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NEIL R. BOCKIAN, JULIA CHRISTINE SMITH, AND ARTHUR E. JONGSMA, JR.

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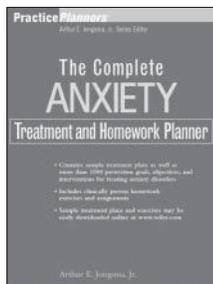
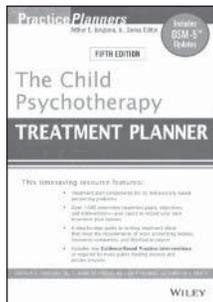
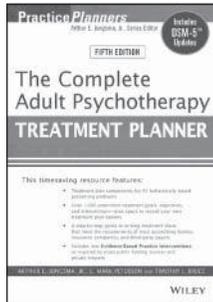
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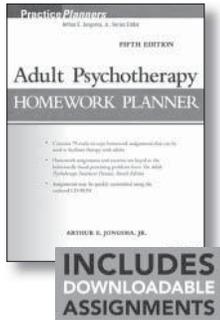
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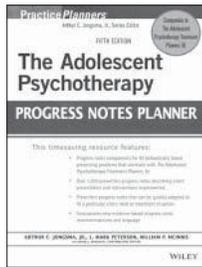
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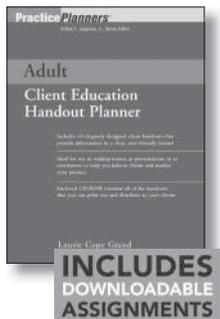
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Julia Christine Smith

Arthur E. Jongsma, Jr.

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SECOND EDITION

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Dedicated to the memory of Theodore Millon (1928–2014)—a great scholar, and my personal mentor and friend. His contributions to the field of psychology have been beyond measure, while his contributions to his family, friends, and those close to him, have been immeasurably greater.

And dedicated to my brother Jeffrey, a man of honor and integrity, my role model and hero.

And dedicated to my uncle Alan Brodsky, a fountain of kindness and generosity, a blessing to all who know him, and a major influence in my life.

—Neil R. Bockian

This book is dedicated to my husband, Mike; my parents, William and Janis; and my mentor, Alina Suris, whose ongoing support and acceptance gives me the energy to challenge myself and continue growing, even when it's difficult.

—Julia Smith

To Ruth and Rodger Rice, whose spiritual directedness and focus is a model for all to emulate.

—Art Jongsma

CONTENTS

Foreword	xi
Acknowledgments	xiii
Introduction	1
Sample Treatment Plan ^{EB} ▽	18
Aggressive/Sadistic	22
Antisocial*	35
Antisocial—Malevolent	48
Avoidant*	59
Avoidant—Conflicted	70
Avoidant—Hypersensitive	81
Borderline* ^{EB} ▽	92
Borderline—Petulant ^{EB} ▽	107
Borderline—Self-Destructive ^{EB} ▽	121
Dependent*	135
Dependent—Selfless	148
Depressive*	160
Histrionic*	173
Histrionic—Disingenuous	185
Intropunitive/Guilty	197
Narcissistic*	212
Narcissistic—Compensatory	225
Narcissistic—Unprincipled	237
Obsessive-Compulsive*	249
Obsessive-Compulsive—Bedeviled	261
Paranoid*	273
Paranoid—Fanatic	286
Paranoid—Malignant	297
Passive-Aggressive (Negativistic)*	308
Schizoid*	320
Schizotypal*	331

*Denotes Elaboration of Dimensional Structure in Appendix A.

^{EB} ▽ Indicates that selected Objectives/Interventions are consistent with those found in evidence-based treatments.

x CONTENTS

Appendix A Proposed Dimensions for Personality Disorders Applied to Presenting Problem Behavioral Definitions (Symptoms) for Selected Chapters	343
Appendix B Bibliotherapy/Self-Help References	365
Appendix C Professional References	370
Appendix D Recovery Model Objectives and Interventions	374

FOREWORD*

Professor Bockian and Dr. Jongsma have found an intriguing way to organize an important therapeutic subject. I am especially impressed by the balance among diverse methods these authors have given and the skill with which they have executed the task of representing alternative therapeutic models. They have condensed as well as sharpened my own earlier efforts to develop a guide for treating the personality disorders. Employing an integrative framework, they have succeeded in organizing a pioneering work, one that will be valuable to mature professionals of diverse orientations, as well as being eminently useful for students.

The authors have outlined solutions to the personality treatment task with a series of powerful, concrete, and readily implemented tools that draw from numerous treatment methodologies. What has been especially helpful to the reader is that their approach to therapy not only addresses the patient's initial complaint—such as depression, anxiety, or alcoholism—but is designed to undercut the patient's long-standing habits and attitudes that give rise to these manifest symptoms. They fully recognize also that personality disorders are themselves pathogenic, that is, these disorders set into motion secondary complications that persist and intensify the patient's initial difficulties. Presenting symptoms not only discomfort the patient, but the forces that undergird them diminish life's potentials by creating persistent unhappiness, undoing close relationships, disrupting work opportunities, and undermining future aspirations.

I was extremely pleased to see the authors' willingness to grapple with the many subtypes of the classical personality disorders. Here they have sought to differentiate the conflicted avoidant from the hypersensitive avoidant as well as to separate the different ways in which one should deal with a petulant borderline compared to a self-destructive one. Their book is more than a simple listing of techniques—it shows sensitive awareness of the uniqueness of each patient and the subtle differences that are called for in their treatment.

My hat is off to Drs. Bockian and Jongsma for undertaking the awesome task of guiding others who treat their patients with personality difficulties—

*This Foreword was written by the late Dr. Millon in reference to *The Personality Disorders Treatment Planner*, First Edition (2001).

xii FOREWORD

and for carrying out their work with clarity and utility. Most textbooks shy away from discussing the treatment of personality disorders owing to their intricacies and uniqueness. By contrast, the good doctors have organized a treatment model that can be understood by all well-trained and motivated students and professionals.

Theodore Millon, *Ph.D., D.Sc.*

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First and foremost, I would like to thank my series editor, coauthor, and friend, Dr. Art Jongsma, whose clinical acumen and pragmatic wisdom provided a solid anchor throughout the writing of the manuscript. My coauthor, former student, and friend, Julia Smith, Psy.D., made invaluable contributions to this draft. There is a particular and indescribable pleasure in seeing one's former student exceed one's own knowledge in a particular area (in this case, Dr. Smith's expertise with Acceptance and Commitment Therapy), which enhanced the quality of this manuscript. In addition, Art's excellent assistant, Sue Rhoda, was extremely helpful. Sue reformatted my drafts, without which the process would have bogged down completely. I will always be grateful for the patience, persistence, and encouragement of these three colleagues. I would also like to thank my (really, our) editor, Marquita Flemming, for her patience and support throughout this project. On those occasions when we met, she was both gracious and thoughtful, and it has been a pleasure working with her.

Undertaking a project as large as writing a book is inevitably a family effort. I would like to thank my wife, Martha, and my children, Chaya and Yaakov, for their love and support as I plowed ahead. Similarly, I owe a debt of gratitude to my parents, Fred and Sandra Bockian, my brother, Jeffrey, as well as my uncle and aunt, Alan and Barbara Brodsky, who were with me in spirit throughout this journey. I am truly blessed to have all of these people in my life.

There are also several professional colleagues to whom I owe a debt of gratitude. From the first edition of this volume, several of my colleagues provided key insights into several different theoretical approaches. Marc Lubin, Ph.D., provided essential feedback on operationalizing the psychodynamic approaches to treating personality disorders. In a similar vein, Marge Witty, Ph.D., provided feedback on client-centered interventions, while Jill Gardner, Ph.D., was instrumental in developing interventions using the self-psychology approach. My continued gratitude goes to Garry Prouty, Ph.D., who provided insights into his unique approach to connecting with extremely detached and psychotic clients; his memory is a blessing to all who knew him. From the current volume, several additional colleagues were instrumental in the development of some important interventions. Sue Johnson, Ph.D., was generous with her time and support, helping me to operationalize several key interventions in

xiv ACKNOWLEDGMENTS

Emotion-Focused Therapy. Similarly, Leigh Johnson-Migalski, Psy.D., provided support that allowed me to include Adlerian interventions in several chapters. Tim Bruce, Ph.D., provided us with a pithy review of the status of evidence-based practice in the personality disorders area. Erin Fletcher, Psy.D., my former student, friend, and a talented clinician, gave invaluable feedback on the use of exposure therapy. I thank Anthony Bateman, Ph.D., for his outstanding feedback on mentalization, as well as my colleagues Cathy McNeilly, Psy.D., and Richard Rutschman, Ed.D., for their invaluable feedback on operationalizing Motivational Interviewing. Aimee Daramus, M.A., my teaching assistant and soon-to-be colleague, did important work on the reference section and helped with the research on evidence-based practice; Gesa Kohlmeier, B.A., also my teaching assistant, provided much-needed help in organizing the various chapters in during the later stages of the project. Special thanks go to my exuberant former student and current colleague and friend Stacy Zeidman, M.A., for her drafting of several sections of the dimensional appendix. Finally, I would like to thank my insightful and talented former student and current colleague and friend Tatiana Zdyb, Ph.D., for her comments on last-minute drafts and for her encouragement during the project's final phases.

Last, but certainly not least, I would like to thank Ted Millon, Ph.D., of blessed memory, for his ongoing guidance and support during my career. He taught me how critically important a relationship with a mentor can be. His teachings and support are gifts that I could never reciprocate. I can only pay it forward by sharing what he has taught me with my students and with the readers of my writings.

NEIL R. BOCKIAN

**The Personality Disorders
Treatment Planner
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INTRODUCTION

ABOUT WILEY PRACTICE PLANNERS® TREATMENT PLANNERS

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As with the rest of the books in the *Wiley Practice Planners*® series, the aim with this volume is to clarify, simplify, and accelerate the treatment planning process so you spend less time on paperwork and more time with your clients.

ABOUT THIS SECOND EDITION PERSONALITY DISORDERS TREATMENT PLANNER

This second edition of the *Personality Disorders Treatment Planner* has been improved in many ways:

- Updated with new and revised evidence-based Objectives and Interventions in the Borderline chapters

2 THE PERSONALITY DISORDERS TREATMENT PLANNER

- Many new and revised best practice Objectives/Interventions have been added to every chapter
- Many more suggested homework assignments integrated into the Interventions
- Appendix A demonstrating the use of the personality disorders Proposed Dimensional System of *DSM-5*. Chapters that are represented in Appendix A are denoted with an asterisk (*) in the contents and in the chapter titles
- Expanded and updated self-help book list in Appendix B
- Revised, expanded professional references in Appendix C
- New Appendix D, “Recovery Model Objectives and Interventions,” allowing the integration of a recovery model orientation into treatment plans
- Integration of *DSM-5* diagnostic labels and codes into the Diagnostic Suggestions section of each chapter

Evidence-based practice (EBP) is steadily becoming the standard of care in mental health care as it has in medical health care. Professional organizations, such as the American Psychological Association, National Association of Social Workers, and the American Psychiatric Association, as well as consumer organizations such as the National Alliance for the Mentally Ill have endorsed the use of EBP. In some practice settings, EBP is becoming mandated. It is clear that the call for evidence and accountability is being increasingly sounded. So, what is EBP, and how is its use facilitated by this *Planner*?

Borrowing from the Institute of Medicine’s definition (Institute of Medicine, 2001), the American Psychological Association (APA) has defined EBP as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 17). Consistent with this definition, we have identified those psychological treatments with the best available supporting evidence, added Objectives and Interventions consistent with them in pertinent chapters, and identified these with this symbol:  As most practitioners know, research has shown that although these treatment methods have demonstrated efficacy (e.g., Nathan & Gorman, 2007), the individual psychologist (e.g., Wampold, 2001), the treatment relationship (e.g., Norcross, 2002), and the patient (e.g., Bohart & Tallman, 1999) are also vital contributors to the success of psychotherapy. As noted by the APA, “Comprehensive evidence-based practice will consider all of these determinants and their optimal combinations” (2006, p. 275). For more information and instruction on constructing evidence-based psychotherapy treatment plans, see our DVD-based training series titled *Evidence-Based Psychotherapy Treatment Planning* (Jongsma & Bruce, 2010–2012).

For any chapter in which EBP is identified, references to the sources used are listed in the Appendix C and can be consulted by those interested for further information regarding criteria and conclusions. In addition to these references, Appendix C also includes references to clinical resources. Clinical

resources are books, manuals, and other resources for clinicians that describe the details of the application, or “how to,” of the treatment approaches described in a chapter.

There is debate regarding EBP among mental health professionals, who are not always in agreement regarding the best treatment or how to weigh the factors that contribute to good outcomes. Some practitioners are skeptical about changing their practice on the basis of research evidence, and their reluctance is fueled by the methodological challenges and problems of psychotherapy research. Our intent in this book is to accommodate these differences by providing a range of treatment plan options, some supported by the evidence-based value of “best available research” (APA, 2006), others reflecting common clinical practices of experienced clinicians, and still others representing emerging approaches, so users can construct what they believe to be the best plan for their particular client.

Each of the chapters in this edition has also been reviewed with the goal of integrating homework exercise options into the Interventions. Many (but not all) of the client homework exercise suggestions were taken from and can be found in the *Adult Psychotherapy Homework Planner* (Jongsma, 2014). This second edition of *The Personality Disorders Treatment Planner* contains many more homework assignments than the previous edition did.

Appendix B of this *Planner* has been expanded and updated from the previous edition. It includes many recently published offerings as well as more recent editions of books cited in the earlier edition. Most of the self-help books and client workbooks cited in the chapter Interventions are listed in this appendix. Many additional books listed are supportive of the treatment approaches described in the chapters. In addition, we reviewed a number of computer/smartphone applications (apps) that can be helpful in supporting therapeutic endeavors.

With the publication of the *DSM-5* (American Psychiatric Association, 2013), we have updated the Diagnostic Suggestions listed at the end of each chapter. The *DSM-IV-TR* (American Psychiatric Association, 2000) was used in the previous edition of this *Planner*. Although many of the diagnostic labels and codes remain the same, several have changed with the publication of the *DSM-5* and are reflected in this *Planner*.

In its final report entitled *Achieving the Promise: Transforming Mental Health Care in America*, The President’s New Freedom Commission on Mental Health called for recovery to be the “common, recognized outcome of mental health services” (New Freedom Commission on Mental Health, 2003). To define recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation (SAMHSA, 2004). Over 110 expert panelists participated including mental health consumers, family members, providers, advocates,

4 THE PERSONALITY DISORDERS TREATMENT PLANNER

researchers, academicians, managed care representatives, accreditation bodies, state and local public officials, and others. From these deliberations, the following consensus statement was derived:

Mental health recovery is a journey of healing and transformation for a person with a mental health problem to be able to live a meaningful life in a community of his or her choice while striving to achieve maximum human potential. Recovery is a multi-faceted concept based on the following 10 fundamental elements and guiding principles:

- Self-direction
- Individualized and person-centered
- Empowerment
- Holistic
- Nonlinear
- Strengths-based
- Peer support
- Respect
- Responsibility
- Hope

These principles are defined in Appendix D. We have also created a set of Goal, Objective, and Intervention statements that reflect these 10 principles. The clinician who desires to insert into the client treatment plan specific statements reflecting a recovery model orientation may choose from this list.

Last, some clinicians have asked that the Objective statements in this *Planner* be written such that the client's attainment of the Objective can be measured. We have written our Objectives in behavioral terms, and many are measurable as written. For example, this Objective from the Obsessive—Compulsive chapter is measurable as written because it either can be done or it cannot: "Reduce clutter by throwing out one or more items that are no longer useful." But at times the statements are too broad to be considered measurable. Consider, for example, this Objective, from the same chapter: "Reduce negative thoughts about self that produce guilt, shame, and self-recrimination." To make it quantifiable, a clinician might modify this Objective to read, "Give two examples of identifying, challenging, and replacing negative thoughts about self that produce guilt, shame, and self-recrimination with balanced, realistic, and empowering self-talk." Clearly, the use of two examples is arbitrary, but it does allow for a quantifiable measurement of the attainment of the objective. Or consider this example from the Avoidant—Conflicted chapter: "Implement relaxation techniques to counteract anxiety during gradual exposure to social situations." To make it more measurable, the clinician might add more specificity to the type, number, or duration of relaxation techniques used, thus: "Implement a specific relaxation technique (e.g., diaphragmatic breathing) for xx minutes

prior to or during a social function.” The exact target number that the client is to attain is subjective and should be selected by the individual clinician in consultation with the client. Once the exact target number is determined, the clinician can very easily modify our content to fit the specific treatment situation. For more information on psychotherapy treatment plan writing, see Jongsma (2005).

Changes in the Current Edition

We made several decisions in order to make the current edition more compact and accessible than the previous one. We eliminated some subtypes, for a variety of reasons. Generally, when we felt that the subtype was a rather linear extension of the main type, we eliminated the subtype. An example of this is the Puritanical Obsessive-Compulsive, which was more extreme, but not different enough in kind, from the Obsessive-Compulsive main type to be included. We eliminated other subtypes because the main disorder is rare. So we eliminated the Schizoid and Schizotypal subtypes that were present in the first edition of this planner; we reasoned that for the vast majority of clinicians, having the main type would suffice. Strong preference was given to retaining subtypes that include elements of the disorders that were in *DSM* appendices but are no longer in the personality disorders section. Specifically, these include the Passive-Aggressive/Negativistic, the Aggressive-Sadistic, and the Self-Defeating/Masochistic. These are incorporated into subtypes such as Borderline-Petulant; see Table I.1 for a complete list.

Table I.1 Personality Disorder Subtypes

Subtype	Personalities of Which It Is Composed
Conflicted Avoidant	Avoidant/Passive-Aggressive (Negativistic)
Hypersensitive Avoidant	Avoidant-Paranoid
Selfless Dependent	Dependent-Depressive
Appeasing Histrionic	Histrionic/Dependent/Obsessive-Compulsive
Disingenuous Histrionic	Histrionic-Antisocial
Unprincipled Narcissist	Narcissistic-Antisocial
Compensatory Narcissist	Narcissistic/Passive-Aggressive (Negativistic)
Malevolent Antisocial	Antisocial/Aggressive-Sadistic/Paranoid
Bedeviled Obsessive-Compulsive	Obsessive-Compulsive/Passive-Aggressive (Negativistic)
Inspid Schizotypal	Schizotypal-Schizoid
Timorous Schizotypal	Schizotypal-Avoidant
Petulant Borderline	Borderline Passive-Aggressive (Negativistic)
Self-Destructive Borderline	Borderline/Depressive/Self-Defeating
Fanatic Paranoid	Paranoid-Narcissistic
Malignant Paranoid	Paranoid/Aggressive-Sadistic

6 THE PERSONALITY DISORDERS TREATMENT PLANNER

In perhaps the strongest theoretical stance taken in this volume, we included the Aggressive-Sadistic and Self-Defeating/Masochistic (which we label “Intropunitive/Guilty”) personality disorders. Although the *DSM* has not recognized these disorders since the appendix of the *DSM-III-R* (American Psychiatric Association, 1987), they remain part of Millon’s taxonomy, and clinicians still see these patients in clinical practice. Once removed from the official nomenclature, a precipitous decline in research and clinical attention follows. These disorders are particularly perplexing. In the Self-Defeating Personality Disorder, how do we work with someone for whom the usual behavioral principles of reward and punishment seem turned inside out? In which rewards that produce pleasure produce, simultaneously, overwhelming feelings of guilt and urges toward self-punishment? Or with the Aggressive-Sadistic, how do we guide someone to stop being harmful when descriptions of hurting others cause pleasure and perhaps even sexual arousal? Millon (1999, 2011) refers to this as the reversal of the pain-pleasure dimension and provides a theoretical description of how this emotional framework came about in the individual and how to treat it. These ideas, and others based on the lead author’s clinical experience, are embodied in this work.

Similarly, the Passive-Aggressive (Negativistic) Personality Disorder is the one that has most frequently tied my supervisees into knots. Eager, helpful emerging clinicians would offer advice, support, encouragement, insights, and behavioral suggestions—the usual therapeutic array—only to find “yes. . . but” at every turn. Most perplexing of all are the smiles, the betrayals of obvious pleasure on the part of the person with Passive-Aggressive Personality Disorder at having “defeated” the therapist . . . even though it is in the task of helping the client himself or herself. Again, ideas are woven into the chapter on this disorder and the relevant subtypes that are helpful in those areas.

Finally, attention is paid to the Depressive Personality Disorder, which is distinguished from its depressive diagnosis cousins by its ego-syntonic quality; individuals with Depressive Personality Disorder see the world as an awful place rather than seeing their downcast mood as a problem (as is the case for Dysthymic Disorder and Recurrent Major Depression). All of these personality types must be coded as “Personality Disorder Otherwise Specified,” as there is no category for them. For subtypes, such as the Compensatory Narcissist, the clinician may use a Narcissistic Personality Disorder designation or the otherwise specified designation noting narcissistic features.

Returning to the Aggressive-Sadistic and Self-Defeating (Intropunitive/Guilty) Personality Disorders, we must urge caution to clinicians when labeling individuals who have one of these conditions. Historically, it is important to note that one reason why the disorders were eliminated from the *DSM* is that the labels were being grotesquely misused in forensic settings. Defense attorneys were arguing, in domestic violence cases, that people with

sadistic personality disorder were unable to control themselves due to their mental disorder and, further, that they could not be blamed for injuring the masochist, who was “asking” to be hurt. I (NB) believe that there were better solutions than to eliminate the diagnoses (e.g., for the American Psychiatric and American Psychological Associations to write unequivocal briefs on how such uses of these diagnoses is inappropriate and misleading), but I understand the committee’s decision, given the harm being done by the misuse of these diagnostic labels. So, we advise the clinician to be mindful of the implications of the use of language and labels, especially if there is the likelihood of documentation being used for legal purposes.

Personality Disorders and Subtypes

Personality disorders have traditionally been considered difficult to treat. Because they are established early, are deeply ingrained, and are ego-syntonic (i.e., are often not seen as problematic or targets of change by the client), prognosis was initially considered poor (Millon, 1981). It is clear, however, that it is necessary to treat personality disorders. In addition to creating problems in their own right, personality disorders have strong associations with reduced quality of life (e.g., Bockian, Dill, Lee, & Fidanque, 1999) and poorer treatment outcomes for other mental illness conditions (e.g., Shea, Widiger, & Klein, 1992). The question, then, is not *whether* to treat them, but *how*.

In the past 35 years, there has been an explosion of research and clinical innovation in the treatment of personality disorders. A variety of treatments have been empirically shown to have a powerful impact on a variety of important outcomes. One exciting example of an accepted, evidence-based therapy is Marsha Linehan’s Dialectical Behavior Therapy (DBT) model for treatment of borderline personality disorder (BPD). Treatment with DBT has produced substantial improvements on important outcomes, such as reduced hospitalizations and suicide risk (Koerner & Linehan, 2000). Unfortunately, the vast majority of research has been applied to BPD, with treatment research for the other personality disorders languishing. Indeed, it is only for BPD that there are true evidence-based treatments available.

Theodore Millon (1969, 1981, 1996, 1999, 2011) developed arguably the most comprehensive theoretical understanding of the personality disorders as a whole. Millon, a member of the *DSM-III* and *DSM-IV* Personality Disorders task forces, has had an important impact on personality disorder theory, research, and practice. This *Personality Disorders Treatment Planner* draws heavily on *Personality Guided Therapy* (1999) and the third edition of *Disorders of Personality* (2011). In these works, Millon provided a general outline for the treatment of personality disorders that integrates a variety of theoretical perspectives: behavioral, cognitive, client-centered, interpersonal,

8 THE PERSONALITY DISORDERS TREATMENT PLANNER

family systems, and psychodynamic. In general, the suggested approach is to establish rapport, then find some areas for change that will be reasonably easy to accomplish; positive changes provide encouragement and also secure the therapeutic bond. Once some basic behavioral change has been established, a more comprehensive approach (e.g., cognitive, interpersonal, and psychodynamic/object relations) can be employed to help the client overcome the ways of thinking, feeling, and behaving that perpetuate the personality disorder. This *Wiley Treatment Planner* draws heavily on Millon's Personality-Guided Psychotherapy approach (also known as Synergistic Psychotherapy and Personalized Psychotherapy), which is described in the two volumes mentioned already.

Although most or all clinicians who use this book are familiar with the personality disorders, some may not be familiar with the various subtypes that have been developed. Subtypes can be extremely useful and are also quite prevalent. Comorbidity studies bear this out, showing not only high degrees of overlap among many of the personality disorders but also indications that many individuals who meet the criteria for one personality disorder also meet the criteria for one or more *additional* personality disorder diagnoses. For example, although there is a prototype for Antisocial Personality Disorder, the clinician who is experienced with this population will immediately recognize that there are several important variations on the theme. There is the brutal, vicious, callous sociopath who becomes a serial killer or rapist and then there is the slick, charming, usually nonviolent con artist who fleeces vulnerable people out of their life's savings. Both have elements of Antisocial Personality Disorder as defined by the *DSM*, but they are in fact rather different types. In this book, the former is labeled the Malevolent Antisocial, while the latter is the Disingenuous Histrionic (a mixture of histrionic and antisocial features) or the Unprincipled Narcissist (a mixture of narcissistic and antisocial features). Table I.1 lists the subtypes. We would advise using the subtype rather than the main type when appropriate, since the subtype treatment plan is inevitably more specific to a particular set of characteristics. Because the subtypes are not codified in the *DSM*, continue to select one or more of the corresponding *DSM* main personality disorders for purposes of formal diagnosis.

The Dimensional Appendix

The *DSM-5* includes an appendix that provides a proposed dimensional system for assessing personality disorders. Back when I scratched my dissertation out on papyrus using a quill pen, I looked into dimensional systems of personality disorders (Bockian, 1990). In a nutshell, dimensional systems have some important advantages. It seems fair to say that personality disorders generally represent extremes of normal personality

dimensions. For example, the Avoidant Personality Disorder can be viewed as a severe extension of shyness, passing through descriptors such as introverted, withdrawn, and, finally, avoidant. Dimensions comfortably capture thorny aspects of categorical systems, such as the fuzzy boundary between normality and pathology and the somewhat perplexing reality that a person can have one personality but meet the criteria for four or five personality disorders; indeed, if someone meets the criteria for one personality disorder, it is typical that he or she will meet criteria for several. Categorical systems, however, create vivid pictures of disorders; these exemplars tend to facilitate learning about the disorders for practitioners and the general public, and facilitate communication among practitioners; these descriptors also tend to be quicker for paperwork purposes. Regarding communication, for example, Brandon Marshall, NFL wide receiver for the New York Jets, announcing to the media that he has Borderline Personality Disorder probably packs a lot more communicative punch than an announcement that he has “extremes on the lability dimension, impulsivity dimension, and relational inconsistency dimension.” Thus both dimensional and categorical systems have pros and cons; the *DSM* committee’s choice to add a dimensional appendix should stimulate significant debate and contributions in this area.

The system that is proposed by the *DSM-5* has two parts. First, the practitioner is instructed to assess the person on Level of Personality Functioning. These levels are broken into two domains (Self and Interpersonal), each of which has two components. The Self domain contains Identity and Self-Direction, while the Interpersonal domain includes Intimacy and Empathy. Clinicians are instructed to rate each of these areas from 0 (healthy/no impairment) to 4 (extreme impairment).

The practitioner then assesses Pathological Personality Traits. These traits fall into five domains: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism. Within each domain, there are a number of facets, that number varying from domain to domain, with a total of 25 facets. For example, under Negative Affectivity (similar to Neuroticism), there are facets such as Anxiousness, Depressivity, and Emotional Lability. It is clear to anyone familiar with the Five Factor Model that there is a strong tie, although the *DSM* has not explicitly acknowledged this, and there are some differences (Widiger & Gore, 2013). Six of the current personality disorders were retained in the proposed dimensional system: Antisocial, Avoidant, Borderline, Narcissistic, Obsessive-Compulsive, and Schizotypal; the remainder are to be described only in the dimensional terms.

We selected 12 of the personality disorders and translated the behavioral definitions from them into the dimensional system. Ten are the personality disorders from the current system: Paranoid, Schizoid, Schizotypal; Antisocial, Borderline, Histrionic, Narcissistic; Avoidant, Dependent, and Obsessive-Compulsive. We then added Depressive and Passive-Aggressive (Negativistic). We chose not to include the Aggressive/Sadistic and

Masochistic/Self-Defeating (Intropunitive/Guilty) —we struggled in our efforts to apply the dimensional system to these disorders, and felt that the system needed modification to capture their essence. For example, with the Aggressive/Sadistic, there is harsh behavior, but unfeeling callousness (in the Empathy domain) did not capture the essence of the problem; indeed, the person is experiencing strong emotion—generally, some form of pleasure. We did not attempt to capture each of the four Levels of Personality categories; rather, we picked the one or two that we believed were most central. Also, note that we were translating a particular criterion/behavioral definition rather than the disorder as a whole, which is a somewhat different mission from that of the *DSM* appendix, and produces somewhat different results. In utilizing the *DSM* proposed dimensional system, we came to understand that there is room for interpretation, and some might disagree with the labels we used for particular criteria. With these caveats noted, we believe our inclusion of the appendix will be thought-provoking and useful to our readers. Each chapter of this volume that has a corresponding dimensional approach in our appendix is marked with an asterisk and a denotation as such.

It is not clear that the proposed dimensional appendix (A) will ever be adopted as the official system. I (NB) have some reservations and have noted some shortcomings as I tried to apply it. I prefer Millon's theory-driven system (active-passive, pain-pleasure, and self-other dimensions) which Millon (2011) explicitly designed for personality disorders. However, we liked the idea of helping clinicians think in dimensional terms and believe that our appendix can help them transition to the new system if necessary.

A Range of Theoretical Approaches

The authors have made a sincere effort to include a diversity of therapeutic approaches. Interventions were inspired by these schools of thought/theorists: Dialectical Behavior Therapy (Linehan), Personality-Guided Psychotherapy (Millon), Cognitive Therapy (Beck), Rational Emotive Therapy (Ellis), Schema Therapy (Young), Emotion-Focused Therapy (Johnson; Greenberg), Acceptance and Commitment Therapy (Hayes), Milan-Systemic Family Therapy (Selvini-Palazzoli), Multigenerational Family Therapy (Bowen), Experiential Family Therapy (Satir), Structural Family Therapy (Minuchin), Psychodynamic Psychotherapy—especially Transference-Focused Psychotherapy (Kernberg et al.), Client-Centered Therapy (Rogers; Gendlin; Prouty), Stress Management/Meditation/Hypnosis (McKay; Kabat-Zinn; Alman; Hammond), Mentalization Therapy (Bateman & Fonagy), Motivational Interviewing (Miller & Rollnick), Behavior Therapy, and, to a lesser degree, Self-Psychology (Kohut; Gardner) and Interpersonal Psychotherapy (Benjamin). Unfortunately, using every theoretical approach for every short-

term objective would lead to a book that is so cumbersome that it is virtually unusable. The authors encourage readers to modify therapeutic interventions to fit therapeutic goals. For example, the Schizoid chapter includes the following Short-Term Objective and Therapeutic Intervention pairing:

SHORT-TERM OBJECTIVES

List the difficulties experienced in forming intimate attachments in prior relationships.

To use this client-centered intervention for a different problem—say, feelings of alienation—the clinician would merely need to modify a few words (shown in bold):

List the difficulties that **are associated with feelings of alienation.**

THERAPEUTIC INTERVENTIONS

Validate the client’s concerns regarding intimate relationships and express unconditional positive regard (i.e., that the feelings are understandable from the client’s perspective).

Validate the client’s concerns regarding **his/her feelings of alienation.** Express unconditional positive regard (i.e., that the feelings are understandable from the client’s perspective).

By making such modifications, a clinician could create a customized set of interventions suited to his or her approach. These modifications can be made using either the software or printed version of the *Personality Disorders Treatment Planner*.

Some additional examples capture key applications of some of the approaches noted. The cognitive and behavioral interventions were rather straightforward to translate into the Wiley *Treatment Planner* format. However, the psychodynamic interventions were trickier, and are worth mentioning here. Note that the basic idea is to communicate, to the degree possible, a behavioral/procedural description, despite the deep and esoteric theories that undergird such interventions.

The following is an intervention from self-psychology, taken from the Narcissistic—Compensatory chapter:

Interpret the underlying grandiosity and disappointment when the client falls short in an effort, connecting the client’s affective experience to his/her wishes and needs. Help him/her transform it into something realistic (e.g., “When they went with someone else’s idea, you felt massively disappointed and deflated; you wanted them to think your idea was wonderful and would

save the day, and when they rejected it you felt defeated and empty”). See “Using Self Psychology in Brief Psychotherapy” (Gardner) and “Speaking in the Interpretive Mode and Feeling Understood: Crucial Aspects of the Therapeutic Action in Psychotherapy” (Ornstein & Ornstein).

The analysis of the transference is a broadly applicable intervention for psychodynamic work; the next quote is taken from the Borderline chapter. The technique is not specific to Transference-Focused Psychotherapy (TFP), but the example here refers to that approach.

When the client becomes angry with the therapist, process the feelings, noting similarities between the therapeutic relationship and other important relationships in the client’s life. Work collaboratively toward an appropriate resolution of the angry feelings (see *Transference-Focused Psychotherapy for Borderline Personality Disorder* by Clarkin, Yeomans, and Kernberg).

We also encourage the reader to note the use of Acceptance and Commitment Therapy (ACT) across many of the personality disorders. ACT is quite nonspecific; it is not driven by specific symptoms but rather by the ability to sit with the discomfort of a particular situation or feeling. Thus, we were able, across the various chapters, to create a fairly complete set of ACT interventions.

Similarly, we encourage clinicians of any of the listed theoretical orientations to skim the book to find examples of the interventions they wish to use. For example, Motivational Interviewing is used heavily in the Passive-Aggressive/Negativistic chapter; Exposure Therapy is included in the Obsessive-Compulsive chapter. Those interventions could be adapted for use with any of the personality disorders, as relevant.

Evidence-Based Practice

It is beyond the scope of this introduction to do a comprehensive review of Evidence-Based Practice (EBP) for personality disorders. In preparation for this volume, the lead author (NB) reviewed a number of studies. Ultimately, we relied primarily on the wisdom embodied in Jeffrey Magnavita’s (2010) *Evidence-Based Treatment of Personality Dysfunction* and a systematic review by Sneed and his colleagues (Sneed, Fertuck, Kanellopoulos, & Culang-Reinlieb, 2012). Magnavita’s volume emphasizes the use of the best available evidence and the creative use of appropriate treatments, which we applied to the personality disorders other than borderline; for borderline personality disorders, evidence-based treatments are available. One other study also was particularly noteworthy. Bamelis, Evers, Spinhoven, and Arntz (2014) randomly assigned a group of 323 individuals who, collectively, had a wide array of personality disorders to either Schema Therapy or to one of two control groups (treatment as usual or clarification-oriented psychotherapy). In general, the results of the study supported the use of Schema Therapy.

For Borderline Personality Disorder, four therapies are considered evidence-based, depending on where the cutoff for the number and type of studies required to be considered EBP is drawn. Dialectical Behavior Therapy (DBT), with at least 11 randomized controlled trials supporting its use, is clearly established as efficacious. Mentalization Therapy is considered probably efficacious. Transference-Focused Psychotherapy (TFP) is considered probably efficacious and is seen by many as having mixed findings (it had one strong finding but performed less well than Schema Therapy in another study). Experts in TFP, however, contest the results of the comparison with Schema Therapy, noting that the TFP therapists were not adequately trained and did not add elements specific to TFP (which differentiate it from standard psychodynamic therapy) into the protocol. We are taking the position that TFP is currently probably efficacious and warrants further study. Finally, Schema Therapy was considered probably efficacious. These EBP designations rely on the review by Sneed et al. (2012). However, the Bamelis et al. (2014) study came out after that review and could be enough to push Schema Therapy up to efficacious. We will leave such assessments to others.

For purposes of this volume, we use the EBP symbol, ∇^{EB} , for interventions that attain both the efficacious and probably efficacious level. We reason that, given the paucity of evidence-based practices and the binary system to which this volume adheres (i.e., evidence based or not), it is best to guide readers toward that which has a probably efficacious level rather than interventions that are considered best practice with lesser evidence. Therefore, DBT, TFP, Schema Therapy (also known as Schema Focused Therapy) and Mentalization all receive the ∇^{EB} symbol. Encouraged by the results of the Bamelis study and hopeful that it will someday be EBP for all personality disorders, we have included Schema Therapy in each of the chapters.

HOW TO USE THIS TREATMENT PLANNER

Use the Wiley *Treatment Planner* to write treatment plans according to the following progression of six steps:

1. **Problem Selection.** Although the client may discuss a variety of issues during the assessment, the clinician must determine the most significant problems on which to focus the treatment process. Usually a primary problem will surface; secondary problems may also be evident. Some other problems may have to be set aside as not urgent enough to require treatment at this time. An effective treatment plan can deal only with a few selected problems, or treatment will lose its direction. Choose the problem within this *Planner* that most accurately represents your client's presenting issues.

14 THE PERSONALITY DISORDERS TREATMENT PLANNER

2. **Problem Definition.** Each client presents with unique nuances as to how a problem behaviorally reveals itself in his or her life. Therefore, each problem that is selected for treatment focus requires a specific definition about how it is evidenced in the particular client. The symptom pattern should be associated with diagnostic criteria and codes, such as those found in the *DSM-5* or the International Classification of Diseases (ICD). This *Treatment Planner* offers such behaviorally specific definition statements to choose from or to serve as a model for your own personally crafted statements.
3. **Goal Development.** The next step in developing your treatment plan is to set broad goals for the resolution of the target problem. These statements need not be crafted in measurable terms but can be global, long-term goals that indicate a desired positive outcome to the treatment procedures. This *Treatment Planner* provides several possible goal statements for each problem, but one statement is all that is required in a treatment plan.
4. **Objective Construction.** In contrast to long-term goals, objectives must be stated in behaviorally measurable language so that it is clear to review agencies, health maintenance organizations, and managed care organizations when the client has achieved the established objectives. The objectives presented in this *Treatment Planner* are designed to meet this demand for accountability. Numerous alternatives are presented to allow construction of a variety of treatment plan possibilities for the same presenting problem.
5. **Intervention Creation.** Interventions are the actions the clinician takes to help the client complete the objectives. There should be at least one intervention for every objective. If the client does not accomplish the objective after the initial intervention, new interventions should be added to the plan. Interventions should be selected on the basis of the client's needs and strengths and the treatment provider's full therapeutic repertoire. This *Treatment Planner* contains interventions from a broad range of therapeutic approaches, and we encourage the clinician to write other interventions reflecting his or her own training and experience. Some suggested interventions listed in the *Planner* refer to specific books that can be assigned to the client for adjunctive bibliotherapy. Appendix B contains a full bibliographic reference list of these materials, including these three popular choices: *The Stress Reduction and Relaxation Workbook* (Davis, Eschelman, and McKay, 2008), *The Dialectical Behavior Therapy Skills Workbook* (McKay, Wood, and Brantley, 2007), and *Wherever You Go, There You Are* (Kabat-Zinn, 1994).
6. **Diagnosis Determination.** The determination of an appropriate diagnosis is based on an evaluation of the client's complete clinical presentation. The clinician must compare the behavioral, cognitive, emotional, and interpersonal symptoms that the client presents with the criteria for diagnosis of a mental illness condition as described in *DSM-5*. Despite

arguments made against diagnosing clients in this manner, diagnosis is a reality that exists in the world of mental health care, and it is a necessity for third-party reimbursement. The clinician's thorough knowledge of *DSM-5* criteria and complete understanding of the client assessment data contribute to the most reliable, valid diagnosis.

Congratulations! After completing these six steps, you should have a comprehensive and individualized treatment plan ready for immediate implementation and presentation to the client. A sample treatment plan for borderline personality disorder (self-destructive subtype) is provided at the end of this introduction.

A FINAL NOTE ON TAILORING THE TREATMENT PLAN TO THE CLIENT

One important aspect of effective treatment planning is that each plan should be tailored to the individual client's problems and needs. Treatment plans should not be mass-produced, even if clients have similar problems. The individual's strengths and weaknesses, unique stressors, social network, family circumstances, and symptom patterns must be considered in developing a treatment strategy. Drawing on our own years of clinical experience and the best available research, we have put together a variety of treatment choices. These statements can be combined in thousands of permutations to develop detailed treatment plans. Relying on their own good judgment, clinicians can select the statements that are appropriate for the individuals whom they are treating. We encourage readers to add their own definitions, goals, objectives, and interventions to the existing samples.

CONCLUSION

We hope that you find *The Personality Disorders Treatment Planner, Second Edition*, to be a useful guide not only for the creation of accurate and appropriate documentation but as a form of brainstorming about cases that often present difficult psychotherapeutic challenges—individuals with personality disorders. As with all of the volumes in the *Treatment Planner* series, it is our hope that this book will help promote effective, creative treatment planning—a process that will ultimately benefit the client, the clinician, and the mental health community.

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SAMPLE TREATMENT PLAN

PROBLEM: BORDERLINE—SELF-DESTRUCTIVE

- Definitions:** Has punitive feelings (anger and guilt) toward self.
 Feels hopeless, helpless, and powerless.
 Has history of conforming, deferential, and ingratiating behavioral patterns.
 Makes frequent suicidal gestures or threats or mutilates himself/herself.
- Goal:** Decrease suicidal and/or self-mutilating behavior.

OBJECTIVES

1. Identify sources of feelings of dissatisfaction with self and others.
2. Express trust in the relationship with the therapist, either verbally or nonverbally.
- ▼ 3. Verbalize an understanding of therapist's policy regarding self-destructive behavior.

INTERVENTIONS

1. Assist the client in developing a list of specific dissatisfactions he/she is currently experiencing, such as feelings of helplessness, hopelessness, or suicidal ideation.
1. Explicitly acknowledge the client's difficulty with trust; reinforce any expressions of trust in the therapist.
2. Express self in a clear, straightforward fashion, free from jargon that could be misinterpreted by the client.
3. Clarify to the client that he/she need not talk about sensitive issues until ready to do so.
1. Express the expectation that the client will control his/her response to the urge to self-mutilate or suicide; contract with the client not to engage in self-harm between sessions (or assign "No Self-Harm Contract" in the *Adult Psychotherapy Homework Planner* by Jongsma). ▼

▼ Indicates that selected Objectives/Interventions are consistent with those found in evidence-based treatments.

- ▼ 4. Identify the reasons for suicidal ideation and/or self-mutilating behavior and the factors in the present environment that reward self-harmful ideas and actions.
- ▼ 5. Decrease frequency of or eliminate suicidal gestures, threats, and attempts and increase hopeful statements about life and the future.
- ▼ 6. Report situations in which increased capacity to cope with stress was demonstrated.
1. Express compassion for the client's pain that leads to suicidal ideation and/or self-injurious behavior. Use active listening to understand the depth of pain and suffering experienced by the client from his/her point of view. ▼
 2. Once the therapist fully understands the pain that leads the client to want to die, examine the suicide attempt/gesture as a form of communication (e.g., a message to a significant other, a message to the world). Explore secondary gains received from such behavior (e.g., attention from significant others or medical staff, being taken seriously). ▼
1. When the therapist fully understands the pain that leads the client to want to die, process reasons that the client wants to live (or assign "Strategies to Resist Suicidal Thoughts and Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); help the client draw strength and specific treatment goals from this list. ▼
 2. Assess with the client the negative consequences of suicidal behavior/gestures on his/her long-term goals (or assign "The Aftermath of Suicide" in the *Adult Psychotherapy Homework Planner* by Jongsma); explore alternate ways to get the short-term relief provided by suicidal and parasuicidal behavior. ▼
1. Train the client to use meditation (e.g., thought-watching exercise) by assigning *Full Catastrophe Living* (Kabat-Zinn) or *How to*

Meditate (LeShan), processing key concepts in a session; demonstrate the technique during the session, and assign practice as homework. Refer to a Mindfulness-Based Stress Reduction program if available locally. ^{EB}▽

2. Provide the client with relaxation training utilizing progressive muscular relaxation, self-hypnosis, autogenics training, and/or visualization (or assign “Progressive Muscle Relaxation” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); tell the client to use these techniques at times of stress. ^{EB}▽
7. Reduce the frequency of distorted, negative thoughts that lower self-esteem.
1. Assign the client to keep a record of dysfunctional thoughts associated with the Defectiveness/Shame schema, such as “I’m bad and should be punished” and “I’m evil and horrible.” Using Socratic dialogue, challenge the client to examine the evidence for and against such statements and find more balanced beliefs, such as “Everyone makes mistakes” and “I can be forgiving toward both others and myself” (or assign “Journal of Distorted, Negative Thoughts” in the *Adult Psychotherapy Homework Planner* by Jongsma). If the client becomes dysregulated, encourage him/her to use emotion regulation or mindfulness skills to recover emotional balance. ^{EB}▽

- ▽ 8. Express anger in a healthy fashion rather than becoming enraged at self.
1. Process the use of relevant Dialectical Behavior Therapy skills—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and/or Distress Tolerance—in an individual session. Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley and/or *DBT Diary and Skills Coach (Durham DBTCards, app)*. ▽

DIAGNOSTIC SUGGESTIONS

ICD-9-CM
301.83

ICD-10-CM
F60.3

Borderline Personality Disorder

AGGRESSIVE/SADISTIC

BEHAVIORAL DEFINITIONS

1. Uses cruelty or violence to establish dominance in social relationships.
2. Publicly degrades or torments others (or takes part in public degradation or humiliation of others).
3. When in a position of power, uses authority to exploit, punish, or persecute others under his/her control.
4. Delights in causing or contributing to the physical or psychological suffering of others (including animals).
5. Engages in deception for the sole purpose of harming, coercing, or inflicting pain on others.
6. Uses intimidation and other fear tactics to obtain desired results and/or meet needs in interpersonal situations.
7. Is highly controlling and/or restrictive of those with whom he or she has a close relationship.
8. Fascinated by instruments and acts of violence, such as weapons, martial arts, injury, or torture.

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LONG-TERM GOALS

1. Reduce hostile, aggressive, belligerent behavior, including both verbal and physical abuse.
2. Decrease humiliation of others.

3. Treat others under his/her authority fairly and with dignity.
4. Discontinue intentionally harming others.
5. Use healthy means to influence others, such as assertiveness and negotiation, rather than rage, intimidation, or terrorizing.
6. Refrain from lying for the purpose of hurting others.
7. Be comfortable with close others having appropriate autonomy.
8. Improve capacity to see how own behaviors are harmful to others.
9. Establish at least one relationship that involves, at minimum, a modest degree of mutuality, empathy, and trust.
10. Let go of, or sublimate, unhealthy fascination with injury and torture.

SHORT-TERM OBJECTIVES

1. Express satisfaction with the therapeutic relationship as indicated by the verbalization of difficulties and concerns.
(1, 2)

2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship.
(3, 4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Establish goals based on the client’s perceived needs, and closely tie discussions to the client’s goals.
2. Express to the client an interest in hearing his/her side of the story that explains his/her argumentative or aggressive behavior.
3. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a

- concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).
4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 5. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
 6. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
 7. Establish a list of goals of treatment, such as to get greater cooperation from others, to discontinue conflicts with authority, to discontinue legal problems due to violence,
3. Establish specific treatment goals. (7)

4. Establish a trusting relationship with the therapist. (8, 9, 10)
5. Reduce hostile, aggressive, belligerent behavior, including both verbal and physical abuse. (11, 12)
6. Express appropriate displeasure or anger toward a person who is critical or generates frustration rather than becoming enraged or vengeful. (13, 14)
- to get better performance evaluations at work, and/or to have more satisfying interpersonal relationships.
8. Express the practical advantages of participating in the psychotherapeutic relationship, such as the opportunity to learn how to get his/her needs met more effectively in the context of the present system (e.g., hospital or prison) or in relationships.
9. Accurately empathize but avoid appearing weak or soft in the client's eyes by refraining from asking directly about his/her feelings and emotions early in the treatment.
10. Enter into the client's worldview by expressing that respect in the therapeutic relationship must be earned.
11. Use Open-ended questions, Affirmations, Reflections, and Summaries (OARS) to establish a therapeutic alliance and begin discussion about change (see *Motivational Interviewing* by Miller and Rollnick).
12. Use motivational interviewing strategies to assess and encourage motivation for change, noticing "change talk," such as Desire, Ability, Reason, and Need for Change, as well as Commitment, Activation, and Taking steps to change (DARN-CAT).
13. Conduct or refer the client to Dialectical Behavior Therapy Skills Training groups—Core Mindfulness, Interpersonal Effectiveness, Emotion

Regulation, and Distress Tolerance—in order to teach the client how to balance and regulate emotions and interact well with others (see *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan). Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley and/or DBT Diary and Skills Coach (Durham DBT, app).

14. Process the use of relevant Dialectical Behavior Therapy skills—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and/or Distress Tolerance—in an individual session. Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* (McKay, Wood, and Brantley) and/or DBT Diary Card and Skills Coach (Durham DBT, app).
7. Decrease or eliminate the use of violence for purposes of intimidation or humiliation. (15)
15. Discuss the history of consequences the client has had with violent encounters (or assign “Anger Journal” in *The Adult Psychotherapy Homework Planner* by Jongsma); process whether the consequences are consistent with the client’s goals at this time. Emphasize the positive aspects (e.g., if client says he/she usually gets his/her way), followed by questions such as “So why would you want to change?” thus encouraging the client to enumerate the reasons he/she is motivated to change (see *Motivational Interviewing* by Miller and Rollnick).

8. Decrease or eliminate humiliation of others. (16)
9. Discontinue intentionally harming others. (17)
10. Engage in respectful relations with superiors. (18)
16. Teach the concept of “self-fulfilling prophecy” and how humiliating others elicits enmity from them, which then leads to more attacks and counterattacks. Discuss how to break the cycle using assertive (and, if the client is ready, empathic) communication (see *Disorders of Personality* by Millon).
17. Use rational emotive therapy to replace extreme beliefs associated with the Punitiveness schema (e.g., “That jerk was disrespecting me and I’m going to teach him a lesson” or “She deserves to be humiliated”) with more balanced ones (e.g., “He is being disrespectful, but who cares, I’m going to follow my own agenda” or “She may have made a mistake”). Support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko (see *Schema Therapy* by Young, Klosko, and Weishaar).
18. Use simple and complex reflections to unearth ambivalence and encourage and guide change-based statements (e.g., when the client says, “I am ready to be assertive with my boss rather than trying to intimidate her,” “You are planning to be more assertive with her,” or “You are feeling confident that you can develop a healthier, more balanced relationship with your boss.”). Further encourage change talk by asking for additional elaboration and details.

