HANDOUTS

Cognitive Behavior Therapy for Personality Disorders and Other Challenging Conditions

Fundamental & Advanced Considerations

Presented by

Arthur Freeman, Ed.D.

Monday

9:00 **Understanding the Complex Patient:**
An Integrative Approach

- Cognitive behavioral mode, dynamic and systemic elements
- Developing treatment conceptualizations and plans

10:20 *Break (coffee and tea)*

10:35 **Developing Conceptual Models for Treatment**

- Data collection, assessment and treatment
- Freeman Diagnostic Profile, Critical Incident Technique, and Functional Behavioral Analysis

12:00 p.m. *Lunch (on your own)*

1:15 **Borderline Personality - Clinical Illustration - Jane**

- Beginning, middle, and end points of treatment

2:30 *Break (coffee, tea, soda, snack)*

2:45 **Conceptualization and Treatment Planning**

- Small group exercise - hypotheses, conceptualization, and treatment planning from clinical example

3:00 **Eating Disorder & Borderline - Clinical Illustration**

4:15 Adjournment

Tuesday

8:30 **Dealing With Impaired Motivation, Resistance, and Impediments to Change:**
Issues of Counter-Transference

9:50 *Break (coffee and tea)*

10:05 **Cognitive, Affective, Situational, Biological and Behavioral Interventions**

11:30 *Lunch (on your own)*

12:45 p.m. **Clinical Illustration - Alfred**

- Partner Abuse and Narcissistic Personality Disorder
- Initial session and treatment planning

2:00 *Break (coffee, tea, soda, snack)*

2:15 **Clinical Illustrations**

- Narcissistic Personality Disorder
- Reluctant Patient
- **Questions and Discussion**

3:45 Adjournment (Pick Up Certificates)

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Cognitive Behavioral Treatment for Personality Disorders and Other Challenging Conditions: Fundamental and Advanced Considerations

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Please Note

- The presenter reserves the right to add, omit, or rearrange slides based on time constraints, audience interest, questions, emerging issues, or new research.
- Thank you for your understanding.

Introduction

Reasons for Referral

- Many personality disordered patients are referred because of problems with depression or anxiety (or mistaken diagnoses), and not the more complex personality disorders *per se*.
- Individuals may come to therapy under coercion, threat, and/or to get “others” off of their back.
- They may come to therapy by force of habit.
- Therapy insures their financial support through insurance or government subsidies.
- They are referred by other therapists who reach therapeutic impasses or have “hit the wall.”
- Primary care medical providers often need help.

Contexts of Referral

- Crisis circumstances (situational)-*something has been said or done which has created an emergent situation.*
- Problematic interactions (skill-based)-*an interpersonal difficulty due to a lack of skills (generally social, and/or empathic skills).*
- Pathological process (mode/trait focused)-this represents *a more consistent stylistic response that has caused problems for the individual over time and in multiple settings.*

"Creating" Difficult to Treat Patients

- Many years in the mental health system.
- They have been treated only enough to create "treatment-resistant" strains of their disorder(s).
- Treated by inexperienced therapists.
- Systems often reinforce and/or maintain pathology via pensions and placement.
- Use of limited or uni-faceted approaches.
- Unrealistic promises of "cure."
- Unrealistic treatment goals (therapist or patient).
- Unrealistic expectations by the patient or family.
- Temperament not factored into treatment.
- Patient is skill deficient in major ways.
- Possible need for life-long treatment (Primary Care model).

Cognitive Behavioral Treatment of Complex Patients

- The unique features of the presenting problem or disorder represents the exaggeration or deficits of basic skills in responding to internal and situational stimuli.
- Individual's may not have the motivation to "stay the course" of treatment.
- There may be hidden agendas on the part of the patient, the family, the significant others, or of the therapist.
- The patient's level (or that of the family) of cognitive ability or processing may be less than expected.
- The environmental support for change may be limited or overstated.
- The individual's response differs markedly from the general population.

Treatment issues-Continued

- The disorders may be mild, moderate, or severe and may fluctuate.
- Disorders may be episodic or circumstantial.
- Behavior is schema driven
- Personality Disorders are the clearest example of Beck's notion of schema.
- Schema evolve through the process of adaptation.
- Schema must be made explicit.
- The "parenthetic" part of the schema is key.
- When schema are challenged, anxiety will result.
- Schema exist as personal, family, gender, social, religious or cultural "rules" or demands.

Stimulus

↓

Response

Stimulus

↓

Awareness

↓

Recognition

↓

Decision making

↓

Response

Patient Difficulties as a Level of Function

- Adequate reality testing but patient's "reality" may appear (to others) altered or deficient.
- Ideas may be overvalued without delusions ("minor thought disorder").
- There may be disturbances in internal image of self and others.
- There may be identity difficulty.
- Severe internal or external stressors.
- Increased and extreme survival focus.
- Decreased overall adaptive behavior.

Difficulties as Part of a Dynamic Constellation

- Problems in attachment and affiliation.
- Problems in separation and individuation.
- Poor boundaries.
- Continual tension because of internal and external stressors and/or demands
- Poor controls for dealing with these stressors and/or demands.
- *****Externalization of their difficulty (other-blaming).

Patient's Difficulties as Accusations or Blaming by the "System"

- Patient's difficulties used as an avoidance of therapist responsibility.
- Ostensible reason for therapeutic breaks and failure.
- Rationale for lack of patient involvement in therapy programs (either inpatient or outpatient),
- Often generated by out-of-control counter-transference
- Slow (or no) therapeutic progress strains institutional or agency resources

Range of Severity

- Problems are MILD (usually do not seek help)
- **Problems are of MODERATE severity (may cause difficulty needing support or help)
- **Problems are SEVERE (causing difficulty, discomfort, and lack or adaptation.

