling better she no longer accepts offers of help.

1. Generally can negotiate ways to take others' needs into account but sometimes will take some advantage of others. Is able to bring this back under control relatively easily and respond at the first hint that others object.

For example: A project leader faced with a deadline expects others to do more than their share of the work without giving them commensurate credit. However, after the deadline pressure is over, he is able to acknowledge their extra contribution.

For example: A male college student conveys to a woman friend that he cares more for her than he really does, in order to have sexual relations with her. He begins to feel regret about this and stops doing it.

2. Moderate tendency to exploit others. Uses people for own purposes without sufficient regard for the others' needs. Able to alter behavior only when others point it out to him and with considerable effort.

For example: A manager does not acknowledge other workers' contributions. She expects others to work for her without giving back much in return. When her fellow employees confront her with this behavior she grudgingly acknowledges it.

For example: A male college student will grossly mislead women about his level of interest and commitment for the purpose of a sexual conquest and then drop them with little remorse. He acts entitled and rationalizes that they wanted sexual relations as much as he did. When it becomes apparent how much he has hurt a woman, he feels badly and backs off.

3. Takes from others without taking their needs into account. Looks after own interests with no regard for the other person's needs. When others point this out or feel disappointed, it has little or no impact.

For example: A boss routinely presents subordinates work as his own. Takes excessive credit for joint efforts and cannot acknowledge team members' contribution to a joint project, even when it is directly pointed out to him.

For example: A woman with a venereal disease has sexual intercourse without informing her partners of the risk they are taking.

B. FROM ABILITY TO REGULATE GIVING TO OTHERS, TO SURRENDER OF SELF

0. **Does not give too much at the expense of the self.**

For example: A mother is asked to do a car pool for the neighbor's kids on an inconvenient day. She agrees to do it one time but stipulates that she can't do it every week.

1. **Slight tendency to give too readily without consideration of own needs. Self-sacrificing behavior can be easily modified when it becomes self-evident or when others point it out.**

For example: A housewife occasionally has difficulty doing things that are important to her when her needs conflict with husband and children. Under pressure of an emergency, she characteristically assumes a self-sacrificing role. After the emergency passes she has some difficulty insisting on having her own needs met, but can usually do so.

2. **Moderate tendency to give to others in a way that is neglectful of the self. Is very ready to give when someone else's needs are expressed and is often vulnerable to exploitation by others. Is able to inhibit excessive giving only with considerable effort or when others point it out.**

For example: Overly self-sacrificing woman sets aside things of importance to her to meet the needs of others. When someone points out to her how foolish and masochistic she is being, she can temporarily alter her behavior.

For example: A man feels obligated to take care of his dying parent virtually on his own, despite offers of help from other siblings. His overly self-sacrificing behavior is to the detriment of himself, his family and his career. When his sibs protest he is able to accept a little more of their involvement.

3. **Has to always be in the giving, self-sacrificing, or martyr position. Is highly vulnerable to exploitation by others. Actively seeks out or maintains relationships where one is constantly giving to someone else at the expense of the self. Is totally unable to insist on getting own fair share.**

For example: A husband stoically puts up with his wife's chronic alcoholism. This has caused him great emotional and financial hardship, but he feels it is his lot in life and should be borne.

For example: A wife repeatedly uses her inheritance to bail out her husband from his gambling debts.

9. TRUST

A. FROM OPENNESS TO OTHERS, TO EXTREME SUSPICIOUSNESS

0. Willing to relate to others with no undue expectations of betrayal, frustration, or disappointment, nor feelings of being too exposed and vulnerable. Does not question others' motives without good evidence. If feelings of skepticism or suspicion do occur, the person can step back and realistically assess the situation and decide whether to trust the other person.

   For example: A woman having lunch with an acquaintance has reason to talk with her about an important, personal subject. She begins with relatively distant or neutral aspects of the situation, watching how the other person reacts, and only when she sees a positive response does she tell the whole story.

1. Generally realistic in trusting appropriate people, but shows some tendency to have doubts or excessively cautious. Will eventually perceive that the doubts are unjustified and put them aside. Relationships with others and ability to function are only slightly affected.

   For example: A divorced woman is extremely cautious in establishing new relationships with men. She realizes in time that her generalized mistrust of men is unfairly applied in many cases and she is able then to socialize appropriately.

2. Shows a distinct tendency to question the motives, honesty or reliability of others. Such unrealistic suspicion can be overcome with concerted effort or with external support such as confrontation, additional evidence, or reassurance. Relationships are sometimes strained by guardedness, and functioning may be compromised by the repetitive need to address issues of trust.

   For example: A man is guarded with people he does not know well, and takes a long time to really trust anyone. Only over time has he been able to develop more open, trusting relationships with his wife and with longstanding friends.

3. Extreme distrust of others and misconstrual of behaviors. Convinced others will act against the self, and is not reassured by promises or evidence to the contrary. Relationships and daily functioning are seriously impaired by extreme suspiciousness.

   For example: A man questions the motives of everyone he knows, and never assumes that intentions are positive. He is always searching out ways others may be taking advantage of him and cannot maintain friendships because others become aware of this suspiciousness.

