PL3106

Anxiety Disorders

Fear is a response to an *objective* threat, whereas **anxiety** is a reaction to an *imagined* threat. However, they share several commonalities, including:

- cognitive & neurochemical changes
- physiological responses
- behavioural reactions

Cross-sectional formulation

Triggering event(s)	specific to different anxiety types
Appraisals/ Cognitions	• misinterpretation of somatic symptoms • subjective perception of threat (i.e., fixation, preoccupation, and anticipation)
Cognitive changes	• hypervigilance • preoccupation with perceived source of threat • reasoning biases • selective memory retrieval
Emotional responses	anxious, scared, significant emotional distress
Physical experiences	• muscular tension and/or stiffness • stomach and chest tightness • hyperventilation • increased heart rate and pulse • trembling and shaking • sweating
Unhelpful behaviour employed	• fight, flight, and freeze responses • escape and withdrawal • avoidance • inaction (due to indecisiveness)

Potential consequences of appraisals

Appraisal of stimulus as threatening
→ significant emotional distress, debilitating physical symptoms, impairments in interpersonal functioning
→ safety behaviours (e.g., escape/withdrawal, avoidance, etc.) maintain and reinforce negative cognitions

Recommended treatments

CBT, whose key treatment goals include:

- graded exposure to perceived source of threat
- gradual abandonment of safety behaviours
- desensitization
- effective management of worry
- development of helpful coping strategies
- overall reduction in emotional distress
- enhancement of quality of life
- increase in subjective well-being

Specific phobia

Indicators/Diagnostic cluster

- Strong and persistent distress or impairment triggered by a specific object or situation, which generally include:
  - animals
  - environments
  - blood-injection-injury
  - situations (e.g., tunnels, elevators, bridges)
  - others (e.g., choking, vomiting)
- Tendency to avoid triggers.
- Fear/Anxiety out of proportion to the actual danger posed by the object or situation.
- Persistent fear, anxiety, or avoidance.

Developmental factors

- The fear response in specific phobia could be conditioned to previously neutral stimuli, via pairing with traumatic/painful events.
- Fear response can also be conditioned via **vicarious/observational classical conditioning**, by watching people behaving fearfully with their phobic object or undergoing a frightening experience.
- Inescapable and uncontrollable events are more likely to condition fear responses.
- Once acquired, phobic fears could generalize to similar objects/situations.

Recommended treatments

Exposure therapy Participant modeling	• graded/controlled exposure to stimuli which elicit phobic fear, over long periods of time • therapist models ways of interacting with the phobic stimulus/situation • guide clients in learning to re-appraise situations in more adaptive and less distressing ways • help clients learn that their anxiety, while unpleasant, is not harmful and will gradually dissipate • guide clients towards abandoning safety behaviours

Social phobia

Indicators/Diagnostic cluster

- Disabling distress triggered by misinterpretations of social situations.
- Tendency to avoid social situations.
- Catastrophic fear/anxiety of being exposed to interpersonal scrutiny, public humiliation, rejection, etc.
- Persistent fear, anxiety, or avoidance, causing significant distress and interpersonal impairment.

Cross-sectional formulation

Appraisals/ Cognitions	• expectation that other people will reject or negatively evaluate them • sense of vulnerability around people • negative self-images • overestimation of others' detection of their anxiety • tendency to interpret ambiguous social information in a negative manner
Unhelpful behaviour employed	• awkward and socially unacceptable behaviour • intense self-preoccupation • inhibited ability for social interaction

Developmental factors

- Social phobia often originate from simple instances of direct/vicarious classical conditioning (e.g., experiencing/witnessing perceived social defeat, humiliation, or criticism).
- Exposure to uncontrollable and unpredictable stressful events increases the risk of social phobia.
- Overprotective/Rejecting parents may also lead to individuals' diminished sense of personal control, which could result in social phobia.

Recommended treatments

Cognitive restructuring	• assist clients with identifying their underlying negative automatic thoughts • help clients understand that their automatic thoughts often involve cognitive distortions • help clients change their inner thoughts and beliefs through logical reanalysis
Videotaped feedback	• help clients modify their distorted self-images

Panic disorder

A **panic attack** consists of:

- highly distressing misinterpretation of personal experiences, especially w.r.t. bodily sensations.
- perception of own physiological reactions as threatening and dangerous.

