

ANTISOCIAL

BEHAVIORAL DEFINITIONS

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

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LONG-TERM GOALS

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

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

SHORT-TERM OBJECTIVES

- 1. Express satisfaction with the therapeutic relationship as indicated by the verbalization of difficulties and concerns. (1, 2)
- 2. Establish specific treatment goals. (3, 4)
- 3. Establish a trusting relationship with the therapist, as demonstrated by freely sharing information. (1, 5, 6, 7)
- 4. Express anger in an appropriate fashion rather than with rage or violence when responding to a situation in which he/she feels wronged or belittled. (8, 9)
- 5. Express appropriate displeasure or anger toward a person who generates frustration rather than becoming enraged or vengeful. (10, 11, 12, 13)

THERAPEUTIC INTERVENTIONS

- 1. Express to the client who was referred for argumentative or aggressive behavior that therapist is interested in hearing the client's side of the story.
- 2. Under appropriate circumstances, engage in humorous interchange with the client, and appropriately compliment positive uses of humor (e.g., by stating, "That was a good one!" or something similar).
- 3. Assist the client in developing a list of specific dissatisfactions he/she is presently experiencing, such as difficulties with the law, inability to sustain an apartment or obtain sufficient income, and difficulty sustaining relationships.
- 4. Express the practical advantages of participating in

6. Verbalize acceptance to having limits set by therapist and/or significant others. (14, 15, 16)
 7. Verbalize disadvantages of unlawful behavior. (3, 17)
 8. Express appropriate displeasure or anger toward a person who generates disappointment rather than becoming enraged. (8, 9, 18)
 9. List difficulties in forming intimate attachments in prior relationships. (12, 19, 20)
 10. Express accurate empathy regarding the feelings of a significant other. (21)
 11. Describe disadvantages of exploitive behavior. (22)
 12. Describe instances in which acting on impulse has led to negative outcomes that were not worth it. (23)
 13. List the pros and cons of an action before making a decision rather than acting on impulse. (24)
 14. Express regret or sorrow about having hurt another person's feelings. (14, 25)
 15. Verbally acknowledge and express regret that his/her sexually exploitive behavior was hurtful to another person. (25, 26)
 16. Provide alternative positive or neutral explanations for others' behavior rather than assuming that they are motivated by envy or malice. (27, 28)
- the psychotherapeutic relationship, such as the opportunity to learn how to get his/her needs met more effectively in the context of the present system (e.g., hospital or prison) or in relationships.
5. Express thoughts in extremely straightforward language, eliminating all jargon and complexities that could be perceived as double-talk.
 6. If the client shares feelings, vulnerabilities, or admits mistakes, compliment him/her (e.g., "It took real strength to tell it like it is" or "Most people wouldn't have had the guts to admit that—that was impressive").
 7. When appropriate, comment on the client's facility with deception and lying, noting that he/she will be able to con the therapist at least some of the time. Process the pros and cons of being deceptive toward therapist. (See *Cognitive Therapy of Personality Disorders* by Beck and Freeman.)
 8. Discuss the impact of the demands of prison culture (i.e., the need to avoid showing vulnerability or weakness and/or the ability to respond to violence with violence) on the client's present behavior; explore how the current situation

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17. Verbalize beliefs that will encourage the maintenance of long-term relationships. (19, 29, 30)
18. Verbalize a warm or tender feeling for another person. (19, 31)
19. Cooperate with a referral to a physician to evaluate the need for psychotropic medication to reduce irritability and hyperreactivity. (32)
20. Take medications as prescribed and report on the medications' effectiveness and side effects. (33, 34)
21. Express readiness to attend group therapy. (35)
22. Verbalize the disadvantages of dishonesty. (24, 36)
23. Each member of the family describe how the client's deceitful or dishonest behavior impacts him/her. (37)
24. Each family member or partner identify and reduce interactions within the family that serve to perpetuate the client's manipulative/exploitive behavior. (38, 39)
25. Share personal information or a secret with a friend or significant other. (31, 40)
26. Identify history of conflict with those in authority. (41)
27. List changes necessary to improve cooperation with authority figures. (42)
28. Describe instances in childhood of emotional, verbal, and/or physical abuse. (12, 19, 43)
9. Instruct the client to imagine the person who angered him/her is in an empty chair in the room. Direct the client to express his/her feelings to the imagined person while continuing to increase the intensity of the reaction until anger is experienced and then released or relieved.
10. Assign the client to read *Of Course You're Angry* (Rosellini and Worden) or *Managing Anger* (Messer, Coronado-Bogdaniak, and Dillon) and process key ideas.
11. Institute stress inoculation training for anger by preparing the client to recognize early cues and mental precursors to anger, using behavioral rehearsal to establish appropriate responses, and establishing self-rewards for maintaining control. (See *Stress Reduction and Prevention* by Meichenbaum and Jaremko.)
12. Explore experiences of abuse in childhood and discuss forgiveness of perpetrators of pain as a process of letting go of anger.
13. Use rational emotive therapy to replace extreme beliefs (e.g., "That jerk was disrespecting me and I'm

- 29. Acknowledge failure to act responsibly toward offspring. (44, 45)
- 30. Attend work reliably and treat supervisor and coworkers with respect. (46, 47)

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- going to teach him a lesson”) with more balanced ones (e.g., “He is being disrespectful, but who cares, I’m going to follow my own agenda” or “He may have made a mistake”).
- 14. When the client uses denigrating behavior toward a family member during a family session, encourage the target person to set limits (e.g., “Answer back and get him to stop!”). Discontinue the intervention when some degree of success has been achieved, and verbally reward both participants.
- 15. Set boundaries on the therapy relationship (e.g., refuse to extend credit or delay payments, decline sexual advances, decline meeting on a social basis), and process them with the client.
- 16. To the degree possible, transfer limit-setting functions outside of therapy to another person (have someone other than the therapist determine privileges in a hospital or prison setting).
- 17. Ask the client if unlawful behaviors have been successful for him/her. Challenge rationalizations by pointing to present predicaments; emphasize how the strategy as a whole has been unsuccessful, thus facilitating openness to change.