B. FROM AVAILABLE SKEPTICISM, TO EXTREME GULLIBILITY

0. **Trusts others only after a realistic appraisal of the person and the situation. Is cautious enough to protect own interests (by getting second opinions, etc.) when there is evidence of untrustworthiness or when the cost of an error in judgment would be great.**

For example: A woman inherits a considerable amount of money and asks friends for recommendations and carefully interviews several financial consultants before deciding which one she can trust most.

1. **Generally able to protect self and own interests by assessing situations and persons realistically, but shows a slight tendency to trust others too readily and to act on others' advice without adequate reflection. Is able to remind self and to take corrective measures spontaneously, so that functioning is only slightly impaired.**

For example: A man already heavily in debt is pressured by a friend to take another loan to join him in a rather risky venture. He initially goes along with the friend's plan, but then realizes that the friend is exaggerating the positive aspects and may be taking advantage of him. He cannot afford to take such a risk, and withdraws from the deal.

2. **Shows distinct tendency to act on others' advice, or accept their opinions without adequate reflection or independent assessment. This tendency to trust too much can be overcome with concerted effort or with external support, such as questioning by a friend, or evidence that such action is leading to negative consequences. Functioning is noticeably impaired by getting self into situations of exploitation.**

For example: A man is identified by all his friends and family members as a "soft touch," so that whenever anyone needs money or other favors, they ask him, with promises to repay him soon. He never asks for a specific understanding and is sometimes not repaid. His wife often needs to intervene to prevent his being exploited.

3. **Extreme gullibility. Discloses information or takes advice with no apparent ability to discriminate or assess others' trustworthiness. Seems convinced that no one would betray, disappoint, or take advantage of others and seems unaffected by evidence to the contrary. Daily functioning is impaired by lack of realistic guardedness and relationships may be unstable as one unreliable person replaces another.**

For example: A young woman does not seem to protect herself in any relationship. She is exploited by men who promise to take care of her, and then become abusive. When she is not living with a man, she tends to allow her female roommates to use her car and clothes, despite many past losses. She is always enthusiastic about any new relationship and consistently believes people when they promise not to abuse her again. Her life is frequently disrupted, as she moves around to live with new men friends or roommates.

10. EMPATHY

A. FROM APPROPRIATE DISTANCE, TO EMOTIONAL ABSORPTION

0. **Is able to distinguish between own viewpoints and reactions and those of the other, even in very emotionally-laden circumstances. Does not become absorbed by emotional states of other people.**

For example: A parent whose child is having a struggle with a teacher is able to listen to and resonate with the child's perceptions and feelings about the problem, but neither takes up the child's battle unnecessarily nor attempts to make the child see things the adult's way.

1. **May become overly reactive to the other's emotional state, expectations, or wishes. Can see and correct such a loss of distance. This has had a slight impact on functioning.**

For example: A woman's mother has a minor illness and wants the daughter to take a leave from work to be at home with her. The daughter's first impulse is to arrange a leave despite being involved in an important project, but she then has second thoughts and realizes this doesn't make sense. She feels somewhat guilty for not responding to her mother's wish, but also feels this is the appropriate course of action.

2. **Overresponds to the internal state of other people. Such distortions or losses of distance may be overcome with difficulty and may require external feedback and support. This has definitely affected functioning.**

For example: A woman works in a small office and cannot concentrate on her own work if any of her co-workers is in a bad mood. Instead she tries to elicit the story of what is causing the other person's distress, to comfort and help them. She will return to her own task when ordered to do so by her employer.

For example: A man has a difficult relationship with his own mother and gets involved in every argument his wife has with her mother, calling up his mother-in-law and extending the argument despite his wife's request to let her handle it herself. After discussion with his wife, he does calm down and apologizes to his mother-in-law.

3. **Strongly overreacts to the emotional states of other people. Not able, even with external support, to maintain appropriate distance.**

For example: A man gets so involved in the minor grievances of his friends that the friends are taken aback and withdraw from the relationship because the intensity of his emotional response is confusing and disturbing to them.

B. FROM EMOTIONAL RESPONSIVENESS, TO EMOTIONAL BLUNTING

0. **Responds to others' expression of feelings, without withdrawing or dampening own feelings.**

For example: A person who is involved in an accident is able to act quickly to call police and get medical help without being swayed by feelings, and cries later when the crisis is over.

For example: A woman has a friend who is extremely upset about a certain situation. She is able to suspend her own emotional reaction in order to help the friend assess what is going on and regain perspective.

1. **Some tendency to lose or withdraw from emotional contact with the other person. Can readily overcome this tendency to take distance with only slight impact on responsiveness.**

For example: A person responds to a stressful period in a marital relationship by spending more time at work and trying to keep conversations with spouse limited to task-oriented issues, but recognizes this tendency and either initiates or responds to spouse's invitation to an open discussion of their feelings.

