DOWNLOAD PDF KEY CHARACTERISTICS OF COGNITIVE THERAPY FOR PERSONALITY DISORDERS

Chapter 1 : ABCT | Association for Behavioral and Cognitive Therapies | Cognitive Behavioral Therapy

Manual Assisted Cognitive Therapy (MACT) is another CBT package that was developed to address the need for a brief, cost-effective intervention for patients with BPD (and other Cluster B personality disorders) who engage in non-suicidal self-injury. MACT is a six-session manualized treatment that combines traditional components of CBT (e.g.

Cognitive Behavioral Therapy CBT is the term used for a group of psychological treatments that are based on scientific evidence. These treatments have been proven to be effective in treating many psychological disorders. Some people have an inaccurate view of what psychological therapy is, perhaps because of the old-fashioned treatments shown on TV or in the movies. This type of psychotherapy is outdated. In fact, very few psychotherapists e. Cognitive and behavioral therapies usually are short-term treatments i. Because emotions, thoughts, and behaviors are all linked, CBT approaches allow for therapists to intervene at different points in the cycle. There are differences between cognitive therapies and behavioral therapies. However, both approaches have a lot in common, such as: The therapist and client work together with a mutual understanding that the therapist has theoretical and technical expertise, but the client is the expert on him- or herself. Treatment is often short-term. Clients actively participate in treatment in and out of session. Homework assignments often are included in therapy. The skills that are taught in these therapies require practice. Treatment is goal-oriented to resolve present-day problems. Therapy involves working step-by-step to achieve goals. The therapist and client develop goals for therapy together, and track progress toward goals throughout the course of treatment. We introduce cognitive therapy and behavior therapy in more detail below. An example is below. Imagine experiencing the sensations of your heart racing and shortness of breath. If these physical symptoms occurred while sitting quietly on a park bench, they would likely be attributed to a medical condition, such as a heart attack, may cause fearful and anxious emotions. In contrast, if these physical symptoms occurred while running on a treadmill, they likely would not be attributed to a medical ailment, and may not lead to fear or anxiety. In short, different interpretations of the same sensations could lead to entirely different emotions. Cognitive therapy suggests that many of our emotions are due to our thinking - i. Sometimes these thoughts may be biased or distorted. For instance, one might interpret an ambiguous phone message as suggesting interpersonal rejection, or physical symptoms as suggesting a medical disorder. Others may set unrealistic expectations for themselves, or harbor pervasive concerns regarding their acceptance among others. These types of thoughts can contribute to distorted, biased, or illogical thinking processes that then affect feelings. In cognitive therapy, clients learn to: Distinguish between thoughts and feelings. Become aware of the ways in which thoughts can influence feelings in ways that sometimes are not helpful. Learn about thoughts that seem to occur automatically, without even realizing how they may affect emotions. Evaluate critically whether these "automatic" thoughts and assumptions are accurate, or perhaps biased. Develop the skills to notice, interrupt, and correct these biased thoughts independently. Behavior therapies can be applied to a wide range of psychological symptoms to adults, adolescents, and children. A couple of examples are below. For instance, imagine a teenager that persistently requests permission to use the family car to go out with friends. Following a tantrum, the parents decide they can not take the hassle any more and allow their child to borrow the car. By granting permission, the child actually has received a "reward" for throwing a tantrum. Behavior therapists say that by granting permission after to a tantrum, the child has "learned" that disobedient behavior is an effective strategy for getting permission. Behavior therapy seeks to understand such links between behaviors, rewards, and learning, and change negative patterns. In other words, in behavior therapy, parents and children can "un-learn" unhealthy behaviors, and instead reinforce positive behaviors. Imagine being afraid to ride in an elevator. To avoid the fear and anxiety, you might eventually choose to avoid all elevators, and walk up flights of stairs instead. The extra time and energy that is needed to walk the stairs could cause you to be constantly late for work or events with friends. However, despite these consequences, the fear that comes with riding an elevator is too great to bear. Behavior therapists suggest that

avoiding the elevator has been rewarded with the absence of anxiety and fear. Behavioral treatments would involve supervised and guided experience with riding elevators until the "rewards" associated with avoidance have been "un-learned," and the negative associations you have with elevators has been "un-learned.

Chapter 2 : Dialectical Behavior Therapy: For More Than Borderline Personality Disorder

Cognitive behavioural therapy (CBT) is a psychological treatment that may be used to modify a person's dysfunctional feelings and convert them into positive emotions in order to have a healthy mental state. CBT covers a broad range of psychological therapeutic techniques, each with its own distinct approach.

