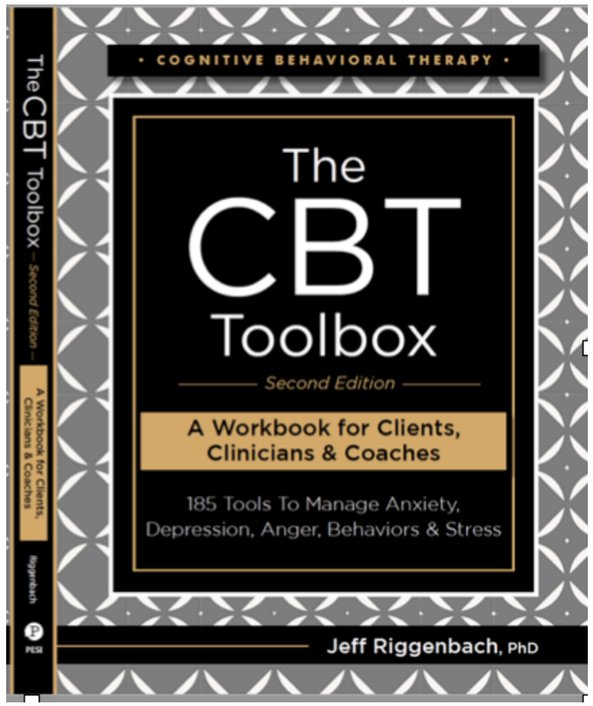
2 Day CBT Intensive:
Tools for Treating Multiple Symptom Sets



Prepared for: Jack Hirose and Associates
July 14-15, 2022

Jeff Riggenbach, PhD
jeffriggenbach.com

2 DAY CBT INTENSIVE: APPLICATION TO CLINICAL PRACTICE

DAY 1 AGENDA

- Session 1: Basic Tenets and Core Competencies
- Session 2: Cognitive Conceptualization/CBT Tools and Techniques

Lunch

- Session 3: The Cognitive Model of Depression
- Sesson 4: The Cognitive Model of Anxiety, Wrap-up

2 DAY CBT INTENSIVE: APPLICATION TO CLINICAL PRACTICE

WHY CBT???

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

2 DAY CBT INTENSIVE:
TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

“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”

2 DAY CBT INTENSIVE:
TOOLS FOR TREATING MULTIPLE SYMPTOM SETS-
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

2 DAY CBT INTENSIVE:
TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

DIALECTICAL BEHAVIOUR THERAPY

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS- DBT

- Developed by Marsha Linehan, 1970s, UW
- Looking for method of treating chronically suicidal women
- Found Traditional CBT to be too invalidating
- Added validation, developed concept of dialectics

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS- DBT

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

2 DAY CBT INTENSIVE:
TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

DBT CORE MODULES

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

2 DAY CBT INTENSIVE:
TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

COGNITIVE BEHAVIOUR THERAPY

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

- **Developed by Aaron Beck, 1960, Penn**
- **Based upon principle that *thoughts influence feelings***

2 DAY CBT INTENSIVE:
TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

TRADITIONAL CBT

Events → **Thoughts** → **Feelings** → **Actions** → **Results**

2 DAY CBT INTENSIVE:
TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

Levels of Cognition

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

Core Beliefs/Schemas

Beck identified beliefs in 3 different areas

1. Beliefs about self
2. Beliefs about others
3. Beliefs about the world

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

- 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”

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

- **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

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

- **Example Beliefs About Self**

  - Others are mean
  - Others are uncaring
  - Others are selfish
  - Others aren't deserving of my time
  - Others are to be taken advantage of
  - Others are unreliable
  - Others are untrustworthy

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

- **Example Beliefs About the World**

  - The world is exciting!
  - The world is boring
  - The world is unfair
  - The world is cruel

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

SCHEMA FOCUSED THERAPY

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

SCHEMA FOCUSED THERAPY

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

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

SCHEMA FOCUSED THERAPY

Domain #1: Disconnection and Rejection

- Abandonment
- Mistrust
- Defectiveness
- Emotional Deprivation
- Social Isolation

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

SCHEMA FOCUSED THERAPY

Domain #2: Impaired Autonomy & Performance

- Dependence
- Vulnerability
- Enmeshment
- Failure

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

SCHEMA FOCUSED THERAPY

Domain #3: Impaired Limits

- Entitlement/Grandiosity
- Insufficient Self-Control

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

SCHEMA FOCUSED THERAPY

Domain # 4: Others Directness

- Subjugation
- Self-Sacrifice
- Approval Seeking

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

SCHEMA FOCUSED THERAPY

Domain #5: Overvigilance

- Negativity
- Emotional Inhibition
- Unrelenting Standards
- Punitiveness

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

SCHEMA FOCUSED THERAPY

- Active vs. Dormant
- Compelling
- Pervasive vs Discrete

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

SCHEMA FOCUSED THERAPY

- Maintenance
- Avoidance
- Overcompensation

Conceptualization & Treatment: The Roadmap to Recovery

Individualized Maps for Every Client!

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

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

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

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

2 DAY CBT INTENSIVE:

CONCEPTUALIZATION DRIVES DOCUMENTATION

2 DAY CBT INTENSIVE:

CONCEPTUALIZATION DRIVES TREATMENT PLANNING

2 DAY CBT INTENSIVE:
CASE CONCEPTUALIZATION

CASE STUDY: LISA

2 DAY CBT INTENSIVE: CASE CONCEPTUALIZATION

Summary

1. Synthesize CBT model with client experience
2. Normalizes presenting problems and validates
3. Helps complex problems seem more manageable
4. Guides focus of interventions

2 DAY CBT INTENSIVE:
CBT TOOLS AND TECHNIQUES

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

Events ➡️ Thoughts ➡️ Feelings ➡️ Actions ➡️ Results

2 DAY CBT INTENSIVE:
CBT TOOLS AND TECHNIQUES - COGNITIVE TOOLS

1. Mindfulness
2. Distraction
3. Cognitive Restructuring

2 DAY CBT INTENSIVE:
CBT TOOLS AND TECHNIQUES - COGNITIVE TOOLS

1. Mindfulness Exercise

2 DAY CBT INTENSIVE:
CBT TOOLS AND TECHNIQUES - COGNITIVE TOOLS

2. Distraction Techniques

- Take a hot bath
- Paint
- Go for a walk
- Play a game on my phone
- Go to a club
- Stretching exercises
- Practice Karate/Martial arts
- Lift weights
- Play with yarn/stressball
- Call a friend

2 DAY CBT INTENSIVE:
CBT TOOLS AND TECHNIQUES - COGNITIVE TOOLS

3. Cognitive Restructuring

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

2 DAY CBT INTENSIVE:
CBT TOOLS AND TECHNIQUES - COGNITIVE TOOLS

3. Cognitive Restructuring

2 DAY CBT INTENSIVE:
DEALING WITH YOUR "INTERNAL ROOMMATE"

2 DAY CBT INTENSIVE:
DEALING WITH YOUR "INTERNAL ROOMMATE"

3. Cognitive Restructuring

Identify Distorted Thought and Challenge!

2 DAY CBT INTENSIVE: COGNITIVE RESTRUCTURING

How do we challenge our thoughts?

2 DAY CBT INTENSIVE:
TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

THE COGNITIVE MODEL OF DEPRESSION

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF DEPRESSION

NEGATIVE COGNITIVE TRIAD

- Self
- Others
- World/Future

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF DEPRESSION

SCHEMAS ASSOCIATED WITH DEPRESSION

- Failure
- Defective
- Worthless
- Helpless
- Hopeless
- Undeserving

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF DEPRESSION

- Depressed Mood
- Loss of Energy
- Cognitive Deficits
- Appetite/Sleep Disturbance
- Hopelessness
- Suicidality

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

Primary Distortions

- **Discounting the Positive/Selectivee Abstraction/Mental Filter**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF DEPRESSION

Behavioral Activation

- Activity Monitoring
- Activity Scheduling

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF DEPRESSION

Self-Care

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF DEPRESSION

Life Areas Associated with Depression

1. Mastery

2. Pleasure

3. Meaning

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF DEPRESSION

Relationships and Social Support

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF DEPRESSION

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

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF DEPRESSION

Gratitude

2 DAY CBT INTENSIVE: GRATITUDE
THE COGNITIVE MODEL OF DEPRESSION

- 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

2 DAY CBT INTENSIVE: GRATITUDE
THE COGNITIVE MODEL OF DEPRESSION

Rainy Day Coping Narrative

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF DEPRESSION

Belief Modification Protocol

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

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF DEPRESSION

Data Logs

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

Characteristics of Anxiety

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

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

Anxiety = Risk/Resources

- Increased Awareness of Resources
- Increase Resources
- More Realistic Appraisal of the Risk