2. **Definite blunting of emotional responsiveness to others. Responds mostly to external behavior with little emotional resonance. In the presence of distinct support or the pressure of circumstance, will be able to experience and acknowledge some emotional connection.**

For example: An employer lives "by the book" and expects all employees to do the same. He arranges the agenda of meetings so that there is no discussion of emotional responses to decisions or events, and never notices the emotional state of employees. He is surprised when feelings come up in meetings, but will make an effort, not always successful, to take feelings into account if someone goes to enough lengths to bring such issues to his attention.

3. **Almost completely unable to respond to emotional states of others. Extreme emotional detachment or flatness. May be inaccurate or uncertain about feelings or simply unaware of this realm of existence. Discussions of feelings are almost completely avoided.**

For example: A teacher is in a very blunt way consistently critical of students in front of entire class with no sense of awareness of the embarrassment involved for the students.

C. FROM TAKING THE PERSPECTIVE OF OTHERS, TO EGOCENTRICITY

0. **Able to understand others as having unique motivations and reactions, and as interpreting events from their own perspective, which may be different from that of the self.**

For example: A man is upset with a woman he has been dating because she went alone to a party at the home of a mutual acquaintance when he was not invited. He explains his reaction to her, including his feelings about not being invited initially and about her going without him. She explains her perception of the party and her feelings about going, even though he was not invited. Although neither of them changed how they felt, each could understand the situation from the other's perspective.

1. **Usually able to understand the motivations and reactions of other people, but at times this requires a special effort. Relationships with others only transiently affected by this behavior.**

For example: A woman who usually is quite understanding toward others finds that she is consistently unable to figure out or predict how a certain co-worker will react to interactions or events at their office. She asks the other woman to lunch and discovers that her background and expectations are very different from her own. With some effort, she is more able to understand their interactions.

2. **Has distinct problems with being able to grasp the point of view of others. With distinct support or the pressure of circumstance, can be gotten to do so.**

For example: A man characteristically has a hard time understanding multiple perspectives and reactions to events with his friends, family and colleagues. With women he dates, he cannot understand their behavior from their perspective, but only in terms of its effect on him. He finds it difficult, but after much effort on a woman's part to explain, he can grasp her separate perspective.

3. **Totally unable to grasp the perspective of others.**

For example: A man judges other people as successes or failures based on his values and on relatively superficial knowledge of their behavior and motivations. He is not able to conceive of other people having a different set of standards and is mystified when others find something admirable that he has no respect for.

11. AFFECT REGULATION

A. FROM CONTROL OF AFFECTS, TO OUT OF CONTROL "AFFECT STORMS"

0. **Can experience affects and exercise control in the sense of not accentuating, acting on, or venting them inappropriately. Does not experience or express unpleasant affects in a way that intimidates or frightens self or others; when pleasant or joyous affect is experienced, does not feel overtaken by it or gush or impose it on others.**

For example: A person recognizes that he has inadvertently hurt a friend's feelings. When he becomes aware of it, he feels regretful, apologizes and makes amends without lapsing into self-recrimination.

1. **In certain situations gives way to sudden or strong affect or spills it inappropriately but brings it back under control without much effort. Readily makes use of internalresources to restore equilibrium.**

For example: Following a disappointment at work, a man feels depressed and thinks about it a lot but stops ruminating when he notices how preoccupied he is becoming and how much it is starting to interfere with his functioning.

For example: A woman, following a success, finds it difficult to contain her enthusiasm and talk about anything else; however, she picks up social cues that she is overdoing it and moderates her behavior.

2. **Has moderately strong affects surges in a variety of circumstances. After person becomes aware of the inappropriateness, either through self-perception or others comments, control can be exerted and relative equilibrium restored, but only with much effort.**

For example: A man is prone to lose his temper whenever he is frustrated or opposed. At work he angrily snaps at his employees when they do not perform up to his expectations, but he can calm down when they refuse to be bullied. When playing tennis he may have a tantrum when he loses a hard-fought point, but can regain control with effort when confronted with his unacceptable behavior.

3. **Person has overwhelming affect surges that dominate internal experience and behavior and is likely to impose this on most people and most social situations.**

For example: After a minor slight to his self-esteem, a man becomes increasingly enraged, can't stop thinking about it, and vents it inappropriately in social situations with no recognition of his effect on others. Doesn't stop even when others protest.

For example: A woman cannot discuss any sentimental or poignant topic without crying, seems inordinately sensitive to sad or tragic elements in any situation and dwells on sad themes to the exclusion of everything else. Only stops crying when she is exhausted.

B. FROM TOLERANCE OF AFFECTS, TO HYPERCONTROL

0. **Is able to relinquish control over emotions and can tolerate painful or unpleasant affect without deflecting, avoiding, or suppressing it. Can allow pleasant or joyous affect without reining it in or inhibiting it.**

For example: A man experiences sad feelings following a loss, can allow himself to cry, and not feel unduly embarrassed or fear that it will overwhelm him.

For example: A man can allow himself to express joy or pride following an accomplishment and will not feel unduly embarrassed.

1. **Mild difficulties experiencing and expressing affect. May develop transient avoidant or inhibitory behaviors in certain situations or with certain persons, but readily regains the ability to experience and express feelings appropriately.**

For example: A person cannot spontaneously express sadness after the loss of a parent and is afraid to lose control. However, during the funeral, is able to show appropriate emotion.