28 THE PERSONALITY DISORDERS TREATMENT PLANNER

11. Verbalize that demeaning statements and verbal abuse are harmful to desired relationships. (19, 20)
12. Acknowledge having hurt another person emotionally and/or physically or having caused undeserved harm. (21)
13. Express regret or sorrow about having hurt another person's feelings or having caused undeserved harm. (22, 23)
19. Review the client's pattern of verbal abuse and confront rationalizations that the verbal abuse was deserved and that there was no other option; label verbal abuse as such and initiate a zero-tolerance policy within therapy sessions, at an inpatient unit, and/or within the client's family.
20. Point out the client's use of demeaning statements and attempts at intimidation when they are directed toward the therapist; explore the purpose of the communication and its effects. Set limits on the use of demeaning and abusive behavior in therapy.
21. Challenge the client's rationalizations about hurting others, such as the belief that hitting someone didn't really hurt them or that words cannot harm anyone, replacing irrational beliefs with more balanced ones, such as that hitting someone virtually always produces harm; most people get angry or sad in response to others' cruel words (or assign "How I Have Hurt Others" in the *Adult Psychotherapy Homework Planner* by Jongsma).
22. In a psychodrama, group, or individual session, with the therapist (or a group member) playing the client, ask the client to play the person who was hurt or intimidated (role reversal). Continue the intervention until the client achieves emotional identification with the victim

- (or assign “Letter of Apology” in the *Adult Psychotherapy Homework Planner* by Jongsma).
23. Train the client to use meditation (e.g., thought-watching exercise) by assigning *Wherever You Go, There You Are* (Kabat-Zinn) or *How to Meditate* (LeShan), processing key concepts with therapist; demonstrate technique during session and assign practice as homework. Refer to a Mindfulness-Based Stress Reduction program, if available.
 14. Use healthy means to influence others, such as assertiveness and negotiation rather than intimidation or terrorizing. (24, 25)
 24. Assign readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons) to the client; discuss the key points. Emphasize how assertiveness, not aggressiveness, is a tool to increase compliance with requests and get needs met over long periods of time (or assign “Becoming Assertive” or “Assertive Communication of Anger” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 25. Use role-play, modeling, and behavioral rehearsal with the client to simulate situations that demand assertiveness; provide feedback regarding the appropriateness of his/her responses.
 15. Treat others under his/her authority fairly and with dignity. (26, 27)
 26. Assign *Good Boss, Bad Boss* by Sutton; process key ideas regarding how cruelty leads to poor worker performance and how attuned leadership leads to excellence.
 27. Utilize interpersonal effectiveness skills from

30 THE PERSONALITY DISORDERS TREATMENT PLANNER

16. Express regret at lying to hurt another person; endeavor to refrain from doing so in the future. (28)
17. Be comfortable with a family member (e.g., spouse, child) having appropriate autonomy rather than being restricting and controlling towards him/her; acknowledge the fears underlying the controlling behavior. (29, 30)
18. Report an instance of being open and self-disclosing in at least one relationship. (31, 32, 33)
28. Explore the meaning of repetition compulsion with the client, connecting current aggressive behavior (e.g., using physical or verbal intimidation or lying to cause emotional pain) with wounds from the past.
29. Explore with the client's significant others the themes of rejection and distancing, encouraging each family member to examine his/her own emotions and how defensiveness against pain and fear of vulnerability contribute to the distancing and reduction of intimacy that occurs. Acknowledge the fears underlying the controlling behavior, such as fear of abandonment or humiliation. Take into account both partners' attachment style (e.g., using the Adult Attachment Scale or the Attachment Style Questionnaire). Support with bibliotherapy, such as *Love Sense* (Johnson) (see also *The Practice of Emotionally Focused Couple Therapy* by Johnson).
30. Process the client's difficulties in allowing autonomy to his/her children. Relate the client's difficulties to his/her fear regarding loss of control. Process individually or with partner/spouse initially, then bring in the affected child(ren) as needed.
31. Confront the client's detachment from tender feelings (e.g., caring, empathy, sadness, compassion, guilt) as a protection from his/her own pain endured in dialectical behavior therapy to improve work relationships.

- childhood. Explore the consequences of the pattern of detachment, including the self-fulfilling prophecy of self-protection from pain leading to isolation and thus greater pain.
32. Frame change (behavioral experiments) in terms of the client's natural boldness (e.g., "So it sounds like there is potentially a big gain to being more open, but there is a big risk of being humiliated. It will take courage to see this through. Are you up for it?").
 33. Encourage the client to view choosing to engage with others differently (without aggression; with compassion) as a "bold move" that he/she must be willing to take; consider using applied willingness techniques, such as the "jump exercise" (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson); or assign "Letter of Apology" in the *Adult Psychotherapy Homework Planner* by Jongsma).
 19. Express empathy for another person. (34, 35)
 34. Express accurate empathy and unconditional positive regard for the client, allowing him/her to learn by example.
 20. Develop socially appropriate outlets for hostile impulses rather than acting them out. (36)
 35. Assign the client to read *Empathy* (Krznaric); process key ideas.
 36. Brainstorm about activities that will allow the client to sublimate hostility and competitiveness into socially acceptable outlets (such as sports, academic pursuit of the topic of torture, or advocacy to stop torture). Integrate ideals, such as

32 THE PERSONALITY DISORDERS TREATMENT PLANNER

- sportsmanship and teamwork, into the intervention. Process with the client the temptation to become overly aggressive or obsessed and the negative consequences that result.
21. Verbalize acceptance of having limits set by the therapist and/or significant others. (37)
 22. Provide alternative positive or neutral explanations for others' behavior rather than assuming that they are motivated by malice. (38, 39, 40)
 37. Set boundaries on the therapy relationship (e.g., set boundaries regarding intimidating behavior, noting its presence and purpose and how it will not work in this context) and process them with the client (e.g., the negative impact it has on relationships). Explore how this interaction generalizes to other important relationships in the client's life.
 38. Explore the client's negative projections about others' motives, such as assuming malicious intent, including the therapist (if applicable). Identify how the client's negative assumptions relate to interactions with others in the client's past (e.g., early interactions with parents).
 39. Brainstorm with the client about alternative positive or neutral explanations for others' behavior (or assign "Check Suspicions Against Reality" in the *Adult Psychotherapy Homework Planner* by Jongsma); encourage the client to identify evidence for and against each belief, thereby assessing its likelihood.
 40. Encourage the client to describe experiences in prison and the rules of prison culture (e.g., how a sign of weakness can lead to physical or mental brutalization). Challenge the client to experiment with different kinds of

- relationships outside of prison settings, providing training on how to recognize trustworthiness in others.
23. Verbalize beliefs that will encourage the maintenance of long-term relationships. (41)
 24. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (42)
 25. Take medications as prescribed, and report on effectiveness and side effects. (43)
 26. Verbalize how being a victim of emotional, verbal, and/or physical abuse affects current relationships and attitudes. (44, 45)
 41. Explore the client's beliefs regarding intimate relationships associated with the Mistrust/Abuse schema (e.g., that you can't trust anyone, that everyone will take advantage of you if they can). Challenge the ideas using rational emotive techniques, replacing unrealistic ideas with more flexible and realistic ones (e.g., most people can be trusted to some degree; everyone has faults; some people can sincerely help others, at least some of the time).
 42. Refer the client to a physician for an evaluation for medication to reduce irritability and hyper-reactivity. Help the client process costs and benefits of a psychiatric evaluation.
 43. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.
 44. Explore the client's history of abuse and family hostility (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner* by Jongsma); relate these experiences to current feelings of anger, distrust, need to control, and intimidating behavior.

45. Process with the client how abuse from others leads to abusive behavior. Discuss the pain caused to everyone by this cycle. Suggest methods for breaking the cycle.

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
312.34	F63.81	Intermittent Explosive Disorder
301.7	F60.2	Antisocial Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

ANTISOCIAL*

BEHAVIORAL DEFINITIONS

1. Persistently breaks the law.
2. Is deceitful, and uses aliases, lies, or cons people to get what is wanted.
3. Acts on impulse, without giving much thought to future consequences.
4. Is aggressive and irritable, with a history of fights or assaults.
5. Engages in reckless behaviors that create dangerous situations for self or others.
6. Is irresponsible with regard to work, financial, and family obligations.
7. Lacks remorse, as shown by indifference to (or rationalizing of) harm he/she has caused.
8. Has a history of antisocial behaviors (rule breaking, lying, physical aggression, disrespect for others and property, substance abuse, etc.) since adolescence.

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LONG-TERM GOALS

1. Demonstrate increased sensitivity to the needs of others rather than displaying only selfish concerns.
2. Improve impulse control and reduce reckless, shortsighted behavior.

*Appendix A elaborates on the dimensional structure for behavioral definitions.

3. Decrease excessive anger and irritability while learning to handle everyday anger appropriately.
4. Learn to view affection and cooperation positively.
5. Exhibit interpersonally responsible conduct.
6. Accept that ordinary rules of law and conduct apply to everyone.

SHORT-TERM OBJECTIVES

1. Express satisfaction with the therapeutic relationship as indicated by the verbalization of difficulties and concerns. (1, 2)

2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Express interest in hearing the client's side of the story even though he/she may have been referred due to argumentative or aggressive behavior that the therapist is interested in hearing the client's side of the story.
2. Under appropriate circumstances, engage in humorous interchanges with the client and appropriately compliment positive uses of humor (e.g., by stating "That was a good one!" or the like).
3. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to

address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
5. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of his/her behavior.
6. Assess for the severity of impairment to the client’s functioning to determine the appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment and the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
3. Establish specific treatment goals. (7, 8)
7. Assist the client in developing a list of specific dissatisfactions he/she is currently experiencing, such as difficulties with the law, inability to sustain an apartment

- or obtain sufficient income, and difficulty sustaining relationships.
4. Establish a trusting relationship with the therapist, as demonstrated by freely sharing information. (9, 10, 11)
 5. Express appropriate displeasure or anger toward a person who generates disappointment rather than becoming enraged or violent. (12, 13)
 8. Express the practical advantages of participating in the psychotherapeutic relationship, such as the opportunity to learn how to get his/her needs met more effectively in the context of the current system (e.g., parole, hospital, or prison) or in relationships.
 9. Express thoughts in extremely straightforward language, eliminating all jargon and complexities that could be perceived as double-talk.
 10. If the client shares feelings, vulnerabilities, or admits mistakes, compliment him/her (e.g., “It took real strength to tell it like it is” or “Most people wouldn’t have had the guts to admit that . . . that was impressive”).
 11. When appropriate, comment on the client’s facility with deception and lying, noting that he/she will be able to con the therapist at least some of the time. Process the pros and cons of being deceptive toward therapist (see *Cognitive Therapy of Personality Disorders* by Beck, Davis, and Freeman).
 12. Discuss the impact of the demands of criminal culture (i.e., the need to avoid showing vulnerability or weakness and/or the ability to respond to violence with violence) on the client’s current behavior; explore how the current situation (e.g., work

- environment, hospital, or therapy session) is sufficiently different to warrant a new approach.
6. Express appropriate displeasure or anger toward a person who generates frustration rather than becoming enraged or vengeful. (14, 15, 16, 17)
 13. Instruct the client to imagine that the person who disappointed him/her is in an empty chair in the room. Direct the client to express his/her feelings to the imagined person while continuing to increase the intensity of the reaction until anger is experienced and then released or relieved.
 14. Teach the client mindfulness skills to assist him/her with becoming a neutral observer of thoughts and feelings without immediately buying into or acting on them. Engage the client in the “Mind Watching” exercise to demonstrate this process (see *The Mindfulness and Acceptance Workbook for Anxiety* by Forsyth and Eifert).
 15. Help the client understand ways to cope with angry feelings to avoid rage or violence (or assign “Alternatives to Destructive Anger” or “Assertive Communication of Anger” in the *Adult Psychotherapy Homework Planner* by Jongsma); assign the client to read *Beyond Anger* by Harbin and/or *The Anger Control Workbook* by McKay and Rogers; process key ideas.
 16. Explore experiences of abuse in childhood and discuss forgiveness of perpetrators of pain as a process of letting go of anger (or assign “Feelings and Forgiveness Letter” in the *Adult Psychotherapy Homework Planner* by Jongsma).

7. Verbalize acceptance to having limits set by the therapist and/or significant others. (18)
8. Verbalize disadvantages of unlawful behavior. (19)
9. List difficulties in forming intimate attachments in prior relationships. (20)
10. Express accurate empathy regarding the feelings of a significant other. (21)
17. Use rational emotive therapy to replace extreme beliefs associated with the Punitiveness schema, such as “That jerk was disrespecting me and I’m going to teach him a lesson” with more balanced ones like “He is being disrespectful, but who cares, I’m going to follow my own agenda” or “He may have made a mistake” (or assign “Crooked Thinking Leads to Crooked Behavior” in the *Adult Psychotherapy Homework Planner* by Jongsma).
18. Set boundaries on the therapy relationship (e.g., refuse to extend credit or delay payments, decline sexual advances, decline meeting on a social basis), and process them with the client.
19. Develop discrepancy using a double-sided reflection, such as: “It sounds like on one hand you value your freedom to do as you like, while on the other hand getting in trouble with the law for doing some of those things limits your freedom” (see *Motivational Interviewing* by Miller and Rollnick).
20. Discuss the client’s early relationship with parents, exploring themes of abandonment or abuse. Explore how these early experiences are impacting his/her ability to be close to others.
21. Hold a family therapy session, and encourage the client to persist in rewording and reflecting back the communication of the family member, until the family

- member agrees that the communication is accurate.
11. Describe disadvantages of exploitive behavior. (22)
 12. Describe instances in which acting on impulse has led to negative outcomes that were not worth it. (23)
 13. List the pros and cons of an action before making a decision rather than acting on impulse. (24)
 14. Verbalize the disadvantages of dishonesty. (25)
 22. Assist the client to make a list of pros and cons of behaviors that exploit others (e.g., inflating someone's expectations regarding commitment in a relationship in order to obtain sex, borrowing money without repaying it), assessing long-term versus short-term consequences (or assign "How I Have Hurt Others" in the *Adult Psychotherapy Homework Planner* by Jongsma).
 23. Assist the client in making a list of instances in which acting on impulse had negative results (or assign "Impulsive Behavior Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma).
 24. Instruct the client to evaluate choices using the "Choice Review" exercise: Have the client list a problem, come up with a range of possible solutions, and then select from among those choices based on what is most consistent with his/her goals (or assign "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma). See *Cognitive Therapy of Personality Disorders* by Beck, Freeman, Davis, and Associates.
 25. Review with the client the costs associated with dishonesty (e.g., loss of trust, loss of self-esteem, legal complications, lies to cover lies, disappointment of others who have been lied to, etc.); urge

42 THE PERSONALITY DISORDERS TREATMENT PLANNER

- him/her to recall instances when lying has had bad results.
15. Verbally acknowledge and express regret that his/her sexually exploitive behavior was hurtful to another person. (26)
 16. Provide alternative positive or neutral explanations for others' behavior rather than assuming that they are motivated by envy or malice. (27, 28)
 17. Verbalize beliefs that will encourage the maintenance of long-term relationships. (29, 30)
 26. During an individual, group, or psychodrama session, use the role-reversal technique to demonstrate to the client the impact of sexual exploitation (e.g., demanding sex from a subordinate, misleading someone to obtain sexual gratification). Continue the intervention until the client achieves emotional identification with the victim (or assign "Looking Closer at My Sexual Behavior" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
 27. Explore the client's projections about others, including the therapist (if applicable). Identify how the client's negative assumptions relate to interactions with others in the client's past (e.g., early interactions with parents).
 28. Brainstorm with the client about alternative positive or neutral explanations for others' behavior (or assign "Check Suspicions Against Reality" in the *Adult Psychotherapy Homework Planner* by Jongsma); encourage the client to identify evidence for and against each belief, thereby assessing their likelihood.
 29. Explore the client's beliefs regarding intimate relationships associated with the Mistrust/Abuse schema (e.g., that you can't trust anyone, that everyone is out for themselves).

- Challenge the ideas using rational emotive techniques, replacing unrealistic ideas with more flexible and realistic ones (e.g., most people can be trusted to some degree; everyone has faults; some people can sincerely help others, at least some of the time). See *Schema Therapy* by Young, Klosko, and Weishaar.
18. Verbalize a warm or tender feeling for another person. (31)
 19. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (32)
 20. Take medications as prescribed, and report on the medications' effectiveness and side effects. (33)
 30. Explore the client's fantasies regarding intimate relationships (e.g., that others are planning to exploit him/her). Explore how these fantasies relate to early childhood relationships and/or the relationship with the therapist. Suggest more realistic, positive beliefs about others.
 31. Point out that the pattern of emotional detachment in relationships and self-focused behavior is related to a dysfunctional attempt to protect the self from pain. Encourage the client to express vulnerable feelings of caring for another person.
 32. Refer the client to a physician for an evaluation for medication to reduce irritability and hyperreactivity. Help the client to process costs and benefits of a psychiatric evaluation.
 33. Monitor the client's use of medications, for effectiveness, side effects, and for compliance with prescription. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.

44 THE PERSONALITY DISORDERS TREATMENT PLANNER

21. Express readiness to attend group therapy. (34)
22. Each family member or partner identifies and reduces interactions within the family that serve to perpetuate the client's manipulative/exploitive behavior. (35)
23. Share personal information or a secret with a friend or significant other. (36)
24. Identify history of conflict with those in authority. (37)
34. Instruct the client about how therapy groups operate and how this may feel unfair to him/her (e.g., all group members must be given an opportunity to speak, everyone's problems are considered equally important, excessive aggression toward other group members will not be tolerated, and regular attendance is critical to the group). Process these themes with the client, and determine his/her readiness to participate in group therapy.
35. Assist family members in identifying behaviors that reinforce the client's manipulative/exploitive behaviors (e.g., efforts to obtain prescription medication from family members, borrowing money with no intention of paying it back). Write a behavioral contract that allows each participant to get his/her needs met more directly (e.g., praise given in response to assertive behavior rather than manipulations).
36. Process the client's fear of becoming intimate with another person, exploring themes such as fear that once he/she is known by the other person, exploitation and betrayal will follow. Assign the task of sharing personal information with someone he/she could trust.
37. Explore the client's history of conflict with authority; relate this to early experiences of pain, rage, and disappointment with parents/ caretakers.

25. List changes necessary to improve cooperation with authority figures. (38)
26. Describe instances in childhood of emotional, verbal, and/or physical abuse. (39)
27. Acknowledge failure to act responsibly toward offspring. (40, 41)
28. Acknowledge own responsibility for poor judgement. (42)
38. Ask the client to make a list of behaviors and attitudes that he/she must modify in order to decrease his/her conflict with authorities. Process the list with the client.
39. Explore the client's history of abuse and neglect (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner* by Jongsma); relate these experiences to current feelings of anger, distrust, and self-centeredness.
40. Confront the client's avoidance of responsibilities toward his/her children.
41. Ask the client to list three actions that he/she could take that would demonstrate responsibility toward his/her offspring (writing a letter to them, sending money for their support, attending work faithfully to increase income for their support, attending a child's school function, etc.).
42. When the client blames others, persistently ask, "And then what did *you* do?" and similar questions (or assign "Accept Responsibility for Illegal Behavior" in the *Adult Psychotherapy Homework Planner* by Jongsma); continue until the client achieves increased awareness of his/her responsibility in the matter (see *Tactics in Counseling and Psychotherapy* by Mosak and Maniacci).

46 THE PERSONALITY DISORDERS TREATMENT PLANNER

29. Attend work reliably and treat supervisor and coworkers with respect. (43, 44)
43. Review the history of and causes for the client's employment instability. Confront his/her minimization and projection of responsibility for problems.
44. Assist the client in listing changes necessary to improve employment behavior such as consistent work attendance, calm problem-solving tactics, and appropriate behavior toward his/her superior (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Treatment Planner* by Jongsma).
Brainstorm ways to implement these changes.

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
03.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
305.20	F12.10	Cannabis Use Disorder, Mild
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
305.60	F14.10	Cocaine Use Disorder, Mild
305.70	F15.10	Amphetamine Use Disorder, Mild
304.40	F15.20	Amphetamine Use Disorder, Moderate or Severe
305.50	F11.10	Opioid Use Disorder, Mild
304.00	F11.20	Opioid Use Disorder, Moderate or Severe

305.90	F18.10	Inhalant Use Disorder, Mild
304.60	F18.20	Inhalant Use Disorder, Moderate or Severe
312.34	F63.81	Intermittent Explosive Disorder
314.00	F90.0	Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Presentation
305.60	F14.10	Cocaine Use Disorder, Mild
314.01	F90.1	Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Presentation
312.31	F63.0	Gambling Disorder
301.7	F60.2	Antisocial Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

ANTISOCIAL—MALEVOLENT

BEHAVIORAL DEFINITIONS

1. Is belligerent and at times vicious, brutal, and violent.
2. Is resentful and distrustful of authority figures.
3. Anticipates betrayal and punishment from others.
4. Lacks the capacity to experience guilt.
5. Is callous, fearless, impulsive, and often commits unlawful acts.
6. Displays self-serving, manipulative, deceitful, and uncooperative attitudes and behaviors.
7. Is irresponsible, failing to live up to obligations such as providing childcare or fulfilling job obligations.
8. Lies to avoid taking responsibility for behavior or to gain own ends at others' expense.
9. Has a childhood history of family chaos, abuse, and neglect.
10. Breaks laws and rules without guilt or remorse, regardless of the pain inflicted on others.

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LONG-TERM GOALS

1. Reduce hostile, aggressive, belligerent behavior, including both verbal and physical abuse.
2. Maintain lawful and/or responsible behavior.
3. Improve ability to tolerate authority relationships appropriately.

4. Increase capacity to delay gratification in order to achieve long-term objectives.
5. Improve capacity to see how own behaviors are harmful to others.
6. Establish at least one relationship that involves, at minimum, a modest degree of trust.

SHORT-TERM OBJECTIVES

1. Express satisfaction with the therapeutic relationship as indicated by the verbalization of difficulties and concerns. (1, 2)

2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Establish goals based on the client’s perceived needs (e.g., legal conflicts, inability to sustain an apartment or obtain sufficient income, and difficulty sustaining relationships), and closely tie discussions to the client’s goals.
2. Express to the client that the therapist is interested in hearing his/her side of the story that explains his/her argumentative or aggressive behavior.
3. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance

regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 5. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
 6. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
 7. Explain the practical advantages of participating in the psychotherapeutic relationship, such as the opportunity to learn how to get the client’s needs met more effectively in the context of the current system (e.g., hospital or prison) or in relationships.
3. Establish specific treatment goals. (7, 8)

4. Establish a trusting relationship with the therapist. (9, 10, 11)
5. Express anger in an appropriate assertive fashion rather than with rage or violence when responding to feeling wronged or belittled. (12, 13, 14, 15)
8. Express that since legal circumstances may have brought the client and therapist together, “We may as well make the best of it.”
9. Avoid appearing weak or soft in the eyes of the client by refraining from asking directly about his/her feelings and emotions early in the treatment.
10. Enter into the client’s worldview by saying that respect in the therapeutic relationship must be earned.
11. Express thoughts in extremely straightforward language, eliminating all jargon and complexities that could be perceived as double-talk.
12. Discuss the history of consequences the client has had with violent encounters; process whether the consequences are consistent with his/her goals at this time.
13. Ask the client to list ways in which anger has impacted his/her life, both positively and negatively. Process the list with him/her in order to unearth existing motivations to reduce angry/violent behavior.
14. Assign readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons) to the client; discuss the key points. Emphasize how assertiveness, not aggressiveness, is a tool to increase compliance with requests and get needs met over long periods of time.
15. Use role-play, modeling, and behavioral rehearsal with the

52 THE PERSONALITY DISORDERS TREATMENT PLANNER

- client to simulate situations that benefit from assertiveness versus aggressiveness; provide feedback regarding the appropriateness of his/her responses (or assign “Assertive Communication of Anger” in the *Adult Psychotherapy Homework Planner* by Jongsma).
6. Express appropriate displeasure or anger toward a person who generates frustration rather than becoming enraged or vengeful. (16, 17)
 7. Verbalize acceptance of having limits set by the therapist and/or significant others. (18, 19)
 16. Institute stress inoculation training for anger by preparing the client to recognize early cues and mental precursors to anger, using behavioral rehearsal to establish appropriate responses, and establishing self-rewards for maintaining control (see *Stress Reduction and Prevention* by Meichenbaum and Jaremko).
 17. Address the Punitiveness schema; use rational emotive therapy to replace extreme beliefs (e.g., “That jerk was disrespecting me and I’m going to teach him a lesson”) with more balanced ones (e.g., “He is being disrespectful, but who cares, I’m going to follow my own agenda” or “I will not let his taunting control what I do”). If the client is open to it, support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko.
 18. Process feelings toward the client (e.g., anger at being manipulated) with colleagues, supervisor, or team members to facilitate perspective and enhance the ability to maintain therapeutic alliance.
 19. Set boundaries on the therapy relationship (e.g., refuse to extend credit or delay payments,

- decline sexual advances, decline meeting informally outside of therapy sessions), and process them with the client.
8. Verbalize the disadvantages of unlawful behavior. (20)
 9. Verbalize that demeaning statements and verbal abuse are harmful to desired relationships. (21)
 10. Express appropriately controlled displeasure toward a person who is critical. (22)
 11. Describe the disadvantages of exploitive behavior. (23)
 20. Ask the client how unlawful behaviors have been both successful and unsuccessful for him/her. Develop Discrepancy using double-sided reflections, such as “On one hand, you like the quick money you get by stealing, while on the other hand, you don’t like the impact that legal consequences have had on you.” Support resulting change talk with affirmations, such as “It sounds like you are ready to make a change” (see *Motivational Interviewing* by Miller and Rollnick).
 21. Review the client’s pattern of verbal abuse, and confront rationalizations that the verbal abuse was deserved and that there was no other option; label verbal abuse as such and initiate a zero-tolerance policy within therapy sessions, at an inpatient unit, and/or within the client’s family.
 22. Use role-play and behavioral rehearsal to shape the client’s nonaggressive responses to criticism rather than him/her becoming enraged.
 23. Assist the client in making a list of pros and cons of behaviors that exploit others (e.g., inflating someone’s expectations regarding commitment in a relationship in order to obtain sex, borrowing money without repaying it), assessing long-term versus short-term consequences.

12. List the pros and cons of an action before making a decision rather than acting on impulse. (24)
13. Acknowledge having hurt another person's feelings or having caused undeserved harm. (25, 26)
14. Express regret or sorrow about having hurt another person's feelings or having caused undeserved harm. (27, 28)
24. Instruct the client to evaluate choices using the problem-solving approach: Have him/her list a problem (e.g., acting too impulsively), come up with a range of possible solutions, and then select from among those choices based on what is most consistent with his/her goals (or assign "Problem Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma).
25. In a psychodrama, group, or individual session, with the therapist (or a group member) playing the client, ask the client to play the person who was hurt or exploited (role reversal). Continue the intervention until the client achieves emotional identification with the victim.
26. Challenge the client's rationalizations about hurting others (e.g., the belief that hitting someone didn't really hurt them or that words cannot harm anyone), replacing irrational beliefs with more balanced ones (e.g., hitting someone virtually always produces harm; most people get angry or sad in response to others' cruel words); or assign "How I Have Hurt Others" in the *Adult Psychotherapy Homework Planner* by Jongsma.
27. Point out the client's pattern of indifference toward abuse of others as it relates to his/her having been abused as a child by an indifferent parent or caretaker. Emphasize the need to break the cycle of violence and indifference.

15. Verbally acknowledge and express regret that his/her sexually exploitive behavior was hurtful to another person. (28, 29)
16. Provide alternative positive or neutral explanations for others' behavior rather than assuming that they are motivated by envy or malice. (30)
17. Verbalize beliefs that will encourage the maintenance of long-term relationships. (31)
28. Confront the client's detachment from tender feelings (e.g., caring, empathy, sadness, compassion, guilt) as a protection from own pain endured in childhood. Emphasize the need to break the pattern of detachment.
28. Confront the client's detachment from tender feelings (e.g., caring, empathy, sadness, compassion, guilt) as a protection from own pain endured in childhood. Emphasize the need to break the pattern of detachment.
29. Explore the meaning of repetition-compulsion with the client, connecting current sexually exploitive behavior (e.g., using physical intimidation to demand sex or misleading someone to obtain sexual gratification) with wounds from the past.
30. Explore the client's negative projections about others' motives, including the therapist (if applicable). Identify how the client's negative assumptions relate to interactions from others in the client's past (e.g., early interactions with parents).
31. Explore the client's beliefs regarding the Mistrust schema in intimate relationships (e.g., that you can't trust anyone, that everyone will take advantage of you if they can). Challenge the ideas using Socratic dialogue, replacing unrealistic ideas with more flexible and realistic ones (e.g., most people can be trusted to some degree; everyone has faults; some people can sincerely help others, at least some of the time).

18. Express beliefs about mistrust in relationships in shades of gray rather than in all-or-none terms. (32)
19. Report an instance of being honest and self-disclosing in at least one relationship. (33)
20. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (34)
21. Take medications as prescribed, and report on effectiveness and side effects. (35)
22. Verbalize how being a victim of emotional, verbal, and/or physical abuse affects current relationships and attitudes. (36)
32. Address mistrust in the here-and-now therapeutic relationship using empathic confrontation. Replace extreme thoughts (“No one can be trusted”) with more balanced ones (“Most people can be trusted to some degree, and some people can be trusted to a high degree”). See *Schema Therapy* by Young, Klosko, and Weishaar.
33. Assist the client in identifying at least one of his/her relationships that merits trust. Assign him/her the task of expressing appreciation and trust to that person.
34. Refer the client to a physician for an evaluation for medication to reduce irritability and hyperreactivity. Help the client process costs and benefits of a psychiatric evaluation.
35. Monitor the client’s use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.
36. Encourage the client to describe experiences in prison and the rules of prison culture (e.g., how a sign of weakness can lead to physical or mental brutalization). Challenge the client to experiment with different kinds of relationships outside of prison settings, providing training on how to recognize trustworthiness in others.

23. Identify history of conflict with those in authority. (37)
24. Discuss changes necessary to improve cooperation with authority figures. (38)
25. Improve ability to form intimate attachments. (39)
26. Acknowledge and correct failure to act responsibly toward offspring. (40)
27. Attend work reliably and treat supervisor and coworkers with respect. (41, 42)
37. Explore the client's history of conflict with authority; relate this to early experiences of pain, rage, and disappointment with parents/caretakers.
38. Ask the client to make a list of behaviors and attitudes that must be modified in order to decrease his/her conflict with authorities. Process the list with the client.
39. Encourage the client to perform behavioral experiments in treating others with respect and kindness in order to explore the effect it has on relationships (or assign "Three Acts of Kindness" in the *Adult Psychotherapy Homework Planner* by Jongsma); prepare the client for possible problematic reactions on the part of others (e.g., mistrusting his/her motives) and the client's own fears of losing control in relationships.
40. If/when the client expresses desire to have a better relationship with his/her children, ask him/her to list three actions he/she could take that would demonstrate responsibility toward them (e.g., writing a letter to them, sending money for their support, attending work faithfully to increase income for their support, attending a child's school function, etc.).
41. Review the history of and causes for the client's employment instability; confront minimization and projection of responsibility for problems.

- 42. Assist the client in listing changes necessary to improve his/her employment behavior. Assign implementation of these changes through consistent work attendance.

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
312.34	F63.81	Intermittent Explosive Disorder
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
305.20	F12.10	Cannabis Use Disorder, Mild
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
305.60	F14.10	Cocaine Use Disorder, Mild
305.70	F15.10	Amphetamine Use Disorder, Mild
304.40	F15.20	Amphetamine Use Disorder, Moderate or Severe
305.50	F11.10	Opioid Use Disorder, Mild
304.00	F11.20	Opioid Use Disorder, Moderate or Severe
305.90	F18.10	Inhalant Use Disorder, Mild
304.60	F18.20	Inhalant Use Disorder, Moderate or Severe
301.7	F60.2	Antisocial Personality Disorder
301.0	F60.0	Paranoid Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
301.89	F60.89	Other Specified Personality Disorder

AVOIDANT*

BEHAVIORAL DEFINITIONS

1. Avoids others due to fears of criticism, disapproval, or rejection.
2. Does not get involved with people unless certain of being liked.
3. Is afraid of being shamed or ridiculed in intimate relationships.
4. Is extremely fearful of criticism and rejection.
5. Is quiet during interpersonal situations due to feelings of inadequacy.
6. Views self as inferior and socially awkward.
7. Inhibits activities due to fear of embarrassment.

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LONG-TERM GOALS

1. Reduce social withdrawal and loneliness due to social anxiety.
2. Improve conversational behaviors and other interpersonal skills, thereby decreasing social isolation.
3. Improve self-esteem and reduce self-criticism.
4. Increase active focus on pleasurable, values-oriented stimuli and decrease focus on painful stimuli.
5. Increase willingness to take risks in interpersonal contexts.
6. Reduce fears and ruminations regarding rejection and humiliation.
7. Improve intimacy in relationships.

*Appendix A elaborates on the dimensional structure for behavioral definitions.

SHORT-TERM OBJECTIVES

1. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to personality functioning, the efficacy of treatment, and the nature of the therapy relationship. (1, 2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).
2. Assess the client for evidence of research-based correlated disorders including vulnerability to suicide, as appropriate.
3. Assess for any diversity issues, such as age, gender, or culture, that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.

2. Cooperate with a comprehensive assessment of psychological functioning. (5)
3. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share concerns and difficulties with socialization. (6)
4. Describe and understand factors that maintain avoidant behavior. (7)
4. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
5. Administer tests or refer the client for personality testing to assess the severity of the depressive pathology and concomitant emotional/behavioral/cognitive problems (e.g., MCMI, Beck Depression Inventory, Basic Adlerian Scales for Interpersonal Success-Adult Form (BASIS-A)).
6. Express empathy for the client's difficulties (e.g., feeling fearful, rejected, and humiliated) through reflective listening and unconditional positive regard; assess the degree of avoidance of social contact.
7. Examine both functional and dysfunctional aspects of isolation (e.g., feeling safer at home but feeling lonely). Facilitate an enactment in which the fearful-avoidant part of the self "talks to" the part of the self that longs for a relationship with another person (see *The Practice of Emotionally Focused Couple Therapy* by Johnson).

62 THE PERSONALITY DISORDERS TREATMENT PLANNER

5. Commit to making a change in avoidant behaviors. (8, 9, 10)
6. Report having an enjoyable conversation with someone. (11, 12)
8. Work with the client to identify and clarify personal values and domains of living where valued action can be taken; use Motivational Interviewing techniques to assess and improve the client's preparation for change (see *Motivational Interviewing* by Miller and Rollnick).
9. Utilize the values card sort experiential exercise in session to promote willingness to engage in committed action (see: <http://actskills.com/vc-instructions-adult/>).
10. Assign the client to work through *Get Out of Your Mind and Into Your Life* by Hayes and Smith, and process chapter assignments during session.
11. Train the client in relationship skills, including suggestions for appropriate topics that the client could discuss with others, appropriate degree and timing of self-disclosure, and improved nonverbal behavior. (See *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman and/or Interpersonal Effectiveness DBT module and handouts in Linehan *DBT® Skills Training Handouts and Worksheets*; see also the *DBT Diary and Skills Coach* (Durham DBT, app).
12. Use role-play, modeling, and behavioral rehearsal to teach the client how to use relevant social skills to interact effectively with another person (or assign "Observe Positive Social

Behaviors” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

7. Initiate an enjoyable activity that can be accomplished only with another person (e.g., playing tennis, going on a date). (13)
8. Decrease mood-dependent behavior and increase values-oriented behavior. (14)
9. Demonstrate accurate perception of others’ thoughts and feelings. (15)
10. Identify cognitions that reduce the likelihood of social interactions. (16)
11. Report an increase in the frequency of thoughts that will increase interpersonal contact and pleasurable activities, and report a decrease in the
13. Assign the client to initiate an invitation to someone to join him/her in social/recreational activity. Process and work through the client’s fears and hesitations (or assign “Developing Conversational Skills” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
14. Teach the client about how projection influences our perceptions of others.
15. Examine evidence for and against common distorted perceptions that the client discloses about others associated with the Social Isolation (e.g., “I will never be accepted into any community”), Emotional Deprivation (e.g. “no one cares”), or Mistrust/Abuse (e.g., “others will humiliate me if they get the chance”) schemas.
16. Assign the client to keep a daily record of dysfunctional beliefs (e.g., believing that he/she is defective and unlikable) that inhibit socialization (or assign “Journal and Replace Self-Defeating Thoughts” in the *Adult Psychotherapy Homework Planner* by Jongsma).
17. Address dysfunctional beliefs associated with the Defectiveness/Shame schema (e.g., “I’m unlikable” and “People will reject me”) by

64 THE PERSONALITY DISORDERS TREATMENT PLANNER

- frequency of negative/interfering thoughts. (17)
12. Describe and understand feelings of rejection in current and/or past relationships. (18, 19)
13. Verbalize situations in which feelings of humiliation or shame were experienced during childhood. (20)
14. Implement relaxation techniques to counteract anxiety during
- probing with questions. Assist the client in defining more realistic, positive beliefs. (See *Cognitive Therapy of Personality Disorders* by Beck, Davis, and Freeman and/or *Schema Therapy* by Young, Klosko, and Weishaar.)
18. Explore assumptions the client makes regarding the therapist's feelings about him/her; compare them to interactions in significant relationships in the past (e.g., early childhood rejection).
19. In a couples therapy session, explore with significant others the themes of rejection and distancing, encouraging each family member to examine his/her own emotions and how defensiveness against pain and fear of vulnerability contributes to the distancing that occurs. Take into account the fearful-avoidant attachment style of people with Avoidant Personality Disorder (see *Emotionally Focused Couple Therapy with Trauma Survivors* by Johnson).
20. Interpret the relationship between the rejection perceived in past and current relationships (possibly including the relationship with the therapist) to help the client gain insight regarding the origin of his/her feelings of shame, inadequacy, and humiliation (or assign "Restoring Socialization Comfort" in the *Adult Psychotherapy Homework Planner* by Jongsma).
21. Train the client to relax using progressive muscular relaxation

- gradual exposure to social situations. (21, 22)
- (or assign “Progressive Muscle Relaxation” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis), autogenics, and/or visualization; support with Breathe2Relax app (Free on iTunes.com).
15. Engage in a social activity (e.g., going to an office party or meeting someone for lunch) that was previously avoided due to excessive anxiety. (23)
 16. Describe feelings of shyness/social anxiety and previous attempts to overcome fears of interacting with others. (24)
 17. Learn to tolerate feelings of anxiety while continuing to function. (25)
 22. Assist the client in identifying a hierarchy of anxiety-provoking stimuli associated with social situations. Train the client to pair relaxation with each stimulus in the hierarchy (see “Use Exposure to Confront Feared Situations and Emotions” in *Cognitive Behavioral Therapy Workbook for Personality Disorders* by Wood).
 23. Encourage the client to gradually expose self to social situations. Have the client use relaxation skills in each situation (or assign “Gradually Reducing Your Phobic Fear” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 24. Assign a book about coping with shyness (e.g., *Shyness* by Zimbardo; *Managing Social Anxiety Workbook* by Hope, Heimberg, and Turk; or *Overcoming Social Anxiety and Shyness* by Butler); discuss major concepts.
 25. Train the client to use meditation or refer the client to a Mindfulness-Based Stress Reduction or similar program. Support with bibliotherapy, such as *Wherever You Go, There You Are* (Kabat-Zinn).

18. Identify negative automatic thoughts about self that produce low self-esteem. (26)
19. Describe feeling more confident and comfortable with self rather than feeling like a failure. (27, 28)
20. Each member of the family describes how the client's avoidant behavior impacts him/her. (29)
21. Express disagreement with a significant other about an interpersonal issue of importance to both. (30)
26. Assign *The Six Pillars of Self-Esteem* (Branden), *Self-Esteem* (McKay and Fanning), or *Ten Days to Self-Esteem* (Burns), and process central ideas with the therapist.
27. Encourage the client to find a creative outlet for the expression of emotion (e.g., playing music or writing poetry).
28. Have the client keep a journal of feelings on a daily basis. Require that at least one positive emotion, self-descriptive statement, accomplishment, or event be recorded per day (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).
29. Explore family interactions that support avoidant behavior (e.g., the client feeling nurtured by understanding family members, family members feeling strong or helpful by supporting the client in avoidant behavior).
30. During a couples therapy session, instruct the client to speak directly to his/her spouse/partner about a conflictual issue, paying attention to ways in which the conflict is avoided. Redirect the client to confront, rather than avoid, a low-risk area of conflict regarding a behavior that would be easy to change (e.g., leaving the toilet seat up or down). Ask the client to speak to progressively more threatening material (expressing love, issues of trust, sexual behavior, etc.).

22. Ask for something from another person, thereby risking being turned down. (31)
23. Partner and client identify how conflict avoidance has contributed to distance in the relationship. (32)
24. Assert preferences in sexual activity with partner. (33)
25. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (34)
26. Take the psychotropic medication as prescribed, and report on the medication's effectiveness and side effects. (35)
31. Assign the client to ask for something (e.g., a raise at work, a favor from a friend) once or twice before next appointment (or assign "Becoming Assertive" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the fear or reality of being refused.
32. Encourage each person in the couple to see how he/she contributes to distancing behavior. Ask what has been done to solve the problem. Assign *Hold Me Tight* (Johnson), and process with the couple.
33. Assign the client to read *Your Perfect Right* (Alberti and Emmons) and/or "Develop Assertive Communication Skills" (in *Cognitive Behavioral Therapy Workbook for Personality Disorders* by Wood). Role-play situations that demand assertiveness.
34. Refer the client to a physician for an evaluation for medication to improve mood and decrease anxiety. Help the client to process costs and benefits of a medication evaluation.
35. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.

68 THE PERSONALITY DISORDERS TREATMENT PLANNER

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| <p>27. Report reduced frequency of thoughts about rejection, humiliation, and embarrassment while in social situations. (36)</p> <p>28. Express willingness to experience negative emotions temporarily in order to achieve long-term goals. (37)</p> <p>29. Express readiness to participate in psychotherapy group activities. (38)</p> <p>30. Attend group therapy to decrease anxiety in social situations. (39)</p> | <p>36. Explore themes of shame that occur spontaneously in dreams, fantasies, and free associations. Interpret their connection to the client's relationships with significant others, in both the past and the present (including the therapist, if applicable).</p> <p>37. Provide feedback that the feelings of shame are understandable from the client's point of view. Be aware of own feelings as they are impacted by the client, and provide feedback to the client about those feelings, thus facilitating perspective on the part of the client.</p> <p>38. Role-play social skills in order to prepare the client for group psychotherapy. Provide the client with information about reasonable expectations regarding what will occur in group therapy sessions, and encourage the client to participate.</p> <p>39. Conduct or refer the client to group therapy to improve interpersonal interactions by increasing the client's awareness of the impact his/her behavior has on others and awareness of others' feelings about him/her.</p> |
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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.23	F40.10	Social Anxiety Disorder
300.22	F40.00	Agoraphobia
300.02	F41.1	Generalized Anxiety Disorder
301.82	F60.6	Avoidant Personality Disorder
301.6	F60.7	Dependent Personality Disorder
301.20	F60.1	Schizoid Personality Disorder
301.22	F21	Schizotypal Personality Disorder
301.0	F60.0	Paranoid Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

AVOIDANT—CONFLICTED

BEHAVIORAL DEFINITIONS

1. Avoids others due to fears of criticism, disapproval, or rejection while simultaneously being pushed toward them due to feelings of loneliness.
2. Inhibits activities due to fear of embarrassment and rejection.
3. Experiences frequent or constant internal conflict regarding feelings about others.
4. Is ambivalent about whether to become more independent or more attached to others.
5. Fears both dependence and independence.
6. Feels confused, unsettled, and tormented, experiencing unrelenting angst.
7. Feels embittered regarding failed relationships.

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LONG-TERM GOALS

1. Resolve feelings of ambivalence about approaching versus avoiding others.
2. Reduce fears and ruminations regarding rejection and humiliation.
3. Reduce fears of being engulfed by others if he/she interacts meaningfully with them as well as fears of being independent and taking charge of important aspects of his/her life.

4. Improve conversational behaviors and other interpersonal skills, thereby decreasing social isolation.
5. Improve self-esteem and reduce self-criticism.
6. Reduce feelings of dread and angst by increasing feelings of inner peace and tranquility.

SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, and openly share concerns and difficulties with socialization. (1)
2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (2, 3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client's difficulties (e.g., feeling anxious, conflicted, and lonely) through reflective listening and unconditional positive regard.
2. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
3. Assess the client for evidence of research-based correlated disorders (e.g., oppositional

72 THE PERSONALITY DISORDERS TREATMENT PLANNER

- defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
4. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 5. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
3. Verbalize an increased capacity to cope with stress. (6)
 4. Learn and implement skills to enhance ability to cope with stress. (7)
 6. Teach the client to decrease hypersensitivity to internal bodily stimuli (e.g., anxiety symptoms such as increased heart rate) through an assigned anxiety tolerance exercise (e.g., having the client lie in a quiet room and pay attention to psychokinesthetic stimuli). See "Body Scan" exercise in *Full Catastrophe Living* by Kabat-Zinn.
 7. Train the client to use meditation (e.g., thought-watching exercise) by assigning

him/her to read *Full Catastrophe Living* by Kabat-Zinn or *How to Meditate* by LeShan, processing key concepts with the therapist. Demonstrate technique during session, and assign practice as homework. Supplement with the use of a smartphone app for between-session practice, such as Mindfulness Meditation app by Mental Workout or Mindfulness Coach (U.S. Department of Veterans Affairs, app).

5. Demonstrate the ability to induce self-hypnosis to relax. (8, 9)
6. Identify reasons for fears and conflicted feelings about others based on prior experiences. (10, 11, 12)
8. Make a hypnosis tape for the client during an in-session hypnotic session; instruct the client to use the tape for follow-up self-hypnosis sessions.
9. Assign the client to read the relevant sections of *Self-Hypnosis* by Alman and Lambrou or *The Relaxation and Stress Reduction Workbook* by Davis, Eshelman, and McKay. Discuss how to make a self-hypnosis tape and/or how to do self-hypnosis.
10. Explore assumptions the client makes regarding the therapist's feelings about him/her. Compare these assumptions to interactions in significant relationships in the past (e.g., early childhood rejection).
11. Discuss with the client experiences in which he/she was rejected by peers and/or bullied and the impact that has on his/her relationships with others in the present.
12. Explore the client's history of harsh, abusive, and/or inconsistent discipline and how

74 THE PERSONALITY DISORDERS TREATMENT PLANNER

- that led to internalizing beliefs that he/she was bad and/or that others were dangerous and untrustworthy.
7. Decrease mood-dependent behavior and increase commitment toward valued action. (13)
 8. Express confidence in setting boundaries with another person without becoming engulfed. (14, 15)
 9. Verbalize an understanding that being independent does not mean being alone and cut off from others. (16)
 13. Clarify and explore the client's values with an experiential exercise in session. Consider utilizing the *Valued Living Questionnaire* by Wilson et al. or the Survey of Guiding Principles Values Card Sort (<https://www.box.com/slp>). See also *Get Out of Your Mind and Into Your Life, Client Workbook* by Hayes and Smith.
 14. Assign the client (and/or significant others, if appropriate) to read *Boundaries* by Katherine, and process key ideas.
 15. While providing unconditional positive regard, validate fears the client has about taking the risk to be close with another person (including opening up to the therapist, if applicable). Process the client's feelings in the here and now of the therapeutic relationship, facilitating the client's ability to develop his/her own boundaries and comfort zone.
 16. Using Socratic dialogue, gently challenge the client's all-or-none thinking associated with the Abandonment schema (e.g., "If I take charge of any situation or assert myself, I will be rejected and abandoned by everyone forever"). Replace distorted beliefs with more flexible and realistic ones (e.g., "If I behave independently, some people will like it and others will not"). See *Schema*

- Therapy* by Young, Klosko, and Weishaar.
10. Express optimism that a new relationship will be different from previous ones and/or that the future will generally be better than the past. (17)
 11. Reduce the frequency of distorted, negative thoughts that lower self-esteem and reduce social interaction; increase the frequency of thoughts that affirm self and increase socialization. (18, 19, 20)
 12. Report success in terminating negative, self-critical thoughts before they control behavior. (21)
 17. Assign the client to read *Learned Optimism* by Seligman. Process key points, and apply the new principles to social relationship-building activity in the client's daily life.
 18. Examine thoughts associated with the Social Isolation/Alienation schema that interfere with social and enjoyable contacts (e.g., "No one will like me anyway"). Challenge these thoughts using Socratic dialogue, encouraging more realistic and flexible beliefs (e.g., "Some people will like me and some will not").
 19. Using rational emotive therapy, examine evidence for and against common distorted perceptions associated with the Defectiveness/Shame schema that the client discloses (e.g., "I'm defective"; "He doesn't like me"). Support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko.
 20. Assign the client to read *The Six Pillars of Self-Esteem* by Branden, *Self-Esteem* by McKay and Fanning, or *Ten Days to Self-Esteem* by Burns, and process central ideas with the therapist.
 21. Use the thought-stopping technique (having the client shout "stop" silently whenever negative thoughts come to mind) until the thought dissipates (or assign "Making Use of the

- Thought-Stopping Technique” in the *Adult Psychotherapy Homework Planner* by Jongsma).
13. Agree to undergo hypnosis to enhance self-esteem. (22)
 14. Implement self-hypnosis to maintain and enhance self-esteem gains. (23)
 15. Identify own positive traits and accomplishments. (24, 25)
 16. Implement relaxation techniques to counteract anxiety during gradual exposure to social situations. (26, 27, 28)
 22. Explore with the client themes that are important to his/her self-esteem (feelings of being acceptable, having a positive body image, etc.), and use these as the basis of hypnotic suggestions. Deliver the suggestions (permissive or directive) while the client is in a trance.
 23. Encourage the client to apply self-hypnosis skills to reinforce the self-affirmation suggestions.
 24. Have the client keep a journal of feelings on a daily basis. Require that at least one positive emotion, self-descriptive statement, accomplishment, or event be recorded per day (or assign “Positive Self-Talk” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 25. Encourage the client to find a creative outlet for the expression of emotion (e.g., playing music or writing poetry).
 26. Assist the client in identifying a hierarchy of anxiety-provoking stimuli associated with social situations.
 27. Train the client to relax using progressive muscular relaxation, autogenics, and/or visualization (or assign “Progressive Muscle Relaxation” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
 28. Administer systematic desensitization using gradual

- imaginal exposure to anxiety-provoking stimuli while the client is deeply relaxed.
17. Report feeling calm in a social or interpersonal situation that previously would have evoked feelings of fear or being overwhelmed. (29)
 18. Participate in social skills training. (30)
 19. Report having an enjoyable conversation with someone. (31)
 20. Report increased accuracy of others' thoughts and feelings. (32, 33)
 29. Accompany the client in order to facilitate in vivo exposure to a social situation (e.g., inpatient social recreation, contact with a family member, or asking for help at a store).
 30. Train the client in relationship skills, including suggestions for appropriate topics that he/she could discuss with others, appropriate degree and timing of self-disclosure, and improved nonverbal behavior (see *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman).
 31. Use role-play, modeling, and behavioral rehearsal to teach the client how to use relevant social skills to interact effectively with another person (or assign "Developing Conversational Skills" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis. Monitor implementation of social skills in daily life (e.g., going to an office party or meeting someone for lunch).
 32. Process with the client how projection influences our perceptions or misperceptions of others (or assign "Check Suspicions Against Reality" in the *Adult Psychotherapy Homework Planner* by Jongsma).
 33. Express accurate empathy toward the client, allowing him/her to learn by example.

