Evidence-Based Treatment of Personality Disorders

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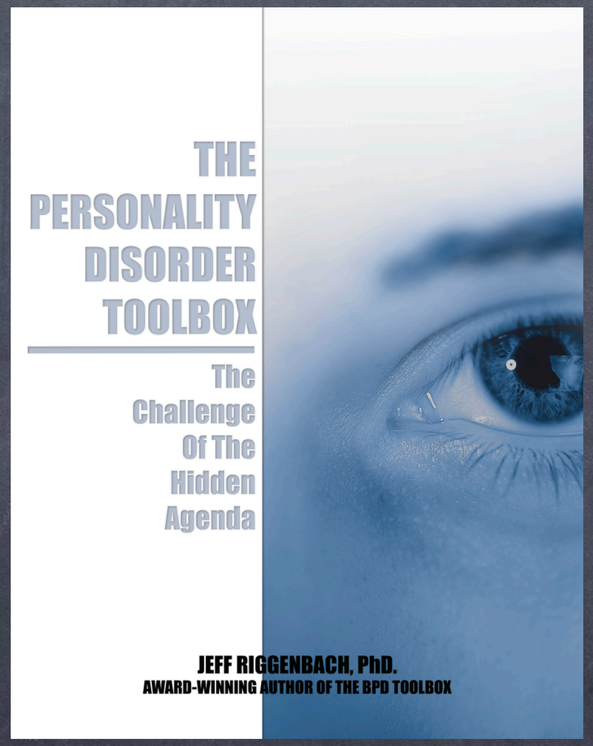

Presented by:

Jeff Riggenbach, PhD

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Session 1: Assessment and Diagnosis

- Etiology, gender distribution, prevalence rates

- Clinical distinctions of PD and implications for accurate assessment
- Assessment of Cluster A Disorders
  - Are Schizoid and Schizotypal really PDs?
  - Distinguish between to types of paranoia

- Assessment of Cluster C Disorders
- Assessment of Non-Borderline Cluster B Disorders

- Assessment of Borderline PD
  - Having the conversation with the client or family member
  - 8 reasons clients with BPD engage in non-suicidal self-injury and important implications for treatment
  - Differential diagnosis with bipolar disorder, PTSD and others

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Session 2: Evidence Based Treatment and Case Conceptualisation

- Evidence-Based Treatments
- Integrated Treatment Approach
  - Dialectical Behavior Therapy
  - Cognitive Behaviour Therapy
  - Schema Focused Therapy
- Case Conceptualisation
  - Conceptualisation drives treatment planning
  - Conceptualisation drives agenda-setting
  - Conceptualisation drives documentation

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Session 3: Treatment, Part 1

- Non-BPD Strategies
- Treatment Set-up/Individual treatment vs group treatment
- Skills Training Groups - CBT Skills
  - Motivational skills
  - Relationship skills
  - Continuums
  - Anger Managment Skills
  - Identity Work
  - Labeling distortions
  - Restructuring suicidal and other destructive cognitions

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Session 4: Treatment, Part 2

- Skills Training Groups - DBT Skills

  - Emotion regulation skills
  - Distraction techniques
  - Soothing strategies
  - Interpersonal effectiveness skills
  - Opposite action
  - Emotional intensity work
  - Radical acceptance

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Session 4: Treatment, Part 2, con

- Individual Therapy
  - The thinking of the therapist
  - Diary cards
  - Complex chain analysis
  - Therapy interfering behaviors
  - Integrated Case Study
- Schema Groups
  - Schema psychoeducation
  - Belief modification protocol
  - Mode dialogues
  - Internalisation work
- Relapse Prevention

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Personality Etiology

- Biopsychosocial = Genes + Environment

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Personality Etiology

- 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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Personality Etiology

- Temperament:

  - Innate, genetic, or constitutional aspects of personality

- Character:

  - Primarily learned, psychosocial influences on personality

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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 there was 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 there was Ever an "Axis II:" DSM Evolution

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

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Why there was Ever an "Axis II:" DSM Evolution

DSM III = 1980

- Abandoned Psychoanalytic terminology
- First DSM to have diagnostic criteria
- First to distinguish between 2 categories of Mental Illness (Axis I & II)
  - Axis I: Issues of Clinical Concern
  - Axis II: Personality Disorders

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Why there was ever an "Axis II": DSM Evolution

DSM III-R - 1987

DSM-IV - 1994

DSM-IV-TR - 2000

DSM 5 - 2013 - abandoned multiaxial diagnostic system

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Problems with Current Conceptualization

1. Line between "normalcy" and pathology harder to delineate

2. Considerable overlap in diagnostic Categories

Personality Disorder Diagnosis

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General Assessment and Diagnosis

PDO Characteristic	Assessment Technique
1) Ego-Syntonic	1) Emphasis on assessment of signs vs. symptoms

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General Assessment and Diagnosis

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

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General Assessment and Diagnosis

Events ➡ Thoughts ➡ Feelings ➡ Actions ➡ Results

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General Assessment and Diagnosis

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

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General Assessment and Diagnosis

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

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General Assessment and Diagnosis

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

Personality Disorder Diagnosis

PDO Characteristic	Assessment Technique
5) Inflexible	5) Monitor Across Contexts

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General Assessment and 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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Cluster A: The Detached Type

- Schizotypal
- Schizoid
- Paranoid

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Schizotypal Personality Disorder

- Prevalence
- 1% General Population
- Gender Distribution - More commonly dx in men
- More Common in 1st Degree Relatives of Schizophrenia
- Heritibility: Estimated .72

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Schizotypal Personality Disorder

- Cognitive Profile

  - View of Self: "I am Unique"

  - View of Others: "Others are Peculiar"

  - View of World: "World is Intriguing"

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Schizotypal Personality Disorder

Diagnostic Criteria

Must have five (5) of Nine (9) Characteristics

1. Ideas of Reference
2. Odd beliefs or magical thinking
3. Unusual perceptual experiences

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Schizotypal Personality Disorder

Diagnostic Criteria

4. Odd thinking, speech
5. Suspicious or paranoid ideation
6. Inappropriate or constricted affect

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Schizotypal Personality Disorder

Diagnostic Criteria

7. Behavior that is Odd, eccentric, or peculiar
8. Lacks personal friends or confidants
9. Excessive social anxiety related to paranoid perceptions, not to self-image

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Schizotypal PD

Video "Case Study"

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Schizoid Personality Disorder

- Prevalence:

  - Approximately 1% of General Population
  - 1% of Clinical Population
  - Gender Distribution - 2x More Common in Men
  - More Common in 1st Degree Relatives of Schizophrenia
  - Heritability: Estimated .70
  - Functionality: Can Maintain Employment w/ Good "Fit"
  - Least Hospitalized of any PD

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Schizoid Personality Disorder

- Cognitive Profile

  - View of Self: "I am Sufficient"

  - View of Others: "Others are Unnecessary"

  - View of World: "World is Boring"

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Schizoid Personality Disorder

Diagnostic Criteria – 4 of following 7

1. Neither desires nor enjoys close relationships
2. Almost always chooses solitary activities
3. Has little interest in sexual experiences

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Schizoid Personality Disorder

Diagnostic Criteria – 4 of 7

4. Takes pleasure in few activities
5. Lacks close friends
6. Appears indifferent to criticism
7. Shows emotional coldness; flattened affect

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Schizoid Personality Disorder

- Associated Features

  - Difficulty Expressing Anger
  - Passivity
  - Brief psychosis under stress
  - Association with Autism Spectrum Disorders

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Schizoid Personality Disorder

- Interview Features

  - Lack of Affective Response
  - Impression of Indifference
  - Anxiety Triggered With Closeness/Intimacy

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Paranoid PD

- Agenda: To stay safe in a dangerous world
- Primary Descriptive Trait: "Suspicious"
- Prevalence rates:
  - 2-3% Clinical population
  - Difficult to tell in general population
- Gender Distribution: More common in men
- Heritability: Estimated .41-.59
- Treatability: Poor

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Paranoid PD Profile

- Common Schemas: Mistrust, Punitiveness
- Cognitive Profile
  - "I am Vulnerable"
  - "Others are out to get you"
  - "The world is dangerous"
- View of Treatment: Treatment Rejecting
- Behavioral Targets: Avoiding necessary tasks, angry outbursts, attacking others

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Paranoid PD

Diagnostic Criteria – 4 of following 7

1) Suspects that others are exploiting, harming, or deceiving them
2) Is preoccupied with doubts about loyalty
3) Is reluctant to confide in others for fear that the info will be used against them

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Paranoid PD

Diagnostic Criteria – 4 of 7

4) Has recurrent suspicions regarding fidelity
5) Reads "hidden meaning" into events or statements
6) Holds persistent grudges; is excessively unforgiving
7) Remarks received as benign to others are taken as personal attacks – quick to anger

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Paranoid PD

- Associated Features

  - Blame others
  - Importance of autonomy - uncomfortable in situations that require dependence on others
  - Associated with IBS, Arthritis and Other Medical Conditions

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Paranoid PD

- Interview Features

  - Not taking responsibility for actions
  - Guarded – not forthcoming in information
  - Secretive
  - May share conspiracy – related stories
  - Expect you to Be Untruthful as Well
  - Irritability
  - Often Low Functioning/Unemployed