2. **Moderate difficulty in experiencing and expressing affect. Appears somewhat flat, overly controlled, detached and uninvolved in a variety of circumstances. Often displays an affect-block or inhibition but can display emotion either with own considerable effort or when actively encouraged to do so. Interpersonal participation and personal functioning are definitely compromised.**

For example: A man cannot comfortably verbalize feelings of tenderness or love toward a woman he cares about and with whom he has been involved for many years. When she brings up this difficulty in expressing his feelings he can, with discomfort, respond. On special occasions, like a birthday, he can be more expressive verbally or perhaps non-verbally with a suitable gift.

3. **Maintains a strong and pervasive control over expressing affect whether potentially unpleasant or pleasant in character. Extreme agitation may surface with any threatened break in this rigid hypercontrol of affect. Maintains steely, numb, tight and rigid style. As a result, others cannot read his feelings and feel very uncomfortable.**

For example: A man is unable to experience or express any sadness when learning about a death in the family. Detached attitude leads his own children to call him a robot.

12. IMPULSE REGULATION

Note: This scale is used to evaluate control over impulses and appetites broadly defined as any pleasurable activity that has at least some driven, peremptory quality; for example, eating, drinking, drug use, gambling, impulse buying, etc. Interviewer should begin with a survey of the person's appetites and pleasures and then clarify their ability to regulate that impulse. Regulation of manifestly sexual and aggressive impulses is rated on separate scales.

A. FROM ABSENCE, TO PRESENCE OF, COMPULSIVE OVER-INDULGENCE

0. **Can control appetites and pleasurable activities. Is easily able to stop or delay when appropriate and without driven or compulsive overindulgence.**

For example: A man can thoroughly enjoy eating a gourmet dinner and drinking on occasion without concern about losing control or overdoing it.

For example: A woman gets a bonus and goes out and buys a wanted new dress with no urge to splurge it all.

1. **Under certain circumstances tends to overindulge, but is able to bring this back under control relatively easily and without constraints from outside.**

For example: A man enjoys celebrations and tends to have a few drinks too many at them, but is also able to moderate himself when necessary, for instance, when he has to drive home.

For example: A woman gets a bonus check and spends it too freely, but is able to get back on her usual budget when the money is spent.

2. **Definitely overindulges but can also regain control, although it may require considerable effort reinforced by urging from others.**

For example: A hard-driving executive drinks and smokes too much each day, but can also moderate himself when co-workers and family put pressure on him.

3. **Grossly overindulges with destructive consequences to work, health, and interpersonal relationships.**

For example: Every payday a man goes on a severe drinking bout and spends his money recklessly, despite the severe protestations of his wife and the major financial hardships that it causes.

For example: A woman parties every weekend with friends, using cocaine with ruinous consequences to her finances and health.

For example: A middle-aged man with a family history of diabetes and hypertension regularly overeats to the point where there is a dangerous risk to his health.

B. FROM ABILITY TO INDULGE IMPULSES, TO CONSTRICTED OVER-INHIBITION

0. **Can allow pleasurable impulses and pursue a particular goal without being either rigid or interpersonally controlling.**

For example: A man watching his diet passes up his favorite dessert.

For example: A woman gets a raise and instead of going shopping for clothes she has wanted decides to save the money toward a needed new car.

1. **Mild inhibition in indulging impulses. Under particular circumstances may feel constrained or inhibited, although it is usually temporary.**

For example: A young woman who likes wine, nevertheless feels worried about drinking too much and embarrassing herself if she has even one glass of wine. However, this is not a big deal all the time and she can relax and allow herself this pleasure from time to time.

2. **Inhibited impulse expression. Can only indulge impulses in special circumstances or with certain people. Indulging may, but not always, be associated with feelings of guilt.**

For example: Despite her relative affluence, a woman is overly controlled about spending any money on clothes. As a result, she restricts herself to only buying clothes that are on sale rather than getting what she really wants.

3. **Maintains a strong and pervasive control over impulses, even when some relaxation of control is appropriate. Very much afraid of losing control; maintains tight, rigid control in all situations. As a result, appears to others as unspontaneous and little fun to be with.**

For example: A wealthy man is terrified by the specter of financial insecurity and always orders the cheapest meal whenever he goes out to a restaurant.

13. REGULATION OF SEXUAL EXPERIENCE

Instructions to raters: Rate the patient based on sexual functioning considered broadly, including fantasy, feeling and behavior.

A. FROM ABILITY TO INHIBIT SEXUAL EXPRESSION, TO IMPULSIVE OR DRIVEN EXPRESSION

0. **No tendency toward impulsive or driven sexuality. The person can turn away from inappropriate contexts for fantasizing about or gratifying sexual impulses.**

For example: A man enjoys sex for its own sake, but does not need it to allay anxiety. If he loses his sexual partner, he can take time to look for a suitable partner without a frenetic need.