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18. Train the client to use meditation (e.g., thought-watching exercise) by assigning *Full Catastrophe Living* (Kabat-Zinn) or *How to Meditate* (LeShan), processing key concepts with therapist; demonstrate technique during session and assign practice as homework.
19. Discuss the client's early relationship with parents, exploring themes of abandonment or abuse. Explore how these early experiences are impacting the ability to be close to others.
20. Validate the client's concerns regarding intimate relationships and express unconditional positive regard (i.e., that the feelings are understandable from the client's perspective).
21. Hold a family therapy session and encourage the client to persist in rewording and reflecting back the communication of the family member, spouse, or partner, until he/she agrees that the communication is accurate.
22. Assist the client to make a list of pros and cons of behaviors that exploit others (e.g., inflating someone's expectations regarding commitment in a relationship in order to obtain sex, borrowing money without repaying it), assessing

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long-term versus short-term consequences.

23. Assist the client to make a list of instances in which acting on impulse had negative results.
24. Instruct the client to evaluate choices using the “Choice Review” exercise: Have the client list a problem, come up with a range of possible solutions, and then select from among those choices based on what is most consistent with his/her goals. (See *Cognitive Therapy of Personality Disorders* by Beck and Freeman.)
25. During an individual, group, or psychodrama session, use role-reversal technique to demonstrate to the client the impact of sexual exploitation (e.g., demanding sex from a subordinate, misleading someone to obtain sexual gratification). Continue the intervention until the client achieves emotional identification with the victim.
26. Explore the meaning of repetition-compulsion with the client, connecting present sexually exploitive behavior with wounds from the past.
27. Explore the client’s projections about others, including the therapist (if applicable). Identify how the client’s negative assumptions relate to interac-

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- tions from others in the client's past (e.g., early interactions with parents).
28. Brainstorm with the client about alternative positive or neutral explanations for others' behavior. Encourage the client to identify evidence for and against each belief, thereby assessing their likelihood.
 29. Explore the client's beliefs regarding intimate relationships (e.g., that you can't trust anyone, that everyone is out for themselves). Challenge the ideas using rational emotive techniques, replacing unrealistic ideas with more flexible and realistic ones (e.g., most people can be trusted to some degree; everyone has faults; some people can sincerely help others, at least some of the time).
 30. Explore the client's fantasies regarding intimate relationships (e.g., that others are planning to exploit him/her). Explore the relationship of these fantasies to early childhood relationships and/or the relationship with the therapist. Suggest more realistic, positive beliefs about others.
 31. Point out that the pattern of emotional detachment in relationships and self-focused behavior is related to a dysfunctional attempt

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to protect self from pain.
Encourage expressing vulnerable feelings of caring for another person.

32. Refer the client to a physician for a medication evaluation. Help the client to process costs and benefits of a psychiatric evaluation.
33. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects.
34. Confer with physician about the effectiveness of the medications on a regular basis.
35. Instruct the client about the way therapy groups operate and how this may feel unfair to him/her (e.g., that all group members must be given an opportunity to speak, that everyone's problems are considered equally important, that excessive aggression toward other group members will not be tolerated, and that his/her regular attendance is critical to the group). Process these themes with the client and determine the client's readiness to participate in group therapy.
36. Help the client develop a list of the (long-term) disadvantages of lying, contrasting it with the possible (short-term) benefits. Process the value of a long-term versus short-term perspective.

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37. Hold a family therapy session to encourage family members to convey instances in which they felt manipulated or lied to (e.g., when the client lied about substance abuse or infidelity), and discuss the impact of this deceit.
38. Assist family members in identifying behaviors that reinforce the client's manipulative/exploitive behaviors (e.g., efforts to obtain prescription medication from family members, borrowing money with no intention to pay back). Write a behavioral contract that will allow each participant to get his/her needs met more directly (e.g., praise given in response to assertive behavior rather than manipulations).
39. Using the positive connotation paradoxical technique, describe the function of the client's maladaptive behavior in the most positive terms (e.g., the client's manipulative behaviors may help family members feel entertained and excited or may help the family stay closely connected to one another due to the many crises). This will challenge the family to find a new way to meet their needs without supporting the antisocial behavior. See *The Work of Mara Selvini Palazzoli* (Selvini).

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40. Process the client's fear of becoming intimate with another person, exploring themes such as his/her fear that once he/she is known by the other person, exploitation and betrayal will follow. Assign the task of sharing personal information with someone he/she could trust.
41. Explore the client's history of conflict with authority; relate this to early experiences of pain, rage, and disappointment with parents/caretakers.
42. Ask the client to make a list of behaviors and attitudes that must be modified in order to decrease his/her conflict with authorities. Process the list with the client.
43. Explore the client's history of abuse and neglect. Relate these experiences to current feelings of anger, distrust, and self-centeredness.
44. Confront the client's avoidance of responsibilities toward his/her children.
45. Ask the client to list three actions that he/she could take that would demonstrate responsibility toward his/her offspring (writing a letter to them, sending money for their support, attending work faithfully to increase income for their support, attending a child's school function, etc.).

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- 46. Review the history of and causes for the client's employment instability. Confront his/her minimization and projection of responsibility for problems.
- 47. Assist the client in listing changes necessary to improve employment behavior. Assign implementation of these changes through consistent work attendance.