Indicators/Diagnostic cluster

- Recurrent unexpected panic attacks.
- Disturbance is independent of other stimuli, e.g., social situations or specific objects/situations.

Cross-sectional formulation

Appraisals/ Cognitions	• catastrophic misinterpretation of own physiological reactions
Emotional responses	panic, terrified
Physical experiences	• nausea and dizziness • hyperventilation • heart palpitations • chills, hot flashes, and sweating • trembling and/or shaking • numbness and/or tingling

Developmental factors

- Typically begins after experiencing feelings of distress, or some highly stressful life circumstance.
- Hypersensitivity to one's bodily sensations or to anxiety, and the tendency of making catastrophic interpretations increases the risk of panic attacks.
- The conditioning of panic attacks to certain internal cues increases the risk of panic attacks, when people unconsciously experience certain internal bodily sensations.

Recommended treatments

Interoceptive exposure	• i.e., deliberate exposure to feared internal sensations (e.g., via exercising) • allows for habituation of one's fears of these sensations
Cognitive restructuring: panic control treatment	1. clients are educated about the nature of anxiety and panic, and how the capacity to experience both is adaptive 2. clients are taught to control their breathing 3. clients are taught about the logical errors that they are prone to making, and learn to subject their own automatic thoughts to logical reanalysis 4. clients are exposed to feared situations and bodily sensations to build up a tolerance to discomfort • help clients control their catastrophic automatic thoughts which maintain panic attacks

Generalized anxiety disorder

Indicators/Diagnostic cluster

- Persistent excessive and uncontrollable worrying, resulting in significant distress and affecting their quality of life.
- Worry themes typically comprise of:
  - health and safety
  - finances
  - relationships and family
  - work or school

Cross-sectional formulation

Appraisals/ Cognitions	"The world is a dangerous place. I might not be able to cope with whatever happens in the future. Hence, I must anticipate all bad things that may happen, so that I can be prepared or avoid them altogether."
Cognitive changes	• distractability and reduced concentration • memory problems • indecisiveness • hypervigilance • detachment from objective reality • less tolerance for uncertainty
Emotional responses	• emotional exhaustion • prolonged anxiety • feeling tuned out and separated from the world • sense of impending doom • demoralization • fatigue
Physical experiences	• back, neck, and/or chest pain • muscle tension • upset stomach • nausea, dizziness, headaches, etc.
Unhelpful behaviour employed	• pacing • agitation or irritability • restlessness or nervousness • nail biting, smoking, etc.

Developmental factors

- Experiences of unpredictable or uncontrollable (important) events increase the risk of GAD.
- People with GAD are more likely to have had childhood trauma.

Recommended treatments

Cognitive restructuring	aims to reduce distorted cognitions and information-processing biases, as well as catastrophizing about minor events

Obsessive-compulsive disorder

Obsessions: unwanted thoughts, images, or impulses that cannot be controlled.
Compulsions: actions, behaviours, or rituals engaged to reduce one's anxiety or distress, but which are excessive or not connected in a realistic way with what they were meant to neutralize or prevent.

Indicators/Diagnostic cluster

- Presence of obsessions, compulsions, or both, which causes significant distress or impairment in daily functioning.
- Obsessions or compulsions are time-consuming, or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Cross-sectional formulation

Appraisals/ Cognitions	e.g., "germs can make me ill; if I get ill, I'll die"
Emotional responses	worried, upset
Unhelpful behaviour employed	engaging in compulsions (e.g., washing hands)

Recommended treatments

Exposure and response prevention	• clients are repeatedly exposed to stimuli which provoke their obsessions, and are refrained from engaging in their compulsions to reduce their anxiety or distress • help clients identify that the anxiety induced by the obsession will dissipate naturally over time

Mood Disorders

Unipolar depressive disorders

Indicators/Diagnostic cluster for major depressive disorder

Presence of 5 or more of the following symptoms, present for at least 2 weeks, causing distress and/or impairment in daily functioning (must include 1 or 2):
1. depressed/low mood
2. loss of interest or pleasure
3. significant change or loss of more than 5% of body weight, or increased/decreased appetite nearly every day
4. sleep disturbance
5. agitation or feelings of being slowed down
6. loss of energy or feeling fatigued every day
7. feelings of worthlessness, low self-esteem, or tendency to feel guilty
8. difficulties in thinking or concentrating
9. thoughts of ending life