78 THE PERSONALITY DISORDERS TREATMENT PLANNER

21. Describe feelings of rejection or humiliation experienced in current and/or past relationships. (34, 35)
22. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (36)
23. Take the psychotropic medication as prescribed, and report on the medication's effectiveness and side effects. (37)
24. Express self using "I" statements. (38)
34. Explore the client's feelings of rejection and humiliation, accepting those feelings without judgment and allowing the feelings of rejection to become clear to the client.
35. Explore themes of shame that occur spontaneously in the client's dreams, fantasies, and free associations. Interpret their connection to the client's relationships with significant others, both in the past and the present (including the therapist, if applicable).
36. Refer the client to a physician for an evaluation for medication to improve mood and decrease anxiety. Help the client to process costs and benefits of a medication evaluation.
37. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.
38. Encourage the client to express his/her feelings in the following manner: "When you say X to me in Y situation, I feel Z." Encourage significant others to do likewise. Instruct them to persist in communicating in that manner until each side reports understanding the other (see *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman).

25. Report increased feelings of closeness and conflict resolution within the family. (39)
26. Report reduced conflicted feelings in a significant relationship. (40)
27. Family will stop supporting avoidant behavior. (41)
28. Identify aspects of life that provide meaning, purpose, or mission. (42)
39. In a family therapy session, explore with significant others the themes of rejection and distancing, encouraging each family member to examine his/her own contribution to the distancing that occurs and how their ambivalence interferes with closeness.
40. During a family therapy session, instruct the client to speak directly to his/her spouse/partner about a conflictual issue, paying attention to ways in which the conflict is avoided. Redirect the client to confront, rather than avoid, a low-risk area of conflict regarding a behavior that would be easy to change (e.g., leaving the toilet seat up or down). Ask the client to speak to progressively more threatening material, such as expressing love, issues of trust, or sexual behavior (or assign “Applying Problem Solving to Interpersonal Conflict” in the *Adult Psychotherapy Homework Planner* by Jongsma).
41. Explore family interactions that support avoidant behavior (e.g., the client feeling nurtured by understanding family members, family members feeling strong or helpful by supporting the client in their avoidant behavior). Process findings with the family, and find healthier ways to get these needs met that do not support the avoidant behavior.
42. Explore aspects of the client’s life that provide a sense of meaning, purpose, or mission. Inquire about spiritual or

- religious participation that provides fortitude, comfort, or meaning to life; encourage increased participation.
29. Express feelings of gratitude, personal satisfaction, and/or inner peace. (43)
43. Assign the client to read a book on leading a satisfying life and finding feelings of peace and tranquility (e.g., *The Road Less Traveled* by Peck or *Everyday Blessings* by Kabat-Zinn and Kabat-Zinn); process key ideas with the therapist.
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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.23	F40.10	Social Anxiety Disorder
300.00	F41.9	Unspecified Anxiety Disorder
301.82	F60.6	Avoidant Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

AVOIDANT—HYPERSENSITIVE

BEHAVIORAL DEFINITIONS

1. Is intensely wary and suspicious.
2. Alternates between being panicky/terrified and thin-skinned/high strung.
3. Tends to be brooding and edgy.
4. Is afraid of being shamed or ridiculed in social situations.
5. Is extremely fearful of criticism and rejection.
6. Views self as socially awkward and can be highly self-deprecatory.
7. Feels poorly understood.

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LONG-TERM GOALS

1. Reduce social withdrawal, wariness, and suspiciousness.
2. Increase ability to self-soothe, self-regulate emotions, and relax.
3. Maintain a reasonably consistent, positive mood rather than alternating between terror and petulance.
4. Improve self-esteem and reduce self-criticism.
5. Reduce fears and ruminations regarding rejection and humiliation.
6. Improve intimacy in relationships.

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SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share concerns and difficulties with socialization. (1)
2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (2, 3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client's difficulties (e.g., feeling fearful, suspicious, and humiliated) through reflective listening and unconditional positive regard.
2. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
3. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
4. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

3. Demonstrate trust in the therapist, as evidenced either by directly saying so or indirectly by sharing personal concerns. (6)
4. Demonstrate trust in the therapy process by actively participating in treatment. (7)
5. Report reduced feelings of anxiety. (8)
6. Learn to tolerate feelings of anxiety while continuing to function. (9)
5. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
6. Using unconditional positive regard, express thoughts in extremely straightforward language, eliminating all jargon and complexities that could be perceived as double-talk.
7. If the client shares feelings or vulnerabilities or admits mistakes, compliment him/her (e.g., "It took real courage to bring that up— that will really help our progress").
8. Provide relaxation training utilizing progressive muscle relaxation, autogenics training, and/or visualization. Encourage the client to practice relaxation techniques regularly and to implement them while in stressful situations (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
9. Train the client to use meditation (e.g., thought-watching exercise) by assigning

Wherever You Go, There You Are by Kabat-Zinn or *How to Meditate* by LeShan, processing key concepts with the therapist; demonstrate technique during session and assign practice as homework.

7. Learn and implement skills to enhance ability to cope with stress and to terminate fear rumination. (10)
8. Report success in increased capacity to cope with stress. (11)
9. Report improved awareness of bodily sensations and their connections to emotions. (12)
10. Verbalize that an experience has been resolved that led to feelings of shame or humiliation. (13)
11. Articulate the connection between negative, distorted thoughts and anxious, depressed, or fearful feelings. (14, 15)
10. Use bibliotherapy, such as *The Relaxation and Stress Reduction Workbook* by Davis, Eschelman, and McKay and/or *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley; enhance skills through role-play and behavioral experiments.
11. Review the client's efforts at implementing new stress management techniques; reinforce success and redirect failures.
12. Teach the client the "Focusing Technique" to connect bodily sensations to thoughts and feelings (see *Focusing-Oriented Therapy* by Gendlin).
13. Explore themes of shame that occur spontaneously in dreams, fantasies, and free associations. Interpret their connection to the client's relationships with significant others in both the past and present (including the therapist, if applicable).
14. Assign the client to keep a record of dysfunctional thoughts associated with the Mistrust/Abuse schema (e.g., "Everyone hates me," "I must be vigilant because others are dangerous,") and the Defectiveness/Shame schema (e.g., "I am worthless"). See

Schema Therapy by Young, Klosko, and Weishaar.

12. Report a decrease in distressing thoughts, such as fears that others will harm or humiliate him/her. (16)
13. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (17)
14. Take the psychotropic medication as prescribed, and report on the medication's effectiveness and side effects. (18)
15. Assign the client to use the "Three-Column Technique" (see *Cognitive Therapy* by Beck), keeping a daily log of antecedent events, the beliefs associated with each event, and the resulting emotional consequences (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma).
16. Institute stress inoculation training for feeling distressed by preparing the client for situations in which he/she becomes overwhelmed, using behavioral rehearsal to establish appropriate responses and initiating self-rewards for maintaining positive feelings (see *Stress Inoculation Training* by Meichenbaum). Frame stress inoculation as a way of being prepared for whatever happens.
17. Refer the client to a physician for an evaluation for medication to improve mood and decrease anxiety. Help the client to process costs and benefits of a medication evaluation.
18. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.

15. Verbalize an understanding of how past interpersonal relationships led to feelings of shame and fear. (19, 20)
16. Describe feelings of rejection in current and/or past relationships. (21)
17. Report reduced sensitivity to rejection. (22, 23, 24)
19. Explore patterns of parental overcontrol, emphasis on keeping up good appearances, and degrading mockery regarding shortcomings (see *Interpersonal Diagnosis and Treatment of Personality Disorders* by Benjamin).
20. Explore how personal and/or multigenerational patterns of sadistic behavior, peer rejection, and/or bullying influenced the client's development.
21. Explore assumptions the client makes regarding the therapist's feelings about him/her; compare them to interactions in significant relationships in the past (e.g., early childhood rejection).
22. In a family therapy session, explore with significant others the themes of rejection and distancing, encouraging each family member to examine his/her own contribution to the distancing that occurs and how their overinvolvement with one another prevents healthy outside relationships. Support with bibliotherapy, such as *Ten Lessons to Transform Your Marriage* by Gottman, Gottman, and DeClaire and/or *Hold Me Tight* by Johnson.
23. Use Socratic dialogue to challenge the client's irrational beliefs about rejection associated with the Defectiveness/Shame, Mistrust/Abuse and Punitiveness schemas (e.g., "It is horrible if I am rejected," "I am rejected because I am a loser," "Everyone is cruel"). Replace

the rigid and global beliefs with more flexible, circumscribed ones (e.g., “Being rejected is disappointing but is part of life for everyone”; “Some people are cruel, but some are nice”).

18. Report reduced feelings of shame and humiliation. (25, 26)
19. Identify negative automatic thoughts about self that produce low self-esteem. (27)
20. Reduce the frequency of thoughts that lower self-esteem and of self-deprecating comments. (23, 28)
24. Assign the client to read *Don't Take It Personally!* by Savage or *Life's Too Short* by Twerski; process key points.
25. Explore the client's feelings of humiliation, accepting his/her feelings without judgment and allowing the feelings of humiliation to become clear to the client.
26. Interpret the relationship between the client's rejection perceived in past and current relationships (possibly including the relationship with the therapist) in order to help the client attain insight regarding the origin of his/her feelings of shame, inadequacy, and humiliation.
27. Assign the client to keep a record of dysfunctional thoughts of self-deprecation associated with the Defectiveness/Shame schema, tracking thoughts such as “I'm a failure” and “Everyone will let me down.” Assist the client in replacing dysfunctional thoughts with more positive, reality-based messages.
23. Use Socratic dialogue to challenge the client's irrational beliefs about rejection associated with the Defectiveness/Shame, Mistrust/Abuse and Punitiveness schemas (e.g., “It is horrible if I am rejected,” “I am rejected

- because I am a loser,” “Everyone is cruel”). Replace the rigid and global beliefs with more flexible, circumscribed ones (e.g., “Being rejected is disappointing but is part of life for everyone”; “Some people are cruel, but some are nice”).
21. Describe feeling more confident and comfortable with self rather than feeling like a failure. (29)
 22. Report having an enjoyable conversation with someone that resulted in a positive feeling toward that person. (30, 31)
 28. Empathize with the client’s feelings of low self-esteem. The therapist must be aware of his/her own feelings as they are impacted by the client, providing feedback to the client about those feelings and thus facilitating perspective on the part of the client.
 29. Assign *The Six Pillars of Self-Esteem* by Branden, *Self-Esteem* by McKay and Fanning, or *Ten Days to Self-Esteem* by Burns; process central ideas with the therapist.
 30. Provide the client with relationship skills training, including suggestions of appropriate topics that the client could discuss with others, appropriate degree and timing of self-disclosure, and improved nonverbal behavior (see *A Couple’s Guide to Communication* by Gottman, Notarius, Gonso, and Markman).
 31. Use role-play, modeling, and behavioral rehearsal to teach the client how to use relevant social skills to interact effectively with another person (or assign “Developing Conversational Skills” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

23. Initiate a new activity with another person or persons. (32, 33)
24. Demonstrate accurate perception of others' thoughts and feelings. (34, 35)
25. Identify cognitions that reduce the likelihood of social interactions. (36)
26. Report an increase in the frequency of thoughts that will facilitate interpersonal contact and pleasurable activities and a decrease in the frequency of negative/interfering thoughts. (37)
27. Report having an improved mood and a brighter, more positive outlook. (38)
32. Brainstorm regarding enjoyable new activities and social interactions in which the client might engage.
33. Assign the client to initiate an invitation to someone to join him/her in a social/recreational activity.
34. Teach the client about how projection influences our perceptions of others.
35. Express accurate empathy toward the client whenever he/she expresses emotions, allowing him/her to learn by example.
36. Identify common distorted perceptions that the client discloses about others (e.g., "She thinks I'm defective" or "He doesn't like me"). Using rational emotive therapy, replace these thoughts with more flexible and positive ones (e.g., "Even if she thinks badly of me, that does not mean I am bad" and "Some people like me and some people don't").
37. Assign the client to keep a daily journal of feelings. Require that at least one positive emotion, self-descriptive statement, accomplishment, or event be recorded per day (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).
38. Assign the client to read *Learned Optimism* by Seligman, and process key points and apply the new principles to social relationship-building activities in the client's daily life.

90 THE PERSONALITY DISORDERS TREATMENT PLANNER

28. Family members decrease activities that inadvertently encourage the client's avoidant/paranoid behavior. (39)
29. Share personal information or a secret with a trusted person; report feeling close to another person. (40)
30. Verbalize why the risk of exposing shameful feelings is so great. (41)
31. Express readiness to participate in psychotherapy group activities. (42)
39. Explore family interactions that support avoidant/paranoid behavior (e.g., the client feeling nurtured and safe with understanding family members, family members feeling strong or helpful by supporting the client in his/her avoidant/paranoid behavior).
40. Process the client's fears of becoming intimate with another person, exploring themes such as the fear that once the client is known by the other person, disapproval, disrespect, and maltreatment will follow.
41. When the client is reluctant to share sensitive or shameful material, fearing that the therapist will abandon him/her, connect empathically to the client's feelings while addressing both the wish for acceptance and the fear of rejection (e.g., "You really long to be understood and would like to tell me what you feel must be hidden, but you worry that if you do, I will pull away from you just when you feel most exposed"). See "Using Self Psychology in Brief Psychotherapy" by Gardner and "Speaking in the Interpretive Mode and Feeling Understood: Crucial Aspects of the Therapeutic Action in Psychotherapy" by Ornstein and Ornstein.
42. Role-play social skills in order to prepare the client for group psychotherapy. Provide the client with information about reasonable expectations regarding what will occur in

- group therapy sessions, and encourage the client to participate.
32. Attend group therapy to decrease anxiety in social situations, more accurately identify others' feelings, and gain insight into own pattern of interpersonal interactions. (43)
43. Conduct or refer the client to group therapy to improve interpersonal interactions by increasing the client's awareness of the impact that his/her behavior has on others and awareness of others' feelings about him/her.
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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.02	F41.1	Generalized Anxiety Disorder
300.4	F34.1	Persistent Depressive Disorder
301.82	F60.6	Avoidant Personality Disorder
301.0	F60.0	Paranoid Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

BORDERLINE*

BEHAVIORAL DEFINITION

1. Makes desperate attempts to avoid abandonment.
2. Has unstable and intense relationships, usually involving alternately idealizing and denigrating another person.
3. Sense of self or self-image is chronically unstable.
4. Acts on impulse in ways that can be self-damaging (e.g., overspending, sex, drugs).
5. Makes frequent suicidal gestures or threats or mutilates himself/herself.
6. Has highly unstable moods (e.g., gets depressed, irritable, or anxious for brief periods).
7. Chronically experiences feelings of emptiness.
8. Is easily provoked to anger or rage.
9. Under stress, can become paranoid or experience dissociative symptoms.

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LONG-TERM GOALS

1. Terminate suicidal and/or self-mutilating behavior.
2. Stabilize interpersonal relationships.
3. Increase respect for self.

*Appendix A elaborates on the dimensional structure for behavioral definitions.

4. Increase behavioral skills, such as problem-solving and communication skills.
5. Increase emotional modulation and decrease emotional reactivity.
6. Increase realistic judgment while decreasing crisis-generating behavior.

SHORT-TERM OBJECTIVES

THERAPEUTIC INTERVENTIONS

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| <ol style="list-style-type: none"> 1. Express satisfaction with therapeutic relationship, either verbally or nonverbally, by openly conveying difficulties and concerns. (1) 2. Cooperate with psychological assessment. (2) 3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a <i>DSM</i> diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6) | <ol style="list-style-type: none"> 1. Express empathy for the client’s difficulties (e.g., feeling out of control, fragile, or having relationship problems) through unconditional positive regard, warm acceptance, and reflective listening. 2. Administer or refer the client for personality testing, such as the MCMI, MMPI, Basic Adlerian Scales for Interpersonal Success-Adult Form (BASIS-A), Schema Questionnaire, and/or Rorschach, to assess personality dynamics and emotional/behavioral/cognitive problems. Review and process the results of psychological testing with the client. 3. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees |
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with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
5. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
6. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).

- ▼ 4. Verbalize an understanding of Dialectical Behavior Therapy, and establish specific treatment goals. (7, 8)
- ▼ 5. Express trust in the relationship with the therapist, either verbally or nonverbally. (9, 10, 11)
- ▼ 6. Verbalize an understanding of the therapist's policy regarding suicidal behavior. (12)
7. Explain the Dialectical Behavior Therapy protocol (required individual therapy, group skills training meeting, long-term commitment to therapy, and prohibition against suicide attempts and self-mutilation). See *Cognitive Behavior Therapy of Borderline Personality Disorder* by Linehan and/or *Doing Dialectical Behavior Therapy* by Koerner. ▼
8. Assist the client in developing a list of specific dissatisfactions he/she is currently experiencing, such as difficulties with relationships, feelings of emptiness, drug problems, or suicidal ideation. ▼
9. Explicitly acknowledge the client's difficulty with trust, and reinforce any expressions of trust in the therapist. ▼
10. Express self in a clear, straightforward fashion. Clarify with the client that he/she need not talk about sensitive issues until he/she is ready to do so. ▼
11. Engage in limited reparenting by setting healthy limits and providing direction and encouragement until the client internalizes these schemas (see *Schema Therapy for Borderline Personality Disorder* by Arntz, van Genderen, and Drost). ▼
12. Elicit a promise (as part of a self-mutilation and suicide prevention contract) from the client that he/she will initiate contact with the therapist or help line if a suicidal urge becomes strong and

▼ Indicates that selected Objectives/Interventions are consistent with those found in evidence-based treatments.

- before any self-injurious behavior occurs (or assign “No Self-Harm Contract” in the *Adult Psychotherapy Homework Planner* by Jongsma); throughout the therapy process, consistently assess the strength of the client’s suicidal potential. ^{EB}▽
- ▽ 7. Respond appropriately to having limits set by the therapist and/or significant others. (13, 14, 15, 16)
13. Set a policy that telephone contacts with the client will be limited to Dialectical Behavior Therapy skill building or dealing with a crisis situation and will generally be limited to 10 minutes; if more time is needed, an additional appointment can be scheduled. ^{EB}▽
14. Instruct the client regarding the requirements of therapy (regular attendance at sessions, payment schedules, arriving at sessions sober, requirements not to engage in suicidal behavior, etc.), and discuss the consequences of failing to comply. ^{EB}▽
15. With a colleague, supervisor, or team members, process feelings toward the client (e.g., anger, exasperation, or feeling manipulated) that are related to the client’s therapy-interfering behaviors (e.g., not showing up at sessions, expecting a friendship or intimate relationship with the therapist) in order to distill perspective and enhance ability to maintain therapeutic alliance. ^{EB}▽
16. The therapist will assess his/her own (dysfunctional) schemas, such as Approval-Seeking, Emotional Inhibition, or Unrelenting Standards as activated by the client’s

- behavior; process with a colleague or consultant if needed (see *Schema Therapy* by Young, Klosko, and Weishaar). ▽
- ▽ 8. Identify the reasons for suicidal ideation and/or self-mutilating behavior and the factors in the current environment that reward self-harmful ideas and actions. (17)
- ▽ 9. Decrease frequency of or eliminate suicidal gestures, threats, and attempts. (18)
- ▽ 10. Cooperate with referral to a physician to evaluate the need for psychotropic medication. (19)
17. Once the therapist fully understands the pain that leads the client to want to die, examine the suicide attempt/gesture as a form of communication (e.g., a message to a significant other, a message to the world). Explore secondary gains received from such behavior (e.g., attention from significant others or medical staff, being taken seriously). ▽
18. Express empathy and compassion for the client's pain that leads to suicidal ideation and/or self-injurious behavior (or assign "Past and Present Hurt—Hope for the Future" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). Use active listening to understand the depth of pain and suffering experienced by the client from his/her point of view. When the therapist fully understands the pain that leads the client to want to die, process reasons that the client wants to live. Help the client draw strength and specific treatment goals from this list. ▽
19. Refer the client to a physician for an evaluation for medication to stabilize mood, decrease anxiety and/or depression, or stabilize the thought process; help the client to process costs and benefits of a medication evaluation. ▽

- ▼^{EB} 11. Take psychotropic medication as prescribed, and report on the medication's effectiveness and side effects. (20)
- ▼^{EB} 12. Express anger in an appropriate fashion rather than with rage when responding to feeling wronged, abandoned, or betrayed. (21, 22, 23)
20. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication. ▼^{EB}
21. Explore the history of consequences the client has had with excessive anger; process whether the consequences are consistent with his/her goals at this time. Use double-sided reflections to help the client process his/her ambivalence (e.g., "On one hand, when you scream and throw things, you feel powerful and heard, but on the other hand, you damage your relationships and feel guilty afterward").
22. Explain to the client the difference between aggression and assertiveness and how they result in different reactions from others (or assign "Assertive Communication Log" in the *Adult Psychotherapy Homework Planner* by Jongsma). Process/apply assertiveness skills learned in materials such as *Your Perfect Right* by Alberti and Emmons or *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley, and/or skills training the client received (e.g., the Dialectical Behavior Therapy Interpersonal Effectiveness skills group). ▼^{EB}

- ▼ 13. Demonstrate a capacity to mentalize (i.e., understand and integrate thoughts, feelings, motivations and other mental states) regarding both self and others. (24, 25)
- ▼ 14. Report how mentalization has improved understanding of self
23. When the client becomes angry with the therapist, process the feelings, noting similarities between the therapeutic relationship and other important relationships in the client's life. Work collaboratively toward an appropriate resolution of the angry feelings (see *Transference-Focused Psychotherapy for Borderline Personality Disorder* by Clarkin, Yeomans, and Kernberg). ▼
24. If the client experiences strong affect while focusing on identified problems and his/her mentalizing appears to be limited or failing and his/her understanding of the way mental states link to behavior is less than adequate, address this by using a structured process of (a) empathy or validation; (b) clarification and, where necessary, challenge; and (c) gently expanding mentalizing by encouraging the client to identify mental states previously outside of his/her awareness (see *Mentalization-Based Treatment for Borderline Personality Disorder* by Bateman and Fonagy). ▼
25. Begin the mentalization therapeutic process in the here and now, but increasingly, as mentalizing improves, move the focus to core attachment relationships, including the relationship with the therapist and key figures in the client's life. ▼
26. Gradually, as the client improves in mentalizing,

- and interpersonal relationships with others. (26)
15. Describe and understand feelings of rejection in current and/or past relationships. (27, 28)
- ▼ 16. Verbalize feeling more stable and in control of emotions. (29, 30)
- encourage him/her to address distorted representations of personal relationships including his/her frequently disorganized attachment with parents. ▼
27. In a couples therapy session, explore with the significant other the themes of rejection and distancing, encouraging each member to examine his/her own emotions and how defensiveness against pain and fear of vulnerability contribute to the distancing and reduction of intimacy that occurs. Take into account the client's disorganized attachment style. Support with bibliotherapy, such as *Love Sense* by Johnson (see *The Practice of Emotionally Focused Couple Therapy* by Johnson).
28. Process the ways in which members of a borderline couple hurt one another by failing to mirror (validate) each other; encourage and/or instruct them to accurately empathize with and validate one another (see *The Disordered Couple* by Carlson and Sperry).
29. Conduct or refer the client to Dialectical Behavior Therapy Skills Training groups—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance—in order to teach the client how to balance and regulate emotions and interact well with others (see *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan). Support with

- bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley and/or DBT Diary Card and Skills Coach (Durham DBT, app). ^{EB}▽
- ▽ 17. Express appropriate displeasure or anger toward a person who generates frustration rather than becoming enraged. (31)
18. Report having a friendship or intimate relationship that is comfortable and balanced. (32)
19. Report reducing or eliminating the use of alcohol and/or drugs. (33, 34)
30. Train the client to use meditation (e.g., thought-watching exercise) by assigning *Wherever You Go, There You Are* by Kabat-Zinn, processing key concepts with the therapist; demonstrate the technique during a session, and assign practice as homework. Refer to a Mindfulness-Based Stress Reduction program if available.
31. Process the use of relevant Dialectical Behavior Therapy skills—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and/or Distress Tolerance—in an individual session. Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley and/or DBT Diary and Skills Coach (Durham DBT, app). ^{EB}▽
32. Assign the client (and/or significant others, if appropriate) to read *Boundaries* by Katherine; process key ideas.
33. Assess the client’s substance abuse pattern; if necessary, refer him/her to a chemical dependence treatment program and/or Alcoholics Anonymous/Narcotics Anonymous.
34. Process with the client the reasons for drug/alcohol use (e.g., to numb painful thoughts,

- to facilitate sex, to cope with memories of sexual abuse, or to “feel alive”). Discuss alternative strategies to meet those needs (see *The Addiction Treatment Planner* by Perkinson, Jongsma, and Bruce).
- ▼ 20. Implement healthy and appropriate ways to cope with conflict rather than using drugs, performing self-injury, or engaging in impulsive, potentially dangerous actions; verbalize increased capacity to cope with stress. (31, 35)
- ▼ 21. Reduce the frequency of distorted, negative thoughts that lower self-esteem; increase frequency of positive thoughts. (36, 37)
31. Process the use of relevant Dialectical Behavior Therapy skills—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and/or Distress Tolerance—in an individual session. Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood and Brantley and/or *DBT Diary and Skills Coach* (Durham DBT, app). ▼
35. Teach the client problem-solving skills including brainstorming possible solutions to conflict, examining the pros and cons of the possible solutions, selecting and implementing a solution, evaluating the outcome (or assign “Plan Before Acting” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▼
36. Use empathic confrontation in the here and now of the therapeutic relationship to challenge thoughts related to the Dependence/Incompetence schema, such as “I’m too inadequate to handle life on my own” and “You must take care of me or I will fall apart” (or assign “Journal of Distorted, Negative Thoughts” in the *Adult Psychotherapy Homework*

- Planner* by Jongsma). See *Schema Therapy* by Young, Klosko, and Weishaar. ▾
37. Assign the client to read material, such as *The Six Pillars of Self-Esteem* by Branden, *Self-Esteem* by McKay and Fanning, or *Ten Days to Self-Esteem* by Burns, that will counter habits of negative thinking; process central ideas with the therapist. ▾
- ▾ 22. Report little or no distress when in between romantic or other close relationships. (38)
38. Challenge and dispute the client's irrational beliefs regarding the Abandonment schema, such as "It is awful to be alone" or "If I disagree with someone I will be abandoned, which would be horrible." Replace extreme reactions with less extreme ones, such as "It would be inconvenient to be alone or to break up" (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko. ▾
23. Identify the impact of childhood abuse on current relationships. (39)
39. Explore the client's history of being abused; discuss the impact that this experience has had on his/her ability to trust others (see *Treating Survivors of Childhood Abuse* by Cloitre, Cohen, and Koenen); if childhood abuse is acknowledged, bring some focus to this in the treatment plan (see "Childhood Trauma" in *The Complete Adult Psychotherapy Treatment Planner* by Jongsma, Peterson, and Bruce).

24. Express a firmer sense of self rather than feeling aimless and confused about own values and goals in life. (40)
25. Report a reduction in feelings of emptiness and depersonalization. (41)
26. Report being able to cope with feelings of emptiness without resorting to self-mutilation or substance abuse. (42)
27. Report feeling calm in a situation that previously would have evoked feelings of terror or being overwhelmed. (43)
40. Encourage experiential exploration of possible valued directions one's life can take in a nonjudgmental environment (such as using the "What Do You Want Your Life to Stand For?" exercise in *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson).
41. Explore aspects of the client's life that provide a sense of meaning, purpose, or mission. Inquire about spiritual/religious participation or other activities (e.g., volunteering to help others) that provides fortitude, comfort, or meaning to life; encourage increased participation. Supplement with bibliotherapy, such as *Man's Search for Meaning* by Frankl and/or *101 Exercises for the Soul* by Siegel.
42. Explore the client's reasons for engaging in self-mutilation, substance abuse, or suicidal gestures; develop adaptive coping behaviors to overcome the tension associated with feelings of emptiness/ detachment (implement relaxation techniques, call a friend or family member, engage in a self-soothing exercise, utilize spiritual meditation, practice vigorous physical exercise, etc.).
43. Challenge the client's catastrophizing (e.g., the belief that the end of the relationship is a disaster that will lead to endless loneliness and isolation), replacing the irrational belief with more balanced ones

- (e.g., endings are painful, but the pain subsides and new beginnings emerge). See *Cognitive Therapy for Personality Disorders* by Beck, Davis, and Freeman.
- ▼ 28. Calmly accept the loss of a relationship (including terminating therapy) rather than making frantic efforts to avoid abandonment. (38, 44)
38. Challenge and dispute the client's irrational beliefs regarding the Abandonment schema, such as "It is awful to be alone" or "If I disagree with someone I will be abandoned, which would be horrible." Replace extreme reactions with less extreme ones, such as "It would be inconvenient to be alone or to break up" (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko. ▼
29. Describe a person or relationship in shades of gray rather than as all good or all bad. (45)
44. Process the client's thoughts and feelings about ending therapy, thereby facilitating his/her ending this relationship differently from others. ▼
30. Continue to think and act as an adult under stress rather than reverting to childlike behavior. (46)
45. Challenge all-or-none thinking by asking the client to recall or imagine instances in which someone was average rather than extreme on a particular dimension (e.g., a person who was neither awesomely talented nor completely inept, a person who elicited friendly feelings rather than total love or total hatred).
46. When the client experiences regression during a session, analyze the impact of regressive actions on the therapeutic

relationship; process this with the client (see *Transference-Focused Psychotherapy for Borderline Personality Disorder* by Clarkin, Yeomans, and Kernberg).

DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
309.81	F43.10	Posttraumatic Stress Disorder
296.89	F31.81	Bipolar II Disorder
300.14	F44.81	Dissociative Identity Disorder
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
305.20	F12.10	Cannabis Use Disorder, Mild
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
305.60	F14.10	Cocaine Use Disorder, Mild
305.70	F15.10	Amphetamine Use Disorder, Mild
304.40	F15.20	Amphetamine Use Disorder, Moderate or Severe
305.50	F11.10	Opioid Use Disorder, Mild
304.00	F11.20	Opioid Use Disorder, Moderate or Severe
305.90	F18.10	Inhalant Use Disorder, Mild
304.60	F18.20	Inhalant Use Disorder, Moderate or Severe
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.83	F60.3	Borderline Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
301.50	F60.4	Histrionic Personality Disorder
301.6	F60.7	Dependent Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

BORDERLINE—PETULANT

BEHAVIORAL DEFINITION

1. Is generally negativistic, sullen, pessimistic, and easily disillusioned.
2. Tends to be impatient and restless.
3. Is stubborn and defiant and has difficulty with authority figures.
4. Has deep, ambivalent feelings about connecting to others, fears losing independence, and dreads isolation and abandonment.
5. Is hypersensitive to criticism and easily feels slighted.
6. Is prone to brief, transient psychotic episodes, especially with mood-dominated features (e.g., delusions of worthlessness).
7. Is prone to suicidal gestures and behaviors.

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LONG-TERM GOALS

1. Decrease suicidal and/or self-injurious behavior.
2. Stabilize interpersonal relationships.
3. Increase self-esteem and emotional stability.
4. Increase behavioral skills, such as deferring gratification, tolerating criticism, problem-solving and communication skills.
5. Resolve ambivalence regarding independence from versus connection to others.
6. Reduce sensitivity to criticism.

7. Reduce frequency and severity of brief psychotic episodes.

SHORT-TERM OBJECTIVES

1. Express satisfaction with the therapeutic relationship, either verbally or nonverbally, as indicated by the client conveying difficulties and concerns. (1)
2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (2, 3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client's difficulties (e.g., feeling unappreciated, resentful, or having relationship problems) through unconditional positive regard, warm acceptance, and reflective listening.
2. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
3. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including

vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

4. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 5. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
 6. Assist the client in developing a list of specific dissatisfactions he/she is currently experiencing, such as difficulties with relationships, feelings of emptiness, drug problems, or suicidal ideation; emphasize how treatment is a way of getting his/her needs met.
 7. Explicitly acknowledge the client's difficulty with trust and reinforce any expressions of trust in the therapist. Express self in a clear, straightforward fashion, eliminating any jargon that might be misinterpreted by the client. Clarify to the client that he/she
3. Identify specific emotional, relational, or behavioral problems. (6)
 4. Express trust in the relationship with the therapist, either verbally or nonverbally. (7)

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| <p>▼^{EB} 5. Verbalize an understanding of the therapist's policy regarding emergency contact. (8)</p> <p>▼^{EB} 6. Make a contract for no self-harm between sessions. (9)</p> <p>▼^{EB} 7. Respond appropriately to having limits set by the therapist. (10, 11, 12)</p> <p>▼^{EB} 8. Identify the reasons for suicidal ideation and/or self-mutilating</p> | <p>need not talk about sensitive issues until ready to do so.</p> <p>8 Set a policy that the client will call 911 or go to the emergency room in a crisis; telephone contacts will be for 10-minute skill-building sessions. ▼^{EB}</p> <p>9. Contract with the client not to engage in self-harm behavior between sessions; if necessary, have the client sign a written no-self-harm contract. ▼^{EB}</p> <p>10. Instruct the client regarding the requirements of therapy (regular attendance at sessions, payment schedules, arriving at sessions sober, etc.); discuss the consequences of failing to comply. ▼^{EB}</p> <p>11. Address fears of abandonment; assure the client that the therapeutic relationship, within the limits discussed, is resilient and secure. ▼^{EB}</p> <p>12. With a colleague, supervisor, or team members, process feelings toward the client (e.g., anger, exasperation, feelings of hopelessness) that are related to the client's therapy-interfering behaviors (e.g., not showing up at sessions, expecting a friendship or intimate relationship with the therapist) in order to distill perspective and enhance ability to maintain therapeutic alliance. ▼^{EB}</p> <p>13. Once the therapist fully understands the pain that leads</p> |
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▼^{EB} Indicates that selected Objectives/Interventions are consistent with those found in evidence-based treatments.

behavior and the factors in the current environment that reward self-harmful ideas and actions, and decrease their frequency. (13)

- ▼ 9. Cooperate with referral to a physician to evaluate the need for psychotropic medication. (14)
 - ▼ 10. Take psychotropic medication as prescribed, and report on the medication's effectiveness and side effects. (15)
 - ▼ 11. Express anger in an appropriate fashion rather than with rage or resentment when responding to feeling wronged, abandoned, or betrayed. (16, 17, 18)
- the client to want to die, examine the suicide attempt/gesture as a form of communication (e.g., a message to a significant other, a message to the world). Explore secondary gains received from such behavior (e.g., attention from significant others or medical staff, being taken seriously). Then process reasons that the client wants to live. Help the client draw strength and specific treatment goals from this list. ▼
- 14. Refer the client to a physician for an evaluation for medication to stabilize mood, decrease anxiety and/or depression, or stabilize thought process; help the client to process costs and benefits of a medication evaluation. ▼
 - 15. Monitor the client's use of psychotropic medication for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medication. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication. ▼
 - 16. Use role-play, modeling, and behavioral rehearsal with the client to simulate situations that demand assertiveness (or assign "Assertive Communication of Anger" in the *Adult Psychotherapy Homework Planner* by Jongsma); provide feedback regarding the appropriateness of his/her responses. Support with

bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley. ▾

17. Instruct the client to imagine the person who angered or frustrated him/her is in an empty chair in the room. Have the client express his/her feelings toward that person until he/she can do so in a respectful, controlled fashion. ▾
 18. When the client becomes angry with or resentful of the therapist, process the feelings, noting similarities between the therapeutic relationship and other important relationships in the client's life. Work collaboratively toward an appropriate resolution of the angry feelings. See *Transference-Focused Psychotherapy for Borderline Personality Disorder* by Clarkin, Yeomans, and Kernberg. ▾
 19. Conduct or refer the client to Dialectical Behavior Therapy Skills Training groups—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance—in order to teach him/her how to balance and regulate emotions and interact well with others. (See *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan.) Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley and/or *DBT Diary and Skills Coach* (Durham DBT, app.) ▾
- ▾ 12. Verbalize feeling calm and relaxed in situations that previously would have evoked feelings of anger, resentment, or frustration. (19, 20)

13. Verbalize feeling more stable and in control of emotions. (21)
- ▽ 14. Describe an experience as neutral or tolerable that was previously considered provocative or anxiety-provoking. (22)
- ▽ 15. Rather than becoming enraged or resentful, express appropriate
20. Provide the client with relaxation training utilizing progressive muscular relaxation, autogenics training, self-hypnosis, and/or visualization or assign “Progressive Muscle Relaxation” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); monitor and reinforce his/her implementation of relaxation techniques in daily life. Support with bibliotherapy, such as *The Relaxation and Stress Reduction Workbook* by Davis, Eshelman, and McKay. ▽
21. Refer the client to a Mindfulness-Based Stress Reduction program, and/or train the client to use meditation (e.g., thought-watching exercise) by assigning *Wherever You Go, There You Are* by Kabat-Zinn or *How to Meditate* by LeShan and processing key concepts in session.; demonstrate the technique during the session, and assign practice as homework.
22. Process the use of relevant Dialectical Behavior Therapy skills—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and/or Distress Tolerance—in an individual session. Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* (McKay, Wood, and Brantley) and/or *DBT Diary and Skills Coach* (Durham DBT, app). ▽
23. Assist the client in identifying coping techniques that allow for

- displeasure or anger toward a person who generates frustration. (23)
16. Verbalize an understanding of the process and benefits of forgiving perpetrators of pain. (24)
17. Report reducing or eliminating the use of alcohol and/or drugs. (25)
18. Learn to self-soothe in healthy and appropriate ways rather than using drugs, performing self-mutilation, or engaging in impulsive, potentially dangerous actions. (26)
- ▽ 19. Let go of angry, resentful, or conflicted feelings toward others rather than ruminating about them. (22, 28)
- a reduction of angry feelings (or assign “Alternatives to Destructive Anger” in the *Adult Psychotherapy Homework Planner* by Jongsma); assign the client to read *Of Course You’re Angry* by Rosellini and Worden or *Managing Anger* by Messer, Dillon, and Coronado-Bogdaniak; process key ideas. ▽
24. Discuss forgiveness of perpetrators of childhood pain as a process of letting go of anger and resentment (or assign “Feelings and Forgiveness Letter” in the *Adult Psychotherapy Homework Planner* by Jongsma); support with bibliotherapy, such as *The Tao of Forgiveness* by Martin.
25. Assess the client’s substance abuse pattern, and, if necessary, refer him/her to a chemical dependence treatment program (e.g., Rational Recovery, inpatient treatment) or 12-step group (e.g., Alcoholics Anonymous or Narcotics Anonymous).
26. Process with the client the reasons for drug/alcohol use (e.g., to numb painful thoughts, to facilitate sex, to cope with memories of sexual abuse, or to “feel alive”). Discuss alternative strategies to meet those needs (see *The Addiction Treatment Planner* by Perkinson, Jongsma, and Bruce).
22. Process the use of relevant Dialectical Behavior Therapy skills—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and/or

- Distress Tolerance—in an individual session. Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley and/or DBT Diary and Skills Coach (Durham DBT, app). ▾
28. Teach the client problem-solving skills including brainstorming possible solutions to a conflict, listing the pros and cons of each solution, selecting and implementing a solution, evaluating the outcome for possible adjustments needed (or assign “Plan Before Acting” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▾
29. Assign the client to keep a record of dysfunctional thoughts associated with the Defectiveness/ Shame and Dependence/Incompetence schemas, such as “I am worthless” and “I will always feel completely overwhelmed.” Using Socratic dialogue, challenge the client to examine the evidence for and against such statements; teach positive, realistic self-talk (or assign “Journal and Replace Self-Defeating Thoughts” in the *Adult Psychotherapy Homework Planner* by Jongsma). See *Schema Therapy* by Young, Klosko, and Weishaar. ▾
30. Empathize with the client’s feelings of low self-esteem. The therapist must be aware of his/her own feelings as they are impacted by the client and, assuming the therapeutic
- ▾ 20. Report a reduction in the frequency of distorted, negative thoughts that lower self-esteem; increase frequency of positive thoughts. (29, 30, 31)

- relationship is sufficiently established, provide feedback to the client about those feelings, thus facilitating perspective on the part of the client.
21. Identify the impact of childhood sexual abuse on current relationships. (32)
 22. Identify the impact of childhood neglect, invalidation, parental inconsistency, and/or abandonment on current functioning. (33)
 23. Express a firmer sense of self rather than feeling aimless and confused about own values and goals in life. (34)
 24. Increase capacity to mentalize (i.e., understand and integrate thoughts, feelings, motivations
 31. Assign the client to read *The Six Pillars of Self-Esteem* by Branden, *Self-Esteem* by McKay and Fanning, or *Ten Days to Self-Esteem* by Burns; process central ideas in session.
 32. Explore the client's history of being sexually abused; discuss the impact that his/her experience has had on increasing feelings of confusion in current intimate relationships (see *Treating Survivors of Childhood Abuse* by Cloitre, Cohen, and Koenen).
 33. Explore the parallels between the client's ambivalence and fears of neglect/abandonment and previous experiences, noting the repetition compulsion between his/her words and actions and those of significant others in the past. ▽
 34. Explore aspects of the client's life that provide a sense of meaning, self-worth, purpose, or mission. Inquire about spiritual or religious participation that provides fortitude, comfort, or meaning to life; encourage increased participation. Support with bibliotherapy, such as *Man's Search for Meaning* by Frankl and/or *101 Exercises for the Soul* by Siegel.
 35. If the client experiences strong affect while focusing on identified problems, his/her

- and other mental states) regarding both self and others. (35, 36, 37)
- mentalizing appears to be limited or failing, and his/her understanding of the way mental states link to behavior is less than adequate, address this by using a structured process of (a) empathy or validation; (b) clarification and, where necessary, challenge; and (c) gently expanding mentalizing by encouraging the patient to identify the mental states previously outside of his/her awareness (see *Mentalization-Based Treatment for Borderline Personality Disorder* by Bateman and Fonagy). ▽
25. Report a reduction in feelings of emptiness and depersonalization. (32, 38)
36. Begin the mentalization therapeutic process in the here and now but increasingly, as mentalizing improves, move the focus to core attachment relationships, including the relationship with the therapist and key figures in the client's life. ▽
37. Gradually, as the client improves in mentalizing, encourage him/her to address distorted representations of personal relationships including his/her frequently disorganized attachment with his/her parents. ▽
32. Explore the client's history of being sexually abused; discuss the impact that his/her experience has had on increasing feelings of confusion in current intimate relationships (see *Treating Survivors of Childhood Abuse* by Cloitre, Cohen, and Koenen).
38. Explore aspects of the client's life that provide a sense of

- meaning, self-worth, purpose, or mission. Inquire about spiritual or religious participation that provides fortitude, comfort, or meaning to life; encourage increased participation. Support with bibliotherapy, such as *Man's Search for Meaning* by Frankl and/or *101 Exercises for the Soul* by Siegel.
26. Report reduced or eliminated delusions/feelings of worthlessness and increased sense of happiness, meaning, and purpose. (39)
 27. Express understanding of the impact of his/her vacillating (i.e., changing his/her mind frequently) in provoking frustration in others. (40)
 28. Verbalize feeling contented with rather than conflicted about another person. (41)
 29. Express feeling fortunate in some way. (42)
 30. Risk disillusionment/disappointment with another person in order to try new approaches that will lead to a satisfying new relationship. (43)
 39. Assist the client in identifying and listing his/her positive traits, accomplishments, relationships, rituals, and values that affirm self-worth; assign him/her to post the list prominently at home for frequent review.
 40. Teach the concept of “self-fulfilling prophecy” and how constant vacillating brings about anger and rejection from others (see *Personality Guided Therapy* by Millon).
 41. Assign the client to read *Hold Me Tight* by Johnson and/or *The Seven Principles for Making Marriage Work* by Gottman and Silver; process main points and key themes within a subsequent session.
 42. Assist the client in making a list of ways in which he/she is fortunate and things for which he/she feels grateful; assign the client to review the list on a regular basis.
 43. Encourage the client to express his/her feelings in the following manner: “When you say X to me in Y situation, I feel Z.” Encourage significant others to do likewise. Encourage them to persist in communicating in that

- manner until each side reports understanding the other (see *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman).
- ▼ 31. Recognize and acknowledge own pattern of hostile defiance and contrition; take steps to correct it. (44)
32. Express misfortunes in a balanced rather than an exaggerated way. (45)
33. Address and resolve mutual feelings of resentment and anger that exist within the client's family. (46)
34. End therapy in an appropriate, positive fashion. (47)
44. When the client is defiant toward the therapist and is then apologetic, process the meaning of the experience, exploring whether the pattern is a repetition of early family interactions (see *Transference-Focused Psychotherapy for Borderline Personality Disorder* by Clarkin, Yeomans, and Kernberg). ▼
45. Challenge the client's mistaken beliefs and private logic (e.g., the belief that the end of the relationship is a disaster that will lead to endless loneliness and isolation) encouraging more balanced thoughts (e.g., endings are painful, but the pain subsides and new beginnings emerge). See *Tactics in Counseling and Psychotherapy* by Mosak and Maniaci and/or *The Individual Psychology of Alfred Adler* by Ansbacher and Ansbacher.
46. Conduct a family therapy session to explore and resolve feelings of resentment and anger that are held by family members.
47. Process the client's thoughts and feelings about ending therapy, facilitating his/her ending this relationship differently from others.

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
309.81	F43.10	Posttraumatic Stress Disorder
296.89	F31.81	Bipolar II Disorder
300.14	F44.81	Dissociative Identity Disorder
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
305.20	F12.10	Cannabis Use Disorder, Mild
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
305.60	F14.10	Cocaine Use Disorder, Mild
305.70	F15.10	Amphetamine Use Disorder, Mild
304.40	F15.20	Amphetamine Use Disorder, Moderate or Severe
305.50	F11.10	Opioid Use Disorder, Mild
304.00	F11.20	Opioid Use Disorder, Moderate or Severe
305.90	F18.10	Inhalant Use Disorder, Mild
304.60	F18.20	Inhalant Use Disorder, Moderate or Severe
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

BORDERLINE—SELF-DESTRUCTIVE

BEHAVIORAL DEFINITIONS

1. Has punitive feelings (anger and guilt) toward self.
2. Feels hopeless, helpless, and powerless.
3. Has history of conforming, deferential, and ingratiating behavioral pattern.
4. Makes frequent suicidal gestures or threats or mutilates self.
5. Is high-strung, moody, and easily angered toward others.
6. Is hypervigilant and fearful.
7. Is hypersensitive to any distorted perception of being abandoned.

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LONG-TERM GOALS

1. Decrease suicidal and/or self-mutilating behavior.
2. Stabilize interpersonal relationships.
3. Increase respect for self.
4. Increase behavioral skills, such as assertiveness.
5. Increase feelings of personal empowerment, hopefulness, and optimism.
6. Increase realistic judgment while decreasing crisis-generating behavior.
7. Reduce hypervigilance and fear of abandonment.

SHORT-TERM OBJECTIVES

1. Express satisfaction with the therapeutic relationship, either verbally or nonverbally, as indicated by the client conveying difficulties and concerns. (1)
2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (2, 3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client's difficulties (e.g., feeling self-destructive, desperate, or having relationship problems) through unconditional positive regard, warm acceptance, and reflective listening.
2. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
3. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including

- vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
4. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 5. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
 6. Assist the client in developing a list of specific dissatisfactions he/she is currently experiencing, such as feelings of helplessness, hopelessness, or suicidal ideation.
 7. Explicitly acknowledge the client's difficulty with trust; reinforce any expressions of trust in the therapist.
 8. Express self in a clear, straightforward fashion, free from jargon that could be misinterpreted by the client.
 9. Clarify to the client that he/she need not talk about sensitive issues until ready to do so.
3. Identify sources of feelings of dissatisfaction with self and others. (6)
 4. Express trust in the relationship with the therapist either verbally or nonverbally. (7, 8, 9)

- ▼^{EB} 5. Verbalize an understanding of the therapist's policy regarding self-destructive behavior. (10)
- ▼^{EB} 6. Agree to the structure of the psychotherapy format. (11, 12)
- ▼^{EB} 7. Identify the reasons for suicidal ideation and/or self-mutilating behavior and the factors in the current environment that reward self-harmful ideas and actions. (13, 14)
10. Express the expectation that the client will control his/her response to the urge to self-mutilate or suicide; contract with the client not to engage in self-harm between sessions (or assign "No Self-Harm Contract" in the *Adult Psychotherapy Homework Planner* by Jongsma). ▼^{EB}
11. Set a policy that telephone contacts with the client between sessions will be brief (about 10 minutes) and will be used primarily for applying Dialectical Behavior Therapy skills in context and for coping with crises. If more is needed, an additional session can be scheduled. ▼^{EB}
12. Instruct the client regarding the requirements of therapy (regular attendance at sessions, payment schedules, arriving at sessions sober, etc.); discuss the consequences of failing to comply. ▼^{EB}
13. Express compassion for the client's pain that leads to suicidal ideation and/or self-injurious behavior. Use active listening to understand the depth of pain and suffering experienced by the client from his/her point of view. ▼^{EB}
14. Once the therapist fully understands the pain that leads the client to want to die, examine the suicide attempt/gesture as a form of communication (e.g., a message

▼^{EB} Indicates that selected Objectives/Interventions are consistent with those found in evidence-based treatments.