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Paranoid PD

- Differential Diagnosis

1. Paranoid Schizophrenia – episodic presence of other psychotic symptoms, blunted affect

2. Delusional Disorder, Paranoid Type

Cluster C: The Anxious Type

- OCPD
- Avoidant PD
- Dependent

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Obsessive-Compulsive PD

- Agenda: to do things the "right" way
- Primary Descriptive Trait: "Anal"
- Prevalence rates:
  - As high as 8% General Population
  - 3% - 13% Clinical Population
- Gender Distribution: More common in men
- Heritability: Estimated .37
- Treatability: Moderate to Good

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Obsessive - Compulsive PD Profile

- Common Schemas: Unrelenting Standards, Hypercritical
- Cognitive Profile
  - "I must be perfect"
  - "Others screw up a lot"
  - "The world must have order"
- View of Treatment: Treatment Rejecting
- Behavioral Targets: Perfectionism, Procrastination, Criticalness

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Obsessive-Compulsive PD

Diagnostic Criteria – 4 of following 8

1. So preoccupied with rules, details, lists, order, organization that point of activity is lost
2. Perfectionism that interferes with task completion
3. Excessively devoted to work and productivity, often to the exclusion of leisure activities or friendships

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Obsessive-Compulsive PD

Diagnostic Criteria – 4 of following 8

4. Overconscientious, scrupulous, and inflexible about morality, ethics, and values, not accounted for by cultural or religious beliefs
5. Is unable to discard old objects, even if they have no sentimental value
6. Is reluctant to delegate tasks, for fear they will not be done "the right way"

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Obsessive-Compulsive PD

Diagnostic Criteria – 4 of following 8

7. Has miserly spending style
8. Rigid and stubborn

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Obsessive-Compulsive PD

- Associated Features
  - Decision Making is time consuming
  - Time allocated poorly
  - Relationships take on serious quality
  - Leisure time viewed as "waste"
  - Play time turned into structured activity

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Obsessive-Compulsive PD

- Interview Features
  - Circumstantial Speech
  - To get answer, must sort through a myriad of other details leading up to current situation
  - Overly analytical

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Avoidant PD

- Agenda: To not be hurt emotionally
- Prevalence rates:
  - 2%-3% of General Population
  - 10% of Clinical Population
- Gender Distribution: Equally diagnosed in men & Women
- Heritability: Estimated .28
- Prognosis: Moderate to Good

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Avoidant PD Profile

- Common Schemas: Approval Seeking, Failure
- Cognitive Profile
  - "I am not likable"
  - "Others will judge me"
  - "The world is scary"
- Behavioral Targets: Isolation, avoiding social, job-related situations

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Avoidant PD

Diagnostic Criteria – 4 of 7

1) Avoids occupational activities that involve significant interpersonal interactions due to fear of rejection, criticism, or disapproval
2) Unwilling to get involved with people unless certain of being liked
3) Inhibited in new interpersonal situations due to feelings of inadequacy

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Avoidant PD

Diagnostic Criteria – 4 of 7

4) Preoccupation with being criticized or rejected
5) Inhibited intimate relationships due to fear of shame or ridicule
6) View selves as socially inept, personally unappealing, or inferior to others
7) Unusually reluctant to take risks or engage in new activities due to fear of embarrassment

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Avoidant PD

- Associated Features
  - Self-Criticism
  - Isolation
  - Avoidance

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Dependent PD

- Agenda: To get taken care of
- Primary Descriptive Trait: "Needy"
- Prevalence rates:
  - 1% - 8% of General Population
  - Difficult to establish in Clinical Population
- Gender Distribution: More common in women
- Heritability: Estimated .27
- Treatability: Moderate to Good

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Dependent PD Profile

- Common Schemas: Failure, Dependence, Approval-Seeking, Self Sacrifice, Subjugation
- Cognitive Profile
  - "I am inadequate"
  - "Others are necessary for me to survive"
  - "The is too vast for me to make it alone"
- View towards Treatment: Treatment Seeking
- Behavioral Targets: Constant phone calls/texts, excessive need for time together, developing hobbies, taking initiative & responsibility

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Dependent PD

Diagnostic Criteria – 5 of 8

1) Has difficulty making every day decisions without excessive reassurance from someone else
2) Requires others to assume responsibility for major areas of their life

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Dependent PD

Diagnostic Criteria – 5 of 8

3) Has difficulty disagreeing with others due to fear of loss of support and/or approval
4) Difficulty initiating projects or doing things on own
5) Goes to excessive lengths to obtain nurturing and support from others – will often volunteer for unpleasant things to get this

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Dependent PD

Diagnostic Criteria – 5 of 8

6) Uncomfortable or helpless when alone – exaggerated fears of being unable to care for self
7) Urgently seeks new relationships for care and support whenever an existing relationship ends
8) Unrealistically preoccupied with fears of being left to care for selves

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Dependent PD

- Associated Features
  - Co-occurring Depression
  - Co-occurring Anxiety Disorders
  - Belittles Abilities
  - Put self down
  - Avoid responsibility

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Dependent PD

- **Interview Features**

  - Overly compliant
  - Cooperative demeanor
  - Rarely misses sessions

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Histrionic PD

- Agenda: To be noticed
- Primary Descriptive Trait: Dramatic
- Prevalence rates:
  - 2-3% General Population
  - 10% Clinical Population
- Gender Distribution: More Common in Women
- Heritability: Estimated .26
- Treatability: Moderate

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Histrionic PD Profile

- **Common Schemas:** Worthless, Emotional Deprivation, Inhibition, Approval Seeking, Insufficient Self-Control
- **Cognitive Profile**
  - "I am noteworthy"
  - "Others should pay attention to me"
  - "The world is my stage"
- View of Treatment: Treatment Seeking
- Behavioral Targets: Inappropriate flirtatious or provocative behaviors

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Histrionic PD

Diagnostic Criteria – 4 of following 8

1) Is uncomfortable with situations in which he or she is not the center of attention
2) Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
3) Displays rapidly shifting and shallow expressions of emotion

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Histrionic PD

Diagnostic Criteria – 4 of 8

4) Consistently uses physical appearance to draw attention to self

5) Has a style of speech that is excessively impressionistic and lacking in detail

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Histrionic PD

Diagnostic Criteria - 4 of 8

6) Shows self-dramatization...exaggerated expression of emotion

7) Is suggestible

8) Considers relationships to be more intimate than they really are

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Histrionic PD

- Associated Features

  - Sexual provocative /flirtatious
  - Solicits compliments about physical appearance
  - Somatic Complaints
  - Impulsive and arbitrary about decision-making
  - Flighty, gregarious, shallow, fickle, need for attention

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Histrionic PD

- Interview Features
  - Demonstrative, shallow
  - Vivid expressions
  - Dramatic gestures
  - Mood changes quickly & has superficial quality

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Antisocial PD

- **Agenda: To get what** I want
- Primary Descriptive Trait: Violator
- Prevalence rates:
  - 3-4% General Population
  - 3x more common in men
- Heritability: Estimated .69
- Treatability: Poor, especially if psychopathic

Psychopath-> Sociopath-> Antisocial PD

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Antisocial Profile

- Common Schemas: Entitlement, Social Isolation, Insufficient Self-control
- Cognitive Profile
  - "I am superior"
  - "Others are in my way"
  - "Do what you have to to survive"
- View of Treatment: Treatment Rejecting
- Behavioral Targets: Rule breaking behaviors, criminal activity

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Antisocial PD

Diagnostic Criteria

A pervasive pattern of disregard for and violation of the rights of others occurring since age 15, as indicated by three (3) or more of the following:

1) Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest

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Antisocial PD

Diagnostic Criteria - 3 of 7

2) Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
3) Impulsivity or failure to plan ahead

4) Irritability or aggressiveness, as indicated by repeated physical fights or assaults

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Antisocial PD

Diagnostic Criteria - 3 of 9

5) Reckless disregard for safety of self or others

6) Consistent irresponsibility

7) Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated or stolen from another

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Antisocial PD

- Associated Features
  - Superficial charm
  - Absence of nervousness

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Antisocial PD

- Interview Features
  - Often brag about sham jobs
  - Street "slang" or jargon others may be unfamiliar with

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Antisocial PD

The Return of the Psychopath?