Indicators/Diagnostic cluster for dysthymia/persistent depressive disorder

Having depressed mood for most of the day on most days, for a period of at least 2 years, with at least 2 of the following symptoms:
1. poor appetite or overeating
2. insomnia or hypersomnia
3. low energy or fatigue
4. low self-esteem
5. poor concentration or difficulty making decisions
6. feelings of hopelessness

Cross-sectional formulation

Appraisals/ Cognitions	(cycles of) unhelpful beliefs, e.g., "no one loves me"
Cognitive changes	• hopelessness and helplessness • suicidal cognitions, plans, and attempts
Physical experiences	drained, exhausted, lack of energy
Unhelpful behaviour employed	• rumination • social withdrawal and isolation • self-blame (or even self-hatred/disgust) • inactivity and abandonment of pleasurable tasks • self-neglect

Potential consequences of appraisals

Exposure to trigger (e.g., break up)
→ significant emotional distress, feelings of hopelessness and helplessness
→ suicidal ideation, self-isolation which reinforces negative cognitions

Developmental factors

- Stressful early/significant life experiences (e.g., loss of a loved one, severe economic or health problems, etc.).
- Formation of dysfunctional, self-defeating core beliefs and unhelpful rules for living.
- Cognitive depression triad (i.e., negative thoughts about self, world, and future) maintained by cognitive biases (e.g., dichotomous/all-or-none reasoning, selective abstraction, and arbitrary inference).
- Learned helplessness: when people find that they have no control over aversive events, they may learn that they are helpless, thus causing them to be unmotivated to try to respond in future.

Recommended treatments

CBT, including:

Behavioural activation	• focuses on getting patients to become more active and engaged with their environment and interpersonal relationships, therefore increasing levels of positive reinforcement and reducing avoidance and withdrawal • includes scheduling daily activities and rating pleasure and mastery while engaging in them, exploring alternative behaviours to reach goals, and role-playing to address specific deficits
Cognitive restructuring	• guide clients to systematically evaluate their dysfunctional beliefs and negative automatic thoughts • help clients to identify and correct their biases or distortions in information processing • help clients to challenge their underlying depressogenic assumptions and beliefs
Mindfulness-based cognitive therapy	• group treatment involving training in mindfulness meditation techniques, aimed at developing clients' awareness of their unwanted thoughts, feelings, and sensations • help clients learn to accept their negative thoughts, feelings, and sensations, instead of trying to avoid them
Interpersonal therapy	• focuses on current relationship issues, trying to help clients understand and change maladaptive interaction patterns

Psychotic Disorders

Psychosis describes a loss of contact with reality. Symptoms include:
- **Hallucinations**: sensing of things which aren't present.
- **Delusions**: false beliefs that are not based in reality.
- **Disorganized thinking/behaviour**: jumbled or difficult to understand speech/thinking/writing.
- Reduced emotional expression.

Schizophrenia

Indicators/Diagnostic cluster

- Presence of two or more of the following for a significant portion of time during a 1-month period, one of which must be amongst the first 3:
  1. Delusions: erroneous beliefs which are firmly held despite clear contradictory evidence.
  2. Hallucinations: sensory experiences which seem real but occurs in the absence of any external perceptual stimuli.
  3. Disorganized speech: where listeners have little to no understanding of the point the speaker is trying to make.
  4. Disorganized/Catatonic behaviour: disruption of goal-directed activities, impairment in daily functioning.
  5. Negative symptoms (i.e., diminished emotional expression or avolition): an absence of behaviours which are normally present.
- Level of functioning in one or more major areas (e.g., work, interpersonal relationships, self-care) is markedly decreased.
- Signs of disturbance persist for at least 6 months.