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DIAGNOSTIC SUGGESTIONS

- Axis I:**
- 304.80 Polysubstance Dependence
 - 312.34 Intermittent Explosive Disorder
 - 314.xx Attention Deficit/Hyperactivity Disorder
 - 300.xx Factitious Disorder
 - V65.2 Malingering
 - 296.xx Major Depressive Disorder
 - 300.81 Somatization Disorder
 - 312.31 Pathological Gambling

- Axis II:**
- 301.7 Antisocial Personality Disorder
 - 301.83 Borderline Personality Disorder
 - 301.50 Histrionic Personality Disorder
 - 301.81 Narcissistic Personality Disorder
 - 301.9 Personality Disorder NOS

ANTISOCIAL—MALEVOLENT

BEHAVIORAL DEFINITIONS

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

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LONG-TERM GOALS

1. Reduce hostile, aggressive, belligerent behavior, including both verbal and physical abuse.
2. Maintain lawful and/or responsible behavior.
3. Improve ability to tolerate authority relationships appropriately.
4. Increase capacity to delay gratification in order to achieve long-term objectives.

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- 5. Improve capacity to see how own behaviors are harmful to others.
- 6. Establish at least one relationship that involves, at minimum, a modest degree of trust.

SHORT-TERM OBJECTIVES

- 1. Express satisfaction with therapeutic relationship as indicated by the verbalization of difficulties and concerns. (1, 2)
- 2. Establish specific treatment goals. (1, 3, 4, 5)
- 3. Establish a trusting relationship with the therapist. (6, 7, 8)
- 4. Express anger in an appropriate fashion rather than with rage or violence when responding to feeling wronged or belittled. (9, 10, 11, 12, 42)
- 5. Express appropriate displeasure or anger toward a person who generates frustration rather than becoming enraged or vengeful. (13, 14, 42)
- 6. Verbalize acceptance of having limits set by the therapist and/or significant others. (15, 16, 17)

THERAPEUTIC INTERVENTIONS

- 1. Establish goals based on the client's perceived needs, and closely tie discussions to the client's goals.
- 2. Express to the client that the therapist is interested in hearing his/her side of the story that explains his/her argumentative or aggressive behavior.
- 3. Assist the client in developing a list of specific dissatisfactions he/she is presently experiencing (e.g., legal conflicts, inability to sustain an apartment or obtain sufficient income, and difficulty sustaining relationships).
- 4. Express the practical advantages of participating in the psychotherapeutic relationship, such as the opportunity to learn how to get his/her needs met more effectively in the context of the present system (e.g., hospital or prison) or in relationships.

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7. Verbalize the disadvantages of unlawful behavior. (18)
8. Verbalize that demeaning statements and verbal abuse are harmful to desired relationships. (19)
9. Express appropriate displeasure or anger toward a person who generated disappointment or is critical rather than becoming enraged. (20)
10. List difficulties in forming intimate attachments in prior relationships. (21, 22)
11. Describe the disadvantages of exploitive behavior. (23)
12. Describe instances in which acting on impulse has led to negative outcomes that were not worth it. (24)
13. List the pros and cons of an action before making a decision rather than acting on impulse. (25)
14. Acknowledge having hurt another person's feelings or having caused undeserved harm. (26, 27, 28, 33)
15. Express regret or sorrow about having hurt another person's feelings or having caused undeserved harm. (27, 29, 30, 31, 33)
16. Verbally acknowledge and express regret that his/her sexually exploitive behavior was hurtful to another person. (32, 33)
17. Provide alternative positive or neutral explanations for others' behavior rather than
5. Express that since legal circumstances may have brought the client and therapist together, "We may as well make the best of it."
6. Avoid appearing weak or soft in the eyes of the client by refraining from asking the client directly about his/her feelings and emotions early in the treatment.
7. Enter into the client's worldview by expressing that respect in the therapeutic relationship must be earned.
8. Express thoughts in extremely straightforward language, eliminating all jargon and complexities that could be perceived as double-talk.
9. Discuss the history of consequences the client has had with violent encounters; process whether the consequences are consistent with his/her goals at this time.
10. Ask the client to list ways in which anger has negatively impacted his/her life. Process the list with him/her.
11. Assign readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons or *When I Say No I Feel Guilty* by Smith) to the client; discuss the key points. Emphasize how assertiveness, not aggressiveness, is a tool to in-

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- assuming that they are motivated by envy or malice. (34, 35, 44)
18. Verbalize beliefs that will encourage the maintenance of long-term relationships (36)
 19. Express beliefs about relationships in shades of gray rather than in all-or-none terms. (36, 37)
 20. Report an instance of being honest and self-disclosing in at least one relationship. (36, 37, 38)
 21. Cooperate with a referral to a physician to evaluate the need for psychotropic medication to reduce irritability and hyperreactivity. (39)
 22. Take medications as prescribed and report on effectiveness and side effects. (40, 41)
 23. Verbalize how being a victim of emotional, verbal, and/or physical abuse affects current relationships and attitudes. (30, 31, 42, 43, 44)
 24. Identify history of conflict with those in authority. (45)
 25. List changes necessary to improve cooperation with authority figures. (46)
 26. Acknowledge failure to act responsibly toward offspring. (47, 48)
 27. Attend work reliably and treat supervisor and coworkers with respect. (44, 49, 50)
- crease compliance with requests and get needs met over long periods of time.
12. Use role play, modeling, and behavioral rehearsal with the client to simulate situations that demand assertiveness; provide feedback regarding the appropriateness of his/her responses.
 13. Institute stress inoculation training for anger by preparing the client to recognize early cues and mental precursors to anger, using behavioral rehearsal to establish appropriate responses and establishing self-rewards for maintaining control. (See *Stress Reduction and Prevention* by Meichenbaum and Jaremko.)
 14. Use rational emotive therapy to replace extreme beliefs (e.g., "That jerk was disrespecting me and I'm going to teach him a lesson") with more balanced ones (e.g., "He is being disrespectful, but who cares, I'm going to follow my own agenda" or "He may have made a mistake").
 15. Process feelings toward the client (e.g., anger or being manipulated) with colleague, supervisor, or team members to facilitate perspective and enhance the ability to maintain therapeutic alliance.