Assessment

Issues of Cognitive Sophistication

- Be aware of the patient's level of cognitive development.
- Be aware of the partner's or family level of cognitive development
- We cannot expect abstract thinking (formal operations) from a preoperational or concrete operational child or adult

Differences Between "Normal" and "Maladaptive" Behavior

Problem	CBT Treatment
Compulsive	Build repertoire
Inflexible	Increase range of movement
Thoughtless	Thoughtful/increase awareness
Highly noticeable	Less noticeable
Negative	Less negative
Maladaptive	More adaptive
At odds with general community	Greater consonance
Energy consuming	Reduce energy spent
Ego-Syntonic	Increase empathy
Interpersonally conflictual	Build skills; decrease conflict

Clinical Clues for Difficulty

- Chronicity
- Noncompliance/resistance
- Therapy appears to stop for no clear reason
- Question of motivation for treatment
- Patient problems are ego-syntonic
- Style is viewed as "core."
- Therapy is an ongoing series of crises
- Extensive previous therapy contacts
- Patient is "satisfied" with therapy but no changes occur.
- Other-blaming

Freeman-Duff Eccentricity Scale (F.A.D.E.S.)

Level one- Problems are situational *("Uncle Joe").*

Level two-Problems are contextual *("What doesn't belong?).*

Level three-Obvious difficulty than can be easily identified *(What's wrong with this picture?).*

Level four-Clear and powerful difficulty that is identified, but with some difficulty. *("Something smells bad")*

Level five- The individual is clearly and powerfully "aberrant" *(Sci-Fi channel).*

Vulnerability to Responding to Internal and External Stressors

Vulnerability Factors

- Hunger
- Fatigue
- Loss
- Anger/frustration
- Chronic pain
- Acute pain
- Loneliness
- New life situation
- Substance use
- Poor problem solving ability

Referral Issues and Possible Treatment

Axis I — Axis II

Axis I ⟶ Axis II

Axis I ⟵ Axis II

Axis I ⟷ Axis II

Freeman-Dolan Stages of Change

- Noncontemplation
- Anticontemplation
- Precontemplation
- Contemplation
- Action planning
- Action
- Prelapse (Redirection)
- Lapse (Redirection)
- Relapse (Redirection)
- Maintenance

Readiness to Change

Motivation + Ability + Situation= Readiness to Change

M + A + S/C = R

Motivation is generally *cognitive*

Ability is generally *behavioral*

Situation/Circumstances are generally *socially related*

- The therapeutic bond describes the *relationship* between patient and therapist
- The therapeutic alliance described the *goals and strategies for change*

Adapting Therapy to Readiness to Change

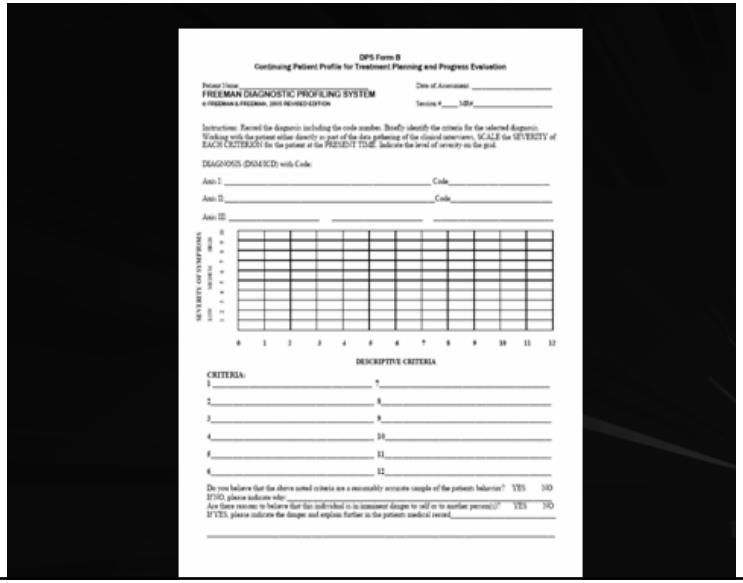
	Therapeutic Work			
	Crisis	"Coaching"	Support	Maintenance
Therapeutic Bond	Low	High	High	Low
Therapeutic Alliance	High	High	Low	Low

Low *High*

Readiness to Change

The Freeman Diagnostic Profiling System

- DSM-IVTR based
- Easily used
- Focuses on problems, not complaints
- Separates problems into component parts
- Leads to focused treatment planning
- Used to evaluate change over time
- Shows patient areas of greatest concern
- Helps supervisors to focus supervision
- Can be used for all disorders (DSM and ICD)


DPS Form B
Continuing Patient Profile for Treatment Planning and Progress Evaluation

FREEMAN DIAGNOSTIC PROFILING SYSTEM

DESCRIPTIVE CRITERIA

DSM IV TR Criteria

Borderline Personality Disorder (BPD) is: "a pervasive pattern of instability of interpersonal relationships, self-image and affects, as well as marked impulsivity, beginning by early adulthood and present in a variety of contexts."

A DSM diagnosis of BPD requires any five out of nine listed criteria to be present for a significant period of time.

There are thus 256 different combinations of symptoms that could result in a diagnosis. The criteria are:

- Frantic efforts to avoid real or imagined abandonment such as lying, stealing, temper tantrums, etc.. *[Not including suicidal or self-mutilating behavior covered in Criterion 5]*
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- Identity disturbance: markedly and persistently unstable self-image or sense of self.
- Impulsivity in at least two areas that are potentially self-damaging (e.g., promiscuous sex, eating disorders, substance abuse, reckless driving, overspending, stealing, binge eating). *[Again, not including suicidal or self-mutilating behavior covered in Criterion 5]*

- Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior.
- Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).[*citation needed*]
- Chronic feelings of emptiness, worthlessness.
- Inappropriate anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights, getting mad over something small).
- Transient, stress-related paranoid ideation or severe dissociative symptoms.