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

Primary Distortions

- **Mind-Reading**
- **Fortune-Telling**
- **Magnification**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

Schemas Associated with Anxiety

- **GAD – Multiple schemas, pervasive, less compelling**
- **Social Anxiety – Helpless, unlikable/unlovable**
- **OCD –Helpless, Vulnerable, worthless, unlovable**
- **PTSD – Helpless, Vulnerability/Defective**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

CBT for GAD

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

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

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**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

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**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

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”**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

CBT for GAD: Negative Unhelpful Strategies

- **“Thought Stopping”**
- **Avoidance**
- **Alcohol/Cannabis**
- **Workaholism**
- **Reassurance Seeking Behaviours**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

CBT for GAD: Negative Helpful Strategies

- **Mindfulness**
- **Acceptance**
- **Tolerating Uncertainty**
- **View as “Static”**
- **“Worry Time”**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

CBT for Phobias

- **In-Vivo/Imaginal**
- **Hierarchies**
- **Behavioral Experiments**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

CBT for Phobias - Behavioural 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=jRFfDps3_6M

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

CBT for Panic Disorder

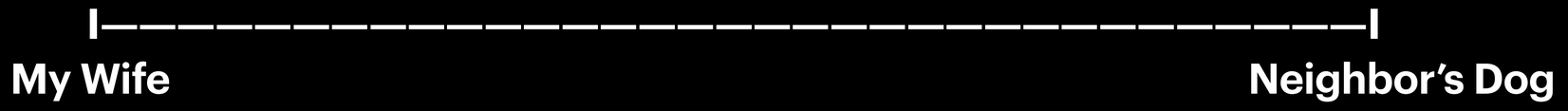
- **Trigger is anxiety vs environmental**
- **Restructure Misinterpretation of sx**
- **Interoceptive Strategies**

Empirically supported protocol: Clark, Barlow

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

CBT for Social Anxiety

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



- **Polling Exercises**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

Perfectionism -Functional vs Dysfunctional

- **Are my standards higher than others?**
- **How often am I able to meet my standards?**
- **Do I expect others to meet those standards?**
- **Do my standards help me meet my goals or get in the way?**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

CBT for Perfectionism

Antony, 2013

Perfectionism is associated with a number of other psychological problems

- **Social Anxiety**
- **OCD**
- **Depression**
- **Eating Disorders**
- **Anger**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

CBT for Perfectionism: Domains Affected

- **Work or School Performance**
- **Romantic Relationships**
- **Friendships**
- **Organization**
- **Communication Skills**
- **Health**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

CBT for Perfectionism - Behavioural Manifestations

- **Rehearsing/Memorizing**
- **Overpreparing**
- **Trying to change the behavior of others**
- **Procrastinate**
- **Not know when to quit**
- **Inability to Delegate**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

CBT for Perfectionism - Change Strategies

- **Exposure**
- **Examine the Evidence**
- **Do the thing you are afraid of**
- **Prevent Safety Behaviors**
- **Prioritize (big from the small)**
- **Learn to Compromise**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

General Strategies

- **Exercise**
- **Yoga**
- **Limit Caffeine Intake**

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ANXIETY

Other Strategies

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

2 DAY CBT INTENSIVE:
TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

APPLICATION TO CLINICAL PRACTICE

2 DAY CBT INTENSIVE:
APPLICATION TO CLINICAL PRACTICE

THE THERAPEUTIC ALLIANCE

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

2 DAY CBT INTENSIVE: APPLICATION TO CLINICAL PRACTICE

THE STRUCTURE OF A SESSION

1. Intro

- ★ Mood Check
- ★ Bridge
- ★ Agenda

2. Middle

- ★ Topic
- ★ Homework

3. End

- ★ Summary/Feedback
- ★ Homework

2 DAY CBT INTENSIVE: APPLICATION TO CLINICAL PRACTICE

PHASES OF TREATMENT

Phase I: (Sessions 1-4)

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

2 DAY CBT INTENSIVE: APPLICATION TO CLINICAL PRACTICE

PHASES OF TREATMENT

Phase II: (Sessions 4 —>)

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

2 DAY CBT INTENSIVE: APPLICATION TO CLINICAL PRACTICE

PHASES OF TREATMENT

Phase III: (Final 4-6 Sessions/Boosters)

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

2 DAY CBT INTENSIVE: APPLICATION TO CLINICAL PRACTICE

BOOSTER SESSIONS (ADAPTED FROM J. BECK, 2011)

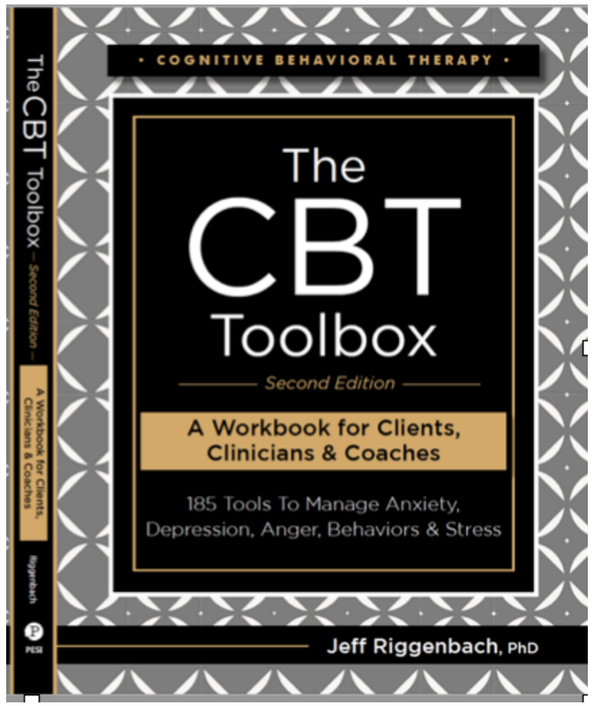
1. Schedule ahead of time
2. Come regardless of progress
3. What has gone well?
4. What problems have arisen? How did you think and cope differently?
5. Do you notice any themes in your thinking and coping?
6. What could arise between now and the next booster? How can you prepare?
7. What CBT work will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

2 DAY CBT INTENSIVE: APPLICATION TO CLINICAL PRACTICE

SELF-THERAPY SESSION FORMAT

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 skills you could use if triggered in the future & write on a coping card
7. Identify strengths you will use this week
8. Assign homework for next session

2 Day CBT Intensive:
Tools for Treating Multiple Symptom Sets



Prepared for: Jack Hirose and Associates
July 14-15, 2022

Jeff Riggenbach, PhD
jeffriggenbach.com

2 DAY CBT INTENSIVE: APPLICATION TO CLINICAL PRACTICE

DAY 2 AGENDA

- Session 1: A Cognitive Approach to PTSD
- Session 2: CBT for Addictions
- Lunch
- Session 3: Personality Disorder/BPD Assessment
- Sesson 4: CBT for PD Treatment

2 DAY CBT INTENSIVE: TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

A COGNITIVE APPROACH TO PTSD

Adapted from Ehlers and Clark, 2000

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO 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
- Most recovery in 1st 3 months
- When persists for 1 yr almost never remits w/o tx

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

- **Traditionally characterized as a normal response to abnormal event**

- **Current thinking is different based upon emerging neurobiology**

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

- When someone experience as a traumatic event brain chemistry is altered
- Affects endocrinology, neurochemistry, brain circuitry

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

* **Neurobiology of Trauma - Lower Region**

  - Lowest brain centers hold our most primitive survival reactions

  - Involved in activating defense\stress reactions

  - Reflexively respond to triggers &response produces startle response, accelerated heart rate,increase breathing, muscle tension

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

The Neurobiology of Trauma - The Limbic System

- Provides neural basis for memories and emotions

- Involved with memories which are encoded differently during traumatic events - may be “gaps” in memory

- Contains amygdala & and hippocampus

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

The Neurobiology of Trauma - The Limbic System

- **In response to triggering images**

  - Amygdala acts as a warning system by scanning the environment for danger and sends the information to the hypothalamus

  - Hypothalamus initiates a set of actions in the endocrine system that releases cortisol and other hormones to engage the body's stress response system

- Hippocampus' role is maintaining long-term memory

  - Context processing also originates in the Hippocampus

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

The Neurobiology of Trauma - The Pre-Frontal Cortex

- The logical reasoning part of the brain
- Responsible for decision-making, rational thinking,logic, planning memory
- Under stress this part of the brain functions at diminished capacity - difficulty thinking through situations