Cross-sectional formulation

Triggering event(s)	• hearing internal (or external) voices
Appraisals/ Cognitions	• interpretation of voices as signs of danger and/or imminent harm from others
Cognitive changes	• hypervigilance • preoccupation with voices
Emotional responses	• anxiety and fear • hypervigilance and threat orientation
Physical experiences	• difficulties with breathing • muscular tension • sweating • trembling • heart racing
Unhelpful behaviour employed	• social withdrawal and isolation • avoidance and suspicion of others • constantly scanning for danger

Potential consequences of appraisals

Hearing voices and/or experiencing delusional beliefs
→ voices appraised to be threatening and as evidence of danger, delusions believed to be true
→ emotional distress (arising from one's subjective misinterpretations), anxiety, fear
→ social withdrawal and deterioration in psychosocial functioning

Developmental/Cultural factors

- Adverse family environments (e.g., rejecting or abusive parents) and communication deviance, especially when the individual has a genetic risk for schizophrenia.
- Urban living could raise a person's risk for developing schizophrenia, as a result of stress and/or social adversity.
- Immigrants having past experiences with discrimination may have a higher risk for schizophrenia, as a result of such experiences causing them to develop a paranoid and suspicious outlook on the world.
- Experiences with stressors during critical periods of our brain development also increases the risk of schizophrenia.

Recommended treatments

Family therapy	• working with patients and their families to educate them about schizophrenia • help them improve their coping and problem-solving skills, and to enhance communication skills (esp. the clarity of family communication) • helps to reduce relapse
CBTp Belief reattribution and cognitive restructuring Socratic dialogue	• aims to decrease the intensity of positive symptoms, reduce relapse, and decrease social disability • typically involves the following steps: 1. assessment and formulation 2. psychoeducation 3. cognitive restructuring of delusional appraisals of voices and/or external events 4. behavioural intervention, coping skills practice 5. self-management planning 6. outcome evaluation • working with clients to explore the subjective nature of their delusions and hallucinations, examine evidence for and against their veracity, and subject delusional beliefs to reality testing • using a series of focused yet open questions to assist clients in determining the accuracy of their beliefs and appraisals • involves unpacking the client's beliefs and exploring with the client how he/she arrived at those thoughts
Personal therapy	• equips patients with a broad range of coping techniques and skills • comprises of different components administered at different points in the patient's recovery: 1. early stages: clients examine the relationship between their symptoms and stress levels 2. clients learn relaxation and cognitive techniques 3. later: focus transits to social and vocational skills • effective in enhancing social adjustment and social role performance in clients
Bibliotherapy	• storytelling or reading with a purpose of healing

Trauma

Post-traumatic stress disorder

Indicators/Diagnostic cluster

- Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
  - directly experiencing or witnessing the traumatic event(s).
  - learning that the event(s) occurred to a close family member or friend.
  - experiencing repeated or extreme exposure to aversive details of the event(s).
- Presence of one (or more) of the following **intrusion symptoms** associated with the traumatic event(s):
  - recurrent, involuntary, and intrusive distressing memories of the event(s).
  - recurrent distressing dreams which content is related to the event(s).
  - dissociative reactions (e.g., flashbacks) in which the individual feels or acts if the event(s) were recurring.
  - intense or prolonged distress and/or marked physiological reactions to internal or external cues which resemble an aspect of the event(s).
- Persistent **avoidance** of stimuli associated with the traumatic event(s), including (efforts of) avoiding distressing memories, thoughts, or feelings about or closely related to the event(s), or external reminders which arouse them.
- Negative alterations in cognitions and mood, including:
  - inability to remember an important aspect of the event(s)
  - persistent and exaggerated negative beliefs or expectations about oneself, others, or the world
  - persistent, distorted cognitions about the cause or consequences of event(s) which lead the individual to blame themselves or others
  - persistent negative emotional state (e.g., guilt, fear, anger, or shame)
  - markedly diminished interest or participation in significant activities
  - feelings of detachment or estrangement from others
  - persistent inability to experience positive emotions
- Alterations in arousal and reactivity.
- Duration of the disturbance lasts more than 1 month.
- Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Disturbance is not attributable to the physiological effects of a substance or another medical condition.

Cross-sectional formulation

Triggering event(s)	memories, thoughts, or feelings about or closely related to the traumatic event(s)
Emotional responses	• significant emotional distress • anxiety and fear
Physical experiences	• breathing difficulties • muscular tension • heart racing
Unhelpful behaviour employed	• irritable behaviour and angry outbursts • reckless or self-destructive behaviour • hypervigilance • exaggerated startle response • problems with concentration • sleep disturbance

Potential consequences of appraisals

Exposure to trigger (e.g., external cues triggering traumatic memories of the event)
→ emotional distress, fear, hypervigilance
→ irritability, self-destructive behaviour, which prevents others from reaching out to provide help

Biological factors

- Over-encoding of the sensory representation of memories and under-encoding of the contextual representation of the same memories.
- Traumatic memories are very intense at the sensory level, to the extent that our brain does not have sufficient working memory capacity to process the context of the experience. When people are exposed to triggers/cues, these sensory memories are then triggered.
- The more we try to suppress a memory, the more likely we will think about it.