The Potentially Dangerous Patient

Factors to watch for:

- High arousal style
- Agitation
- Marked lability and mood swings
- History of impulsivity
- Anger or rage reactions
- Mania

Combined/exacerbating factors

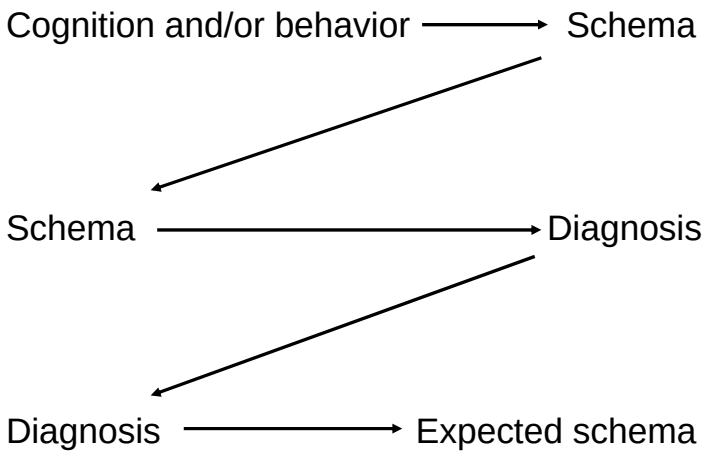
- Poor problem solving ability
- “Angry victim stance”/ Paranoia
- Hallucinations and/or delusions
- Substance abuse

Addiction or Personality D/O: Which is it?

ADDICTION	PERSONALITY D/O
1. Support system exhaustion	1. Support system exhaustion
2. Other-blaming	2. Other-blaming
3. Usually begins early to mid-teens	3. Usually begins early to mid-teens
4. Progression	4. Progression
5. Exacerbations and remissions with crises	5. Exacerbations and remissions with crises
6. Manipulative interactions	6. Manipulative interactions
7. At risk for affective disorders	7. At risk for affective disorders

Understanding Schema

- The issues in treatment revolve around not so much the events in the person's life, but what the individual has learned from those early experiences (coded as schema).
- We must think in terms of temperament *(genotype),* observed behavior *(phenotype),* and environmental context *(sociotype).*
- The interplay of these elements make for the colors and shading of any behavior.



Understanding Beliefs

- There must be a therapeutic focus on the basic ideas, learning, beliefs, and assumptions developed in the patient's family of origin and that now govern perception, motivation, affect, cognitions, and behavior.
- The beliefs hardest to modify are those learned very early in life, were strongly reinforced, were modeled by significant others, or acquired from a credible source.

Schema are the sum total of the individual's learning and experience within the:

- Family group
- Religious group
- Ethnic group
- Gender group
- Company group/team
- Regional group
- Broader society

Schematic Shift Potential

Schematic Paralysis	Schematic Rigidity	Schematic Stability	Schematic Flexibility	Schematic Instability
"Ossified"	*"Dogmatic"*	*"Steady"*	*"Creative"*	*"Chaotic"*
Nothing will bring about change	Change may come, but with difficulty	Internal rules are clear and predictable	Rules can be bent or changed, as needed	Rules shift and change without warning

Schema can be:

- Active or dormant
- Active schema govern more day to day behavior
- Dormant schema called into play to control behavior at times of stress

- Compelling vs. non-compelling
- Compelling – more compelling more likely it is the individual/family will respond to the schema
- Non-compelling – less compelling less likely it is the individual/family will respond to the schema

When political or religious beliefs are strongly maintained (or not surrendered) in the face of overwhelming threat or “evidence,” the person is termed “patriot” or “martyr.”

When dysfunctional personal beliefs are strongly maintained (or not surrendered) in the face of overwhelming threat or “evidence,” the person is termed “fanatic” or “resistant.”

Understanding Personality Disorders

- Personality disorders are styles of responding (behavioral)
- That evolve through life (adaptive)
- Are designed for survival (life protecting)
- Come to be self-defining (cognitive)
- Become how others define the individual (situational)

Meet Melissa

- 27 years old
- Recently divorced after 7 months of marriage
- Irregular work history (presently working)
- No friends or social circle
- Lives at home
- Intense familial conflict
- 7th year of 2 year college program
- No progress in dealing with anxiety after 6 months of weekly therapy

Treatment Issues

Focus of Treatment

As much as possible, focus on the here-and-now

Vague Goals

↓

Vague Therapy

↓

Vague Results

Setting treatment goals that are:

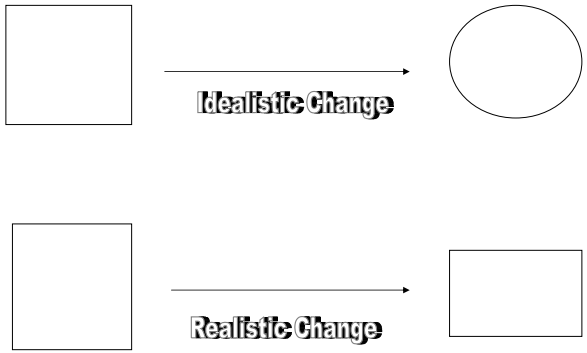
- Reasonable
- Sequential
- Proximal
- Well-delineated
- Within the patient's repertoire
- Agreed to
- Seen by the patient as valuable
- Within the therapist's range of treatment

Developing a Change Focus

Unless the therapist has a clear, strong, reasonable, and realistic idea and image of what the desired outcome will be, treatment cannot be successful or will succeed by accident.

The therapist must be able to collaborate with the patient to outline what the "finished product" will look like, act like, and sound like. The patient must agree.

Idealistic vs. Realistic Change



The Value of Change

The goal of therapeutic change must be to provide the patient with a high enough value to the change to make the commitment, use the effort, spend the time, spend the money, disrupt (and possibly) upset significant others, and risk the anxiety of being "different."

The Need for Conceptualization

Offers the therapist and patient a direction and plan for travel

Explains past behavior

Makes sense of present behavior

Predicts future behavior

"

Alice in Wonderland

"Would you please tell me which way I ought to go from here?"

"That depends on where you want to get to" said the cat.

"I don't much care….." said Alice

"Then it doesn't matter which way to go" said the cat.

"….so long as I get somewhere" Alice offered as an explanation.

"Oh you will certainly do that" said the cat "if only you walk long enough.

All therapy should be one session treatment.