1. **Generally able to exercise judgment about when not to indulge sexual impulses and fantasies and able to express sexual needs in a satisfying and appropriate way. Under some circumstances, however, may become excessively preoccupied with sex or overly active, but can regain appropriate control relatively easily.**

For example: In certain situations of questionable appropriateness, a man tells dirty jokes but he gets embarrassed and stops.

For example: A man requires a particular perverse fantasy to achieve sexual gratification; the fantasy does not affect his overt sexual behavior. His partner can even be unaware of the presence of the fantasy.

2. **Definite tendency to act sexually in impulsive, or driven ways. With external pressure or if faced with unpleasant consequences, will feel uncomfortable about this and curb the behavior. These behaviors cause some impairment of social functioning or risks to health.**

For example: A woman is preoccupied with sexual thoughts in a way that intrudes into other activities. In social situations she often brings up sexual topics and jokes in a way that is embarrassing to others, and only stops when others make a strong request.

For example: Sexual experiences are contingent on intrusive vivid sadomasochistic fantasies and seeks to have partner share them. When the partner demurs, sexual gratification is impaired.

3. **Highly driven, impulsive or bizarre sexual expression. Preoccupation with sexuality which seriously intrudes into work and/or social relationships.**

For example: A promiscuous man constantly searches out new sexual partners and becomes intensely anxious if none are available.

For example: A man cannot refrain from making sexual jokes and comments at inappropriate times and embarrasses himself and those around him. When others press him to stop, he ignores this and laughs at their prudishness.

For example: A woman insists, despite his discomfort, that her partner beat her, in order for her to feel sexually satisfied. She has no interest in any sexual activity in which her partner does not adhere completely to a role she has scripted for him.

B. FROM ACTIVE SEXUAL INTEREST AND EXPRESSION, TO INHIBITION

0. **Is interested in and able to express sexual needs. Sexual fantasy and activity are enjoyed and actively initiated. No evidence of sexual inhibition.**

   For example: A person looks forward to and enjoys sexual experiences. Is able to initiate sexual activity, or be responsive when partner initiates it.

1. **Usually feels sexual interest and expresses needs without inhibition, but may under certain circumstances or with certain people feel constrained. Under particular circumstances which may be associated with feelings of guilt or anxiety there may be a withdrawal or inhibition of sexual interest and a blocking of sexual fantasy; however, the inhibition is usually only transitory.**

   For example: A woman feels more comfortable engaging in sexual activity with her husband at night with the lights out. She doesn't initiate any sexual relations during daylight but if approached, she feels anxious but goes along with it.

   For example: A man wants to engage in sex at the beginning of a new relationship, but feels inhibited and anxious. Although his partner is willing, he delays some period of time to help overcome his anxiety.

2. **Definite tendency to inhibit sexual interest and expression. Can come out of withdrawal, or overcome inhibition, with the urging of a willing partner and with effort. Definite impact on sexual relations.**

   For example: A young woman, even when sexually interested in a man, feels very inhibited. She may engage comfortably in some sexual play but additional sexual activity makes her very uncomfortable and is not pleasurable.

   For example: A man can become sexually interested in and able to perform sexually with women he considers socially beneath him, but is much more anxious and quite inhibited with appropriate partners.

3. **Avoids sexual activity and shows no current interest. If put in a situation where sexual activity is expected, the person will feel intensely anxious. Lacks overt sexual drive. May have no conscious sexual wishes, fantasies, or thoughts; leads a predominantly asexual life.**

   For example: A withdrawn man shows no sexual interest or involvement. Feels intensely anxious and guilty about the thought of sex, but rationalizes that he is too busy with work and hobbies to get involved.

14. SELF-ASSERTION

A. FROM ABILITY TO YIELD, TO BULLYING

0. **Is able to follow other's lead, to give up pursuit of one's own goal, or to concede a point when that is the appropriate course.**

For example: A man recently promoted to a management position forcefully presents some ideas for reorganizing his office, but meets with resistance from the staff. He is able to drop the idea without resentment or loss of self-esteem when he sees that pushing too hard will create poor morale.

1. **For the most part, is able to adopt a flexible course of action or lose a battle when there are good reasons to yield. However, finds it somewhat hard to lose an argument or may push demands slightly beyond reasonable limits. Experiences some discomfort (e.g., resentment, humiliation) about "giving in," but can do so appropriately, so relationships are only slightly impaired.**

For example: A woman doesn't forget a certain argument with her husband and attempts to bring up the issue long after he feels it should have been settled. She catches herself at this and can then drop her argumentative stance.

2. **States views strongly and attempts to take charge and have wishes carried out without adequate consideration of rights of others, social impact, or other consequences. Likely to be somewhat intimidating in the use of power. Clearly reluctant to recognize when someone else presents a better argument or has the right to decide what is done. Yields only after persistent pressure from others or after extreme internal effort.**

For example: A man argues strongly in any situation where a decision is to be made, is unwilling to abide by a group decision if he does not agree with it, and constantly lobbies to have it changed. He stops arguing only with distinct pressure from someone of higher authority or the entire group.

For example: A shop foreman likes to have things his own way. He uses his authority over working conditions to force others to submit. Backs off when the workers complain to the front office.