Developmental factors

- Childhood traumas and adverse childhood experiences increases the subsequent risk of PTSD.
- Negative and unsupportive social environments also increases vulnerability to post-traumatic stress.

Recommended treatments

Trauma-focused CBT (tf-CBT)	• client is asked to vividly recount the traumatic event over and over, until there is a decrease in their emotional responses
Prolonged exposure	• help clients become gradually desensitized to the traumatic event(s) over time, by repeatedly confronting their traumatic memories • extensive discussion of aspects of the client's life which are related to the trauma
Narrative exposure therapy	• helps to strengthen the contextual details of the memory, rather than only storing the sensory details of the memory • evidence shows that once the client is able to develop a narrative and contextualize the memory longitudinally, the brain's arousal w.r.t. the memory will be more moderated
Eye movement desensitization and reprocessing	• encourages the client to briefly focus on the trauma memory, while simultaneously experiencing bilateral stimulation associated with a reduction in vividness and emotion linked with the traumatic memories • aims to have a better understanding of the nature of the problem → greater utilization of psychoeducation • aims to reduce clients' avoidance and suppression of traumatic memories (which typically results in the re-triggering of these memories instead) via repeated exposure

Personality Disorders

The function of a **personality** involves the regulation of:

- individual levels of arousal, impulsivity, and emotions.
- self-directness and self-soothing in response to survival challenges of stress and change
- reality testing.
- maintaining an integrated sense of self over time.
- social cooperativeness through verbal and non-verbal communications, and predictability of behaviour.

Personality disorders:

- begin early in development, and lasting a lifetime.
- tend to be inflexible and pervasive across different domains of functioning.
- lead to clinically significant distress or impairment.
- deviate markedly from the expectation of the person's culture.
- are not due to another mental disorder, or the direct physiological effects of a substance or medical condition.

Major components of clinical features in PDs include:

Intrapersonal	• marked individual dysregulation of arousal, impulse, and affect systems in response to stress • clients typically hyperaroused or hypoaroused in unpredictable ways
Interpersonal	• dysfunctional interpersonal attachment patterns that reduce healthy functioning and results in a further source of stress • these may take the form of getting too close, or being detached and uninvolved
Social	• dysfunctions in social behaviours which bring individuals with personality disorders into conflict with others, and sometimes into contact with statutory agencies (e.g., mental health/criminal justice systems)

Personality disorders are grouped into 3 clusters in the DSM-5:

- A: paranoid, schizoid, and schizotypal personality disorders.
- B: histrionic, narcissistic, antisocial, and borderline personality disorders.
- C: avoidant, dependent, and obsessive-compulsive personality disorders.

Cluster A

Indicators/Diagnostic cluster for paranoid personality disorder (PPD)

- Persistent interpretation of others' intent as malicious, coupled with an array of distrust and suspiciousness.
- Assumption that other people will exploit, harm, or deceive them even if no evidence exists to support this expectation.
- Preoccupied with doubts about the trustworthiness of others.
- Always scrutinise the actions of others for evidence of malevolent intentions.
- Rarely confide in or become close to others, fearing that anything they share may be used against them.
- Often bear grudges over long periods of time and are unwilling to forgive.
- Rarely in intimate relationships, but if they are, there is often a recurrent suspicion regarding the partner's fidelity.
- Preoccupation with unsubstantiated conspiratorial explanations of events.
- Combative sense of personal rights.

Cross-sectional formulation

Triggering event(s)	exposure to social situations
Appraisals/ Cognitions	paranoia, suspicion of others
Emotional responses	hypervigilance and rumination
Unhelpful behaviour employed	• activation of paranoid cognitive biases and behaviours • exacerbation of self-consciousness

Potential consequences of appraisals

Impeded ability for social interaction, lack of close relationships, social withdrawal or rejection which maintains negative cognitions.

Developmental factors

- Parental neglect and/or abuse.
- Exposure to violent adults in childhood.
- Experience of traumatic brain injury or chronic use of alcohol/cocaine.