The session needs to have a goal, an introduction, a middle, and a termination point.

We cannot be assured that there will be another session unless preparations are made for the succeeding session.

Illustrating the Conceptualization

- Use as visual metaphor
- Shared with the patient
- Patient asked for reaction and input
- Illustration modified after patient input
- Use to set out goals

The Range of Narcissism

1. **Positive self-esteem -** the individual generally views themselves in positive ways
2. **"Healthy" narcissism-** the individual has attributes that they recognize as special or superior. However they do not flaunt their "gifts"
3. **"Group" narcissism-** one's special status is conferred and maintained by membership in a group. Without the group the status is lost and is not transferable
4. **"Helpful" narcissism-** usually unaware that their "helpfulness" at guiding and correcting others is negatively perceived
5. **"Real" narcissism-** the personal view that one is superior to others may be justified and consensually validated. They are not, however, hesitant to point out their "gifts" to others
6. **"Compensated" narcissism-** the individual feels so badly about him or herself that they create a super-person to make up for the perceived lacks and failures
7. **"Oblivious" narcissism-** the individual is unaware of their effect on others.
8. **"Hypervigilant" narcissism-** the individual is constantly scanning for insult, denigration, or being discovered to be vulnerable.
9. **"Ruthless" narcissism-** the individual gains satisfaction and enjoyment from the discomfort of others

The Refractory Patient and "Helpless Narcissism" (The Yes-But Patient)

10. The patient presents for therapy with apparent "low-self-esteem" expressed directly or interpreted by the therapist and associated with depression. They may, in fact, be a manifesting "helpless narcissism."

"Helpless" Narcissism

Refractory Axis I disorders (e.g.,anxiety, depression) may be a manifestation of "helpless narcissism"

Typical schema might include:

"If I surrender my symptoms I will be like everyone else."
'I am special and my weekly meeting with my therapist attests to that."
"Some of the best known shrinks in this area have failed to cure me."
"I can't be beat at this therapy game."
"I have you all to myself for the session time."
"Being 'sick' allows me to avoid uncomfortable or disliked tasks."
" SSI has allowed me to take early retirement"

What is the individual's enlightened self-interest?

It is important to focus both on the patient's *short-term* and *long-term* self interest in working to help him or her to choose the most adaptive courses of action and in trying to motivate him or her to take that action as part of the <u>treatment alliance</u>.

The "Silent" Assumptions of a Narcissist: Understanding Schema

I am more special than others (I must learn to share my gifts).
I am more special than others (Others must recognize that and pay me homage).
I am more special than others (and if I do not get special favor, others must be punished).
I am more special than others (and should only have to associate with like individuals who approximate my special status).
I am more special than others (I must learn to hide my gifts so as to not upset others).

Meet Alfred

- 40 years old
- His girlfriend recently left him after 4 years of living with him
- Regular work history (presently working)
- No friends or social circle
- Has older sister with whom he sometimes stays
- No apparent familial conflict
- Never graduated from high school
- This recent “abandonment” leaves him wondering at why she would have done this to him.

The Importance of Homework

- Increases therapeutic contact
- Makes sessions contiguous
- Has the patient “invest” in therapy
- Allows for a laboratory experience
- Evaluates motivation

Why I Didn’t Do My Homework

- I forgot
- I was distracted by other things
- I didn’t want to do it
- I thought that it was a stupid homework
- You cannot tell me what to do
- You’re not the boss of me!
- It would not help
- I’ve done it before without profit
- I assumed that you would forget it

Dealing with Co-morbid Problems

- When there are multiple problems, the patient can be said to have

"Symptom Profusion"

Problems in the CBT of Substance Abusing Individuals

- **1. Ongoing need for external support (and supporters), possibly for life.**
- **2. Often other-blaming.**
- **3. Substance use and/or abuse often involves family or friends.**
- **4. The individual's limited or poor ability to problem solve.**
- **5. Reluctance, refusal, or fear of experiencing discomfort (discomfort anxiety).**
- **6. Inability or reluctance to see the hindrance or dysfunction caused by substance use.**
- **7. Unrealistic view of their personal ability to control substance use.**
- **8. Unrealistic view of their personal ability for control of life issues.**
- **9. Unwillingness to view their problem as needing a *process* rather than a cure.**
- **10. Seeking long-term, permanent, easy ways of maintaining addiction without getting into trouble.**
- **11. Limited, poor, or inaccurate reporting of situations and events.**
- **12. Often co-morbid physical or health problems.**

- **13. Possible complications of prescribed medications.**
- **14. Chronicity of problem(s).**
- **15. Highly reinforcing nature of substance use.**
- **16. Possible use of substances as method of self-medication.**
- **17. Long history of therapy in conflicting therapeutic programs models.**
- **18. The patient's words or style may seem adversarial.**
- **19. Patients often have diagnoses on Axes I, II, III, and IV.**
- **20. Have learned the language, techniques, and course of detoxification, recovery, and relapse.**
- **21. May have processing difficulty related to substance use and resultant cognitive impairment.**
- **22. May come to therapy "high" resulting in poor focus or state dependent learning.**
- **23. May engender negative reactions on the part of therapists.**
- **24. Often involved with the criminal justice system.**
- **25. Therapists must be sophisticated in the language and culture of addictions.**

How Do They Explain Their Problem?

- **No explanation**
- **Minimal explanation**
- **Attribution**
- **Justification**
- **Rationalization**

Level of Need

- **Interest**
- **Yen**
- **Wish**
- **Desire**
- **Want**
- **Yearning**
- **Longing**
- **Need**
- **Craving**
- **Demand**
- **Irresistible force**

Specific techniques

- ✓ Do not debate or argue with the patient.
- ✓ Avoid historical "reviews" after taking initial history (Euphoric Recall).
- ✓ Evaluate motivation for change in each session.
- ✓ Involve significant others (routine collateral interviews) when possible and useful.
- ✓ Focus on behavioral demonstration of motivation as opposed to patient report (e.g. "Yeah, this is great therapy."
- ✓ Maintain constant intercommunication with other professionals involved in treating this individual.

