Evidence-Based Techniques for Working with Your 5 Most Difficult Clients

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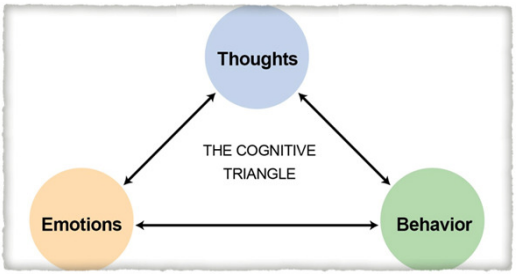
Workshop Agenda

- Introductory Remarks
- Overview of Evidence - Based Treatment Approaches
- Case Conceptualization
- Treatment Techniques
- Dealing with Angry Clients
- Dealing with Depressed Clients
- Dealing with Anxious Clients
- Q & A/Dismissal

Cognitive Behavior Therapy (CBT)



Cognitive Behavior Therapy (CBT)

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

Cognitive Behavior Therapy (CBT)

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

Cognitive Behavior Therapy - Tenets

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

Cognitive Behavior Therapy - Tenets: Identifying Core Beliefs

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

Cognitive Behavior Therapy - Tenets: Identifying Core Beliefs

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

Cognitive Behavior Therapy - Tenets: Identifying Core Beliefs

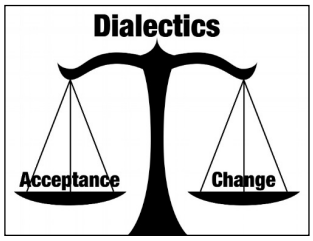
- Example Beliefs About the World
  - The world is exciting
  - The world is boring
  - The world is scary
  - The world is evil
  - The world is a lost cause
  - I am defective
  - The world is dangerous

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy

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

Dialectical Behavior Therapy



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

Dialectical Behavior Therapy: Core Modules

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

Schema Focused Therapy (SFT)

Schema Focused Therapy (SFT)

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

Schema Focused Therapy (SFT)

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

Schema Focused Therapy (SFT)

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

Schema Focused Therapy (SFT)

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

Schema Focused Therapy (SFT)

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

Schema Focused Therapy (SFT)

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

CBT Umbrella/"Offshoot" Models

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

Morning Break

Complex Case Conceptualization: The Roadmap to Recovery

Cognitive Conceptualization: The Roadmap to Recovery

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

Conceptualization Drives Goal Setting

Problem List

Goal List

Behavioral Targets

Identify Triggers for Behaviors

Identify Cognitions associated with target behaviors

Case Study: “Lisa”

The Cognitive Model of Depression

The Cognitive Model of Depression

- **Negative Cognitive Triad**
  - **Self**
  - **Others**
  - **World**

The Cognitive Model of Depression

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

The Cognitive Model of Depression

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

The Cognitive Model of Depression

- Common Distortions
  - Selective Abstraction/Discounting the positive

Behavioral Activation

- Activity Monitoring
- Activity Scheduling

The Cognitive Model of Depression: Self Care

PHYSICAL	EMOTIONAL	RELATIONAL	SPIRITUAL

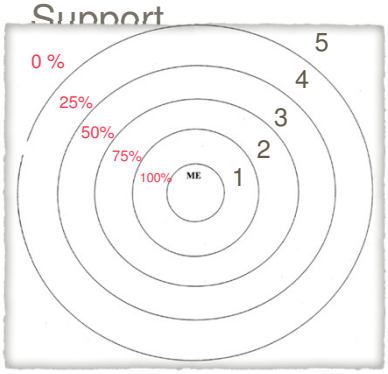
My plan for the week:

Life Areas Associated with Depression

1. Mastery
2. Pleasure
3. Meaning

The Cognitive Model of Depression: Relationships and Support

Intimacy
=
"Into - Me - See"



The Cognitive Model of Depression: Gratitude

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

The Cognitive Model of Depression: Other Cognitive Strategies

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

The Cognitive Model of Depression: Other Cognitive Strategies

Rainy Day Coping Narrative
Data Logs

The Cognitive Model of Anxiety

Anxiety = Risk/Resources

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

The Cognitive Model of Anxiety: Primary Distortions

- Mind-Reading
- Fortune-Telling
- Magnification

Characteristics of Anxiety

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

Schemas Associated with Anxiety Disorders

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

CBT for GAD

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

CBT for GAD: Positive Metacognitive Beliefs

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

CBT for GAD: Negative Metacognitive Beliefs

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

CBT for GAD: Negative Metacognitive Beliefs

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

CBT for Phobias

- In-Vivo
- Hierarchies
- Behavioral Experiments

CBT for Panic Disorder

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

- **Empirically supported protocol: Clark, Barlow**

CBT for Social Anxiety

- Trigger is People
- Unlovable schema work
- Continuum Work

Spouse
Neighbors dog

I——————————————————————————I

- Challenge people pleasing cognitions
- Polling exercises

Other Anxiety Strategies

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

Interoceptive Demonstration

The Cognitive Model of Anger

The Cognitive Model of Anger

trigger → Should

- Identification of Triggers
- Identification of Target Behaviors
- Identify Bodily Sensations
- Identification of Emotions
- Challenging "Hot" Cognitions
- Coping Statements
- Role Plays
- Letter Writing
- Values Clarification
- Schema/Forgiveness Work
- Pros and Cons