Indicators/Diagnostic cluster for schizotypal personality disorder (StPD)

A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- Ideas of **reference**: experiencing innocuous events or mere coincidences and believing that they have strong personal significance.
- Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations).
- Unusual perceptual experiences, including bodily illusions.
- Odd thinking and speech (e.g., vague, circumstantial, metaphorical, over-elaborate, or stereotyped).
- Suspiciousness or paranoid ideation.
- Inappropriate or constricted affect.
- Behavior or appearance that is odd, eccentric, or peculiar.
- Lack of close friends or confidants other than first-degree relatives.
- Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self.

Developmental factors

- Development of schizotypal personalities associated with childhood neglect, hypersensitivity to criticism, passivity, and lack of engagement in early years, along with anxious-avoidant attachment styles.
- These attachment styles seem to predict both positive schizotypy (hallucinatory experiences and unusual beliefs) and negative schizotypy (withdrawal and anhedonia).

Indicators/Diagnostic cluster for schizoid personality disorder (SPD)

A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- Neither desires nor enjoys close relationships, including being part of a family.
- Almost always chooses solitary activities.

- Has little, if any, interest in having sexual or platonic experiences with another person.
- Takes pleasure in few, if any, activities.
- Lacks close friends or confidants other than first-degree relatives.
- Appears indifferent to the praise or criticism of others.
- Shows emotional coldness, detachment, or flattened affect.
- Excessive preoccupation with introspection, which is most often negative.
- Insensitivity to prevailing social norms and conventions.

Note: individuals with SPD are less likely to demonstrate odd/eccentric behaviour as compared to individuals with StPD, and do not experience emotional distress w.r.t. their lack of social interaction, but distressed by pressure from others to get involved.

Cross-sectional formulation

Triggering event(s)	interpersonal and social attempts resulting in frustration, distress, and shame
Appraisals/ Cognitions	perception of life as safer without communication with others
Emotional responses	• loneliness • emotional distress • shame about lack of social contacts and underdevelopment of interpersonal abilities
Unhelpful behaviour employed	• avoidance of social interaction → maintains schizoid patterns • lack of socio-emotional interaction → key interpersonal skills underdeveloped (e.g., recognition of subtle socio-emotional cues)

Potential consequences of appraisals

Long periods of self-isolation leading to loneliness and emotional distress/ deterioration in psychosocial functioning.

Recommended treatments

CBTpd	• the formation of a therapeutic alliance with the client from the very onset of treatment is crucial, since these individuals are less likely to be compliant, obedient, and grateful as other therapy clients • hence, the typical steps of CBTpd involve: 1. eliciting trust within therapy by exploring ambivalence, respecting the client's autonomy and emotional boundaries, and remaining entirely non-defensive (via Socratic dialogue and guided discovery) 2. exploring the impact and accuracy of unhelpful beliefs about others in key interpersonal and social contexts, and working collaboratively to develop alternative, more functional and balanced beliefs (via cognitive restructuring strategies) 3. experimenting with adaptive social behaviours and skills to support the development of new, functional beliefs, and reduce predominance of suspicion and/or mistrust (via behavioural experiments and graded behavioural exposure)
Cognitive techniques	• identify and evaluate clients' dysfunctional thoughts • uncover clients' core schema/beliefs • restructure, modify, and/or reinterpret core schema/beliefs • address clients' self-defeating behaviours
Behavioural techniques	• teaching of new adaptive skills • behavioural assignments set to promote skill rehearsal and generalization
Imagery	• help clients restructure past experiences

Cluster B

Indicators/Diagnostic cluster for borderline personality disorder (BPD)

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

- Frantic efforts to avoid real or imagined abandonment.
- A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.
- **Identity disturbance**: markedly, persistently unstable self-image and sense of self.
- Impulsivity in at least two areas that are potentially self damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating).
- Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
- **Affective instability** due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
- Chronic feelings of emptiness.
- Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).
- Transient, stress-related paranoid ideation or severe dissociative symptoms.

Cross-sectional formulation

Triggering event(s)	social interaction
Appraisals/ Cognitions	excessive reading/over-interpretation of social cues, leading to negative exaggerated appraisals (e.g., being ignored by others)
Emotional responses	unhappy, emptiness, anger
Unhelpful behaviour employed	• impulsivity: rapidly responding to environmental triggers without thinking about long-term consequences • erratic, self-destructive behaviours (e.g., suicide attempts, self-mutilation)

Potential consequences of appraisals

Impeded ability for social interaction, lack of close relationships, social withdrawal or rejection which reinforces negative cognitions.

