ADVANCED 2 DAY INTENSIVE TRAINING: COGNITIVE-BEHAVIOURAL THERAPY FOR MULTIPLE SYMPTOM SETS

Created For: Jack Hirose and Associates

July 26-27, 2021

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CBT FOR MULTIPLE SYMPTOM SETS: DAY 1 AGENDA

- Introductory Remarks
- Socialisation to the Cognitive Model
- Levels of Cognition
- Early Maladaptive Schemas
- Behavioural Pattern Breaking
- Cognitive Conceptualisation
- CBT Tools and Techniques
- Application to Clinical Practice

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MYTHS ABOUT CBT

- CBT Deals only with matters of the head and not matters of the heart
- In CBT the therapeutic relationship isn't important
- CBT is helpful for simple problems, but to treat more serious problems you need a more complex approach
- CBT is just about positive thinking
- CBT doesn't get at the "root" of the problem

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WHY CBT??

- Easily implemented in clinical setting
- Evidence based treatment
- Neurobiological findings

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COGNITIVE BEHAVIOR THERAPIES

"A SET OF PSYCHOTHERAPEUTIC INTERVENTIONS THAT ATTEMPTS TO HELP CLIENTS AMELIORATE SYMPTOMS AND ENHANCE GENERAL WELL-BEING BY FOCUSING ON DIFFERENT ASPECTS OF THINKING AND BEHAVIOR"

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CBT UMBRELLA/"OFFSHOOT" MODELS

- Rational Emotive Therapy
- Schema-Focused Therapy
- Dialectical Behavior Therapy
- EMDR
- Acceptance & Commitment Therapy
- Strengths Based Cognitive Therapy
- Trial - Based Cognitive Therapy
- Mindfulness-Based Cognitive Therapy

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ADVANCED COGNITIVE BEHAVIOR THERAPY (CBT)

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DIALECTICAL BEHAVIOR THERAPY (DBT)

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DIALECTICAL BEHAVIOR THERAPY

- Developed by Marsha Linehan in the 1970s
- Looking for a method to treat chronically suicidal
- Found traditional CBT to be too invalidating
- Added validation to empirically supported CBT
- Concept of Dialectics

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DIALECTICAL BEHAVIOR THERAPY

"Juxtaposes contradictory ideas and seeks to resolve a conflict; a method of examining opposing ideas in order to find truth"

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DIALECTICAL BEHAVIOR THERAPY: CORE MODULES

- Mindfulness Skills
- Emotion Regulation Skills
- Distress Tolerance Skills
- Interpersonal Effectiveness Skills

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COGNITIVE BEHAVIOR THERAPY (CBT)

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COGNITIVE BEHAVIOR THERAPY (CBT)

- Aaron T. Beck, 1960, University of Pennsylvania
- Principle that thoughts influence feelings

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ADVANCED COGNITIVE BEHAVIOR THERAPY (CBT)

Events  Thoughts → Feelings → Actions → Results

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COGNITIVE BEHAVIOR THERAPY - CORE BELIEFS

- Core Beliefs/Schemas
- Beck identified beliefs in 3 different areas
  1. Beliefs about self
  2. Beliefs about others
  3. Beliefs about the world

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COGNITIVE BEHAVIOR THERAPY - TENETS

- Term "schema" Coined in 1926 by Piaget - "Structures that integrate meaning into events
- Beck - "Cognitive structures that organize experience and behavior"
- Landau & Goldfried - "mental filters that guide the processing of information"

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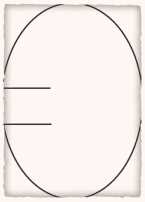
COGNITIVE BEHAVIOR THERAPY - TENETS: IDENTIFYING CORE BELIEFS



Judith Beck, 2011

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COGNITIVE BEHAVIOR THERAPY - TENETS: IDENTIFYING CORE BELIEFS

- Example Beliefs About Self
  - I am a failure
  - I am worthless
  - I am vulnerable
  - I am helpless
  - I am a burden
  - I am defective
  - I am unlovable

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COGNITIVE BEHAVIOR THERAPY - TENETS: IDENTIFYING CORE BELIEFS

- Example Beliefs About Others
  - Others are mean
  - Others are uncaring
  - Others are self-absorbed
  - Others aren't deserving of my time
  - Others are to be taken advantage of
  - Others are unreliable
  - Others are untrustworthy

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COGNITIVE BEHAVIOR THERAPY - TENETS: IDENTIFYING CORE BELIEFS

- Example Beliefs About the World
  - The world is exciting
  - The world is boring
  - The world is scary
  - The world is evil
  - The world is a lost cause
  - I am defective
  - The world is dangerous

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ADVANCED COGNITIVE BEHAVIOR THERAPY (CBT)

Events ⟷ Thoughts ➡ Feelings ➡ Actions ➡ Results

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SCHEMA FOCUSED THERAPY (SFT)

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SCHEMA FOCUSED THERAPY (SFT)