Scaling Your Anger

Event (CB) Thoughts → Feelings → Actions → Results

10 _____
9 _____
8 _____
7 _____
6 _____
5 _____
4 _____
3 _____
2 _____
1 _____

CBT for Anger: Behavioral Strategies

- Assertiveness Exercises
- Express anger in safe environment
- Letter writing
- Journal of triggers and responses
- Exercise
- Develop ability to empathize with person angry with
- Count to 10
- Walk away

CBT for Anger: Cognitive Strategies

- Rational Responding Techniques
- Reduce Personalization
- Challenge "Shoulds"
- Id and replace "Hot" Cognitions
- Forgiveness Work
- Pros and Cons

CBT for Anger: Schematic Considerations

- Values-Based Work

CBT for Anger: Forgiveness Interfering Cognitions

- Forgive and Forget
- Forgiveness = Trust
- If I forgive I have to like/love and stay in relationship with them
- If I forgive him I am letting him off the hook
- If I forgive I am saying what she did is ok
- I will not give him the satisfaction of my forgiveness

Structure of a CBT Session

Intro
- Mood Check
- Bridge
- Set Agenda
- Review of Homework

Middle
- Cover Agenda

End
- Summary of Learning /Cards
- Assign Homework

Cognitive Model of Addiction

Motivational Enhancement Therapy

Stages of Change

Pre-Contemplation Preparation Maintenance
I----------I----------I----------I----------I
Contemplation Action

Conceptualization – Essential Components

- Relevant Childhood Data
- Current Life Stressors
- Core beliefs
- Beliefs about usage
- Thoughts
- Emotions
- Behaviors

Case Conceptualization Addresses

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

Cognitive Model of Addiction - Interventions

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

Cognitive Model of Addiction

Case Study

Cognitive Model of Substance Abuse

CB Chain Analysis

CB Chain Analysis

Cognitive Model of Substance Addiction – Cue Card

Schema Based Letter Writing

Relapse Prevention Questions

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

Relapse Prevention Questions

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

Smart Recovery 4 Point Program

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

Afternoon Break

Personality Disorders

Obsessive-Compulsive PD

OCPD Profile

- *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

Obsessive - Compulsive PD

OCPD 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

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

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"

Obsessive-Compulsive PD

- Diagnostic Criteria – 4 of following 8

  7) Has miserly spending style
  8) Rigid and stubborn

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

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

Obsessive-Compulsive PD

- Risk Assessment: Lowest of all PDOs

Obsessive-Compulsive PD

- Successful Contexts
  - Accountants
  - Quality Control
  - Airline Mechanic
- Unsuccessful Contexts
  - Mental Health Professionals
  - Sales
  - Telemarketing

Obsessive - Compulsive PD

Management & Treatment Strategies

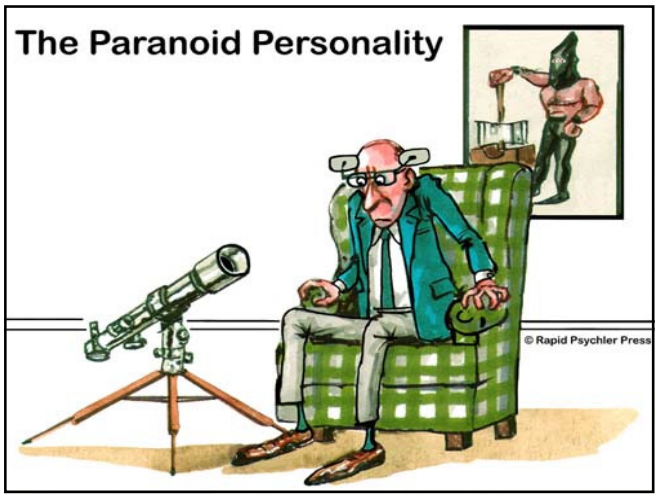
OCPD Treatment: Goals

- Decrease Rigidity
- Increase Flexibility/Spontaneity
- Develop Compassion

OCPD Symptom-Targeted Strategies

- 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

Case Study



Paranoid PD

Paranoid Profile

- 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

Paranoid PD

Paranoid 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

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

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

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

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
  - Irritibility
  - Often Low Functioning/Unemployed