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO 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

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO 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

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Trigger is Exposure to actual or threatened death, serious injury, or violation

- Directly experiences traumatic event
- Witnesses traumatic event in person
- Learns that traumatic event happened to a close family member or close friend
- Experiences first hand repeated or extreme exposure to aversive details of traumatic event

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Trigger is exposure to actual or threatened death, serious injury, or sexual violation

<u>Examples include:</u>

- Domestic, family, dating violence
- Community violence
- Sexual or physical assault
- Natural disaster
- Motor vehicle or other related accident
- War, refugee experiences, combat related trauma

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

- **SYMPTOM CLUSTERS**

1. Reliving
2. Avoiding
3. Pervasive negative changes in emotion
4. Excessive physiological arousal

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO 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

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO 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

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Goals

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

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Stages of Treatment

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

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Stage 1: Psychoeducaton 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

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Stage 1: Psychoeducaton and Teaching of Tools

- Soothing
- Distraction
- Grounding

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Stage 2: Exposure Stage

★ 3 part summary of life

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

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Stage 2: Exposure Stage

IMPACT STATEMENT

Views of:

- Self
- World
- Safety
- Trust
- Power
- Competency
- Intimacy

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Stage 2: Exposure Stage

★ 3 part summary of life

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

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Stage 2: Exposure Stage

Guidelines for Trauma Narrative

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

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Stage 3: Cognitive and Closure Strategies

- 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 & other quality of life work

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Stage 3: Cognitive and Closure Strategies:

- Pre-emptive Nightmare
- Nightmare Rescripting

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO 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"

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Moral Injury

- Trauma is an event that has an effect on one's ongoing sense of threat as well as moral injury

- Not just violence happening TO people; but acts they did or did not commit towards others

- 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

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Moral Injury is Associated With

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

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Moral Injury - Strategies

- Coming out of hiding
- Restructure cognitions related to guilt and shame
- Spiritual healing
- Making meaningful connections
- Reassigning meaning associated with suffering
- Promoting Resilience

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Moral Injury - 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

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Shame Silencer

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Trauma Taken Tool

2 DAY CBT INTENSIVE:
A COGNITIVE APPROACH TO PTSD

Silver Lining Tool

2 DAY CBT INTENSIVE:
TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

THE COGNITIVE MODEL OF ADDICTION

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

BIOLOGICAL RISK FACTORS

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

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

ENVIRONMENTAL RISK FACTORS

- Peer and School Experiences
- Lack of Parental Supervision
- Drug Experimentation in Adolescence
- How Drug is Used
- Community Poverty

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

ADDICTIVE BEHAVIOUR DISORDERS

- Substance Use Disorders
- Gambling Addiction

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

PROPOSED DISORDERS

- Internet Addiction
- Compulsive Buying Disorder
- Sexual Addiction
- Computer Game Addiction

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

ADDICTIVE BEHAVIOUR DISORDERS: DSM 5

1. Taking the substance in larger amounts or for longer than you meant to

2. Inability to cut back or stop in spite of repeated attempts to

3. Excessive amount of time devoted to behaviour

4. Cravings and Urges to engage in the behaviour or usage

5. Unable to meet school, work, family, or other obligations due to the behaviour or the results of the behaviour

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

ADDICTIVE BEHAVIOUR DISORDERS:DSM 5

6. Continuing to engage in behaviour in spite of problematic relationships

7. Quitting social, occupational, recreational activities

8. Continuing to engage in the behaviour in even when doing so puts one in danger

9. Continuing to engage in behaviour in spite of knowing a condition of some kind will be worsened

10. Needing increasing amount to gain desired effect

11. Withdrawl symptoms, which remit with additional use/behaviour

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

ADDICTIVE BEHAVIOUR DISORDERS:DSM 5

- 2 or 3 = Mild Use Disorder
- 4 or 5 = Moderate Use Disorder
- 6 or more = Severe Use Disorder

★ Substances: Alcohol, Cannabis, Hallucinagins, Stimulants, etc

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

GAMBLING ADDICTION

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

CASE CONCEPTUALISATION

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

CASE CONCEPTUALISATION:
ESSENTIAL COMPONENTS

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

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

CASE CONCEPTUALISATION 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?

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

CASE STUDY: “VONNIE”

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

TREATMENT

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

TRANSTHEORETICAL MODEL

Stages of Change

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

GAINING INSIGHT

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

CONTEMPLATION STAGE EXAMPLE: PROS AND CONS

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

CONTEMPLATION STAGE EXAMPLE:
PROS AND CONS OF HEROIN USE

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

Treatment - Why People Use

- To not feel at all (numb)
- To feel Good
- To forget
- To alleviate pain
- To regulate emotions
- To foster feelings of relaxed state or excitement

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

Session Acuity Protocol

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

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

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 doin
- On a scale of 0-10 how strong was the craving at that time.
- What was going through your mind at the time?

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

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?

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

Cognitive Behavioral Chain Analysis

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

Cognitive Behavioral Chain Analysis:
Cognitive Cue Card

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

Cognitive Behavioral Chain Analysis:
Behavioral Coping Card

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

Schema-Based Letter Writing

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

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 doin
- On a scale of 0-10 how strong was the craving at that time.
- What was going through your mind at the time?

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

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?

2 DAY CBT INTENSIVE:
THE COGNITIVE MODEL OF ADDICTION

Smart Recovery 4 Point Program

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

2 DAY CBT INTENSIVE:
TOOLS FOR TREATING MULTIPLE SYMPTOM SETS

PERSONALITY DISORDERS

2 DAY CBT INTENSIVE: PERSONALITY DISORDERS

Personality Disorders Etiology

Biopsychosocial = Genes + Environment

2 DAY CBT INTENSIVE: PERSONALITY DISORDERS

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

2 DAY CBT INTENSIVE: PERSONALITY DISORDERS

What is Personality?

- Temperament

- Character

2 DAY CBT INTENSIVE: PERSONALITY DISORDERS

Biosocial Model

3 Types of Invalidating Families

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

2 DAY CBT INTENSIVE:

Classification

Why was there ever an “Axis II?”

2 DAY CBT INTENSIVE:

Why was there ever an "Axis II?"

DSM I =1952

- **Approximately 60 different disorders**
- **5 Personality Dysfunction Subdivisions**

2 DAY CBT INTENSIVE:

Why was there ever an "Axis II?"

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

2 DAY CBT INTENSIVE:

Why was there ever an "Axis II?"

DSM II = 1968

Eliminated subheadings

Specific Descriptions
- **Not based on clinical trials**
- **No distinction between normal and abnormal**
- **No specific diagnostic criteria**

No distinction between axis I and II

2 DAY CBT INTENSIVE:

Why was there ever an “Axis II?”

2 DAY CBT INTENSIVE:

Why was there ever an "Axis II?"

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

2 DAY CBT INTENSIVE:

Why was there ever an "Axis II?"

DSM III-R - 1987

DSM-IV - 1994

DSM-IV-TR - 2000

DSM 5 - 2013 - abandoned multiaxial diagnostic system

2 DAY CBT INTENSIVE: PERSONALITY DISORDER

Assessment and Diagnosis

2 DAY CBT INTENSIVE:

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

2 DAY CBT INTENSIVE:

Personality Disorder Diagnosis - Problems with current conceptualization

1. Line between “normalcy” and pathology harder to delineate
2. Significant overlap between diagnostic categories

2 DAY CBT INTENSIVE:

Personality Disorder Diagnosis

PD Characteristic	Assessment Technique
1. Ego-Syntonic	1. Emphasis on signs vs symptoms

2 DAY CBT INTENSIVE:
Personality Disorder Diagnosis

PD Characteristic	Assessment Technique
2. External Locus of Control	2. Monitore for Non-Responsibile Language

2 DAY CBT INTENSIVE:
CBT TOOLS AND TECHNIQUES

Events ➡️ Thoughts ➡️ Feelings ➡️ Actions ➡️ Results

2 DAY CBT INTENSIVE

Personality Disorder Diagnosis

PD Characteristic	Assessment Technique
3. Pervasive	3. Observe Areas

2 DAY CBT INTENSIVE:

Personality Disorder Diagnosis

PD Characteristic	Assessment Technique
4. Enduring vs Episodic	4. Video vs Snapshot

2 DAY CBT INTENSIVE:

Personality Disorder Diagnosis

PD Characteristic	Assessment Technique
5. Inflexible	5. Monitor Across Contexts

2 DAY CBT INTENSIVE: BORDERLINE PD

Diagnostic Criteria

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:

2 DAY CBT INTENSIVE: BORDERLINE PD

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

2 DAY CBT INTENSIVE: BORDERLINE PD

Diagnostic Criteria

4. Impulsivity in at least two areas that are potentially self-damaging

6. Affective Instability

2 DAY CBT INTENSIVE: BORDERLINE PD

Diagnostic Criteria

5. Recurrent Suicidal behaviour, gestures, threats, self-mutilating behaviour

3 Components of Criteria 5

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

2 DAY CBT INTENSIVE: BORDERLINE PD

Diagnostic Criteria

★ Parasuicide: Intentional self-harm with no intent of lethality

2 DAY CBT INTENSIVE: BORDERLINE PD

Diagnostic Criteria

Why People 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

2 DAY CBT INTENSIVE: BORDERLINE PD

Diagnostic Criteria

Why People Self-Injure

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

2 DAY CBT INTENSIVE: BORDERLINE PD

Diagnostic Criteria

Why People Self-Injure

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

2 DAY CBT INTENSIVE: BORDERLINE PD

Diagnostic Criteria

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

2 DAY CBT INTENSIVE: BORDERLINE PD

Diagnostic Criteria

7. Emptiness
8. Inappropriate or Intense Anger
9. Transient Stress Related Paranoid Ideation or Dissociative Symptoms

2 DAY CBT INTENSIVE: BORDERLINE PD

DSM 5 Diagnostic Criteria

2 DAY CBT INTENSIVE: BORDERLINE PD

Treatment

2 DAY CBT INTENSIVE: BORDERLINE PD

There is Hope!

“Prognosis for most people with BPD is quite good.”

- APA, 1995

2 DAY CBT INTENSIVE: BORDERLINE PD

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)

2 DAY CBT INTENSIVE:
CBT TOOLS AND TECHNIQUES

Events → Thoughts → Feelings → Actions → Results

2 DAY CBT INTENSIVE: BORDERLINE PD

General Treatment Strategies

7. Emptiness
8. Inappropriate or Intense Anger
9. Transient Stress Related Paranoid Ideation or Dissociative Symptoms

2 DAY CBT INTENSIVE: BORDERLINE PD

General Treatment Strategies

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

2 DAY CBT INTENSIVE: BORDERLINE PD

General Treatment Strategies:

The Thinking of the Therapist

2 DAY CBT INTENSIVE: BORDERLINE PD

Treatment Components and Their Roles

1. INDIVIDUAL TREATMENT

2. GROUP TREATMENT

2 DAY CBT INTENSIVE: BORDERLINE PD

Types of Groups and Goals of Each

1. SKILLS TRAINING (PSYCHOEDUCATIONAL)

2. SCHEMA GROUP (PROCESSING)

2 DAY CBT INTENSIVE: BORDERLINE PD

Skills Training

2 DAY CBT INTENSIVE: BORDERLINE PD

Standard CBT Skills

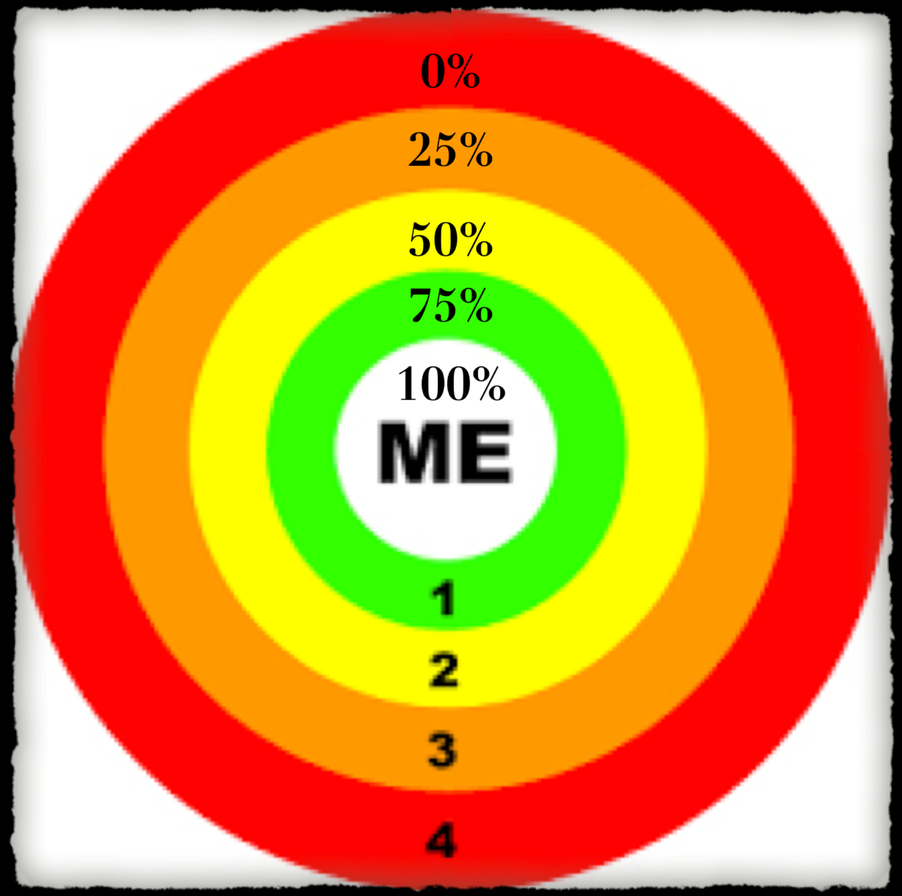
2 DAY CBT INTENSIVE: BORDERLINE PD

Standard CBT Skills

- Relationship Work
- Restructuring Suicidal and Parasuicidal cognitions
- Identity work
- Continuums

2 DAY CBT INTENSIVE: BORDERLINE PD

Standard CBT Skills: Relationship Work



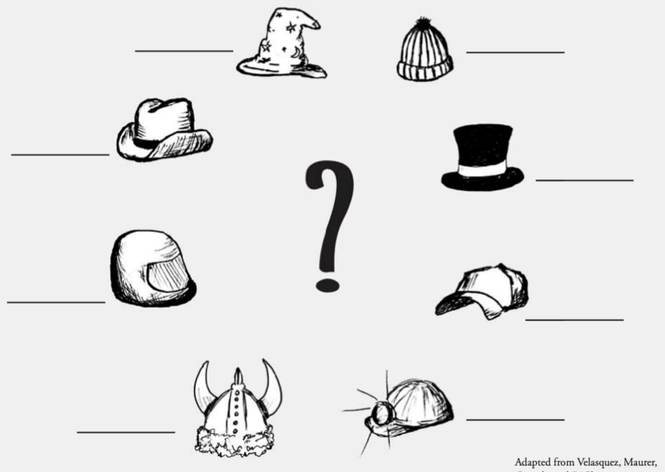
2 DAY CBT INTENSIVE: BORDERLINE PD

Standard CBT Skills:
Restructuring Destructive Cognitions

2 DAY CBT INTENSIVE: BORDERLINE PD

Standard CBT Skills: Identity Development

Near each hat in the following illustration, put one of the ways you currently define yourself or a way that you may like to see yourself in the future. For instance, one particular participant's "hats" included being a *"niece, a sister, a friend, a Christian, a church member, a stamp collector, a chef, a taxi cab driver, a secretary, and a movie goer,"* etc.



Adapted from Velasquez, Maurer, Crouch, and DiClemente, 2001

The "hat" I most identify with is _____

The one I least identify with is _____

Three ways I can develop my identity as a _____ **are:**

1. _____
2. _____
3. _____

2 DAY CBT INTENSIVE: BORDERLINE PD

Standard CBT Skills: Continuums

“Since my parents have $ and help me, they have it Completely all together.”

“Since mom is critical and nosy and drinks too much I don’t know if I can be in her life anymore.”