3. **Chronically aggressive, bullying, and possibly threatening toward others. Tries to force others to obey, and refuses to concede a point or to act according to another person's wishes. Does not acknowledge the rights of others, or discriminate between what is worth fighting for and when it might be better to drop an argument. If pressured to leave, may threaten to leave the relationship. All relationships are adversely affected by over-aggressive style.**

For example: An employer insists that all his staff follow rigid requirements, and threatens to fire people for minor infringements, a threat he sometimes carries out. He refuses to listen to anyone perceived as "lower" in status and considers any act of independence as insubordination.

B. FROM ABILITY TO ASSERT OWN INTERESTS, TO TIMIDITY

0. **Able to assert own interests without being unduly hampered by inhibition or intimidated by external prohibition.**

For example: A person for whom the time has passed for a merit review and salary increase brings up the subject to employer and delineates reasons why the raise is deserved. This is done straightforwardly, with a sense of security.

1. **For the most part, is able to assert own wishes and interests, but shows some tendency to capitulate in order to avoid uncomfortable confrontations. Experiences slight uneasiness about self-assertion and may tend to rationalize not acting, but is capable of pushing a point when an issue is perceived as important.**

For example: A man who is generally able to negotiate with his wife wants to do something he knows she will object to. He hesitates to bring it up, dreading the argument which might ensue, but is able to tell himself that what he wants is important enough to risk an argument.

2. **Shows a definite tendency to inhibit self and fails to act in own behalf because of a perception that this is necessary to "keep the peace" or avoid conflict. Assertive behavior occurs only when directly asked or encouraged, and then with reluctance and significant discomfort.**

For example: A woman goes along with any plans made by others, feeling that no one really cares what she wants, unless she is asked repeatedly to state a preference.

For example: A man tries to rearrange his work schedule to allow him to share child rearing responsibilities and meets with a great deal of resistance from his colleagues. He is strongly tempted to go back to the old, less convenient schedule in order to avoid the pressure, and is barely able to stick to his own plans with strong counter-pressure from his wife.

3. **Chronically passive and timid and ready to abandon own interests. Extremely uncomfortable making slight everyday requests; yields to others very easily, even to detriment of self.**

For example: A woman consistently gives up her own plans, including important ones, without even mentioning them, when anyone asks her to do something else.

15. RELIANCE ON SELF AND OTHERS

A. FROM SECURE RELIANCE ON OTHERS, TO RARELY ABLE TO RELY ON OTHERS

0. **Able to rely on others with no real exceptions. Done without noticeable anxiety, suspicion, humiliation, or resentment. Appreciates that in certain areas or circumstances others may have resources or capacities to offer not possessed by the self, without feeling inadequate or insufficient.**

For example: A female attorney especially enjoys collaborating with others who have skills that complement her own. She relies confidently on their judgments in areas of their special experience. People like to work with her because they feel valued and trusted by her.

1. **Usually able to rely on others, with some circumscribed exceptions. Exceptions characterized by presence of some anxiety, suspicion, or humiliation, but person nevertheless able to function, perform relevant tasks adequately.**

For example: A scientist prefers working alone because he feels nervous about relying on the judgment of others when working collaboratively. Nevertheless, he can and does, albeit with discomfort, productively carry out collaborative research.

2. **Moderately difficulty in relying on others. Likely to experience definite anxiety, suspicion, or humiliation. While able to overcome difficulties, this requires much effort and/or external reassurance. Functioning is noticeably affected.**

For example: A person feels humiliated whenever he has to seek or incorporate advice of any kind from another person. Despite this discomfort can, when pressed, accept help, albeit with a disgruntled or sulking attitude.

3. **Rarely relies on others by choice, only when forced. Very pervasive disability with intense anxiety, suspicion, or humiliation generated in most circumstances where there is any pressure to rely on others. Functioning seriously compromised.**

For example: A young man becomes enraged whenever he finds himself in need of help from others.

B. FROM SECURE SELF-RELIANCE, TO RARELY ABLE TO RELY ON SELF

0. **Able to rely on self with no real exceptions. Person able to use own resources or capacities and function alone without any significant anxiety, loneliness, sadness, or feeling depleted.**

For example: A businessman usually works closely with his partner on all aspects of their small business, but is left to handle everything on his own for several weeks while his partner is in the hospital. While this involves considerable effort and is taxing, he matter-of-factly and confidently goes ahead and does his best without any anxiety or resentment.

For example: An artist enjoys working alone on his current project and tells his wife not to let anyone disturb him for several hours.

1. **Usually able to be self-reliant with some circumscribed exceptions. Exceptions characterized by presence of some anxiety or loneliness, but person nevertheless able to function alone and performs relevant tasks adequately.**

For example: A professional prefers doing collaborative work because he feels lonely and has trouble concentrating when working by himself. Nonetheless, he can and does, with some discomfort, successfully carry out solitary endeavors.

For example: A man feels he needs to take his wife along to help him when he shops for clothes. It's not that he can't do this by himself, but he would much rather not because the process makes him anxious. He rationalizes this need by thinking of his wife as having a better sense of design and color matching than he does.