- Broad, comprehensive theme or pattern
- Comprised of memories, cognitions, emotions, bodily sensations
- Developed in childhood, elaborated in adulthood
- 18 Schamas in 5 different domains

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SCHEMA FOCUSED THERAPY (SFT)

- Domain #1: Disconnection and Rejection
  - Abandonment
  - Mistrust
  - Defectiveness
  - Emotional Deprivation
  - Social Isolation

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SCHEMA FOCUSED THERAPY (SFT)

- Domain #2: Impaired Autonomy & Performance
  - Dependence
  - Vulnerability
  - Enmeshment
  - Failure

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SCHEMA FOCUSED THERAPY (SFT)

- Domain #3: Impaired Limits
  - Entitlement/Grandiosity
  - Insufficient Self-Control

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SCHEMA FOCUSED THERAPY (SFT)

- Domain # 4: Others Directness
  - Subjugation
  - Self-Sacrifice
  - Approval Seeking

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SCHEMA FOCUSED THERAPY (SFT)

- Domain #5: Overvigilance
  - Negativity
  - Emotional Inhibition
  - Unrelenting Standards
  - Punitiveness

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SCHEMA FOCUSED THERAPY (SFT): CHARACTERISTICS OF SCHEMAS

- Active vs Dormant
- Compelling
- Pervasive vs Discrete

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COGNITIVE BEHAVIOR THERAPY (CBT): SCHEMA REINFORCEMENT PROCESS

- Maintenance
- Avoidance
- Overcompensation

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SCHEMA MODIFICATION: BEHAVIOURAL PATTERN-BREAKING

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Cognitive Conceptualisation: The Road to Recovery

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COGNITIVE CONCEPTUALIZATION: THE ROADMAP TO RECOVERY

- Develop Hypothesis
- Look for Opportunity to Share With Patient
- Ongoing with Accumulation of New Data

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CONCEPTUALIZATION DRIVES GOAL SETTING

1. Problem List
2. Goal List
3. Behavioral Targets
4. Identify Triggers for Behaviors
5. Identify Cognitions associated w/ target behaviors

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CONCEPTUALIZATION DRIVES TREATMENT PLANNING

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DOCUMENTATION ACRONYM

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CONCEPTUALIZATION DRIVES DOCUMENTATION

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CBT TOOLS AND TECHNIQUES

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Types of Interventions

1. Environmental Interventions
2. Behavioral Interventions
3. Cognitive Interventions
4. Pharmacological Interventions

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COGNITIVE INTERVENTIONS

1. Mindfulness
2. Distraction
3. Cognitive Restructuring

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MINDFULNESS

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COGNITIVE INTERVENTIONS

1. Mindfulness
2. Distraction
3. Cognitive Restructuring

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DISTRACTION TECHNIQUES

1.Take a hot bath
2.Paint
3.Go for a walk
4.Play a game on my phone
5.Go to a club
6.Stretching exercises
7.Practice Karate/Martial arts
8.Lift weights
9.Play with yarn/stressball
10.Call a friend

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COGNITIVE RESTRUCTURING

- Identify and Label Distortions
- Challenging
- Rational Disputation
- Statistics and Likelihood
- Imagery
- Perspective/Comparison
- Polling Exercises
- Belief Modification Strategies

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COGNITIVE DISTORTIONS

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IDENTIFYING AND LABELLING COGNITIVE DISTORTIONS

1. Rationalization. In an attempt to protect yourself from hurt feelings, you create excuses for events in life that don't go your way or for poor choices you make. We might call these *permission-giving statements* that give ourselves or someone else permission to do something that is in some way unhealthy.

2. Overgeneralization. You categorize different people, places, and entities based on your own experiences with each particular thing. For example, if you have been treated poorly by men in the past, "all men are mean," or if your first wife cheated on you, "all women are unfaithful." By overgeneralizing, you miss out on experiences that don't fit your particular stereotype. This is the distortion on which all of those "isms" (e.g., racism, sexism) are based.

3. All-or-nothing thinking. This refers to a tendency to see things in black and white categories with no consideration for gray. You see yourself, others, and often the whole world in only positive or negative extremes rather than considering that each may instead have both positive and negative aspects. For example, if your performance falls short of perfect, you see yourself as a total failure. If you catch yourself using extreme language (best ever, worst, love, hate, always, never), this is a red flag that you may be engaging in all-or-nothing thinking. Extreme thinking leads to intense feelings and an inability to see a "middle ground" perspective or feel proportionate moods.

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COGNITIVE DISTORTIONS

4. Discounting the positive. You reject positive experiences by insisting that they "don't count" for some reason or another. In this way, you can maintain a negative belief that is contradicted by your everyday experiences. The terms *mental filter* and *selective abstraction* basically describe the same process.

5. Fortune telling. You anticipate that things will turn out badly and feel convinced that your prediction is already an established fact based on your experiences from the past. Predicting a negative outcome before any outcome occurs leads to anxiety.