2 DAY CBT INTENSIVE: BORDERLINE PD

Standard CBT Skills: Continuums

"Mom is not perfect…she can be critical and nosy and aggressive and she drinks too much…but she has done a lot right as a parent over the years – even though some of her behaviors are unacceptable, I know she still loves me and I can still love her"

2 DAY CBT INTENSIVE: BORDERLINE PD

DBT Skills

2 DAY CBT INTENSIVE: BORDERLINE PD

DBT Skills Modules

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

2 DAY CBT INTENSIVE: BORDERLINE PD

DBT Skills Modules:
Interpersonal Effectiveness Skills

1. Objective Effectiveness
2. Relationship Effectiveness
3. Self-Respect Effectiveness

2 DAY CBT INTENSIVE: BORDERLINE PD

DBT Skills Modules: Objective Effectiveness

D escribe the situation

Express your feelings

A sk for what you want

Reinforce

Mindfully focused

Appear confident

N egotiate

2 DAY CBT INTENSIVE: BORDERLINE PD

DBT Skills Modules: Relationship Effectiveness

G entle

I interested

V alidate

E asy Manner

2 DAY CBT INTENSIVE: BORDERLINE PD

DBT Skills Modules: Self-Respect Effectiveness

F air

NO
A pologies

S tick

T ruthful

2 DAY CBT INTENSIVE: BORDERLINE PD

Individual Treatment

2 DAY CBT INTENSIVE: BORDERLINE PD

Session Acuity Protocol

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

2 DAY CBT INTENSIVE: BORDERLINE PD

Standard CBT Skills

- Relationship Work
- Restructuring Suicidal and Parasuicidal cognitions
- Identity work
- Continuums

2 DAY CBT INTENSIVE: BORDERLINE PD

Integrated DBT/CBT/SFT Case Study

2 DAY CBT INTENSIVE: BORDERLINE PD

Case Study

2 DAY CBT INTENSIVE: BORDERLINE PD

Interpersonal Effectiveness Case Study: Cognitive Work

Key Cognitions

- “Since you impose rules/requirements, you don’t care”
- “Since you won’t pay for this one, I am not willing to look for any others”
- “You should pay for anything i need - since you wont you probably wish I was dead (never born)”

Key Schemas

- “Others take advantage of you”
- “Others are Controlling/Uncaring”
- “I am Unlovable”
- Dependent Entitlement

2 DAY CBT INTENSIVE: BORDERLINE PD

Interpersonal Effectiveness Case Study: Data Logs

2 DAY CBT INTENSIVE: BORDERLINE PD

Interpersonal Effectiveness Case Study: Cue Cards

2 DAY CBT INTENSIVE: RELAPSE PREVENTION

Relapse Prevention

- Relapse - “a recurrence of symptoms after a period of improvement”

2 DAY CBT INTENSIVE: 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

2 DAY CBT INTENSIVE: RELAPSE PREVENTION

Road To Recovery!

- Things I’m doing right
- Vulnerabilities to relapse
- Episode management
- Failing forward
- Road to recovery
- Restructuring cognitions related tolLoss
- Booster sessions

2 DAY CBT INTENSIVE: RELAPSE PREVENTION

Relapse Prevention Plan

Things I am doing right I need to continue doing are: _____

_____

_____

My Vulnerability Factors/Warning Signs I need to be aware of this week include:

_____

_____

_____

If I get in trouble and am tempted to relapse, I will call:

1.

2.

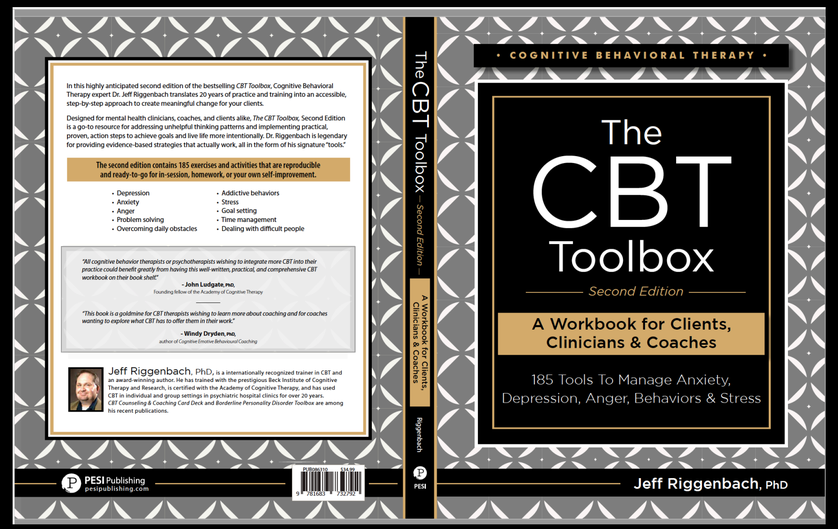
3.

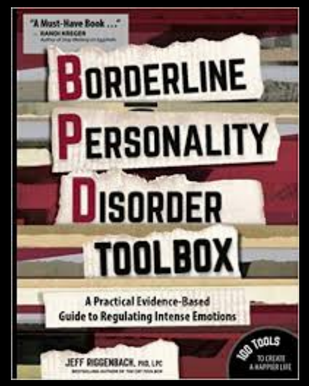
LET'S CONNECT!

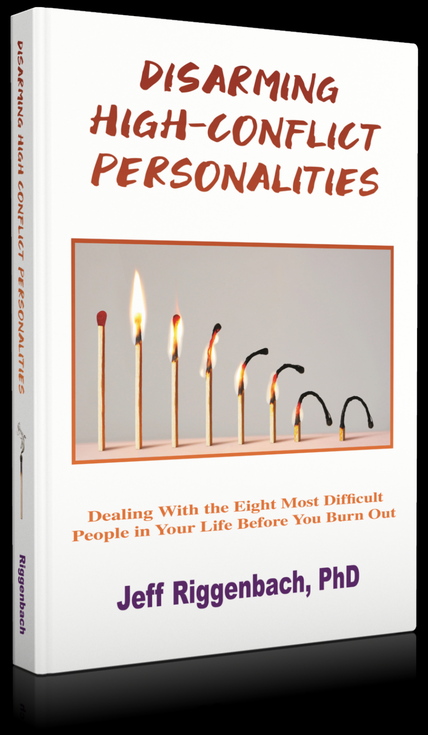
Website: clinicaltoolboxset.com

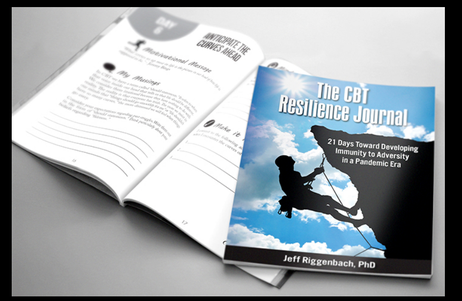
Email: jeff@jeffriggenbach.com

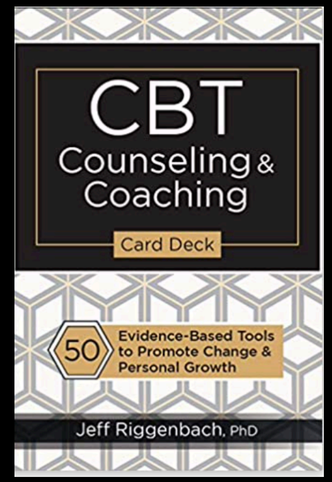
Facebook: DrJeff Riggenbach











CBT Socialization Tool

EVENTS → THOUGHTS → FEELINGS → ACTIONS → RESULTS

Identifying Thoughts and Feelings

I Felt…	Because I Thought…

Thought Log

AUTOMATIC THOUGHT	RATIONAL RESPONSE

Cognitive Distortions

1. Rationalization – Making excuses for events in life that don't go your way or poor choices you make in an attempt to protect yourself from hurt feelings. You try to convince yourself that just because your wife cheated on you that it's OK because, "that guy probably initiated it" or it's OK for your husband to be abuse because "he just doesn't know how to show his love, and besides, he only did it twice."

2. Overgeneralization – You see a single negative event as applicable to *all* or *no* situations. Just because you had a bad experience with a civic group or church, you assume all such organizations or churches are bad.

3. All or nothing thinking – You see things in black and white categories. You view yourself, others and/or the world in only positive or negative extremes, and are unable to see positive or negative aspects. Certain family members can do no wrong or co-workers are the worst of humanity.

4. Discounting the positive – You reject positive experiences or compliments insisting they don't count for one reason or another. In this way, you maintain a negative belief system that is inconsistent with the "real you," your experiences, or your achievements. When someone gives you a compliment, you respond as "oh, it was nothing anyone else couldn't have done."

5. Fortune Teller – You make irrational doomsday predictions about the future based solely on your negative experiences in the past. "I will probably end up unemployed and alone for the rest of my life and my kids will hate me."

6. Mind Reading – you assume you know what people are thinking in given situations based upon how others in your past have thought in similar situations. You fail to consider that these are different people, and, perhaps, you are a different person at this point in your life as well. "I know he will say no, so I'm not even going to ask – He probably thinks I'm not consistent enough."

7. Should Statements- You place false or unrealistic expectations upon yourself or others, believing that "I should have done" this or they "should have done" that. Then when you or they do not, you have set yourself up to

become angry, depressed or anxious.