- to a significant other, a message to the world). Explore secondary gains received from such behavior (e.g., attention from significant others or medical staff, being taken seriously). ▾
- ▾ 8. Decrease frequency of or eliminate suicidal gestures, threats, and attempts and increase hopeful statements about life and the future. (15, 16)
- ▾ 9. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (17)
- ▾ 10. Take psychotropic medication as prescribed, and report on the medication's effectiveness and side effects. (18)
15. When the therapist fully understands the pain that leads the client to want to die, process reasons that the client wants to live (or assign "Strategies to Resist Suicidal Thoughts and Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); help the client draw strength and specific treatment goals from this list. ▾
16. Assess with the client the negative consequences of suicidal behavior/gestures on his/her long-term goals (or assign "The Aftermath of Suicide" in the *Adult Psychotherapy Homework Planner* by Jongsma); explore alternate ways to get the short-term relief provided by suicidal and parasuicidal behavior. ▾
17. Refer the client to a physician for an evaluation for medication to stabilize mood, decrease anxiety and/or depression, or stabilize thought process; help the client to process costs and benefits of a medication evaluation. ▾
18. Monitor the client's use of psychotropic medication for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medication. On a

- regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication. ^{EB}▽
- ▽^{EB} 11. Report situations in which increased capacity to cope with stress was demonstrated. (19, 20)
12. Report termination of drug and/or alcohol use to cope with negative emotions. (21, 22, 23)
19. Train the client to use meditation (e.g., thought-watching exercise) by assigning *Full Catastrophe Living* (Kabat-Zinn) or *How to Meditate* (LeShan), processing key concepts in session; demonstrate the technique during the session, and assign practice as homework. Refer to a Mindfulness-Based Stress Reduction program if available locally. ^{EB}▽
20. Provide the client with relaxation training utilizing progressive muscular relaxation, self-hypnosis, autogenics training, and/or visualization (or assign “Progressive Muscle Relaxation” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); tell the client to use these techniques at times of stress. ^{EB}▽
21. Assess the client’s substance abuse pattern and, if necessary, refer him/her to a chemical dependence treatment program (e.g., Rational Recovery, Alcoholics Anonymous, Narcotics Anonymous).
22. Process with the client the reasons for drug/alcohol use (e.g., to numb punitive thoughts, to cope with memories of abuse, or to “feel alive”); discuss alternative strategies to meet those needs (see *The Addiction Treatment Planner* by Perkinson, Jongsma, and Bruce).

- ▼ 13. Implement healthy and appropriate ways to cope with conflict rather than using drugs, performing self-injury, or engaging in impulsive, potentially dangerous actions; verbalize increased capacity to cope with stress. (24, 25)
14. Reduce the frequency of distorted, negative thoughts that lower self-esteem. (26, 27, 28)
23. Assist the client in increasing his/her ability to identify, observe, and discuss unpleasant cognitive or affective states without becoming overwhelmed or fused with content; try a deliteralization technique, such as “The Passengers on the Bus” exercise in *ACT for Depression* by Zettle.
24. Process the use of relevant Dialectical Behavior Therapy skills—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and/or Distress Tolerance—in an individual session. Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley and/or *DBT Diary and Skills Coach* (Durham DBTCards, app). ▼
25. Teach the client problem-solving skills including brainstorming possible solutions to conflict, examining the pros and cons of the possible solutions, selecting and implementing a solution, and evaluating the outcome (or assign “Plan Before Acting” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▼
26. Assign the client to keep a record of dysfunctional thoughts associated with the Defectiveness/Shame schema, such as “I’m bad and should be punished” and “I’m evil and horrible.” Using Socratic dialogue, challenge the client to examine the evidence for and against such statements and find

more balanced beliefs, such as “Everyone makes mistakes” and “I can be forgiving toward both others and myself” (or assign “Journal of Distorted, Negative Thoughts” in the *Adult Psychotherapy Homework Planner* by Jongsma). If the client becomes dysregulated, encourage him/her to use emotion regulation or mindfulness skills to recover emotional balance. ▾

27. Empathize with the client’s feelings of low self-esteem. The therapist must be aware of his/her own feelings as they are impacted by the client and, assuming the therapeutic relationship is sufficiently established, provide feedback to the client about those feelings, thus facilitating perspective on the part of the client. ▾
28. Assign the client to read *The Six Pillars of Self-Esteem* by Branden, *Self-Esteem* by McKay and Fanning, or *Ten Days to Self-Esteem* by Burns, which will counter habits of negative thinking; process central ideas with the therapist. ▾
15. Identify the impact of childhood abuse on current emotions and relationships. (29)
29. Explore the client’s history of being sexually, physically, or emotionally abused, and discuss the impact that his/her experience has had on feelings of trust, guilt, fear, anger, hypervigilant scanning for betrayal, and submissiveness in relationships.
- ▾ 16. Resolve emotional and relationship issues related to childhood abuse. (30, 31)
30. When the client becomes emotionally dysregulated during a session, help him/her to

- self-regulate using validation; also instruct the client to use mindfulness and other skills to become more regulated. Discuss the self-regulation process; integrate highly arousing emotional material (such as processing intropunitive thoughts or sexual trauma material) only when the client can re-regulate appropriately (see *Doing Dialectical Behavior Therapy* by Koerner). ^{EB}▽
31. Conduct or refer the client to a stepped model of treatment for recovery from trauma, such as Skills Training in Affective and Interpersonal Regulation (STAIR) therapy. Begin by training the client in emotion regulation and interpersonal skills. Follow with exposure therapy to traumatic material using narratives: Begin with a neutral memory, then move on to fear, shame, and loss narratives (see *Treating Survivors of Childhood Abuse* by Cloitre, Cohen, and Keonen). ^{EB}▽
- ^{EB}▽ 17. Verbalize an understanding of the connection between prior abuse and current punitive feelings, beliefs, and behaviors. (32)
32. Explore the parallels between the client's punitive behavior and previous experiences, noting the repetition compulsion between the words and actions directed against the self currently and those of the punitive other from the past. See *Transference-Focused Psychotherapy for Borderline Personality Disorder* by Clarkin, Yeomans, and Kernberg. ^{EB}▽
18. Verbalize positive beliefs about self, including acceptance of own intrinsic value. (33)
33. Provide the client with unconditional positive regard, allowing him/her to learn by

- example that he/she can be accepted for who he/she is rather than what he/she can do.
- ▼^{EB} 19. Express anger in a healthy fashion rather than becoming enraged at self. (24, 34)
- ▼^{EB} 20. Reduce or eliminate patterns of impulsive expression of anger and resentment followed by guilt and contrition. (35)
24. Process the use of relevant Dialectical Behavior Therapy skills—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and/or Distress Tolerance—in an individual session. Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley and/or *DBT Diary and Skills Coach* (Durham DBTCards, app). ▼^{EB}
34. When the client becomes angry with the therapist, process the feelings, noting similarities between the therapeutic relationship and other important relationships in the client's life; work collaboratively toward an appropriate resolution of the angry feelings (or assign “Alternatives to Destructive Anger” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▼^{EB}
35. Use role-play, modeling, and behavior rehearsal with the client to simulate situations that demand assertiveness (or assign “Assertive Communication of Anger” in the *Adult Psychotherapy Homework Planner* by Jongsma); provide feedback regarding the appropriateness of his/her responses. Support with bibliotherapy, such as *Your Perfect Right* by Alberti and Emmons. ▼^{EB}

- ▼ 21. Acknowledge that own needs and desires are independent of what others want; state how they can be reasonably satisfied. (36)
22. Risk displeasing someone in order to meet own needs in an area that is considered important. (37)
- ▼ 23. Set limits on another person without feeling guilty. (36, 38)
36. Use assertiveness skills from Dialectical Behavior Therapy, employing interpersonal effectiveness (e.g., DEAR-MAN) in combination with Mindfulness, Emotion Regulation, and Distress Tolerance skills (in order to stay regulated while being assertive) See *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan. ▼
37. Assist the client in identifying an unmet need that has been stifled out of fear of displeasing someone; assign implementation of an activity that will lead to need fulfillment.
36. Use assertiveness skills from Dialectical Behavior Therapy, employing interpersonal effectiveness (e.g., DEAR-MAN) in combination with mindfulness, emotion regulation, and distress tolerance skills (in order to stay regulated while being assertive). ▼
38. Explain to the client the difference between aggression and assertiveness and how they result in different reactions from others (or assign “Assertive Communication Log” in the *Adult Psychotherapy Homework Planner* by Jongsma); process/apply assertiveness skills learned in materials such as *Your Perfect Right* by Alberti and Emmons, *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley), and/or skills training the client received (e.g., the Dialectical Behavior

132 THE PERSONALITY DISORDERS TREATMENT PLANNER

24. Verbalize an understanding of the destructive impact of excessive guilt on the self and on relationships. (39)
25. State a commitment to let go of past hurt and resentment and to work on the process of forgiveness. (40)
- ▼ 26. Verbalize feeling optimistic or confident about a situation that previously would have provoked feelings of pessimism or despair. (41)
27. Report having a friendship or intimate relationship that is comfortable and balanced and lasts for more than six months. (42)
- ▼ 28. Report little or no distress when in between romantic or other close relationships. (43)
- Therapy Interpersonal Effectiveness skills group). ▼
39. Use role reversal and/or role-play to help the client empathize with the feelings of another person, especially guilt. Process how the guilt impacts self and others (e.g., promotes low self-esteem; alienates others from self; leads to behavior based on obligation, not free expression, etc.).
40. Discuss forgiveness of self and others as a process of letting go of anger and pain (or assign “Feelings and Forgiveness Letter” in the *Adult Psychotherapy Homework Planner* by Jongsma). Support with bibliotherapy, such as *The Tao of Forgiveness* by Martin and *The Other Side of Pain* by Mecozzi and Hayes.
41. Examine the evidence for/against the client’s beliefs associated with the Negativity/Pessimism schema that all is hopeless and all efforts are futile; challenge the beliefs by examining previous instances of success as well as the possibility that the outcome will be different because he/she is trying a new approach or technique. ▼
42. Teach the client the value of tolerance and patience for others’ shortcomings or faults in order to promote longevity and continuity in relationships.
43. Challenge and dispute the client’s irrational beliefs regarding being alone associated with the Abandonment schema

(e.g., “It is awful to be alone” and “If I disagree with someone I will be abandoned, which would be horrible”). Replace extreme reactions with less extreme ones (e.g., “It would be inconvenient to be alone or to break up” and “Endings are painful, but the pain subsides and new beginnings emerge”). Support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko. ▽

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| <p>29. Report a reduction in feelings of emptiness and emotional poverty/deprivation. (44)</p> | <p>44. Explore aspects of the client’s life that provide a sense of meaning, purpose, or mission. Inquire about spiritual or religious participation that provides fortitude, comfort, or meaning to life; encourage increased participation.</p> |
| <p>30. Verbalize an understanding of how vigilantly scanning for signs of betrayal or abandonment can trigger anger in others. (45)</p> | <p>45. Teach the concept of “self-fulfilling prophecy,” how testing others or searching for signs of betrayal and abandonment provokes suspicion and anger on the part of others (see <i>Disorders of Personality</i> by Millon).</p> |
| <p>31. Terminate therapy with calm, appropriate emotions. (46)</p> | <p>46. Process the client’s thoughts and feelings about ending therapy, facilitating his/her ending this relationship differently from others. Review the skills learned in therapy and how they can help him/her cope with this transition.</p> |

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
309.81	F43.10	Posttraumatic Stress Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.4	F34.1	Persistent Depressive Disorder
300.14	F44.81	Dissociative Identity Disorder
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

DEPENDENT*

BEHAVIORAL DEFINITIONS

1. Requires excessive advice and reassurance in order to make everyday decisions.
2. Urges others to take responsibility for most of the important areas of his/her life.
3. Overly hesitant to express disagreement for fear of losing support or approval of others.
4. Lacks self-confidence, which causes problems initiating activities.
5. Makes an inordinate effort to obtain nurturance or support from others (e.g., volunteers to do unpleasant tasks that no one would want to do).
6. Has excessive fear of not being able to take care of self, which causes feelings of discomfort or helplessness when alone.
7. Desperately seeks someone to take care of him/her as soon as a nurturing relationship ends.
8. Worries excessively about being left to take care of self.

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LONG-TERM GOALS

1. Improve self-confidence.
2. Decrease submissive and obsequious behavior.

*Appendix A elaborates on the dimensional structure for behavioral definitions.

3. Increase comfort with being alone and engaging in independent activities.
4. Increase range and adequacy of coping behaviors, social skills, and competencies.
5. Increase decisiveness and independence in decision making.
6. Increase assertiveness.
7. Increase awareness of own desires and needs.
8. Decrease fear of being alone.
9. Reduce frequency and intensity of clinging behavior.

SHORT-TERM OBJECTIVES

THERAPEUTIC INTERVENTIONS

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share difficulty and concerns. (1)
2. Cooperate with comprehensive assessment. (2)

1. Express empathy for the client’s difficulties (e.g., feeling inadequate, incompetent, and fragile) through unconditional positive regard, warm acceptance, and reflective listening.
2. Administer personality evaluation instruments, such as MCMI, Schema Questionnaire, Rorschach, and/or Basic Adlerian Scales for Interpersonal Success-Adult Form (BASIS-A); process results with the client. Assess diversity considerations: Age, Developmental and acquired Disabilities, Religion, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender (ADDRESSING, see *Addressing cultural complexities*)

- in practice* by Hays). Consider how diversity factors can make interventions more effective, and/or avoid pathologizing culturally normative attitudes and behaviors.
3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)
 3. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
 4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 5. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 6. Assess for the severity of the level of impairment to the client's functioning to determine

- appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
4. Verbalize an increased awareness of own need to be dependent. (7, 8)
 5. Identify situations in which decision making is difficult. (9, 10)
 6. Report making a minor decision (e.g., making a minor purchase) without receiving advice or assurances and taking full responsibility for the decision. (11)
 7. Assign the client to read *Codependent No More* by Beattie or *Women Who Love Too Much* by Norwood; process key ideas within subsequent sessions.
 8. Develop a genogram to increase the client's awareness of family patterns of dependence in relationships and of how he/she is repeating them in the current relationship.
 9. Assign the client to keep a journal of activities that provoke anxiety and/or the desire to turn to others for advice and reassurance.
 10. Elicit feedback from the client regarding difficulties in making decisions, allowing the client to clarify his/her own point of view and gain a greater sense of self-acceptance, thus feeling freer to make decisions.
 11. Explore dysfunctional attitudes ("I can't do it," "Another person would do that better than me, maybe they will do it," etc.) that are associated with the Dependence/Incompetence schema. Examine the evidence

- for and against each belief, and encourage the client to challenge his/her beliefs when appropriate (see *Schema Therapy* by Young, Klosko, and Weishaar).
7. Verbalize making a decision regarding an important item (making a large purchase, career change, etc.), asking for an appropriate (i.e., nonexcessive) amount of input from others. Client reports taking full responsibility for the decision. (12, 13, 14)
 8. Reduce the frequency of distorted, negative thoughts that lower self-esteem; increase the frequency of positive thoughts. (15, 16, 17, 18)
 12. Develop a behavioral contract with the client, providing rewards for making independent decisions.
 13. Provide advice and reassurance initially, followed by gradually requiring the client to make more and more decisions independently in order to earn verbal positive reinforcement from the therapist (or assign “Making Your Own Decisions” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 14. Assist the client in recognizing dependent patterns in his/her relationship with the therapist (e.g., asking the therapist for excessive advice or reassurance). Compare this pattern to other relationships in the client’s life, and provide feedback to the client about the impact of his/her behaviors.
 15. Assign the client to track dysfunctional thoughts, such as “I’m too inadequate to handle life on my own” and “I’m stupid.” Use the Five-Column Technique to challenge the thoughts (see *Cognitive Therapy of Personality Disorders* by Beck, Davis, and Freeman).
 16. Train the client to use meditation (e.g., thought-watching exercise) to identify distorted thoughts by assigning *Wherever You Go, There You Are* by Kabat-Zinn,

processing key concepts in session; demonstrate the technique during the session, and assign practice as homework.

17. Train the client to develop a nonjudgmental attitude toward self and let go of negative thoughts, using mindfulness techniques. Supplement with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley.
 18. Empathize with the client's feelings of low self-esteem. The therapist must be aware of his/her own feelings as they are impacted by the client and provide feedback to the client about those feelings, thus facilitating perspective on the part of the client.
 19. Describe the meaning of "secondary gain" (e.g., attention and nurturance from others, having others take over responsibilities) to the client; assist the client in identifying how self-disparagement and avoidance of risk-taking can be reinforced through secondary gain.
 20. Use encouragement to increase the client's confidence by pointing out efforts that led to success and encouraging him/her to feel good about it (e.g., "You worked very hard on your independence, and it appears to have paid off; do you feel good about yourself for that?"). See *The Individual Psychology of Alfred Adler* by Ansbacher and Ansbacher.
9. Identify secondary gain that results from speaking disparagingly about self and refusing to take responsibility. (19)
 10. Report pride in several accomplishments or talents. (20)

11. Positively acknowledge and accept verbal compliments from others. (21, 22)
12. Verbalize an understanding of gradations of dependent/independent behavior. (23)
13. Describe feeling more confident and comfortable with self in the face of problems rather than feeling incompetent and inadequate. (24, 25)
14. Family members/partner reduce interactions that serve to perpetuate the client's clinging behavior and/or self-deprecating behavior. (26)
21. Assign the client to be aware of and acknowledge graciously (without discounting) praise and compliments from others; practice this acknowledgment using role-play.
22. Assign the client to keep a daily journal of feelings. Require that at least one positive emotion, accomplishment, or self-descriptive thought be recorded per day.
23. Assist the client in developing a list of his/her strengths (skills, positive personality characteristics, etc.), including partial successes and competencies (or assign "Acknowledging My Strengths" in the *Adult Psychotherapy Homework Planner* by Jongsma).
24. Train the client in problem-solving skills (e.g., brainstorming to generate possible solutions, weighing pros and cons of each solution, and evaluating possible solutions by anticipating potential consequences); or assign "Applying Problem Solving to Interpersonal Conflict" in the *Adult Psycho-therapy Homework Planner* (Jongsma).
25. Assign the client to read *The Six Pillars of Self-Esteem* by Branden, *Self-Esteem* by McKay and Fanning, or *The Self-Esteem Workbook* by Schiraldi; process central ideas in session.
26. Explore family interactions that support the client's dependent behavior (e.g., the client feeling nurtured by understanding family members and family

142 THE PERSONALITY DISORDERS TREATMENT PLANNER

- members feeling strong or helpful by supporting the client in his/her clinging behavior).
15. Acknowledge the pursuer-distancer pattern in the relationship; commit to changing the pattern. (27, 28)
 16. Verbalize an awareness of the origins of own feelings of inadequacy. (29)
 17. Report a willingness to try taking on a new responsibility despite fears of failure. (30, 31)
 27. Teach the client the meaning of the pursuer-distancer pattern and how each person is reinforcing the other (i.e., pursuit encourages distancing, and distancing encourages pursuit). Explore the historical pattern of pursuit and distancing within the family/spouse relationship and within the extended family.
 28. Encourage the client to explore independent interests as a means of breaking the cycle of pursuit and distancing. Explore with the client the question “What is your life without that person?”
 29. Explore themes related to feelings of inadequacy that occur spontaneously in dreams, fantasies, and free associations. Interpret their connection to the client’s relationships with significant others in both the past and the present (including the therapist, if applicable).
 30. Suggest that the client discuss fears of independent functioning during an individual or group therapy session; process the feelings (or assign “Making Steps Toward Independence” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 31. Teach the client appropriate survival skills (how to obtain employment, write a resume, shop, find housing, etc.), or refer the client to an appropriate specialist (e.g., vocational rehabilitation counselor or social

- worker) for proper training. Insist that the client implement his/her own skills rather than passively accepting help from others (e.g., having a social worker find housing for him/her).
18. Increase assertiveness in situations in which passivity was previously used. (32, 33)
 19. Express disagreement with a significant other about an interpersonal issue of importance to both. (34)
 32. Assign to the client readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons) and other social skills (*The Cognitive Behavioral Therapy Workbook for Personality Disorders* by Wood) (or assign “Becoming Assertive” in the *Adult Psychotherapy Homework Planner* by Jongsma); discuss the key points.
 33. Use role-play and behavioral rehearsal to improve the client’s social skills (or assign “Restoring Socialization Comfort” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 34. During a family therapy session, instruct the client to speak directly to his/her spouse/partner about a conflictual issue, paying attention to ways in which conflict is avoided. Redirect the client to confront rather than immediately submitting to the partner’s desires in a low-risk area of conflict (e.g., an easily changeable behavior, such as leaving the toilet seat up or down). Ask the client to address progressively more threatening material (expressing love, issues of trust, sexual behavior, etc.). Support with bibliotherapy, such as *Ten Lessons to Transform Your Marriage* by Gottman, Gottman, and

20. Reduce the frequency of volunteering to do undesirable tasks. (35)
21. Reduce fear of being left alone/not being in a romantic relationship. (36)
22. Report pride in having completed an independent activity (e.g., going alone to a store or museum or for a walk). (37)
23. Cooperate with referral to a physician to evaluate the need for psychotropic medication. (38)
- Declaire and/or *Hold Me Tight* by Johnson.
35. Instruct the client to describe instances in which he/she volunteered to do unpleasant tasks. Explore the reasons that he/she wanted to do these tasks (approval from others, fears of rejection if he/she did not do them, etc.). Clarify the relationship of such behavior to relevant schemas, such as Subjugation and/or Self-Sacrifice, and the associated childhood experiences. Support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko.
36. Challenge the client's irrational beliefs associated with the Abandonment schema regarding being alone (e.g., "It is awful to be alone" and "If I disagree with someone I will be abandoned, which would be horrible") by disputing them, replacing extreme reactions with less extreme ones (e.g., "It would be inconvenient to be alone or to break up").
37. Assign the client to list one independent activity that can be accomplished per day for the next week (or assign "Making Steps Toward Independence" in the *Adult Psychotherapy Homework Planner* by Jongsma); solicit a commitment from the client to follow through with enactment of this list.
38. Refer the client to a physician for an evaluation for medication to increase energy level, improve mood, and decrease anxiety; help

- the client to process costs and benefits of a medication evaluation.
24. Take psychotropic medication as prescribed, and report on the medication's effectiveness and side effects. (39)
 25. Express awareness of own unique and separate needs rather than stating that his/her only need is to go along with what others want. (16, 40)
 26. Report improved awareness of the impact of personal actions on others. (41)
 27. Verbalize a decreased fear that a current intimate partner relationship will end in abandonment. (42)
 39. Monitor the client's use of psychotropic medication for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medication. Coordinate and confer with the prescribing physician as needed.
 16. Train the client to use meditation (e.g., thought-watching exercise) to identify distorted thoughts by assigning *Wherever You Go, There You Are* by Kabat-Zinn, processing key concepts in session; demonstrate the technique during the session, and assign practice as homework.
 40. Teach the client about *introjection* (identification with another person, believing that their characteristics are yours); explore how that process is interfering with adaptive functioning.
 41. Conduct or refer the client to group therapy to improve interpersonal interactions by increasing the client's awareness of the impact that his/her dependent behavior has on others and others' feelings about him/her.
 42. Evaluate evidence for and against the client's belief that the current partner relationship will end, assessing its likelihood. Challenge the client's *catastrophizing* (i.e., the belief that a small disagreement is a

disaster that will lead to the end of the relationship), replacing irrational beliefs with more balanced ones (e.g., a small disagreement may or may not be a sign that there is a problem in the relationship).

28. Resolve painful dynamics (e.g., cycle of denigration) within a relationship with a narcissistic spouse. (43, 44)

43. Administer the Millon Clinical Multiaxial Inventory (MCMI) to each member of the couple; process, with each individually, their personality tendencies and how they contribute to the couple's dynamics, both positive and negative (e.g., the narcissist's tendency to denigrate others and the dependent's tendency to denigrate him-/herself; the dependent's tendency to admire and the narcissist's tendency to crave admiration). Process how each individual achieving personal balance in these areas will help to resolve interpersonal difficulties (see *The Dependent/Narcissistic Couple* by Nurse, 1998).

44. Use Emotion-Focused Couple Therapy techniques, such as cycle deescalation, withdrawer engagement, and blamer softening, to reduce problematic withdrawal and facilitate improved intimacy within the couple (see *The Practice of Emotionally Focused Couple Therapy* by Johnson).

DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
309.0	F43.21	Adjustment Disorder, With Depressed Mood
300.4	F34.1	Persistent Depressive Disorder
300.02	F41.1	Generalized Anxiety Disorder
301.6	F60.7	Dependent Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.50	F60.4	Histrionic Personality Disorder
301.82	F60.6	Avoidant Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

DEPENDENT—SELFLESS

BEHAVIORAL DEFINITIONS

1. Willingly gives up own identity due to lack of independent sense of self and in order to be connected to another person.
2. Becomes depressed and/or frantic if disconnected from other with whom he/she identifies.
3. Is prone to depression and feelings of worthlessness.
4. Derives self-esteem through association with a person or organization.
5. Is overly hesitant to express disagreement for fear of losing support or approval of others.

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LONG-TERM GOALS

1. Develop an independent sense of self (e.g., increase awareness of own desires and needs).
2. Maintain feelings of calm when separated from significant others.
3. Establish a happy, upbeat mood.
4. Decrease submissive and obsequious behavior.
5. Increase range and adequacy of coping behaviors, skills, and competencies.
6. Decrease fear of being alone.
7. Improve self-esteem.

SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share difficulty and concerns. (1)
2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (2, 3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client's difficulties (e.g., feeling inadequate, incompetent, sad, and/or aimless) through unconditional positive regard, warm acceptance, and reflective listening.
2. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
3. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an

anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

4. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
5. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
3. Identify negative automatic thoughts about self that produce low self-esteem. (6)
6. Assign the client to keep a record of dysfunctional thoughts associated with the Dependence/Incompetence schema (e.g., "I'm too inadequate to handle life on my own," "My spouse is the smart one; I need to do what he/she does/says," "If I don't do what I'm supposed to, I'll be abandoned"); assist the client in replacing distorted automatic thoughts with more realistic, positive thoughts. See *Schema Therapy* by Young, Klosko, and Weishaar.

4. Report a reduced frequency of distorted, negative thoughts that lower self-esteem; increase frequency of positive thoughts. (7)
5. Report pride in one or more unique accomplishments or talents. (8)
6. Report feelings of self-worth that are independent of a significant other or an organization with which he/she is connected (e.g., a place of employment or a volunteer organization). (9)
7. Verbalize being able to cope with painful emotions. (10)
7. Reinforce the client's positive self-talk; empathize with feelings of low self-esteem. Be aware of own feelings as they are impacted by the client and provide feedback to the client about those feelings, thus facilitating perspective on the part of the client.
8. Assign the client to keep a daily journal of feelings. Require that he/she record at least one positive emotion, accomplishment, or self-descriptive thought per day and that at least one accomplishment/activity be for himself/herself and not connected to helping a significant other or organization.
9. Evaluate the evidence for and against the client's self-deprecatory comments associated with the Defectiveness/Shame schema (e.g., "I am worthless," "Without my significant other I am nothing"). Using Socratic dialogue, challenge the client to provide more realistic alternative possibilities (e.g., "Each person is valuable, including me," "I have people in my life who care about me," "I have a number of things I want to accomplish"). Support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko.
10. Conduct or refer client to a Mindfulness-Based Stress Reduction Program. Recommend smartphone apps to assist with daily practice, such as Mindfulness Coach (U.S.).

- Department of Veterans Affairs), Mindfulness Meditation (Mental Workout), or Simply Being (Meditation Oasis).
8. Verbalize being able to cope with current feelings of rejection and abandonment. (11)
 9. During a period of recent rejection, verbalize having a goal in addition to finding another relationship. (12)
 10. Express awareness of own unique and separate needs rather than stating that the only need is to go along with what others want. (13, 14, 15, 16)
 11. Assign the client to read a book on empowerment (e.g., *Don't Take It Personally!* by Savage or *Life's Too Short* by Twerski); process key points.
 12. Assist the client in developing a list of activities that he/she would enjoy (e.g., going for a hike, getting a professional massage) and/or goals that he/she would like to accomplish (e.g., advance professionally, attend a conference, attain a better-paying job); process how doing the activities on this list can provide a sense of positive focus and direction.
 13. Train the client to use meditation (e.g., thought-watching exercise) to identify distorted thoughts by assigning *Full Catastrophe Living* by Kabat-Zinn, processing key concepts with the therapist; demonstrate the technique during the session, and assign practice as homework.
 14. Explore family patterns related to gaining a feeling of competence and independence (or assign "Taking Steps Toward Independence" in the *Adult Psychotherapy Homework Planner* by Jongsma). Evaluate instances of overprotection and messages suggesting incompetence.
 15. Help the client to understand the validity of his/her experience, then use this as the basis for

action (e.g., “Even though you went along with what everyone else wanted to do yet again, inside you wanted to do something different but felt that it would not be okay to express that”). See “Using Self Psychology in Brief Psychotherapy” by Gardner and “Speaking in the Interpretive Mode and Feeling Understood” by Ornstein and Ornstein.

11. Identify triggers for fear of being left alone. (17, 18)
12. Verbalize an awareness of the proclivity to submerge own identity into that of another person. (18)
16. Help the client to understand how his/her reactions that are causing him/her pain also serve a protective function (e.g., “Of course you go along with everyone else, because growing up you learned that was the only way to stay safe”). See “Using Self Psychology in Brief Psychotherapy” by Gardner and *How Does Analysis Cure?* by Kohut.
17. Explore themes related to fear of abandonment that occur spontaneously in dreams, fantasies, and free associations. Interpret their connection to the client’s relationships with significant others in both the past and the present (including the therapist, if applicable).
18. Suggest that the client discuss fear of independent functioning and tendency to subjugate self to others during an individual or group therapy session; process the feelings.
18. Suggest that the client discuss fear of independent functioning and tendency to subjugate self to others during an individual or group therapy session; process the feelings.

13. State confidence in possessing the survival skills necessary to earn adequate income, obtain food and shelter, access transportation, and maintain relationships. (19, 20)
14. Each member of the family describes how the client's selfless behavior impacts him/her. (21, 22)
19. Train the client in problem-solving skills through brainstorming to generate possible solutions, weighing pros and cons of each solution, and evaluating possible solutions by anticipating potential consequences (or assign "Applying Problem Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma).
20. Using role-play, role reversal, and behavioral rehearsal, provide relationship skills training, including a focus on *sending skills* (delivering a message to others), *receiving skills* (getting a message from others), and *processing skills* (choosing which skill to use in a particular situation). See *Social Skills Training for Psychiatric Patients* by Liberman, DeRisi, and Mueser.
21. In a family session, explore each family member's feelings regarding the client's selfless behavior (e.g., seeing his/her own needs as identical to those of others, doing whatever others want, and denying any independent desires), noting those who reinforce it versus those who discourage/confront it.
22. Explore couple's interactions that support the client's dependent behavior, such as the partner feeling proud and flattered by the client's submission to the partner's needs and desires. Support with bibliotherapy, such as *Hold Me Tight* by Johnson.

15. Family members/significant other reduce interactions that serve to perpetuate the client's selfless behavior. (23)
16. Report awareness of own identity that is separate from another person. (24)
17. State a desire to increase independence and sense of independent identity. (25, 26)
18. Express anger in an appropriate fashion in response to a situation in which hurt, unfairness, or violation of rights occurred. (27, 28)
23. Develop a behavioral contract between the client and one or more family member(s), in which both the client and family member(s) receive rewards for reinforcing/ encouraging the client's independent behavior.
24. Explore with the client his/her process of *introjection* (identification with another person, believing that their characteristics are yours); examine how that process is interfering with adaptive functioning.
25. Examine the concept of self-fulfilling prophecy (how excessively submerging his/her own needs elicits the abandonment he/she fears most). See *Disorders of Personality* by Millon.
26. Explore valued domains of living (e.g., work/career, education, intimate relationships, parenting, etc.) in terms of importance and level of current satisfaction. Then assist the client with an experiential exercise designed to facilitate direction and forward movement, such as the "Building Your Life Compass" (see *The Mindfulness and Acceptance Workbook for Anxiety* by Forsyth and Eifert).
27. Instruct the client to imagine that the person who hurt his/her feelings is in an empty chair in the room. Direct the client to express his/her feelings to the imagined person while continuing to increase the intensity of the reaction until a deep emotional response is achieved.

19. Increase assertiveness in situations in which passivity previously was used. (29)
20. Express disagreement with a significant other about an interpersonal issue of importance to both. (30)
21. Family members encourage the client to participate in independent activities. (31)
22. Express feelings using “I” statements. (32)
28. Assign the client to read *The Dance of Anger* by Lerner; process key points in the session.
29. Assign readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons); discuss the key points.
30. Use role-play, modeling, and behavioral rehearsal with the client to simulate situations that demand assertiveness (or assign “Becoming Assertive” in the *Adult Psychotherapy Homework Planner* by Jongsma); provide feedback regarding the appropriateness of the responses.
31. During a family therapy session, instruct the client to speak directly to his/her spouse/partner about a conflictual issue, paying attention to ways in which conflict is avoided. Redirect the client to confront rather than immediately submitting to the partner’s desires in a low-risk area of conflict (e.g., an easily changeable behavior, such as leaving the toilet seat up or down). Ask the client to address progressively more threatening material, such as expressing love, issues of trust, or sexual behavior (or assign “Applying Problem Solving to Interpersonal Conflict” in the *Adult Psychotherapy Homework Planner* by Jongsma).
32. Encourage the client to express his/her feelings in the following manner: “When you say X to me in Y situation, I feel Z.” Encourage the significant other to do likewise. Instruct both to persist in communicating in that

- manner until each side reports understanding the other (see *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman).
23. Set appropriate boundaries with a significant other. (33)
 24. Verbalize an awareness of the origins of own feelings of inadequacy. (34)
 25. Reduce the frequency of volunteering to do undesirable tasks. (35, 36)
 33. When a family member evidences enmeshment (finishes the client's sentence for him/her, answers questions for him/her, etc.), help the family draw clearer boundaries (e.g., say to the family member, "You are very good and very helpful; however, when you finish his/her sentence, you take away his/her voice. Let him/her answer my question"). See *Family Therapy Techniques* by Minuchin and Fishman.
 34. Develop a genogram to increase the client's awareness of family patterns of dependence in relationships and to show how he/she is repeating them in the current relationship.
 35. Using rational emotive techniques, challenge the client's beliefs that motivate doing unpleasant tasks. Replace exaggerated fears (e.g., "If I don't jump in and do things, no one will want me around and I will be completely abandoned") with more realistic assessments (e.g., "If I don't do things for others, some will not like it, and others will prefer the new way I behave").
 36. Compare the client's choosing to do unpleasant tasks to gain approval in current relationships (e.g., significant others or the relationship with the therapist)

- to similar actions in past behaviors (e.g., with parents). Process with the client his/her feelings about maintaining this practice, and discuss the fear of making changes.
26. Report pride in having completed an independent activity that reflects own wishes rather than being part of another person's plans (e.g., going to a museum exhibit that nobody else wants to see). (37)
 27. Cooperate with referral to a physician to evaluate the need for psychotropic medication. (38)
 28. Take psychotropic medication as prescribed, and report on the medication's effectiveness and side effects. (39)
 29. Report little or no distress when in between romantic or other close relationships. (40)
 37. Assign the client to list one independent activity that can be accomplished per day for the next week; solicit a commitment from the client to follow through with enactment of this list (or assign "Taking Steps Toward Independence" in the *Adult Psychotherapy Homework Planner* by Jongsma).
 38. Refer the client to a physician for an evaluation for psychotropic medication to increase energy level, improve mood, and decrease anxiety; help the client to process costs and benefits of a medication evaluation.
 39. Monitor the client's use of psychotropic medication for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medication. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.
 40. Challenge and dispute the client's irrational beliefs regarding being alone (e.g., "It is awful to be alone" and "If I disagree with someone I will be abandoned, which would be horrible"). Replace extreme reactions with less extreme ones (e.g., "It would be inconvenient

- to be alone or to break up”); explore how the client can meet his/her own emotional needs (or assign “Satisfying Unmet Emotional Needs” in the *Adult Psychotherapy Homework Planner* by Jongsma).
30. Attend group therapy to gain insight into own pattern of interpersonal interactions and develop a stronger sense of self. (41)
 31. Develop a plan to end relationship with abusive partner; with therapist’s guidance, implement the plan. (42, 43)
 41. Conduct or refer the client to group therapy to improve interpersonal interactions by increasing the client’s awareness of the impact that his/her behavior has on others and others’ feelings about him/her.
 42. Refer the client to a safe house and/or a specific domestic violence program; monitor and encourage continued involvement in the program.
 43. Assign the client to read *The Verbally Abusive Relationship* by Evans; in subsequent sessions process key ideas and insights gathered from reading.
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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.6	F60.7	Dependent Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
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DEPRESSIVE*

BEHAVIORAL DEFINITIONS

1. Mood is usually dejected, gloomy, and joyless.
2. Has low self-esteem and deep feelings of inadequacy.
3. Is self-derogatory.
4. Frequently worries and frets.
5. Engages in critical and judgmental attitude toward both self and others.
6. Tends to be highly pessimistic and complaintive.
7. Experiences a great deal of guilt and regret.

LONG-TERM GOALS

1. Brighten downcast mood.
2. Improve self-esteem and feelings of self-worth.
3. Decrease ruminative worry.
4. Enhance optimism.
5. Reduce feelings of guilt and remorse.
6. Reduce griping and complaining.
7. Facilitate positive interpersonal relationships.
8. Expand active problem solving, thereby decreasing passive resignation.

*Appendix A elaborates on the dimensional structure for behavioral definitions.

SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share difficulties and concerns. (1)
2. Cooperate with a comprehensive assessment. (2)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client's difficulties (e.g., feeling inadequate, incompetent, and morose) through unconditional positive regard, warm acceptance, and reflective listening.
2. Administer or refer the client for personality testing to assess the severity of the depressive pathology and concomitant emotional/behavioral/cognitive problems (e.g., MCMI; Schema Questionnaire; Beck Depression Inventory; Basic Adlerian Scales for Interpersonal Success-Adult Form (BASIS-A)). Assess diversity considerations: Age, Developmental and acquired Disabilities, Religion, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender (ADDRESSING, see *Addressing cultural complexities in practice* by Hays). Consider how diversity considerations can make interventions more effective,

162 THE PERSONALITY DISORDERS TREATMENT PLANNER

- and/or avoid pathologizing culturally normative attitudes and behaviors.
3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)
 3. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
 4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 5. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 6. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted

- creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
4. Explore ambivalence regarding changing cynical, pessimistic attitudes. (7)
 5. Commit to changing negative, cynical attitudes. (8)
 6. Identify negative automatic thoughts about self that produce low self-esteem. (9, 10)
 7. Use Open-ended questions, Affirmations, Reflections, and Summaries (OARS) to unearth ambivalence about change, as seen in statements such as “There’s no use in trying, it’s hopeless” juxtaposed with “I can’t go on with the way things are” (see *Motivational Interviewing* by Miller and Rollnick).
 8. Use change-talk strategies, such as siding with the status quo (negative); for example, “Perhaps your self-protective pessimism is so important to you that you are unwilling to give it up, regardless of the price you have to pay.”
 9. Assign the client to keep a record of dysfunctional thoughts associated with the Negativity/Pessimism and/or Failure schemas, such as: “Life stinks,” “Bad things always happen to me,” or “I’m stupid” (or assign “Negative Thoughts Trigger Negative Feelings” in the *Adult Psychotherapy Homework Planner* by Jongsma). See *Schema*

Therapy by Young, Klosko, and Weishaar.

7. Reduce the frequency of distorted, negative thoughts that lower self-esteem; increase the frequency of positive thoughts. (11, 12, 13, 14)
10. Empathize with the client's feelings of low self-esteem. The therapist must be aware of his/her own feelings as they are impacted by the client and provide feedback to the client about those feelings, thus facilitating perspective on the part of the client.
11. Train the client to use meditation (e.g., thought-watching exercise) to identify distorted thoughts by assigning *Wherever You Go, There You Are* by Kabat-Zinn, processing key concepts within session; demonstrate the technique during session, and assign practice as homework.
12. Assign the client to keep a daily journal of thoughts and feelings (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma); require that he/she record at least one positive emotion, accomplishment, or self-descriptive thought per day.
13. Using Socratic dialogue, challenge and help the client reframe his/her negative thoughts, such as "I am pathetic," replacing them with balanced thoughts, such as "I have strengths and weaknesses, just like everyone else." Support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko.

8. Identify and address secondary gain that results from speaking disparagingly about self. (15)
9. Cooperate with referral to a physician to evaluate the need for psychotropic medication. (16)
10. Take psychotropic medication as prescribed, and report on the medication's effectiveness and side effects. (17)
11. Positively acknowledge and accept verbal compliments from others. (18)
12. Describe feeling more confident and comfortable with self in the face of problems rather than feeling incompetent and inadequate. (19)
14. Assign the client to read *The Six Pillars of Self-Esteem* by Branden, *Self-Esteem* by McKay and Fanning, or *The Self-Esteem Workbook* by Schiraldi. Process central ideas with therapist.
15. Assist the client in identifying how self-disparagement and avoidance of risk-taking can be reinforced through secondary gain (e.g., attention and nurturance from others, evading fear of reprisal for becoming angry).
16. Refer the client to a physician for an evaluation for medication to improve mood and decrease anxiety; help the client to process costs and benefits of a medication evaluation.
17. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.
18. Assign the client to be aware and acknowledge graciously (without discounting) praise and compliments from others; practice this acknowledgment using role-play.
19. Discuss with the client his/her interpersonal conduct role models from prior generations (parents, uncles/aunts, grandparents, etc.) in order to

- gain an understanding of the origins of the self-demeaning behavior. Process the effectiveness and appropriateness of these behaviors in the current circumstances.
13. Verbalize feeling optimistic or confident about a situation that previously would have provoked feelings of pessimism or despair. (20, 21)
 14. Actively engage in problem solving regarding a current difficulty that previously triggered passivity and resignation. (22)
 20. Examine the evidence for and against the client's beliefs that all is hopeless and all efforts are futile (or assign "Analyze the Probability of a Feared Event" in the *Adult Psychotherapy Homework Planner* by Jongsma); challenge the beliefs by examining previous instances of success as well as the possibility that the outcome will be different because the client is trying a new approach or technique.
 21. Ask the client to recall, one at a time, five incidents that occurred before the age of 10. Prompt the client for age of the early recollection (ER), and write down verbatim the whole ER. Ask about the feeling in the ER as well as the most vivid moment. Select an ER with a theme involving depression or pessimism; ask the client to rewrite the ER with a more positive, optimistic outcome. See *The Individual Psychology of Alfred Adler* by Ansbacher and Ansbacher.
 22. Train the client in problem-solving skills including: brainstorming to generate possible solutions, weighing pros and cons of each solution, and evaluating

- possible solutions by anticipating potential consequences (or assign “Applying Problem Solving to Interpersonal Conflict” in the *Adult Psychotherapy Homework Planner* by Jongsma); teach the client how his/her negativity leads to self-fulfilling prophecies (e.g., complaining creates relationships with negative others, who then engage in a cycle of mutual negativity). See *Disorders of Personality* by Millon.
15. Reduce the frequency of negative automatic thoughts about self that produce guilt and self-recrimination. (23)
 16. Express no longer feeling guilty about an issue that was previously very disturbing. (24, 25)
 23. Use rational emotive techniques to challenge the client’s distorted thoughts associated with the Defectiveness/Shame schema (e.g., “I am a terrible person,” “I should not have done that”). Replace them with more balanced thoughts (e.g., “I am a fallible human being,” “To err is human, to forgive divine”).
 24. Explore the client’s feelings of guilt related to important figures (e.g., parents) from early childhood; process how these feelings are impacting his/her current experiences.
 25. Process (or refer the client to clergy to process) the client’s belief about the loving and forgiving nature of God in the context of his/her images of God as judge and punisher. Encourage the client to find peace in God’s loving acceptance of us.

17. Verbalize being able to let go of ruminative, worrisome thoughts regarding a current situation. (26, 27)
18. Verbalize appropriate and balanced thoughts about an issue that formerly caused excessive rumination and guilt. (28)
19. Make fewer self-derogatory statements, as indicated by decreasing such statements during therapy sessions. (29)
20. Verbalize feeling more happy, light, or loose. (30)
26. Examine the client's spiritual beliefs regarding ways to repent for or resolve prior wrongs (e.g., seeking forgiveness, prayer, trying to make certain that similar incidents do not happen again to oneself or others); process with the client or refer him/her to clergy.
27. Assign the client to use *The Cognitive Behavioral Workbook for Depression* by Knaus and Ellis or *The Mindful Way Workbook* by Teasdale, Williams, Segal, and Kabat-Zinn and/or Depression CBT Self Help Guide Moodkit (ThrivePort, app); process key points.
28. Explore the relationship of current feelings of guilt and rumination to previous experiences in the client's family of origin.
29. When the client makes a self-derogatory statement during therapy, explore his/her fantasies about the anticipated therapist response. Examine the meaning of the client's projections and their relationship to significant figures from his/her past.
30. Assign the client to read a book on how to lead a fulfilling life (e.g., *Don't Sweat the Small Stuff and It's All Small Stuff* by Carlson; *Everyday Blessings* by Kabat-Zinn and Kabat-Zinn; *The Road Less Traveled* by Peck); process key ideas in the session.

21. Increase assertiveness in situations in which passivity previously was used. (31, 32)
22. Increase frequency of pleasurable leisure activities, such as attending a movie with family, playing pool, or going for a hike. (33)
23. Describe an experience as tolerable, humorous, or an opportunity for personal growth rather than complaining about it. (34, 35)
31. Assign readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons); discuss the key points in subsequent sessions.
32. Use role-play, modeling, and behavioral rehearsal with the client to simulate situations that demand assertiveness (or assign “Becoming Assertive” in the *Adult Psychotherapy Homework Planner* by Jongsma); provide feedback regarding the appropriateness of his/her responses.
33. Ask the client to list activities in which he/she could engage for pure enjoyment, such as attending a symphony concert, hiking in the woods, writing poetry, or going on a picnic with his/her family; collaborate with the client to develop a plan to incorporate these into his/her life (or assign “Identify and Schedule Pleasant Activities” in the *Adult Psychotherapy Homework Planner* by Jongsma); reinforce enactment of such activities.
34. Assign *The Healing Power of Humor* by Klein or *Fun as Psychotherapy* by Ellis, and discuss key points. Discuss the use of humor, the concept of taking oneself lightly (even in serious circumstances), and the ability to laugh and have fun with others.
35. Encourage and monitor the client in doing one random, spontaneous act of kindness on a daily basis, and explore

- the positive results (or assign “Three Acts of Kindness” in the *Adult Psychotherapy Homework Planner* by Jongsma).
24. Have a pleasant conversation with a family member, coworker, or new acquaintance without complaining or commiserating. (36)
 25. Express feelings of anger and/or resentment harbored toward significant others who abandoned him/her in the past, and achieve some feeling of resolution. (37, 38)
 26. Express compassion toward another person’s difficulties rather than being judgmental or critical. (39, 40, 41, 42)
 36. Provide relationship skills training, including a focus on *sending skills* (delivering a message to others), *receiving skills* (getting a message from others), and *processing skills* (choosing which skill to use in a particular situation). See *Social Skills Training for Psychiatric Patients* by Liberman, DeRisi, and Mueser.
 37. Discuss with the client his/her relationships with significant others from prior generations (parents, uncles/aunts, grandparents, etc.), looking for punitive or abandoning relationships in order to gain an understanding of the origins of resentful feelings and behaviors. Help the client to gain perspective, separating others’ needs and feelings from his/her own.
 38. Instruct the client to imagine that a person who hurt his/her feelings is in an empty chair in the room. Direct the client to express his/her feelings to the imagined person while continuing to increase the intensity of the reaction until a deep emotional response is achieved.
 39. During a family session, use a genogram to clarify multigenerational family relationships and to identify

- sources of hurt that have been unresolved; process these resentments to resolution.
40. Within a family therapy session, explore each family member's feelings regarding the client's harsh, judgmental behavior. Ask the client to reflect those feelings back to each family member until understanding is achieved.
 41. Use role reversal to help the client empathically see a problem from another person's point of view.
 42. When the therapist makes an error, elicit and process the client's harsh, judgmental feelings during the session, drawing connections to the client's relationships with current or past significant others.
 43. During a family therapy session, encourage the client (and the relevant family member) to express feelings in the following manner: "When you say X to me in Y situation, I feel Z." Encourage the significant other to do likewise. Encourage them to persist in communicating in that manner until each side reports understanding the other (see *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman).
 44. When the client is harsh or judgmental to someone during a family session, encourage the targeted person to set limits
27. Decrease frequency of harsh, critical statements to minimal levels. (43, 44)

with the client (e.g., “Answer back to him and get him to stop!”). Discontinue the intervention when some degree of success has been achieved, and verbally reward both participants (see *Family Therapy Techniques* by Minuchin and Fishman).

28. Verbalize having come to terms with disappointments. (45)

45. Assist the client in developing a long-term plan that will lead to greater feelings of fulfillment and satisfaction. Encourage involvement in spiritual activity.

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.9	F60.9	Unspecified Personality Disorder
301.82	F60.6	Avoidant Personality Disorder
301.6	F60.7	Dependent Personality Disorder
_____	_____	_____
_____	_____	_____

HISTRIONIC*

BEHAVIORAL DEFINITIONS

1. Has a strong desire to be the center of attention.
2. Is often inappropriately provocative or sexually seductive.
3. Expresses shallow, rapidly shifting emotions.
4. Uses physical appearance to gain attention from others.
5. Speech is impressionistic and lacks detail.
6. Is dramatic, theatrical, and displays emotions in an exaggerated fashion.
7. Is highly suggestible.
8. Overestimates the intimacy of relationships.

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LONG-TERM GOALS

1. Reduce focus on gaining attention from others while strengthening self-awareness and self-image.
2. Decrease manipulative actions designed to gain attention from others.
3. Form genuine social relationships.
4. Decrease seductive behavior and excessive use of physical appearance to secure attention.
5. Stabilize erratic moods and dramatic displays of emotion.
6. Reorient flighty cognitive style, increasing attention to relevant detail.

*Appendix A elaborates on the dimensional structure for behavioral definitions.

- 7. Improve self-esteem.
- 8. Decrease suggestibility.

SHORT-TERM OBJECTIVES

- 1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share difficulties and concerns. (1)
- 2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (2, 3, 4, 5)

THERAPEUTIC INTERVENTIONS

- 1. Using unconditional positive regard, express empathy for the client’s difficulties (e.g., feeling lonely, bored, or anguished).
- 2. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).
- 3. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased

suicide risk when comorbid depression is evident).

4. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 5. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
 6. Assist the client in developing a list of goals for therapy based on how he/she would like to feel or behave after treatment. The list must include specific attitudes and actions that the client can attain independently (e.g., "Express my feelings calmly," "Learn to play tennis") rather than goals for others (e.g., "My spouse will be more attentive to me").
 7. Assign the client readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons or "Develop Assertive Communication Skills" in *Cognitive Behavioral Therapy Workbook for Personality*
3. Set specific goals for psychotherapy. (6)
 4. Increase appropriate assertiveness in situations in which behavior was previously overly dramatic and unrestrained. (7, 8)

Disorders by Wood); discuss the key points.