2. **Moderate difficulty in relying on self. Can do so only with definite anxiety, loneliness, or sadness. Noticeable effect on functioning; may not always be able to adequately carry out actions or tasks.**

For example: A housewife gets terribly anxious, almost panicky, whenever she has to make decisions--of any kind--without the help of her husband. Nonetheless, she does, when forced by circumstances, make these decisions.

3. **Not self-reliant by choice, only when absolutely forced. Circumstances which call for self-reliance result in loneliness, or sadness. Functioning seriously compromised.**

For example: A person makes frantic attempts to get others to do things with or for him rather than do them by himself.

For example: A young man becomes disorganized and experiences panic while shopping for a car, when his father has to leave for awhile.

For example: A widow requires company when venturing out of the house for almost any reason. Without someone with her, she experiences overwhelming anxiety. This problem emerged shortly after the death of her husband, on whom she had depended extensively.

C. FROM SECURITY IN HAVING OTHERS RELY ON SELF, TO RARELY ABLE TO BE PERSON RELIED UPON

0. **Able to let others rely on self. Willing and able to provide (if asked) or spontaneously offer emotional support, comfort, or other help, without noticeable ambivalence and/or dysphoric affect.**

For example: A man is viewed by his close friends as someone they can confidently turn to for emotional support during difficult times. When he provides support he does so willingly and without making them feel inadequate. In the work setting he values collaboration where his own resources complement those of others.

1. **Usually able to allow others to rely on self but some circumscribed exceptions. Exceptions characterized by some ambivalence and/or dysphoric affect. But person nevertheless able to function, perform relevant tasks, adequately.**

For example: A man is generally viewed by his close friends as someone they can turn to for emotional support during difficult times. When older male friends attempt to get support from him, however, he is aware of feeling some ambivalence about providing it. This ambivalence is connected with a vague sense of resentment toward older men who present as needy in any way. He is aware that this is an unfair and irrational feeling and is able to go ahead and be supportive. These men may or may not pick up his ambivalence, but in any case it is not so problematic that they avoid relying upon him.

2. **Moderate difficulty in letting others rely on self. Done only with ambivalence and dysphoric affect. Noticeable impairment in functioning.**

For example: A woman finds herself quite resentful whenever someone comes to her for help. Despite her wishes and considerable effort to be otherwise, she does not really succeed in masking these feelings. While she does not spontaneously offer help, when directly asked she will agree. Others are relatively reluctant to seek her out.

3. **Not able to allow others to rely on self, only when forced. Very pervasive disability with intense ambivalence and dysphoric affect generated in most circumstances where there is pressure to provide emotional support for others. Functioning seriously compromised.**

For example: A woman is overwhelmed by feelings of depletion and resentment whenever someone in distress approaches her for comfort or support. She seldom offers help to others. When approached, she often becomes angry and pushes the person away, saying things like "Take care of yourself, I have enough trouble handling my own problems." This posture has negative implications for her relationships.

16. SELF-ESTEEM

A. FROM HUMILITY TO GRANDIOSITY

0. **Can put own accomplishments in perspective without a sense of arrogance, conceit, or depreciation of others. Is seen by others as appropriately modest. If momentarily inflated, person readily bounces back due to an intact ability to realistically evaluate situations.**

For example: At a regular meeting of a moderately large business organization, an executive is surprised by the presentation to her of an award for an unusual contribution to the company. She blushes at first but then bursts into an obvious smile of self-pride that gratifies her colleagues for making her feel good. Later during that day she enjoys pleasant fantasies of being the company president and increasing productivity tenfold. At the same time, she is quite aware that achieving such a position would mean many more years of sustained effort.

1. **Circumscribed but non-crippling areas of over-evaluation of self. May put on airs in these areas and may alienate other people. Functioning is not objectively impaired; person is not so preoccupied that cannot concentrate or so impaired that performance is affected.**

For example: A car salesman who is generally liked by his co-workers privately feels he is the most effective salesperson in his group, despite the fact that sales records indicate otherwise. He at times subtly communicates this attitude, which irritates his co-workers.

2. **Moderate tendency to over-evaluate self in several areas. There is danger of alienating others by inappropriate statements or actions. Alienating behavior may be inhibited only with considerable effort by self or by some sort of aid (forceful feedback or confrontation) from others.**

For example: A medical resident who is of average ability has a tendency to put on airs of intellectual superiority to fellow residents. She is puzzled when they try to give her feedback about why she is alienating them, though with effort she is able to inhibit self-aggrandizing statements after such feedback.

3. **Constant over-evaluations of self. Presence of arrogance, haughtiness, with no distance. There is very little self-doubt, and person acts on beliefs of superiority or grandiosity.**

For example: A mediocre physicist believes he is destined to become a Nobel laureate and consistently acts as if superior to his co-workers. When they confront his obnoxious attitude, he confidently shrugs it off as their jealousy.

For example: A lawyer who is of mediocre ability constantly puts on airs of intellectual superiority to colleagues in his firm. Attempts at feedback have no effect on self-inflating remarks, and this stands in the way of his being considered for partner.