Behavior Therapy and Cognitive Behavior Therapy are types of treatment that are based firmly on research findings. These approaches aid people in achieving specific changes or goals. Changes or goals might involve: A way of acting: Behavior Therapists and Cognitive Behavior Therapists usually focus more on the current situation and its solution, rather than the past. Behavior Therapists and Cognitive Behavior Therapists treat individuals, parents, children, couples, and families. Replacing ways of living that do not work well with ways of living that work, and giving people more control over their lives, are common goals of behavior and cognitive behavior therapy. If you are looking for help, either for yourself or someone else, you may be tempted to call someone who advertises in a local publication or who comes up from a search of the Internet. You may, or may not, find a competent therapist in this manner. It is wise to check on the credentials of a psychotherapist. It is expected that competent therapists hold advanced academic degrees. They should be listed as members of professional organizations, such as the Association for Behavioral and Cognitive Therapies or the American Psychological Association. Of course, they should be licensed to practice in your state. You can find competent specialists who are affiliated with local universities or mental health facilities or who are listed on the websites of professional organizations. You may, of course, visit our website www. These aims are achieved through the investigation and application of behavioral, cognitive, and other evidence-based principles to assessment, prevention, and treatment. We eat to live and eating is an important focus for our family and social lives. In a country like the United States, food is readily available. But large amounts of food put us at risk for the three major eating disorders: This fact sheet will discuss the role of behavior therapy in the treatment of these disorders. Over one quarter of all women, and nearly as many men, in the United States fall into this category. Obesity is related to health risks, including high blood pressure, diabetes, and gall bladder disease. At very high levels of obesity, life expectancy is shortened. People should lose weight for health reasons and not for beauty reasons. We do not understand all the causes of obesity. Recent research suggests that both family genetics and the environment are involved. Environmental factors include easy access to large amounts of food, eating high-caloric and high-fat foods, and having lower activity levels, including little or no excercise. Treatment For people who have up to about 50 pounds to lose, behavior therapy has been a successful approach to treatment. It is better than medicines that curb the appetite and dietary treatments. Treatment is usually done in groups of 8 to 12 people. It consists of learning to look at and change key behaviors. Keeping records of eating activity forms the basis of treatment. The records are used to help change the way one eats, for example, eating in fewer places and eating more slowly; to change to a heart-healthy diet by decreasing the amount of fat one eats and increasing dietary fiber; and to increase activity levels. Losing weight and keeping it off is hard work. People who manage to change these key behaviors and continue to practice them over the years are the ones who lose the most weight at first and who keep it off the longest. Weight loss of about a pound a week can be expected with this treatment. In addition, the lost weight is usually kept off for at least a year. People who have more weight to lose should try a combination of behavior therapy and a very-low-calorie diet less than calories. The diet should be done under medical supervision. The combination has been shown to be more successful than using the very-low-calorie diet alone. These treatment programs are usually available in specialized centers, such as eating disorders clinics. These clinics are usually found at major medical centers. Should overweight children be treated? Overweight children at any age have a greater risk of becoming obese adults than normal-weight children. These children tend to have higher blood pressure and cholesterol levels than normal weight children do. High blood pressure and cholesterol are risk factors for heart disease in later life. This is why overweight children should be

treated. These programs usually involve parents. Bulimia Characteristics Social standards for body shape change over time. This is especially true for women. In the United States, a thin body is expected for women. Most women diet from time to time. However, a few restrict their diet in a major way. These women tend lose control of their eating and begin to binge-eat. Binge eating leads to the possibility of weight gain. As a result, individuals begin to purge. Some ways people purge include vomiting or using laxatives or diuretics. Less often, people purge by not eating for several days. Over time, an extreme concern about body shape develops. This fosters more severe dieting and increases the frequency of purging when diet rules are broken. These behaviors are known as bulimia. Bulimia carries health risks, including increased dental problems and a loss of potassium, which may lead to problems such as abnormal heart rhythms. Psychological problems, including irritability and depression, can also occur. The vast majority of bulimics are women, although a few men do develop this problem. Treatment Cognitive behavior therapy has been shown to be helpful in overcoming bulimia. Treatment consists of careful record keeping. This can be used to help the patient form new behaviors, including: The length of treatment depends on the severity of the bulimia. The average number of treatment sessions is between 15 and Cognitive behavior therapy has some benefits for people who are bulimic. Most people have increased self-control of binge eating and purging. Also, about two-thirds of patients are able to return to normal eating patterns. Weight gain after treatment is the exception rather than the rule. When people do gain weight, these gains are usually small. Behavior therapy for bulimia nervosa is available at a number of eating disorders centers. Antidepressant medications have also been shown to be useful. Such medication may be especially helpful for patients who do not get better with behavior therapy. Should bulimics be hospitalized? Unless there are major medical problems, or a related severe mental health problem, hospitalization is not usually necessary for the treatment of bulimia. Hospitalization takes people out of the environment in which the problem occurs. This may make recovery from the disorder harder because bulimics must learn to eat normally in their own environment. Anorexia Nervosa Characteristics Anorexia is the rarest of the three eating disorders. Anorexia is characterized by a large loss of body weight. Anorexia nervosa may become a chronic illness. It usually begins in early adolescence. It can require frequent hospitalization for the medical problems of starvation. About half of those die from the complications of the disorder and about half from suicide. Most patients with this disorder need to be hospitalized, preferably in a unit designed for the treatment of eating disorders. Early cases, in which weight loss has not fallen to low levels, can be treated on an outpatient basis. Treatment Behavior therapy forms the basis of modern treatment of anorexia nervosa. Most patients with this disorder are worried about gaining weight. They know they need to gain weight to be healthy and to have normal social functioning. However, weight gain and changes in body shape can be frightening for the anorexic. A rewarding environment that helps the anorexic want to gain weight is set up to help them overcome their problems. Within such an environment, weight gain leads to access to pleasant activities. This rewards weight gain. As the patient gains weight, the family is usually involved in helping the patient return to a normal social life. In addition, the anorexic is helped to build up behaviors that will aid in the process. Research has shown that about three quarters of anorexics treated with behavior therapy will gain a reasonable amount of weight.

Chapter 3 : Cognitive Therapy

Cognitive Therapy for Personality Disorders It is increasingly recognised that a signiï¬•cant number of individuals with personality disorders can bene ï¬•t from therapy.