5. Express anger in an appropriate fashion rather than in an overly dramatic fashion in response to feeling wronged, hurt, or violated. (9)
6. Become aware of and change the tendency to automatically entertain others. (10)
7. Express vulnerable feelings with a partner/spouse. (11)
8. Use role-play, modeling, and behavioral rehearsal with the client to simulate impersonal (interacting with a store manager, salesperson, etc.) or personal (e.g., interactions with a friend or family member) situations that demand assertiveness (or assign “Becoming Assertive” in the *Adult Psychotherapy Homework Planner* by Jongsma); provide feedback regarding the appropriateness of his/her responses.
9. Instruct the client to imagine the person who hurt his/her feelings is in an empty chair in the room. Direct the client to express his/her feelings to the imagined person while continuing to increase the intensity of the reaction until a deep emotional response is achieved.
10. Challenge the client when he/she begins entertaining the therapist by remarking that the behavior is entertaining and then asking whether this is an effective use of time toward achieving the goals of therapy.
11. During a couples therapy session, instruct the client to speak directly to his/her spouse/partner, paying attention to ways in which conflict is avoided. Encourage each person to express his/her emotions, taking into account the insecure attachment style of the person with Histrionic Personality Disorder. Process his/her fear of

- being vulnerable and use of defensive anger to hide vulnerability (see *The Practice of Emotionally Focused Couple Therapy* by Johnson).
8. Report an improved personal sense of identity. (12, 13)
 9. Each member of the family describes how the client's dramatic and/or attention-seeking behavior impacts him/her. (14)
 10. Each family member/partner reduces interactions within the family that serve to perpetuate client's dramatic and/or manipulative behavior. (15, 16)
 12. Highlight for the client unique aspects of his/her identity as they spontaneously arise during sessions (e.g., client stating "I am impatient" or "I love having new adventures").
 13. Explore and clarify valued attributes that the client has or would like to have other than physical attractiveness (e.g., honesty, adventurousness, compassion, boldness, etc.). Work with the client to identify why these attributes are important and how to meaningfully work toward connection with the valued quality using collaborative, stepwise goal setting and action. Consider using a values checklist as a guide (see "Checklist for Personal Values" in *The Fifth Discipline Fieldbook*, by Senge, Kleiner, Roberts, Ross, and Smith).
 14. Explore how the client's dramatic behavior impacts family members (e.g., the client is attended to by family members; family members feel excited by or resent the client's dramatic displays).
 15. Assign the client and spouse to read *The Seven Principles for Making Marriage Work* by Gottman and Silver and/or *Love Sense* by Johnson; process the central ideas with the couple.

11. Acknowledge the pursuer-distancer pattern in the relationship, and commit to changing the pattern. (17, 18)
12. Report little or no distress when in between romantic or other close relationships. (19)
13. Express shades of gray regarding relationships with and characteristics of other people
16. Identify family members' behaviors that reinforce the client's dramatic and immature behaviors (e.g., significant other reassures the client with vows of love after the client throws a tantrum). Write a behavioral contract that allows each participant to get his/her needs met more directly (e.g., praising affectionate and/or assertive behavior rather than tantrums).
17. Teach the client the meaning of the pursuer-distancer pattern, whereby each person is reinforcing the other (i.e., pursuit encourages distancing and distancing encourages pursuit). Explore the historical pattern of pursuit and distancing in the client's current relationships.
18. Encourage the client to explore independent interests as a means of breaking the cycle of pursuit and distancing. Explore with the client the question "What is your life without that person?"
19. Challenge and dispute irrational beliefs associated with the Emotional Nurturance schema (e.g., "I'm not lovable unless I entertain others," "If he/she leaves me, it would be horrible"). Replace extreme reactions with milder ones (e.g., "It would be inconvenient to be alone or to break up;" see "Challenge Your Negative Core Beliefs" in the *Cognitive Behavioral Therapy Workbook for Personality Disorders* by Wood).
20. Challenge the client's catastrophizing associated with the Abandonment/Instability

rather than viewing them with an all-or-none attitude. (20)

schema (e.g., the belief that a small disagreement is a disaster that will lead to the end of the relationship), replacing irrational beliefs with more balanced ones (e.g., a small disagreement may or may not be a sign that there is a problem in the relationship). See *Schema Therapy* by Young, Klosko, and Weishaar. Support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko.

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| <p>14. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (21)</p> <p>15. Take medication as prescribed, and report on its effectiveness and side effects. (22)</p> <p>16. Express awareness of own separate needs rather than stating that the only need is to go along with what others want. (23)</p> <p>17. Report improved awareness of the impact of theatrical and overly dramatic behavior on others. (24, 25)</p> | <p>21. Refer the client to a physician for an evaluation for medication to stabilize mood; process costs and benefits of a psychiatric evaluation.</p> <p>22. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.</p> <p>23. Explore the client's <i>introjections</i> (identification with another person, believing that their characteristics are yours); examine how that process is interfering with adaptive functioning.</p> <p>24. Explore assumptions the client makes regarding the therapist's feelings about him/her, and compare them to interactions in significant relationships in the past (e.g., early childhood).</p> <p>25. Conduct or refer the client to group therapy to improve</p> |
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- interpersonal interactions by increasing the client's awareness of the impact that his/her behavior has on others and others' feelings about him/her.
18. Report a decrease in attention-seeking behavior in social settings (e.g., when out with friends). (26, 27)
 19. Report a decrease in dramatic, theatrical behavior in work settings. (28)
 20. Verbalize awareness of excessive use of sexually seductive behavior to gain attention, to meet someone's expectations, or to obtain special treatment. (29, 30)
 26. Role-play social scenarios with the client, eliciting his/her feelings and providing feedback about the feelings of the person interacting with him/her; evaluate pros and cons of the attention-seeking behavior.
 27. Conduct or refer the client to a psychodrama group, taking advantage of the client's proclivity to be dramatic while providing opportunities for personal growth. Use psychodrama techniques in a group to re-create workplace or personal interactions that created problems for the client and direct the client to explore different endings to the scenario, thereby increasing understanding of potential consequences and feelings associated with each outcome.
 28. Use role-play, modeling, and behavioral rehearsal to teach the client about the impact of his/her dramatic behavior on superiors, colleagues, and/or subordinates at work.
 29. Highlight the client's seductive behavior as it occurs during the therapy session; explore what the motivation for this behavior might be.
 30. In a group or individual session, use role-play to reenact interactions with others, especially interactions in which unwanted sexual attention or

- unexpected special favors occurred; highlight for the client instances of seductive behavior.
21. Verbalize an understanding of the negative consequences of using seductive behavior in nonintimate situations. (31)
 22. Verbalize reasons that someone would be interested in him/her other than his/her physical appearance. (32)
 23. Report negative consequences of excessive focus on physical appearance. (33)
 24. Realistically appraise the intimacy of a new relationship rather than believing it is more intimate than it really is. (34)
 25. Verbalize feeling good in a social situation without being the center of attention. (35)
 31. Explore the client's fantasies regarding sexual relationships, including fantasies about the therapist (if present); consider the impact of these fantasies on current functioning.
 32. Assist the client in creating a list of positive attributes other than physical appearance; discuss how these attributes might be constructively demonstrated to others.
 33. Assist the client in developing a list of pros and cons regarding the use of physical appearance to gain attention; explore how the negative consequences may have been experienced.
 34. Teach the client criteria for an intimate relationship; ask him/her to provide evidence regarding the intimacy of a current relationship. Support with bibliotherapy, such as *Love Sense* by Johnson and/or *The Seven Principles for Making Marriage Work* by Gottman and Silver.
 35. Use rational emotive or cognitive techniques to challenge the client's beliefs about being the center of attention (Approval Seeking/Recognition Seeking schema). Replace extreme thoughts (e.g., "I must be the center of attention or else I am totally unloved or a total failure") with more rational thoughts (e.g., "It is okay for me

182 THE PERSONALITY DISORDERS TREATMENT PLANNER

- to be the center of attention sometimes and not to be the center of attention at other times”; “Just because I am not the center of attention does not mean that others do not like me”).
26. Report increased ability to focus and less time feeling distracted. (36, 37)
27. List difficulties in forming intimate attachments in prior relationships. (38, 39)
36. Train the client to relax using progressive muscle relaxation, hypnosis, autogenics, and/or visualization (or assign “Progressive Muscle Relaxation” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); augment with HeartRate+ (heartrateplus.com) or Breathe2Relax (National Center for Telehealth and Technology).
37. Conduct or refer the client to a Mindfulness-Based Stress Reduction program to improve self-awareness and the ability to remain calm. Consider augmenting practice with a mindfulness smartphone app, such as ACT Companion (Berrick Psychology), Mindfulness Meditation (Mental Workout), or Mindfulness Coach (U.S. Department of Veterans Affairs).
38. Ask the client to describe any dreams that he/she had; discuss themes involving intimacy and connection to others.
39. Discuss early relationships with parents, and assess resolution of conflicts related to interpersonal relationships. Encourage the client to persist despite difficulty with recall (repression).

28. Verbalize beliefs that will encourage maintenance of long-term relationships. (40)
29. Express a memory or line of thought clearly and distinctly, tracing the connection between one thought and another. (41, 42)
30. Describe a mildly conflictual interaction with a significant other in detail, noting the behaviors and emotional responses of each participant. (43)
31. Report a reduced frequency of thoughts that lower self-esteem. (44, 45, 46)
40. Explore the client's fantasies regarding intimate relationships (e.g., that there is a perfect person who will take care of all of his/her needs). Explore the relationship of these fantasies to early childhood relationships and/or the relationship with the therapist.
41. Help the client identify thoughts that are so vague and impressionistic, so broad and general, that they convey little information (e.g., "My childhood was wonderful").
42. Encourage the client to practice identifying internal thought processes, providing feedback regarding areas that are vague and impressionistic.
43. Assign as homework that the client solicit feedback from a significant other with whom the client has had a mild conflict. Discuss the accuracy of the client's conclusions regarding his/her significant other's feelings.
44. Assign the client to keep a record of dysfunctional thoughts (e.g., "I can't do it myself" and "I must get someone to take care of me"). See *Cognitive Therapy of Personality Disorders* by Beck, Davis, and Freeman. Look for indications of the core belief "I am inadequate and unable to handle life on my own." Suggest thoughts that are more realistic and affirming (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma).

- 45. Maintain an attitude of nonjudgment fully focused on the client's feelings. Provide the client with an opportunity to discuss feelings regarding self-esteem and self-worth. Ask the client for clarification and feedback until the therapist thoroughly understands the client's point of view and the client gains self-awareness regarding his/her strengths and anxieties, thus becoming more autonomous and self-compassionate.
- 46. Assign the client to read *The Six Pillars of Self-Esteem* by Branden, *Self-Esteem* by McKay and Fanning, or *Ten Days to Self-Esteem* by Burns; process central ideas with the client.

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.81	F45.1	Somatic Symptom Disorder
300.11	F44.x	Conversion Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.50	F60.4	Histrionic Personality Disorder
301.6	F60.7	Dependent Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

HISTRIONIC—DISINGENUOUS

BEHAVIORAL DEFINITIONS

1. Has a superficial veneer of charm, friendliness, and seductiveness; is often effective at making initial acquaintances and getting dates, but relationships generally are shallow and fleeting.
2. Seeks excitement and stimulation, often acting on impulse without giving much thought to future consequences.
3. Is scheming, contriving, plotting, guileful, and crafty, devising ways to take advantage of others.
4. Despite the guise of caring for others, is egocentric and insincere.
5. Is deceitful; uses aliases, lies, or cons people to get what is wanted.
6. Is irresponsible with regard to work, financial commitments, and family obligations.
7. Rationalizes or blames others for problems that occur; rarely takes responsibility.

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LONG-TERM GOALS

1. Improve intimacy in interpersonal relationships rather than having only brief, superficial relationships.
2. Find positive ways to manage stress rather than unhealthy stimulation seeking; improve impulse control.
3. Reduce the tendency to con others by increasing desire for and satisfaction from genuine accomplishments and relationships.

4. Demonstrate increased sensitivity to the needs of others rather than displaying only selfish concerns.
5. Exhibit interpersonally responsible conduct.

SHORT-TERM OBJECTIVES

1. Express satisfaction with the therapeutic relationship as indicated by the verbalization of difficulties and concerns. (1)
2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (2, 3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client’s difficulties (e.g., feeling generally bored or ungratified in relationships).
2. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).
3. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if

appropriate (e.g., increased suicide risk when comorbid depression is evident).

4. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
5. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
3. Identify current problems with relationships, self, or society that are causing distress. (6)
4. Verbalize, or imply by consistently attending appointments and verbally engaging with the therapist, motivation to participate in therapy. (7)
5. Establish a trusting relationship with the therapist, as demonstrated by freely sharing information. (8, 9, 10)
6. Assist the client in developing a list of specific dissatisfactions he/she is currently experiencing, such as difficulties with the law, work performance, and sustaining relationships.
7. Express the practical advantages of participating in the psychotherapeutic relationship, such as the opportunity to learn how to get his/her needs met more effectively.
8. If the client shares feelings, vulnerabilities, or admits mistakes, compliment him/her (e.g., "It took real strength to tell it like it is" and "Most

people wouldn't have had the guts to admit that—that was impressive”).

6. Verbalize acceptance of having limits set by the therapist and/or significant others. (11)
7. Verbalize disadvantages of dishonest and unlawful behavior. (12)
8. Complete assigned tasks at work or school rather than directing efforts toward ways to avoid work or cheat. (13)
9. When appropriate, comment on the client's facility with deception and lying, noting that he/she will be able to con the therapist at least some of the time. Process the pros and cons of being deceptive toward the therapist (see *Cognitive Therapy of Personality Disorders* by Beck, Davis, and Freeman).
10. Confront inconsistencies in the client's stories; ask him/her to clarify until attempts at deception become obvious. Process with the client the reasons for lying and the impact of prevarication on the relationship.
11. Set boundaries on the therapy relationship (e.g., refuse to extend credit or delay payments, decline sexual advances, decline meeting on a social basis); process them with the client.
12. Ask the client if dishonest, unlawful, or exploitive behaviors have been successful for him/her. Challenge rationalizations by pointing to current predicaments; help the client to see how the strategy as a whole has been unsuccessful, thus facilitating openness to change.
13. Brainstorm with the client regarding the positive (long-term) consequences of sticking with a particular task or vocational or educational activity.

9. Report an increase in honest accomplishment of goals and completion of tasks. (14, 15)
10. Describe disadvantages of exploitive behavior. (16)
11. Each member of the family describes how the client's deceitful or dishonest behavior impacts him/her. (17)
12. Each family member/partner identifies and reduces interactions within the family that serve to perpetuate the client's manipulative/exploitive behavior. (18)
14. Assist the client to break large, overwhelming goals (e.g., getting a college degree) into small, manageable ones (e.g., completing tonight's studying). Develop a behavioral contract with the client to build in short-term rewards for behaviors that will lead to the accomplishment of long-term goals.
15. Assign the client to read *The Seven Habits of Highly Effective People* by Covey and/or *First Things First* by Covey and Merrill in order to learn about setting priorities and focusing on long-term goals; process key points in the session.
16. Assist the client to make a list of pros and cons of behaviors that exploit others (e.g., inflating someone's expectations regarding commitment in a relationship in order to obtain sex, borrowing money without repaying it), assessing long-term versus short-term consequences.
17. Hold a family therapy session to encourage family members to convey instances in which they felt manipulated or lied to (e.g., when the client lied about substance abuse or infidelity); facilitate their expression of feelings regarding this deception.
18. Assist family members in identifying behaviors that reinforce the client's manipulative/exploitive behaviors (e.g., trying to obtain prescription medication from family members, borrowing money with no intention to pay back). Write a behavioral

- contract that will allow each participant to get his/her needs met more directly (e.g., praise given in response to assertive behavior rather than manipulations).
13. Report engaging in a cooperative relationship with another person. (19)
 14. Attend group therapy in order to learn how to relate to others based on a true self rather than a facade. (20)
 15. Increase expressions of empathy by accurately identifying the feelings of another person and verbalizing understanding of the other person's predicament. (21)
 16. Express regret or sorrow about having exploited another person or hurt his/her feelings. (22)
 17. Express accurate empathy regarding the feelings of a significant other. (23)
 19. Teach the client about self-fulfilling prophecies (e.g., how exploitation leads to revenge from others, thus continuing cycles of mistrust; conversely, how trustworthy behavior leads to mutual cooperation); see *Personality Guided Therapy* by Millon.
 20. Conduct or refer the client to group psychotherapy in order to obtain feedback from others regarding his/her behavior and to develop basic trust and accurate understanding of others.
 21. Express accurate empathy toward the client, allowing him/her to learn by example; use role-play and/or the empty chair to allow the client to express empathy for another person and the difficult or painful circumstance the other person is in.
 22. In a psychodrama, group, or individual session, the therapist (or a group member) plays the client and the client plays the person who was hurt or exploited. Continue the intervention until the client achieves emotional identification with the victim.
 23. Hold a family therapy session, and encourage the client to persist in rewording and

- reflecting back the communication of the family member, spouse, or partner until he/she agrees that the communication is accurate.
18. Describe instances in which acting on impulse have led to negative outcomes that were not worth it. (24)
 19. List the pros and cons of an action before making a decision rather than acting on impulse. (25)
 20. Identify behavioral and emotional antecedents for impulsive behaviors. (26, 27)
 24. Assist the client to make a list of instances in which acting on impulse had negative results; review more thoughtful alternatives that could have produced positive consequences. Consistently frame the consequences in terms of the client's internal motivation to change. See *Motivational Interviewing* by Miller and Rollnick.
 25. Instruct the client to evaluate choices using the problem-solving approach: Have the client list a problem (e.g., acting too impulsively), come up with a range of possible solutions, and then select from among those choices based on what is most consistent with his/her goals (or assign "Problem Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma). See *Cognitive Therapy of Personality Disorders* by Beck, Davis, and Freeman.
 26. Do a functional analysis of behavior with the client, identifying behavioral and emotional antecedents of acting out.
 27. Assign the client to keep a daily log of thoughts and the associated feelings using the "Three-Column Technique," identifying emotional

192 THE PERSONALITY DISORDERS TREATMENT PLANNER

- antecedents and consequences of acting out (see *Anxiety Disorders and Phobias* by Beck and Emery).
21. Report using alternative ways to handle stress rather than impulsive acting out. (28, 29)
 22. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (30)
 23. Take medication as prescribed, and report on its effectiveness and side effects. (31)
 24. Identify experiences with parent figures that have encouraged distance in relationships to protect self from further pain. (32)
 28. Institute stress inoculation training by preparing the client for stressful situations, using behavioral rehearsal to establish appropriate responses and initiating self-rewards for maintaining control (see *Stress Inoculation Training* by Meichenbaum).
 29. Train the client to use meditation (e.g., thought-watching exercise) by assigning *Full Catastrophe Living* by Kabat-Zinn, processing key concepts with therapist. Demonstrate the technique during session, and assign practice as homework.
 30. Refer the client to a physician for an evaluation for medication to improve mood and decrease anxiety; help the client to process costs and benefits of a psychiatric evaluation.
 31. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.
 32. Discuss the client's early relationship with parents, exploring themes related to Abandonment, Neglect, and/or Abuse schemas. Explore how

- these early experiences are impacting the ability to be close to others.
25. List difficulties in forming intimate attachments in prior relationships. (33, 34)
 26. Report exercising patience rather than pushing for a relationship to emerge immediately. (35)
 27. Verbalize beliefs that will encourage the maintenance of long-term relationships. (19, 35, 36)
 33. Validate the client's concerns regarding intimate relationships, and express unconditional positive regard (i.e., that the feelings are understandable from the client's perspective).
 34. Explore the client's projections about others, including the therapist (if applicable); identify how the client's negative assumptions relate to interactions from others in the client's past (e.g., early interactions with parents).
 35. Explore with the client how his/her pattern of emotional detachment in relationships and self-focused behavior is related to a dysfunctional attempt to protect the self from pain. Encourage expressing vulnerable feelings of caring for another person. Support with bibliotherapy, such as *Love Sense* by Johnson.
 19. Teach the client about self-fulfilling prophecies (e.g., how exploitation leads to revenge from others, thus continuing cycles of mistrust; conversely, how trustworthy behavior leads to mutual cooperation); see *Personality Guided Therapy* by Millon.
 35. Explore with the client how his/her pattern of emotional detachment in relationships and self-focused behavior is related to a dysfunctional attempt to protect the self from pain.

- Encourage expressing vulnerable feelings of caring for another person. Support with bibliotherapy, such as *Love Sense* by Johnson.
28. Verbalize a warm or tender feeling for another person. (37)
29. Establish a genuine relationship rather than one based on a false front. (35, 37, 38)
35. Explore with the client how his/her pattern of emotional detachment in relationships and self-focused behavior is related to a dysfunctional attempt to protect the self from pain. Encourage expressing vulnerable feelings of caring for another person. Support with bibliotherapy, such as *Love Sense* by Johnson.
36. Explore the client's mistaken beliefs (e.g., "Nobody will love me unless I make them do so"). Help the client to replace these thoughts with more realistic and flexible ones (e.g., "I can be loved for who I am"). See *The Individual Psychology of Alfred Adler* by Ansbacher and Ansbacher.
37. Explore who the client may feel close to and why; verbally reinforce any warm or tender expressions of feeling for others.
37. Explore who the client may feel close to and why; verbally reinforce any warm or tender expressions of feeling for others.
38. Ask the client to describe any dreams that he/she has had, and discuss themes involving intimacy and connections to others; interpret the dreams in relation to significant others in his/her life.

- 30. Verbalize awareness of the connection between egocentricity and poor self-esteem. (39)
- 39. Assign the client to read a book on self-esteem (e.g., *Life's Too Short* by Twerski); process key points in the session.
- 31. Attend work/school reliably, and treat supervisor and coworkers with respect. (40, 41)
- 40. Review the history of and causes for the client's vocational/employment instability; confront his/her minimization and projection of responsibility for problems.
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- 41. Assist the client in listing changes necessary to improve work behavior; assign implementation of these changes through consistent work attendance.

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
305.00	F10.10	Alcohol Use Disorder, Mild
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
305.20	F12.10	Cannabis Use Disorder, Mild
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
305.60	F14.10	Cocaine Use Disorder, Mild
305.70	F15.10	Amphetamine Use Disorder, Mild
304.40	F15.20	Amphetamine Use Disorder, Moderate or Severe
305.50	F11.10	Opioid Use Disorder, Mild
304.00	F11.20	Opioid Use Disorder, Moderate or Severe
305.90	F18.10	Inhalant Use Disorder, Mild
304.60	F18.20	Inhalant Use Disorder, Moderate or Severe

196 THE PERSONALITY DISORDERS TREATMENT PLANNER

300.xx	F68.10	Factitious Disorder
V65.2	Z76.5	Malingering
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.50	F60.4	Histrionic Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
301.89	F60.89	Other Specified Personality Disorder (Histrionic and Antisocial Traits)

INTROPUNITIVE/GUILTY

BEHAVIORAL DEFINITIONS

1. Places self in relationships and situations that lead to disappointment, failure, or mistreatment.
2. Avoids or undermines pleasurable experiences.
3. Rejects or nullifies others' attempts to help.
4. After positive personal events or opportunities for pleasure, experiences depression, pain, or guilt.
5. Makes poor choices when interacting with others, eliciting anger or rejection, then feels hurt or humiliated.
6. Fails to accomplish tasks essential for personal goals, despite having adequate skills.
7. Rejects people who treat him/her well; excessively tolerates people who treat him/her poorly.
8. Unduly self-sacrificing, to own detriment.

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LONG-TERM GOALS

1. Improve image of self as a worthwhile person, deserving respect and caring from others.
2. Engage in healthy relationships that involve mutual respect and satisfaction.
3. Take pleasure in healthy activities without experiencing guilt.

4. Appropriately accept and offer help in reciprocal relationships.
5. Learn to set appropriate boundaries in relationships.
6. Accomplish personal goals in a timely fashion.
7. Avoid inappropriate entanglements, such as excessive self-sacrifice and/or subjugation that interfere with accomplishing goals.
8. Understand the reasons for his/her own tendencies toward inappropriate interpersonal behaviors, such as self-subjugation and excessive self-sacrifice, and thereby decrease the frequency of problematic interactions.
9. Process and resolve sexual abuse history, if relevant.

SHORT-TERM OBJECTIVES

1. Express satisfaction with the therapeutic relationship as indicated by the verbalization of difficulties and concerns. (1, 2)

2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Empathize with the client’s feelings of being abused, neglected, abandoned, and/or exploited.
2. Clarify to the client that he/she need not talk about sensitive issues until ready to do so.
3. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of

the “problem described,” is not concerned, and has no motivation to change).

4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 5. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
 6. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
 7. Explore the client’s history of being sexually, physically, or emotionally abused, and discuss the impact that his/her experience has had on feelings of guilt, fear, anger, and submissiveness in relationships (or assign “Share the Painful
3. Understand the impact of having a history of attachment to a caregiver who was abusive and/or neglectful or of witnessing such a relationship between one’s primary caregivers/parents. (7)

- Memory” in the *Adult Psychotherapy Homework Planner* by Jongsma). Assess for potentially related schemas, such as Defectiveness, Negativity, Mistrust/Abuse, Emotional Deprivation, Failure, and/or Abandonment (see *Schema Therapy* by Young, Klosko, and Weishaar).
4. Understand the impact of having a history of attachment to a caregiver who provided nurturance primarily when one was in pain or ill or of witnessing such a relationship between one’s primary caregivers/parents. (8)
 5. Process emotional trauma associated with abuse. (9)
 6. Learn to self-soothe in healthy and appropriate ways rather than engaging in passive coping strategies and self-deprecating ruminations. (10, 11, 12)
 8. Explore how attachment to or witnessing a relationship based on pain or illness is related to expectations that only through suffering can needed love and nurturance be attained.
 9. Engage in a stepped model of treatment for recovery from trauma, such as Skills Training in Affective and Interpersonal Regulation (STAIR) therapy. Begin by training the client in emotion regulation and interpersonal skills. Follow with exposure therapy to traumatic material using narratives: Begin with a neutral memory, then move on to fear, shame, and loss narratives. See *Treating Survivors of Childhood Abuse* by Cloitre, Cohen, and Keonen.
 10. Conduct or refer the client to Dialectical Behavior Therapy Skills Training groups—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance—order to teach the client how to balance and regulate emotions and interact well with others (see *Skills Training Manual for Treating*

Borderline Personality Disorder by Linehan). Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley and/or *DBT Diary and Skills Coach* (Durham DBT, app).

11. Conduct or refer the client to a Mindfulness-Based Stress Reduction Program to learn mindfulness meditation skills including mindfulness meditation, body scanning, and simple yoga postures; support with bibliotherapy, such as *Wherever You Go, There You Are* by Kabat-Zinn and/or Buddhify (Mindfulness Everywhere, app).
12. When the client becomes emotionally dysregulated during a session, help him/her to self-regulate using validation; also instruct the client to use mindfulness and other skills to become more regulated. Discuss the self-regulation process; integrate highly arousing emotional material (such as processing intropunitive thoughts or sexual trauma material) only when the client can re-regulate appropriately (see *Doing Dialectical Behavior Therapy* by Koerner).
7. Understand the impact of having a caregiver who role-modeled excessive self-sacrifice or manipulation with guilt or who had excessive demands and was never satisfied. (13)
13. Explore how attachment to or witnessing a relationship based on self-sacrifice, guilt, and/or excessive demands is related to the client's expectations that he/she must sacrifice the self in relationships in order to be deemed worthy and that

202 THE PERSONALITY DISORDERS TREATMENT PLANNER

- inducing guilt is the best or only way to get another person to attend to his/her needs (Self-Sacrifice, Subjugation, and Unrelenting Standards schemas).
8. Express balance in understanding of the value of self-sacrifice. (14)
 9. Accomplish an essential task in a timely fashion. (15)
 10. Reduce the frequency of distorted, negative thoughts that lower self-esteem, and state feeling worthy of respect and caring in a relationship (16, 17, 18)
 14. Assess mistaken beliefs associated with the Self-sacrifice schema, such as “I am selfish if I do not do everything this person needs” and “If I cause anyone pain, it means I am terrible.” Using Socratic dialogue, challenge the client to examine the evidence for and against such statements and find more balanced beliefs, such as “Relationships are best when there is a balance of give-and-take” and “My withdrawal from a problematic relationship, even if painful to the other person, is best.” During this process, explore for metacognitive beliefs, such as “I am worthless and stupid” and “I should have known that already.” Process the intropunitive metacognitive beliefs along with the challenges to the self-sacrificing thoughts, helping the client to self-soothe and re-regulate as needed.
 15. Facilitate motivation to stay on task using motivational interviewing techniques, such as processing how the achievement of a particular task is in alignment with the client’s values and long-term goals.
 16. Assign the client to journal and/or keep a record of dysfunctional thoughts associated with the Defectiveness/Shame schema, such as “I’m bad and should be

punished” and “I’m evil and horrible.” Using Socratic dialogue, challenge the client to examine the evidence for and against such statements and find more balanced beliefs, such as “Everyone makes mistakes” and “I can be forgiving toward both others and myself.” During this process, explore for meta-cognitive beliefs, such as “I am stupid” and “I should have known that already.” Process the metacognitive beliefs along with the challenges to the intropunitive thoughts, helping the client to self-soothe and re-regulate as needed.

17. Empathize with the client’s feelings of low self-esteem. The therapist must be aware of his/her own feelings as they are impacted by the client and, assuming the therapeutic relationship is sufficiently established, provide feedback to the client about those feelings, thus facilitating perspective on the part of the client.
 18. Assign the client to read *The Six Pillars of Self-Esteem* by Branden, *Self-Esteem* by McKay and Fanning, or *Ten Days to Self-Esteem* by Burns; process central ideas with the therapist.
 19. Teach the concept of self-fulfilling prophecy and how guilt-inducing behavior elicits painful rebuffs from other people, which then leads to more guilt-inducing behavior in an effort to reconnect. Discuss how to break the cycle using
11. Explore reinforcement history for instrumentally using guilt; find healthier alternatives. (19, 20, 21, 22)

empathic and assertive communication. See *Disorders of Personality* by Millon.

20. Use role-play and role reversal to augment empathy for the other person who experiences the guilt-inducing behavior.
21. Clarify the client's values, such as the desire to be in a healthy intimate relationship or to have smooth working relationships. Juxtapose these values with behaviors that interfere with their achievement (e.g., regarding guilt inducement: "In your experience, has the way in which you have expressed your needs to your significant other helped to bring you closer to him/her?" Or use a double-sided reflection to develop discrepancy, such as: "On one hand, inducing guilt has gotten others to pay attention, while on the other hand, you do not like how your partner withdraws or attacks you when you do so.>").
22. Assess and encourage motivation for change by noticing "change talk," such as Desire, Ability, Reason, and Need for change as well as Commitment, Activation, and Taking steps to change (DARN-CAT). Use simple and complex reflections to encourage and guide such change-based statements (e.g., when the client says, "I am ready to be assertive with my significant other rather than getting him to feel guilty," say, "You are planning to be more assertive with him/her" or

- “You are feeling confident that you can develop a healthier, more balanced relationship with your significant other.”). Further encourage change talk by asking for additional elaboration and details (see *Motivational Interviewing* by Miller and Rollnick).
12. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (23)
 13. Take psychotropic medication as prescribed, and report on the medication’s effectiveness and side effects. (24)
 14. Verbalize an understanding of the connection between prior abuse and current intropunitive feelings, beliefs, and behaviors. (25, 26)
 23. Refer the client to a physician for an evaluation for medication to stabilize mood, decrease anxiety and/or depression, or stabilize thought processes. Help the client to process costs and benefits of a medication evaluation.
 24. Monitor the client’s use of psychotropic medication for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medication. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.
 25. Explore the client’s history of being sexually, physically, or emotionally abused, and discuss the impact that his/her experience has had on feelings of guilt, fear, anger, and submissiveness in relationships as well as the ability to trust others and beliefs about safety (or assign “How the Trauma Affects Me” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 26. When the client expresses intropunitive thoughts in relation to the therapist

- (e.g., fantasies or beliefs that the therapist will be angry or punitive), process the feelings, noting similarities between the therapeutic relationship and other important relationships in the client's life; work collaboratively toward an appropriate resolution of the painful and guilty feelings.
15. Express self assertively rather than becoming guilty or punitive. (27, 28)
 16. Express anger in a healthy fashion rather than becoming intropunitive. (28, 29, 30)
 27. Assign the client readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons or relevant sections of Dialectical Behavior Therapy interpersonal effectiveness skills in *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley.) Emphasize how assertiveness is a tool to help achieve a positive balance in a relationship and get both people's needs met over long periods of time.
 28. Use role-play, modeling, and behavior rehearsal with the client to simulate situations that demand assertiveness (or assign "Becoming Assertive" in the *Adult Psychotherapy Homework Planner* by Jongsma); provide feedback regarding the appropriateness of his/her responses.
 28. Use role-play, modeling, and behavior rehearsal with the client to simulate situations that demand assertiveness (or assign "Becoming Assertive" in the *Adult Psychotherapy Homework Planner* by Jongsma); provide feedback regarding the appropriateness of his/her responses.

17. Verbalize an understanding of how vigilantly scanning for signs of betrayal or abandonment can trigger anger and/or mistrust in others; reduce such information seeking to normal levels. (31)
18. Decrease or eliminate self-deprecating comments. (32, 33)
29. Assist the client in identifying more constructive ways to express anger, and urge the client to implement these in daily life (or assign “Alternatives to Destructive Anger” in the *Adult Psychotherapy Homework Planner* by Jongsma).
30. Assign the client to read *The Dance of Anger* by Lerner; process the main points within subsequent sessions.
31. Teach the concept of self-fulfilling prophecy and how scanning for signs of betrayal elicits anger and mistrust from others, which then leads to more vigilance and suspiciousness. Discuss how to break the cycle using empathic and assertive communication (see *Personality Guided Therapy* by Millon).
32. Review instances of the client’s impulsive and strong expressions of self-deprecation; utilize skills such as “opposite action” and assertiveness (e.g., “DEAR-MAN”) to express self in healthy ways. Help the client to develop healthier attitudes toward the self by encouraging him/her to use self-validation. Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley and/or *DBT Diary and Skills Coach* (Durham DBT, app).
33. During a couples session, when the pattern of interaction between the couple involving self-deprecation or guilt induction by one partner and

- frustration in the other occurs, stop the interaction and process with the couple the meaning of the client's behavior. Examine unwitting reinforcers from the partner, and collaborate to reward and strengthen healthy behavior.
19. Reduce or eliminate patterns of impulsive, provocative interpersonal interactions. (34)
 20. Decrease mood-dependent behavior while increasing the frequency of value-dependent behavior (35)
 21. Acknowledge own needs and desires that are independent of what others want; state how he/she can be reasonably satisfied. (36, 37)
 34. In a couples therapy session, explore with significant others the themes of rejection and distancing, encouraging each person to examine his/her own emotions and how defensiveness against pain and fear of vulnerability contribute to the distancing and reduction of intimacy that occurs. Take into account the introjective/guilty person's anxious and/or trauma-based attachment style. Support with bibliotherapy, such as *Hold Me Tight* or *The Practice of Emotionally Focused Couple Therapy*, both by Johnson.
 35. Clarify and explore the client's values with an experiential exercise in session. Consider utilizing the *Valued Living Questionnaire* by Wilson et al. (or the Survey of Guiding Principles Values Card Sort, <https://www.box.com/slp>). See also *Get Out of Your Mind and Into Your Life* by Hayes and Smith.
 36. Assist the client in making a list of his/her unique wants and needs; process how these needs and desires are legitimate and how they can be reasonably met.
 37. Assist the client in identifying an unmet need that has been stifled out of fear of displeasing

- someone; assign implementation of an activity that will lead to need fulfillment (or assign “Satisfying Unmet Emotional Needs” in the *Adult Psychotherapy Homework Planner* by Jongsma).
22. Risk displeasing someone in order to meet own needs. (36, 38, 39).
23. Develop a plan to end relationship with abusive partner; implement the plan with therapist’s guidance. (25, 40)
25. Explore the client’s history of being sexually, physically, or emotionally abused, and discuss the impact that his/her experience has had on feelings of guilt, fear, anger, and submissiveness in relationships
36. Assist the client in making a list of his/her unique wants and needs; process how these needs and desires are legitimate and how they can be reasonably met.
38. Challenge the client’s catastrophizing associated with the Abandonment schema (e.g., the belief that the end of the relationship is a disaster that will lead to endless loneliness and isolation), replacing irrational beliefs with more balanced ones (e.g., endings are painful, but the pain subsides and new beginnings emerge).
39. Utilize the Chinese Finger Cuffs metaphor/experiential exercise with the client to demonstrate how experiential avoidance maintains the problematic patterns that are causing distress and how being willing to move toward a problem, instead of away from it, allows for the opportunity to reduce “stuckness” and increase flexibility (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson).

- as well as the ability to trust others and beliefs about safety (or assign “How the Trauma Affects Me” in the *Adult Psychotherapy Homework Planner* by Jongsma).
24. State a commitment to let go of past hurt and to work on the process of forgiveness. (41)
 25. Accept a compliment gracefully, and experience pleasure in doing so. (42, 43)
 26. Engage in a secure and mutually satisfying relationship. (44)
 27. Verbalize positive beliefs about self, including acceptance of own intrinsic value. (45)
 40. Coordinate with a domestic violence center to help the client to safely transition away from the abusive partner.
 41. Discuss forgiveness of perpetrators of pain as a process of letting go of anger and pain. Support with bibliotherapy, such as *The Tao of Forgiveness* by Martin; in session, process key points in subsequent session as applied to the client’s painful experiences.
 42. Use role reversal (i.e., ease of giving compliments to others) to facilitate a broader perspective. Highlight awareness of improvements in self-esteem to support the validity of the compliments.
 43. Review how messages learned in primary relationships interfere with accepting positive thoughts about the self; gently help the client to dispute such thoughts.
 44. Support healthy intimate relationship patterns with bibliotherapy, such as *Love Sense* by Johnson and *The Seven Principles for Making Marriage Work* by Gottman and Silver; process key themes in session.
 45. Explore aspects of the client’s life that provide a sense of meaning, purpose, or mission (or assign “What’s Good About Me and My Life?” in the *Adult*

Psychotherapy Homework Planner by Jongsma). Inquire about spiritual or religious participation that provides fortitude, comfort, or meaning to life; encourage increased participation. Support with bibliotherapy, such as *Man's Search for Meaning* by Frankl and/or *101 Exercises for the Soul* by Siegel.

28. Terminate therapy with calm, appropriate emotions. (46)

46. Discuss the client's thoughts and feelings about ending therapy, facilitating his/her ending this relationship differently from others. Process fears of abandonment and beliefs of incompetence as needed.

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
301.9	F60.9	Unspecified Personality Disorder
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
309.81	F43.10	Posttraumatic Stress Disorder
300.15	F44.81	Unspecified Dissociative Disorder
301.83	F60.3	Borderline Personality Disorder
301.6	F60.7	Dependent Personality Disorder
301.82	F60.6	Avoidant Personality Disorder
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NARCISSISTIC*

BEHAVIORAL DEFINITIONS

1. Exaggerates self-importance in a grandiose manner.
2. Has excessive fantasies of unlimited success, power, intelligence, or ideal love.
3. Believes only special, high-status individuals can understand his/her unique thoughts, talents, and/or problems.
4. Needs excessive admiration.
5. Has an air of entitlement, expecting special treatment from others.
6. Takes advantage of others in an exploitive manner.
7. Is unable or unwilling to relate to the needs and feelings of others; has insufficient empathy.
8. Envy others or believes they envy him/her.
9. Is arrogant or haughty, maintaining an egotistical attitude.

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LONG-TERM GOALS

1. Increase tendency to act rather than merely fantasize about achievements.
2. Improve empathy, increasing the ability and desire to understand others' feelings.
3. Decrease arrogant attitudes and behaviors.

*Appendix A elaborates on the dimensional structure for behavioral definitions.

4. Moderate tendency to see self as perfect and invulnerable.
5. Decrease or eliminate interpersonal exploitation.
6. Increase capacity to set realistic, achievable goals.
7. Reduce feelings of entitlement and expectations of special treatment.
8. Reduce or eliminate tendency to denigrate or put down others.
9. Acquire greater discipline and self-control over emotions, especially anger and rage.
10. Reduce feelings of envy and suspiciousness toward others.

SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share difficulties and concerns. (1)
2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (2, 3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client’s difficulties (e.g., feeling bored, misunderstood, or undermined) while assessing the depth and chronicity of the psychological issues presented.
2. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).
3. Assess the client for evidence of research-based correlated

disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

4. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
5. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
3. Increase expressions of empathy by accurately identifying the feelings of another person and verbalizing understanding of his/her predicament. (6, 7, 8)
6. Explore how the client perceives other people and what he/she believes about their motivations. Brainstorm about alternative possibilities regarding what others believe and feel in order to facilitate improved understanding of others.
7. Use role-play and behavioral rehearsal of common interpersonal situations to provide the client with accurate feedback regarding likely emotional

- reactions others would have to his/her statements and nonverbal behaviors.
4. Express compassion for others who are experiencing difficult situations. (9, 10)
 5. State a request in a respectful manner rather than as a demand or expectation. (11, 12)
 8. Assign the client to read a book that will help him/her to understand the perspective of another person (e.g., *Empathy* by Krznaric or *You Just Don't Understand* by Tannen). Process major points within subsequent sessions.
 9. Express empathy for the client's feelings about others, questioning the client until the therapist fully understands how the client feels; allow the client to experience empathic connection and, through it, grow more empathic toward others.
 10. Train the client to use meditation (e.g., thought-watching exercise) by assigning *Full Catastrophe Living* by Kabat-Zinn; process key concepts, demonstrate the technique during the session, and assign practice as homework. Refer the client to a Mindfulness-Based Stress Reduction program if available locally.
 11. Set limits with the client regarding basic therapy arrangements (on availability by phone, payment arrangements, meeting times, etc.) in response to client requests for special treatment.
 12. Discuss with the client his/her role models for interpersonal conduct from prior generations (parents, uncles/aunts,

- grandparents, etc.) in order to gain an understanding of the origins of the demanding behavior; process the effectiveness and appropriateness of these behaviors in the current circumstances.
6. Express understanding of how a belittling statement may be perceived by another person and how that may harm a desired relationship. (13, 14, 15)
 13. Conduct or refer the client to Dialectical Behavior Therapy Skills Training groups—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance—in order to teach the client how to balance and regulate emotions and interact well with others (see *Skills Training Manual for Treating Borderline Personality Disorder* by Linehan). Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley and/or DBT Diary and Skills Coach (Durham DBT, app).
 14. Process the use of relevant Dialectical Behavior Therapy skills—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and/or Distress Tolerance—to address the client’s belittling statements. Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* by McKay, Wood, and Brantley and/or DBT Diary and Skills Coach (Durham DBT, app).
 15. When the client devalues the therapist, explore the client’s beliefs or fantasies regarding the impact that this has on the

- therapist, or even whether the client has considered its impact on the therapist. Analyze whether similar interactions may underlie difficulties in other important relationships.
7. Engage in mutual behaviors with a partner that will promote a secure attachment bond between them. (16)
 8. Each family member/partner reduces interactions within the family that serve to perpetuate the client's denigrating behavior. (17, 18)
 9. Each family member/partner reduces interactions within the family that serve to perpetuate the client's exploitive behavior. (19)
 16. During a couples therapy session, instruct the client to speak directly to his/her spouse/partner, paying attention to ways in which conflict is avoided. Encourage each client to express his/her emotions, taking into account the avoidant attachment style of the person with Narcissistic Personality Disorder. Process his/her fear of being vulnerable and defensive anger to hide his/her vulnerability. (See *The Practice of Emotionally Focused Couple Therapy* by Johnson). Support with bibliotherapy (*Hold Me Tight* by Johnson).
 17. Examine family interactions that reinforce the client's criticizing behavior, such as the client getting his/her way and family members yielding to the client to gain relief from his/her demands. Highlight such interactions, and process with the family ways to withdraw such reinforcement.
 18. Employ the family sculpture technique to relive emotionally important events in the client's family (e.g., instances in which the client belittled another family member).
 19. Assist family members in identifying their behavior that reinforces exploitive behavior (e.g., significant other agrees to do all chores in the house).

- Write a behavioral contract that will allow each participant to get his/her needs met more directly (e.g., sharing chores and using praise and other social rewards to reinforce the behavior). Augment couple's functioning with bibliotherapy, such as *The Seven Principles for Making Marriage Work* by Gottman and Silver.
10. Express anger in an appropriate fashion rather than becoming enraged when feeling wronged, hurt, or belittled. (20, 21, 22)
 20. Process with the client the use of relevant Dialectical Behavior Therapy skills—Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and/or Distress Tolerance—to improve anger control (consider supplementing with assigning “Alternatives to Destructive Anger” and/or “Anger Journal” in the *Adult Psychotherapy Homework Planner* by Jongsma). Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* (McKay, Wood, and Brantley) and/or DBT Diary and Skills Coach (Durham DBT, app).
 21. Explore how the client's hypersensitivity and quick use of anger is related to his/her self-esteem deficit. Facilitate improving the self-esteem problem by working through feelings of neglect, emotional abandonment, and/or peer rejection early in life.
 22. Assign the client to read *The Anger Control Workbook* by McKay and Rogers or *The Dance of Anger* by Lerner;

- process key ideas within subsequent sessions.
11. Verbalize a willingness to work toward an important goal (e.g., a promotion at work) rather than merely expecting it to be given. (23)
 12. Demonstrate a willingness to work collaboratively in a relationship, including the therapeutic relationship, rather than expecting the other person to cater to one's own needs. (24)
 13. Express having average talent or ability at a particular activity (e.g., a sport, work activity, or social activity) and feeling comfortable about it. (25, 26)
 23. Using Socratic dialogue, assist the client in replacing distorted thoughts associated with the Entitlement/Grandiosity schema (e.g., "The promotion should be given to me based on my superior talent") with more realistic ones (e.g., "There is a lot of competition for that job, and I will need to demonstrate that I deserve the position"). Support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko.
 24. Set limits when the client oversteps boundaries and expects special treatment (e.g., demands special scheduling or fee arrangements, wants to smoke in the office, tries to touch the therapist inappropriately). Use these instances to demonstrate to the client his/her cognitive schemas and belief systems; relate these to areas in which he/she has problems in other relationships.
 25. Encourage the client to relate his/her grandiose fantasies (e.g., of becoming enormously wealthy or creating fabulous inventions). Explore how these fantasies are related to the expectations of significant others from the client's past, such as parental expectations during early childhood.
 26. Empathize with the client's perception of enormous expectations of self. The therapist will be aware of his/her own feelings as they are

- impacted by the client and provide feedback to the client about those feelings, thus facilitating perspective on the part of the client.
14. Decrease exploitive behavior. (27)
 15. Verbally acknowledge and express regret that one's own sexually exploitive behavior was hurtful to another person. (28)
 16. Provide alternative explanations for others' behavior rather than assuming that they are motivated by envy or malice. (29, 30)
 27. Assist the client in making a list of pros and cons of behaviors that exploit others (e.g., stockbrokers making unnecessary trades to inflate commissions). Use double-sided reflections to develop the discrepancy between long-term negative consequences versus short-term positive consequences (see *Motivational Interviewing* by Miller and Rollnick).
 28. In a psychodrama, group, or individual session, the therapist (or a group member) plays the client and the client plays the person who was hurt or sexually exploited (e.g., demanding sex from a subordinate or misleading someone to obtain sexual gratification). Continue the intervention until the client achieves emotional identification with the victim (consider supplementing with "Looking Closer at My Sexual Behavior" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
 29. Explore the client's projections about others, including the therapist (if applicable); identify how the client's assumptions relate to interactions from others in his/her past (e.g., early interactions with parents).

17. Accept feedback from another person without dismissing or rejecting it. (31, 32)
18. Report a decrease in attention-seeking behavior in social settings. (33, 34)
30. Brainstorm with the client about alternative explanations for another's behavior rather than jealousy or malice (or assign "Check Suspicions Against Reality" in the *Adult Psychotherapy Homework Planner* by Jongsma); encourage the client to identify evidence for and against each belief, thereby assessing its likelihood.
31. Explore the client's dreams and fantasies regarding omnipotent power or perfection; connect these to current or past relationships and the ability to engage in collaborative relationships.
32. Use mindfulness and acceptance skills to observe "what shows up" in the face of criticism or feedback that may not align with the client's expectations or desires. Try the "Physicalizing" and/or the "Leaves on a Stream" exercise (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson).
33. Use role-play, modeling, and behavioral rehearsal to simulate social scenarios with the client in which he/she is typically attention seeking, eliciting his/her feelings and providing feedback for the client about the feelings of the person interacting with him/her; evaluate pros and cons of the attention-seeking behavior.
34. Conduct or refer the client to a psychodrama group, taking advantage of the client's desire to be center stage while

19. Verbalize feeling good in a situation when not the center of attention. (35)
20. List the difficulties that have been experienced in forming intimate attachments in prior relationships. (36)
21. Report the negative consequences of an excessive focus on physical appearance. (37)
22. Verbalize beliefs that will encourage the maintenance of long-term relationships. (38)
35. Use rational emotive or cognitive techniques to challenge the client's beliefs associated with the Recognition-seeking schema. Replace extreme thoughts (e.g., "I must be the center of attention or else I am totally unappreciated and ignored") with more rational thoughts (e.g., "It is okay for me to be the center of attention sometimes and not to be the center of attention at other times; I do not need constant attention and admiration to be happy").
36. Discuss the client's early relationship with parents, exploring themes of abandonment or high expectations. Explore how these early experiences may be negatively impacting the client's ability to be close to others and accept their foibles.
37. Assist the client in developing a list of pros and cons regarding the use of physical appearance to gain attention. Highlight the long-term negative consequences (being perceived by others as vain or superficial, consuming excessive time or resources on clothing or cosmetic surgery, attracting others based on superficial appearance and thereby leading to long-term disappointment, etc.).
38. Explore the client's distorted, negative beliefs regarding intimate relationships associated with the Grandiosity and providing opportunities for personal growth.

- Abandonment schemas (e.g., that there is a perfect person who is worthy of him/her, that there is a person who will never disappoint him/her). Use rational emotive techniques to challenge the ideas, replacing unrealistic ideas with more flexible and realistic ones (e.g., that everyone has faults, that any long-term relationship has peaks and valleys).
23. Express shades of gray regarding talents and achievements rather than viewing self in all-or-none terms. (39)
 24. Verbalize a warm or tender feeling for another person. (40)
 25. Increase productive activity while decreasing excessive escape into fantasy. (41)
 26. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (42)
 39. Challenge the client's all-or-none thinking by asking him/her to recall or imagine instances in which he/she was average rather than extreme (e.g., neither completely successful nor completely unsuccessful at something, eliciting friendly feelings rather than total love/admiration or total hatred/denigration).
 40. Reinforce the client's expression of tender emotions toward another person. Augment with bibliotherapy, such as *Love Sense* by Johnson.
 41. Teach the client both the functional and dysfunctional aspects of fantasizing (e.g., it provides positive emotions and relief from boredom but currently occupies so much time that it interferes with productive activity). Encourage a balance between productive and unproductive time engaged in fantasy.
 42. Refer the client to a physician for an evaluation for medication to improve mood; help the client to process costs and benefits of a psychiatric evaluation.