6. Mind reading. Rather than predicting future events, engaging in this distortion involves predicting that you know what someone else is thinking when in reality you don't. This distortion commonly occurs in communication problems between romantic partners.

7. Should statements. You place false or unrealistic expectations on yourself or others, thereby setting yourself up to feel angry, guilty, or disappointed. Words and phrases such as *ought to, must, has to, needs to*, and *supposed* to are indicative of "should" thinking.

8. Emotional reasoning. You assume that your negative feelings reflect the way things really are. "I feel it, therefore it must be true."

9. Magnification. You exaggerate the importance of things, blowing them way out of proportion. Often, this takes the form of fortune telling and/or mind reading to an extreme. This way of thinking may also be referred to as *catastrophizing* or *awfulizing*.

10. Personalization. You see yourself as the cause of some external negative event for which, in fact, you were not primarily responsible. You make something about you that is not about you and get your feelings hurt.

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IDENTIFYING AND LABELLING COGNITIVE DISTORTIONS

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MODIFYING COGNITIONS – IDENTIFYING ATS

- Pt language
- "What was going through your mind?"
- Thought Logs
- Journaling

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COGNITIVE RESTRUCTURING - ELICITING BELIEFS

- Downward Arrow
- Themes in Thought Logs
- Heightened Affect
- Belief Questionnaire

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COGNITIVE INTERVENTIONS: DEALING WITH YOUR "INTERNAL ROOMMATE"

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COGNITIVE RESTRUCTURING

Identify Distorted Thought and Challenge!

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THE COGNITIVE MODEL OF DEPRESSION

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BEHAVIOURAL INTERVENTIONS

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THE COGNITIVE MODEL OF DEPRESSION: BELIEF MODIFICATION PROTOCOL

- Identify Maladaptive Belief
- Identify Alternate Adaptive Belief
- Rate Believability
- Interventions
- Rate Believability at Regular Intervals

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THE COGNITIVE MODEL OF DEPRESSION: NEGATIVE COGNITIVE TRIAD

- Self
- Others
- World/Future

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THE COGNITIVE MODEL OF DEPRESSION

Depressed Mood

Loss of Energy

Cognitive Deficits

Appetite/Sleep Disturbance

Hopelessness

Suicidality

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THE COGNITIVE MODEL OF DEPRESSION

- Common Schemas
  - Failure
  - Defective
  - Worthless
  - Helpless
  - Hopeless
  - Undeserving

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THE COGNITIVE MODEL OF DEPRESSION

- **Common Distortions**
  - **Selective Abstraction/Discounting the positive**

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BEHAVIORAL ACTIVATION

- Activity Monitoring
- Activity Scheduling

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THE COGNITIVE MODEL OF DEPRESSION: SELF CARE

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LIFE AREAS ASSOCIATED WITH DEPRESSION

1. Mastery
2. Pleasure
3. Meaning

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THE COGNITIVE MODEL OF DEPRESSION: RELATIONSHIPS AND SUPPORT

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THE COGNITIVE MODEL OF DEPRESSION: GRATITUDE

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THE COGNITIVE MODEL OF DEPRESSION: GRATITUDE

- Family
- Friends
- Housing
- Financial Provision
- Senses
- Teachers
- God
- Nature
- Sun & Moon
- Pets
- Entertainment
- Kind Strangers
- Shoes
- Time to be on earth
- Employment
- Good Food
- Laughter
- Physical Health

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THE COGNITIVE MODEL OF DEPRESSION: OTHER COGNITIVE STRATEGIES

- Gratitude List
- Evaluating and Testing Negative Interpretations
- Positive Psychology
- Rainy Day Coping Narrative
- Schema Modification Work

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THE COGNITIVE MODEL OF DEPRESSION: OTHER COGNITIVE STRATEGIES

Rainy Day Coping Narrative

"Just because I can't see it now
doesn't mean it isn't coming"

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THE COGNITIVE MODEL OF DEPRESSION:ONGOING DATA LOGS

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BIPOLAR DISORDER – CHARACTERISTICS OF MANIA

- Overly positive cognitions
- Elevated Mood
- Risk-Taking Behaviors

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BIPOLAR DISORDER –MANIA COPING SKILLS

- Medication
- Mood Tracker
- Exercise, other "energy burning" tasks
- Self-Control Strategies
- Limit Setting
- Inoculate against manic distorted thinking

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BIPOLAR DISORDER: MOOD TRACKER

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COGNITIVE STRATEGIES FOR INSOMNIA

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CBT STRATEGIES FOR INSOMNIA: MIDDLE OF THE NIGHT ACTIVITIES

- Make a grocery list
- Look at pictures
- Watch infomercials
- Draw/color/children's book

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CBT STRATEGIES FOR INSOMNIA: GET OUT OF BED STRATEGIES

- Have a reason!
- Make coffee!
- Walk the dog
- Make breakfast
- Walk to the mailbox
- Make you bed