Guided discovery is used to determine the meaning and nature of automatic thoughts and interpretations, and to elicit and define underlying assumptions and beliefs. Belief in dysfunctional automatic thoughts, assumptions and beliefs are modified through collaborative empiricism which involves techniques such as questioning the evidence for thoughts, examining counter-evidence, reviewing alternative explanations, education, and strategies for combating cognitive biases. Some early cognitive-behavioural interventions tended to use behavioural techniques and cognitive techniques as components of eclectic treatment packages. A criticism of such approaches is that they lack theoretical integrity, and may be combining strategies in a suboptimal way. In this book a more conceptually coherent approach is advocated that uses behavioural strategies tailored specifically to modify cognition with the aim of challenging dysfunctional thoughts and beliefs. Use of a behavioural strategy, like any other strategy, should be defensible in terms of the therapeutic aims specified by an individual cognitive case conceptualisation. For example, the cognitive model of panic suggests that treatment should focus on modifying belief in symptom misinterpretations. Teaching panic patients relaxation and distraction techniques are unlikely to produce optimal changes in belief in misinterpretations since patients could attribute the nonoccurrence of catastrophe to use of their relaxation strategy. Behavioural attempts to maintain anxious sensations and reduce self-control behaviours to discover that misinterpretations are false is likely to be a better strategy. Problems of selecting behavioural strategies are diminished if the strategies are primarily selected on the basis that they will modify cognition that is central in the anxiety model being implemented. Typical behavioural strategies include, exposure experiments, mini-surveys, activity monitoring and scheduling, manipulation of safety behaviours, attentional manipulations, and symptom inductions. In the next chapter basic techniques such as use of socratic dialogue, guided discovery, verbal reattribution and behavioural experiments are presented. The remainder of this chapter is devoted to a detailed account of the characteristics of cognitive therapy, beginning with structure and then focusing on the therapy process. Sessions are usually held weekly and the duration of a session is between 45 and 60 minutes. In certain cases of multiple presenting problems, such as major depression and anxiety disorders, or anxiety disorders with personality disorder, treatment may consist of a greater number of sessions. However, in some uncomplicated cases of panic disorder, social phobia, and generalised anxiety fewer than ten sessions may be required for effective treatment. In a course of treatment, the initial sessions focus on assessment, conceptualisation, engagement, and socialisation. As treatment progresses more emphasis is placed on modifying behaviours and cognition involved in the maintenance of anxiety. Initially this is symptom-focused work, aimed at alleviating the symptoms of the presenting problem. When symptom relief is accomplished treatment focuses on underlying issues that are conceptualised as risk factors for subsequent anxiety problems or relapse. This focus is typically a component of the later stages of treatment, consisting of relapse prevention work. Follow-up appointments at six and twelve months post-treatment are desirable in order to ensure that treatment gains have been maintained. A guiding structure for a twelve-week course of therapy is presented in Figure 3. Individual factors will of course modify timing. Case conceptualisation Formulation Following a full assessment, the early treatment sessions are predominantly devoted to conceptualisation based on a cognitive model. Conceptualisation and assessment are ongoing throughout treatment, however they occupy most of the session time during the first session of treatment. Goal setting is a component of the initial treatment session: Strategies for building individual case conceptualisations are presented in each of the anxiety disorder chapters. Reading material bibliotherapy is provided to assist socialisation, and demonstrations of the model are used, in particular demonstrations of the links between cognition, anxiety and behaviour. Aims of socialisation include laying the foundations for a

psychological explanation of presenting problems, providing a general rationale for understanding the content of treatment, and providing accurate expectations concerning the type and level of patient involvement in the treatment process. Symptom and schema-focused intervention The most part of cognitive therapy of anxiety disorders should consist of modifying the cognitive and behavioural variables involved in the maintenance of the presenting anxiety problem. In most cases schema-focused interventions should be introduced only after symptomatic relief is accomplished, or when there is reason to believe that underlying assumptions or beliefs are interfering with engagement in therapy or with progress. Primary schemas in anxiety disorders are beliefs and assumptions that are hypothesised to contribute to anxiety vulnerability. These schemas tend to be modified in the latter part of treatment as a component of relapse prevention work. The same techniques that are used for modifying automatic thoughts are also used for modifying cognition at the schema level. Relapse prevention Relapse prevention strategies other than schema modification are undertaken in the last few sessions of treatment. Relapse prevention typically consists of checking for residual beliefs in negative automatic thoughts and challenging them. The reversal of any remaining avoidance behaviours tied to target fears is also undertaken. Booster sessions are scheduled for monitoring progress and dealing with any emerging difficulties. Each session of cognitive therapy has a core structure involving the following elements: Implementation of specific strategies. Provision of new homework. Summary and patient feedback. Review of objective measures Since cognitive therapy is a problem-focused and scientific approach to treatment, measurement is a crucial component of hypothesis testing and treatment outcome assessment. Mood, anxiety, the intensity and frequency of specific symptoms, base rates for behaviour, and so on, are typical measures in treatment. Specific measures were reviewed in more detail in Chapter 2. Self-report questionnaires are completed on a sessional basis and diaries are provided for monitoring of thoughts and symptoms on a daily basis between therapy sessions. The initial task of the patient is to complete relevant self-report instruments just before the therapy session or during the first few minutes of therapy. The measures are reviewed collaboratively and the therapist looks for changes in anxiety, symptoms, behaviours, etc. A decrease in target measures is used to encourage the patient and signals the exploration of factors that have contributed to improvement. The factors that have been useful may be isolated for continued development. An increase in symptoms or problem status or no change signals the need to explore exacerbatory and blocking processes in treatment. Two to three minutes should be devoted to reviewing measures at the beginning of each session. Agenda setting Cognitive therapy is guided by a session agenda. Following the review of objective scores the agenda is collaboratively established. Initially in the course of treatment this process may have to be less collaborative as the patient knows little of what to expect from therapy. Later on, most of the responsibility for agenda setting may rest with the patient. The agenda offers a means of reinforcing a collaborative working agreement between patient and therapist. It makes both therapist and patient responsible for deciding targets in treatment, and it allows flexibility to work on problems as they emerge. The agenda should be used to maintain a focus to therapy that is consistent with the case conceptualisation and with specific goals. The content of the agenda is influenced by the stage of treatment. However, it typically incorporates the following:

Chapter 4 : CBT Therapy for EATING DISORDER

The key characteristics of cognitive therapy for personality disorders are discussed, highlighting the modifications made to improve the efficacy of treatments. More detailed accounts of techniques are given, enabling the clinician to select the most appropriate approach for each individual case.