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Narcissistic PD

- Agenda: To achieve and to maintain" special" status
- Primary Descriptive Trait: Special
- Prevalence rates:
  - 1% - 6% - General Population
  - 7% - 9% Clinical Population
- Gender Distribution: More common in men
- Heritability: Estimated .23
- Treatability: Poor - Moderate

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Narcissistic Profile

- Common Schemas: Defectiveness, Emotional Deprivation, Insufficient Self-Control, Subjugation, unrelenting standards
- Cognitive Profile
  - "I am more deserving than others"
  - "Others are less deserving"
  - "The world is a mountain to be climbed"
- View of Treatment: Treatment Rejecting
- Behavioral Targets: Verbally & emotionally abusive behaviors, addictions

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Narcissistic PD

Diagnostic Criteria

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (5) or more of the following:

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Narcissistic PD

Diagnostic Criteria - 5 of 9

1. Grandiose sense of self-importance (exaggerates achievements, talents, etc..)
2. Is preoccupied with fantasies of unlimited success, power, brilliance, or ideal love

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Narcissistic PD

Diagnostic Criteria - 5 of 9

3. Believes that he or she is "special" and unique and can only be understood by other "special" or high status people

4. Requires excessive admiration

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Narcissistic PD

Diagnostic Criteria - 5 of 9

5. Has sense of entitlement (unreasonable expectations of especially favorable treatment)

6. Is interpersonally exploitive – takes advantage of others to achieve his or her own ends

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Narcissistic PD

Diagnostic Criteria - 5 of 9

7. Lacks empathy – unable or unwilling to recognize or identify with feelings or needs of others

8. Believes others are envious of him or her

9. Shows arrogant, haughty behaviors/attitudes

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Narcissistic PD

- Associated Features
  - Exaggerate their own achievements
  - Intolerant of criticism
  - Appearance of humility that masks grandiosity

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Narcissistic PD

- **Interview Features**

  - Presents self in positive light
  - Puts others down/may talk down to you
  - Exaggerates or emphasizes accomplishments
  - Hypersensitive to criticism

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Narcissistic PD

Types of Narcissist

- Compensated/"Fragile"
- "Spoiled"
- High Functioning
- "Malignant"/Low Functioning

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Borderline PD

- Agenda: To keep from being left
- Primary Descriptive Trait: "Intense"
- Prevalence rates:
  - 3-6% of General Population
  - 10% Outpatient
  - 20% Inpatient
- Gender Distribution: More Common in Women
- Heritability: Estimated .49 - .65
- Prognosis: Good

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Borderline Profile

- Common Schemas: Abandonment, Defectiveness, Approval Seeking, Vulnerable, Insufficient Self-Control
- Cognitive Profile
  - "I am worthless (bad)
  - "Others are flawless"
  - "Others will never understand me"
  - "Others are evil"
  - "The world is unfair"
- Behavioral Targets: Self-injurious behaviors, substance use, promiscuous sex, spending, lashing out, shutting down

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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:

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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

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Borderline PD: Diagnostic Criteria

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

6. Affective Instability

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Borderline PD: Diagnostic Criteria

5. Recurrent suicidal behavior, gestures, threats, and self-mutilating behavior

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Borderline PD: Diagnostic Criteria

Three components of criteria 5

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

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Borderline PD: Diagnostic Criteria

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

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Borderline PD: 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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Borderline PD: 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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Borderline PD: Diagnostic Criteria

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

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Borderline PD: Diagnostic Criteria

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

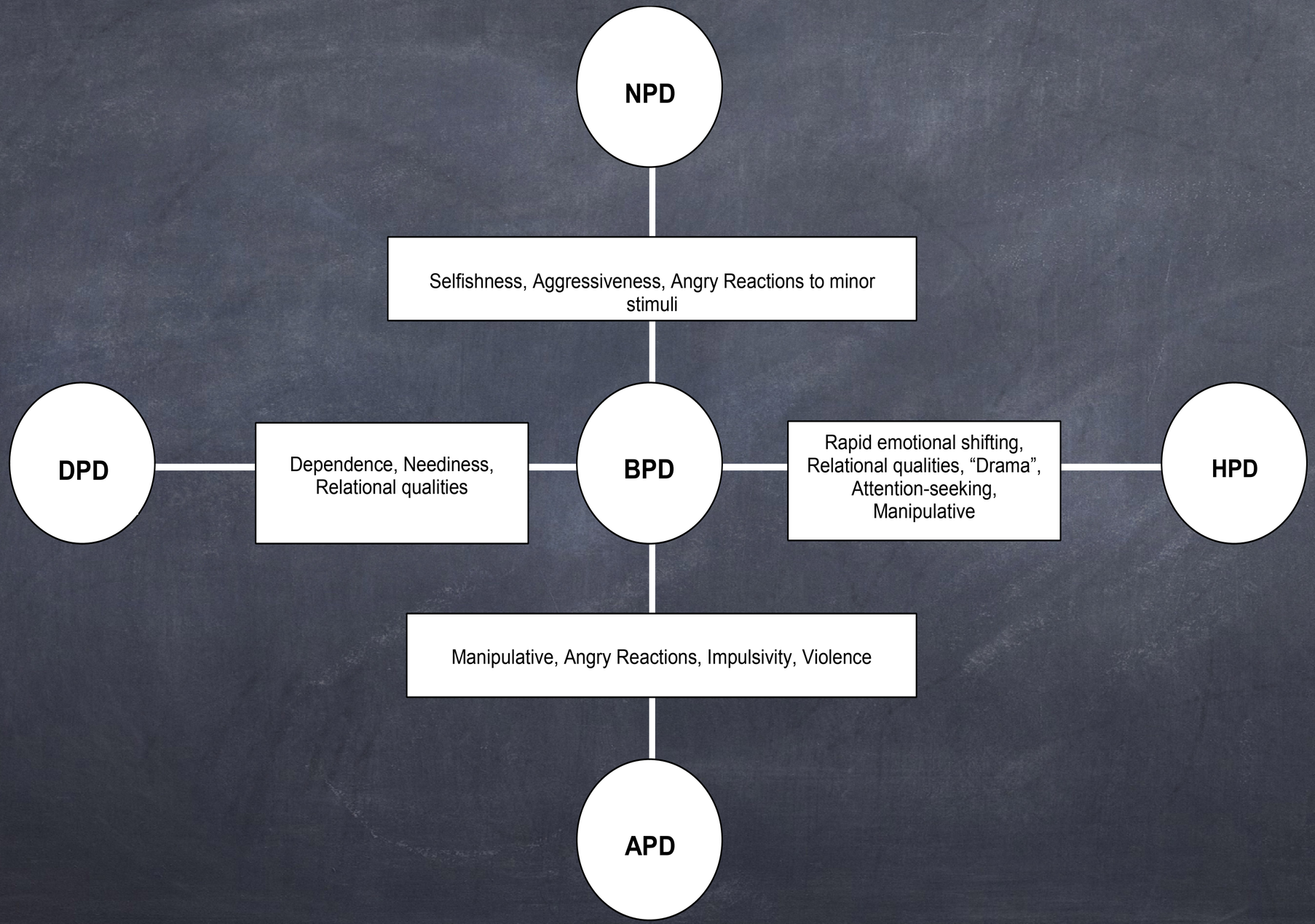
BPD Differential Diagnosis: PTSD

Borderline PD	PTSD
• Absence of hypervigilence, flashbacks, abandonment fears • Dissociative sx with ANY stressor • B & W Thinking • Anger/Rage	• Hypervigilence, flashbacks • Dissociative sx directly related to specific trauma • No B & W thinking • Primary affect is one of anxiety/fear

BPD Differential Diagnosis: Bipolar Disorder

Borderline PD	Bipolar Disorder
• “Mood swings” environmentally cued • Swing short in length, unstable • Black & White thinking • Anger/Rage	• “Mood swings” biologically cued • Swing usually longer, more stable • No B & W thinking • No Inherent anger

Other PD Rule Outs



BPD Differential Diagnosis: HPD

Borderline PD	Histrionic PD
• Intense drama • Claim to hate intensity of drama • “Upset” is often rage and hurts self and occasionally others	• Soap opera, but less intense • Enjoy drama • “Upset” is usually tears

BPD Differential Diagnosis: NPD

Borderline PD	Narcissistic PD
• "Selfishness" is genuinely needy • Idealize/Devalue others/Self • Openly express their needs or perceived needs	• "Selfishness" w/o dependency aspect • Idealize Self/Devalue others • Do have a need for admiration, but express it more subtly

BPD Differential Diagnosis: DPD

Borderline PD	Dependent PD
• Reaction to being left is Rage (and impulsive behavior) • Idealize and devalue others, self • Unstable relationships	• Reaction to being left is Anxiety (and devastation) • Idealize others, devalue self • Relatively stable relationships

Session 2: Evidence Based Treatment and Case Conceptualisation

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Schizotypal Personality Disorder

- Cognitive Profile

  - View of Self: "I am Unique"

  - View of Others: "Others are Peculiar"

  - View of World: "World is Intriguing"

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Schizotypal Personality Disorder

Diagnostic Criteria

Must have five (5) of Nine (9) Characteristics

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3. Unusual perceptual experiences

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Schizotypal Personality Disorder

Diagnostic Criteria

4. Odd thinking, speech
5. Suspicious or paranoid ideation
6. Inappropriate or constricted affect

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Schizotypal Personality Disorder

Diagnostic Criteria

7. Behavior that is Odd, eccentric, or peculiar
8. Lacks personal friends or confidants
9. Excessive social anxiety related to paranoid perceptions, not to self-image

Evidence-Based Treatment of Personality Disorders

Schizoid Personality Disorder

- Cognitive Profile

  - View of Self: "I am Sufficient"

  - View of Others: "Others are Unnecessary"

  - View of World: "World is Boring"

Evidence-Based Treatment of Personality Disorders

Schizoid Personality Disorder

Diagnostic Criteria – 4 of following 7

1. Neither desires nor enjoys close relationships
2. Almost always chooses solitary activities
3. Has little interest in sexual experiences

Evidence-Based Treatment of Personality Disorders

Schizoid Personality Disorder

Diagnostic Criteria – 4 of 7

4. Takes pleasure in few activities
5. Lacks close friends
6. Appears indifferent to criticism
7. Shows emotional coldness; flattened affect

Evidence-Based Treatment of Personality Disorders
Schizoid Personality Disorder

- Associated Features

  - Difficulty Expressing Anger
  - Passivity
  - Brief psychosis under stress
  - Association with Autism Spectrum Disorders

Evidence-Based Treatment of Personality Disorders

Schizoid Personality Disorder

- Interview Features

  - Lack of Affective Response
  - Impression of Indifference
  - Anxiety Triggered With Closeness/Intimacy

BPD Differential Diagnosis: PTSD

Borderline PD	PTSD
• Absence of hypervigilence, flashbacks, abandonment fears • Dissociative sx with ANY stressor • B & W Thinking • Anger/Rage	• Hypervigilence, flashbacks • Dissociative sx directly related to specific trauma • No B & W thinking • Primary affect is one of anxiety/fear

Treatment!