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CBT STRATEGIES FOR INSOMNIA: COGNITIVE WORK

- "I have to sleep!"
- "I must have 8 hours"
- "If I don't sleep it will be horrible"
- "I can't sleep more than x hours"
- "I can't sleep without medicine"
- "Sleep is not that big of deal"

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THE COGNITIVE MODEL OF ANXIETY

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CHARACTERISTICS OF ANXIETY

- Triggers
- Cognitive Biases in Processing
- Physical Sx
- Compulsive or Safety Behaviors
- Cognitive and Behavioral Avoidance
- Environmental Factors

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THE COGNITIVE MODEL OF ANXIETY

Anxiety =
Risk/Resources

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THE COGNITIVE MODEL OF ANXIETY: PRIMARY DISTORTIONS

- Mind-Reading
- Fortune-Telling
- Magnification

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SCHEMAS ASSOCIATED WITH ANXIETY DISORDERS

- GAD – multiple schemas, pervasive, less compelling
- Social Anxiety – helpless, unlikable/unlovable
- OCD –Helpless, vulnerable, worthless, unlovable
- PTSD – Helpless, Vulnerability/Defective

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CBT FOR GAD

- Verbal Cognitive Strategies
- Behavioral experiments
- Journaling
- Deep Breathing exercises
- Metacognitive Strategies

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CBT FOR GAD: POSITIVE METACOGNITIVE BELIEFS

- Worrying helps me cope
- If I worry, Ill be more prepared
- Worrying helps me stay in control
- If I worry, I can anticipate problems

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CBT FOR GAD: NEGATIVE METACOGNITIVE BELIEFS

- I have no control over my worry
- Worry has taken over my life
- I have lost control of my thoughts

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CBT FOR GAD: NEGATIVE METACOGNITIVE BELIEFS

- "Worry will make me lose my mind"
- "Worry will make me have a breakdown"
- "Worry will cause a heart attack"

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CBT FOR PHOBIAS

- In-Vivo
- Hierarchies
- Behavioral Experiments

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COGNITIVE BEHAVIORAL THERAPY: BEHAVIORAL EXPERIMENTS

1) Identify Assumption w/ specific predicted Outcome
2) Collaboratively ID task that will test assumption
3) Experiment must have clear bearing on validity
4) Review Findings

https://www.youtube.com/watch?v=iRFfDps3_6M

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CBT FOR PANIC DISORDER

- Trigger is anxiety vs environmental
- Restructure Misinterpretation of sx
- Interoceptive Strategies

- Empirically supported protocol: Clark, Barlow

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CBT FOR SOCIAL ANXIETY

- Trigger is always people
- Approval-Seeking Schema Work
- Challenging People Pleasing Cognitions
- Continuums

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My Wife Neighbor's Dog

- Polling Exercises

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OTHER ANXIETY STRATEGIES

- Distraction Techniques
- Facing Your Fears
- Schema-Based-Journaling

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GENERAL STRATEGIES FOR DEALING WITH ANXIETY

- Exercise
- Yoga
- Limit Caffeine, Sugar
- Journaling

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ADVANCED CBT INTENSIVE

Application to Clinical Practice

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THE THERAPEUTIC ALLIANCE

- Predictive of outcome
- Collaborative approach
- Non-Judgmental
- Neutral inquiry
- Ruptures

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APPLICATION TO CLINICAL PRACTICE: STRUCTURE OF A SESSION

1. Intro
   - Mood Check
   - Bridge
   - Agenda
2. End
   - Topic
   - Homework
3. End
   - Summary/Feedback
   - Homework

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APPLICATION TO CLINICAL PRACTICE

Phase I: (sessions 1-4)

- T.A.
- Assessment variables
- Socialization to Cognitive Model
- Development of Treatment Goals

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APPLICATION TO CLINICAL PRACTICE

Phase II: Sessions 4 →

- Cognitive Conceptualization
- Cognitive Restructuring
- Ongoing Education/behavioral interventions
- Homework

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APPLICATION TO CLINICAL PRACTICE

Phase III: Final 4-6 Sessions/Booster

- Relapse Prevention
- Cognitions related to ending/loss
- Booster Sessions

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APPLICATION TO CLINICAL PRACTICE: BOOSTER SESSIONS (ADAPTED, J. BECK, 2011)

1. Schedule ahead of Time
2. Come regardless of Progress
3. What has gone well?
4. What problems have arisen? How did you think and cope? Differently?
5. Do you notice any themes in your thinking and coping? What CBT work will you commit to?
6. What could arise between now and the next booster? How can you prepare?

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APPLICATION TO CLINICAL PRACTICE: SELF-THERAPY SESSIONS

1. Schedule ahead of time
2. Set an agenda
3. Mood check
4. Identify and event in which you were triggered
5. Identify and challenge distorted thoughts
6. Identify coping skills you could use if triggered similarly in the future and write on coping card
7. Identify strengths you will use this week
8. Assign homework for next session

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LET'S CONNECT!