Introduction Over years ago the Greek Stoic philosopher Epictetus said that people are disturbed not by things but by the views they take of them. It is the interpretation we place on events, rather than events themselves, that determine our emotions. If you thought the window had blown open accidentally, you might feel angry or annoyed. However, if you thought that someone was trying to break in, you would be more likely to feel anxious. Therefore, our feelings are not just automatic reactions to events, they are created by the thoughts that we have. Just as individuals construct irrational thoughts that maintain their negative emotions and maladaptive behaviour, they can reconstruct their thoughts and view situations differently, which will result in positive feelings and adaptive behaviour. What Is Cognitive Therapy? Cognitive Therapy is a way of talking about the connections between how we think, how we feel and how we behave. It particularly concentrates on ideas that are unrealistic. These often undermine our self-confidence and make us feel depressed or anxious. Looking at these can help us work out different ways of thinking and behaving, that in turn will help us cope better. The basic premise of cognitive therapy therefore, is that the way we think about events in our lives cognitions determines how we feel about them emotions , which in turn influences how we react behaviour. Schemas are cognitive structures or templates that organise how we think, feel, act, relate, and understand and are typically referred to as our personality style. Schemas are outside of conscious awareness and determine how we interpret the world and respond to situations. Whilst cognitive structures can be adaptive, allowing us to process information rapidly, the same rapid processing can result in entrenched maladaptive structures. This is because they are strong beliefs and assumptions about how we should live our lives, which we develop whilst we are growing up. How does psychological and emotional distress occur? Psychological and emotional distress occurs when people perceive the world as threatening. Seeing things in black-or-white categories that exist on a continuum. Dwelling on a single negative detail, instead of seeing the whole picture. Interpreting things negatively when there is no evidence to support it. Predicting the future in a negative way, without any supporting evidence. Assuming negative emotional thinking reflects reality. Attaching a negative label to an action i. Seeing only the negative aspects of a situation. Research has shown that specific patterns of thinking are associated with a wide range of emotional and psychological problems. These negative or extreme thought patterns have frequently become so habitual that they are experienced as automatic and go unnoticed by the individual. Cognitive Restructuring Cognitive Therapy treats emotional problems by changing or restructuring maladaptive patterns of thought. Clients are taught how to uncover and re-examine these negative beliefs, and replace them with more adaptive ways of viewing life events. Through this process, clients learn self-help techniques that can produce rapid symptom shifts, solve current life problems, and improve self-esteem. This negative pattern of thought called negative automatic thoughts, can be seen as abbreviations of deeper cognitive structures called schemas. Cognitive Therapists also teach clients coping skills, which serves two functions: In essence, Cognitive Therapy is a school of psychotherapy that: How Cognitive Therapy is different from other therapies. Cognitive Therapy incorporates a variety of features that differ from traditional psychotherapy and shorten the process of change. Five of these elements are briefly described below: Collaborative Conceptualisation - a compass for successful treatment Collaborative conceptualisation formulation is the foundation of cognitive therapy because it ties together all of the presenting issues, so that the problems are not seen as a random collection of difficulties. This formalisation will explain how current problems are being maintained and will guide therapeutic interventions. This process has been called collaborative empiricism. Sometime this will be a single difficulty or complex mix of difficulties. This may include a brief exploration of some of the following areas: At the end of the consultation

a preliminary psychological formulation or understanding of your difficulties will have been made. Broadly, this psychological understanding will provide a description of the origin of your difficulties, how they are currently maintained and treatment options. This will enable you to experience a feeling of mastery and control over your emotions early on in therapy. You may also be given some questionnaires to take away and complete before the next session, which may provide a further understanding of your difficulties. Treatment sessions The focus of the treatment sessions will vary depending upon the nature of your difficulties. Meanwhile, for people with chronic or lifelong problems, an expansion of cognitive therapy called Schema Focused Cognitive therapy is available. Length of treatment The overall duration of therapy will vary depending upon the complexity of your issues. In some cases an improvement can be achieved after the assessment itself, whilst in others, a longer period of contact is required before problems are resolved. Most courses of cognitive therapy last from 5 to 15 weeks, with once-weekly sessions lasting 50 minutes. The treatment as a whole is seen as having a beginning, middle, and end, with the total length of treatment depending on the nature of the problems and the needs of the client. Focus on specific symptoms, problems, or issues on the current life situation and experiences on mutually agreed upon, measurable goals Cost-Effective. The active and focussed psychotherapeutic approach makes the cost of treatment less expensive than other forms of therapy. The focus on skill building and client independence minimises the course of treatment and reduces the risk of relapse after the end of treatment. Cognitive Therapy emphasises many practical strategies that can be used, even when therapy is over, to cope with life more effectively. Cognitive Behaviour Therapy has three main goals: To relieve symptoms and resolve problems. To help the client to acquire skills and coping strategies. To help the client to modify underlying cognitive structures in order to prevent relapse. How effective is Cognitive Behaviour Therapy? Cognitive Therapy is the most widely researched form of all psychotherapies. It is one of the few forms of psychotherapy that has been scientifically tested and found to be highly effective in hundreds of clinical studies. In study after study, it has been shown to be as effective as drugs in treating both depression and anxiety states. Results overwhelmingly support the effectiveness of Cognitive Therapy with virtually all emotional problems and is the preferred treatment for:

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Chapter 5 : Cognitive Therapy for Personality Disorders : Kate Davidson :

Cognitive Therapy for Personality Disorders provides a thorough description of how to apply cognitive behavioural therapy to patients who are traditionally regarded as being difficult to treat: those with borderline personality disorders and those with antisocial personality disorders. The book contains detailed descriptions and strategies of.