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16. Set boundaries on the therapy relationship (e.g., refuse to extend credit or delay payments, decline sexual advances, decline meeting informally outside of therapy sessions), and process them with the client.
17. Instruct the client regarding the requirements of therapy (regularly attending sessions, participating in discussions, etc.), and discuss consequences of violations.
18. Ask the client if unlawful behaviors have been successful for him/her. Challenge rationalizations by pointing to present predicaments; emphasize how the strategy as a whole has been unsuccessful, thus facilitating openness to change.
19. Review the client's pattern of verbal abuse and confront rationalizations that the verbal abuse was deserved and that there was no other option; label verbal abuse as such and initiate a zero-tolerance policy within therapy sessions, at an inpatient unit, and/or within the client's family.
20. Use role play and behavioral rehearsal to shape nonaggressive responses to criticism.
21. Assist the client in developing a list of his/her prob-

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lems in intimate relationships (e.g., inability to be close to someone, perceived as being hostile and abusive).

22. Discuss the client's early relationship with parents, exploring themes of abandonment or abuse. Explore how these early experiences are impacting his/her ability to be close to others.
23. Assist the client in making a list of pros and cons of behaviors that exploit others (e.g., inflating someone's expectations regarding commitment in a relationship in order to obtain sex, borrowing money without repaying it), assessing long-term versus short-term consequences.
24. Assist the client in making a list of instances in which acting on impulse had negative results.
25. Instruct the client to evaluate choices using the "Choice Review" exercise: Have the client list a problem, come up with a range of possible solutions, and then select from among those choices based on what is most consistent with his/her goals. (See *Cognitive Therapy of Personality Disorders* by Beck and Freeman.)
26. Instruct the client to imagine the person whose feel-

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ings he/she hurt is in an empty chair in the room; direct the client to express his/her feelings to the imagined person while continuing to increase the intensity of the reaction until an intense emotional response is achieved.

27. In a psychodrama, group, or individual session, with the therapist (or a group member) playing the client, ask the client to play the person who was hurt or exploited (role reversal). Continue the intervention until the client achieves emotional identification with the victim.
28. Challenge the client's rationalizations about hurting others (e.g., the belief that hitting someone didn't really hurt them or that words cannot harm anyone), replacing irrational beliefs with more balanced ones (e.g., hitting someone virtually always produces harm; most people get angry or sad in response to others' mean words).
29. Confront the client's calloused indifference to having caused pain to another person; attempt to generate a sense of regret or guilt.
30. Point out the client's pattern of indifference toward abuse of others as it relates to his/her having been abused as a child by an indifferent parent or care-

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- taker. Emphasize the need to break the indifferent cycle of violence.
31. Confront the client's detachment from tender feelings (e.g., caring, empathy, sadness, compassion, guilt) as a protection from own pain endured in childhood. Emphasize the need to break the pattern of detachment.
 32. Explore early family relationships in order to understand origins of sexually exploitive behavior (e.g., role models within the family, including extended family, or history of own victimization).
 33. Explore the meaning of repetition-compulsion with the client, connecting present sexually exploitive behavior (e.g., using physical intimidation to demand sex, or misleading someone to obtain sexual gratification) with wounds from the past.
 34. Explore the client's negative projections about others' motives, including the therapist (if applicable). Identify how the client's negative assumptions relate to interactions from others in the client's past (e.g., early interactions with parents).
 35. Brainstorm with the client about alternative positive or neutral explanations for others' behavior. Encourage the client to identify evidence for and against each

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belief, thereby assessing their likelihood.

36. Explore the client's beliefs regarding intimate relationships (e.g., that you can't trust anyone, that everyone will take advantage of you if they can). Challenge the ideas using rational emotive techniques, replacing unrealistic ideas with more flexible and realistic ones (e.g., most people can be trusted to some degree; everyone has faults; some people can sincerely help others, at least some of the time).
37. Use Socratic dialogue to challenge the client's belief that trust is an all-or-none concept. Replace extreme thoughts ("No one can be trusted") with more balanced ones ("Most people can be trusted to some degree, and some people can be trusted to a high degree").
38. Assist the client in identifying at least one of his/her relationships that merits trust. Assign him/her the task of expressing appreciation and trust to that person.
39. Refer the client to a physician for a medication evaluation. Help the client process the costs and benefits of a psychiatric evaluation.
40. Monitor the client's use of medications for compliance

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- with prescription, effectiveness, and side effects.
41. Confer with physician about the effectiveness of the medications on a regular basis.
 42. Explore the client's history of abuse and neglect; relate these experiences to current feelings of anger, distrust, and self-centeredness.
 43. Process with client how abuse from others leads to abusive behavior. Discuss the pain caused to everyone by this cycle. Suggest methods for breaking the cycle.
 44. Encourage the client to describe experiences in prison and the rules of prison culture (e.g., how a sign of weakness can lead to physical or mental brutalization). Challenge the client to experiment with different kinds of relationships outside of prison settings, providing training on how to recognize trustworthiness in others.
 45. Explore the client's history of conflict with authority; relate this to early experiences of pain, rage, and disappointment with parents/caretakers.
 46. Ask the client to make a list of behaviors and attitudes that must be modified in order to decrease his/her conflict with authorities. Process the list with the client.

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- 47. Confront the client's avoidance of responsibilities toward his/her children.
- 48. Ask the client to list three actions that he/she could take that would demonstrate responsibility toward his/her offspring (writing a letter to them, sending money for their support, attending work faithfully to increase income for their support, attending a child's school function, etc.).
- 49. Review the history of and causes for the client's employment instability; confront minimization and projection of responsibility for problems.
- 50. Assist the client in listing changes necessary to improve his/her employment behavior. Assign implementation of these changes through consistent work attendance.