Evidence-Based Treatment of Personality Disorders
Evidence-Based Treatments

"Prognosis for most people with BPD is actually quite good"

- APA, 1995

Evidence-Based Treatment of Personality Disorders
Evidence-Based Treatments

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)

Evidence-Based Treatment of Personality Disorders
Evidence-Based Treatments

“COGNITIVE BEHAVIORAL 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”

Evidence-Based Treatment of Personality Disorders

“COGNITIVE BEHAVIORAL THERAPIES”

Events  Thoughts ⇉ Feelings ⇉ Actions ⇉ Results

Evidence-Based Treatment of Personality Disorders

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

Evidence-Based Treatment of Personality Disorders
Dialectal 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

Evidence-Based Treatment of Personality DisordersDialectal Behavior Therapy: Core Modules

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

Evidence-Based Treatment of Personality Disorders

Dialectal Behavior Therapy: Components

1. Individual Therapy
2. Skills Training
3. Phone Coaching
4. Peer Consultation

Evidence-Based Treatment of Personality Disorders
Dialectal Behavior Therapy: Components

- 24/7 availability

- "Im sure you'd rather take a phone call than a trip to the morgue"

  - Marsha Linehan

Evidence-Based Treatment of Personality Disorders
Dialectal Behavior Therapy: Outcomes

- Decreased treatment dropout rate
- Decreased hospital admission
- Decreased inpatient days
- Decreased parasuicidal acts

The Personality Disorder Toolbox Integrated Evidence Based Model

Events  Thoughts → Feelings → Actions → Results

Evidence-Based Treatment of Personality Disorders
Cognitive Behavior Therapy

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

Evidence-Based Treatment of Personality Disorders
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

Evidence-Based Treatment of Personality Disorders
CBT - Core Beliefs/Schemas

- 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"

Evidence-Based Treatment of Personality Disorders
CBT - Beliefs About Self

- I am a failure
- I am unlovable
- I am worthless
- I am defective
- I am vulnerable
- I am helpless
- I am a burden

Evidence-Based Treatment of Personality Disorders
CBT - 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

Evidence-Based Treatment of Personality Disorders
CBT - 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

Evidence-Based Treatment of Personality Disorders
Schema-Focused Therapy

Domain #1: Disconnection and Rejection

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

Evidence-Based Treatment of Personality Disorders
Schema-Focused Therapy

Domain #2: Impaired Autonomy and Performance

- Dependence
- Vulnerability
- Enmeshment
- Failure

Evidence-Based Treatment of Personality Disorders
Schema-Focused Therapy

Domain #3: Impaired Limits

- Entitlement
- Insufficient Self-Control

Evidence-Based Treatment of Personality Disorders
Schema-Focused Therapy

Domain #4: Others Directedness

- Subjugation
- Self-Sacrifice
- Approval-Seeking

Evidence-Based Treatment of Personality Disorders
Schema-Focused Therapy

Domain #5: Overvigilance

- Negativity
- Emotional Inhibition
- Unrelenting Standards
- Punitiveness

Evidence-Based Treatment of Personality Disorders
Schema-Focused Therapy

Characteristics of Schemas

- Active vs Dormant
- Compelling
- Pervasive vs Discrete

Evidence-Based Treatment of Personality Disorders
Schema-Focused Therapy

Schema Reinforcement Process

- Maintenance
- Avoidance
- Overcompensation

Evidence-Based Treatment of Personality Disorders
Integrated Evidence Based Model

Evidence-Based Treatment of Personality Disorders
Case Conceptualization

Evidence-Based Treatment of Personality Disorders
Case Conceptualization

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

Evidence-Based Treatment of Personality Disorders
Conceptualization Drives Goal-Setting

1) Problem List
2) Goal List
3) Behavioral Targets
4) Identify Triggers for Behaviors
5) Identify Cognitions associated with target behaviors

Evidence-Based Treatment of Personality Disorders
Conceptualization Drives Treatment Planning

Evidence-Based Treatment of Personality Disorders Documentation Acronym

B

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Evidence-Based Treatment of Personality Disorders

Conceptualization
Drives Documentation

Evidence-Based Treatment of Personality Disorders
Case Conceptualization - Summary

1. Synthesizes patient experience with treatment model
2. Normalizes presenting problems and validates
3. Facilitates development of rapport
4. Makes complex problems seem more manageable
5. Guides the focus of intervention

Evidence-Based Treatment of Personality Disorders

The Hirose Institute

Session 3: Treatment, Part 1

- Conceptualisation Wrap-up
- Transdiagnostic Skills

- Non-BPD Strategies

- Treatment Set-up/Individual treatment vs group treatment

- Skills Training Groups - CBT Skills

  - Motivational skills
  - Relationship skills
  - Continuums
  - Labeling distortions
  - Restructuring suicidal and other destructive cognitions
  - Identity Work

Transdiagnostic PD Skills

Evidence-Based Treatment of Personality Disorders

General Strategies

1. THE THINKING OF THE THERAPIST
2. VALIDATION
3. STRUCTURE
4. CONSEQUENCES AND FOLLOW THROUGH
5. CONSISTENCY
6. RELATIONSHIP MANAGEMENT

Evidence-Based Treatment of Personality Disorders

The Thinking of the Therapist

Evidence-Based Treatment of Personality Disorders

Definitions

- DSM - An enduring pattern of inner experience and behavior that deviates markedly from the individual's culture, is pervasive and inflexible, has onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

- Shea - "An ongoing set of defense mechanisms that cause considerable distress for self and others."

Evidence-Based Treatment of Personality Disorders

Definitions

- Axis I: Patient Suffers
- Axis II: Therapist Suffers
- Lester - any referral preceded by an apology