But if you suffer from obsessive-compulsive disorder OCD , obsessive thoughts and compulsive behaviors become so consuming they interfere with your daily life. But help is available. With treatment and self-help strategies, you can break free of the unwanted thoughts and irrational urges and take back control of your life. What is obsessive-compulsive disorder OCD? Obsessive-compulsive disorder OCD is an anxiety disorder characterized by uncontrollable, unwanted thoughts and ritualized, repetitive behaviors you feel compelled to perform. If you have OCD, you probably recognize that your obsessive thoughts and compulsive behaviors are irrationalâ€”but even so, you feel unable to resist them and break free. Like a needle getting stuck on an old record, OCD causes the brain to get stuck on a particular thought or urge. You may try to avoid situations that trigger or worsen your symptoms or self-medicate with alcohol or drugs. OCD obsessions and compulsions Obsessions are involuntary thoughts, images, or impulses that occur over and over again in your mind. Unfortunately, these obsessive thoughts are often disturbing and distracting. Compulsions are behaviors or rituals that you feel driven to act out again and again. Usually, compulsions are performed in an attempt to make obsessions go away. However, the relief never lasts. In fact, the obsessive thoughts usually come back stronger. And the compulsive rituals and behaviors often end up causing anxiety themselves as they become more demanding and time-consuming. This is the vicious cycle of OCD. Most people with OCD fall into one of the following categories: Washers are afraid of contamination. They usually have cleaning or hand-washing compulsions. Checkers repeatedly check things oven turned off, door locked, etc. Counters and arrangers are obsessed with order and symmetry. They may have superstitions about certain numbers, colors, or arrangements. Hoarders fear that something bad will happen if they throw anything away. OCD signs and symptoms Just because you have obsessive thoughts or perform compulsive behaviors does NOT mean that you have obsessive-compulsive disorder. With OCD, these thoughts and behaviors cause tremendous distress, take up a lot of time at least one hour per day , and interfere with your daily life and relationships. Most people with obsessive-compulsive disorder have both obsessions and compulsions, but some people experience just one or the other. Common obsessive thoughts in OCD include: Fear of being contaminated by germs or dirt or contaminating others Fear of losing control and harming yourself or others Intrusive sexually explicit or violent thoughts and images Excessive focus on religious or moral ideas Fear of losing or not having things you might need Order and symmetry: OCD self-help tip 1: One of the most powerful strategies is to eliminate the compulsive behaviors and rituals that keep your obsessions going. It might seem smart to avoid the situations that trigger your obsessive thoughts, but the more you avoid them, the scarier they feel. Instead, expose yourself to your OCD triggers, then try to resist or delay the urge to complete your relief-seeking compulsive ritual. If resistance gets to be too hard, try to reduce the amount of time you spend on your ritual. By anticipating your compulsive urges before they arise, you can help to ease them. For example, if your compulsive behavior involves checking that doors are locked, windows closed, or appliances turned off, try to lock the door or turn off the appliance with extra attention the first time. Create a solid mental picture and then make a mental note. You could exercise, jog, walk, listen to music, read, surf the web, play a video game, make a phone call, or knit. The important thing is to do something you enjoy for at least 15 minutes, in order to delay your response to the obsessive thought or compulsion. At the end of the delaying period, reassess the urge. In many cases, the urge will no longer be quite as intense. Try delaying for a longer period. The longer you can delay the urge, the more it will likely change. Challenge obsessive thoughts Everyone has troubling thoughts or worries from time to time. But obsessive-compulsive disorder causes the brain to get stuck on a particular anxiety-provoking thought, causing it to play over and over in your head. The following strategies

can help you get unstuck. Write down your obsessive thoughts or worries. Keep a pad and pencil on you, or type on a laptop, smartphone, or tablet. When you begin to obsess, write down all your thoughts or compulsions. Writing it all down will help you see just how repetitive your obsessions are. Writing down the same phrase or urge hundreds of times will help it lose its power. Writing thoughts down is much harder work than simply thinking them, so your obsessive thoughts are likely to disappear sooner. Create an OCD worry period Rather than trying to suppress obsessions or compulsions, develop the habit of rescheduling them. Choose a set time and place e. During your worry period, focus only on negative thoughts or urges. At the end of the worry period, take a few calming breaths, let the obsessive thoughts or urges go, and return to your normal activities. The rest of the day, however, is to be designated free of obsessions and compulsions. Save it for later and continue to go about your day. Reflect on the thoughts or urges you wrote down during the day. Create a tape of your OCD obsessionsFocus on one specific worry or obsession and record it to a tape recorder, laptop, or smartphone. Recount the obsessive phrase, sentence, or story exactly as it comes into your mind. Play the tape back to yourself, over and over for a minute period each day, until listening to the obsession no longer causes you to feel highly distressed. By continuously confronting your worry or obsession you will gradually become less anxious. You can then repeat the exercise for a different obsession. Free Yourself from Obsessive-Compulsive Behavior, offers the following four steps for dealing with obsessive thoughts: I need to do another behavior. It is not significant in itself. It has no meaning. You can learn to go on to the next behavior. Westwood Institute for Anxiety Disorders Tip 3: Make lifestyle changes to ease OCD A healthy, balanced lifestyle plays a big role in easing anxiety and keeping OCD compulsions, fears, and worry at bay. Exercise is a natural and effective anti-anxiety treatment that helps to control OCD symptoms by refocusing your mind when obsessive thoughts and compulsions arise. For maximum benefit, try to get 30 minutes or more of aerobic activity on most days. Ten minutes several times a day can be as effective as one longer period especially if you pay mindful attention to the movement process. Not only can anxiety and worry cause insomnia, but a lack of sleep can also exacerbate anxious thoughts and feelings. Avoid alcohol and nicotine. Alcohol temporarily reduces anxiety and worry, but it actually causes anxiety symptoms as it wears off. Similarly, while it may seem that cigarettes are calming, nicotine is actually a powerful stimulant. Smoking leads to higher, not lower, levels of anxiety and OCD symptoms. Accessing the Relaxation Response Practice relaxation techniques. Mindful meditation, yoga, deep breathing, and other relaxation techniques can help lower your overall stress and tension levels and help you manage your urges. For best results, practice a relaxation technique regularly. Just talking about your worries and urges can make them seem less threatening. Stay connected to family and friends. Obsessions and compulsions can consume your life to the point of social isolation. In turn, social isolation will aggravate your OCD symptoms. Talking face-to-face about your worries and urges can make them feel less real and less threatening. Join an OCD support group. OCD support groups enable you to both share your own experiences and learn from others who are facing the same problems. For a searchable database of OCD support groups, see the Recommended reading section below. Treatment for OCD Cognitive-behavioral therapy is the most effective treatment for obsessive-compulsive disorder and involves two components: Exposure and response prevention requires repeated exposure to the source of your obsession. For example, if you are a compulsive hand washer, you might be asked to touch the door handle in a public restroom and then be prevented from washing up. As you sit with the anxiety, the urge to wash your hands will gradually begin to go away on its own. Cognitive therapy focuses on the catastrophic thoughts and exaggerated sense of responsibility you feel. A big part of cognitive therapy for OCD is teaching you healthy and effective ways of responding to obsessive thoughts, without resorting to compulsive behavior. Antidepressants are sometimes used in conjunction with therapy for the treatment of obsessive-compulsive disorder. However, medication alone is rarely effective in relieving the symptoms. Since OCD often causes problems in family life and social adjustment, family therapy can help promote understanding of the disorder and reduce family conflicts. It can also motivate family members and teach them how to help their loved one with OCD.