Questions regarding self-efficacy

- ***What would be the hardest thing for you about making changes?***
- ***What kinds of things do you think would help you make changes?***
- ***What kinds of things do you think would help you maintain changes?***

Allow the person to express feelings about the fears about difficulties making and maintaining change

Understanding our Mental Filters

- You are wearing very heavily colored dark lenses on a sunny day. How does the world look?
- You are wearing yellow lenses on a cloudy day. How does the world look?
- You are wearing blue lenses and look at a lemon. What color would the lemon be?

- Making change, one step at a time.
- Focus on problems, not complaints.
- Break problems down into the smallest units possible.
- Avoid searching for the one grand change that will make everything fall into place.
- Avoid looking for a lowest common denominator.
- Avoid skipping steps.

Let's Make Pasta

- How many steps will it take?

The Use of Therapeutic Questioning

Think of therapeutic questions like test questions, e.g.

Multiple choice (2, 3, or 4 choice)

True-False

Fill-in (one or two words)

Brief essay

Matching

Long essay (Use minimally)

Depression and Depressive Behavior

vs.

Self-Directed Negative Behavior

1. Self Denigration

The individual tends to verbally and cognitively demean and debase themselves both internally and externally. They are prone to negative expectations inasmuch as they have a negative perceptual bias. Both episodically and stylistically this individual is prone to depression. Their view may be stated directly (e.g., "I'm so dumb," or "No one would want to be with me.").

2. Self Punishment

The individual will deprive themselves of enjoyable activities or experiences inasmuch as they believe that they should "pay a price" for thoughts, actions, transgressions, or feelings in the present or past This is related to and is often a sequelae of guilt and/or shame (e.g., "I deserve the bad things that happen to me," or, "I cannot go to the movies with my friends because I did not study enough last night.")

3. Self Harm

The individual engages in behaviors or activities that <u>may</u> have a negative impact on their life. This would include smoking, avoidance of prescribed medication, potentially life threatening activities such as unprotected sex with multiple partners, or the choice of occupation. There is no guarantee that the risk-related behavior will cause self-directed injury. The risk factor may, in fact, be anti-depressive in nature (e.g., "I am invulnerable and the risk is worth it" or, "There's no sure way of predicting that these things WILL hurt me.")

4. Self Abuse

The individual engages in activities that have, or will likely have a direct negative impact on their present life circumstance. This would include extensive and regular use of alcohol, and addictive drugs (both illegal and prescription. Also included would be overeating, bulimia and anorexia. (e.g., "Sure they have a negative effect but I only do it on weekends and I can stop whenever I want," or, "These things reduce my anxiety and that makes it worth the risk.")

5. Self Danger

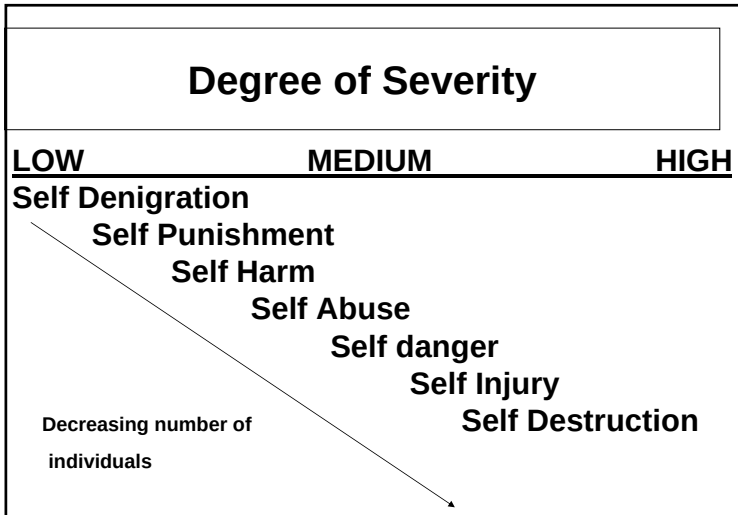
The individual places themselves in situations, circumstances, and relationships that are hurtful, dangerous, or potentially lethal. They may be in abusive relationships, involved as a victim of abusive family members, or place themselves into situations of high risk (e.g., going to an area of their city at night that is known to be dangerous. (e.g., "I cannot get out of this family/relationship. I am helpless to fight back."

6. Self Injury

The individual involves themselves in a pattern of bodily damage such as burning, cutting, or ingestion of poisons. They may refuse needed and necessary medication. They may describe the self-injurious behavior as distracting them from their psychic pain, and/or a way of attracting attention or calling for help. Included would be parasuicidal behavior. (e.g., "Look what I have to do to get anyone to notice me," or, "I need this as a release.")

7. *Self Destruction*

The individual takes clear and powerful action to end their life. The means are not important, and the destruction is sooner rather then later. If they survive they are often surprised. (e.g., "There is no hope for things to get any better so that I will act to end my life," or, "Anything is better than living this awful life.")



Treatment of the Patient with Antisocial Personality Disorder

- Not a homogenous group
- Great variability within the group
- Need for collecting collateral data (inasmuch as DSM requires a diagnosis of conduct disorder)
- Need to re-organize into subtypes based on symptom differences
- Need to develop specific treatments for each subtype
- May be differences within subtypes

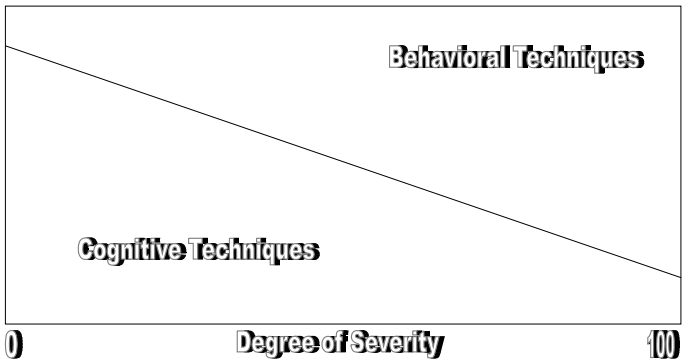
Coping with Countertranference

- Countertransference *reaction*
- Countertransference *stress*
- Countertransference *structure*
- Countertransference *neurosis*
- "Reasonable person" *hypothesis*