Evidence-Based Treatment of Personality Disorders

Definitions

- People who have unique ways of asking for help

Evidence-Based Treatment of Personality Disorders

Definitions

The Thinking of the Therapist

Validation

"NOT EVERYONE IS READY TO CHANGE...BUT EVERYONE IS READY TO BE VALIDATED" - ROBERT LEAHY

Evidence-Based Treatment of Personality Disorders

6 Levels of Validation

LEVEL 1: STAY AWAKE AND PAY ATTENTION

LEVEL 2: ACCURATE REFLECTION

LEVEL 3: STATE WHAT HASN'T BEEN SAID OUT LOUD

LEVEL 4: VALIDATE USING PAST HISTORY OR BIOLOGY

LEVEL 5: VALIDATE BASED UPON PRESENT SITUATION

LEVEL 6: RADICAL GENUINENESS

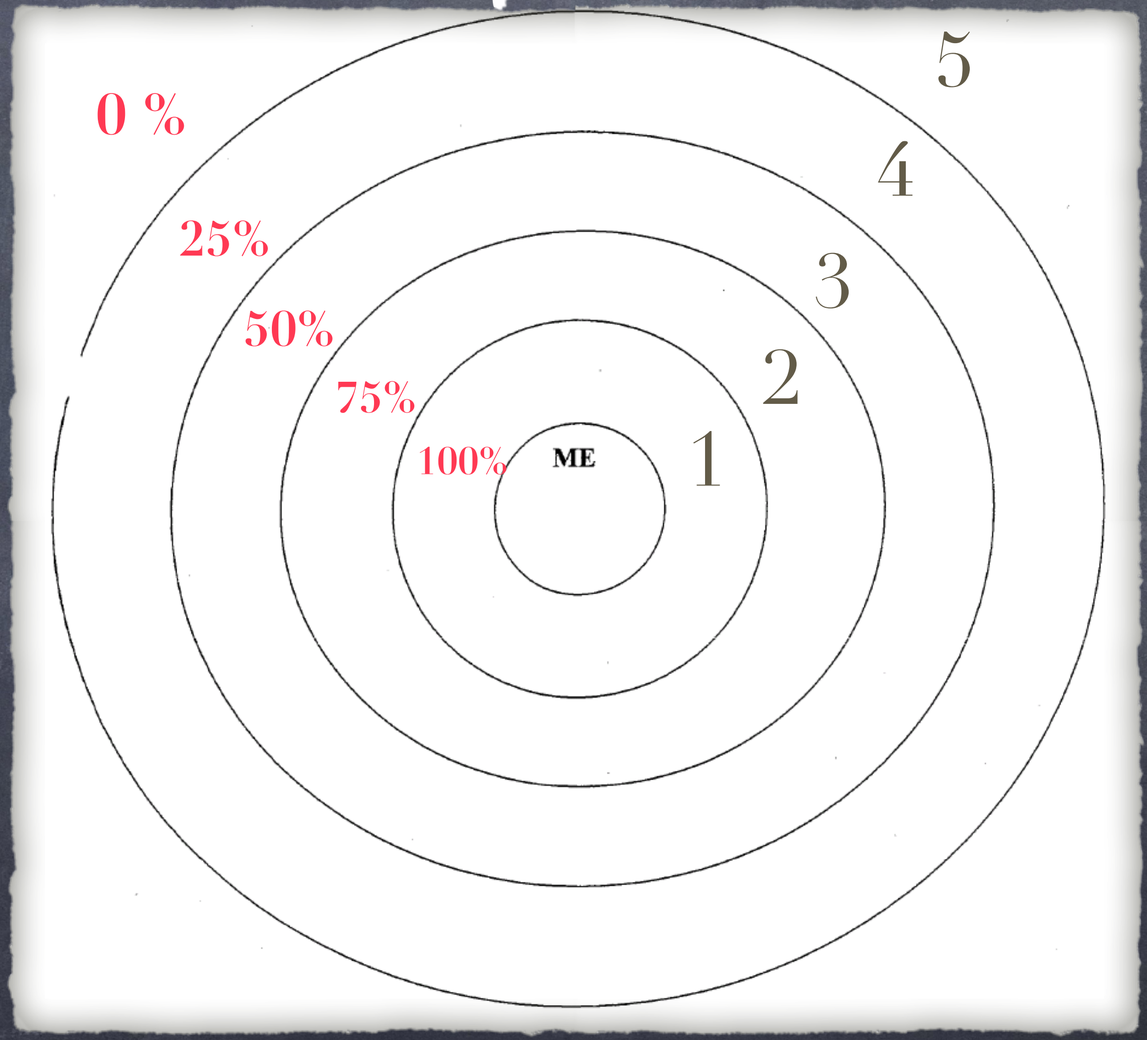
Evidence-Based Treatment of Personality Disorders

RELATIONSHIP SKILLS

Evidence-Based Treatment of Personality Disorders

Relationship Circles

Intimacy
=
"Into - Me - See"



Evidence-Based Treatment of Personality Disorders
Paranoid PD

Management & Treatment Strategies

Evidence-Based Treatment of Personality Disorders

Diagnosis Specific Management and Treatment Strategies

The Personality Disorder Toolbox: Paranoid PD

Paranoid PD:

Considering
Alternative
Explanations

5
4
3
2
1

The Personality Disorder Toolbox: Paranoid PD

Paranoid PD:

Cue Card

Paranoid Cue Card

"Even thought I felt threatened, I always feel threatened and
II am not always in danger. I have been safe in here before. She
almost seemed believable. I trust Jeff and Jeff trusts Cindy,
so maybe it was just about the decoration."

Evidence-Based Treatment of Personality Disorders
Obsessive-Compulsive PD

- Decrease Rigidity
- Increase Flexibility/Spontaneity
- Develop Compassion

Evidence-Based Treatment of Personality Disorders

Obsessive-Compulsive PD

- Schema Feeding Language
- Pay attention to detail
- Structure session
- Use of Intellectualization
- Behavioral experiments
- Distress Tolerance
- Develop Compassion
- Pleasurable events/soothing strategies
- Historical Schema Work

Evidence-Based Treatment of Personality Disorders

Obsessive-Compulsive PD Tools

- OCPD Tool # 1: Progress, Not Perfection Tool
- OCPD Tool # 2: Productivity Planner Tool
- OCPD Tool # 3: Tolerating Distress Tool
- OCPD Tool # 4: Delegation Tool
- OCPD Tool # 5: Accepting Reality Tool
- OCPD Tool # 6: Developing Compassion Tool

Evidence-Based Treatment of Personality Disorders
Avoidant PD

Management & Treatment Strategies

Evidence-Based Treatment of Personality Disorders
Avoidant PD

- Things accomplish if not avoid/Pros&Cons
- Behavioral Interventions
  - Social Skills Training
  - Hierarchy of Social Interactions
  - Behavioral Pattern Breaking

- Cognitive Interventions
  - Identifying and Restructuring ATs
    - Rationalizations
    - Mind Reading

Evidence-Based Treatment of Personality Disorders
Avoidant PD

- Distress Tolerance Skills
- Identify Belief Inhibiting Emotional Expression
- Test Belief

Evidence-Based Treatment of Personality Disorders
Avoidant PD

Hierarchy of Social Interactions

1) Checker
2) Mail Woman
3) Neighbor over Fence
4) SS Teacher
5) Husbands Coworker

Evidence-Based Treatment of Personality Disorders
Avoidant PD

Untangling the Web of Excuses

Evidence-Based Treatment of Personality Disorders
Avoidant PD

Taking Risks

Evidence-Based Treatment of Personality Disorders
Dependent PD

Management & Treatment Strategies

Evidence-Based Treatment of Personality Disorders

Dependent PD

- Constantly reinforce positive gains
- Establish and keep firm, consistent limits
- Establish and strive for clear treatment goals

Evidence-Based Treatment of Personality Disorders

Histrionic PD

- Maintain high degree of empathy
- Assign homework
- Relationship building exercises

Evidence-Based Treatment of Personality Disorders
Histrionic PD

Management & Treatment Strategies

Evidence-Based Treatment of Personality Disorders
Histrionic PD

Symptom-Targeted Strategies

- Be Exciting!
- Compliment frequently at first
- Role Plays
- Psychodrama
- Family Sculpting

Evidence-Based Treatment of Personality Disorders
Histrionic PD

Symptom-Targeted Strategies

- "Left Brain" Strategies
- Develop more rational approach to problem solving
- Educate re length of Tx
- Pros and Cons
- Relationship insight work
- Schema Work

Evidence-Based Treatment of Personality Disorders
Histrionic PD Tools

- Histrionic Tool #1: Get Noticed! Tool
- Histrionic Tool #2 Sculpting Tool
- Histrionic Tool #3: Getting Needs Met Appropriately Tool
- Histrionic Tool #4 Expanding Self-Worth Tool
- Histrionic Tool # 5: Intimacy Tool
- Histrionic Tool #6: Making Connections Tool

Evidence-Based Treatment of Personality Disorders
Antisocial PD

Management & Treatment Strategies

Evidence-Based Treatment of Personality Disorders
Antisocial PD

Symptom-Targeted Strategies

- Serve as "coach"
- Shoot Straight
- Allow them to see your antisocial side/traits for them to ID with - IF YOU HAVE IT
- Colombo Approach
- Seek Corroboration of outside info/sources
- Use of Non-responsible Language
- As rapport develops, turn/challenge

Evidence-Based Treatment of Personality Disorders
Antisocial PD

Symptom-Targeted Strategies

- Rapport Building Statements Convey interest in hearing about their exploits
- Attachment work when possible
- Guard for Manipulation - Structure treatment so they can't con
- Set and Enforce Strict Limits - Allow no "wiggle-room" - emphasize following rules as way of "getting what you want"

Evidence-Based Treatment of Personality Disorders

Antisocial PD

Symptom-Targeted Tools

- Antisocial Tool #1: Secondary Gain Tool
- Antisocial Tool #2: Recognition of Consequences Tool
- Antisocial Tool #3: Time out Tool
- Antisocial Tool #4: Regaining Responsibility Tool
- Antisocial Tool #5: Mode Messages Tool
- Antisocial Tool #6 Developing Attachment Tool

Evidence-Based Treatment of Personality Disorders
Antisocial PD

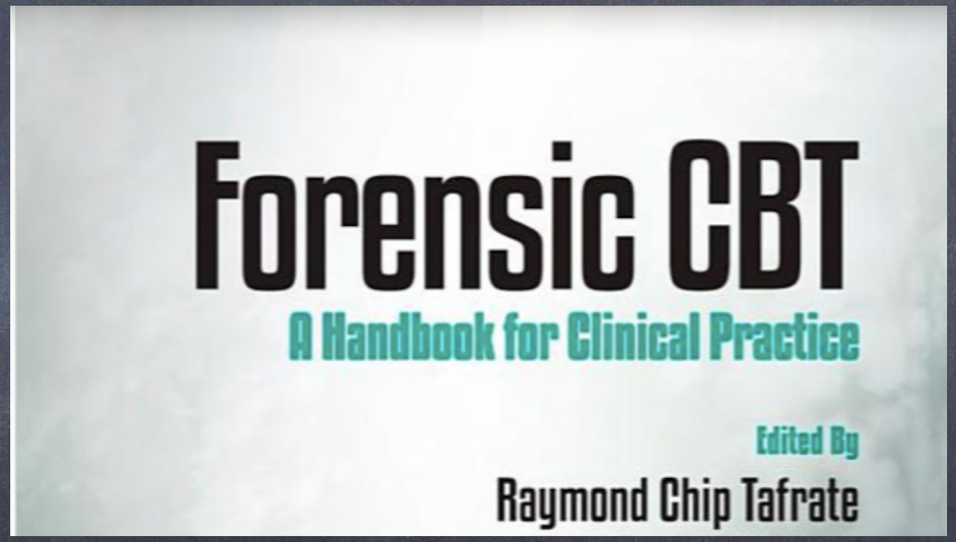
Secondary Gain Tool

Evidence-Based Treatment of Personality Disorders
Antisocial PD

Reassigning Blame Tool

Evidence-Based Treatment of Personality Disorders
Antisocial PD

- TruThought
- MRT



Evidence-Based Treatment of Personality Disorders

Narcissistic PD

Management & Treatment Strategies

Evidence-Based Treatment of Personality Disorders
Antisocial PD

Schema Modes in Narcissism

1) Lonely Child
2) Self-Aggrandizer
3) Detached Self-Soother

Evidence-Based Treatment of Personality Disorders
Narcissistic PD: Modes in Narcissism