Developmental factors

- Child maltreatment and other extreme early life experiences → higher risk of BPD.

Recommended treatments

Dialectical behaviour therapy (DBT)	• problem-focused treatment based on a clear hierarchy of goals, prioritizing decreasing suicidal and self-injurious behaviour and increasing coping skills • aims to encourage patients to accept their negative affect without engaging in self-destructive or other maladaptive behaviours • in a group setting, clients learn interpersonal effectiveness, emotion regulation, and distress tolerance skills • individual therapy and phone coaching is also utilized to help patients identify and change problematic behaviour patterns and apply newly learned skills
Transference-focused psychotherapy	• aims to strengthen the weak egos of clients, with a particular focus on their primary primitive defense mechanism of splitting (which typically leads them to all-or-none thinking) • aims to help clients see the shades of gray between extremes, and integrate positive and negative views of themselves and others into more nuanced views
Mentalization	• uses a therapeutic relationship to help clients develop the skills they need to accurately understand others' and their own feelings and emotions

Eating Disorders

Binge: out-of-control consumption of food, i.e., far greater than what most people would eat in the same amount of time under the same circumstances.
Purge: attempts to remove the food one has eaten from their bodies (e.g., through vomiting, usage of laxatives, or over-exercising).

Indicators/Diagnostic cluster for anorexia nervosa (AN)

- Restriction of energy intake relative to requirements, leading to a significant low body weight in the context of the age, sex, developmental trajectory, and physical health (less than minimally normal/expected).
- Intense fear of gaining weight or becoming fat or persistent behaviour that interferes with weight gain.
- Disturbed by one's body weight or shape, self-worth influenced by body weight or shape, or persistent lack of recognition of seriousness of low body weight.
  - Restricting type: during the last 3 months, has not regularly engaged in binge-eating or purging; instead, calorie intake is tightly controlled.
  - Binge-eating/purging type: during the last 3 months, has regularly engaged in binge-eating or purging.

Indicators/Diagnostic cluster for bulimia nervosa (BN)

- Recurrent episodes of binge eating, as characterized by both:
  - Eating, within any 2-hour period, an amount of food that is larger than what most individuals would eat in a similar period under similar circumstances.
  - A feeling that one cannot stop eating or control what or how much one is eating.
- Recurrent inappropriate compensatory behaviours in order to prevent weight gain such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting or excessive exercise.
- The binge eating and inappropriate compensatory behaviours occur, on average, at least once a week for 3 months.
- Self-evaluation is unjustifiably influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

Note: AN is characterized by a relentless pursuit of thinness, whereas BN characterized by uncontrollable binge eating and efforts to prevent resulting weight gain by using inappropriate behaviors. Additionally, individuals with AN are underweight, whereas being underweight is not a diagnostic criteria for BN.

Indicators/Diagnostic cluster for binge eating disorder (BED)

- Recurrent episodes of binge eating, which are characterised by both:
  - Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances.
  - The sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating.
- Binge-eating episodes are associated with three (or more) of the following:
  - Eating much more rapidly than normal.
  - Eating until feeling uncomfortably full.
  - Eating large amounts of food when not feeling physically hungry.
  - Eating alone because of being embarrassed by how much one is eating.
  - Feeling disgusted with oneself, depressed, or very guilty after overeating.
- Marked distress regarding binge eating is present.
- The binge eating occurs, on average, at least 1 day a week for 3 months.
- The binge eating is not associated with the regular use of inappropriate compensatory behaviour (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of anorexia nervosa or bulimia nervosa.

Cross-sectional formulation

Appraisals/ Cognitions	dissatisfied with one's physique
Emotional responses	distressed, unhappy
Physical health complications	AN • heart arrhythmia (irregular rhythm) • kidney damage • renal failure • irregular menstruation BN • electrolyte imbalances • hypokalemia (low potassium) • damage to heart, throat, and teeth
Unhelpful behaviour employed	binge-eating and/or purging

Potential consequences of appraisals

Poor physical health and medical problems, concerned family members, risk of death (due to malnutrition).

Developmental factors

- Male homosexuality increases the risk of eating disorders.
- Distorted self-perceptions about one's body (e.g., due to media, advertising, etc.).
- Desires to establish a sense of self-control, or having perfectionistic tendencies.
- Family dysfunction: e.g., more rigid, less cohesive, having poor communication.