Chapter 6 : COGNITIVE THERAPY: BASIC CHARACTERISTICS | Musculoskeletal Key

Obsessive compulsive personality disorder (OCPD), is a personality disorder in which the diagnosed individual becomes extremely anxious, when things are not as they perceive them to be. Notorious for their rules regarding routines, cognitive behavioral therapy is the primary recommended treatment.

CBT is a highly effective, evidence-based therapy. Therapists have successfully used CBT to treat a variety of mental disorders particularly depressive disorders and anxiety disorders such as Obsessive Compulsive Disorder, and Posttraumatic Stress Disorder Paris, However, we will limit our discussion to the application of CBT in the treatment of personality disorders. CBT techniques emerge from a fundamental premise of cognitive-behavioral theory. Our thoughts cognitions lead to our emotions and subsequent behavior. Of particular importance for people with personality disorders is the way in which external events in the environment such as interpersonal interactions with others are uniquely interpreted and assigned a meaning based upon core beliefs. Childhood experiences, coupled with an innate, biologically-determined disposition, establish our initial beliefs about the world. When these preconceived beliefs are faulty, distorted, or biased, we may end up drawing incorrect, irrational conclusions about the meaning of external events particularly interpersonal interactions. We may subsequently behave in ways that cause us unnecessary distress and suffering. For more detailed information about these concepts please return to the section on cognitive-behavioral theory. You may recall, people with personality disorders have characteristic patterns of thinking that get them into trouble. This is because their ways of thinking tend to be somewhat extreme, inflexible, and distorted. CBT is particularly helpful for people with personality disorders because of its emphasis on identifying and changing dysfunctional thinking patterns. In particular, core beliefs underlying those patterns are exposed and challenged. Thus, cognitive-behavioral therapy functions to identify and challenge automatic and faulty interpretations of the environment that are driven by core beliefs. A person corrects these faulty interpretations of the environment by replacing them with more accurate, rational interpretations. With a more accurate interpretation, new, more accurate core beliefs are formed. This is because there is a circular causality between people and their environment: The environment has an effect upon me, and I have an effect upon my environment. These new, positive experiences allow the person to update their core beliefs about the world. This in turn enables them to have more positive and affirming experiences and so on. This results in emotional and behavioral reactions that are less exaggerated and problematic. There are several steps to this corrective process. First, the therapist and participant work together to identify the problematic thinking patterns.. This is accomplished by asking the therapy participant to keep track of troubling events. Participants record their thoughts in response to these events. In other words, the therapy participant records what they say to themselves during these events. Next, the participant would learn to consider whether there are alternative interpretations of the same event. The ultimate goal of this process is to interrupt the automatic but distorted thoughts as they occur, while learning to consider alternative, more accurate interpretations of these same events. With practice and gradual success, the recovering person begins to feel better and behave differently. Because they are behaving differently, people respond to them more favorably. This sets the stage for more accurate core beliefs to form about themselves-in-the-world. CBT would begin by asking him to record situations in which he felt threatened and to record his immediate thoughts and feelings when these situations occur. So one day when the clumsy foot stepper accidently stepped on our hypothetical man with Paranoid Personality Disorder, he might find himself thinking: That person just stepped on my foot intentionally. They want to hurt me. I better stand up for myself and get back at them. Just who do they think they are anyway? The therapist would also ask the therapy participant to rationally examine the evidence that led to the conclusion the foot-stepper was intentionally trying to harm him. Why would the foot-stepper single out this one person to step on? In so doing, the client comes into contact with the core belief, the-world-is-a-dangerous-place, and learns to challenge that belief.

Over time, the core belief is repeatedly challenged and is subsequently replaced with a core belief that is more realistic, flexible, and adaptive. As the dysfunctional core belief evolves into a more adaptive one, the therapy participant begins to behave in ways that are less hostile and aggressive. In so doing, other people respond in kind. This new, positive experience of being treated well by other people further solidifies the new, more accurate belief, that most people are safe and usually kind.

Chapter 7 : Cognitive-Behavioral Therapy for Personality Disorders (CBT)

Cognitive Behavioral Therapy (CBT) derives from cognitive-behavioral theory. CBT is a highly effective, evidence-based therapy. CBT is a highly effective, evidence-based therapy. Therapists have successfully used CBT to treat a variety of mental disorders particularly depressive disorders and anxiety disorders such as Obsessive Compulsive.