Schemas: Defectiveness, Emotional Deprivation

Triggers: Loss of status/lack of achievement, etc

Assumptions: "Since I am not CEO, I'm Nothing"
"Since I have flaw, completely defective"

Manifestations: Depression

Goals: Identify Needs, find alternate ways of meeting needs, Emotional Connections... substitute "feeds" in interim

Evidence-Based Treatment of Personality Disorders
Narcissistic PD: Modes in Narcissism

Schemas: Entitlement, Unrelenting Standards, Subjugation, Approval-Seeking

Triggers: People, public eye

Assumptions:

"If I overachieve, I am superior"
"If I'm admired, I'm special"
"If I control others, I stay in charge"
"If I'm special in some way, I'm better than others"
"Since I'm special, I deserve privileges"

Manifestations: Bullying, Bragging, aggressive behavior, controlling behavior, lack of empathy

Goals: Limit setting/Identify Underlying Defectiveness, alternative ways to meet needs/Making Emotional Connections

Evidence-Based Treatment of Personality Disorders
Narcissistic PD: Modes in Narcissism

Schemas: Insufficient Self Control, Emotional Deprivation, Defectiveness

Triggers: Alone

Assumptions: "If I _____, I don't have to feel"

Manifestations: Substance abuse, pornography, workaholism, gambling

Goals: Limit Setting, Distress Tolerance, Making Emotional Connections

Evidence-Based Treatment of Personality Disorders

Narcissistic PD

- Narcissistic Tool #1: Protect Your Image Tool
- Narcissistic Tool #2: Lowering the Bar Tool
- Narcissistic Tool #3: Valuing Others Tool
- Narcissistic Tool #4: Empathy Builder Tool
- Narcissistic Tool #5: Mode Messages Tool
- Narcissistic Tool #6: Go Deep Tool!

Evidence-Based Treatment of Personality Disorders
Narcissistic PD: Strategies

5

4

The Empathy Builder Tool

Evidence-Based Treatment of Personality Disorders
Narcissistic PD: Strategies

5

4

The Mode Message Tool

Evidence-Based Treatment of Personality Disorders

Narcissistic PD: Strategies

1. Validation
2. Empathetic Confrontation
3. Limit Setting
4. Utilization of Leverage
5. Behavioral Pattern-Breaking
6. Development of Authentic Relationships

Evidence-Based Treatment of Personality Disorders
Narcissistic PD: Strategies

Empathic Confrontation

Evidence-Based Treatment of Personality Disorders

Treatment Setup

Setting Treatment up to Succeed

Evidence-Based Treatment of Personality Disorders

Treatment Setup

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

Evidence-Based Treatment of Personality Disorders

Treatment Setup

1. Individual Treatment

2. Group Treatment

Evidence-Based Treatment of Personality Disorders

Treatment Setup

1. SKILLS TRAINING (PSYCHOEDUCATIONAL)

2. SCHEMA GROUP (PROCESSING)

Evidence-Based Treatment of Personality Disorders

Treatment Setup

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

Evidence-Based Treatment of Personality Disorders

Treatment Setup

Program Expectations: Phone Agreement

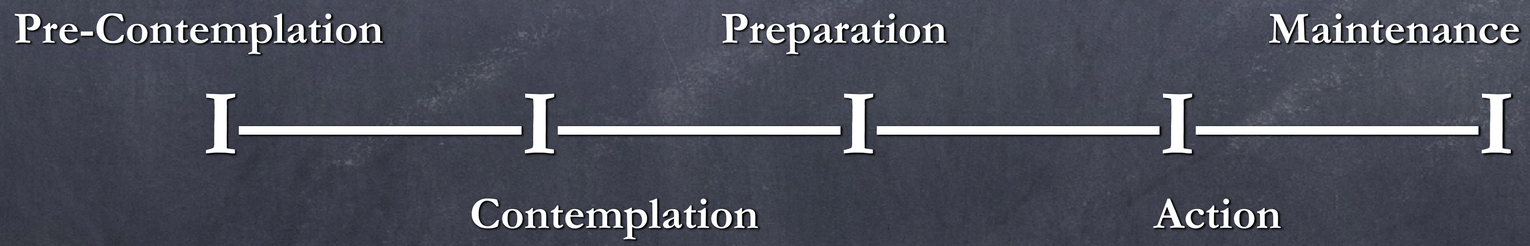
Skills Training Groups

Motivational and Standard CBT Skills

Motivational Skills

Evidence-Based Treatment of PDs
Motivational Skills

Motivational Enhancement Therapy: Stages of Change



Evidence-Based Treatment of PDs
Motivational Skills

Expressions of Concern

Evidence-Based Treatment of PDs
Motivational Skills

Pros and cons

Standard CBT Skills

Evidence-Based Treatment of PDs
Standard CBT Skills

- Labeling Distortions
- Cognitive Awareness Exercises
- Identifying and Challenging Automatic Thoughts
- Continuum Work – "shades of gray"
- Identity Development

Evidence-Based Treatment of PDs
Standard CBT Skills

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.

Evidence-Based Treatment of PDs
Standard CBT Skills

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.

Evidence-Based Treatment of PDs

Identifying and Responding to Automatic Thoughts

Evidence-Based Treatment of PDs
Standard CBT Skills

BPD - Specific Thoughts

- "Because he is late coming home, he is probably leaving me"
- "If I tell him everything about me on the first date I can test him to find out if he's really interested."
- "Since she pissed me off, I have to quit. I can't work with someone like her."
- "Since she betrayed me once, I can never trust her again - she really isn't even worth talking to again."

Evidence-Based Treatment of PDs
Standard CBT Skills

BPD - Specific Thoughts

- "If I cut myself, he will not leave me"
- "If I cut myself, he will not leave me"
- "Since she"It's ok to cut myself, because cutting is better than other things I could do"

Evidence-Based Treatment of PDs
Standard CBT Skills

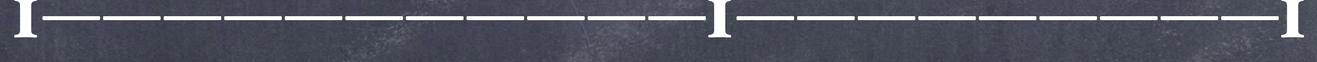
Restructuring Self-Destructive Cognitions

Evidence-Based Treatment of PDs
Standard CBT Skills

Cognitive Continuum

"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."



Evidence-Based Treatment of PDs
Standard CBT Skills

BPD Continuum Cue Card

"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"

Evidence-Based Treatment of PDs
Standard CBT Skills

Identity Development - “The Hats” Tool

Evidence-Based Treatment of Personality Disorders

Certification Course Sponsored by:

The Hirose Institute

Session 4: Treatment, Part 2

- Skills Training Groups - DBT Skills

  - Mindfulness
  - Emotion Regulation Skills
  - Distress Tolerance
  - Interpersonal effectiveness skills
  - Opposite action
  - Radical acceptance

Evidence-Based Treatment of PDs

Dialectical Behavior Therapy Skills

Evidence-Based Treatment of PDs
DBT Skills

Mindfulness - States of Mind

Evidence-Based Treatment of PDs
DBT Skills
Mindfulness -Reason Mind

- Logical part of brain
- Prefrontal cortex Involved
- Pros & Cons

Evidence-Based Treatment of PDs
DBT Skills
Mindfulness - Emotion Mind

- Emotionally Flooded
- More Reactive
- More Impulsive
- Pros & Cons

Evidence-Based Treatment of PDs
DBT Skills

Mindfulness - Wise Mind

- Acknowledge what we are feeling and at the same time able to process - acting a way consistent w goals & values

Evidence-Based Treatment of PDs
DBT Skills

Goals of Mindfulness

- Experience and Learn that tolerable and way out of painful emotion is a willingness to relate to them
- Change qualitative relationship to emotions...not right or wrong way to feel in given situations
- Decrease pace of Cognitions