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| <p>27. Take psychotropic medications as prescribed, and report on the effectiveness and side effects. (43)</p> | <p>43. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medication. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.</p> |
| <p>28. Express readiness to attend group therapy. (44)</p> | <p>44. Instruct the client about the way groups operate and that this may feel unfair to him/her (e.g., that all group members must be given an opportunity to speak, that everyone's problems are considered equally important, and that group members may not always be supportive, appreciative, or admiring). Process these themes, and refer the client to group therapy when he/she is ready to participate.</p> |
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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.4	F34.1	Persistent Depressive Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.50	F60.4	Histrionic Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

NARCISSISTIC—COMPENSATORY

BEHAVIORAL DEFINITIONS

1. Has underlying feelings of inferiority and low self-esteem that he/she seeks to offset by creating illusions of superiority.
2. Makes grandiose, arrogant statements to enhance self-esteem.
3. Attributes self-worth to self-enhancement (advancing in career, receiving praise or recognition, etc.).
4. Has deep-seated feelings of ambivalence toward others.
5. Vacillates, at times rapidly, between wanting to take charge and wanting others to take charge.
6. Is highly motivated to obtain prestige and acclaim but often expects them to be bestowed rather than earned.
7. Is hypersensitive to slights, criticisms, and disapproval.
8. Is prone to anger, peevishness, and blaming.

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LONG-TERM GOALS

1. Decrease acting out associated with anger.
2. Improve self-esteem.
3. Include interpersonal relationships and nonconditional beliefs regarding self-worth to assess self rather than relying excessively on accomplishments or praise.
4. Reduce hostile, blaming attitudes.

5. Stabilize vacillating desires and mood to promote a more consistent presence.
6. Tolerate and/or learn from criticism and disapproval.

SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share concerns and difficulties. (1, 2)
2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client's difficulties (e.g., feeling misunderstood and unappreciated by others) through unconditional positive regard, warm acceptance, and reflective listening.
2. Compliment the client regarding genuine strengths (e.g., actual accomplishments, appropriate ambitions) in order to help facilitate rapport and balance the client's need/desire to impress the therapist while being cautious not to praise excessively (which could inappropriately encourage grandiose thinking).
3. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence

regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
5. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
6. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).

3. Express anger in an appropriate fashion rather than becoming hostile or contentious when feeling wronged, hurt, or belittled. (7)
4. Verbalize feeling calm and relaxed in situations that would have previously provoked feelings of anger, hostility, and resentment. (8, 9)
5. Describe as neutral, tolerable, or humorous an experience that previously was considered provocative or anxiety provoking (e.g., feeling slighted or criticized). (10, 11, 12)
7. Ask the client to keep a daily journal of persons, situations, thoughts, feelings, and actions associated with moments of anger (or assign “Anger Journal” or “Alternatives to Destructive Anger” in the *Adult Psychotherapy Homework Planner* by Jongsma).
8. Train the client to relax using progressive muscular relaxation, autogenics, hypnosis, and/or visualization (or assign “Progressive Muscle Relaxation” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). Role-play situations in which this skill could be used to promote calm rather than anger or hostility.
9. Teach the client to decrease hypersensitivity to bodily stimuli (e.g., anxiety symptoms, such as increased heart rate) through an assigned exercise (e.g., having the client lie in a quiet room and pay attention to psychokinesthetic stimuli). See “Body Scan” exercise in *Full Catastrophe Living* by Kabat-Zinn.
10. Assign the client to read *The Healing Power of Humor* by Klein or *Fun as Psychotherapy* by Ellis; discuss key points during a session. Discuss the use of humor and the concept of taking oneself lightly (even in serious circumstances), and cultivate the ability to laugh with others.

6. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (13)
7. Take the psychotropic medication as prescribed, and report on its effectiveness and side effects. (14)
8. Express feeling satisfied with a conversation in which no attempt was made to impress the other person but rather to engage in an equal, give-and-take dialogue. (15)
11. Train the client to use meditation (e.g., thought-watching exercise) to identify distorted thoughts that prompted anxiety by assigning *Full Catastrophe Living* by Kabat-Zinn, processing key concepts with the therapist. Demonstrate the technique during a session, and assign practice as homework.
12. When the client feels slighted by the therapist, explore his/her projections, relating them to interactions with significant others in the past.
13. Refer the client to a physician for an evaluation for medication to improve mood and decrease anxiety; help the client to process costs and benefits of a medication evaluation.
14. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.
15. Use role-play, modeling, and behavioral rehearsal to teach the client how to use relevant social skills to interact effectively with another person; confront and reframe the client's attempts at impressing others.

9. Verbalize feeling comfortable in a situation in which praise was expected but not received. (16, 17)
10. Express feeling a reduced need to be praised by others. (18)
11. Family members express frustration with the client's excessive vacillating and ambivalence. (19)
12. Reduce inconsistent behaviors and mixed messages toward family members and significant others. (20)
16. Using Socratic dialogue, challenge the client's distorted beliefs about praise associated with the Approval Seeking/Recognition Seeking schema (e.g., "I must be praised, otherwise I am being insulted and humiliated"). Replace these with realistic beliefs (e.g., "I enjoy praise, but if I don't get it that's okay" and "I will try to improve my performance to earn praise"). See *Schema Therapy* by Young, Klosko, and Weishaar.
17. Engage the client in a mindfulness exercise to increase tolerance of upsetting thoughts and/or feelings without reacting. Try the "Leaves on a Stream" exercise as described in *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson.
18. Explore how the client's hypersensitivity to criticism and strong need for praise may be related to a self-esteem deficit.
19. Encourage family members to use "I" statements to express their feelings regarding the client's vacillating. If blaming emerges, redirect the family member to stay with describing his/her experiences and feelings while avoiding blaming as it triggers defensiveness.
20. Employ family sculpture technique of dramatic re-enactment of a situation in which the client's indecision and/or rapidly changing mood

- created disharmony. Process the meaning of the event with the client and his/her family, and collaborate with them to discover new and more satisfying ways of relating to one another (see *Conjoint Family Therapy* by Satir).
13. Express empathic understanding of another person's point of view. (21)
 14. Take responsibility rather than blaming others for something that went wrong. (22)
 15. Verbalize realistic expectations regarding advancement and promotion at work. (23)
 21. In a psychodrama, group, or individual session, the therapist (or a group member) plays the client and the client plays the person who was hurt, belittled, or blamed (role reversal technique). Continue the intervention until the client achieves emotional identification with the other person.
 22. During a couples/family session, encourage the client to express his/her feelings in the following manner: "When you say X to me in Y situation, I feel Z." Encourage his/her significant other to do likewise. Encourage them to persist in communicating in that manner until each side reports understanding the other without blaming each other (see *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman).
 23. Using rational emotive techniques, assist the client in replacing distorted thoughts regarding his/her employment situation associated with the Entitlement/Grandiosity schema (e.g., "The promotion should be given to me based on my superior talent") with

232 THE PERSONALITY DISORDERS TREATMENT PLANNER

16. Express understanding of how an insensitive statement may be perceived by another person and how that may harm a desired relationship. (24, 25)
17. Verbalize understanding that grandiose, arrogant statements may irritate others and reduce available friendships and social support. (26)
18. Develop a daily routine that reflects a balance between the desire for accomplishment and recognition on one hand and appreciation of relationships and aesthetic things on the other. (27)
19. Prioritize activities and time allotted to them appropriately
24. When the client uses denigrating behavior toward a family member during a family session, the therapist will encourage the target person to set limits (e.g., “Is that acceptable to you? Get him/her to stop!”). Discontinue the intervention when some degree of success has been achieved, and verbally reward both participants.
25. When the client devalues the therapist, explore the client’s beliefs or fantasies regarding the impact that this has on the therapist or whether the client even has considered its impact. Analyze whether similar interactions may underlie difficulties in other important relationships.
26. Use role-play and role reversal to help the client gain an understanding of the impact of his/her grandiose, arrogant statements on others.
27. Assign the client to read a book on increasing self-awareness and moment-to-moment appreciation of life (e.g., *Full Catastrophe Living* or *Wherever You Go, There You Are* by Kabat-Zinn or *The Road Less Traveled* by Peck); discuss key points in a session.
28. Assign the client to read *The Seven Habits of Highly*
- more realistic ones (e.g., “There is a lot of competition for that job, and I will need to demonstrate that I deserve the position”).

- in order to balance private life and pursuit of accomplishments and/or praise. (28)
20. Verbalize insight into how the strong need for praise is connected to childhood experiences. (29, 30)
21. Acknowledge that the excessive need for praise and accolades indicates feelings of insecurity and/or problems with self-esteem. (31, 32, 33)
- Effective People* by Covey and/or *First Things First* by Covey and Merrill; process key points in a session. Encourage a healthy balance between work life and private life (relationships, hobbies, exercise, spirituality, etc.).
29. Explore the client's explanations of why he/she needs to be praised or acknowledged. Supportively challenge the client's rationalizations (e.g., "Yes, most everyone enjoys being praised, but what is the meaning of praise to *you*?"). Explore with the client the connection between insufficient praise he/she received as a child, his/her feeling of hurt and shame at the time, and his/her hunger for praise.
30. Examine the client's relationship to important others from the past (e.g., parents or other role models) regarding the giving and withholding of praise. Help the client assess whether emulating or reacting to those behaviors is appropriate to current circumstances.
31. Assign the client to use the "Three Column Technique," keeping a daily log of antecedent events, the beliefs associated with each event, and the resulting emotional consequences (see *Anxiety Disorders and Phobias* by Beck and Emery).
32. Work with the client to connect his/her mood

- (e.g., depression) to beliefs about the self that are consistent with low self-esteem (e.g., “I’ve failed,” “I’m a failure”).
22. Identify negative automatic thoughts about self that produce low self-esteem. (34, 35)
 23. Express feeling more secure and comfortable with self. (36)
 24. State feeling worthwhile simply for being human. (37, 38)
 33. If the client shares feelings or vulnerabilities or admits mistakes, compliment him/her (e.g., “It took real strength to tell it like it is,” “Most people wouldn’t have had the guts to admit that—that was impressive”).
 34. Assign the client to keep a record of dysfunctional thoughts (e.g., “If I fail, I’m worthless”), or assign “Replacing Fears with Positive Messages” in the *Adult Psychotherapy Homework Planner* by Jongsma.
 35. Empathize with the client’s feelings of low self-esteem. The therapist must be aware of his/her own feelings as they are impacted by the client and provide feedback to the client about those feelings, thus facilitating perspective on the part of the client.
 36. Assign the client to read *The Six Pillars of Self-Esteem* by Brandon, *Self-Esteem* by McKay and Fanning, or *Ten Days to Self-Esteem* by Burns; process central ideas in a session.
 37. Empathize with the client’s perception of enormous expectations of self. The therapist will be aware of his/her own feelings as they are impacted by the client and

- provide feedback to the client about those feelings, thus facilitating perspective on the part of the client.
25. Verbalize feeling average in some ways and unique in others, and realistically appraise those attributes. (39, 40)
 38. Explore the client's spiritual values as they apply to viewing the self as loved, valued, and important; encourage acceptance of self without regard to accomplishment.
 39. Encourage the client to relate his/her grandiose fantasies (e.g., of becoming enormously wealthy or creating fabulous inventions). Explore how these fantasies are related to the expectations of significant others from the client's past, such as parental expectations during early childhood.
 40. Interpret the underlying grandiosity and disappointment when the client falls short in an effort, connecting the client's affective experience to his/her wishes and needs. Help him/her transform the experience into something realistic (e.g., "When they went with someone else's idea, you felt massively disappointed and deflated; you wanted them to think your idea was wonderful and would save the day, and when they rejected it, you felt defeated and empty"). See "Using Self Psychology in Brief Psychotherapy" by Gardner and "Speaking in the Interpretive Mode and Feeling Understood" by Ornstein and Ornstein.

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.02	F41.1	Generalized Anxiety Disorder
300.4	F34.1	Persistent Depressive Disorder
309.0	F43.21	Adjustment Disorder, With Depressed Mood
301.81	F60.81	Narcissistic Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

NARCISSISTIC—UNPRINCIPLED

BEHAVIORAL DEFINITIONS

1. Exaggerates self-importance in a grandiose manner, resorting to outright lies to inflate his/her self-image if that seems expedient.
2. Has feelings of entitlement, believing ordinary rules that apply to others are inapplicable to him/her.
3. Has deficient conscience; is unscrupulous and amoral.
4. Does not maintain loyalties and will, if the opportunity arises, exploit a trusting other.
5. Is fraudulent and deceptive and is often a con or a con artist or a charlatan.
6. Is arrogant; is contemptuous and/or vindictive toward victims of his/her exploitive endeavors.
7. Is indifferent to the welfare of others; lacks empathy for their feelings.
8. Is domineering, exercising high levels of control in relationships.

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LONG-TERM GOALS

1. Decrease arrogant, contemptuous attitudes and behaviors.
2. Reduce feelings of entitlement and expectations of special treatment.
3. Improve empathy, increasing the ability and desire to understand others' feelings.
4. Decrease or eliminate interpersonal exploitation.
5. Reduce or eliminate tendency to denigrate or put down others.

6. Acquire greater discipline and self-control over emotions, especially anger and rage.

SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share difficulties and concerns. (1)
2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (2, 3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client’s difficulties (e.g., feeling constrained, angry, or frustrated).
2. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).
3. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including

- vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
4. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 5. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
 6. Assist the client in developing a list of specific dissatisfactions he/she currently is experiencing (e.g., conflicts with the law, relationship conflicts).
 7. Avoid appearing weak or soft in the eyes of the client by refraining from directly asking about his/her feelings and emotions early in the treatment.
 8. When appropriate, comment on the client's facility with deception and lying, noting that he/she will be able to con the therapist at least some of the time. Process the pros and cons
3. Identify current problems experienced in society and/or interpersonal relationships. (6)
 4. Establish a trusting relationship with the therapist. (7, 8, 9, 10)

- of being deceptive toward the therapist (see *Cognitive Therapy of Personality Disorders* by Beck, Davis, and Freeman).
9. If the client shares feelings or vulnerabilities or admits mistakes, compliment him/her (e.g., “It took real strength to tell it like it is” and “Most people wouldn’t have had the guts to admit that—that was impressive”).
 10. Convey to the client that the purpose of the meetings with the therapist is to evaluate and find solutions to situations that are interfering with the client’s success in getting what he/she wants out of life.
 11. Set limits with the client regarding basic therapy arrangements (availability by phone, payment arrangements, meeting times, etc.) in response to the client’s request for special treatment.
 12. Set limits when the client oversteps boundaries and expects special treatment (demands special scheduling or fee arrangements, wants to smoke in the office, tries to touch the therapist inappropriately, etc.). Use these instances to demonstrate to the client his/her cognitive schemas and belief systems; relate these to areas in which the client has problems in other relationships.
 13. When the client devalues the therapist, explore the client’s beliefs or fantasies regarding the impact that this has on the therapist or whether the client
5. Respond appropriately to having limits set in therapy. (11, 12)
 6. Express understanding of how a belittling statement may be perceived by another person and how that may harm a desired relationship. (13, 14)

- even has considered its impact. Analyze whether similar interactions may underlie difficulties in other important relationships.
7. Each family member or partner reduces interactions within the family that serve to perpetuate the client's denigrating behavior. (15)
 8. State a request in a respectful manner rather than as a demand or an expectation. (16, 17)
 9. Express readiness to attend group therapy. (18)
 14. Explore with the client the consequences of his/her denigrating or disrespectful statements, evaluating long-term negative consequences and how they interfere with the client's goals.
 15. Explore family interactions that support denigrating behavior (e.g., the client feeling superior to family members) and family members' tolerance of the behavior.
 16. Discuss with the client his/her role models for interpersonal conduct from prior generations (parents, uncles/aunts, grandparents, etc.) in order to gain an understanding of the origins of the demanding behavior; process the effectiveness and appropriateness of these behaviors in the current circumstance.
 17. During a couples therapy session, instruct the client and significant other to engage in a dialogue regarding how to make requests in a way that is respectful (or assign "How Can We Meet Each Other's Needs and Desires?" in the *Adult Psychotherapy Homework Planner* by Jongsma).
 18. Instruct the client about the way groups operate and that this may feel unfair to him/her (e.g., that all group members must be

- given an opportunity to speak, that everyone's problems are considered equally important, and that group members may not always be appreciative or admiring, but they usually provide important feedback). Process these themes, and refer the client to group therapy when he/she is ready to participate.
10. Each family member or partner reduces interactions within the family that serve to perpetuate the client's exploitive behavior. (19)
 11. Verbalize an awareness of long-term disadvantages of deception, conning, ruthless exploitation, and disloyalty to others. (20)
 12. Verbalize realistic, achievable goals rather than grandiose fantasies that lead to perpetual disappointment. (21)
 19. Assist family members in identifying their behavior that reinforces exploitive behavior (e.g., significant other agrees to do all chores in the house). Write a behavioral contract that will allow each participant to get his/her needs met more directly (e.g., sharing chores and using praise and other social rewards to reinforce the behavior).
 20. Teach how lying and disloyalty lead to a self-fulfilling prophecy that leads to further distrust (e.g., betraying people leads to being betrayed by them). See *Disorders of Personality* by Millon.
 21. Interpret the underlying grandiosity and disappointment when the client falls short in an effort, connecting the client's affective experience to his/her wishes and needs. Help him/her transform the experience into something realistic (e.g., "When they went with someone else's idea, you felt massively disappointed and deflated; you wanted them to think your idea was wonderful and would save the day, and when they rejected it you felt defeated and empty"). See "Using Self Psychology in

- Brief Psychotherapy” by Gardner and “Speaking in the Interpretive Mode and Feeling Understood” by Ornstein and Ornstein.
13. Identify reasons for wanting or needing to control and dominate others. (22, 23, 24)
 14. Engage in a relationship in a cooperative, rather than a controlling or domineering, manner. (25)
 15. Express regret or sorrow about having hurt another person’s feelings. (26)
 22. Discuss relationships in early childhood in which the client was abused or deceived by an important figure (or assign “Share the Painful Memory” in the *Adult Psychotherapy Homework Planner* by Jongsma); examine the repetition compulsion in the client’s behavior toward others now.
 23. Employ the family sculpture technique of dramatic re-enactment of a situation in which the client was controlling or manipulative; process the meaning of the event with the client and his/her family, and collaborate with them to discover new and more satisfying ways of relating to one another.
 24. Explore the client’s dreams and fantasies regarding omnipotent power, riches, or control; connect these to current or past relationships and the ability to engage in collaborative relationships.
 25. Challenge the client’s all-or-none thinking about dominance by encouraging him/her to think of role models (e.g., sports figures or other leaders) who were successful by virtue of their team play and team spirit rather than their hostile aggression.
 26. Conduct or refer the client to group psychotherapy in order to provide feedback from others

- regarding his/her hurtful behavior and to develop basic trust and accurate understanding of others.
16. Increase expressions of empathy by accurately identifying the feelings of another person and verbalizing understanding of his/her predicament. (27)
 17. Verbalize feelings of empathy and/or nurturance. (28)
 18. Express anger in an appropriate fashion rather than becoming enraged and/or vindictive when feeling wronged, hurt, or belittled. (27)
 19. Identify how the masculine role has impacted behavior; verbalize developing a more flexible gender role. (28, 29)
 27. Hold a family therapy session, and encourage the client to persist in rewording and reflecting back the communication of the family member, spouse, or partner until he/she agrees that the communication is accurate.
 28. Assign the client to read a book on understanding others' feelings (e.g., *Empathy* by Krznaric); process key ideas during a session.
 27. Assist the client in identifying constructive ways to express anger (or assign "Alternatives to Destructive Anger" in the *Adult Psychotherapy Homework Planner* by Jongsma); assign *The Anger Management Workbook* by McKay and Rogers or *The Dance of Anger* by Lerner; process key ideas in subsequent sessions.
 28. Process the meaning of masculinity to the client (e.g., needing to be strong, to dominate, to always be on top, and to not show feelings or weakness); explore the impact of these attitudes and actions and how to create a healthy male identity (see *A New Psychology of Men* by Levant and Pollack). Process with the client ways to retain masculine virtues (e.g., assertiveness, toughness under adversity, and willingness to sacrifice for others) while transcending arbitrary societal

- limitations (e.g., not showing emotions and nonintimate relationships).
20. Verbally acknowledge and express regret that own sexually exploitive behavior was hurtful to another person. (30)
 21. Verbalize an awareness of disadvantages of living by the philosophy “Do unto others before they can do unto you.” (20, 31)
 22. Express some degree of trust in and caring for another person while verbalizing beliefs that will encourage the maintenance of satisfying long-term relationships (32, 33)
 29. Assign the client to read a book on male gender role identity (e.g., *Masculinity Reconstructed* by Levant and Kopecky); process the key ideas within subsequent sessions.
 30. Explore the client’s sexual exploitation pattern (e.g., demanding sex from a subordinate or misleading someone to obtain sexual gratification), emphasizing the painful consequences to his/her victims (or assign “Looking Closer at My Sexual Behavior” or “How I Have Hurt Others” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 20. Teach how lying and disloyalty initiates a self-fulfilling prophecy that leads to further distrust (e.g., betraying people leads to being betrayed by them). See *Disorders of Personality* by Millon.
 31. Assist the client in listing the disadvantages of distrust and unkindness toward others as well as the advantages of kindness toward others (or assign “Three Acts of Kindness” in the *Adult Psychotherapy Homework Planner* by Jongsma).
 32. Conduct or refer the client to a structured therapeutic wilderness adventure program (e.g., Outward Bound), taking advantage of the client’s action orientation and providing opportunities to learn about

trust (see *Interpersonal Diagnosis and Treatment of Personality Disorders* by Benjamin).

23. List the difficulties that have been experienced in forming intimate attachments in prior relationships. (12, 34)
24. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (35)
33. Explore the client's distorted, negative beliefs regarding intimate relationships associated with the Mistrust/Abuse schema (e.g., that there is a person who will never disappoint him/her, that no one is worth the effort since all people are basically rotten). Use rational emotive techniques to challenge these ideas, replacing them with more flexible and realistic ones (e.g., everyone has faults; any long-term relationship has peaks and valleys; most people have redeeming features). See *Schema Therapy* by Young, Klosko, and Weishaar.
12. Set limits when the client oversteps boundaries and expects special treatment (demands special scheduling or fee arrangements, wants to smoke in the office, tries to touch the therapist inappropriately, etc.). Use these instances to demonstrate to the client his/her cognitive schemas and belief systems; relate these to areas in which he/she has problems in other relationships.
34. Validate the client's concerns regarding intimate relationships, and express unconditional positive regard (i.e., that the feelings are understandable from the client's perspective).
35. Refer the client to a physician for an evaluation for medication to improve mood and/or to decrease irritability; help the client to process costs and

- benefits of a psychiatric evaluation.
25. Take psychotropic medications as prescribed, and report on the effectiveness and side effects. (36)
 26. Describe feelings of respect for one other person. (37)
 27. Verbalize an expectation of average treatment rather than special treatment or being above the rules in most or all situations. (38)
 28. Express satisfaction with what he/she has rather than always wanting more. (24, 39)
 36. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.
 37. Challenge the client's all-or-none thinking by asking him/her to recall or imagine instances in which an individual was worthy of trust or respect (e.g., a person, just once, did not betray him/her or did him/her a favor with no expectation of anything in return).
 38. Using Socratic dialogue, challenge the client's beliefs associated with the Entitlement/Grandiosity schema (e.g., "I should be rewarded by virtue of my superior talent") by gently exploring the supportive evidence (e.g., listing actual accomplishments). Support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko.
 24. Explore the client's dreams and fantasies regarding omnipotent power, riches, or control; connect these to current or past relationships and the ability to engage in collaborative relationships.
 39. Assign the client to read *How to Want What You Have* by Miller; process key points within subsequent sessions.

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.4	F34.1	Persistent Depressive Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

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OBSESSIVE-COMPULSIVE*

BEHAVIORAL DEFINITIONS

1. Loses the main point of an activity by focusing excessively on details.
2. Perfectionism interferes with completing tasks and projects.
3. Works or thinks about work so much that it interferes with leisure activities and friendships.
4. Is excessively high-handed and/or moralistic.
5. Has difficulty throwing out worn-out or worthless items.
6. Is hesitant to delegate tasks or work unless others will submit to his/her exact way of doing things.
7. Is miserly, believing money must be hoarded to prepare for future disasters.
8. Is rigid and stubborn.
9. Becomes preoccupied with organizing, ordering, and/or cleaning.
10. Has restricted emotionality; comes across as constrained and/or cold.

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LONG-TERM GOALS

1. Reduce preoccupation with rules, details, and minutiae.
2. Reduce perfectionism.
3. Decrease guilt and self-criticism.

*Appendix A elaborates on the dimensional structure for behavioral definitions.

4. Increase flexibility in problem solving and in interpersonal relationships.
5. Enhance ability to relax.
6. Increase emotional expressiveness and richness of inner emotional experience.
7. Brighten solemn or melancholy mood.
8. Let go of hoarded items and money.

SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share concerns and difficulties. (1)
2. Cooperate with psychological assessment. (2)
3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client's difficulties (e.g., feeling overwhelmed by busyness, rules, and details) through unconditional positive regard, warm acceptance, and reflective listening.
2. Administer or refer the client for personality testing to assess the severity of the obsessive-compulsive pathology and concomitant emotional/behavioral/cognitive problems (e.g., MCMI, Schema Questionnaire, Beck Anxiety Inventory, Basic Adlerian Scales for Interpersonal Success-Adult Form (BASIS-A)).
3. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees

with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

4. Assess the client for evidence of research-based correlated disorders (e.g., hoarding disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 5. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
 6. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
4. Provide behavioral, emotional, and attitudinal information relevant to personality functioning. (7)
 7. Assess diversity considerations: Age, Developmental and acquired Disabilities, Religion, Ethnicity, Socioeconomic status,

- Sexual orientation, Indigenous heritage, National origin, and Gender (ADDRESSING, see *Addressing cultural complexities in practice* by Hays). Consider how diversity considerations can make interventions more effective, and/or avoid pathologizing culturally normative attitudes and behaviors.
5. Verbalize insights into current personality functioning. (8)
 6. Demonstrate a reduced ambivalence and resistance to change. (9)
 7. Report completing a task (e.g., making a purchase, or completing a project at work) without obsessive rumination or perfectionism. (10, 11)
 8. Review and process the results of the previously administered psychological testing with the client.
 9. Utilize motivational interviewing techniques (e.g., focusing and guiding to process ambivalence; change talk when the client is ready) to facilitate overcoming resistance to change (see *Motivational Interviewing* by Miller and Rollnick).
 10. Explore dysfunctional attitudes regarding decision making associated with the Unrelenting Standards/ Hypercriticalness schema (e.g., “If no perfect option is available, it is best to defer the decision,” and “If I do not gather every bit of information, I might make a mistake, which would be awful”). Examine the evidence for and against each belief, encouraging the client to challenge his/her distorted beliefs (see *Schema Therapy* by Young, Klosko, and Weishaar).
 11. Use exposure therapy to reduce perfectionism by asking the client to intentionally make mistakes (e.g., have the client go to a fast food drive-thru when it is busy and stumble through the order,

ask questions, change the order, not have money ready, etc.; have the client go to a store and ask a “dumb” question, e.g., at a tech store, ask “What does ‘www’ mean?”). Process the meaning of the experience and the skills the client used to get through it.

8. Reduce clutter by throwing out one or more items that are no longer useful. (12, 13)
9. Reduce negative thoughts about self that produce guilt, shame, and self-recrimination. (14, 15)
12. Assist the client in identifying a hierarchy of anxiety-provoking stimuli associated with discarding worthless items. Encourage the client to gradually expose himself/herself imaginally to discarding such items, increasing levels of anxiety provocation; ask the client to address feelings of anxiety and confidence present in each situation. Repeat the exercise in vivo as homework (or assign “Gradually Reducing Your Phobic Fear” in the *Adult Psychotherapy Homework Planner* by Jongsma).
13. Encourage the client to explore the symbolic meaning of throwing out items (fears of poverty, the evils of wastefulness, etc.). Facilitate a reduction in the significance of these meanings and their relationship to current actions.
14. Interpret the relationship between the shame perceived in past and current relationships (possibly including the relationship with the therapist in order to help the client attain insight regarding the origin of his/her feelings of inadequacy).
15. Use rational emotive techniques to challenge thoughts associated with the Punitiveness schema, such as “I should do everything

- properly all the time or else I am a terrible person” and “I made a mistake and should be punished.” Replace them with thoughts such as “I am a fallible human being” and “To err is human, to forgive divine.”
10. Identify specific beliefs that support driven, overachieving behavior. (16)
 11. Delegate a task to someone at work, accepting that the other person may do that task differently. (17, 18)
 12. Develop a daily routine that reflects a balance between the quest for achievement on one hand and appreciation of aesthetic things on the other. (19, 20)
 16. Assign the client to keep a record of dysfunctional thoughts (e.g., “I must work harder in order to save for future disasters” and “I must avoid mistakes, otherwise I am a failure”). See *Cognitive Therapy of Personality Disorders* by Beck, Davis, and Freeman.
 17. Express empathy for the client’s feelings about delegating a task (e.g., feeling a loss of control, fearing that the task will not be done properly) through unconditional positive regard, warm acceptance, and reflective listening.
 18. Challenge dysfunctional beliefs associated with the Unrelenting Standards/Hypercriticalness schema, such as “If I do not do it, it will be done improperly,” “Things must be done perfectly or it will be a disaster,” and “There is only one way to do something correctly.” Support with bibliotherapy, such as *Reinventing Your Life* (Young and Klosko).
 19. Assign the client to read a book on increasing self-awareness and moment-to-moment appreciation of life (e.g., *Wherever You Go, There You Are* by Kabat-Zinn) and/or assign The Mindfulness App (MindApps, app); discuss key points within a subsequent session.

13. Appropriately prioritize activities and the time allotted to them in order to balance private life and work life. (21, 22)
14. Spend money on an item or activity just for enjoyment. (23)
15. Increase assertiveness in situations in which passivity was used previously. (24)
20. Ask the client to list activities in which he/she could engage for purely aesthetic enjoyment (e.g., visiting an art museum, attending a symphony concert, hiking in the woods, writing poetry) and incorporate these into his/her life.
21. Assign the client to read *The Seven Habits of Highly Effective People* by Covey, *First Things First* by Covey and Merrill, and/or *Living the Seven Habits* (Franklin Covey, app); process key points during a subsequent session.
22. Assist the client in his/her listing of priorities, focusing on the need for balancing work- and non-work-related activities (relationships, recreation, spirituality, relaxation, etc.).
23. Encourage the client to examine whether specific attitudes about money are interfering with task completion. Use rational emotive techniques to challenge such beliefs, replacing rigid, dysfunctional thoughts (e.g., "Spending money is a waste") with more flexible, adaptive ones (e.g., "Sometimes it costs money to get something done" or "It's okay to spend some money in order to have some fun").
24. Use role-play, modeling, and behavioral rehearsal with the client to simulate situations that demand assertiveness (or assign "Becoming Assertive" in the *Adult Psychotherapy Homework Planner* by Jongsma); provide feedback regarding the appropriateness of his/her

- responses. Support with readings, such as *Your Perfect Right* by Alberti and Emmons and/or the *Cognitive Behavioral Therapy Workbook for Personality Disorders* by Wood.
16. Report an increased capacity to stay focused and relaxed when routine is broken or schedule is interrupted. (25, 26)
 17. Report an improved awareness of own feelings and motivations. (27, 28)
 18. Express an emotional experience in a clear, unambiguous fashion while feeling some of the affect associated with that experience. (29)
 25. Teach the client deep-muscle and deep-breathing relaxation techniques (or assign “Progressive Muscle Relaxation” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
 26. Ask the client to implement relaxation skills while engaging in stressful activity. Monitor progress using the Subjective Units of Distress (SUDs) scale to assess his/her comfort level and/or anxiety.
 27. Conduct or refer the client to a Mindfulness-Based Stress Reduction class or similar. Process what was learned, and have the client integrate mindfulness into daily activities.
 28. Explore the possibility that the client projects his/her own feelings onto others, including the therapist, thereby misperceiving others’ feelings and intentions.
 29. Instruct the client to imagine different feelings associated with an emotionally important event (e.g., a bodily sensation, such as sweaty palms) or with a significant other (e.g., a deceased parent) who occupies an empty chair in the room. Have the client discuss his/her true feelings with the imaginary participant, encouraging a dramatic expression of feeling.

19. Demonstrate a willingness to be fully present with the entirety of the emotional experience, thereby increasing tolerance of emotional distress. (30)
20. Report an awareness of family patterns of interaction and the impact that such patterns have had on his/her actions and emotions. (31)
21. Verbalize increasing desire for pleasure in sexual activity. (32, 33)
22. Express feelings clearly and directly using "I" messages. (34)
30. Engage in willingness and acceptance exercises, such as "Giving Your Target a Form," "The Tin Can Monster," and "Acceptance in Real Time" (see *Get Out of Your Mind and into Your Life* by Hayes and Smith).
31. During a family therapy session, employ the family sculpture technique to assist the client in reliving emotionally important events in his/her family; process the experience.
32. Conduct or refer the client to sex therapy.
33. When the client expresses readiness, encourage less constricted sexual behavior by assigning body-pleasuring exercises with the client's partner. Assign books to guide exercises (e.g., *The Gift of Sex* by Penner and Penner, or *The Joy of Sex* by Comfort). Process any emotional inhibition schemas that arise, such as "I must not let loose or I will lose control, and that would be terrible."
34. Encourage the client to express his/her feelings in the following manner: "When you say X to me in Y situation, I feel Z." Encourage the significant other to do likewise. Instruct them to persist in communicating in that manner until each side reports understanding the other. Support with bibliotherapy, such as *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman.

23. Express empathy toward another person's difficulties rather than being judgmental or moralistic. (35, 36)
24. Increase demonstrations of interpersonal warmth. (37, 38)
25. Identify and resolve feelings associated with pattern of trying unsuccessfully to please a parent figure since childhood. (39)
35. Use role reversal to help the client see the problem from another person's point of view.
36. Process (or refer the client to clergy to process) the loving and forgiving nature of God in the context of the image of God as judge and punisher.
37. Validate the client's concerns regarding intimate relationships and express unconditional positive regard (i.e., that the feelings are understandable from the client's perspective), allowing the client to learn about empathy by example.
38. When the client imposes rigid, excessively high standards during a family couple's session, encourage the person who was targeted to express his/her feelings, focusing on underlying vulnerability in each partner. Process in light of the insecure attachment of the person with Obsessive-Compulsive Personality Disorder. Support with bibliotherapy, such as *Hold Me Tight* by Johnson.
39. Probe the client's family-of-origin history of being pressured to achieve but never succeeding at satisfying a parent figure. Teach the concept of self-fulfilling prophecy and how efforts to avoid displeasing others (e.g., perfectionism and procrastination) bring about the unwanted displeasure and frustration (see *Personality Guided Therapy* by Millon).

26. Each member of the family describes how the client's exacting and perfectionistic behavior impacts him/her. (40)
27. Reduce power struggles and improve intimacy in an obsessive-compulsive couple. (41)
28. Attend group therapy sessions focused on increasing awareness of thoughts and feelings of self and others and enhancing emotional connection and expressiveness. (42)
29. Follow through on an idea for an activity, focusing on the main thrust of the activity rather than on the schedules, details, and minutia. (43)
30. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (44)
40. Within a family therapy session, explore each family member's feelings regarding the client's coldness, distancing, and perfectionistic demands; ask the client to reflect those feelings back to each family member.
41. During a couples session, help the obsessive partner to let go of defensive denial of feelings while encouraging the histrionic partner to create a safer communication environment by modulating rage.
42. Conduct, or refer the client to, group therapy to improve interpersonal interactions through increasing the client's awareness of his/her own feelings, motivations, and actions and the impact that his/her behavior has on others.
43. Assign the client to participate in an activity with the directive that he/she enjoy the activity itself rather than getting immersed in the minute details. Process the experience, and repeat the assignment, reinforcing an increasing degree of freedom from obsession with details.
44. Refer the client to a physician for an evaluation for medication to improve mood and/or decrease anxiety; if the client is resistant, process costs and benefits of a medication evaluation.

31. Take medications as prescribed, and report on effectiveness and side effects. (45)

45. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.

DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.4	F34.1	Persistent Depressive Disorder
300.02	F41.1	Generalized Anxiety Disorder
301.4	F60.5	Obsessive-Compulsive Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.20	F60.1	Schizoid Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

OBSESSIVE-COMPULSIVE—BEDEVILED

BEHAVIORAL DEFINITIONS

1. Has great difficulty making decisions, which results in procrastination and inefficiency.
2. Ruminates about the mixed, conflicted feelings he/she has about people and events.
3. Reports feeling tormented, muddled, and/or confused.
4. Is rigid and stubborn.
5. Expresses great fear that he/she will lose control of his/her emotions or thought process.
6. Uses rituals and obsessive thinking to maintain feelings of being in control.
7. Becomes preoccupied with organizing, ordering, and/or cleaning.

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LONG-TERM GOALS

1. Take action in a timely manner after efficiently considering the alternatives.
2. Clarify and resolve conflicted feelings about other people.
3. Increase flexibility in problem solving and thinking.
4. Enhance ability to relax.
5. Increase emotional self-awareness.
6. Reduce fears regarding loss of control.

262 THE PERSONALITY DISORDERS TREATMENT PLANNER

7. Decrease guilt and self-criticism.
8. Reduce rumination regarding conflicted feelings toward others.

SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share concerns and difficulties. (1)
2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (2, 3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client's difficulties (e.g., feeling overwhelmed by rituals, details, and conflicted feelings) through unconditional positive regard, warm acceptance, and reflective listening.
2. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
3. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD,

depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

4. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
5. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
3. Comply with psychological assessment. (6, 7)
6. Administer or refer the client for personality testing, such as the MCMI, to assess the severity of the obsessive-compulsive pathology and any concomitant emotional/behavioral/cognitive problems.
4. Report completing a minor task (e.g., making a minor purchase) or a major task (e.g., completing
7. Review and process the results of testing with the client.
8. Elicit feedback from the client regarding difficulties in making decisions, allowing the client to

a major project at work) without obsessive rumination or perfectionism. (8, 9, 10, 11)

clarify his/her own point of view and gain a greater sense of self-acceptance, thus feeling freer to make decisions.

9. Explore the client's dysfunctional attitudes regarding decision making associated with the Unrelenting Standards/Hypercriticalness schema (e.g., "If no perfect option is available, it is best to defer the decision" and "If I do not gather every bit of information, I might make a mistake, which would be awful"). Examine the evidence for and against each belief, encouraging the client to challenge his/her distorted beliefs when appropriate (see *Schema Therapy* by Young, Klosko, and Weishaar).
10. Examine the client's approach to the psychotherapy process and how his/her indecisiveness interferes with progress (e.g., unwillingness to begin doing homework due to procrastination and inability to decide how to start); process how such attitudes interfere with attaining therapeutic goals.
11. Review the pros and cons of the options for a minor decision; then assign the client the task of enacting a minor decision that has been postponed. Process the results, and positively reinforce the client for making decisions in a more rapid and effective manner. Continue this process for major decisions (or assign "Making Your Own Decisions"

in the *Adult Psychotherapy Homework Planner* by Jongsma).

5. Reduce the frequency of negative automatic thoughts about self that produce guilt and self-recrimination. (12, 13, 14, 15)
12. Assign the client to keep a record of dysfunctional thoughts associated with the Punitiveness schema (e.g., “If I make a mistake, I should be punished” and “I made a mistake, which is horrible”). Support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko.
13. Use rational emotive techniques to challenge the client’s distorted thoughts (e.g., “I should do everything properly all the time or else I am a terrible person,” “I made a mistake and should be punished”). Replace them with realistic thoughts (e.g., “I am a fallible human being,” “To err is human, to forgive divine”). Support with bibliotherapy, such as *The Tao of Forgiveness* by Martin.
14. Explore feelings of guilt related to important figures (e.g., parents) from the client’s early childhood; process how these feelings are impacting his/her current experience.
15. Process (or refer the client to clergy to process) the client’s belief about the loving and forgiving nature of God in the context of his/her images of God as judge and punisher. Encourage the client to find peace in God’s loving acceptance of us.

6. Increase frequency of engaging in pleasurable leisure activities. (16, 17)
7. Report reduced anxiety caused by changes in schedule and/or routine. (18, 19, 20, 21)
16. Reflect back the client's words and thoughts about participating in more pleasurable activities (e.g., spending time with family, playing a game, going for a hike, etc.), providing unconditional positive regard. Allow the client to explore the meaning of these potential activities and how he/she would experience a change in routine.
17. Assign the client to read a book on how to lead a fulfilling life (e.g., *The Road Less Traveled* by Peck or *Everyday Blessings* by Kabat-Zinn and Kabat-Zinn); process key ideas with the therapist.
18. Assist the client in identifying a hierarchy of anxiety-provoking stimuli associated with unanticipated circumstances.
19. Teach the client deep-muscle and deep-breathing relaxation techniques (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). For between-session practice, introduce the use of a smartphone app, such as *Breathe2Relax* by the National Center for Telehealth and Technology.
20. Conduct imaginal systematic desensitization to the hierarchy of anxiety-provoking stimuli while the client is deeply relaxed. Encourage the client to apply the relaxation skills to daily in vivo situations (or assign "Journal and Replace

- Self-Defeating Thoughts” or “Reducing the Strength of Compulsive Behaviors” in the *Adult Psychotherapy Homework Planner* by Jongsma).
8. Report an increased capacity to stay focused and relaxed during uncertain circumstances. (22, 23)
 21. Have the client use relaxation skills during unexpected circumstances. Monitor progress using the Subjective Units of Distress Scale (SUDS) to assess level of comfort and/or anxiety.
 22. Teach the client the thought-watching exercise (i.e., asking the client to pay attention to his/her thoughts and feelings as they are experienced in the present moment) to enhance self-awareness (see *Full Catastrophe Living* by Kabat-Zinn).
 23. Teach the client to increase his/her body awareness through an assigned exercise, such as having the client lie in a quiet room and pay attention to psychokinesthetic stimuli (see “Body Scan” exercise in *Full Catastrophe Living* by Kabat-Zinn). For between-session practice, introduce the use of a smartphone app, such as: Mindfulness Meditation by Mental Workout, or Mindfulness Coach by U.S. Department of Veterans Affairs.
 9. Verbalize appropriate and balanced thoughts about a relationship that formerly caused excessive rumination. (24)
 24. Use rational emotive techniques to challenge the client’s distorted beliefs about current ways of thinking about relationships (e.g., “If I think about it enough, I’m sure I can figure out the right answer to this situation”).

10. Report an improved awareness of own feelings and motivations. (25, 26)
11. Express an emotional experience in a clear, unambiguous fashion while feeling some of the affect associated with that experience. (27, 28)
12. Report an awareness of family patterns of interaction and the impact that such patterns have had on actions and emotions. (29, 30)
25. Explore the possibility that the client projects his/her own feelings onto others, including the therapist, thereby misperceiving others' feelings and intentions.
26. Assign the client to read a book on increasing self-awareness (e.g., *Full Catastrophe Living* or *Wherever You Go, There You Are* by Kabat-Zinn), and discuss key points.
27. Encourage the client to practice identifying and clarifying emotional experiences, processing areas in which the client appears to be rationalizing or denying feelings.
28. Instruct the client to imagine different feelings associated with an emotionally important event (e.g., a bodily sensation, such as sweaty palms) or with a significant other (e.g., a deceased parent) who occupies an empty chair in the room. Have the client discuss his/her true feelings with the imaginary participant, encouraging a dramatic expression of feeling.
29. Discuss the client's early relationship with parents; assess resolution of conflicts related to interpersonal relationships; relate these conflicts to current difficulties in intimate relationships.
- Replace these beliefs with more realistic thoughts (e.g., "Sometimes my actions will work well, and other times they will not, no matter how much I think about it").

13. Express feelings clearly and directly using “I” messages. (31)
14. Increase expression of empathy by accurately identifying the feelings of others and verbalizing an understanding of their predicament. (32)
15. List the difficulties experienced in forming intimate attachments in prior and current relationships. (33, 34)
30. Explore in either an individual or a family session the client’s early family interactions regarding implicit rules of interpersonal conduct.
31. Encourage the client to express his/her feelings in the following manner: “When you say X to me in Y situation, I feel Z.” Encourage the significant other to do likewise. Instruct them to persist in communicating in that manner until each side reports understanding the other (see *A Couple’s Guide to Communication* by Gottman, Notarius, Gonso, and Markman).
32. Use role-play, role reversal, and modeling of common interpersonal situations to provide the client with accurate feedback regarding likely emotional reactions others would have to the client’s statements and nonverbal behaviors.
33. Validate the client’s concerns regarding intimate relationships, and express unconditional positive regard for his/her feelings (i.e., that the feelings are understandable from the client’s perspective).
34. Encourage the client to explore fantasies regarding his/her relationship with the therapist (e.g., whether he/she sees the therapist as a punitive authority figure); process how this impacts the therapeutic relationship and, by extension, relationships with other significant figures in the client’s life.

16. Reduce reliance on rituals and obsessions to feel in control. (35, 36)
17. Family members express frustration with the client's indecisive and vacillating behavior. (37)
18. Report reduced conflicted feelings in a significant relationship. (31, 37, 38)
35. Teach the client coping mechanisms, such as assertiveness (see "Develop Assertive Communication Skills" in *Cognitive Behavioral Therapy Workbook for Personality Disorders* by Wood).
36. Using Socratic dialogue, challenge the client's distorted beliefs regarding his/her rituals (e.g., "I am powerful enough to initiate or prevent the occurrence of catastrophes by magical rituals or obsessional ruminations," "Without my rules and rituals, I'll collapse in an inert pile"). Replace them with more balanced thoughts (e.g., "I have many skills with which to cope with difficulties").
37. Within a family therapy session, explore each family member's feelings regarding the client's indecisive and vacillating behavior; ask the client to reflect those feelings back to each family member.
31. Encourage the client to express his/her feelings in the following manner: "When you say X to me in Y situation, I feel Z." Encourage the significant other to do likewise. Instruct them to persist in communicating in that manner until each side reports understanding the other (see *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman).
37. Within a family therapy session, explore each family member's

- feelings regarding the client's indecisive and vacillating behavior; ask the client to reflect those feelings back to each family member.
19. Demonstrate flexible problem solving regarding a matter that has been troubling rather than relying on current constricted, rigid strategies. (39)
 20. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (40)
 21. Take psychotropic medication as prescribed, and report on the medication's effectiveness and side effects. (41)
 38. Assist the client in identifying conflicted feelings in two significant relationships; challenge the client to resolve these feelings to his/her satisfaction.
 39. Train the client in steps in problem solving including brainstorming to generate possible solutions, weighing pros and cons of each solution, and evaluating possible solutions by anticipating potential consequences (or assign "Applying Problem Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma).
 40. Refer the client to a physician for an evaluation for medication to improve mood and decrease anxiety; help the client to process costs and benefits of a medication evaluation.
 41. Monitor the client's use of psychotropic medication for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of abuse of or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the client's psychotropic medication.

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.02	F41.1	Generalized Anxiety Disorder
301.4	F60.5	Obsessive-Compulsive Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

PARANOID*

BEHAVIORAL DEFINITIONS

1. Suspects, without adequate justification, that others are trying to mistreat, deceive, or take advantage of him/her.
2. Is consumed with unwarranted doubts about the loyalty or trustworthiness of friends or associates.
3. Is extremely hesitant to confide in others due to excessive fears that the information will be used against him/her.
4. Finds hidden, degrading messages in others' innocent comments.
5. Doggedly holds grudges against others who insulted or slighted him/her.
6. Is hypersensitive to attacks on his/her character and reacts with angry counterattacks.
7. Repeatedly suspects, without evidence, that his/her spouse or partner has been unfaithful.

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LONG-TERM GOALS

1. Reduce suspiciousness of others and increase trust.
2. Let go of distorted suspicious beliefs and replace them with more reasonable, reality-based beliefs.

*Appendix A elaborates on the dimensional structure for behavioral definitions.

3. Increase appropriate involvement with other people and decrease self-protective withdrawals.
4. Increase flexibility in thinking and problem solving.
5. Express anger in a healthy manner.
6. Reduce or eliminate provocations of rejection from others. Increase comfort with feelings of vulnerability.