Some traits may be more culturally desirable than others and individuals who are sensitive to perceived social norms and values may alter their endorsement of items according to how they wish to represent themselves and who is enquiring. Partly for this reason, many assessments of personality disorder use reports from knowledgeable informants, though agreement between informants and subjects is not always high Bernstein et al. A more accurate assessment of personality disorder may be obtained by assessing an individual during a period of remission from a clinical disorder or at more than one point in time. For a thorough review of assessment and related issues the reader is referred to other sources Zimmerman, ; Weissman, ; Jackson, Dimensional or categorical classifications? In addition, if personality disorders were not dichotomous, then measures that rely on dimensions would include more information than categories and would enable more reliable measurement Loranger et al. Alternative approaches, arising from mainstream academic psychology with its lengthy history of research in personality using psychometric analysis, may be clinically useful in describing more fully the negative traits associated with personality disorder. Other measures of dysfunctional traits, such as the Schedule for Nonadaptive and Adaptive Personality SNAP , which measures traits relevant to personality disorder, may also be useful in investigating theoretical hypotheses on the structure of personality disorder Clark, It is clear that there appears to be increasing rapprochement between academic and clinical researchers in this area and it is likely that both normal and abnormal personality will be construed in dimensions, but with some overlap between the approaches, in the future Deary and Power, The disorder has to be manifested in at least two of the following domains: In addition, the disorder has to be stable and longstanding and present since early adulthood, if not adolescence. Paranoid personality disorder This is characterized by a pervasive distrust and suspiciousness of others, who are regarded as malevolent APA, At least four of the following characteristics have to be evident: Schizoid personality disorder This is characterized by a pattern of detachment in relationships and a restricted range of emotional expression in interpersonal situations APA, Three of the following have to be evident: Histrionic personality disorder This disorder is characterized as a pattern of excessive emotionality and attention seeking APA, Narcissistic personality disorder This disorder is described as a pattern of grandiosity and need for admiration, with lack of empathy APA, The implication of making personality disorder diagnoses on a separate axis is that this type of disorder is thought to exist continuously from late adolescence and is not associated with a condition that is characterized by a relapsing course or that remits like a typical illness syndrome. Rather an individual with a diagnosis of personality disorder will display attributes that are relatively enduring and persistent and are unlikely to show much variation in that the traits will be observed in a wide number of environmental and interpersonal contexts. Narcissistic and passive aggressive personality disorders are not found in ICD In addition, unlike ICD, DSM-IV has grouped personality disorders into clusters, with the assumption that these clusters may have some shared attributes. Fearful or anxious Avoidant Dependent Obsessive-compulsive 10 Background How common is personality disorder? Community estimates of personality disorder may misclassify individuals or overestimate the prevalence of personality disorder in the community. This is partly because information from other sources is not accessed, and individuals are usually assessed by completing questionnaires asking about the presence or absence of a particular trait or behaviour. Using a two stage method in which only subjects who were screened as positive for personality disorder on a self-completion personality disorder inventory were interviewed by clinicians, the point-prevalence estimate for DSM-III-R personality disorder in a student population obtained a similar rate of This sample may, however, be unrepresentative of the population. Further data analysis from the British National Survey of Psychiatric

Morbidity, using a two phase survey, suggests that the prevalence of personality disorder in the UK is around 4. Within Cluster A, schizotypal is the most prevalent personality disorder in this group up to 5. In the UK, these rates are similar with a weighted prevalence of 1. Cluster B â€" prevalence In Cluster B antisocial, histrionic, borderline and narcissistic , antisocial personality disorder has the highest prevalence rate, varying from 2. This diagnosis is associated with notably higher rates in males compared to females and higher rates in younger as opposed to older males. In community surveys narcissistic personality disorder is low in prevalence, with two studies reporting a rate of 0. However, for those over this age, the prevalence rate in women compared to men was over eight times higher Nestadt et al. The prevalence rate of borderline personality disorder varies between 0. In general, the diagnosis of borderline personality disorder is associated with being young, single and female, and with relatively high rates of alcohol and tobacco use, suicide attempts, and comorbid diagnosis of schizophrenia and phobias as well as other personality disorders Zimmerman and Coryell, Cluster C â€" prevalence Within Cluster C avoidant, dependent, compulsive, passive aggressive , Reich et al. Dependent personality disorder is more prevalent, with rates of between 1. Using the PDQ, Zimmerman and Coryell reported a prevalence rate of 4 per for obsessive compulsive personality disorder and again a lower rate of 1. Untypically of personality disorders, this disorder is more common among educated, married individuals Nestadt et al. Using the PDQ, Zimmermann and Coryell found a low rate of passive aggressive personality disorder 0. In a UK community sample, obsessive compulsive personality disorder was more common than avoidant or dependent personality disorders 1. Studies have found variable rates depending on the sampling procedure, the diagnostic criteria, the assessment instruments and other factors such as admission policies and availability of services. Borderline, schizotypal and histrionic personality disorders are commonly found in samples of treated patients, many of whom may require admission to hospital, or intensive psychiatric care due to the level of severity of psychological and social impairment. In outpatient samples, dependent and passive aggressive personality disorders are also commonly found Girolamo and Reich, With the introduction of diagnostic tools for personality disorder with DSM-III, these disorders are increasingly recognized and diagnosed. There are several uses of the term in psychiatric research and practice Maser and Cloninger, Clinical studies use the concept of comorbidity to describe the fact that more than one disorder can be diagnosed in the same individual, whereas in psychiatric epidemiological studies the term is used to indicate the relative risk of disorders, other than the index disorder, being present within an individual patient. Coid and his colleagues Coid et al. This has several implications. Suicide and personality disorder Suicidal behaviour is associated with patients who have more than one personality disorder, though it is not clear whether certain combinations of disorders carry a higher suicide risk than others Oldham et al. Can psychological treatment help? There are an increasing number of psychological treatment approaches to personality disorder, many coming from cognitive therapy Beck et al. Some of these treatments have been systematically evaluated in randomized controlled trials and found to be helpful in reducing problems associated with personality disorder, particularly borderline personality disorder. Most often the comparison has been made between the specialized treatment and the prevailing treatment at the time of the study and in the country where the study takes place. From these latter studies, there is evidence that behaviour therapy, cognitive therapy and cognitive analytical therapy can be helpful in improving relationships and in reducing dysfunctional 14 Background behaviour e. The main therapies that have been evaluated using these more rigorous designs are cognitive behaviour therapy Davidson et al. All of these therapeutic approaches reduced self-harm when compared with a control treatment for patients who had self-harmed before entering into the trial. In one of the DBT trials Koons et al. Not all of the above studies followed up patients to see what happened to them after treatment ended. All patients, regardless of which treatment they received, showed a gradual and sustained improvement in important outcomes such as in-patient hospitalization, suicidal behaviour and use of accident and emergency treatment facilities, and in symptoms and problems. The study showed that CBT can deliver clinically important changes in relatively few clinical sessions in real clinical settings. Giesen-Bloo and her colleagues Giesen-Bloo et al. Eighty-eight