8. Emotional Reasoning – You assume that your negative feelings reflect the way things really are. “If I feel angry, therefore I will yell at my boss,” or “I feel depressed, thus the world really must suck.”

9. Magnification – You blow things out of proportion. You exaggerate the impact/importance of events. “Just because I didn’t get this job, there will be a one-month gap on my resume’ and no one will ever hire me. Nobody will see my skills and I will never get a job and will have to go on welfare!”

10. Personalization – You see yourself as the cause of something you had nothing to do with. You lean over and say something to your husband on the 4th and 10 during a football game and he does not respond and you think “I must not be important to him” or “he must not love me”. Possibly, he loves you more than anything in the world but did not hear you because he was so tuned in to the game. Another examples is that children often believe they are responsible for their parents’ divorce.

LISA Case Study

Lisa was born and raised in a small rural Colorado. The closest "real city" as she called it, Boulder, was almost an hour and a half away. She was the youngest of two children, her brother being 5 years older than she. Lisa describes her relationship with her mother as being volatile. "She tried, but she always had such a temper." Her mother did not work, and was frequently in bed complaining of "some kind of physical ailment," and was rarely there for Lisa or her brother. She recalls one evening when she was 7 having "a really bad tummy ache" and asking her mom for some medicine. Her mother replied "Ill try to in a few minutes," but never got around to it. I laid in pain and couldn't sleep all night but didn't want to ask my mom again "because I didn't want to bother her" and "she would probably just yell at me again." She reports many times remembering her mother yell "you good for nothing little girl – why cant you do it yourself like your brother?" On another occasion, she recalls still being hungry and asking for a second cup of macaroni and getting spanked with a switch and told she was "selfish" and "bad" for asking. "The older people who work and are good for something get what they want first – then if there is any extra you can have some more." At age 5 she remembers her mother burning her with an iron because she "made a mess on the floor with colors. Another morning she remembers rushing out the door because she was late for school but running back in telling her mother she forgot to take her medicine. At age 7 Lisa recalls her mother going into a rant screaming "I can believe you are asking your mother to go back downstairs already this morning after I was tired and back in bed" and throwing her down the stairs and breaking her arm.

Her mother committed suicide when she was in 12.

Lisa's father worked for the sheriff's department and was a member of the national guard. She remembers him being gone much of the time when she was young. Upon her mother's death, her father remarried almost immediately and gave most of his attention to his new wife. His new wife took little interest in either of the kids and often became angry when Lisa asked for things. One night when Lisa was a sophomore her first and only "boyfriend" of sorts broke up with her she recalls leaving school early and crying most of the afternoon and evening. When she came out of her room to ask her father for a hug she was scolded for "interrupting" while they were watching a movie on the couch. She remembers well the phrase "you needy girl – can't you do anything for yourself."? Routine requests always seemed to be an "imposition."

Her brother Jared was attractive, social, and charming. He was intelligent and motivated. He made friends easily. He had a paper route in junior high and sold books during the summers while at college. Lisa states "he was always nice to me, but never really had much time for me...He was almost graduated when mom died, had a lot of friends, a job, and a coach and a friend's youth pastor for mentors.... "I was shy and awkward and had no friends and no one to turn to. "I didn't do

particularly good in school." She also reports having few hobbies, talents, or interests, other than making "bead bracelets, necklaces, and crafty things."

Lisa describes her school years as very lonely years. With few friends, her brother involved with his many extra-curriculars, and her father, when home, consumed with his new wife, 'companionship was hard to come by" and "I was really kind of a misfit." The rural area she grew up in was far enough from town it was difficult to get in for activities and she had no transportation. She rarely ask others for a ride into town because "we lived so far out I hated to ask people to go out of their way."

When Lisa was 17 she met and quickly married a man who was 23 who worked in quality control at a local factory. He was a decent man who rarely treated her poorly, but worked long hours and "was emotionally distant." After 5 years of marriage, he was laid off, so the couple relocated to Oklahoma where he worked for his father. They struggled with fertility issues, but eventually became pregnant and had a son, Cody, "who became my life." She immersed herself in Cody's life doing little else. After 22 years of marriage her husband divorced her for being "needy, clingy, and never getting any better."

At age 43, Lisa has now been divorced 5 years, has joint custody of Cody, and is struggling to complete a technical degree before her alimony runs out. He husband remarried immediately "a biker chic" and "took on a whole new lifestyle." Although they often "exposed Cody to things he shouldn't see," they did live a more active lifestyle and the means to take him on trips and buy him "expensive toys," while Lisa struggles to pay the bills in her apartment in a less desirable part of town.

Cody has started to engage in some mild acting out behaviors at school. He has been called to the principal's office on a couple of occasions and has been suspended once for a day. He has become argumentative at home, started lying at home and school, and has had difficulty taking responsibility for his actions.

Lisa constantly struggles with being a "bad parent" and many times believes "Cody would be better off with his dad...he will probably just leave me like everyone else."

One day when attempting to discipline him for coming home 30 minutes late from playing in the neighborhood he yells at her stating "you always nitpick at me – Carlos' mom lets him stay out till midnight - You are the worst mom in the neighborhood!"

Depression Monitoring Log

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
0000							
0100							
0200							
0300							
0400							
0500							
0600							
0700							
0800							
0900							
1000							
1100							
1200							

1300							
1400							
1500							
1600							
1700							
1800							
1900							
2000							
2100							
2200							
2300							

Observations: _____

_____

_____

_____.

101 Things I can do Instead of hurt Myself/To Calm Myself Down

1. **Take a hot bath 2. Put a rubber band around my wrist 3. Cuddle with a stuffed animal 4. Hold a cold ice cube 5. Eat 6. Get in bed 7. Karate/martial arts 8. Fly a kite 9. Arrange flowers 10.Have sex (responsible) 11.Play with a pet 12.Garden 13.Go for a drive 14.Cooking 15.Play golf 16.Recycle 17.Give a hug 18.Receive a hug 19.Burn incense 20.Go grocery shopping 21.Go for a walk 22.Go to church 23.Sing 24.Ride a bike 25.Plug in a heating blanket 26.Go for a run 27.Yoga 28.Walk on a beach 29.Do 50 sit-ups 30.Go to spa 31.Crochet 32.Jumping jacks 33.Photography 34.Journal 35.Use mouthwash 36.Picture getting married 37.Daydream 38.Go to a sporting event 39.Watch a movie 40.Refinish furniture 41.Write a letter 42.Paint 43.Go to a park 44.Get a backrub 45.Deep breathing exercise 46.Listen to a relaxation cd 47.Make a list 48.Clean house 49.Floss your teeth 50.Give a massage 51.Drink hot coffee, tea 52.Read a children's story 53.Blow bubbles 54.Call a friend 55.Quilt 56.Pray 57.Hold a pillow 58.Comb your hair 59.Go for a swim 60.Work with clay 61.Tear paper 62.Wash your hands 63.Knit 64.Lay out 65.Get a haircut 66.Color in a coloring book 67.Do your nails 68.Mow your lawn 69.Sit in a hot tub 70.Swing 71.Workout video 72.Do artwork 73.Window shop 74.Burn a candle 75.Smoke a cigarette 76.Brush your teeth 77.Eat popcorn 78.Drink 6 bottles of water 79.Meditate 80.Play the piano 81.Pop your knuckles 82.Call a friend 83.Drink coffee 84.Do something that will make you laugh 85.Play cards 86.Sew 87.Gambling 88.Computer games 89.Go to tanning bed 90.Daydream 91.Talk on the phone 92.Make a craft 93.Woodworking 94.Collections 95.Go to a club 96.Go to a library 97.Sleep 98.Stretching exercises 99.Bite your fingernails 100. Lift weights 101. Play with yarn/stress ball**

REASONS FOR LIVING INVENTORY

Check the boxes below that indicate why you would stay alive when contemplating suicide.

☐ I owe it to my family to stay alive.

☐ I believe I can learn to manage my problems.

☐ I believe I have control over my own destiny.

☐ I believe only God has the right to end a life.

☐ I am afraid of death.

☐ I want to watch my children grow.

☐ Life is all we have and is better than nothing.

☐ I have future plans I am looking forward to carrying out.

☐ No matter how bad I feel, I know that it will not last.

☐ I love and enjoy my family too much and could not leave them.

☐ I am afraid that my method of killing myself would fail.

☐ There are many experiences I have not had yet that I want to have.

☐ It would not be fair to leave the children for others to take care of.

☐ My religious beliefs forbid it.

☐ It would hurt my children/family too much and I would not want them to suffer.

☐ I have the courage to face life. ☐ I am afraid of the actual "act" of killing myself (the pain, blood, violence).