Evidence-Based Treatment of PDs
DBT Skills

Grounding Exercise

Evidence-Based Treatment of PDs
DBT Skills

Grounding Exercise

5 Things you can see

4 Things you can touch/feel

3 Things you can hear

2 Things you can smell

1 Thing you can taste

Emotion Regulation Skills

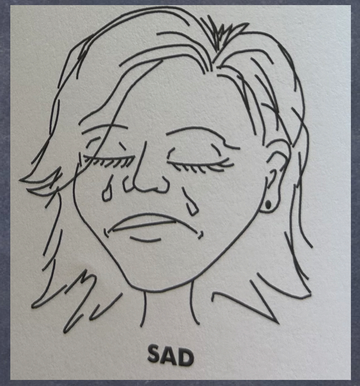
Evidence-Based Treatment of PDs
DBT Skills

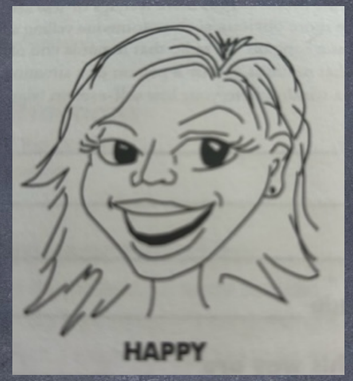
Goals of Emotion Regulation

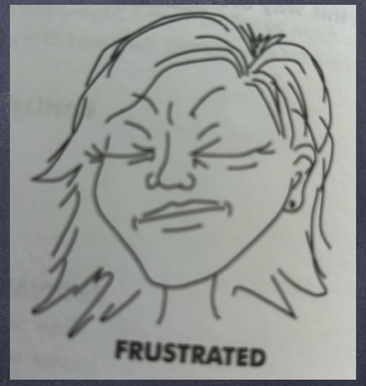
- Emotions Education
- Decrease Emotional Intensity
- Reduce Vulnerability to Negative Emotions
- Decrease Acting out on Emotions

Evidence-Based Treatment of PDs
DBT Skills

Emotion Education







Evidence-Based Treatment of PDs
DBT Skills

Emotion Education

- Anxiety = Risk/Resources
- Depression - Selective Abstraction of Negative Data
- Anger - Values Violation/Shoulds

Evidence-Based Treatment of PDs
DBT Skills

Decrease Emotional Intensity

Scaling Your Emotions

Evidence-Based Treatment of PDs
DBT Skills

Decreasing Vulnerability to Negative Emotions

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Evidence-Based Treatment of PDs
DBT Skills

Decreasing Vulnerability to Negative Emotions

BUILD MASTERY

Evidence-Based Treatment of PDs
DBT Skills

Opposite Action

Evidence-Based Treatment of PDs
DBT Skills

Opposite Action

- Anxiety
- Depression
- Anger
- Shame

Distress Tolerance Skills

Evidence-Based Treatment of PDs
DBT Skills
Distraction Techniques

- ANY coping skill that inherently requires thought

Evidence-Based Treatment of PDs
DBT Skills

Soothing Strategies

- Any coping skill that has a calming effect

Engaging Through the 5 Senses

1. Vision
2. Hearing
3. Smell
4. Touch
5. Taste

Evidence-Based Treatment of PDs
DBT Skills

“Wise Mind Accepts”

A

C

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E

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S

Evidence-Based Treatment of PDs
DBT Skills

Improve the moment

I

M

P

R

O

V

E

Evidence-Based Treatment of PDs
DBT Skills

Take a Vacation!

- https://m.youtube.com/watch?v=pDKiMYgdxSs

Evidence-Based Treatment of PDs
DBT Skills

Radical Acceptance

- "Pain is inevitable, suffering is optional"

3 choices

1) If you can change the situation, change it
2) if not, accept
3) stay miserable

Interpersonal Effectiveness Skills

Evidence-Based Treatment of PDs
DBT Skills

Interpersonal Effectiveness Skills

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

Evidence-Based Treatment of PDs

Objective Effectiveness Skills

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Evidence-Based Treatment of PDs

Relationship Effectiveness Skills

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Evidence-Based Treatment of PDs
DBT Skills

Self-Respect Effectiveness

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A

S

T

Evidence-Based Treatment of PDs

Individual Therapy

Evidence-Based Treatment of PDs
Individual Therapy

- Goals - Process triggers, internalize new thinking, apply skills learned to everyday practice

Format

- Diary Card/Check-In
- Session Acuity Protocol
  - Life Interfering Behaviors
  - Therapy Interfering Behaviors
  - Quality of Life Interfering Behaviors

Evidence-Based Treatment of PDs
Individual Therapy

Diary Cards

- Improve Self-Monitoring
- Structure Sessions
- Target Behaviors
- Awareness of Mood States
- Schema Focused Skills
- Monitor Urges

Life Interfering Behaviors

Evidence-Based Treatment of PDs
Individual Therapy

CB Chain Analysis

Therapy Interfering Behaviors

Evidence-Based Treatment of PDs
Individual Therapy
Therapy Interfering Behaviors

- Unexcused Absences
- Homework Non-Compliance
- "I don't know"
- Disrespectful Behaviour Toward Therapist

Quality of Life Interfering Behaviors

Evidence-Based Treatment of PDs Individual Therapy

Integrated DBT/SFT Case Study

Evidence-Based Treatment of PDs

Integrated Case Study

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 Iwas dead (never born)”

Key Schemas

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

Evidence-Based Treatment of PDs
Individual Therapy

Evidence Logs

Evidence-Based Treatment of PDs
Individual Therapy

Schema Flashcards

Schema-Focused Skills

Evidence-Based Treatment of PDs
Schema-Based Interventions

1. SCHEMA PSYCHOEDUCATION AND TARGETING

2. BEHAVIOURAL PATTERN-BREAKING

3. SCHEMA CONSTRUCTION - DATA LOGS

4. OTHER SCHEMA STRATEGIES

5. MODE WORK

Evidence-Based Treatment of PDs
Schema-Based Interventions

1. SCHEMA PSYCHOEDUCATION AND TARGETING

- Patient language
- Downward arrow
- Themes in thought logs or journaling
- Heightened affect
- Formal Schema/Belief Inventories

Evidence-Based Treatment of PDs
Schema-Based Interventions

2. BEHAVIOURAL PATTERN-BREAKING

- Name
- Mood Check
- Identify 1 Maladaptive Behaviour
- Identify Schema Targeting
- Identify Coping Category
- Identify 3 Alternate Behaviours

Evidence-Based Treatment of PDs
Schema-Based Interventions

3. Schema Modification Process

1) Identify the Maladaptive Belief
2) Identify Alternate Adaptive Belief
3) Rate Baseline Believability
4) Interventions
5) Rate Believability at Regular Intervals

Evidence-Based Treatment of PDs
Schema-Based Interventions

3. Schema Reconstruction

Evidence-Based Treatment of PDs
Schema-Based Interventions

6:13:17

Data Logs

Evidence-Based Treatment of PDs
Schema-Based Interventions

Internalization Exercises - "Adding a But"

- **Evidence Supporting Adaptive Belief:** "Took initiative to make dinner for my husband and kids"

Discounting 'But': "But "its no big deal – all good mothers do it."

Add a But "But "I did something all good mothers do"

Evidence-Based Treatment of PDs
Schema-Based Interventions

4. Other Strategies - Schema-Based Journaling

Evidence-Based Treatment of PDs
Schema-Based Interventions

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=jRFfDps3_6M

Evidence-Based Treatment of PDs
Schema-Based Interventions

5. Schema Modes

Maladaptive BPD Schema Mode Cheat Sheet

BPD Schema Mode	Common Feelings	Typical Behaviors
Abandoned Child	Feels misunderstood, rejection, lonely, desperate, anxiety	Smothering, clinging, tearful, multiple calls, texts, desperate attempts to restore, maintain relationship
Impulsive Child	Unmanageable urges, inability to delay gratification, impatient	Impulsive substance use, sexually promiscuous behavior, spending sprees, binge eating
Angry Child	Intense anger, rage	Yelling, screaming, name calling, throwing things, damaging property
Punitive Parent	Anger, Hatred, Shame, Self-Loathing	Blames self or others, litigious acts, filing frequent grievances, self-injurious behav
Detached Protector	Numbness, may report feeling "ok" but show no emotional attachment, emptiness	Cuts off needs, "goes through the motions," appears bored, voice/eyes may appear

Evidence-Based Treatment of PDs
Schema-Based Interventions

Historical Analysis of a Schema

Evidence-Based Treatment of PDs

Relapse Prevention

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

- John Ludgate

Evidence-Based Treatment of PDs Relapse Prevention and Ending Well

Warning Signs of Relapse

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

Evidence-Based Treatment of PDs
Relapse Prevention and Ending Well

Relapse Prevention

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

Evidence-Based Treatment of PDs Relapse Prevention and Ending Well

Phases of Treatment

Phase I: (sessions 1-4)