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ADVANCED 2 DAY INTENSIVE TRAINING: COGNITIVE-BEHAVIOURAL THERAPY FOR MULTIPLE SYMPTOM SETS: DAY 2

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APPLICATION TO CLINICAL PRACTICE: STRUCTURE OF A SESSION

1. Intro
   - Mood Check
   - Bridge
   - Agenda
2. End
   - Topic
   - Homework
3. End
   - Summary/Feedback
   - Homework

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CBT FOR MULTIPLE SYMPTOM SETS: DAY 2 AGENDA

- Bridge and Introduction to Day 2
- Cognitive Approach to PTSD
- PTSD, Trauma, and Addiction
- Lunch
- Personality Disorder
- Relapse Prevention

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A Cognitive Approach to PTSD

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COGNITIVE APPROACHES TO TRAUMA AND PTSD

- 60-80% Canadians/Americans experience 1 traumatic event
- 8% of lifetime ptsd
- Most trauma survivors never develop ptsd symptoms and majority who do recover
- Women 2x more likely than men
- Most recovery in 1st 3 months
- When persists for 1 yr almost never remits w/o tx

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COGNITIVE APPROACHES TO TRAUMA AND PTSD

- Classification - Trauma and Stressor - Related Disorders

- PTSD dx requires having been exposed to traumatic or stressful event that involved actual or threatened death or serious injury

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COGNITIVE APPROACHES TO TRAUMA AND PTSD

- Becomes pathological when

1) Associations among stimuli do not accurately reflect the world
2) Harmless stimulus erroneously associated with threat meaning
3) Avoidance behaviours are evoked by harmless stimuli
4) Excessive and easily triggered response elements

interfere with daily function

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COGNITIVE APPROACHES TO TRAUMA AND PTSD

- Traditionally characterized as a normal response to abnormal event
- Much current thinking is to view this differently

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COGNITIVE APPROACHES TO TRAUMA AND PTSD: GOALS

- Decrease/Eliminate flashbacks and dissociation
- Move from flashback to intentional recall
- Change meaning associated with
- Acceptance
- Benefits/Growth/Resilience
- Improve overall functioning

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COGNITIVE APPROACHES TO TRAUMA AND PTSD

- PTSD persists when information is processed in such a way that real past threat is perceived as current ("fear conditioning")
- Cognitive and Emotional processing is mechanism underlying successful reduction of symptoms
- Goal is to help pts face traumatic memories and situations associated with them
- Fear is represented in memory as cognitive structure that is program for escaping danger
- Structure includes 1) fear stimuli and 2) fear response

and 3) meaning associated with

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COGNITIVE APPROACHES TO TRAUMA AND PTSD

- Conditions necessary for successful modification of fear structure:
  - Fear structure must be activated, otherwise it is not available for modifications
  - New information incompatible with fear structure must be incorporated
  - Confrontation with stimuli that are safe or low probability of harming

- Requires deliberate, systematic confrontation with stimuli that are safe or low probability of harming

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COGNITIVE APPROACHES TO TRAUMA AND PTSD

1. **Pre-Exposure Stage**
2. **Exposure Stage**
3. **Post-Exposure Stage**

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COGNITIVE APPROACHES TO TRAUMA AND PTSD: STAGE 1 - PSYCHOEDUCATION AND TEACHING OF TOOLS

- Psychoeducation re PTSD
- Psychoeducation re Neurobiology of Trauma
- Explain Rationale for Exposure based treatment & Obtain Consent
- Teach Basic De-escalation Skills

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COGNITIVE APPROACHES TO TRAUMA AND PTSD: STAGE 1 - EDUCATION AND TOOLS

- **Soothing**
- **Distraction**
- **Grounding**

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COGNITIVE APPROACHES TO TRAUMA AND PTSD: STAGE 2 - EXPOSURE

- 3 part summary of life

1. Post Trauma (Impact statement)
2. Pre trauma life (emphasis on positives)
3. Trauma Narrative

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COGNITIVE APPROACHES TO TRAUMA AND PTSD: STAGE 2 - EXPOSURE

- Views of:
  - Self
  - World
  - Safety
  - Trust
  - Power
  - Competency
  - Intimacy

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COGNITIVE APPROACHES TO TRAUMA AND PTSD: STAGE 2 - EXPOSURE

Guidelines for Trauma Narrative

- Hand written
- First person
- As much detail as possible

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COGNITIVE APPROACHES TO TRAUMA AND PTSD: STAGE 3

- Residual Nightmare work
- Dealing with moral injury & cognitions related to guilt and shame
- Reclaim former self and other post-traumatic growth
- Silver Lining Technique
- Trauma taken tool and other resilience strategies
- Attaching shame, relational healing, & seeking connection
- Values - Based Recovery
- Managing triggers, anger management, skills training and other quality of life improving work