Paranoid PD

Differential Diagnosis

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

2) Delusional Disorder, Paranoid Type

Paranoid PD

- Risk Assessment

  - More at risk to harm others than self
  - Can Become Violent

Paranoid PD

- Successful Contexts:
  - Police
  - CIA/FBI
  - IRS
- Unsuccessful Contexts:
  - Relationships
  - Boss
  - Business Partner

Paranoid PD

Video

Paranoid PD: Treatment Goals

- Treatment Goals
  - Develop Trust
  - Decrease aggression
  - Improve/develop relationships

Paranoid PD

Management & Treatment Strategies

Paranoid PD: Symptom-Targeted Strategies

- Accept patient mistrust
- Avoid power struggles
- Scale trust periodically
- Be a man (or woman) of your word
- Schematic vulnerability work

Paranoid PD

Case Study

Histrionic PD

Histrionic Profile

- *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

Histrionic PD

Histrionic 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

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

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

Histrionic PD

* Diagnostic Criteria – 4 of 8

6) Shows self-dramatization…exaggerated expression of emotion

7) Is suggestible (easily influenced by others)

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

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

Histrionic PD

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

Histrionic Personality Disorder

- Successful Contexts
  - Theatre
  - Charismatic Pastors
  - Fashion Industry
- Unsuccessful Contexts
  - Surgeons
  - Accountants
  - Engineers

Histrionic PD

Management & Treatment Strategies

Histrionic PD:
Symptom Targeted Treatment Strategies

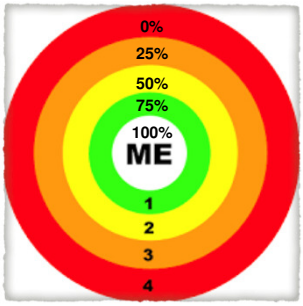
- Be Exciting!
- Compliment frequently at first
- Role Plays
- Psychodrama
- Family Sculpting

Histrionic PD:
Symptom Targeted Treatment Strategies

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

Histrionic PD:Intimacy Circles

Intimacy = "Into-Me-See"



Narcissistic PD

Narcissism Profile

- *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

Narcissistic PD

Narcissism Profile

- *Common Schemas: Defectiveness, Emotional Deprivation, Insufficient Self-Control, Subjugation, unrelenting standards*
- *Cognitive Profile "I must be perfect"*
  - "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

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:

Narcissistic PD

- Diagnostic Criteria

  1) Grandiose sense of self-importance (exaggerates achievements, talents, etc..)

  2) Is preoccupied with fantasies of unlimited success, power, brilliance, or ideal love

Narcissistic PD

- Diagnostic Criteria

  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

Narcissistic PD

- Diagnostic Criteria

  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

Narcissistic PD

- Diagnostic Criteria

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

Narcissistic PD

- Types of Narcissists?

- "Spoiled"
- "Compensated"/"Fragile"
- "Malignant"
- "Functional"

Narcissistic PD

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

Narcissistic PD

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

Narcissistic PD

- Risk Assessment: Relatively Low – can become violent/crushed if source of "feed" removed

Narcissistic PD

- Successful Contexts:
  - Physicians
  - Politician
  - Radio Talk Show Hosts
  - Professional athletes/models
- Unsuccessful Contexts:
  - Social Services
  - Spouse

Narcissistic PD

Management & Treatment Strategies

Narcissistic PD: Typical Presenting Problems

1) Forced/Others initiated
2) Problem related to addictive behavior
3) Depression

Narcissistic PD: Common Histories

1) Loneliness and Isolation
2) Insufficient Limits
3) Hx Being Manipulated or Controlled
4) Conditional Approval

Narcissistic PD: Schema Modes

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

Narcissistic PD: Lonely Child Mode

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

Narcissistic PD: Self-Aggrandizer Mode

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

Narcissistic PD: Detached Self-Soother Mode

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

Narcissistic PD: Techniques

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

Borderline PD

BPD Profile

- 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*

Borderline PD

BPD 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

Borderline PD

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

BPD: Diagnostic Criteria

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

BPD: Diagnostic Criteria

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

BPD: Diagnostic Criteria

6) Affective Instability

7) Emptiness

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

Cognitive-Behavioral Chain Analysis

Relapse Prevention

- Relapse - “a recurrence of symptoms after a period of im

Relapse Prevention: Warning Signs

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

Relapse Prevention: How Do I Know I am Getting Better?

Ways I know I'm Better

1. Have held a job for over a year for the first time in my life
2. Havent smoked pot in 3 months
3. Have a boyfriend who is actually healthy
4. Hage a better relationhip with my daughter than i ever have
5. Have reduced my cutting to one time a week
6. I am volunteering at the animal shelter
7. Haven't had any spending episodes in the last 2 months
8. I am taking a class
9. I am taking responsibility to pay my own bills

Relapse Prevention: Wrapping Up

Relapse Prevention Plan

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

_____

_____

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

_____

_____

_____

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

1.

2.

3.

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