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

Evidence-Based Treatment of PDs Relapse Prevention and Ending Well

Phases of Treatment

Phase II: Sessions 4 →

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

Evidence-Based Treatment of PDs Relapse Prevention and Ending Well

Phases of Treatment

Phase III: Final 4-6 Sessions/Booster

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

Evidence-Based Treatment of PDs
Relapse Prevention and Ending Well

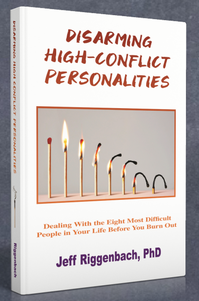
1. Schedule ahead of Time
2. Come regardless of Progress
3. What has gone well?
4. What problems have arisen? How did you think and cope? Differently?
5. Do you notice any themes in your thinking and coping? What CBT work will you commit to?
6. What could arise between now and the next booster? How can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

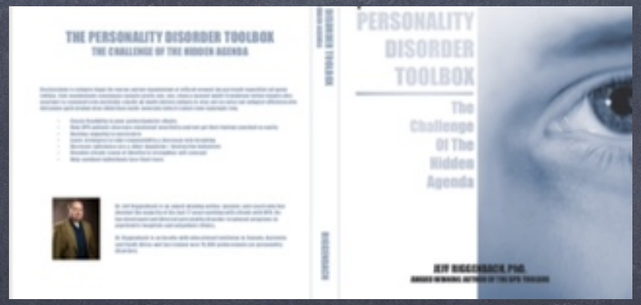
Evidence-Based Treatment of PDs
Schema-Based Interventions

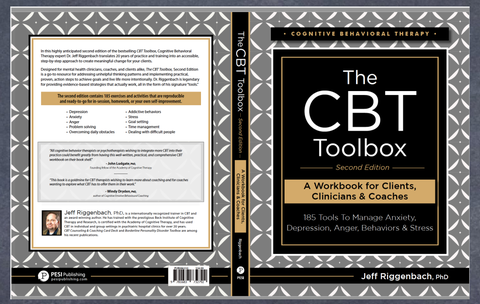
1. Schedule ahead of time
2. Set an agenda
3. Mood check
4. Identify and event in which you were triggered
5. Identify and challenge distorted thoughts
6. Identify coping skills you could use if triggered similarly in the future and write on coping card
7. Identify strengths you will use this week
8.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

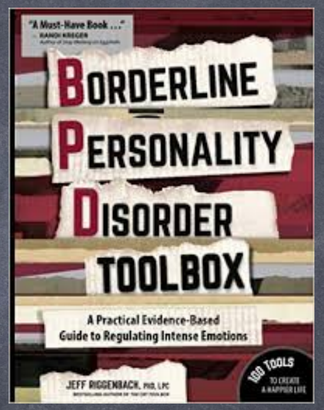
Let's Connect!

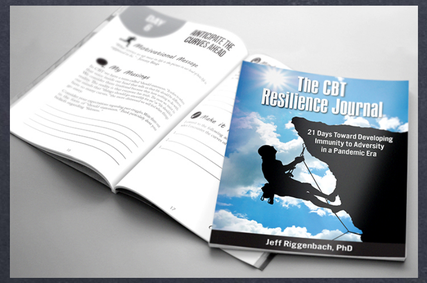
Email: jeff@jeffriggenbach.com
Facebook: Dr. Jeff Riggenbach
Author Page: clinicaltoolboxset.com
Website: jeffriggenbach.com

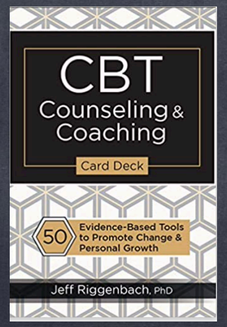




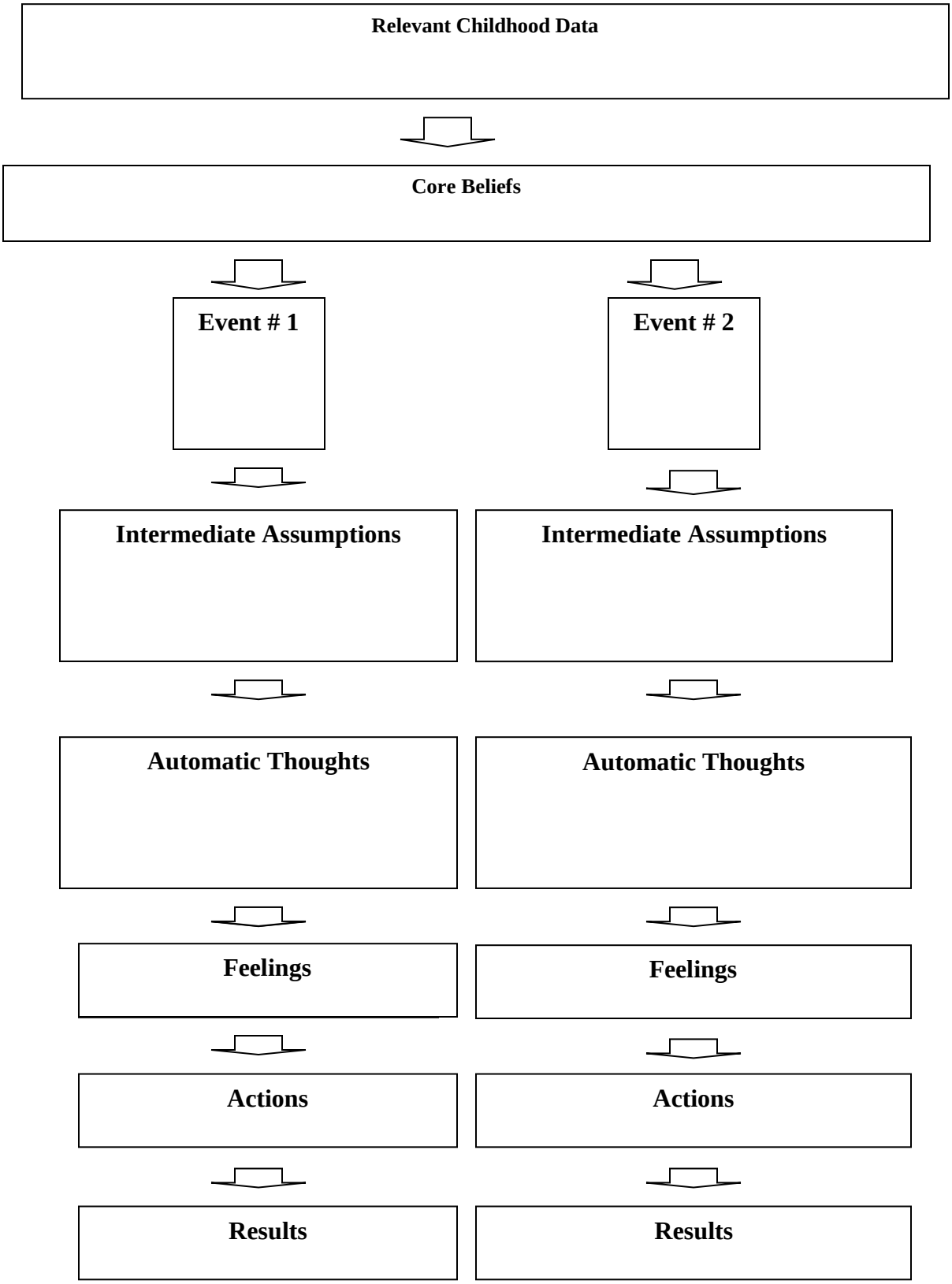








Cognitive Conceptualization Diagram



Cognitive Distortions

1. **Rationalization -** We make excuses for poor choices we have made or are about to make in life or things we allow others to do to us. We tell ourselves "It's ok because this, or it's ok because that." By doing so, we give ourselves or others permission to do something that is not in our best interest.

2. **Overgeneralization -** We put people or things in categories based upon our experiences with a representation of that particular "group" in the past. By doing so, we maintain misconceptions and "miss out" on positive experiences we could have with those that don't fit our specific ideas.

3. **All or Nothing Thinking -** We see ourselves, others, or the wold in extreme "black and white" ways, with no room for gray - and not able to recognize that people or situations may have both positive and negative characteristics at the same time.

4. **Discounting the Positive -** We reject positive experiences or compliments insisting that they "don't count' for one reason or another. By doing so, we maintain a negative belief system about ourselves that is inconsistent with our actual attributes, accomplishments or achievements.

5. **Fortune Telling -** We anticipate that things will turn out badly or assume that our predictions are already established fact. This "what if" thinking also often assumes we are in danger of some kind.

6. **Mind Reading -** Rather than predicting we know what is going to happen in the future, we think know what somebody else is thinking. This often goes hand in hand with fortune-telling.

7. **Magnification -** This distortion involves taking fortune - telling and mind reading statements and blowing them way out of proportion. You may also see this referred to as "catastrophizing."

8. "**Should" Statements -** We place false or unrealistic expectations on ourselves or others insisting that we/they "should" do this or "shouldn't" have done that. We mentally insist that some aspect of reality "shouldn't" be the way that it "is."

9. **Emotional Reasoning -** We assume that our feelings reflect reality and make decisions based upon our emotions in the moment. If we feel threatened we assume our environment really is dangerous and act accordingly.

10. **Personalization -** We make something about us that is not about us. Attributing a comment or situation to us that was not intended to be so is common among people in "beat themselves up" or engage in self-blame.