SHORT-TERM OBJECTIVES

THERAPEUTIC INTERVENTIONS

1. Express satisfaction with therapeutic relationship, either verbally or nonverbally, as indicated by verbalizing difficulties and concerns. (1, 2)

2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)

1. Express empathy for the client’s difficulties (e.g., feeling fearful, attacked, and humiliated) through reflective listening and unconditional positive regard.
2. Avoid power struggles with the client by expressing respect for his/her need for privacy and understanding.
3. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance

regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
5. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
6. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
3. Establish a trusting relationship with the therapist. (7, 8)
7. Enter into the client’s worldview by expressing that trust in the therapist must be earned (e.g., suggest that the client see how the therapist acts and follows through rather than merely believing what he/she says);

- follow up by working on a concrete, specific behavior or problem (see *Cognitive Therapy of Personality Disorders* by Beck, Davis, and Freeman).
4. Confirm feeling safe and in control during therapy sessions. (9, 10)
 5. Identify distorted beliefs that result in feelings of fear. (11)
 6. Verbalize experiencing reduced feelings of fear in a common situation (e.g., being at work). (12, 13)
 8. If the client shares feelings and vulnerabilities or admits mistakes, compliment him/her (e.g., “It took real strength to tell it like it is” and “Most people wouldn’t have had the guts to admit that—that was impressive”).
 9. Facilitate safety by describing how some people react in a given circumstance and allowing or encouraging the client to discuss some problems indirectly, especially early in therapy.
 10. Negotiate session frequency, seriously considering less-frequent sessions (e.g., once every few weeks) to allow the client to be less threatened by the therapeutic process.
 11. Assign the client to keep a record of dysfunctional thoughts, such as “This is a very dangerous situation” or “I must be on guard” (or assign “Journal and Replace Self-Defeating Thoughts” in the *Adult Psychotherapy Homework Planner* by Jongsma). See *Cognitive Therapy of Personality Disorders* by Beck, Davis, and Freeman.
 12. Using Socratic dialogue, gently challenge distorted beliefs associated with the Mistrust/Abuse schema (e.g., “The person who is trying to

- harm me can cause great damage”) with more balanced ones (e.g., “The person is probably not trying to harm me,” “Even if the person is trying to harm me, it is unlikely that he/she can do much damage”). See *Schema Therapy* by Young, Klosko, and Weishaar. Support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko.
7. Express anger in an appropriate fashion rather than with unjustified accusations and withdrawal in response to feeling wronged or belittled. (14)
 8. During a psychotherapy session, express emotions regarding a vulnerable area. (15, 16)
 13. Explore the client’s feelings of fear, accepting his/her feelings without judgment and allowing the feelings to become clear to the client.
 14. Instruct the client to imagine that the person who angered him/her is in an empty chair in the room; direct the client to express his/her feelings to the imagined person while continuing to increase the intensity of the reaction until a powerful emotional response is achieved.
 15. Explore situations from the client’s past in which significant others have proven to be untrustworthy, unreliable, neglectful, or hurtful (or assign “Share the Painful Memory” in the *Adult Psychotherapy Homework Planner* by Jongsma); process the client’s feelings of hurt and anger in a session.
 16. Discuss forgiveness of perpetrators of the client’s pain as a process of letting go of anger and anguish (or assign “Feelings and Forgiveness

- Letter” in the *Adult Psychotherapy Homework Planner* by Jongsma); support with bibliotherapy, such as *The Tao of Forgiveness* by Martin.
9. Express appropriate displeasure or anger toward a person who generates frustration rather than becoming enraged or vengeful. (17, 18, 19)
 17. Assist the client in identifying alternatives to rage expression, such as assertiveness, problem solving, deep breathing/relaxation, diversion, etc. (or assign “Alternatives to Destructive Anger” in the *Adult Psychotherapy Homework Planner* by Jongsma) or *Beyond Anger* by Harbin and/or *The Anger Control Workbook* by McKay and Rogers; process key ideas in a subsequent session.
 18. Clarify the client’s values, such as the desire to be in a healthy intimate relationship or to have smooth work relationships. Juxtapose these values with behaviors that interfere with their achievement (e.g., regarding hypervigilant/defensive style, “In your experience, has the way in which you have expressed yourself to your boss resulted in the smooth working relationship you desire?”). See *Motivational Interviewing* by Miller and Rollnick.
 19. Institute stress inoculation training for anger by preparing the client to recognize early cues and mental precursors of anger (such as recognizing that slights are very provocative to him/her). Use behavioral rehearsal to establish appropriate responses (discounting the importance of the slight, calmly expressing a

- sense of hurt, etc.) and establish self-rewards for maintaining control (e.g., making positive self-statements). See *Stress Inoculation Training* by Meichenbaum.
10. Respond assertively in a situation in which withdrawal and vengeful fantasies were previously used. (20, 21)
 11. Demonstrate an increased flexibility in thinking style by accepting ideas generated by self or others and expressing willingness to try a new way of looking at an old problem. (22)
 12. Acknowledge that own behavior may alienate some people. (23, 24)
 20. Assign readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons and/or “Develop Assertive Communication Skills” in the *Cognitive Behavioral Therapy Workbook* by Wood); discuss key points.
 21. Use role-play, modeling, and behavioral rehearsal with the client to simulate situations that demand assertiveness (or assign “Becoming Assertive” in the *Adult Psychotherapy Homework Planner* by Jongsma); provide feedback regarding the appropriateness of his/her responses.
 22. Engage the client in various experiential exercises to increase willingness for discomfort, for trying something new, etc., such as the “Physicalizing Exercise” and/or “Jump Exercise” in *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson.
 23. Use role reversal to help the client empathize with the person whom he/she is alienating with his/her suspiciousness or “counterattacks.”
 24. Examine the concept of self-fulfilling prophecy and how testing others and accusing them of wrongdoing evokes suspicion and anger on the part of others.

13. Accept responsibility for a negative outcome rather than using denial or blaming someone else. (25)
14. Verbalize feeling some trust toward another person. (26, 27)
15. Verbalize beliefs that will encourage the maintenance of a trusting relationship with a significant other. (28)
16. Work through a problem by engaging with others rather than self-protectively withdrawing from the situation. (29)
25. Use rational emotive techniques to challenge thoughts such as “I am never at fault” or “That person is entirely to blame.” Replace them with thoughts such as “I am a fallible human being,” “Partial mistakes can be made by several people,” and “To err is human, to forgive divine.”
26. Explore the client’s beliefs regarding intimate relationships (e.g., that he/she can’t trust anyone, that everyone is ready to harm him/her). Use rational emotive techniques to challenge the ideas. Replace unrealistic ideas with more flexible and realistic ones (e.g., most people can be trusted to some degree; everyone has faults; some people can sincerely help others, at least some of the time).
27. Use Socratic dialogue to challenge the client’s emotional reasoning (e.g., “I feel that they are trying to undermine me; therefore they are”).
28. Explore the client’s fantasies regarding significant relationships (e.g., that others are planning to exploit him/her). Explore the meaning of these fantasies with regard to early childhood relationships (e.g., victimization by a sadistic caretaker) and/or the relationship with the therapist (e.g., the client’s projection that the therapist will try to control him/her).
29. Examine both functional and dysfunctional aspects of the client’s isolation (e.g., feels safer at home but feels lonely; feels

- comfortable withdrawing from a difficult situation but the problem gets worse). Assess the balance between productive versus unproductive time alone and amount of time alone.
17. Express self using “I” statements. (30)
 18. Spouse or family member(s) express frustration with the client’s mistrustful and suspicious behavior. (31)
 19. Verbalize accurate empathy with the feelings of another person. (32)
 20. Share personal information with another person. (33)
 30. Encourage the client and partner or family members to express their feelings in the following manner: “When you say X to me in Y situation, I feel Z.” Encourage them to persist in communicating in that manner until each side reports understanding the other (see *A Couple’s Guide to Communication* by Gottman, Notarius, Gonso, and Markman).
 31. In a conjoint session, facilitate partner and/or family members’ expression of feelings to one another, encouraging increased vulnerability (e.g., partner feeling frustrated with the client’s distancing; client feeling misunderstood and frightened). Support with bibliotherapy, such as *The Seven Principles for Making Marriage Work* by Gottman and Silver or *Ten Lessons to Transform Your Marriage* by Gottman, Gottman, and DeClaire.
 32. Empathize with the client’s pain, allowing him/her to learn by example and become more compassionate to both self and others.
 33. Provide the client with relationship skills training, including suggestions of appropriate topics he/she could discuss with others, appropriate

- degree and timing of self-disclosure, and improved nonverbal behavior; assign two such conversations per week, and process the results (see *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman and/or the Interpersonal Effectiveness DBT module and handouts in *DBT Skills Training Handouts and Worksheets* by Linehan; see also DBT Diary and Skills Coach (Durham DBT, app).
21. Identify negative automatic thoughts about self that produce low self-esteem or feelings of shame. (34, 35)
22. Verbally acknowledge feelings of inadequacy and take steps to improve self-esteem. (36)
34. Identify metaphorical/symbolic meaning of the client's paranoid fears (e.g., fearing that a spouse is unfaithful may indicate that the client feels unworthy of being loved; fearing that someone will attack him/her may be a projection of anger toward the other person); process alternative explanations in light of the client's life experience.
35. Assign the client to read a self-help book on building self-esteem (e.g., *The Six Pillars of Self-Esteem* by Branden or *The Self-Esteem Workbook* by Schiraldi); process key ideas in session.
36. Build optimism by suggesting that the new thoughts, behaviors, and approaches the client is trying will be more effective than previous attempts and that he/she is likely to be more successful this time because a new approach is being tried (or assign "Replacing Fears with Positive Messages")

- in the *Adult Psychotherapy Homework Planner* by Jongsma); support with bibliotherapy, such as *Learned Optimism* by Seligman.
23. Verbalize that quasi-delusional material is only one of many possible explanations for a series of events. (37)
 24. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (38)
 25. Take medications as prescribed, and report on effectiveness and side effects. (39)
 37. Assist in restructuring the client's delusional ideas by collaboratively examining whether there is any empirical evidence to support those ideas (or assign "Check Suspicions Against Reality" in the *Adult Psychotherapy Homework Planner* by Jongsma); identify more realistic conclusions to substitute for distorted cognitions (see *Cognitive Behavior Therapy for Severe Mental Illness* by Wright, Kindon, Turkington, and Ramirez-Bosco).
 38. Refer the client to a physician for an evaluation for medication to improve mood and/or disordered thinking. Process his/her resistance to meeting with a physician (e.g., not trusting doctors, fears about medications or mind control). Help the client to process costs and benefits of a psychopharmacologic evaluation.
 39. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.

- 26. Express forgiveness toward someone against whom he/she held a grudge. (40)
- 27. Identify feeling vulnerable and react calmly rather than with rage or withdrawal. (41)
- 28. Verbalize acceptance that spouse has been faithful to him/her; report discontinuing to test him/her. (42)
- 29. Express a tender emotion for a significant other. (43)
- 30. Express that while some people are untrustworthy or vengeful, most people do not have malicious intent against him/her. (44)
- 40. Explore the client's spiritual beliefs regarding forgiveness (e.g., how forgiveness cleanses the forgiver and the forgiven); process with the client or refer to clergy.
- 41. Train the client to use meditation (e.g., thought-watching exercise) by assigning *Full Catastrophe Living or Wherever You Go, There You Are*, both by Kabat-Zinn, processing key concepts with the therapist; demonstrate the technique during the session, and assign practice as homework.
- 42. Assign the client (and/or the partner/spouse) to read *Insecure in Love* by Becker-Phelps or *Jealousy and Envy* by Friday; process key points in session.
- 43. Acknowledge feelings of vulnerability generated by expressing tenderness; praise the client for his/her courage.
- 44. Verbally reinforce all of the client's expressions of increased trust in others and his/her rejection of formerly held suspicions. Support with bibliotherapy, such as *Love Sense* by Johnson.

DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
295.30	F20.9	Schizophrenia
297.1	F22	Delusional Disorder
301.0	F60.0	Paranoid Personality Disorder
310.22	F21	Schizotypal Personality Disorder
301.82	F60.6	Avoidant Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
301.9	F60.9	Unspecified Personality Disorder (Personality Disorder NOS)

PARANOID—FANATIC

BEHAVIORAL DEFINITIONS

1. Has grandiose beliefs supported by irrational and flimsy evidence.
2. Pretentiously puts on airs of superiority.
3. Demonstrates contempt and arrogance toward others.
4. Reestablishes lost pride with extravagant claims and fantasies.
5. Brags about accomplishments in an attempt to be admired by others.
6. Verbalizes a belief that others envy him/her.

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LONG-TERM GOALS

1. Increase tendency and capacity to value others and trust their judgment.
2. Decrease arrogant, denigrating attitudes and behaviors.
3. Reduce or eliminate grandiose beliefs.
4. Improve empathy, increasing the ability and desire to understand others' feelings.
5. Increase acceptance of own limitations and capacity to set realistic, achievable goals.
6. Reduce feelings of envy and suspiciousness toward others.

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SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share difficulties and concerns. (1)
2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (2, 3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Express empathy and warm acceptance for the client's difficulties (e.g., feeling frustrated, misunderstood, or undermined).
2. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
3. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
4. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

3. Identify interpersonal conflicts and beliefs about the competencies and motivations of others. (6)
4. Verbalize a feeling of trust and safety in the relationship with the therapist. (7, 8)
5. Express anger in an appropriate fashion rather than becoming enraged when feeling wronged, hurt, or belittled. (9, 10, 11)
5. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
6. Assist the client in developing a list of specific dissatisfactions he/she is currently experiencing (e.g., someone intentionally giving him/her a hard time at work or not getting the recognition and admiration that he/she feels he/she deserves).
7. If the client shares feelings or vulnerabilities or admits mistakes, compliment him/her (e.g., "It took real strength to tell it like it is" and "Most people wouldn't have had the guts to admit that—that was impressive").
8. Facilitate safety by describing how some people react in a given circumstance and allowing or encouraging the client to discuss some problems indirectly, especially early in therapy.
9. When the client rages against a person who challenged the content of his/her grandiose assertion, empathize while gently confronting the client by

acknowledging the (excessive) impact of the introjected other (e.g., “What that person says really matters to you, and he/she has hurt your feelings”). See *Interpersonal Diagnosis and Treatment of Personality Disorders* by Benjamin.

10. Assign the client to read *The Anger Control Workbook* by McKay and Rogers or *The Dance of Anger* by Lerner; process key ideas.
11. Institute stress inoculation training for anger by preparing the client for situations in which he/she becomes angry; use behavioral rehearsal to establish appropriate responses, and initiate self-rewards for maintaining control (see *Stress Inoculation Training* by Meichenbaum). Frame stress inoculation as a way of preparing for battle or getting an edge by being in control of self and the situation.
6. State feeling understood by the therapist. (12)
12. Go beyond the literal meaning of the client’s communication by making empathic contact with his/her subjective experience and affect (e.g., when the client states that no one can understand his/her ideas, reflect back that it must feel very lonely and isolating). See “Using Self Psychology in Brief Psychotherapy” by Gardner and *The Analysis of the Self* by Kohut.
7. Speak and behave respectfully toward the therapist, avoiding denigrating language and tone. (13, 14)
13. When the client denigrates or is condescending toward the therapist, explore the client’s beliefs or fantasies regarding

the impact that manner has on the therapist or whether the client has even considered its impact; analyze whether similar interactions may underlie difficulties in other important relationships.

8. Report being motivated to become more aware of the thoughts and feelings of others. (15)
9. Initiate pleasant social conversation with at least one person per week, and report on feelings about the experience. (16, 17)
14. When the client becomes angry with the therapist, apologize for any hurtful statements made, modeling courtesy and respect. Then discuss the severity/excessiveness of the client's reaction; if the client was abusive, set limits with him/her, clarifying that verbally abusive or insulting language is unacceptable.
15. When the client expresses anger or other strong emotions regarding what someone said, use this heightened affect to demonstrate that he/she cares deeply about what others think and feel. Use this as a bridge to motivate the client to understand others more accurately in order to meet his/her own needs better.
16. Provide the client with relationship skills training, including suggestions of appropriate topics he/she could discuss with others, appropriate degree and timing of self-disclosure, and improved nonverbal behavior; assign one such conversation per week, and process the results (see *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman).
17. Use role-play and behavioral rehearsal of common

- interpersonal situations to provide the client with accurate feedback regarding likely emotional reactions others would have to his/her statements and nonverbal behaviors.
10. Verbalize a realistic assessment of others' beliefs and feelings. (18, 19)
 11. Increase expressions of empathy for others by accurately identifying the feelings of another person and verbalizing understanding of his/her predicament. (20, 21)
 18. Gently explore the evidence for and against the client's beliefs about others, such as "Everyone is so jealous of me that they avoid me!" (or assign "Check Suspicions Against Reality" in the *Adult Psychotherapy Homework Planner* by Jongsma). Using Socratic dialogue, help the client to become more realistic and balanced (e.g., "I can help others to be comfortable around me").
 19. Use role-play and behavioral rehearsal of common interpersonal situations to provide the client with accurate feedback regarding likely emotional reactions others would have to his/her statements and nonverbal behaviors.
 20. Assign the client to read a book that will help him/her understand the perspective of another person (e.g., *You Just Don't Understand* by Tannen, or *Men Are from Mars, Women Are from Venus* by Gray); process major points in session.
 21. In a psychodrama, group, or individual session, the therapist (or a group member) plays the client and the client plays the person who was hurt or exploited. Continue the

- intervention until the client achieves emotional identification with the victim.
12. Express understanding of how a condescending or belittling statement may be perceived by another. (22)
 13. Express a sophisticated array of feelings rather than a narrow, constricted range (e.g., only anger). (23, 24)
 14. Verbalize an increased understanding of the impact of the male gender role on expressing feelings and excessive use of anger. (25)
 15. Limit discussing grandiose beliefs to trusted others, physicians, and mental health personnel. (26)
 16. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (27)
 17. Take psychotropic medications as prescribed, and report on the effectiveness and side effects. (28)
 22. Use the empty-chair and role-reversal techniques to teach the client about the pain caused by his/her belittling, condescending statements to others and how such statements may harm a desired relationship.
 23. Teach the client the focusing technique to connect bodily sensations to thoughts and feelings (see *Focusing-Oriented Therapy* by Gendlin).
 24. Assign the client to read *Focusing-Oriented Therapy* by Gendlin; process key points in session.
 25. Explore with the client how societal and cultural expectations regarding males acting aggressively can influence the expression of angry feelings.
 26. Brainstorm with the client the consequences of sharing grandiose beliefs with individuals other than a physician, therapist, close friend, or relative. Teach the client to share information selectively.
 27. Refer the client to a physician for an evaluation for medication to improve mood and/or decrease delusions. Help the client to process costs and benefits of a psychiatric evaluation.
 28. Monitor the client's use of medications for compliance with prescription, effectiveness,

- and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.
18. Set small, realistic goals that can be achieved rather than ruminating about grandiose fantasies and delusions. (29, 30)
 19. Verbalize insights into the reasons for needing/wanting to be extraordinary. (31, 32, 33)
 29. Brainstorm with the client steps that will lead to the attainment of one step of a goal.
 30. Using Socratic dialogue, challenge the client's irrational beliefs (e.g., "It is demeaning to do the work required at intermediate levels of success") and emotional reasoning (e.g., "It feels demeaning to me; therefore it is"). Help the client to replace these thoughts with more realistic and flexible ones (e.g., "Each step brings me closer to my goal" and "I need to look at all the evidence in addition to my feelings").
 31. Encourage the client to relate grandiose fantasies (e.g., of becoming enormously wealthy or of creating fabulous inventions); explore how these fantasies may be related to high expectations for self from significant others in the client's past (e.g., high parental expectations/pressure during early childhood) or may be a reaction against being told he/she would be a failure.
 32. Empathize with the client's perception of enormous expectations of self, reflecting back his/her thoughts and feelings, thus facilitating perspective on the part of the client.

20. Verbalize that grandiose beliefs are fantasy-based rather than reality-based. (34)
21. Express readiness to attend group therapy. (35)
22. Attend group therapy to improve self-awareness and awareness of others' feelings. (36)
23. Provide alternative explanations for others' behavior rather than assuming that they are motivated by envy or malice. (37)
33. Assign the client to read *How to Want What You Have* by Miller; process key points within a subsequent session.
34. Assist in restructuring the client's irrational ideas by collaboratively examining whether there is any empirical evidence to support those ideas. Identify more realistic conclusions to substitute for distorted cognitions (see *Cognitive-Behavioral Therapy of Schizophrenia* by Kingdon and Turkington).
35. Instruct the client about how groups operate and that this may feel unfair to him/her (e.g., that all group members must be given an opportunity to speak, that everyone's problems are considered equally important, and that group members may not always be supportive, appreciative, or admiring). Process these themes, and refer the client to group therapy when he/she is ready to participate.
36. Conduct or refer the client to group therapy to improve interpersonal interactions by increasing awareness of the impact that his/her behavior has on others and others' feelings about him/her; monitor and reinforce consistent attendance and interpersonal concepts learned.
37. Brainstorm with the client alternative explanations for others' behavior rather than jealousy or malice; encourage the client to identify evidence

- for and against each belief, thereby assessing their likelihood (or assign “Check Suspicions Against Reality” in the *Adult Psychotherapy Homework Planner* by Jongsma).
24. Describe feeling positively toward another person rather than envious or suspicious. (38)
 25. Identify role models or disappointing experiences from the past that taught an attitude of distrust. (39, 40, 41)
 38. As the client gets in touch with his/her own feelings, through empathic connection to the therapist, focusing, or insight-oriented work, encourage him/her to list how many of these experiences are shared by most people. Those shared experiences can then become a bridge to empathic connection with others.
 39. In an individual or family session, discuss with the client his/her role models regarding interpersonal conduct from prior generations (parents, uncles/aunts, grandparents, etc.) in order to gain an understanding of the origins of the feelings of mistrust; process the effectiveness and appropriateness of these behaviors in the current circumstance.
 40. Employ the family sculpture technique to relive emotionally important events in the client’s family relating to feeling betrayed or the development of mistrust (see *Conjoint Family Therapy* by Satir).
 41. Discuss the client’s early relationship with parents, exploring themes of abandonment or high expectations. Explore how these early experiences may be

- negatively impacting his/her ability to be close to others and to accept their foibles.
- 26. Express shades of gray regarding talents and achievements rather than viewing self in all-or-none terms. (42)
 - 27. Express awareness of problems with own self-esteem and willingness to address these issues. (43)
 - 42. Challenge the client's all-or-none thinking about achievement (e.g., "Either I'm on top or I'm nothing") by encouraging him/her to recall intermediate degrees of success in self or others (e.g., "I did well but there was room for improvement" and "Joe is a great piano player even though Bill is better").
 - 43. Explore how the client's hypersensitivity may be related to his/her self-esteem deficit; take steps to improve self-esteem (see "Low Self-Esteem" in *The Complete Adult Psychotherapy Treatment Planner* by Jongsma, Peterson, and Bruce).
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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.4	F34.1	Persistent Depressive Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.0	F60.0	Paranoid Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

PARANOID—MALIGNANT

BEHAVIORAL DEFINITIONS

1. Is prone to persecutory beliefs.
2. Projects own malicious outlook onto others.
3. Fantasizes about or takes revenge in response to perceived wrongs and slights.
4. Is callous, belligerent, tyrannical, and intimidating.
5. Tends to be ornery and cantankerous.
6. Vents hostility primarily in fantasy.

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LONG-TERM GOALS

1. Let go of distorted suspicious beliefs and persecutory delusions, replacing them with more reasonable, reality-based beliefs.
2. Reduce belligerent, tyrannical behavior.
3. Improve irascible mood.
4. Express anger in a healthy manner.
5. Reduce or eliminate desires for revenge.
6. Reduce or eliminate hostile feelings and fantasies.

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SHORT-TERM OBJECTIVES

1. Express satisfaction with therapeutic relationship, either verbally or nonverbally, as indicated by verbalizing difficulties and concerns. (1, 2)
2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client's difficulties (e.g., feeling angry, attacked, and undermined) through reflective listening and unconditional positive regard.
2. Avoid power struggles with the client by expressing respect for his/her need for privacy.
3. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
5. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem

behavior” and factors that could offer a better understanding of the client’s behavior.

3. Identify problems experienced in personal relationships. (7)
4. Verbalize a feeling of trust and safety in the relationship with the therapist. (8, 9, 10, 11)
6. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
7. Assist the client in developing a list of specific dissatisfactions he/she currently is experiencing (e.g., someone intentionally giving him/her a hard time at work or anger that someone is planning to take advantage of him/her).
8. Enter into the client’s worldview by expressing that trust in the therapist must be earned (e.g., suggest that the client see how the therapist acts and follows through rather than merely believing what he/she says); follow up by working on a concrete, specific behavior or problem (see *Cognitive Therapy of Personality Disorders* by Beck, Davis, and Freeman).
9. If the client shares feelings and vulnerabilities or admits mistakes, compliment him/her (e.g., “It took real strength to

- tell it like it is” and “Most people wouldn’t have had the guts to admit that—that was impressive”).
5. Express anger in an appropriate fashion rather than with unjustified accusations, belligerence, or hostile fantasies in response to feeling wronged or belittled. (12, 13)
 6. Express appropriate displeasure or anger toward a person who
 10. Facilitate safety by describing how some people react in a given circumstance and allowing or encouraging the client to discuss some problems indirectly, especially early in therapy.
 11. Negotiate session frequency, seriously considering less-frequent sessions (e.g., once every few weeks) to allow the client to be less threatened by the therapeutic process.
 12. Prepare the client for stress inoculation therapy by emphasizing how this approach enables one to be prepared for whatever may come up; promote a positive outcome. Compare the procedure to a battle plan or an immune-strengthening inoculation shot.
 13. Institute stress inoculation training for anger by preparing the client to recognize early cues and mental precursors of anger (e.g., recognizing that slights are very provocative to him/her). Use behavioral rehearsal to establish appropriate responses (discounting the importance of the slight, calmly expressing a sense of hurt, etc.); establish self-rewards for maintaining control (e.g., making positive self-statements). See *Stress Inoculation Training* by Meichenbaum.
 14. Using rational emotive therapy techniques, replace the client’s

- generates frustration rather than becoming enraged or vengeful. (14, 15)
7. Respond assertively in a situation in which belligerence and vengeful fantasies previously were used. (16, 17)
8. Verbalize an understanding of how masculine gender role expectations have impacted violent, vengeful feelings and fantasies. (18)
9. Describe feeling comfortable with ways of showing strength other than violence and domineering behavior. (19)
- extreme beliefs (e.g., “That rotten jerk is trying to get me in hot water at work” and “I’ll show him who he’s dealing with”) with more balanced ones (e.g., “She is being disrespectful, but who cares, I’m going to follow my own agenda” or “He may have made a mistake”).
15. Assign the client to read *Anger Management for Everyone* by Tafrate and Kassinove; process key ideas in session.
16. Assign the client readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons); discuss the key points in session.
17. Use role-play, modeling, and behavioral rehearsal with the client to simulate situations that demand assertiveness (or assign “Assertive Communication of Anger” in the *Adult Psychotherapy Homework Planner* by Jongsma); provide feedback regarding the appropriateness of his/her responses.
18. Ask the male client if others’ actions have threatened his feelings of being a man or his masculinity; process the meaning of masculinity to the client (e.g., needing to be strong, dominant, ready to fight, and to not show feelings or weakness). See *A New Psychology of Men* by Levant and Pollack.
19. Challenge the client’s all-or-none thinking about dominance by encouraging him/her to think of role models (e.g., sports

- figures or other leaders) who were successful by virtue of their team play and team spirit rather than their hostile aggression.
10. Report a decrease in the frequency of hostile fantasies. (20)
 11. Acknowledge that own behavior alienates many people. (21)
 12. Verbalize awareness of the drawbacks of alienating others. (22)
 13. Decrease the frequency of alienating behavior, such as belligerence and assuming others are malevolent. (23)
 14. Verbalize an acceptance of responsibility for a negative outcome rather than using denial or blaming someone else. (24)
 20. Identify the metaphorical/ symbolic meaning of the client's paranoid thinking (e.g., vengeful fantasies as an indication of feelings of powerlessness, the fear that someone will attack him/her as a projection of anger toward the other person); process alternative explanations in light of the client's life experience.
 21. Use role reversal to help the client understand the person he/she is alienating with his/her suspiciousness or counterattacks.
 22. Assist the client in listing the negative effects of alienating others (e.g., loss of being trusted, social isolation, being the target of reciprocal anger, etc.).
 23. Teach the concept of self-fulfilling prophecy and how testing others, accusing them of wrongdoing, and/or behaving belligerently toward them evokes their suspicion and anger.
 24. Explore the client's role models regarding interpersonal conduct (e.g., blame, denial) from prior generations (parents, uncles/aunts, grandparents, etc.) in order to gain an understanding of the origins of the behavior. Process with the client the effectiveness and

- appropriateness of these behaviors in the current circumstance.
15. Verbalize that persecutory interpretation is only one of many possible explanations for a series of events. (25)
 16. Identify distrustful thoughts and beliefs about others' behaviors and motives. (26)
 17. Verbalize beliefs that will encourage the maintenance of a trusting relationship with a significant other. (27, 28, 29)
 25. Assist in restructuring the client's irrational ideas regarding persecution by collaboratively examining whether there is any empirical evidence to support those ideas (or assign "Check Suspicions Against Reality" in the *Adult Psychotherapy Homework Planner* by Jongsma); identify more realistic conclusions to substitute for distorted cognitions (see *Cognitive-Behavioral Therapy of Schizophrenia* by Kingdon and Turkington).
 26. Explore the client's beliefs regarding relationships (e.g., that you can't trust anyone, that everyone is ready to harm him/her).
 27. Use Socratic dialogue to challenge the client's emotional reasoning (e.g., "I feel that they are trying to undermine me; therefore they are").
 28. Use rational emotive techniques to challenge and replace unrealistic ideas with more flexible and realistic ones (e.g., that most people can be trusted to some degree, that everyone has faults, that some people can sincerely help others at least some of the time).
 29. Explore the client's fantasies regarding significant relationships (e.g., that others are planning to exploit

- him/her). Explore the meaning of these fantasies with regard to early childhood relationships (e.g., victimization by a sadistic caretaker) and/or the relationship with the therapist (e.g., the client's projection that the therapist will try to control him/her).
18. Report successfully taking a risk in trusting someone in a small way by sharing personal information. (30, 31, 32)
 19. Implement the use of "I" statements to express feelings and resolve conflict. (33)
 30. Provide unconditional positive regard, thereby allowing the client to experience an accepting relationship and challenging his/her assumptions regarding others' malevolent intents.
 31. Brainstorm with the client areas that entail minimal risk and in which he/she would be willing to take a chance (e.g., sharing some personal information that causes feelings of vulnerability but no real risk of harm); assign risk-taking behavior.
 32. Provide the client with relationship skills training, including suggestions of appropriate topics he/she could discuss with others, appropriate degree and timing of self-disclosure, and improved nonverbal behavior; assign two such conversations per week, and process the results (see *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman).
 33. Encourage the client and partner or family members to express their feelings in the following manner: "When you say X to me in Y situation, I feel Z." Encourage them to persist in communicating in that manner until each side reports

- understanding the other
(see *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman).
20. Spouse or family members discontinue behaviors that support belligerent, tyrannical behavior; increase support for cooperative behavior. (34)
 21. Cooperate with a referral to a physician to evaluate the need for psychotropic medication to improve mood and/or disordered thinking. (35)
 22. Take medications as prescribed, and report on effectiveness and side effects. (36)
 34. Assist family members in identifying their behavior that reinforces the client's domineering behavior (e.g., significant other agrees to do all chores in the house or to stay home when he/she would rather go out). Write a behavioral contract that will allow each participant to get his/her needs met more directly (e.g., sharing chores, using praise and other social rewards to reinforce the behavior).
 35. Refer the client to a physician for an evaluation for medication to improve mood and/or disordered thinking; process his/her resistance to meeting with a physician (e.g., not trusting doctors, fearing medications or mind control). Help the client to process costs and benefits of a psychopharmacologic evaluation.
 36. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.

- 23. Identify the impact of childhood physical abuse, neglect, or abandonment on current relationships. (37, 38)
- 24. Express beginning a process of forgiveness toward someone against whom a grudge was held. (39, 40)
- 25. Identify aspects of life that provide meaning, purpose, or mission. (41)
- 37. Explore the client's history of being physically abused, neglected, or abandoned; discuss the impact that his/her experience has had on decreasing trust and increasing feelings of anger and need for control in relationships.
- 38. Explore the parallels between the abuse and/or neglect experiences and the client's current behavior, noting the repetition compulsion between his/her words and actions and those of abusive/neglectful others in the past.
- 39. Discuss forgiveness of perpetrators of the client's pain as a process of letting go of anger and anguish (or assign "A Blaming Letter and a Forgiving Letter to Perpetrator" in the *Adult Psychotherapy Homework Planner* by Jongsma).
- 40. Assign the client to read a book on the process of forgiveness (e.g., *Forgiveness* by Hamilton or *The Art of Forgiving* by Smedes); process key concepts in a subsequent session.
- 41. Explore aspects of the client's life that provide a sense of meaning, purpose, or mission. Inquire about spiritual or religious participation that provides fortitude, comfort, or meaning to life; encourage increased participation.

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
301.0	F60.0	Paranoid Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
301.89	F60.89	Other Specified Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
295.30	F20.9	Schizophrenia
297.1	F22	Delusional Disorder
_____	_____	_____
_____	_____	_____

PASSIVE-AGGRESSIVE (NEGATIVISTIC)*

BEHAVIORAL DEFINITIONS

1. Passively fails to complete both social and job-related tasks after directly or indirectly pledging to complete them (e.g., “forgets” to water someone’s plants as promised, which subsequently die).
2. Complains that he/she is misunderstood and unappreciated.
3. Is moody and quarrelsome.
4. Criticizes and scorns authority in an unreasonable and self-defeating manner.
5. Believes that others are more fortunate and expresses envy and resentment toward them.
6. Makes frequent, exaggerated complaints about his/her personal misfortune.
7. Frequently or constantly complains about his/her woes.
8. Is alternately defiantly hostile and remorsefully apologetic.

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LONG-TERM GOALS

1. Perform obligations responsibly and reliably.
2. Reduce the frequency of contrary/resentful behaviors; increase cooperativeness.

*Appendix A elaborates on the dimensional structure for behavioral definitions.

3. Express feelings of anger and resentment directly, and take responsibility for those expressions.
4. Resolve or reduce the intensity of ambivalence regarding whether to be independent of others or connected to them.
5. Stabilize erratically changing actions and emotions.
6. Increase perceptions of joy, happiness, and contentedness.
7. Reduce frequency of complaining (e.g., about misfortunes or authority figures).
8. Interact with others in a sensitive, empathic manner that elicits kindness rather than exasperation and anger.

SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share concerns and difficulties. (1, 2)
2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client's difficulties (e.g., feeling misunderstood and unappreciated by others) through unconditional positive regard, warm acceptance, and reflective listening.
2. Explicitly acknowledge the client's autonomy with statements such as "The decision to change as well as what changes to make are entirely up to you."
3. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is

motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
5. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
6. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).

3. Comply with psychological assessment. (7, 8)
4. Verbalize feeling calm and relaxed in situations that previously would have evoked feelings of anger and resentment. (9)
5. Describe as neutral or tolerable an experience that previously was considered provocative or anxiety provoking. (10)
6. Report increased feelings of happiness and serenity that replace sullen or discontented mood. (11, 12)
7. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (13)
7. Administer or refer the client for personality testing (e.g., MCMI) to assess personality dynamics, emotional status, and cognitive style.
8. Review and process the results of testing with the client.
9. Train the client to relax using progressive muscular relaxation, autogenics, and/or visualization; urge application of this new coping skill in situations that previously would have provoked feelings of anger and resentment.
10. Process with the client experiences he/she has in distressing interpersonal situations; encourage the client to apply relaxation skills in each stressful situation.
11. Train the client to use meditation (e.g., thought-watching exercise) by assigning *Full Catastrophe Living* (Kabat-Zinn); process key concepts in session. Demonstrate the technique during a session, and assign practice as homework.
12. Conduct or refer the client to a Mindfulness Based Stress Reduction program. Support with bibliotherapy, such as *The Dialectical Behavior Therapy Skills Workbook* (McKay, Wood, and Brantley) and/or *DBT Diary and Skills Coach* (Durham DBT, app).
13. Refer the client to a physician for an evaluation for medication to improve mood and decrease anxiety. Help the client to process costs and benefits of a medication evaluation.

8. Take the psychotropic medication as prescribed, and report on the medication's effectiveness and side effects. (14)
9. Express self directly and assertively rather than implementing previous pattern of passivity. (15, 16)
10. Express willingness to try new behaviors through completion of homework assignments. (17)
11. Fulfill expectations regarding format and structure of psychotherapy, such as attending sessions on time and making payments in a timely fashion. (18, 19)
14. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.
15. Use role-play, modeling, and behavioral rehearsal with the client to simulate situations that demand assertiveness (or assign "Becoming Assertive" in the *Adult Psychotherapy Homework Planner* by Jongsma); provide feedback regarding the appropriateness of his/her responses.
16. Assign readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons); discuss key points within a subsequent session.
17. Process resistance to completing homework assignments by discussing how they fit into the client's long-term goals; reaffirm that it is the client's choice and decision regarding whether to do any homework assignment (see *Motivational Interviewing* by Miller and Rollnick).
18. Set limits with the client regarding missing payments and arriving late to appointments, providing clear expectations and explicit consequences; enforce consistently and in a nonpunitive manner.

12. Describe a long-term plan that will lead to greater feelings of serenity and inner peace. (20)
13. Report improved effectiveness at work. (21)
14. Report increased awareness of feelings toward others, such as feeling angry or conflicted, that one finds unacceptable to acknowledge. (22, 23)
15. Express understanding of the impact of vacillating (i.e., changing one's mind frequently) on others. (24)
19. Analyze the relationship between the client's resistance to fulfilling expectations in therapy and his/her relationships with significant others, whether in the past (e.g., with parents during childhood) or the present (e.g., with an employer); process the difficulties that ensue in the context of his/her actions.
20. Assist the client to make a list of situations or feelings that he/she finds unsettling; brainstorm with him/her a plan for improving feelings of well-being.
21. To address the client's issues at work, assign him/her to read *The Seven Habits of Highly Effective People* by Covey and/or *First Things First* by Covey and Merrill; process key points within a subsequent session.
22. Explore themes related to feelings of anger or ambivalence that occur spontaneously in the client's dreams, fantasies, and free associations. Interpret their relationship to the client's relationships with significant others, in both the past and the present (including the therapist, if applicable).
23. Use role-reversal to help the client learn another person's perspective and gain empathy for that person.
24. When the client exhibits passive-aggressive, vacillating behavior toward a family member during a family session, encourage the target person to

- set limits (e.g., “Is that acceptable to you? If not, keep going—get a commitment to something different!”). Discontinue the intervention when some degree of success has been achieved, and verbally reward both participants (see *Family Therapy Techniques* by Minuchin and Fishman).
16. Verbalize increased awareness of the impact on others of one’s passive-aggressive behavior. (25)
 17. Risk disillusionment/disappointment with another person in order to try new approaches that will lead to a satisfying new relationship. (26, 27, 28, 29)
 25. Require in a direct, authoritative manner that the client act in a passive-aggressive manner (e.g., being forgetful, procrastinating, or intentionally doing things slowly) in daily life. Anticipate that the client may resist (i.e., not procrastinate) in response to the directive. Process the interpersonal aspects of the client’s response with him/her, whether he/she cooperates with or defies the directive.
 26. Validate fear the client has about taking the risk to be intimate with another person and risking disappointment, accepting his/her feelings without judgment and allowing the meaning of the fear to become clear to the client.
 27. Assist the client in identifying his/her behaviors that have led to relationship problems in the past (e.g., testing others to see if they are reliable, breaking off relationships early in order to avoid feeling hurt or disappointed); encourage the client to experiment with healthy, rewarding behaviors.
 28. Affirm positive attitudes and change talk by the client

- (e.g., “It looks like you really are committed to improving your relationships”).
29. Utilize the Chinese Finger Cuffs metaphor/experiential exercise with the client to demonstrate how experiential avoidance maintains the problematic patterns that are causing distress and how being willing to move toward a problem, instead of away from it, allows for the opportunity to reduce “stuckness” and increase flexibility (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson).
 18. Express misfortunes in a balanced rather than an exaggerated way. (30, 31)
 30. Using Socratic questioning, examine the evidence that the client is excessively unfortunate, replacing extreme beliefs associated with the Negativity/Pessimism schema (e.g., “Nothing ever works out for me” and “Life is miserable”) and/or Emotional Deprivation schema (e.g., “No one cares”) with more balanced ones (e.g., “Sometimes things work out and sometimes they don’t”; “I am more fortunate than some and less fortunate than others”; “Some people care, and others don’t”). See *Schema Therapy* by Young, Klosko, and Weishaar.
 19. Verbalize no longer feeling envious of someone believed to be more fortunate. (32)
 31. Assign the client to read *Man’s Search for Meaning* by Frankl; process key ideas to help him/her develop an awareness of the trials and vicissitudes of life.
 32. Assist the client in making a list of ways in which he/she is fortunate and things for which

20. Report feeling understood and/or appreciated by another person. (33, 34, 35, 36)
33. Develop discrepancy using complex, double-sided reflections such as, “It looks as if, on one hand, you would like to get closer to this person while, on the other hand, you are afraid that if you do you will be engulfed and lose your independence.”
34. Clarify the client’s values, such as the desire to be in a healthy intimate relationship or to have smooth working relationships. Juxtapose these values with behaviors that interfere with their achievement (e.g., regarding a complaining style, “In your experience, has the way in which you have expressed your needs to your significant other helped to bring you closer to her?”).
35. During a family therapy session, encourage the client to express his/her feelings in the following manner: “When you say X to me in Y situation, I feel Z.” Encourage his/her significant other to do likewise. Encourage them to persist in communicating in that manner until each side reports understanding the other (see *A Couple’s Guide to Communication* by Gottman, Notarius, Gonso, and Markman).
36. To address the client’s issues surrounding intimate relationships, assign him/her to read *Intimate Connections* by he/she feels grateful; assign the client to review the list on a regular basis.

- Burns and/or *Love Sense* by Johnson; process key ideas with the therapist to build social skills.
21. Report feeling comfortable with receiving and giving in a relationship. (37)
 22. Report feeling comfortable in an interaction with an authority figure. (38)
 23. Act cooperatively rather than being oppositional or argumentative with an authority figure. (39, 40)
 37. Assist the client in identifying his/her anxieties elicited by becoming close with another person (e.g., fears of becoming engulfed and losing his/her own identity) versus feelings of loneliness and alienation; process how those feelings are related to previous experiences, and examine their relevance to current situations and relationships.
 38. Use the “Change Ruler” technique in order to evoke reasons that the client is motivated to change: Ask: “On a scale from 1 to 10, how important is it for you to change the way in which you relate to (authority figure), where 1 is not at all important and 10 is extremely important?” Follow up by asking, “And why are you at ___ and not ____ [a lower number than stated]?” “What might happen that could move you from ___ to [a higher number]?” Refrain from moving on to change-based interventions until the client expresses strong motivation to change (e.g., 8 or higher). See *Motivational Interviewing* by Miller and Rollnick.
 39. Challenge beliefs that interfere with authority relations (e.g., “I’ll do what I want to do!” and “How dare they tell me what to do!”). Use rational emotive techniques to replace them with

more balanced thoughts (e.g., “For us to do our best, we all have to be team players, and every team has a leader”).

40. Assess and encourage motivation for change by noticing “change talk,” such as Desire, Ability, Reason, and Need for change as well as Commitment, Activation, and Taking steps to change (DARN-CAT). Use simple and complex reflections to encourage and guide such change-based statements (e.g., when the client says, “I am ready to be assertive with my boss rather than not say anything and feel resentful,” say, “You are planning to be more assertive with her” or “You are feeling confident that you can develop a healthier, more balanced relationship with your boss.”). Further encourage change talk by asking for additional elaboration and details (see *Motivational Interviewing* by Miller and Rollnick).
24. Recognize and acknowledge own pattern of hostile defiance and contrition; take steps to correct it. (41)
41. When the client is defiant during the course of therapy and is then apologetic, process the meaning of the experience, exploring whether the pattern is a repetition of other relationship patterns, including those from early family interactions.
25. Express readiness to participate in psychotherapy group activities. (42)
42. Role-play social skills in order to prepare the client for group psychotherapy. Provide the client with information about reasonable expectations regarding what will occur in group therapy sessions, and encourage the client to participate.

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| <p>26. Participate in group therapy in order to address interpersonal difficulties. (43)</p> | <p>43. Conduct or refer the client to group therapy to improve interpersonal interactions by increasing awareness of the impact that his/her behavior has on others and awareness of others' feelings about him/her; process the group therapy experience, and reinforce empathy, clarity of expression, and assertiveness.</p> |
| <p>27. Accept responsibility for own role in provoking the frustration or exasperation of another person. (44)</p> | <p>44. As a means of increasing self-awareness, guide the client in analyzing a specific situation, interaction, or outcome, and utilize the "responsibility pie" metaphor to assist the client in identifying his/her own contribution to the outcome. Process with the client whether this has been a pattern in past interactions/outcomes (see <i>Mind Over Mood</i> by Greenberger and Padesky).</p> |
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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.9	F60.9	Unspecified Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.6	F60.7	Dependent Personality Disorder
_____	_____	_____
_____	_____	_____

SCHIZOID*

BEHAVIORAL DEFINITIONS

1. Does not desire close relationships, even with family members.
2. Consistently chooses solitary activities.
3. Has little interest in engaging in sexual activity.
4. Rarely experiences pleasure.
5. Has few if any close friends or confidants other than first-degree relatives.
6. Is unresponsive to praise or criticism.
7. Is cold, detached, or unemotional.

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LONG-TERM GOALS

1. Enhance experience of pleasure in activities and/or relationships.
2. Increase activity level.
3. Reduce social withdrawal.
4. Increase interest in and performance of sexual activity.
5. Increase emotionality, including the experience and expression of feelings.
6. Improve interpersonal skills, such as conversational behavior and empathy skills, thereby decreasing social isolation.

*Appendix A elaborates on the dimensional structure for behavioral definitions.

7. Bring clarity to vague cognitions.
8. Decrease apathy by increasing level of energy and enthusiasm.
9. Increase ability to have warm, intimate, personal relationships.

SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share feelings of alienation and history of isolation. (1, 2)

2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Establish rapport by expressing empathy for the client's feelings of alienation (e.g., feeling like an outsider, feeling empty).
2. Examine both functional and dysfunctional aspects of isolation (e.g., is able to get work done while alone at home but spends almost all time alone). Assess balance between productive and nonproductive time alone and amount of time alone.
3. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of

the “problem described,” is not concerned, and has no motivation to change).

4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
5. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
6. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
3. Identify the reasons underlying the decision to avoid social interaction and the development of friendships. (7)
7. Assign the client to keep a daily record of dysfunctional beliefs connected with social contact (e.g., believing that he/she is a detached and alienated observer rather than a person who is

- connected and involved or that he/she is perceived as dull and uninteresting to others).
4. Verbalize alternative points of view that are inconsistent with socially isolating thoughts and behaviors. (8)
 5. Increase the frequency of engaging in pleasurable leisure activities that do not necessarily involve socialization with others but are done in the presence of others. (9)
 6. Identify interpersonal situations in which passivity contributed to isolation or feelings of alienation or frustration. (10)
 7. Increase the implementation of assertiveness in social situations. (11, 12)
 8. Assist the client in replacing dysfunctional beliefs associated with the Social Isolation/ Alienation schema (e.g., “I have no motivation” and “Human relationships are just not worth the bother”) with more positive, realistic thoughts (e.g., “This experience may be interesting” and “It would be nice to have a friend to share with”). See *Cognitive Therapy of Personality Disorders* (Beck, Davis, and Freeman). Support with bibliotherapy, such as *Reinventing Your Life* by Young and Klosko.
 9. Assist the client in identifying thoughts that are interfering with pursuing pleasurable activities associated with the Negativity/Pessimism schema (e.g., “I don’t care,” “I won’t succeed,” “I never enjoy myself”). Use rational emotive techniques to dispute these thoughts (see *Schema Therapy* by Young, Klosko, and Weishaar).
 10. Explore the client’s interactions with other people in which his/her objective was not achieved (e.g., unable to get others to cooperate with his/her goal, did not introduce self to a desirable person, etc.); identify the role of the client’s passivity in the typical sequence of events.
 11. Use role-play, modeling, and behavioral rehearsal with the client to simulate situations that

- demand assertiveness (or assign “Becoming Assertive” in the *Adult Psychotherapy Homework Planner* by Jongsma); provide feedback regarding the appropriateness of his/her responses.
8. Report having had an enjoyable conversation with someone. (13)
 9. Initiate an enjoyable activity that can be accomplished only with another person. (14, 15)
 12. Assign the client readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons); process key points in session.
 13. Provide the client with relationship skills training, including suggestions for appropriate topics he/she could discuss with others, appropriate degree and timing of self-disclosure, and improved nonverbal behavior (or assign “Developing Conversational Skills” in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). See *A Couple’s Guide to Communication* (Gottman, Notarius, Gonso, and Markman).
 14. Use role-play, modeling, and behavioral rehearsal to teach the client how to use relevant social skills to ask a person to participate in an activity with him/her (e.g., playing tennis, going on a date).
 15. List any activities or material goods that the client finds rewarding for use as positive reinforcers; develop a behavioral contract with the client, providing rewards for participating in an exercise program, activities, and/or social situations.

10. Engage in a physical exercise regimen on a regular basis. (16)
11. Verbalize thoughts and beliefs that are held regarding the motives and feelings of others. (17, 18)
12. Increase expression of empathy by accurately identifying the feelings of others and verbalizing an understanding of their predicament. (19, 20)
16. Encourage the client to discuss with his/her physician beginning a program of regular aerobic exercise. Explore the client's motivational obstacles to starting an exercise program.
17. Explore how the client perceives other people and what he/she believes about their motivations; brainstorm with the client other possibilities regarding what others believe and feel in order to get the client to think more broadly and to overcome rigid, impoverished thinking.
18. Explore the possibility that the client projects his/her own feelings onto others, including the therapist, thereby misperceiving others' feelings and intentions.
19. Use role-play and modeling of common interpersonal situations to provide the client with accurate feedback regarding likely emotional reactions others would have to the client's statements and nonverbal behaviors.
20. Assign the client to interview a family member, friend, or acquaintance regarding thoughts and feelings related to a social topic (e.g., candidates for office, welfare restrictions, abortion). Repeat the assignment for a personal problem (e.g., divorce, death of a family member, loss of job). Ask the client to repeat his/her perceptions back to the interviewee to check for accuracy of empathic listening.

13. Report improved awareness of own thoughts, feelings, and motivations. (21, 22)
14. Attend group therapy sessions focused on increasing sensitivity to the thoughts and feelings of self and others. (23)
15. Report a reduction in feelings of emptiness and depersonalization. (24, 25)
21. Assign the client to read a book on increasing self-awareness (e.g., *Wherever You Go, There You Are* by Kabat-Zinn); discuss key points in session.
22. Teach the client the thought-watching technique (i.e., asking the client to pay attention to his/her thoughts and feelings as they are experienced in the present moment) to enhance self-awareness (see *Full Catastrophe Living* by Kabat-Zinn or *The Mindfulness and Acceptance Workbook for Anxiety* by Forsyth and Eifert).
23. Conduct or refer the client to group therapy to improve interpersonal interactions by increasing the client's awareness of his/her own feelings, motivations, and actions and the impact that his/her behavior has on others.
24. Explore aspects of the client's life that provide a sense of meaning, purpose, or mission. Inquire about spiritual or religious participation that provides fortitude, comfort, or meaning to life; encourage increased participation.
25. Ask the client to list any activity or relationship that would increase satisfaction or meaning to his/her life; process how to include that activity or relationship more consistently in his/her life. Consider in-session experiential exercises designed to further explore or clarify personal values or valued attributes, such as completing the *Valued Living Questionnaire*

- by Wilson et al. or the *Survey of Guiding Principles/Values Card Sort* (<https://www.box.com/slp>). Also see *Get Out of Your Mind and Into Your Life, Client Workbook* by Hayes and Smith.
16. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (26)
 17. Take medications as prescribed, and report on effectiveness and side effects. (27)
 18. Express a line of thought clearly and distinctly, tracing the connection between one thought and another. (28)
 19. Express an emotional experience in a clear, unambiguous fashion while feeling some of the affect associated with that experience. (29, 30, 31)
 26. Refer the client to a physician for an evaluation for medication to improve mood and energy level or to improve disordered thinking; if the client is resistant, process costs and benefits of a medication evaluation.
 27. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.
 28. Encourage the client to practice identifying and clarifying internal thought processes by describing an emotional experience; provide feedback about areas that are confusing or vague.
 29. Employ the family sculpture technique to assist the client in reliving emotionally important events in his/her family (See *Conjoint Family Therapy* by Satir).
 30. Identify the client's nonverbal expressions of emotion, such as a tightened jaw or clenched fist. Encourage the client to identify the feeling associated with the

- nonverbal behavior, then expand or exaggerate the feeling.
31. Instruct the client to imagine different feelings associated with an emotionally important event (e.g., a bodily sensation, such as sweaty palms) or with a significant other (e.g., a deceased parent) who occupies an empty chair in the room. Have the client discuss his/her true feelings with the imaginary participant, encouraging a dramatic expression of feeling.
 20. Discuss prior sexual experiences; describe what was satisfying and unsatisfying. (32)
 32. Explore satisfying and dissatisfying feelings related to prior sexual experiences; validate that such feelings are understandable.
 21. Verbalize increasing desire for and pleasure in sexual activity. (33)
 33. Give permission for less constricted sexual behavior by assigning body-pleasuring exercises with a partner. Assign books to guide exercises (e.g., *The Joy of Sex* by Comfort, *Sexual Awareness* by McCarthy and McCarthy, or *The Gift of Sex* by Penner and Penner).
 22. Make the acquaintance of one new person. (34, 35)
 34. Teach the client social skills for improving casual conversations and developing appropriate expectations for such conversations; practice small talk (see *The Feeling Good Handbook* by Burns).
 35. Assign the client to implement social skills by introducing self and making the acquaintance of someone he/she has not formally met previously.