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COGNITIVE APPROACHES TO TRAUMA AND PTSD: NIGHTMARE RESCRIPTING

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RESCRIPTING CUE CARD

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COGNITIVE APPROACHES TO TRAUMA AND PTSD

Moral Injury

"- the damage done to one's conscience or moral compass when that person perpetuates, witnesses, or fails to prevent acts that transgress one's own moral beliefs, values, or ethical code of conduct"

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COGNITIVE APPROACHES TO TRAUMA AND PTSD

- Trauma is an event that has an effect on one's ongoing sense of threat as well as m
- Not just violence happening TO people; but acts they did or did not commit tow
- Importance of ongoing creating a sense of safety as well as reassigning blame and redefining value and helping them see good things can come from difficult situations

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COGNITIVE APPROACHES TO TRAUMA AND PTSD: MORAL INJURY

- Isolation
- Anger
- Guilt and Shame
- Powerlessness
- Suicide

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COGNITIVE APPROACHES TO TRAUMA AND PTSD: MORAL INJURY

- Come out of hiding
- Restructure cognitions related to guilt and shame
- Spiritual healing
- Making meaningful connections
- Reassign meaning associated with suffering and promote resilience

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COGNITIVE APPROACHES TO TRAUMA AND PTSD: POST-TRAUMATIC GROWTH

* Positive psychological changes resulting from the struggle with challenging circumstances around the crisis
* They say what does not kill you makes you stronger - not always the case - but with proper cognitive approach can be true
* May never be exactly the same afterwards, but can be healthy and happy

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COGNITIVE APPROACHES TO TRAUMA AND PTSD: SHAME SILENCER TOOL

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COGNITIVE APPROACHES TO TRAUMA AND PTSD: TRAUMA TAKEN TOOL

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COGNITIVE APPROACHES TO TRAUMA AND PTSD
SILVER LINING TOOL

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Cognitive Model of Addiction

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CBT FOR ADDICTION:
ADDICTION BIOLOGICAL RISK FACTORS

- Trait Impulsivity/Aggression
- Other Genetic factors (estimated 40-60%)
- Race
- Gender
- Stage of Development

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CBT FOR ADDICTION: ENVIRONMENTAL RISK FACTORS

- Lack of Parental Supervision
- Peer and School Experiences
- Drug experimentation as children or adolescents
- How the drug is used
- Community Poverty

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THE TRANSTHEORETICAL MODEL

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GAINING INSIGHT: EXPRESSIONS OF CONCERN

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CBT FOR ADDICTIONS - PROS AND CONS

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CASE CONCEPTUALISATION

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CONCEPTUALIZATION – ESSENTIAL COMPONENTS

- Relevant Childhood Data
- Current Life Stressors
- Core beliefs
- Substance/Addiction Related Beliefs
- Thoughts
- Emotions
- Behaviors

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CASE CONCEPTUALIZATION ALSO ADDRESSES

* Why did the pt start using?
* How did recreational use lead to problem usage?
* Why has pt not been able to stop on their own?
* How did key beliefs and coping skills develop?
* How did the pt function before substance problem?

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CASE STUDY: "VONNIE"

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CONCEPTUALISATION DRIVES TREATMENT PLANNING

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COGNITIVE MODEL OF ADDICTION: SESSION ACUITY PROTOCOL

1. Usage or other Destructive Behaviors
2. Therapy Interfering Behaviours
3. Quality of Life Interfering Behaviours

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COGNITIVE MODEL OF ADDICTION - TREATMENT

Interventions

- Restructure cognitions related to function of use
- ID drug related beliefs
- Pros & Cons
- Imagery
- Flashcards
- Addict Letters
- Cue Cards

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CBT FOR TRAUMA AND ADDICTION: WHY PEOPLE USE SUBSTANCES

- To Feel Good
- To Not Feel at all (numb)
- To Forget
- To alleviate pain
- To regulate emotions
- To foster feelings of relaxed state or excitement

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ADDICTIVE BEHAVIOUR RELAPSE PREVENTION QUESTIONS

- Did you relapse this week?
- If yes, tell *me* what happened
- On a scale of 0-10 how close did you get?
- At what point during the week were you *most* tempted to use? What were you doing?
- On a scale of 0-10 how strong was the craving at that time.
- What was going through your mind at the time?

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ADDICTIVE BEHAVIOUR RELAPSE PREVENTION QUESTIONS

- What kept you from relapsing? Anything else?
- How many times to you think you were tempted to use this week but didn't?
- What skills did you use to resist the urges?
  - Behavioral Skills? (what did you do?)
  - Cognitive (what did you think?)
- What did you do right this week
- What changes do you need to implement this week?