Arranging Therapy Sessions

- Work in therapy modules
- Modules should be 1-10 sessions
- Each session should be a "complete therapy."
- The therapist must maintain the structure and focus of the session through agenda setting and agenda maintenance
- "Mid-course" corrections are made, as needed
- The length of the module dictated by:
  - Patient and therapist motivation for change
  - Patient and therapist skill to effect change
  - Affective loading of both overall and specific session material
  - Time constraints for therapy
  - Severity or breadth of the problem

Choosing Cognitive or Behavioral Interventions



Types of Interventions

- Biological/Physical/Physiological
- Emotional
- Behavioral
- Situational/circumstantial
- Cognitive

Cognitive Techniques

- Setting an agenda
- Use of imagery
- Externalization of “voices”
- Downward arrow technique
- Use of the Socratic Dialogue
- Problem Identification
- Problem Prioritization
- Closure on each issue or area
- Homework
- Identification of schema

Behavioral Techniques

- “Fixed Role” therapy
- Role playing
- Activity scheduling
- Mastery and pleasure exercises
- Shame attach exercises
- Relaxation
- Skill development
- Breathing exercises
- Stimulus control
- Response prevention

Points to Avoid

- Interpretations (use Socratic questioning)
- Patient questions (restate as declarative statements)
- Diagnoses (identify collective problems)
- Behavioral, cognitive, or affective endpoints (focus on process)

Using the Socratic Dialogue

- The therapist must have a *general* idea of the direction of therapy.
- Use short, focused questions. Often close-ended.
- Keep patient's anxiety to a minimum.
- Ask questions that will most likely elicit an *affirmative* response.
- Try to avoid questions that will elicit a negative response. If there is a negative response, restate the question in a manner that will then elicit an affirmative response.
- Carefully monitor the patient's mood and reactions.

- Gauge reaction time and latency of response.
- Move slowly and be aware of the timing and placement of interventions.
- Be aware of the need for logical sequencing.
- Avoid interpretations.
- Be ready to back away when necessary.
- Admit to the kernel or truth in the patient's response.
- Use minimal self-disclosure
- Use everyday teaching metaphors.
- Metaphors can be verbal, visual, or physical.

- It is essential for the therapist to establish and maintain firm guidelines and limits in therapy. This may be as straightforward as asking a patient to not put muddy shoes on a couch in the office, or, it may be more involved.

Arguments for Personality Disorders in Childhood and Adolescence

1. **These children need to be diagnosed very early so that they can receive the best, most intensive, and most appropriate care.**
2. **Early detection and intervention may limit the chronicity.**
3. **Since most adults with personality disorders can identify childhood and adolescent manifestations of the disorder, clinicians can take a more preventative stance.**
4. **We can initiate therapy for the child, request/require parental involvement, request school or agency intervention, and develop opportunities for postvention over the years.**
5. **Early identification and intervention may halt or limit traumatic experiences.**

Arguments Against Personality Disorders in Childhood and Adolescence

1. **Personality is still forming and that to label it as "disordered“ gives the impression that the personality of the child is fully formed and encased in stone.**
2. **"Inappropriate" labeling with such a powerful diagnosis may lead to care-givers, therapists, and teachers giving up on the child.**
3. **It could become a convenient "cop-out" for therapists who are unsuccessful with a child or family.**
4. **The personality disorder diagnosis will be applied inappropriately to culturally different groups.**
5. **"Personality" does not exist absent the specific behaviors, therefore there can be no "personality disorder."**
6. **Too weighty a diagnosis for a child.**

Functional and Dysfunctional Manifestations of Disorders

For some children and adolescents a particular disorder may cause significant and severe personal discomfort and dysfunction.

For others, the personality style and behavior is ego-syntonic and the “distress,” if any, comes from others (family, peers, school).

For still others, the style is, at this point, functional. Few individuals in the child’s life are distressed.

Assessment

Assessment involves extensive data collection from as many sources as possible, as quickly as possible.

One of the most valuable sources of data is the clinician’s personal reactions to the child, family, and circumstance (the “reasonable person hypothesis”).

Look for the simplest answer first before investigating the possibility of more complex answers (multi-axial diagnoses).

Viewing Children's Personality Problems

Mild manifestation

- **May (or may not) be noticed.**
- **May (or may not) be functional.**
- **Often seen as a personal style, without prejudice.**
- **"Problems," if any, will depend on the parents, teachers, and school personnel.**

Moderate manifestation

- **Has likely been noticed.**
- **Often the pattern is dysfunctional.**
- **Seen as an impaired personal "style."**
- **Severity and impact of the resulting problems depends on the parents, teachers and school personnel.**

Severe manifestation

- **Has frequently come to the notice of school personnel.**
- **Impaired function (moderate to severe).**
- **Causes significant conflict**
- **May be supported or enabled by the family.**

Assessment and Data Collection

1. Structured clinical interviews with parent(s) and significant others.
2. Structured clinical interview with child.
3. Family (especially sibling) history from accurate reporter (or the best we have).
4. Behavioral observations at home.
5. Structured school behavior report forms.
6. Informal comments of classroom personnel
7. Direct observation of the child
8. Medical or psychological reports/archives
9. Formal testing
10. Clear, specific, and targeted referral

Comparing the Child's Behavior with Normative Behavior

1. Is there a normal developmental explanation for the child's behavior?
2. Is the behavior variable or cyclical or is it constant, consistent, and predictable.
3. Could it be a result of discrepancies or inconsistencies between the child's chronological age and cognitive, emotional, social, and/or behavioral ages?
4. Does the child function similarly in different environments and with different people?
5. Does the problem behavior relate to the child's environment or situation?
6. Is the observed behavior a result of the child's linguistic style, thinking style, or attitude.
7. Is the behavioral style culturally related?