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DIAGNOSTIC SUGGESTIONS

Axis I: 312.34 Intermittent Explosive Disorder
304.80 Polysubstance Dependence
300.xx Factitious Disorder

Axis II: 301.7 Antisocial Personality Disorder
301.0 Paranoid Personality Disorder
301.9 Personality Disorder NOS

ANTISOCIAL—REPUTATION DEFENDING

BEHAVIORAL DEFINITIONS

1. Expresses need to be thought of as unflawed.
2. Presents an image of being tough, indomitable, and formidable.
3. Becomes angry and defensive when status is questioned.
4. Is highly overreactive to slights.
5. Is irritable and aggressive.
6. Is extremely concerned with or obsessed with enhancing or defending his/her own or his/her family's reputation.
7. Consistently presses to be in the dominant position in relationships and/or work settings.
8. Lacks remorse, as shown by indifference to (or rationalizing of) the harm he/she has caused.

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LONG-TERM GOALS

1. Reduce the need to be dominant in all circumstances.
2. Increase flexibility and acceptance of a variety of roles, including equal and subordinate relationships.
3. Soften tough, indomitable image.
4. Reduce defensiveness regarding slights.
5. Decrease aggressiveness and irritability.
6. Increase acceptance of own flaws.

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SHORT-TERM OBJECTIVES

1. Express satisfaction with therapeutic relationship as indicated by the verbalization of difficulties and concerns. (1, 2)
2. Establish specific treatment goals. (1, 3)
3. Establish a trusting relationship with the therapist. (4, 5, 6, 7)
4. Express anger in an appropriate fashion rather than with rage or violence when responding to feeling wronged or belittled. (8, 9, 10, 11)
5. Express appropriate displeasure or anger toward a person who generates frustration rather than becoming enraged or vengeful. (12, 13, 14)
6. Verbalize the disadvantages of constantly maintaining a tough, intimidating appearance. (15)
7. Report on an instance of reducing tough, intimidating stance with at least one person. (15, 16, 17)

THERAPEUTIC INTERVENTIONS

1. Establish goals based on the client's perceived needs, and closely tie discussions to the client's goals.
2. Avoid power struggles with the client by validating that he/she is the expert on his/her perception of his/her situation.
3. Assist the client in developing a list of specific dissatisfactions he/she is presently experiencing (e.g., difficulties obtaining sufficient respect, conflicts with the law, relationship conflicts).
4. Avoid appearing weak or soft in the eyes of the client by refraining from asking the client directly about his/her feelings and emotions early in the treatment.
5. Enter into the client's worldview by expressing that respect in the therapeutic relationship must be earned.
6. If the client shares feelings, vulnerabilities, or admits

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8. Describe vulnerability in shades of gray rather than as an all-or-none concept. (18, 19)
 9. Verbalize compliance with having limits set by therapist and/or significant others. (20, 21)
 10. Verbalize that demeaning statements and verbal abuse are harmful to desired relationships. (22)
 11. Express appropriate displeasure or anger toward a person who challenges his/her status, rather than becoming enraged. (23, 24)
 12. Respond to a criticism with acceptance (learning something new) or polite disagreement rather than rage or dismissiveness. (24, 25)
 13. Express an accurate understanding of the communication of a significant other. (26)
 14. List the pros and cons of an action before making a decision rather than acting on impulse. (27)
 15. Express regret or sorrow about having hurt another person physically or emotionally. (14, 22, 28, 29, 30)
 16. Provide alternative positive or neutral explanations for others' behavior rather than assuming that they are motivated by desires to undermine him/her or ruin his/her reputation. (31, 32)
7. Convey to the client that the purpose of the meetings with the therapist is to evaluate situations that are interfering with the client's independence and success in getting what he/she wants and to find solutions.
 8. Discuss the client's history of consequences resulting from violent encounters; process whether the consequences are consistent with his/her goals at this time.
 9. Ask the client to list ways in which anger has negatively impacted his/her life; process the list with him/her.
 10. Assign readings on assertiveness training (e.g., *Your Perfect Right* by Alberti and Emmons or *When I Say No I Feel Guilty* by Smith) to the client; discuss the key points. Emphasize how assertiveness, not aggressiveness, is a tool to increase compliance with requests and get needs met over long periods of time.
 11. Use role play, modeling, and behavioral rehearsal with the client to simulate situations that demand assertiveness; provide mistakes, compliment him/her with phrases such as "It took real strength to tell it like it is" or "Most people wouldn't have had the guts to admit that—that was impressive."

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17. Verbalize beliefs that will improve the quality of long-term relationships. (33, 34)
 18. Cooperate with a referral to a physician to evaluate the need for psychotropic medication to reduce irritability and hyperreactivity. (35)
 19. Take medications as prescribed and report on effectiveness and side effects. (36, 37)
 20. Each family member/partner identify and reduce interactions within the family that serve to perpetuate the client's domineering behavior. (38)
 21. Describe instances of childhood emotional, verbal, and/or physical abuse. (39, 40)
 22. Acknowledge having a flaw without experiencing excessive distress. (41)
 23. Report an instance of having tolerated a perceived slight to his/her reputation calmly. (24, 32, 34)
 24. Express satisfaction with a relationship in which he/she is equal to or subordinate to the other person. (43)
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12. Assign the client to read *Of Course You're Angry* (Rosellini and Worden) or *Managing Anger* (Messer, Coronado-Bogdaniak, and Dillon). Process the key ideas.
 13. Use rational emotive therapy to replace the client's extreme beliefs (e.g., "That jerk was disrespecting me and I'm going to teach him a lesson") with more balanced ones (e.g., "He is being disrespectful, but who cares, I'm going to follow my own agenda" or "He may have made a mistake").
 14. Instruct the client to imagine the person who angered him/her is in an empty chair in the room. Direct the client to express his/her feelings to the imagined person while continuing to increase the intensity of the reaction until a powerful emotional response is achieved.
 15. Brainstorm with the client about advantages and disadvantages of constantly maintaining a tough, intimidating appearance (e.g., having others express respect versus courting backlash from others, having difficulty becoming close to anyone). Role-play alternative, sensitive modes of responding.