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COGNITIVE MODEL OF ADDICTION

CB Chain Analysis

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COGNITIVE MODEL OF ADDICTION:
COGNITIVE CUE CARD

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COGNITIVE MODEL OF ADDICTION
BEHAVIOURAL COPING CARD

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COGNITIVE APPROACHES TO ADDICTION:
SCHEMA-BASED LETTER WRITING

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SMART RECOVERY 4 POINT PROGRAM

- Building and Maintaining Motivation
- Coping with Urges
- Managing Thoughts, Feelings, and Behaviors
- Living a Balanced Life

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CBT for Personality Disorders

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PERSONALITY DISORDERS: ETIOLOGY

Biopsychosocial = Genes + Environment

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WHAT IS PERSONALITY?

Trait:

An enduring pattern of perceiving, relating to, or thinking about the world and one's self.

Habit:

An acquired or learned patterns of thinking and behaving

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WHAT IS PERSONALITY?

Temperament:

Innate, genetic, or constitutional aspects of one's personality

Character:

Primarily learned, psychosocial influences on personality

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BIOSOCIAL MODEL

3 Types of Invalidating Families

1) The Chaotic Family
2) The Perfect Family
3) The Normal Family

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Classification

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WHY WAS THERE EVER AN "AXIS II?"

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Why was there ever an Axis II?

DSM I =1952 - Approximately 60 different disorders

5 Personality Dysfunction Subdivisions

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Why Was There Ever an "Axis II:"DSM Evolution

DSM I Personality Subdivisions

1. Personality Pattern Disturbance
2. Personality Trait Disturbance
3. Sociopathic Personality Disturbance
4. Special Symptom Reaction
5. Transient Situational Personality Disorder

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Why Was There Ever an "Axis II:" DSM Evolution

DSM II = 1968

Eliminated subheadings

Not based on clinical trials
No distinction between normal and abnormal
No specific diagnostic criteria
No distinction between axis I and II

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Why Was There Ever an "Axis II:"DSM Evolution

DSM III = 1980

Abandoned Psychoanalytic terminology

First DSM to have diagnostic criteria

First to distinguish between two categories of Mental Illness (Axis I & II)

Axis I: Issues of Clinical Concern
Axis II: Personality Disorders

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Why Was There Ever an "Axis II:"DSM Evolution

DSM III-R - 1987

DSM-IV - 1994

DSM-IV-TR - 2000

DSM 5 - 2013 -
Abandoned multi-axial diagnostic system

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Assessment and Diagnosis

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Personality Disorder Diagnosis

"If you don't have the data, you have no business making a personality disorder diagnosis. If you DO have the data, you have no business NOT making the diagnosis."

- Shawn Christopher Shea

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Categorical vs. Dimensional Models

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WHAT MAKES SOMEONE "CHALLENGING?"

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PROBLEMS WITH CURRENT PERSONALITY DISORDER CONCEPTUALIZATION

1. Line between "normalcy" and pathology harder to delineate
2. Considerable overlap in diagnostic Categories

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What Makes People "Difficult" ?

It can't Just be that:

- **We don't like them**
- **They are different than us**
- **If they are only a problem for YOU!**

But...

There are people that are problems for EVEDRYBODY

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Personality Disorder Diagnosis

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Personality Disorder Diagnosis

PDO Characteristic	Assessment Technique
2) External Locus of Control	2) Monitor for non-responsible language

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Personality Disorder Diagnosis

PDO Characteristic	Assessment Technique
2) External Locus of Control	2) Monitor for non-responsible language

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Personality Disorder Diagnosis

PDO Characteristic	Assessment Technique
3) Pervasive	3) Look for patterns of behavior that are showing up in different areas

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Personality Disorder Diagnosis

PDO Characteristic	Assessment Technique
4) Enduring vs. Episodic	4) Videotape vs. Snapshot

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Borderline Personality Disorder

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BORDERLINE PD

A pervasive pattern of instability of interpersonal relationships, self-image and affects and marked impulsivity, beginning in early adulthood and present in a variety of contexts, as indicated by five (5) or more of the following:

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BPD: DIAGNOSTIC CRITERIA

1) Frantic efforts to avoid real or imagined abandonment
2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3) Identity Disturbance – markedly and persistently unstable self-image or sense of self

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BPD: DIAGNOSTIC CRITERIA

4) Impulsivity in at least two areas that are potentially self-damaging
5) Recurrent suicidal behavior, gestures, threats, and self-mutilating behavior

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BPD: DIAGNOSTIC CRITERIA

Three components of criteria 5

- Parasuicide (SIB, NSSI)
- Chronic Suicide
- Acute Suicide

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BPD: DIAGNOSTIC CRITERIA

- Parasuicide: intentional self-harm with no intent of lethality

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BPD: DIAGNOSTIC CRITERIA

Why people with BPD self-injure

a. To make anguish known to others
b. Revenge on a partner
c. To force someone else to demonstrate a caring act
d. Anxiety reduction

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BPD: DIAGNOSTIC CRITERIA

Why people with BPD self-injure

e. To end an argument
f. Punish perceived "bad self"
g. Method of reorganization
h. Numbness

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BPD: DIAGNOSTIC CRITERIA

- Chronic Suicide: repetitive thoughts of killing self
- Acute Suicide: plan, intent, means to end ones life

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BPD: DIAGNOSTIC CRITERIA

6) Affective Instability

7) Emptiness

8) Inappropriate or Intense Anger
9) Transient Stress Related Paranoid Ideation or Dissociative Symptoms

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BPD DIFFERENTIAL DIAGNOSIS

Lester's Functional Definition of Borderline Personality Disorder: "On the Border" of so many other diagnoses

"Other associated Syndromes"

- Mood Disorders
- Anxiety Disorders
- Substance Disorders
- Eating Disorders
- ADHD

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Treatment

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TREATMENT - THERE IS HOPE!