Other reasons for living.

☐ _____

☐ _____

☐ _____

Substance Use Case Study

Vonnie is a divorced 38 y/o Caucasian female. She has no children and is currently living with her new boyfriend. Her primary complaints at initial assessment are chronic depression, anxiety, and a lengthy history of alcohol and methamphetamine abuse. She reports recently her mood instability had worsened due to relationship concerns that her new boyfriend might leave her as well as conflict with a coworker and she fears she may relapse "and ruin my 3 months' sobriety." She reports "quitting" many times for short stints of time with 7 months being her longest period of abstinence from any substance. Vonnie had maintained a professional career, holding down the same job for the past 7 years for which she made a good salary.

Upon completion of her initial assessment, Vonnie met criteria for Major Depressive Disorder Borderline Personality Disorder features, Alcohol and Methamphetamine use disorders

Since her divorce 12 years ago, It was noted that she hadn't dated a man any longer than 6 months and triggers for usage often centered around these breakups or "relational spats." A pattern was also identified of "dating men who are in some way less than me so I didn't have to worry about them leaving me – I could just date them until I got tired of them and them dump them."

Vonnie's mother completed suicide when she was 12. She was an only child who from that age forward was raised by her "pillhead dad" who "floundered around doing odd jobs" and barely bringing home enough income to put food on the table. Vonnie recalls "one week when I was in high school I remember we had to share a large can of beans all week." Vonnie recalls living in fear on a daily basis wandering whether or not her father would come home that night. "After my mom left me and died, I just lived in fear of another loss. She describes a history of "on and off" relationships in high school that "often got me pretty worked up - I felt so bad I could hardly stand it." When not during one of her dating courses, she describes feeling boredom frequently. "I was home alone a lot and didn't have anything to do – we lived on a farm and if Dad didn't come home I was by myself and had no friends close – and I couldn't text yet then"! Vonnie reports stealing her fathers' pills as early as age 9. "They just gave me a lot of energy and a high I hadn't felt before and some excitement for once in my life." Although she had few friends, Vonnie reports excelling academically, graduating as the salutatorian of her class with a 3.9 GPA. "I began to realize even though I couldn't keep a boyfriend and girls didn't seem to like me much, that if I worked hard I could at least be good at something...and dads Ritalin kept me going."

Anxiety Resources Tool

Fear	Internal Resources	External Resources
1)		
2)		
3)		
4)		
5)		
6)		

Silver Lining

Traumatic events are terrible things to go through in life. They often bring about indescribable suffering. The good news is most people recover from trauma. Some need therapy, some do not. One common theme in most people who recover from traumatic events has to do with their ability to find a “silver lining” in what they went through. That is, what are they now “uniquely qualified” to offer the world as a result of what they went through. As you think about your experiences in life, what “silver linings” are you able to see and how might that change what you do with your life moving forward?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The Blame Game Tool

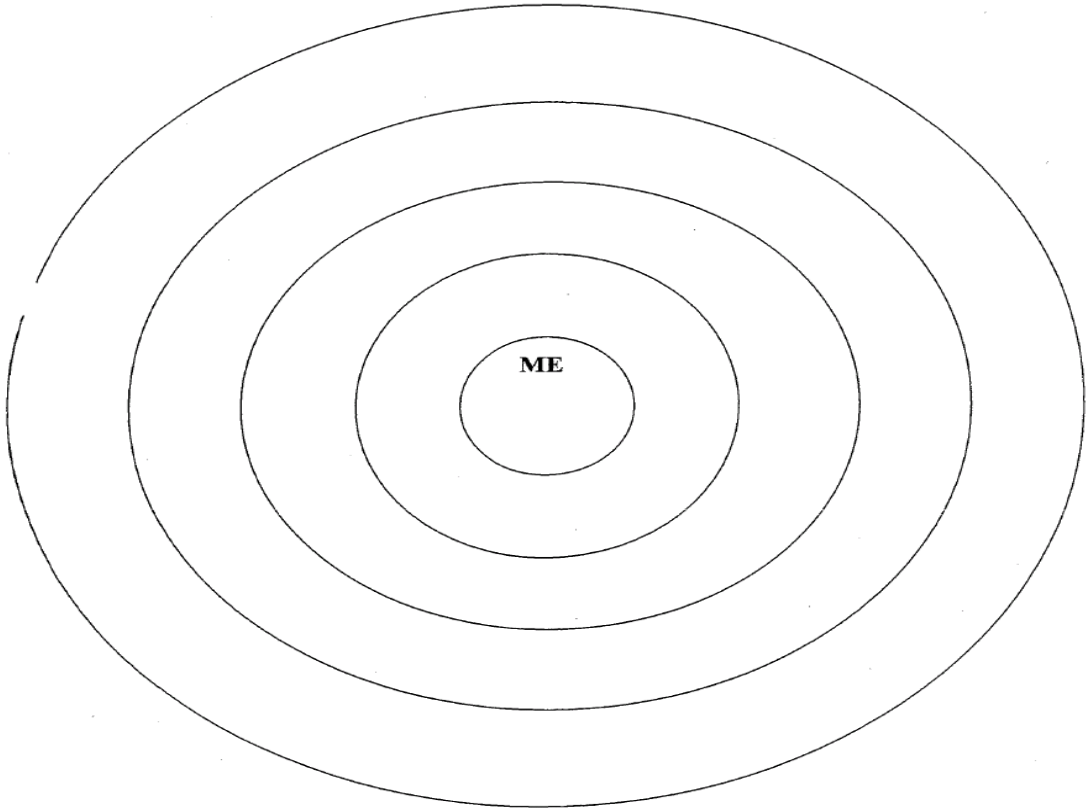
When we hear the term "blame game" it is often referring to people (often couples, but is also applied to employee, friend, or any number of kinds of disputes) in an argument blaming the other, without being able to see their role in the altercation. People who have been victims of traumatic experiences often have the exact opposite problem with their thinking; that is they blame themselves for aspects (or sometimes the entire traumatic experience) event that were NOT their fault. An important part of healing from trauma related incidents in life is being able to *assign blame where it rightfully belongs.* Use the following tool to identify aspects of the event you are working on that you are currently ***blaming yourself*** for and record them in column #1. Then use column #2 to identify why your reasoning is being unfair to yourself. You will likely need to enlist the help of a family member, friend, or trusted professional.

Areas/Reasons I am blaming Myself	**Reasons It is <u>UNFAIR</u> to blame myself**

Summary Statement: "Although I am tempted to blame myself due to _____,
I know it is not my fault because _____.

Intimacy Circles

People need people, but this can be a “catch 22” for many people. On one hand, we need human interaction for support, encouragement, touch, fun, and a sense of connectedness. But on the other hand, relationships can be very difficult for a variety of reasons. Depression influences us to want to isolate. Anxiety makes us too fearful to put ourselves out there. Anger often influences us to “blow up” verbally or physically which estranges us from the people we care about most. While it is not necessary that you become “the life of the party” if that is not “you,” it is vital to have a support system. Take a few minutes to evaluate the relationships you have in your life, writing them in the circle you view as appropriate.



Adapted from Velasquez, Maurer, Crouch, and DiClemente, 2001

Relationship Questions

What changes would I like to make to my circles?

_____

_____

Are there people I would like to have closer in? Further out? Who and why?

_____

_____

Some hurtful things I have done that have damaged one or more relationships:

_____

_____

Some helpful things I have done that have helped me in maintaining relationships:

_____

_____

Changes I could make in the way I relate to people may include:

_____

_____

Would I like to add people to my circles who currently aren't there? Why or why not?

_____

_____

What are some qualities of the people I would like to add?

_____

_____

Where might I go to meet people with those qualities?

_____

_____

What are some "red flag" qualities of people I may be drawn to but that I have learned from experience are NOT good candidates for my circles?

_____

_____

One Step I am willing to take to improve my circles is …

CBT REFERENCES

Abelson, J. L., Liberzon, I., Young, E. A., & Khan, S. (2005). Cognitive modulation of endocrine stress response toa pharmacological challenge in normal and panic disorder subjects. *Archive of General Psychiatry*, 62(6), 668–675.

Ameli, R. (2014). *25 lessons in mindfulness: Now time for healthy living* (1st ed.). Washington, DC: American Psychological Association.

Antony, M. (2009). *When perfect isn't good enough: Strategies for coping with perfectionism*. New Harbinger Publications.

Antony, M., & Norton, P. J. (2008). *The anti-anxiety workbook: Proven strategies to overcome worry, phobias, panic, and obsessions*.
Guilford Press.