If it looks like a duck, walks like a duck, and quacks like a duck, it may very well be a duck.

The Child Who “Got Away”

There are children for whom the disorder serves a purpose and who may never be referred for help.

The child who is the “squeaky wheel” may get all of the grease.

The Child Who “Got Away”

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The child who is the “squeaky wheel” may get all of the grease.

- For example, the compliant, dependent, obsessive compulsive, hard-working, success-driven/demanding child may succeed at school and be seen by teachers as a hard worker and may be a superior student as measured by academic success.
- The results of the personality style in this instance may serve to enhance a child's school performance. The child may be rewarded by certificates, plaques, public recognition, or admiration of other students.
- The child may receive the approval of teachers, school administrators and parents. After all, who wants their child to be an academic failure?
- The teacher earns acknowledgement for having a “good student” who “does well” and “brings credit to the school.” Parents may get a bumper sticker.

- The avoidant child may be overlooked by teachers and clinicians inasmuch as they are reserved in response, do not generally call attention to themselves, and generally cause little trouble in class.
- The fact that they play by themselves, stay on the outskirts of work and play groups will usually not bring them into conflict with schools as long as they do relatively well in school.
- Inasmuch as they may relate well to family and first degree relatives, the families may not see any problems other than the child is noted to be “kind of shy."

Cognitive Interventions for Children

Self-instructional training

Building coping statements

Problem-solving training

Monitor self-statements

Identifying negative self-talk

Developing adaptive self-talk

Examining and challenging attributions

Expanding emotional vocabulary

Behavioral Interventions

- **Exposure based strategies (imaginal or *in vivo)***
- **Systematic desensitization (useful with anxiety)**
- **Relaxation training**
- **Construct a problem hierarchy**
- **Flooding (imaginal or *in vivo)***
- **Response Prevention**
- **Stimulus control**
- **Contingency management**
- **Modeling**
- **Extinction procedures (extinction burst/spontaneous recovery)**
- **Positive reinforcement**
- **Negative reinforcement**
- **Feedback**
- **Shaping procedures**
- **Variable schedule reinforcement**
- **Prompting**
- **Task analysis**

Treatment of Families and Caretaker Systems

It is essential to include the patient's family and/or caretaker system as major "players" in the therapeutic process.

Selecting the Optimal Focus for Treatment

1. Is the referral problem a result of a lack of knowledge regarding normal development?
2. Does the child's behavior relate to parental behavior and expectations?
3. What are the parent's skills for parenting?
4. What is the family communications style?
5. Does the child's behavior relate to classroom stressors?
6. Is the identified behavior related to (and limited to) peer interactions?
7. What are the child's schema relating to potential danger (self/world/future)?

Treating the Military Person

Duty is the sublimest word in our language. Do your duty in all things. You cannot do more. You should never wish to do less.

It is well that war is so terrible, or we should grow too fond of it.

General Robert E. Lee

The present conflict in which the United States and its allies are engaged in Iraq and Afghanistan are but the latest manifestation of how harm's way impacts individuals at the front, those who train and equip them, and those in the family systems that support the service member.

Harm's way is a broad blanket that stretches from the war-front to the home-front.

Cultural Competence

- Much has been written about the need for "cultural competence."
- Many returning military, of all services, may have severe and significant emotional and behavioral problems that are related to their military service. Many of these individuals will be seen by therapists who do not have military experience and are therefore not competent in military culture.

- Several key models are important and useful for a comprehensive treatment program. These will include cognitive behavior therapy as a key ingredient with the additions of systemic and behavioral components.

The soldier's mind: Motivation, mindset, and attitude.

- From the time a soldier completes basic training until long after the time they retire they are trained to think of their fellow soldiers as one with themselves, act as a unit, to be mission-oriented and motivated, to work tirelessly, to be respectful to the chain of command, to follow all lawful orders, have a high moral purpose, and act in the best interests of their country, their unit, and their service.
- Loyalty, Duty, Respect, Selfless Service, Honor, Integrity, and Personal Courage: These are the soldier's values that must be understood to understand the soldier.

Training for battle: Preparing to be the warrior and savior.

- These individuals are trained to be combatants and warriors. They are taught weapon usage, military tactics, survival techniques, and defensive strategies.
- They are taught to survive being in harm's way.
- They are also inculcated with the skills to be the saviors of a country and a people that are dependent on them for survival.

Deployment

- Being deployed has many meanings. Some are rather simple and obvious. The individuals are being sent away from home to various sites for further training or to foreign countries where there is risk of personal losses, physical injury, and possibly death.
- In addition to fears related to death and injury, Service Members are faced with challenging environmental conditions, uncertainty about relationships back home, lack of freedom and personal space, and increased conflict between peers and superiors.

Women in the military: Culture, gender, and the warrior's creed

- In past wars, there were clear battle lines, and women generally served behind them.
- Now women serve actively in combat roles.
- The way in which women are acculturated and treated within the military is often out of step with the "traditional" views and roles of women.

Normal stress, combat stress, chronic stress, acute stress, and PTSD: Understanding and identifying the differences

- Stress is both a motivator and an impediment to performance. This chapter will address the various manifestations of stress experienced by military personnel who have served in both combat and non-combat situations. The military refers to the ability to deal with stress as resilience.
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Scanning for Danger: Readjustment to the Non-Combat Environment

- In a combat environment, any shadow, movement, or sound could signal attack. In a non-combat environment the same or similar stimuli may trigger a trained response in the combat trained soldier.
- Therefore the backfire of a car or a sudden and unexpected movement may be responded to with a defensive maneuver.
- If the adaptive response becomes intrusive and/or prevents an individual from performing their usual activities they may require assistance in reducing hypervigilant intrusive responses.

Assessment of Emotional and Behavioral Disorders among Military Personnel

- The assessment of emotional and behavioral disorders among military personnel can be complex. Behaviors in a civilian setting may be labeled as paranoia while in a military setting they may be considered exceptional acumen for a sniper. Feelings of loss and hopelessness after being airlifted after an injury in which you are an only survivor are normal parts of a grieving process and not necessarily major depression.