ANTISOCIAL—REPUTATION DEFENDING 39

16. Provide skills training for building trust in others (e.g., trusting someone with something relatively trivial and slowly trusting the person with more and more sensitive information).
17. Encourage the client to experiment with trusting another person enough to share his/her feelings of vulnerability, beginning with the therapist or a significant other.
18. Brainstorm with the client regarding situations and experiences that reflect partial vulnerability (e.g., taking a small risk that someone could take advantage of a kindness as opposed to revealing a deeply personal secret).
19. Use Socratic dialogue to challenge the client's belief that trust is an all-or-none concept. Replace extreme thoughts ("No one can be trusted") with more balanced ones ("Most people can be trusted to some degree, and some people can be trusted to a high degree").
20. When the client uses domineering behavior toward a family member during a family session, encourage the target person to set limits (e.g., "Answer back and get him to stop!"). Discontinue the intervention when

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some degree of success has been achieved, and verbally reward both participants.

21. Instruct the client regarding the requirements of therapy (regularly attending sessions, participating in discussions, etc.), and discuss consequences of violations.
22. In a psychodrama, group, or individual session, with the therapist (or a group member) playing the client, ask the client to play the person who was hurt or exploited (role reversal). Continue the intervention until the client achieves emotional identification with the victim.
23. Institute stress inoculation training for anger by preparing the client to recognize early cues and mental precursors of anger, using behavioral rehearsal to establish appropriate responses and establishing self-rewards for maintaining control. (See *Stress Reduction and Prevention* by Meichenbaum and Jaremko.)
24. Train the client to use meditation (e.g., thought-watching exercise) by assigning *Full Catastrophe Living* (Kabat-Zinn) or *How to Meditate* (LeShan), processing key concepts with therapist; demonstrate technique during session and assign practice as homework.

ANTISOCIAL—REPUTATION DEFENDING 41

25. Brainstorm with the client about the benefits of feedback and criticism from others. Use modeling and role play to teach acceptance of feedback.
26. Hold a family session and encourage the client to persist in rewording and reflecting back the communication of the family members, spouse, or partner until he/she agrees that the communication is accurate.
27. Instruct the client to evaluate choices using the “Choice Review” exercise: Have the client list a problem, come up with a range of possible solutions, and then select from among those choices based on what is most consistent with his/her goals. (See *Cognitive Therapy of Personality Disorders* by Beck and Freeman.)
28. Confront the client’s calloused indifference to having caused pain to another person. Attempt to generate a sense of regret or guilt.
29. Point out the client’s pattern of indifference toward abuse of others as it relates to his/her having been abused as a child by an indifferent parent or caretaker. Emphasize the need break the indifferent cycle of violence.
30. Confront the client’s detachment from tender feelings

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(e.g., caring, empathy, sadness, compassion, guilt) as a protection from own pain endured in childhood. Emphasize the need to break the pattern of detachment.

31. Explore the client's negative projections about others' motives (e.g., when others are unsupportive of the client's idea or plan), including the therapist (if applicable). Identify how the client's negative assumptions relate to interactions from others in the client's past (e.g., early interactions with parents).
32. Brainstorm with the client about alternative positive or neutral explanations (other than malice) for others' behavior. Encourage the client to identify evidence for and against each belief, thereby assessing their likelihood.
33. Explore the client's beliefs regarding intimate relationships (e.g., that you can't trust anyone, that everyone is out for themselves). Challenge the ideas using rational emotive techniques, replacing unrealistic ideas with more flexible and realistic ones (e.g., most people can be trusted to some degree; everyone has faults; some people can sincerely help others, at least some of the time).

ANTISOCIAL—REPUTATION DEFENDING 43

34. Challenge the client's rationalizations (e.g., the belief that hitting someone didn't really hurt them or that words cannot harm anyone), replacing irrational beliefs with more balanced ones (e.g., hitting someone virtually always produces harm; some people get angry or sad in response to others' words).
35. Refer the client to a physician for a medication evaluation. Help him/her to process costs and benefits of a psychiatric evaluation.
36. Monitor the client's use of medications for compliance with prescription, effectiveness, and side effects.
37. Confer with physician about the effectiveness of the medications on a regular basis.
38. Assist family members in identifying behaviors that reinforce the client's domineering behaviors (e.g., verbal or physical harshness). Write a behavioral contract that will allow each participant to get his/her needs met more directly (e.g., praise given in response to assertive behavior rather than domination).
39. Explore the client's history of abuse, neglect, or abandonment in childhood; process the impact that has on current relationships.

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- 40. Explore the meaning of repetition-compulsion with the client, connecting present behavior with wounds from the past.
- 41. Use rational emotive techniques to challenge the client's thoughts such as "I am flawless." Replace with thoughts such as "I am a fallible human being" and "Nobody is perfect."
- 42. Use Socratic dialogue to challenge the client's belief that the other person's statement was an intentional attack on his/her honor. Consider alternative beliefs such as "Perhaps the person was mistaken" or "There may be a different explanation for that statement."
- 43. Use rational emotive or cognitive techniques to explore and challenge the client's beliefs about being in control of and superior to others. Replace extreme thoughts (e.g., "I must be dominant to the other person") with more rational thoughts ("It is okay to be equal to another person"; "If you can't beat 'em, join 'em").