23. List the difficulties experienced in forming intimate attachments in prior relationships. (36, 37, 38, 39)
24. Verbalize a warm or tender feeling for another person. (40, 41)
25. Report awareness of family patterns of interaction and the impact that such patterns have had on own actions and emotions. (42)
26. Family members express acceptance for the client's need for solitude. (43)
36. Explore the client's experience in forming intimate attachments; assist in identifying the difficulties experienced.
37. Ask the client to describe any dreams that he/she has had; discuss themes involving intimacy and connections to others.
38. Discuss early relationship with parents; assess resolution of conflicts related to interpersonal relationships; relate these conflicts to current difficulties in intimate relationships.
39. Validate the client's concerns regarding intimate relationships, and express unconditional positive regard (i.e., that the feelings are understandable from the client's perspective).
40. Explore for the presence of any feelings of tenderness or emotional intimacy that the client has for another person.
41. Reinforce the client's expression of tender emotions for another person.
42. In an individual or a family session, explore early family interactions regarding implicit rules of interpersonal conduct.
43. Within a marital and/or family therapy session, improve the family's understanding of the client's high need for privacy; encourage them to reduce their demands and expectations for interaction from the client.

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| <p>27. Express readiness to participate with others doing group activities. (44)</p> | <p>44. Role-play and implement social skills training in order to prepare the client for group activities; explain what is likely to occur, and encourage the client to participate.</p> |
|--|--|

<p>_____</p>	<p>_____</p>

DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
299.0	F84.0	Autism Spectrum Disorder
295.30	F20.9	Schizophrenia
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.4	F34.1	Persistent Depressive Disorder
301.20	F60.1	Schizoid Personality Disorder
301.22	F21	Schizotypal Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
<p>_____</p>	<p>_____</p>	<p>_____</p>
<p>_____</p>	<p>_____</p>	<p>_____</p>

SCHIZOTYPAL*

BEHAVIORAL DEFINITIONS

1. Believes that everyday events are directed at or have special meaning specifically for self (ideas of reference).
2. Believes in magical phenomena (e.g., telepathy, clairvoyance, and extrasensory perception) beyond what is usual for own culture.
3. Has unusual perceptual experiences (e.g., believing that he/she can sense the presence of another person).
4. Exhibits odd, vague, unusually abstract, or unusually concrete thinking and speech.
5. Tends to be suspicious of others, at times even paranoid.
6. Has inappropriate or constricted affect.
7. Shows odd or eccentric appearance and behavior.
8. Has few, if any, close friends or confidants other than first-degree relatives.
9. Becomes highly anxious in social situations because of fears and suspicions about others.

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LONG-TERM GOALS

1. Bring clarity to vague cognitions; reduce odd, magical thinking and feelings of depersonalization.

*Appendix A elaborates on the dimensional structure for behavioral definitions.

2. Enhance experience of pleasure in activities and/or relationships.
3. Improve interpersonal skills, such as conversational behavior and empathy skills, thereby decreasing social isolation.
4. Increase emotionality, including the experience and expression of feelings.
5. Reduce fears and ruminations regarding rejection and humiliation or suspiciousness of others' motives.

SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share concerns and difficulties with interpersonal relationships. (1, 2)

2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Express empathy for the client's difficulties (e.g., feeling fearful, suspicious of others, or "dead inside") through reflective listening and unconditional positive regard.
2. Examine both functional and dysfunctional aspects of the client's isolation (e.g., feeling safer at home but lonely). Assess balance between productive and unproductive time alone and amount of time alone.
3. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to

address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
 5. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
 6. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment, but the presenting problem now is causing mild or moderate impairment).
 7. Gently confront and give direction regarding the client’s lack of attention to grooming and hygiene; recognize and reinforce positive change in this area.
3. Attend appropriately to grooming and hygiene. (7)

4. Verbalize an awareness of appropriate venues to share beliefs in clairvoyance, telepathy, or mind reading. (8)
5. Demonstrate an awareness of and report positive implementation of social interaction skills. (9, 10)
6. Cooperate with a referral to a physician to evaluate the need for psychotropic medication. (11)
7. Take the psychotropic medication as prescribed and report on the medication's effectiveness and side effects. (12)
8. Brainstorm with the client consequences of sharing his/her unusual beliefs with individuals other than a physician, therapist, close friend, or relative. Teach the client to share information selectively.
9. Provide the client with relationship skills training, including suggestions of appropriate topics he/she could discuss with others, appropriate degree and timing self-disclosure, and improved nonverbal behavior (see *Social Skills Training for Schizophrenia* by Bellack.).
10. Teach the client social skills for improving casual conversations and developing appropriate expectations for such conversations (or assign "Developing Conversational Skills" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); practice small talk.
11. Refer the client to a physician for an evaluation for medication to improve thought processes and/or decrease anxiety; if the client is resistant, process costs and benefits of a medication evaluation.
12. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects. Regularly assess for signs of dependence on or addiction to prescription medications. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.

8. Report a decreased use of fantasy and an increased frequency of contact with the world to obtain information and personal satisfaction. (13)
9. Verbalize that having a particular feeling does not mean that the associated thought is necessarily true. (14)
10. Report reduced frequency of thoughts about how others may harm, humiliate, and/or embarrass him/her. (15, 16)
11. Report improved awareness of own thoughts, feelings, and motivations. (17)
13. Acknowledge the self-soothing function of the use of fantasy; then assist the client in evaluating the positive and negative impact of the extensive use of fantasy.
14. Assist in restructuring the client's irrational ideas by collaboratively examining whether there is any empirical evidence to support those ideas (or assign "What Do You See and Hear?" in the *Adult Psychotherapy Homework Planner* by Jongsma); identify more realistic conclusions to substitute for distorted cognitions (see *Cognitive Behavior Therapy for Severe Mental Illness* by Wright, Kingdon, Turkington, and Ramirez-Bosco).
15. Examine evidence for and against common distorted perceptions that the client discloses about others (e.g., "I know what he is thinking," "Is that person watching me?"). See *Cognitive Therapy of Personality Disorders* by Beck, Davis, and Freeman.
16. Explore themes of fear and paranoia that occur spontaneously in dreams, fantasies, and free associations; interpret their relationship to the client's relationships with significant others in both the past and the present (including the therapist, if applicable).
17. Conduct or refer the client to a Mindfulness-Based Stress Reduction program that focuses on formal meditation practices

(sitting meditation, body scan, mindful yoga) and the integration of this capacity into everyday life as a coping resource for dealing with intense physical symptoms and difficult emotions (see *Full Catastrophe Living* by Kabat-Zinn).

12. Increase expression of empathy by accurately identifying the feelings of others and verbalizing an understanding of their predicament. (18, 19, 20)
13. Describe one or more incidents in which a fantasy or illusion has influenced behavior. (21)
18. Use role-play and modeling of common interpersonal situations to provide the client with accurate feedback regarding likely emotional reactions others would have to his/her statements and nonverbal behaviors.
19. Assign the client to interview a family member, friend, or acquaintance regarding thoughts and feelings related to a social topic (e.g., recent movies, a good book, candidates for office, welfare restrictions, abortion). Repeat the assignment for a personal problem (e.g., divorce, death of a family member, loss of job). Then ask the client to articulate within the session.
20. Explore how the client perceives other people and what he/she believes about their motivations. Brainstorm with the client other possibilities regarding what others believe and feel in order to get the client to think less restrictively and to overcome rigid, impoverished thinking.
21. Explore the possibility that the client projects his/her own feelings onto others, including the therapist, thereby misperceiving others' feelings and intentions.

14. Report an increased ability to focus and less time feeling distracted. (22)
15. Express a line of thought clearly and distinctly, tracing the connection between one thought and another. (23)
16. Express an emotional experience in a clear, unambiguous fashion while feeling some of the affect associated with that experience. (24)
17. Report having an enjoyable conversation with someone. (25, 26)
22. Assign the client to keep a journal of his/her perceptions of others' behaviors and expressed ideas or opinions (or assign "Observe Positive Social Behaviors" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); reinforce the client's focus on others in the social interaction rather than being distracted by his/her own thoughts and anxiety.
23. Encourage the client to practice identifying and clarifying internal thought processes by describing an emotional experience; provide feedback regarding areas that are confusing or vague.
24. Identify the client's nonverbal expressions of emotion, such as a tightened jaw or clenched fist. Encourage the client to identify the feeling associated with the nonverbal behavior, and then expand or exaggerate the feeling.
25. List any activities or material goods that the client finds rewarding for use as positive reinforcers; develop a behavioral contract with the client, making rewards contingent on participating in activities and/or social situations.
26. Provide feedback that the feelings of fear and mistrust are understandable from the client's point of view. Be aware of own feelings as they are impacted by the client and provide feedback to the client about those feelings, thus facilitating perspective on the part of the client.

18. Report increasing the frequency of thoughts that will augment interpersonal contact and pleasurable activities; decrease the frequency of negative/interfering thoughts. (27)
19. Implement relaxation techniques to counteract anxiety during gradual exposure to social situations. (28, 29)
27. Examine the client's distorted thoughts that interfere with social contacts and enjoyable contacts associated with the Isolation/Alienation and Negativity/Pessimism schemas (e.g., "No one will like me anyway"). Challenge these thoughts using rational emotive or cognitive therapy techniques (or assign "Restoring Socialization Comfort" in the *Adult Psychotherapy Homework Planner* by Jongsma). See *Schema Therapy* by Young, Klosko, and Weishaar. Support with bibliotherapy, such as *Reinventing Your Life* (Young and Klosko).
28. Teach the client deep-muscle and deep-breathing relaxation techniques (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). Augment with HeartRate+ Coherence (SoftArea srl, app) or Breathe2Relax (National Center for Health and Technology, app).
29. Assist the client in identifying a hierarchy of anxiety-provoking stimuli. Encourage the client to gradually expose himself/herself imaginally to social situations that are associated with increasing levels of anxiety provocation; ask the client to address feelings of anxiety and confidence present in each situation. Repeat the exercise in vivo as homework (or assign "Gradually Reducing Your Phobic Fear" in the *Adult Psychotherapy Homework Planner* by Jongsma).

20. Report an increased tolerance for feelings of anxiety while continuing to function. (30)
21. Verbalize an increased awareness of the function served by magical thinking. (31)
22. Describe incidents of abuse that occurred in current and/or past relationships; verbalize understanding the impact these events have had on current feelings and behaviors. (32, 33)
23. Verbalize a more rational explanation of an event that formerly was interpreted irrationally. (34)
30. Engage the client in the “continuous you”/observer exercise to begin to establish a sense of self that exists in the present (as context) to assist with cognitive defusion (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson and/or *ACT for Depression* by Zettle).
31. Help the client to see how the magical belief is connected to a wish to magically protect oneself or others while remaining connected to an abusive figure (see *Interpersonal Diagnosis and Treatment of Personality Disorders* by Benjamin).
32. Support and encourage the client when he/she begins to express feelings of anger, sadness, fear, and rejection relating to family abuse or neglect.
33. Assign the client to read material on coping with trauma (e.g., *Complex PTSD* by Walker; *The Compassionate-Mind Guide to Recovering from Trauma and PTSD* by Lee, James, and Gilbert; or *Healing the Child Within* by Whitfield); in session, identify insights obtained.
34. Explore the metaphorical meaning of the client’s irrational beliefs (e.g., that the messages sent to the client make him/her feel special, that images regarding harm symbolize feelings of vulnerability or fear); process the feelings that underlie the metaphor/image.

24. Report a reduction in feelings of emptiness and depersonalization. (35, 36, 37, 38)
25. Make the acquaintance of one new person. (39, 40)
35. Explore aspects of the client's life that provide a sense of meaning, purpose, or mission. Inquire about spiritual or religious participation that provides fortitude, comfort, or meaning to life; encourage increased participation in healthy spiritual activities.
36. Ask the client to list any activity or relationship that would increase satisfaction or meaning in his/her life; process how to include that activity or relationship more consistently in his/her life. Supplement with bibliotherapy, such as *Man's Search for Meaning* by Frankl or *Wherever You Go, There You Are* by Kabat-Zinn.
37. Assign the client to keep a daily record of dysfunctional beliefs associated with the Alienation schema (e.g., believing that he/she is a nonbeing) or those that lead to feelings of alienation; assist the client in identifying more realistic, positive thoughts (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma).
38. Explore the client's feelings of alienation, accepting these feelings without judgment and allowing the sense of estrangement to become clear to the client.
39. Provide the client with relationship skills training, including a focus on *sending skills* (delivering a message to others), *receiving skills* (getting a

- message from others), and *processing skills* (choosing which skill to use in a particular situation). See *Social Skills Training for Psychiatric Patients* by Liberman, DeRisi, and Mueser.
26. Express readiness to participate in psychotherapy group activities. (41)
 27. Attend group therapy to decrease anxiety in social situations and to improve awareness of feelings and motivations of self and others. (42)
 28. Identify family patterns of interaction and the impact that such patterns have had on his/her actions and emotions. (43, 44)
 40. Assign the client to read *The Loneliness Workbook* by Copeland; process key ideas with therapist.
 41. Role-play and implement social skills training in order to prepare the client for group activities; explain what is likely to occur, and encourage the client to participate.
 42. Conduct or refer the client to group therapy to improve interpersonal interactions by increasing the client's awareness of own feelings, motivations, and actions and the impact that his/her behavior has on others.
 43. In a family therapy session, explore with significant others the themes of rejection and distancing, encouraging each family member to examine his/her own contribution to the distancing that occurs and how their overinvolvement with one another prevents healthy outside relationships.
 44. During a family session, observe how boundaries are handled; encourage one family member to set appropriate boundaries with another, and verbally offer praise when some measure of success is achieved.

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DIAGNOSTIC SUGGESTIONS

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
297.1	F22	Delusional Disorder
295.30	F20.9	Schizophrenia
301.22	F21	Schizotypal Personality Disorder
301.0	F60.0	Paranoid Personality Disorder
301.20	F60.1	Schizoid Personality Disorder
301.82	F60.6	Avoidant Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
_____	_____	_____
_____	_____	_____

Appendix A

PROPOSED DIMENSIONS FOR PERSONALITY DISORDERS APPLIED TO PRESENTING PROBLEM BEHAVIORAL DEFINITIONS (SYMPTOMS) FOR SELECTED CHAPTERS

ANTISOCIAL

Behavioral Definitions

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

Impaired Domain(s) of Personality Functioning:

Self-Direction: Absence of prosocial internal standards, associated with failure to conform to lawful, normative ethical behaviors despite possible consequences

Pathological Personality Trait(s):

Disinhibition: Risk Taking

2. Deception as indicated by repeatedly lying, use of aliases, or conning others for personal profit

Impaired Domain(s) of Personality Functioning:

Self-Direction: Absence of prosocial internal standards, associated with failure to conform to lawful, normative ethical behaviors despite possible consequences

Intimacy: Exploitation as a primary means of relating to others, including by deceit and coercion

Pathological Personality Trait(s):

Antagonism: Deceitfulness

3. Impulsivity or failure to plan ahead

Impaired Domain(s) of Personality Functioning:

Self-Direction: Goal setting ability compromised as a result of impulsive tendencies

Pathological Personality Trait(s):

Disinhibition: Impulsivity

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

Impaired Domain(s) of Personality Functioning:

Identity: Self-esteem derived from power; potential threats to ego provoke strong emotions such as anger, rage, shame

Pathological Personality Trait(s):

Antagonism: Hostility

Disinhibition: Impulsivity

5. Reckless disregard for safety of self or others

Impaired Domain(s) of Personality Functioning:

Empathy: Lack of concern for feelings, needs, suffering of others; lack of remorse after hurting or mistreating another

Pathological Personality Trait(s):

Antagonism: Callousness

6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations

Impaired Domain(s) of Personality Functioning:

Self-Direction: Absence of prosocial internal standards, associated with failure to conform to lawful, normative ethical behaviors despite possible consequences

Pathological Personality Trait(s):

Disinhibition: Irresponsibility

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

Impaired Domain(s) of Personality Functioning:

Empathy: Lack of concern for feelings, needs, suffering of others; lack of remorse after hurting or mistreating another

Pathological Personality Trait(s):

Antagonism: Callousness

AVOIDANT

Behavioral Definitions

1. Avoids others due to fears of criticism, disapproval, or rejection

Impaired Domain(s) of Personality Functioning:

Identity: Has vulnerable self-esteem controlled by exaggerated concern about external evaluation

Intimacy: Feelings about intimate involvement with others alternate between fear/rejection and need for connection

Pathological Personality Trait(s):

Detachment: Social Withdrawal, Social Detachment, Intimacy Avoidance

2. Does not get involved with people unless certain of being liked

Impaired Domain(s) of Personality Functioning:

Identity: Emotional regulation depends on positive external appraisal; threats to self-esteem may engender strong emotions such as rage or, in this case, shame

Self-Direction: Personal standards may be unreasonably high (e.g., a need to always please others or avoid criticism)

Intimacy: Has some desire to form relationships; feelings about intimate involvement with others alternate between fear/rejection and need for connection

Pathological Personality Trait(s):

Negative affectivity: Separation Insecurity (related to fear of rejection)

Detachment: Social Withdrawal, Intimacy Avoidance

3. Is afraid of being shamed or ridiculed in intimate relationships

Impaired Domain(s) of Personality Functioning:

Identity: Emotional regulation depends on positive external appraisal; threats to self-esteem may engender strong emotions such as rage or, in this case, shame

Intimacy: Has some desire to form relationships; feelings about intimate involvement with others alternate between fear/rejection and need for connection; in more severe cases, cooperative efforts often are disrupted due to the perception of slights from others

Pathological Personality Trait(s):

Negative affectivity: Pessimism, Separation Insecurity, Guilt/Shame

Detachment: Intimacy Avoidance

4. Is extremely fearful of criticism and rejection

Impaired Domain(s) of Personality Functioning:

Identity: Emotional regulation depends on positive external appraisal; threats to self-esteem may engender strong emotions such as rage or, in this case, shame

Self-Direction: Goals are more often a means of gaining external approval than self-generated and thus may lack coherence and/or stability

Pathological Personality Trait(s):

Negative affectivity: Pessimism, Separation Insecurity, Guilt/Shame

5. Is quiet during interpersonal situations due to feelings of inadequacy

Impaired Domain(s) of Personality Functioning:

Self-Direction: Personal standards may be unreasonably high (e.g., a need to always please others or avoid criticism). Goals are more often a means of gaining external approval than self-generated and thus may lack coherence and/or stability

Intimacy: Has some desire to form relationships; feelings about intimate involvement with others alternate between fear/rejection and need for connection; in more severe cases, cooperative efforts often are disrupted due to the perception of slights from others

Pathological Personality Trait(s):

Negative affectivity: Guilt/Shame, Low Self-Esteem

Detachment: Social Withdrawal

6. Views self as inferior and socially awkward

Impaired Domain(s) of Personality Functioning:

Identity: Emotional regulation depends on positive external appraisal; threats to self-esteem may engender strong emotions such as rage or, in this case, shame. Has sense of inferiority with deflated self-appraisal

Pathological Personality Trait(s):

Negative affectivity: Low Self-Esteem, Guilt/Shame

7. Inhibits activities due to fear of embarrassment

Impaired Domain(s) of Personality Functioning:

Self-Direction: Personal standards may be unreasonably high (e.g., a need to always please others or avoid criticism) Goals are more often a means of gaining external approval than self-generated and thus may lack coherence and/or stability

Intimacy: Has some desire to form relationships; feelings about intimate involvement with others alternate between fear/rejection and need for connection; in more severe cases, cooperative efforts often are disrupted due to the perception of slights from others

Pathological Personality Trait(s):

Negative affectivity: Guilt/Shame, Low Self-Esteem

Detachment: Social Withdrawal, Intimacy Avoidance

BORDERLINE

Behavioral Definitions

1. Makes desperate attempts to avoid abandonment

Impaired Domain(s) of Personality Functioning:

Identity: Has a weak sense of autonomy; boundary definition is poor or rigid and may show overidentification with others; overemphasis on independence; or vacillation between these three attributes

Empathy: Is hyperattuned to the experience of others, but only with respect to perceived relevance to self

Intimacy: Relationships are based on a strong need for the intimate other(s) and/or expectations of abandonment or abuse; there is little mutuality, others are conceptualized primarily in terms of how they affect the self (in this case, negatively)

Pathological Personality Trait(s):

Negative affectivity: Separation Insecurity, Suspiciousness, Anxiousness

Disinhibition: Impulsivity

2. Has unstable and intense relationships, usually involving alternately idealizing and denigrating another person

Impaired Domain(s) of Personality Functioning:

Identity: Emotional regulation depends on positive external appraisal; threats to self-esteem may engender strong emotions, such as rage or shame; has a weak sense of autonomy; boundary definition is poor or rigid and may show overidentification with others; overemphasis on independence; or vacillation between these five attributes.

Self-Direction: Internal standards for behavior are unclear or contradictory; in more severe cases, instability in goals, aspirations, values or career plans

Empathy: Perceptions of others selectively biased toward negative attributes or vulnerabilities

Intimacy: Feelings about intimate involvement with others alternate between fear/rejection and desperate desire for connection

Pathological Personality Trait(s):

Negative affectivity: Guilt/Shame, Suspiciousness, Emotional Lability

Antagonism: Hostility, Aggression

Disinhibition: Impulsivity

3. Sense of self or self-image is chronically unstable

Impaired Domain(s) of Personality Functioning:

Identity: Weak sense of autonomy; experience of a lack of identity, or emptiness; fragile self-esteem is easily influenced by events, and self-image often is impoverished and lacks coherence

Self-Direction: Has difficulty establishing and/or achieving personal goals

Pathological Personality Trait(s):

Negative affectivity: Submissiveness, Low Self-Esteem, Separation Insecurity

4. Acts on impulse in ways that can be self-damaging (e.g., overspending, sex, drugs)

Impaired Domain(s) of Personality Functioning:

Self-Direction: Has impaired capacity to reflect on internal experience and, in severe cases, has significantly compromised ability to reflect on and understand own mental processes

Pathological Personality Trait(s):

Disinhibition: Impulsivity, Risk Taking

5. Makes frequent suicidal gestures or threats or mutilates himself/herself

Impaired Domain(s) of Personality Functioning:

Identity: Fragile self-esteem is easily influenced by events; self-appraisal lacks nuance

Self-Direction: Internal standards for behavior are unclear or contradictory, at times based on immediate emotional response instead of goals or personal values

Pathological Personality Trait(s):

Negative affectivity: Self-Harm, Depressivity

Disinhibition: Impulsivity

6. Has highly unstable moods (e.g., gets depressed, irritable, or anxious for brief periods)

Impaired Domain(s) of Personality Functioning:

Identity: Rapidly shifting emotions; emotional experience is easily aroused, intense, and/or out of proportion to events and circumstances

Empathy: Compromised ability to recognize the feelings and needs of others associated with hypersensitivity (e.g., prone to feeling slighted or insulted)

Pathological Personality Trait(s):

Negative affectivity: Emotional Lability, Depressivity, Anxiousness

Antagonism: Aggression, Hostility

Disinhibition: Impulsivity

7. Chronically experiences feelings of emptiness

Impaired Domain(s) of Personality Functioning:

Identity: Weak sense of autonomy; experience of a lack of identity, or emptiness; fragile self-esteem is easily influenced by events, and self-image often is impoverished and lacks coherence

Pathological Personality Trait(s):

Negative affectivity: Depressivity

8. Is easily provoked to anger or rage

Impaired Domain(s) of Personality Functioning:

Identity: Rapidly shifting emotions

Empathy: Compromised ability to recognize the feelings and needs of others associated with hypersensitivity (e.g., prone to feeling slighted or insulted)

Pathological Personality Trait(s):

Negative affectivity: Emotional lability

Antagonism: Hostility, Aggression

Disinhibition: Impulsivity

9. Under stress, can become paranoid or experience dissociative symptoms

Impaired Domain(s) of Personality Functioning:

Identity: Prone to dissociative states under stress

Pathological Personality Trait(s):

Negative affectivity: Suspiciousness

Psychoticism: Cognitive and Perceptual Dysregulation, Dissociation
Prone to

DEPENDENT

Behavioral Definitions

1. Requires excessive advice and reassurance in order to make everyday decisions

Impaired Domain(s) of Personality Functioning:

Self-Direction: Difficulty establishing/achieving personal goals

Pathological Personality Trait(s):

Negative affectivity: Submissiveness

2. Urges others to take responsibility for most of the important areas of his/her life

Impaired Domain(s) of Personality Functioning:

Identity: Weak sense of autonomy/agency

Pathological Personality Trait(s):

Negative affectivity: Submissiveness

3. Overly hesitant to express disagreement for fear of losing support or approval of others

Impaired Domain(s) of Personality Functioning:

Intimacy: Strong belief in absolute need for other

Pathological Personality Trait(s):

Negative affectivity: Separation Insecurity

4. Lacks self-confidence, which causes problems initiating activities

Impaired Domain(s) of Personality Functioning:

Identity: Weak sense of autonomy/agency

Self-Direction: Difficulty establishing/achieving personal goals

Pathological Personality Trait(s):

Anxiousness: Fearful of Uncertainty

5. Makes an inordinate effort to obtain nurturance or support from others (e.g., volunteers to do unpleasant tasks that no one would want to do)

Impaired Domain(s) of Personality Functioning:

Intimacy: Strong belief in absolute need for other

Pathological Personality Trait(s):

Negative affectivity: Submissiveness

6. Has excessive fear of not being able to take care of self, which causes feelings of discomfort or helplessness when alone

Impaired Domain(s) of Personality Functioning:

Identity: Weak sense of autonomy/agency

Pathological Personality Trait(s):

Negative affectivity: Separation Insecurity

7. Desperately seeks someone to take care of him/her as soon as a nurturing relationship ends

Impaired Domain(s) of Personality Functioning:

Intimacy: Strong belief in absolute need for other

Pathological Personality Trait(s):

Negative affectivity: Separation Insecurity

8. Worries excessively about being left to take care of self

Impaired Domain(s) of Personality Functioning:

Identity: Weak sense of autonomy/agency

Pathological Personality Trait(s):

Negative affectivity: Separation Insecurity

DEPRESSIVE

Behavioral Definitions

1. Mood is usually dejected, gloomy, and joyless

Impaired Domain(s) of Personality Functioning:

Self-Direction: Mood-dependent behavior interferes with goal identification and completion

Pathological Personality Trait(s):

Negative affectivity: Depressivity, Pessimism

Detachment: Anhedonia

2. Has low self-esteem and deep feelings of inadequacy

Impaired Domain(s) of Personality Functioning:

Identity: Sees self as inconsequential, contemptible, as someone who should be criticized; internal sense of incompleteness influences deflated self-appraisal

Self-Direction: Discouraged; hopelessness impedes pursuit of goals

Pathological Personality Trait(s):

Negative affectivity: Low Self-Esteem, Depressivity

Detachment: Anhedonia

3. Is self-derogatory

Impaired Domain(s) of Personality Functioning:

Identity: Self-appraisal is unnuanced: sees self as worthless with no praiseworthy traits; self-loathing

Pathological Personality Trait(s):

Negative affectivity: Depressivity, Low Self-Esteem, Pessimism

4. Frequently worries and frets

Impaired Domain(s) of Personality Functioning:

Identity: Characteristically worrisome and brooding

Self-Direction: Mood-dependent behavior interferes with goal identification and completion

Pathological Personality Trait(s):

Negative affectivity: Anxiousness

5. Engages in critical and judgmental attitude toward both self and others

Impaired Domain(s) of Personality Functioning:

Identity: Self-appraisal is unnuanced; significant distortions around self-appraisal; weak or distorted self-image that is easily influenced by others

Intimacy: Limited connection with others

Empathy: Difficulty appreciating others' ideas and feelings

Pathological Personality Trait(s):

Negative affectivity: Low Self-Esteem, Pessimism

Detachment: Intimacy Avoidance

6. Tends to be highly pessimistic and complaining

Impaired Domain(s) of Personality Functioning:

Identity: Possesses defeatist and fatalistic attitudes about most matters, including self

Empathy: Difficulty appreciating others' ideas and feelings

Pathological Personality Trait(s):

Negative affectivity: Pessimism

Detachment: Intimacy Avoidance, Social Detachment

7. Experiences a great deal of guilt and regret

Impaired Domain(s) of Personality Functioning:

Identity: Threats to self-esteem may engender strong emotions, such as shame or anger; internal sense of incompleteness influences deflated self-appraisal

Pathological Personality Trait(s):

Negative affectivity: Guilt/Shame

HISTRIONIC

Behavioral Definitions

1. Has a strong desire to be the center of attention

Impaired Domain(s) of Personality Functioning:

Identity: Depends excessively on others for identity definition, with compromised boundary delineation

Self-Direction: Goals are more often a means of gaining external approval than self-generated and thus may lack coherence

Pathological Personality Trait(s):

Antagonism: Attention Seeking

2. Is often inappropriately provocative or sexually seductive

Impaired Domain(s) of Personality Functioning:

Identity: Vulnerable self-esteem controlled by concern about external evaluation, with a wish for approval

Pathological Personality Trait(s):

Antagonism: Attention Seeking

3. Expresses shallow, rapidly shifting emotions

Impaired Domain(s) of Personality Functioning:

Identity: Emotions may be rapidly shifting

Pathological Personality Trait(s):

Negative affectivity: Emotional Lability

4. Uses physical appearance to gain attention from others

Impaired Domain(s) of Personality Functioning:

Identity: Vulnerable self-esteem controlled by concern about external evaluation, with a wish for approval

Self-Direction: Goals are more often a means of gaining external approval than self-generated and thus may lack coherence

Pathological Personality Trait(s):

Antagonism: Attention Seeking

5. Speech is impressionistic and lacks detail

Impaired Domain(s) of Personality Functioning:

N/A

Pathological Personality Trait(s):

N/A

6. Is dramatic, theatrical, and displays emotions in an exaggerated fashion

Impaired Domain(s) of Personality Functioning:

N/A

Pathological Personality Trait(s):

Antagonism: Attention Seeking

7. Is highly suggestible

Impaired Domain(s) of Personality Functioning:

Self-Direction: Internal standards for behavior are unclear

Pathological Personality Trait(s):

Negative affectivity: Submissiveness

8. Overestimates the intimacy of relationships

Impaired Domain(s) of Personality Functioning:

Intimacy: Connections may be largely superficial

Pathological Personality Trait(s):

Negative affectivity: Separation Insecurity

NARCISSISTIC

Behavioral Definitions

1. Exaggerates self-importance in a grandiose manner

Impaired Domain(s) of Personality Functioning:

Identity: Exaggerated self-appraisal; emotional regulation mirrors fluctuations in self-esteem

Pathological Personality Trait(s):

Antagonism: Grandiosity

2. Has excessive fantasies of unlimited success, power, intelligence, or ideal love

Impaired Domain(s) of Personality Functioning:

Self-Direction: Goal setting based on gaining approval from others; personal standards unreasonably high in order to see self as exceptional; often aware of own motivations

Pathological Personality Trait(s):

Antagonism: Grandiosity, Attention Seeking

3. Believes only special, high-status individuals can understand his/her unique thoughts, talents, and/or problems

Impaired Domain(s) of Personality Functioning:

Identity: Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal; emotional regulation mirrors fluctuations in self-esteem

Intimacy: Relationships largely superficial and exist to serve self-esteem regulation; mutuality constrained by little genuine interest in others' experiences and predominance of a need for personal gain

Pathological Personality Trait(s):

Antagonism: Grandiosity

4. Needs excessive admiration

Impaired Domain(s) of Personality Functioning:

Identity: Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal; emotional regulation mirrors fluctuations in self-esteem

Self-Direction: Goal setting based on gaining approval from others;

Intimacy: Relationships largely superficial and exist to serve self-esteem regulation; mutuality constrained by little genuine interest in others' experiences and predominance of a need for personal gain

Pathological Personality Trait(s):

Antagonism: Attention Seeking

5. Has an air of entitlement, expecting special treatment from others

Impaired Domain(s) of Personality Functioning:

Identity: Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal; emotional regulation mirrors fluctuations in self-esteem

Self-Direction: Goal setting based on gaining approval from others

Pathological Personality Trait(s):

Antagonism: Grandiosity

6. Takes advantage of others in an exploitive manner

Impaired Domain(s) of Personality Functioning:

Empathy: Impaired ability to recognize or identify with the feelings and needs of others; excessively attuned to reactions of others, but only if perceived as relevant to self; over- or underestimates own effect on others.

Intimacy: Relationships largely superficial and exist to serve self-esteem regulation; mutuality constrained by little genuine interest in others' experiences and predominance of a need for personal gain

Pathological Personality Trait(s):

Antagonism: Callousness, Manipulativeness

7. Is unable or unwilling to relate to the needs and feelings of others; has insufficient empathy

Impaired Domain(s) of Personality Functioning:

Empathy: Impaired ability to recognize or identify with the feelings and needs of others; excessively attuned to reactions of others, but only if perceived as relevant to self; over- or underestimates own effect on others.

Intimacy: Relationships largely superficial and exist to serve self-esteem regulation; mutuality constrained by little genuine interest in others' experiences and predominance of a need for personal gain

Pathological Personality Trait(s):

Antagonism: Callousness

8. Envy others or believes they envy him/her

Impaired Domain(s) of Personality Functioning:

Identity: Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal; emotional regulation mirrors fluctuations in self-esteem

Empathy: Impaired ability to recognize or identify with the feelings and needs of others; excessively attuned to reactions of others, but only if perceived as relevant to self; over- or underestimates own effect on others.

Intimacy: Relationships largely superficial and exist to serve self-esteem regulation; mutuality constrained by little genuine interest in others' experiences and predominance of a need for personal gain

Pathological Personality Trait(s):

Antagonism: Grandiosity

9. Is arrogant or haughty, maintaining an egotistical attitude

Impaired Domain(s) of Personality Functioning:

Identity: Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal; emotional regulation mirrors fluctuations in self-esteem

Self-Direction: Personal standards unreasonably high in order to see self as exceptional or too low based on a sense of entitlement; often aware of own motivations

Pathological Personality Trait(s):

Antagonism: Grandiosity

OBSESSIVE-COMPULSIVE

Behavioral Definitions

1. Loses the main point of an activity by focusing excessively on details

Impaired Domain(s) of Personality Functioning:

Self-Direction: Difficulty realizing goals

Pathological Personality Trait(s):

Negative affectivity: Perseveration

2. Perfectionism interferes with completing tasks and projects
 Impaired Domain(s) of Personality Functioning:
 Self-Direction: Difficulty completing tasks
 Pathological Personality Trait(s):
 Extreme Conscientiousness: Rigid Perfectionism

3. Works or thinks about work so much that it interferes with leisure activities and friendships
 Impaired Domain(s) of Personality Functioning:
 Identity: Sense of self derives from work/productivity
 Pathological Personality Trait(s):
 Detachment: Intimacy Avoidance

4. Is excessively high-handed and/or moralistic
 Impaired Domain(s) of Personality Functioning:
 Self-Direction: Overly conscientious and moralistic
 Empathy: Difficulty appreciating others' ideas/feelings
 Pathological Personality Trait(s):
 Extreme Conscientiousness: Rigid Perfectionism

5. Has difficulty throwing out worn-out or worthless items
 Impaired Domain(s) of Personality Functioning:
 Self-Direction: Overly conscientious
 Pathological Personality Trait(s):
 Extreme Conscientiousness: Excessive Responsibility, Low Risk Taking

6. Is hesitant to delegate tasks or work unless others will submit to own exact way of doing things.
 Impaired Domain(s) of Personality Functioning:
 Empathy: Difficulty appreciating others ideas/feelings
 Self-Direction: Excessively high standards
 Pathological Personality Trait(s):
 Extreme Conscientiousness: Rigid Perfectionism

7. Is miserly, believing money must be hoarded to prepare for future disasters
 Impaired Domain(s) of Personality Functioning:
 Self-Direction: Overly conscientious
 Pathological Personality Trait(s):
 Extreme Conscientiousness: Excessive Responsibility, Low Risk Taking

8. Is rigid and stubborn

Impaired Domain(s) of Personality Functioning:

Intimacy: Rigid/stubborn

Pathological Personality Trait(s):

Extreme Conscientiousness: Rigid Perfectionism

9. Becomes preoccupied with organizing, ordering, and/or cleaning

Impaired Domain(s) of Personality Functioning:

Self-Direction: Difficulty completing tasks

Pathological Personality Trait(s):

Negative affectivity: Perseveration

10. Has restricted emotionality; comes across as constrained and/or cold

Impaired Domain(s) of Personality Functioning:

Identity: Constricted emotions

Intimacy: Difficulty developing close relationships

Pathological Personality Trait(s):

Detachment: Restricted Affectivity

PASSIVE-AGGRESSIVE/NEGATIVISTIC

Behavioral Definitions

1. Passively fails to complete both social and job-related tasks after directly or indirectly pledging to complete them (e.g., “forgets” to water someone’s plants as promised, which subsequently die)

Impaired Domain(s) of Personality Functioning:

Self-Direction: Internal standards for behavior are unclear or contradictory

Pathological Personality Trait(s):

Antagonism: Oppositionality

2. Complains about being misunderstood and unappreciated

Impaired Domain(s) of Personality Functioning:

Identity: Boundary definition is poor or rigid; may show over-identification with others, overemphasis on independence, or a vacillation between these

Empathy: Difficulty with considering alternate viewpoints; threatened by differences in opinion or alternative viewpoints

Pathological Personality Trait(s):

N/A

3. Is moody and quarrelsome

Impaired Domain(s) of Personality Functioning:

Identity: Emotions not congruent with context or internal experience; weak or distorted self-image is easily threatened by interactions with others

Empathy: Difficulty with considering alternate viewpoints; threatened by differences in opinion or alternative viewpoints

Pathological Personality Trait(s):

Antagonism: Hostility

4. Criticizes and scorns authority in an unreasonable and self-defeating manner

Impaired Domain(s) of Personality Functioning:

Identity: Emotions not congruent with context or internal experience; weak or distorted self-image is easily threatened by interactions with others

Empathy: Difficulty with considering alternate viewpoints; threatened by differences in opinion or alternative viewpoints

Intimacy: Engagement with others is detached, disorganized, or consistently negative

Pathological Personality Trait(s):

Antagonism: Hostility, Oppositionality

5. Believes that others are more fortunate and expresses envy and resentment toward them

Impaired Domain(s) of Personality Functioning:

Intimacy: Little mutuality; others are conceptualized primarily in terms of how they affect the self (negatively or positively); cooperative efforts are disrupted due to the perception of slights from others

Pathological Personality Trait(s):

Antagonism: Hostility

Negative affectivity: Depressivity

6. Makes frequent, exaggerated complaints about own personal misfortune

Impaired Domain(s) of Personality Functioning:

Self-Direction: Internal standards for behavior are unclear or contradictory

Pathological Personality Trait(s):

Negative affectivity: Depressivity

7. Frequently or constantly complains about own woes

Impaired Domain(s) of Personality Functioning:

Identity: Emotions not congruent with context or internal experience; weak or distorted self-image is easily threatened by interactions with others

Self-Direction: Internal standards for behavior are unclear or contradictory

Pathological Personality Trait(s):

Negative affectivity: Depressivity

8. Is alternately defiantly hostile and remorsefully apologetic

Impaired Domain(s) of Personality Functioning:

Identity: Boundary definition is poor or rigid; may show over-identification with others, overemphasis on independence, or a vacillation between these

Self-Direction: Internal standards for behavior are unclear or contradictory

Pathological Personality Trait(s):

Negative affectivity: Guilt/Shame

Antagonism: Hostility

SCHIZOID

Behavioral Definitions

1. Does not desire close relationships, even with family members

Impaired Domain(s) of Personality Functioning:

Intimacy: Desire for affiliation is limited because of profound disinterest; engagement with others is detached

Pathological Personality Trait(s):

Detachment: Social Withdrawal, Intimacy Avoidance

2. Consistently chooses solitary activities

Impaired Domain(s) of Personality Functioning:

Intimacy: Desire for affiliation is limited because of profound disinterest; engagement with others is detached

Pathological Personality Trait(s):

Detachment: Social Withdrawal, Social Detachment

3. Has little interest in engaging in sexual activity
 Impaired Domain(s) of Personality Functioning:
 Self-Direction: Internal standards for behavior are lacking; genuine fulfillment seems inconceivable
 Intimacy: Desire for affiliation is limited because of profound disinterest; engagement with others is detached
 Pathological Personality Trait(s):
 Detachment: Intimacy Avoidance, Social Detachment, Anhedonia
4. Rarely experiences pleasure
 Impaired Domain(s) of Personality Functioning:
 Identity: Emotions not congruent with context or internal experience
 Self-Direction: Internal standards for behavior are lacking; genuine fulfillment seems inconceivable
 Pathological Personality Trait(s):
 Detachment: Anhedonia, Restricted Affectivity
5. Has few if any close friends or confidants other than first-degree relatives
 Impaired Domain(s) of Personality Functioning:
 Empathy: Social interactions might be perceived as confusing or disorienting
 Intimacy: Desire for affiliation is limited because of profound disinterest; engagement with others is detached
 Pathological Personality Trait(s):
 Detachment: Social Withdrawal, Social Detachment, Intimacy Avoidance
6. Is unresponsive to praise or criticism
 Impaired Domain(s) of Personality Functioning:
 Identity: Emotions not congruent with context or internal experience
 Self-Direction: Internal standards for behavior are lacking; genuine fulfillment seems inconceivable
 Pathological Personality Trait(s):
 Detachment: Restricted Affectivity, Anhedonia
7. Is cold, detached, or unemotional
 Impaired Domain(s) of Personality Functioning:
 Empathy: Social interactions might be perceived as confusing or disorienting
 Intimacy: Desire for affiliation is limited because of profound disinterest; engagement with others is detached

Pathological Personality Trait(s):

Detachment: Social Detachment, Restricted Affectivity, Anhedonia

SCHIZOTYPAL

Behavioral Definitions

1. Believes that everyday events are directed at or have special meaning specifically for self (ideas of reference)

Impaired Domain(s) of Personality Functioning:

Identity: Confused boundaries between self and others; distorted self-concept

Empathy: Frequent misinterpretations of others' motives or behavior

Pathological Personality Trait(s):

Negative affectivity: Suspiciousness

Psychoticism: Unusual Beliefs and Experiences, Eccentricity

2. Believes in magical phenomena (e.g., telepathy, clairvoyance, and extrasensory perception) beyond what is usual for own culture

Impaired Domain(s) of Personality Functioning:

Identity: Confused boundaries between self and others; distorted self-concept; emotional expression often not congruent with context or internal experience

Pathological Personality Trait(s):

Psychoticism: Unusual Beliefs and Experiences

3. Has unusual perceptual experiences (e.g., believing that one can sense the presence of another person)

Impaired Domain(s) of Personality Functioning:

Identity: Confused boundaries between self and others; distorted self-concept; emotional expression often not congruent with context or internal experience

Pathological Personality Trait(s):

Psychoticism: Unusual Beliefs and Experiences, Eccentricity

4. Exhibits odd, vague, unusually abstract, or unusually concrete thinking and speech

Impaired Domain(s) of Personality Functioning:

Identity: Distorted self-concept; emotional expression often not congruent with context or internal experience

Self-Direction: Unrealistic or incoherent goals

Pathological Personality Trait(s):

Psychoticism: Eccentricity, Cognitive and Perceptual Dysregulation

5. Tends to be suspicious of others, at times even paranoid

Impaired Domain(s) of Personality Functioning:

Empathy: Pronounced difficulty understanding impact of own behaviors on others; frequent misinterpretations of others' motivations and behaviors

Intimacy: Marked impairment in developing close relationships; associated with mistrust and anxiety

Pathological Personality Trait(s):

Negative affectivity: Suspiciousness

6. Has inappropriate or constricted affect

Impaired Domain(s) of Personality Functioning:

Identity: Emotional expression often not congruent with context or internal experience

Pathological Personality Trait(s):

Detachment: Restricted Affectivity

7. Shows odd or eccentric appearance and behavior

Impaired Domain(s) of Personality Functioning:

Identity: Distorted self-concept; emotional expression often not congruent with context or internal experience

Self-Direction: Unrealistic or incoherent goals

Pathological Personality Trait(s):

Psychoticism: Cognitive and Perceptual Dysregulation, Eccentricity, Unusual Beliefs and Experiences

8. Has few if any close friends or confidants other than first-degree relatives

Impaired Domain(s) of Personality Functioning:

Intimacy: Marked impairment in developing close relationships; associated with mistrust and anxiety

Pathological Personality Trait(s):

Detachment: Social Withdrawal

9. Becomes highly anxious in social situations because of fears and suspicions about others

Impaired Domain(s) of Personality Functioning:

Empathy: Pronounced difficulty understanding impact of own behaviors on others; frequent misinterpretations of others' motivations and behaviors

Intimacy: Marked impairment in developing close relationships associated with mistrust and anxiety

Pathological Personality Trait(s):

Negative affectivity: Anxiousness, Suspiciousness

Appendix B

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Appendix C

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Appendix D

RECOVERY MODEL OBJECTIVES AND INTERVENTIONS

Listed below are the 10 core principles developed by a multidisciplinary panel at the 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation convened by the Substance Abuse and Mental Health Services Administration.

1. **Self-Direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
2. **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
4. **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of

life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

5. **Non-Linear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
6. **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. **Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
8. **Respect:** Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
9. **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
10. **Hope:** Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.¹

Each Objective in the treatment plan below corresponds to one of the numbered core principles listed above. Each of the 10 Objectives was written to capture the essential theme of the like-numbered core principle. The numbers in parentheses after the Objectives denote the Interventions designed to assist the client in attaining each respective Objective. The clinician may select any or all of the Objective and Intervention statements to include in the client's treatment plan.

One generic Long-Term Goal statement is offered, should the clinician desire to emphasize a recovery model orientation in the client's treatment plan.

LONG-TERM GOAL

1. To live a meaningful life in a self-selected community while striving to achieve full potential during the journey of healing and transformation.

SHORT-TERM OBJECTIVES

1. Make it clear to therapist, family, and friends what path to recovery is preferred. (1, 2, 3, 4)
2. Specify any unique needs and cultural preferences that must be considered during the treatment process. (5, 6)

THERAPEUTIC INTERVENTIONS

1. Explore the client's thoughts, needs, and preferences regarding his/her desired pathway to recovery from depression, bipolar disorder, Posttraumatic Stress Disorder, and so on.
2. Discuss with the client alternative treatment interventions and community support resources that might facilitate his/her recovery.
3. Solicit from the client his/her preferences regarding the direction treatment will take; allow for these preferences to be communicated to family and significant others.
4. Discuss and process with the client the possible outcomes that may result from his/her decisions.
5. Explore with the client any cultural considerations, experiences, or other needs that must be considered in

3. Verbalize an understanding that decision making throughout the treatment process is self-controlled. (7, 8)
4. Express mental, physical, spiritual, and community needs and desires that should be integrated into the treatment process. (9, 10)
5. Verbalize an understanding that during the treatment process, there will be successes and failures, progress and setbacks. (11, 12)
6. Modify treatment planning to accommodate the client's cultural and experiential background and preferences.
7. Clarify with the client that he/she has the right to choose and select among options and participate in all decisions that affect him/her during treatment.
8. Continuously offer and explain options to the client as treatment progresses in support of his/her sense of empowerment, encouraging and reinforcing the client's participation in treatment decision making.
9. Assess the client's personal, interpersonal, medical, spiritual, and community strengths and weaknesses.
10. Maintain a holistic approach to treatment planning by integrating the client's unique mental, physical, spiritual, and community needs and assets into the plan; arrive at an agreement with the client as to how these integrations will be made.
11. Facilitate realistic expectations and hope in the client that positive change is possible but does not occur in a linear process of straight-line successes; emphasize a recovery process involving growth, learning from advances as well as setbacks, and staying this course toward recovery.
12. Convey to the client that you will stay the course with him/her through the difficult times of lapses and setbacks.

6. Cooperate with an assessment of personal strengths and assets brought to the treatment process. (13, 14, 15)
7. Verbalize an understanding of the benefits of peer support during the recovery process. (16, 17, 18)
8. Agree to reveal when any occasion arises that respect is not shown by the treatment staff, family, self, or the community. (19, 20, 21)
13. Administer to the client the *Behavioral and Emotional Rating Scale (BERS)* by Epstein.
14. Identify the client's strengths through a thorough assessment of social, cognitive, relational, and spiritual aspects of the client's life; assist the client in identifying what coping skills have worked well in the past to overcome problems and what talents and abilities characterize his/her daily life.
15. Provide feedback to the client of his/her identified strengths and how these strengths can be integrated into short-term and long-term recovery planning.
16. Discuss with the client the benefits of peer support (e.g., sharing common problems, receiving advice regarding successful coping skills, getting encouragement, learning of helpful community resources, etc.) toward obtaining the client's agreement to engage in peer activity.
17. Refer the client to peer support groups of his/her choice in the community and process his/her experience with follow-through.
18. Build and reinforce the client's sense of belonging, supportive relationship building, social value, and community integration by processing the gains and problem solving the obstacles encountered through the client's social activities.
19. Discuss with the client the crucial role that respect plays in recovery, reviewing subtle and obvious ways in which disrespect

- may be shown to or experienced by the client.
20. Review ways in which the client has felt disrespected in the past, identifying sources of that disrespect.
 21. Encourage and reinforce the client's self-concept as a person deserving of respect; advocate for the client to increase incidences of respectful treatment within the community and/or family system.
 22. Develop, encourage, support, and reinforce the client's role as the person in control of his/her treatment and responsible for its application to his/her daily life; adopt a supportive role as a resource person to assist in the recovery process.
 23. To build hope and incentive motivation in the client discuss potential role models who have achieved a more satisfying life by using their personal strengths, skills, and social support to live, work, learn, and fully participate in society.
 24. Discuss and enhance internalization of the client's self-concept as a person capable of overcoming obstacles and achieving satisfaction in living; continuously build and reinforce this self-concept using past and present examples supporting it.
9. Verbalize acceptance of responsibility for self-care and participation in decisions during the treatment process. (22)
 10. Express hope that better functioning in the future can be attained. (23, 24)

¹From: Substance Abuse and Mental Health Services Administration, National Mental Health Information Center, & Center for Mental Health Services. (2004), *National consensus statement on mental health recovery*. Washington, DC: Author. Available at: <http://mental-health.samhsa.gov/publications/allpubs/sma05-4129/>.

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