Recommended treatments

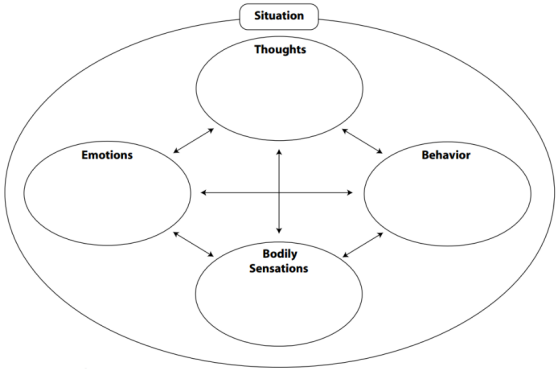
CBT	• aims to modify distorted beliefs concerning weight and food, and beliefs about the self • aims to normalize eating patterns via e.g.: – meal planning – nutritional education (esp. for clients with AN) – ending binging/purging cycles by teaching the client to eat small amounts of food more regularly • aims to change the cognitions and behaviours that initiate or perpetuate a binge cycle, e.g., by challenging dysfunctional thought patterns (e.g., dichotomous thinking) by: – providing factual information w.r.t. food – arranging for clients to demonstrate to themselves that ingesting "bad" food does not inevitably lead to a total loss of control over eating
Enhanced cognitive behavioural therapy (CBT-E)	• targets eating issues and concerns about shape and weight, extreme dieting, purging, and binge eating • may also address cognitions including perfectionism, low self-esteem, and relationship problems • highly individualised treatment involving 4 stages: 1. focuses on gaining a mutual understanding of the client's eating problem and helping them modify and stabilise their pattern of eating. There is also emphasis on personalised education and the addressing of concerns about weight. 2. progress is systematically reviewed and plans are made for the main body of treatment (stage 3) 3. weekly sessions focusing on the processes that are maintaining the client's eating problem, which typically involves the addressing of concerns about shape and eating, enhancing the ability to deal with day-to-day events and moods, and the addressing of extreme dietary restraints 4. focuses on dealing with setbacks and maintaining the changes that have been obtained
Interpersonal therapy (IPT)	• aims to improve interpersonal functioning by focusing on clients' current relationship issues • attempts to help clients understand and change maladaptive interaction patterns • particularly helpful for clients who have become "stuck" in their eating disorder for reasons associated with problematic relationships
Multidisciplinary team approach (MDT)	• bringing together the expertise and skills of different professionals (e.g., nutritionists, physicians, psychologists) to jointly assess, plan and manage care
Family therapy	• family meals are observed by the therapist, who attempts to guide parents in their child's recovery • subsequently, focus transitions to the addressing of family issues and the development of healthy relationships between the parents and their child
Medication	• used when one's physical health is at risk • especially helpful when used in combination with CBT-e/other psychological treatments

CBT Models

Sequential/ABC formulation

1. **Antecedent**: an external or internal experience/event.
2. **Belief** (about the antecedent): the individual's cognition, interpretation, or appraisal of the antecedent.
3. **Consequences** (of having the belief): the emotional, behavioural, physical, and information processing consequences as a result of having the belief.

Maintenance/Cross-sectional formulation



Longitudinal/Developmental formulation

1. **Early significant life experiences**: i.e., distal causes; e.g., rejecting parents, childhood bullying.
2. **Core beliefs**: about the self, others, and the world; e.g., "I am a waste of time", "People always abandon me", etc.
3. **Unhelpful assumptions and rules for living**: e.g., "I must always please others, or else they will reject me".
4. **Critical incident**: violation of unhelpful assumptions and rules for living; e.g., breaking up of a relationship.
5. (Unhelpful) **thoughts**, (negative) **emotions, physical reactions, & behaviour**.

Exam Tips

What to look out for:

- Indicators of psychological distress.
- General presentation (bio-psycho-social).
- Problematic events and situations.
- Unhelpful misinterpretations of such events.
- Emotional experiences.
- Physical disturbances (bodily sensations).
- Dysfunctional behaviour employed to cope (safety behaviour).
- Cultural aspects, such as specific upbringing and socialisation into unhelpful coping styles (as in developmental, longitudinal formulation).