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DIAGNOSTIC SUGGESTIONS

Axis I:	312.34	Intermittent Explosive Disorder
	296.xx	Major Depressive Disorder
	300.81	Somatization Disorder
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

AVOIDANT

BEHAVIORAL DEFINITIONS

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

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LONG-TERM GOALS

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

SHORT-TERM OBJECTIVES

1. Express comfort with the therapeutic relationship, either verbally or nonverbally, and openly share concerns and difficulties with socialization. (1, 2)
2. Report having an enjoyable conversation with someone. (3, 4)
3. Initiate an enjoyable activity that can be accomplished only with another person (e.g., playing tennis, going on a date). (3, 4, 5, 6)
4. Demonstrate accurate perception of others' thoughts and feelings. (7, 8, 9, 54)
5. Identify cognitions that reduce the likelihood of social interactions. (9, 10, 11, 12)
6. Report an increase in the frequency of thoughts that will increase interpersonal contact and pleasurable activities, and report a decrease in the frequency of negative/interfering thoughts. (13, 14)

THERAPEUTIC INTERVENTIONS

1. Express empathy for client's difficulties (e.g., feeling fearful, rejected, and humiliated) through reflective listening and unconditional positive regard.
2. Examine both functional and dysfunctional aspects of isolation (e.g., feeling safer at home, but feeling lonely). Assess balance between productive and unproductive time alone and amount of time alone.
3. Train client in relationship skills, including suggestions for appropriate of topics that the client could discuss with others, appropriate degree and timing of self-disclosure, and improved nonverbal behavior. (See *A Couple's Guide to Communication* by Gottman, Notarius, Gonso, and Markman and/or *Social Skills Training for Psychiatric Patients* by Liberman, DeRisi, and Mueser.)

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7. Describe feelings of rejection in current and/or past relationships. (9, 15, 16, 17)
8. Verbalize situations in which feelings of humiliation or shame were experienced during childhood. (1, 18)
9. Describe an experience as neutral, tolerable, or humorous that was previously considered humiliating. (19)
10. Implement relaxation techniques to counteract anxiety during gradual exposure to social situations. (20, 21, 22, 23)
11. Engage in a social activity (e.g., going to an office party or meeting someone for lunch) that was previously avoided due to excessive anxiety. (12, 21, 23, 24)
12. Describe feelings of shyness/social anxiety and previous attempts to overcome fears of interacting with others. (17, 24)
13. Learn to tolerate feelings of anxiety while continuing to function. (20, 23, 24, 26)
14. Identify negative automatic thoughts about himself/herself that produce low self-esteem. (10, 11, 25, 27)
15. Reduce the frequency of thoughts that lower self-esteem. (13, 27, 28)
16. Describe feeling more confident and comfortable with self rather than feeling like a failure. (13, 27, 29, 30)
4. Use role play, modeling, and behavioral rehearsal to teach the client how to use relevant social skills to effectively interact with another person.
5. Brainstorm regarding enjoyable new activities and social interactions that the client might engage in.
6. Assign the client to initiate an invitation to someone to join him/her in social/recreational activity.
7. Teach the client about how projection influences our perceptions of others.
8. Express accurate empathy toward client whenever he/she expresses emotions, allowing him/her to learn by example.
9. Examine evidence for and against common distorted perceptions that the client discloses about others (e.g., "She thinks I'm defective" or "He doesn't like me").
10. Assist the client in identifying the negative, distorted cognitions or beliefs about self or others that inhibit socialization.
11. Assign the client to keep a daily record of dysfunctional beliefs (e.g., believing that he/she is defective and unlikable) that inhibit socialization.
12. Reflect back the client's words and thoughts about participating in more social

17. Each member of the family describe how the client's avoidant behavior impacts him/her. (31, 32)
18. Verbalize an awareness of the origins of own risk avoidance. (33)
19. Verbalize why the risk of rejection is such a great fear. (18, 24, 34)
20. Express disagreement with a significant other about an interpersonal issue of importance to both. (35)
21. Share personal information, a secret, or something potentially embarrassing with a trusted person. (34, 36, 37)
22. Ask for something from another person, thereby risking being turned down. (38)
23. Partner and client identify how conflict avoidance has contributed to distance in the relationship. (37, 39, 40)
24. Assert preferences in sexual activity with partner. (41, 42, 43)
25. Set limits on children who intrude on private time between parents. (44, 45)
26. Cooperate with a referral to a physician to evaluate the need for psychotropic medication to improve mood and decrease anxiety. (46)
27. Take the psychotropic medication as prescribed and report on the medication's effectiveness and side effects. (47, 48)
13. Address dysfunctional beliefs (e.g., "I'm unlikable" and "People will reject me") by probing with questions. Assist the client in defining more realistic, positive beliefs. (See *Cognitive Therapy of Personality Disorders* by Beck and Freeman.)
14. Examine thoughts that interfere with social and enjoyable contacts (e.g., "No one will like me anyway"). Challenge these thoughts using rational emotive techniques.
15. Explore assumptions the client makes regarding the therapist's feelings about him/her; compare them to interactions in significant relationships in the past (e.g., early childhood rejection).
16. In a family therapy session, explore with significant others the themes of rejection and distancing, encouraging each family member to examine his/her own contribution to the distancing that occurs and how their overinvolvement with one another prevents healthy outside relationships.
17. Explore the client's feelings of rejection, accepting the client's feeling without judg-
activities, providing unconditional positive regard. Allow the client to explore the meaning of these potential activities.

uations unaccompanied by the therapist. Have the client use relaxation skills in each situation.