Beattie, M. (1986). *Codependent no more: How to stop controlling others and start caring for yourself*. Hazelden

Foundation. Beck, A. T. (1967). *The diagnosis and management of depression*. Philadelphia, PA:

University of Pennsylvania Press. Beck, A. T. (2000). *Prisoners of hate: The cognitive basics of anger,*

hostility, and violence. HarperCollins.

Beck, A. T. (2015). *Cognitive therapy of personality disorders* (3rd ed.). Guilford Press.

Beck, A. T., & Clark, D. (2011). *The anxiety and worry workbook: The cognitive behavioral solution*. Guilford Press.

Beck, A. T., Rector, N. A., Stolar, N., & Grant, P. (2011). *Schizophrenia: Cognitive theory, research, and therapy*.

Guilford Press. Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1987). *Cognitive therapy of depression* (1st

ed.). Guilford Press.

Beck, J. S. (2005). *Cognitive therapy for challenging problems* (1st ed.).

Guilford Press. Beck, J. S. (2011). *Cognitive therapy: Basics and beyond*

(2nd ed.). Guilford Press.

Burns, D. D. (1999). *The feeling good handbook*. Plume.

Cloud, H., & Townsend, J. (1992). *Boundaries: When to say yes, how to say no to take control of your life*. Zondervan.

Connors, G. J., DiClemente, C. C., Velasquez, M. M., & Donovan, D. M. (2004). *Substance abuse treatment and the stages of change: Selecting and planning interventions* (2nd ed.). Guilford Press.

DeRubeis, R. J., Siegle, G. J., & Hollon, S. D. (2008). Cognitive therapy versus medication for depression: Treatmentoutcomes and neural mechanisms. *Nature Reviews Neuroscience*, 9(10), 788–796.

De Shazer, S. (1985). *Keys to Solution in Brief Therapy*. Norton.

Edwards, D. J. A. (2014). Schemas in clinical practice: What they are and how we can change them. *Independent Practitioner*, 34(1), 10–13.

Edwards, D. J. A. (2015). Self-pity/victim mode: A surrender schema mode. *Schema Therapy Bulletin*,

1(1), 3–6. Ellis, A., & Harper, R. A. (1975). *A new guide to rational living*. Wilshire Book Co.

Ellis, T. (Ed.). (2006). *Cognition and suicide: Theory, research, and therapy*. American Psychological

Association. Gilbert, P., & Leahy, R. L. (2017). *The therapeutic relationship in cognitive behavioral psychotherapies* (1st ed.). Routledge. Greitens, E. (2016). *Resilience: Hard-won wisdom for living a better life.* Mariner Books.

Hackman, A., Bennett-Levy, J., & Holmes, E. A. (2011). *Oxford guide to imagery in cognitive therapy.* Oxford University Press.

Hayes, S., & Smith, S. (2005). *Get out of your mind and into your life: The new acceptance and commitment therapy.* New Harbinger Publications.

Kahl, K. G., Winter, L., & Schweiger, U. (2012). The third wave of cognitive behavioural therapies: What is new andwhat is effective? *Current Opinion in Psychiatry*, 25(6), 522–528.

Kuyken, W., Padesky, C. A., & Dudley, R. (2009). *Collaborative case conceptualization: Working effectively with clients in cognitive- behavioral therapy.* Guilford Press.

Leahy, R. (2003a). *Cognitive therapy techniques: A practitioner's guide* (1st ed.). Guilford Press. Leahy, R. (2003b). *Overcoming resistance in cognitive therapy* (1st ed.). Harmony Books.

Leahy, R. (2006). *The worry cure: Seven steps to stop worry from stopping you.* Harmony Books. Leahy, R. (2019). *Emotional schema therapy*. Routledge.

Leahy, R., & Gilbert, P. (2018). *The jealousy cure: Learn to trust, overcome possessiveness, and save your relationship.* Guilford Press. Lester, G. (1995). *Power with People: How to handle just about anyone and accomplish just about anything.* Ashcroft Press.

Linehan, M. (1993). *Cognitive behavioral treatment of borderline personality disorder.* Guilford Press.

Linehan, M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. A. (1983). Reasons for staying alive when you are thinking ofkilling yourself: The reasons for living inventory. *Journal of Consulting and Clinical Psychology*, 51, 276–286.

Ludgate, J. (2009). *Cognitive behavioral therapy and relapse prevention for depression and anxiety.* Professional Resource Press.

Makinson, R. A., & Young, J. S. (2012). Cognitive behavioral therapy and the treatment of posttraumatic stressdisorder: Where counseling and neuroscience meet. *Journal of Counseling & Development*, 90(2), 131–140.

Maxwell, J. C. (2007). *Failing forward: Turning mistakes into stepping stones for success.* Thomas Nelson Publishers.

Miller, W. R., & Rollnick, S. (1992). *Motivational interviewing: Preparing people to change addictive behavior.* Guilford Press. Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change* (3rd ed.). Guilford Press.

Moody, T. D., Morfini, F., Cheng, G., Sheen, C., Tadayonnejad, R., Reggente, N., O'Neill, J., & Feusner, J. D. (2017).Mechanisms of cognitive-behavioral therapy for obsessive-compulsive disorder involve robust and extensive increases in brain network connectivity. *Translational Psychiatry 7*, Article e1230.

Navoco, R. (2007). Anger dysregulation. In T. A. Cavell & K. T. Malcolm (Eds.), *Anger, aggression, and interventions for interpersonal violence* (pp. 3–54). Routledge.

Neenan, M., & Dryden, W. (2013). *Life coaching: A cognitive behavioural approach.* Routledge.

Neehan, M., & Palmer, S. (2012). *Cognitive behavioural coaching in practice: An evidence-based approach*. Routledge.

Padesky, C. A., & Mooney, K. A. (2012). Strengths-based cognitive-behavioural therapy: A four-step model to build resilience. *Clinical Psychology & Psychotherapy*, 19(4), 283–290.

Perlis, M. L., Jungquist, C., Smith, M. T., & Posner, D. (2008). *Cognitive-behavioral treatment of insomnia: A session-by-session guide*. Springer.

Porto, P. R., Oliveira, L., Mari, J., Volchan, E., Figueira, I., & Ventura, P. (2009). Does cognitive behavioral therapy change the brain? A systematic review of neuroimaging in anxiety disorders. *The Journal of Neuropsychiatry and Clinical Neurosciences*, 21(2), 114–125.

Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (2010). *Changing for good: A revolutionary six-stage program for overcoming bad habits and moving your life positively forward*. HarperCollins.

Ramy, H. (2020). The biology of cognitive behavior therapy. *European Psychiatry*,

41(S1), s637. Reis de Oliveiria, I. (2015). *Trial-based cognitive therapy: A manual for*

clinicians. Routledge.

Riggenbach, J. (2013). *The CBT toolbox: A workbook for clients and clinicians* (1st ed.). PESI Publishing.

Rohn, R. (2005). *Positive personality profiles: D-I-S-C-over personality insights to understand yourself and others!* Personality Insights.

Scrimali, T. (2012). *Neuroscience-based cognitive therapy: New methods for assessment, treatment, and self-regulation* (1st ed.).

Wiley-Blackwell.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2018). *Mindfulness-based cognitive therapy for depression* (2nd ed.). Guilford Press.

Seligman, M. E. P. (2006). *Learned optimism: How to change your mind and your life*. Vintage Books.

Sokol, L., & Fox, M. (2009). *Think confident, be confident: A four-step program to eliminate doubt and achieve lifelong self-esteem*.

TarcherPerigee.

Thoma, N. C., & McKay, D. (2015). *Working with emotion in cognitive-behavioral therapy: Techniques for clinical practice* (1st ed.).

Guilford Press.

Velasquez, et.al (2001). *Group Treatment of Substance Abuse: A Stages of Change Model.*

Guilford Press. Warren, R. (2012). *The purpose-driven life: What on earth am I here for?*

Zondervan.

Weisinger, D. (1985). *Dr. Weisinger's anger work-out book: Step-by-step methods for greater productivity, better relationships, healthier life*. William Morrow and Company.

Wells, A. (2011). *Metacognitive therapy for anxiety and depression*. New York: Guilford

Press. Wells, A., & Matthews, G. (1994). *Attention and emotion: A clinical perspective.*

Psychology Press.

Whitmore, S. J. (2017). *Coaching for performance: The principles and practice of coaching and leadership*. Nicholas Brealey Publishing.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide* (1st ed.). Guilford

Press.

Young, J. E., & Klosko, J. S. (1994). *Reinventing your life: The breathtaking program to end negative behavior and feel great again.*
Plume.