B. FROM SELF-RESPECT TO SELF-DEPRECIATION

0. **Usual level of global self-respect is high. This includes a secure view and sense of self as a person of worth. This does not exclude transient episodes of disappointment in self or feelings of shame, especially when criticisms are judged valid or come from highly valued sources. Self-respect is readily restored when interrupted.**

   For example: A college student who usually gets "A's" in her courses and cares about being a good student feels chagrined for a few minutes after finding out that she got a "C" on a particular test. She then admits to herself that, in fact, she didn't prepare for the test, deserved not to do well, and decides to spend extra time on this course. She subsequently goes about her day without any remaining dysphoria about this.

1. **Moderate level of global self-respect, but a proneness to periods where it drops. Although there may be considerable dysphoria at such times, functioning is minimally or not at all affected from an external perspective. Self-respect is restored without undue difficulties.**

   For example: A college student who generally feels okay about herself berates herself severely for a day or so when, for some inexplicable reason, she gets less than an "A" on an exam. This does not, however, appreciably affect her ability to study and is not picked up by her friends.

2. **Moderately low level of global self-respect. There are expressions of self-depreciation that are likely to be noticed by others. Restoration of a some self-respect takes effort and may require external supports. Functioning is impaired, though not grossly. Person may be confused about self-worth.**

   For example: A college student frequently disparages his own abilities in friendships, schoolwork, and athletics. He is usually able to function in these areas, but after a setback in almost any area has to get special support from friends in order to regain a modicum of self-respect.

3. **Low to very low level of global self-respect. Views self as unworthy, inadequate, and seriously deficient most of the time. Functioning is seriously impaired and external supports have only transitory effects.**

   For example: A college student feels so self-deprecatory after not getting an "A" that she decides to drop the course and considers dropping out of school because she isn't worth being offered an education. Friends fail in their attempts to reassure her that she is not a bad person just because she didn't get an "A."

17. SELF-COHERENCE

A. FROM COHERENCE, TO INCONSISTENCY OF BEHAVIOR AND EXPERIENCE

0. **Private experience as well as public behaviors are coherent, in that they characteristically reflect an internal consistency among person's actions, thoughts, and affects. Coherence is reflected in behavior that is reasonably consistent over time and in a variety of circumstances. There is an inner sense of harmony and a feeling that the various aspects of oneself really fit together.**

For example: After acquiring a new skill, person is aware of strange feeling like "Was it really me who did that?" This feeling goes away fairly quickly as the skill is consolidated.

1. **Circumscribed disruption in coherence of self (as defined above). While person may be quite bothered by this, it does not discernibly affect functioning and others may not be aware of it.**

For example: A woman finds herself having deprecatory feelings toward a minority person at work that are completely inconsistent with her thoughts about herself as an unprejudiced person. She wishes she didn't have these feelings but she does, and this makes her feel uncomfortable with herself, as if she shouldn't have the feelings that she does.

For example: A woman who has achieved professional status and recognition has trouble experiencing her own actions as having legitimately led to this. She frequently feels like an imposter, despite the fact that rationally she realizes that this is unfounded. Except for a tendency toward self-effacement, no one really notices this and she continues to perform at a high level.

2. **Moderate disruption in cohesion of self. Able to function, albeit with difficulty.**
There are two forms in which disruption of cohesion may be manifest: One involves a disturbance in sense of self-coherence directly accompanied by anxiety. A second involves a pattern of internally inconsistent statements and actions that is obvious to others yet may not be noticed by the person. This pattern may get person into problematic situations or relationships that then secondarily generate frustration, anger, or anxiety. These two forms may occur in an individual at different times.

For example: A young man has trouble firmly knowing his own mind. He searches for external validation. In the absence of validation or in the presence of contradiction, he becomes confused. Although this can create discomfort and awkwardness in various contexts and types of relationships, in structured situations when not under pressure to state feeling or opinions he functions quite well.

3. **Pervasive disturbance in coherence. Functioning is seriously impaired. Either such persons constantly need to attend to disruptions in their sense of coherence or their inconsistent actions make relationships chaotic. Two major types of manifestations may occur simultaneously or at different times in the same individual: One involves a major and pervasive disturbance in sense of self-coherence, with accompanying panic or other strong dysphoric affect. Another involves a pattern of inconsistent statements or actions that is patently obvious to others yet may be unnoticed by the person; this pattern is likely to get person into untenable situations or relationships that generate severe frustration, rage, or anxiety.**

For example: In social settings a woman frequently feels like she is outside herself, observing herself from a distance. When talking with another person she is prone to feeling sort of funny, like the conversation she is having isn't really being carried out by her, or like she is in a dream. These experiences are frightening for her and interfere in forming relationships, which she avoids. Others react to her as odd, distant, or preoccupied and confused. She can only manage to work in situations where she works alone.

For example: A man frequently acts in ways that are highly inconsistent and contradictory. This makes him prone to erratic and disorganized behavior in many contexts. When this gets him into

example cont.:
trouble with others, he becomes confused and doesn't understand what they are talking about. He may then become panicky and feel like he must be two different people. This man has chaotic relationships and can't hold down a job because he is prone to serious interpersonal conflict.