184

EVIDENCE-BASED APPROACHES

Over the past twenty-five years a number of borderline-specific psychotherapies have been developed. Of these, seven have research evidence supporting their efficacy:

1. Dialectical Behavior Therapy (DBT)
2. Schema-focused Therapy (SFT)
3. Systems Training for Emotional Predictability & Problem-Solving (STEPPS)
4. Mentalisation-based Treatment (MBT)
5. Transference Focused Psychotherapy (TFP)
6. Good Psychiatric Management for Borderline Personality Disorder (GPM)
7. Interpersonal Group Psychotherapy (IGP)

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ADVANCED CBT FOR BPD: GENERAL TX STRATEGIES

- Validate Feelings
- Validate Past Experiences
- Validate Present Experiences
- Be Consistent
- Set and Keep Limits
- "Slicing"/Relational Work
- Know Your "Buttons"

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ADVANCED CBT FOR BPD: GENERAL TX STRATEGIES

- Validate Feelings
- Validate Past Experiences
- Validate Present Experiences
- Be Consistent
- Set and Keep Limits
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- Know Your "Buttons"

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DEFINITIONS

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The Thinking of the Therapist

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PD TREATMENT PRINCIPLES

1. Belief Modification
2. Longer Duration
3. Validation
4. Challenge Effectiveness
5. Increased Emphasis on Relationship and the Thinking of the Therapist

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BPD: SETTING UP TREATMENT TO SUCCEED!

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THE TREATMENT AGREEMENT

1) INDIVIDUAL AND SKILLS EXPECTATIONS AND FUNCTION OF EACH

2) SESSION ACUITY PROTOCOL
- LIFE INTERFERING BEHAVIORS
- THERAPY INTERFERING BEHAVIORS
- QUALITY OF LIFE INTERFERING BEHAVIORS

3) SAFTEY CONTRACTING/PLANNING

4) PHONE AGREEMENT

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SCHEMA BASED COGNITIVE THERAPY: COMPONENTS OF TREATMENT AND THEIR ROLES

1. Individual Treatment
2. Group Treatment

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THE TREATMENT AGREEMENT

1) INDIVIDUAL AND SKILLS EXPECTATIONS AND FUNCTION OF EACH

2) SESSION ACUITY PROTOCOL
LIFE INTERFERING BEHAVIORS
THERAPY INTERFERING BEHAVIORS
QUALITY OF LIFE INTERFERING BEHAVIORS

3) SAFTEY CONTRACTING/PLANNING

4) PHONE AGREEMENT

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Skills Training

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Integrated DBT/SFT Case Study:Objective Effectiveness

D
E
A
R
M
A
N

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Integrated DBT/SFT Case Study: Relationship Effectiveness

G
I
V
E

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Integrated DBT/SFT Case Study: Relationship Effectiveness

F
A
S
T

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INDIVIDUAL TREATMENT

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CBT FOR BPD: SESSION ACUITY PROTOCOL

- Life-Interfering Behaviors
- Therapy Interfering Behaviours
- Quality of Life Interfering Behaviours

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COGNITIVE-BEHAVIORAL CHAIN ANALYSIS

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BPD CHAIN: COGNITIVE CUE CARD

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INTEGRATED DBT/CBT/SFT CASE STUDY

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INTERPERSONAL EFFECTIVENESS EXERCISE: COGNITIVE WORK

Key Cognitions

Key Schemas

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BPD EVIDENCE LOG

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SCHEMA FLASHCARDS

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RELAPSE PREVENTION

* Relapse - "a recurrence of symptoms after a period of improvement"

J. Ludgate

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RELAPSE PREVENTION: WARNING SIGNS

- Appetite Disturbance
- Sleep Disturbance
- Escalation in suicidal or self-injurious thoughts
- Increased "moodiness"/agitation/"Stressed out"
- Social Withdrawl
- Feeling "disconnected"/Paranoid

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RELAPSE PREVENTION: ROAD TO RECOVERY

- Things I'm Doing Right
- Vulnerabilities to relapse
- Episode Management
- Failing Forward
- Road to Recovery
- Restructuring Cognitions Related to Loss
- Booster Sessions

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RELAPSE PREVENTION: HOW DO I KNOW I AM GETTING BETTER?

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RELAPSE PREVENTION: WRAPPING UP

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THANK YOU!

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clinicaltoolboxset.com

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