24. Assign the book *Shyness: What It Is and What to Do About It* (Zimbardo) and discuss its major concepts.
25. Train the client to use meditation (e.g., thought-watching exercise) by assigning *Full Catastrophe Living* (Kabat-Zinn) or *How to Meditate* (LeShan), processing key concepts with therapist; demonstrate technique during session and assign practice as homework.
26. Teach the client to decrease hypersensitivity to bodily stimuli (e.g., anxiety symptoms such as increased heart rate) through an assigned exercise (e.g., having the client lie in a quiet room and pay attention to psychokinesthetic stimuli). See “Body Scan” exercise in *Full Catastrophe Living* by Kabat-Zinn.
27. Assign *The Six Pillars of Self-Esteem* (Brandon), *Self-Esteem* (McKay and Fanning), or *Ten Days to Self-Esteem* (Burns) and process central ideas with therapist.
28. Use thought-stopping technique (having the client shout “Stop” silently whenever negative thoughts come to mind) until the thought dissipates.

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29. Encourage client to find a creative outlet for the expression of emotion (e.g., playing music or writing poetry).
30. Have client keep a journal of feelings on a daily basis. Require that at least one positive emotion, self-descriptive statement, accomplishment, or event be recorded per day.
31. Explore family interactions that support avoidant behavior (e.g., the client feeling nurtured by understanding family members, family members feeling strong or helpful by supporting the client in their avoidant behavior).
32. Use positive connotation (paradoxical) technique to describe the function of the client's avoidant behavior in the most positive terms (e.g., the client not wanting to go out helps the family to stay close to one another and avoid the dangers of the outside world), thereby challenging the family members to find new ways to meet their needs without supporting the client's avoidant behavior.
33. Explore family patterns related to taking risks in relationships. Find out who else in the family may also be shy or risk-averse. Discover how that person may have influenced the client, directly or indirectly, and

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evaluate whether that influence is currently felt by the client.

34. Validate fear the client has about taking the risk to be intimate with another person and to risk rejection, accepting the client's feelings without judgment and allowing the meaning of the fear to become clear to the client.
35. During a family therapy session, instruct the client to speak directly to his/her spouse/partner about a conflictual issue, paying attention to ways in which the conflict is avoided. Redirect the client to confront, rather than avoid, a low-risk area of conflict regarding a behavior that would be easy to change (e.g., leaving the toilet seat up or down). Ask the client to speak to progressively more threatening material (expressing love, issues of trust, sexual behavior, etc.).
36. Assign the client to read *Intimate Connections: The New Clinically Tested Program for Overcoming Loneliness* (Burns) and process key ideas with therapist.
37. Process the client's fears of becoming intimate with another person by exploring themes such as the fear that once the client is known by the other person, disapproval, dislike, and disrespect will follow.

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38. Assign the client to ask for something (e.g., a raise at work, a favor from a friend) once or twice before next appointment. Process the fear of or reality of being refused.
39. Assist the client in identifying how conflict avoidance has led to distancing in the relationship with the significant other.
40. Encourage each person to see how he/she contributes to distancing behavior. Ask what has been done to solve the problem.
41. Assign the client to read *Your Perfect Right* (Alberti and Emmons) or *When I Say No I Feel Guilty* (Smith). Role-play situations that demand assertiveness.
42. Use role play, modeling, and behavioral rehearsal to teach the client how to use relevant communication and assertiveness skills to ask a significant other for preferred sexual conduct.
43. During conjoint meeting with the client and significant other, have the couple discuss any issues they have regarding sexual pleasure and conduct, encouraging direct communication.
44. Have the client set limits with children during the therapy session. Praise the client the moment the limit has been set with some effectiveness.

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45. Use role play, modeling, and behavioral rehearsal to teach the client how to use relevant communicating, parenting, and assertiveness skills to require his/her child to respect parental boundaries.
46. Refer the client to a physician for a psychotropic medication evaluation; help the client to process costs and benefits of a medication evaluation.
47. Monitor the client's use of psychotropic medication for compliance with prescription, its effectiveness, and side effects.
48. On a regular basis, confer with the prescribing physician about the effectiveness of the psychotropic medication.
49. Explore themes of shame that occur spontaneously in dreams, fantasies, and free associations. Interpret their connection to the client's relationships with significant others, both in the past and the present (including the therapist, if applicable).
50. Empathize with the feelings of shame and humiliation from the client's point of view, reflecting back these feelings and eliciting feedback to be sure that the therapist's understanding is accurate.
51. Provide feedback that the feelings of shame are under-

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standable from the client's point of view. Be aware of own feelings as they are impacted by the client and provide feedback to the client about those feelings, thus facilitating perspective on the part of the client.

52. Assist the client in weighing the pros and cons of avoiding negative emotions, encouraging client to consider the benefits that will be experienced once the long-term goal is achieved (e.g., the benefits of having a new friend if the initial anxiety of making contact can be overcome).
53. Validate the client's difficulties, focusing on painful material, accepting the client's feelings without judgment, and allowing the meaning of the discomfort to become clear to the client.
54. Acknowledge the self-soothing function of the use of fantasy, then assist the client in evaluating the positive and negative impact of the extensive use of fantasy.
55. Role-play social skills in order to prepare the client for group psychotherapy. Provide the client with information about reasonable expectations regarding what will occur in group therapy sessions and encourage the client to participate.
56. Conduct or refer the client to group therapy to improve

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interpersonal interactions by increasing the client's awareness of the impact that his/her behavior has on others and awareness of others' feelings about him/her.

- 57. Assign the client to journal his/her perceptions of others' behavior and expressed ideas or opinions. Reinforce the client's focus on others in the social interaction rather than being distracted by his/her own thoughts and anxiety.

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DIAGNOSTIC SUGGESTIONS

- Axis I:** 300.23 Social Phobia
 300.21 Panic Disorder with Agoraphobia
 300.02 Generalized Anxiety Disorder

- Axis II:** 301.82 Avoidant Personality Disorder
 301.6 Dependent Personality Disorder
 301.20 Schizoid Personality Disorder
 301.22 Schizotypal Personality Disorder
 301.0 Paranoid Personality Disorder
 301.9 Personality Disorder NOS