patients were randomized and received outpatient therapy over a prolonged period of three years. In each condition, patients received twice-weekly therapy. Patients were assessed over two months and this served to test their motivation for long-term therapy. The main outcome measure was severity of borderline personality disorder assessed using the Borderline Personality Disorder Severity Index Arntz et al. In the schema-focused therapy Young et al. These modes, or sets of schemas, were detached protector, punitive parent, abandoned or abused child, and angry impulsive child. Change was presumed to take place through a range of behavioural, cognitive and experiential techniques including the therapeutic relationship, daily life and dealing with current problems, and past traumatic experiences. In transference-focused psychotherapy, change was assumed to occur through the analysis and interpretation of the transference relationship and the focus is on the present, not the past. Follow-up of these patients once therapy has ended will be important in establishing their longer-term naturalistic outcome. They suggest that systematic psychological therapy, particularly cognitive therapy, can help reduce the disabling and distressing problems that borderline patients experience. No randomized controlled trials are reported, as yet, for antisocial personality disorder. That these promising results can be repeated for another type of personality disorder, such as antisocial personality disorder, now appears a possibility but we cannot be overly optimistic without evidence. Long-term outcome for personality disorder Personality disorder has traditionally been thought of as a stable and unchanging disorder, that is, one that endures over time. Several long-term follow-up studies of patients with borderline personality disorder have been carried out, spanning to year follow-up periods McGlashan, ; Paris, ; Stone, ; Plakun et al. All patients were of high socio-economic status except in the Montreal study Paris, , where the sample came from a general hospital and had more mixed socio-economic status. Recovery or remission from the diagnosis of borderline personality disorder status was seen to continue into middle age. In terms of changes in type of problem, over time patients became less impulsive and relationships improved, though often at the cost of intimacy. Prospective studies following up borderline personality disorder patients are fewer. However, for those who do not kill themselves, there can be symptomatic improvement over six to seven years Links et al. These prospective studies are likely to be more reliable than other types of follow-up studies because of the assessments carried out. From these studies and others, several factors are known to predict whether outcome is poor in the longer term. Prospective studies are likely to be more reliable than other types of follow-up studies. Background 17 How do we explain personality disorder to our patients? It may also be potentially disturbing to an individual and to others as the label has very negative associations and has been used to exclude patients from services. Evidence from long-term follow-up studies of patients, particularly with borderline personality disorder, suggest that the label may not be as discouraging as was once thought, as change in personality status does occur. Nonetheless, we have to consider what the label might mean to an individual. The label has a pejorative connotation and this may imply a defective condition. There are probably some personality disorders that are more dysfunctional or severe than others. To the layperson, however, the distinction between a disorder such as avoidant personality disorder and antisocial personality disorder may not be meaningful. The salient term to the layperson may be personality disorder per se and the distinctions between disorders less salient and meaningful. While many researchers and clinicians also use the labels reluctantly, they are useful as a means of communicating a complex clinical entity even though agreement about what it is, and how reliable and valid its measurement may be, still varies. That some individuals with personality disorder come to us distressed about their condition is incontrovertible. However, even they may be aware that changing their behaviour and thinking could have positive consequences. How can cognitive therapy help? We now have evidence that cognitive therapies are helpful in treating borderline personality disorder. The best evidence, as can be seen above, 18 Background comes from randomized controlled trials with patients with a diagnosis of borderline personality disorder. Clinicians will know from experience that patients with the same diagnosis may be dissimilar in the range and type of problems that are presented.

Chapter 8 : Obsessive-Compulsive Disorder (OCD): Symptoms, Treatment, and Self-Help

AARON BECK ON COGNITIVE THERAPY WITH AARON T. BECK, MD A strong therapeutic alliance is a key feature of cognitive therapy. personality disorders, comorbidity.

It is now considered the treatment of choice for individuals with characteristics associated with symptoms of BPD such as impulsivity, interpersonal problems, emotion dysregulation, self-harm, and chronic suicidal behaviors. Dialectical Behavioral Therapy is a type of cognitive therapy that focuses on the balance between acceptance and change. DBT works with individuals to validate their pain and suffering while developing skills to make the changes needed to have a life worth living. A key component of DBT is skills training. DBT has 4 modules of skills, mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance. Each module helps individuals develops skills to manage their life more effectively and develop improved quality of life. The skills training and treatment of DBT is applicable to people with a wide range of mental health conditions to improve overall well-being, emotion management, and decrease negative emotions and distress. Therefore, DBT treatment or DBT informed therapy may be beneficial for individuals with depression , anxiety , eating disorders, addiction, and post-traumatic stress disorder. DBT for Depression Dialectical Behavior Therapy has skills to address specifically for people struggling with depression. DBT teaches mindfulness helping individuals learning to live in the moment rather than the past. DBT teaches increasing pleasurable activities to empower people to add more joyous experiences to their lives. DBT also teaches behavior activation and opposite to emotion action. These are evidence based tools for depression and it helps to know what works. It teaches people to observe, describe, and participate in the moment. For individuals with anxiety this can be particularly challenging. DBT focuses on mindfulness and how to use these skills to decrease the intensity of negative emotions so feelings become manageable. DBT for Eating Disorders Dialectical Behavior Therapy has been adapted for treating individuals with eating disorders and focuses on skills that increase mindfulness, appropriately regulate emotion, and safely tolerate distress. DBT helps individuals identify the trigger and utilize skills to avoid the eating disorder behavior. DBT-SUD focused on mindfulness one day at a time and non-judgmental stance , distress tolerance, and emotion regulation skills to help individuals develop long term recovery skills. The skills can also be applied to other types of addiction than just substances such as gambling. DBT teaches distress tolerance skills to manage crisis, such as grounding skills, and mindfulness skills to bring individuals to the present. DBT can address and decrease dangerous behaviors common among survivors or trauma; DBT helps individuals develop effective interpersonal skills for setting boundaries and learning trust the self; and DBT teaches skill to regulate emotions or other symptoms of PTSD on a daily basis. DBT is currently used and a highly effective treatment for an array of mental health issues. She is also sought after as a mental health expert and has been asked to provide trainings and consultation to other agencies. For more information please visit her website at www.

Chapter 9 : Obsessive Compulsive Personality Disorder Cognitive Behavioral Therapy

Cognitive behavioural therapy (CBT) explores the links between thoughts, emotions and behaviour. It is a directive, time-limited, structured approach used to treat a variety of mental health disorders. It aims to alleviate distress by helping patients to develop more adaptive cognitions and.