Sleep Disorders

- Sleep disorders include problems of sleep onset, sleep maintenance, and early waking. An additional issue for many post deployment military involves vivid dreaming and nightmares.

Aggression and homicide

- Aggression always has the potential for deadly consequences. The use of words and weapons, coupled with the combat skills acquired and mastered to survive harm's way may be deadly in the civilian milieu.
- The problems of impulsivity, poor executive control, and potentially dangerous behaviors that are a danger to others need to be addressed.

Family and parenting

- The typical issues of family and parenting can present significant problems for the military family.
- Many families feel emotional trauma due to multiple deployments. Military spouses feel trapped at home fearing they will miss a phone call while their spouse is depressed and grieving the loss of family gatherings, children's activities and daily life.
- Every day the spouse at home fears the knock on the door bearing "The Bad News."
- The "IBM" syndrome

Intimate Relationships and the military

- Spouses that have been close and intimate on a daily basis are suddenly dealing with being apart for a year or more. Contact is reduced to sporadic phone calls, letters and occasional packages.
- During the long deployment there is a brief period of leave before the return to the combat zone and being separated again.
- Fears of the spouse losing interest, finding someone else loom heavy for some.
- For others it is difficulty upon return and getting to know each other again and having someone else "in your space" regularly.
- Moving from group identification and affiliation to one-to-one intimacy can present a number of issues that must be dealt with by the therapist.

The community response to returning military: Homeless after the parade

- Unlike the mass anger and community degradation of the Vietnam era, the contemporary returnee may be applauded, cheered, honored, saluted or ignored.
- However, after the parades and kind words, many veterans find themselves unemployed and even homeless.
- They may return home to find that their spouse is remarried and their bank account is empty.
- Many of our reserve and guard soldiers find that they have no benefits if they are wounded and are now unable to work.

Issues of Grief and Loss, Honor and remembrance, The loss of innocence and survivor guilt: Spirituality issues in working with military personnel and their families.

- Young men and women survive harm's way, some, however do not. They may be wounded, injured, disabled, or killed. Survivors have the task of returning to homes, families, and lives while leaving buddies behind.
- The veteran will normally suffer the same losses as non-military, i.e., the death or loss of parents and relatives that have been, at some point their major supports.

Thank you for inviting me to beautiful Lancaster. I truly appreciate the hard work and superb organization of the people at J & K (Judi, Ken, Jason, and Lauren).

I hope that this workshop has been useful, thought-provoking, and applicable to your practice.

I welcome your comments and critique.

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DPS Form B
Continuing Patient Profile for Treatment Planning and Progress Evaluation

Patient Name:_____ Date of Assessment: _____

FREEMAN DIAGNOSTIC PROFILING SYSTEM

Session #_____ MR#_____

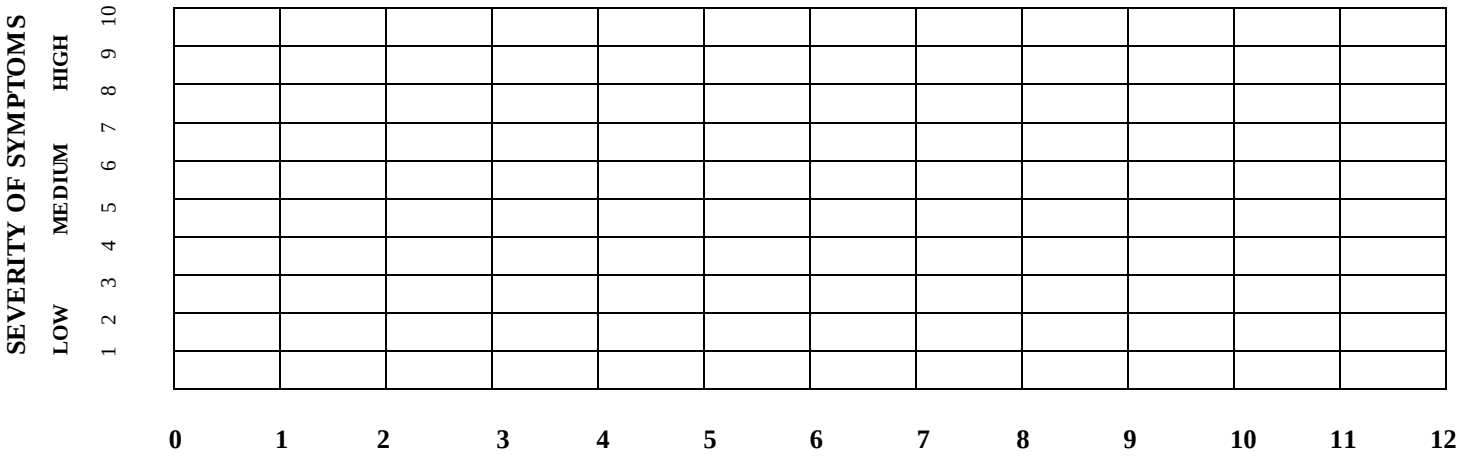
Instructions: Record the diagnosis including the code number. Briefly identify the criteria for the selected diagnosis. Working with the patient either directly as part of the data gathering of the clinical interviews, SCALE the SEVERITY of EACH CRITERION for the patient at the PRESENT TIME. Indicate the level of severity on the grid.

DIAGNOSIS (DSM/ICD) with Code:

Axis I: _____ Code_____

Axis II:_____Code_____

Axis III: _____ _____ _____



DESCRIPTIVE CRITERIA

CRITERIA:

1 _____ **7**_____

2_____ **8**_____

3_____ **9**_____

4_____ **10**_____

5_____ **11**_____

6_____ **12**_____

Do you believe that the above noted criteria are a reasonably accurate sample of the patients behavior? YES NO
If NO, please indicate why:_____
Are there reasons to believe that this individual is in imminent danger to self or to another person(s)? YES NO
If YES, please indicate the danger and explain further in the patients medical record_____

_____