BEHAVORIAL HEALTH DEPARTMENT – PRIMARY CARE CENTER AND FIREWEED
TREATMENT GUIDELINES FOR

PERSONALITY DISORDERS

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TREATMENT PLAN FOR BORDERLINE PERSONALITY DISORDER 15

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Executive Summary

Introduction and statement of Intent

This treatment guideline is intended to assist clinicians in the Behavioral Health department in treatment planning and service delivery for patients with Personality Disorders. It may also assist clinicians treating patients who have problematic personality traits but do not meet the full criteria for a personality disorder or where their traits and symptoms are better accounted for by another disorder. The treatment guideline is not intended to cover every aspect of clinical practice, but to focus specifically on the treatment models, modalities, and/or referrals that clinicians in our outpatient treatment setting could provide. These guidelines were developed through a process of literature review and discussion amongst clinicians in the Behavioral Health department and represent a consensus recommendation for service provision for this disorder. The guideline is intended to inform both clinical and administrative practices with the explicit goals of outlining treatment that is: Effective, Efficient, Age Appropriate, Culturally Relevant, and Acceptable to clinicians, program managers, and patients and family

Definition of disorder

The DSM-IV defines a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture." The pattern must be manifested in two or more of the following areas: cognition, affectivity, interpersonal functioning and impulse control. The pattern must be inflexible and pervasive across a broad range of personal and social situations. It must lead to significant impairment in important areas of functioning. The pattern must stable and of long duration traceable back to adolescence or early adulthood, not better accounted for by another mental illness, and not secondary to the direct physiological effects of a substance or a medical problem.

By definition, it excludes those under 18, though problematic personality traits are often evident in adolescents and are often the focus of concern and clinical attention. The DSM describes 10 distinct personality disorders plus a "not otherwise specified" category. They are listed here, but not described in the interest of brevity. They are further categorized into 3 clusters. Many of these occur in people presenting for care to our clinics at too low a frequency to warrant a guideline for their treatment. The cluster B personality disorders, on the other hand, are frequently the focus of clinical attention. They frequently co-occur with mood, anxiety and substance abuse disorders making treatment more complex.

General Goals of treatment

Within the allied mental health fields of psychiatry, psychology, and social work, there are competing and sometimes conflicting theories and goals related to treatment of persons with these pervasive problems. As clinicians, we would like to lessen the impairment these individuals suffer by helping them change their patterns of interaction with others and providing a relatively tolerant setting in which they can maintain some relationships and build needed skills over time.

Unfortunately, these global, and necessarily long term goals are not easily reconciled with an outcome driven, short term therapy model. However, one cannot ethically or practically exclude these patients from treatment, particularly when referral to longer term, specialized treatment is not available. Given the resource limitations of our clinics and our mandate to provide service to all eligible persons in a timely manner, we have had to settle for compromise goals in which the focus is not on providing the full variety and duration of treatments that would be ideal for these individuals, but instead on discrete, objective goals aimed at the most distressing or impairing immediate problems and with an expectation of multiple rounds of treatment over time.

Summary of 1st, 2nd and 3rd line treatment

We are not able to provide a rank ordered list of treatment options for patients with these disorders, but psychotherapy has been considered the mainstay of treatment for most of them with medications providing an ancillary role.

For Borderline Personality Disorder, intensive psychotherapies, often including a mixture of group and individual modalities and with 4 or more hours a week of direct contact are recommended. Two specific treatments, Linehan's (1993) dialectical behavioral therapy and Piper et als (1996) Therapeutic Community Model of treatment , are supported by controlled trials demonstrating improved outcomes over standard community treatments. However, these require a higher intensity of services than can be provided in our current setting and structure.

See the literature review and summary, appendix B for additional information.

Approaches for patients who do not respond to initial treatment

Developing and maintaining a therapeutic alliance is often more challenging with personality disordered patients than with other groups. The use of peer consultation is particularly recommended when an impasse has been reached such as little progress or ongoing therapy interfering behavior on the part of the patient or therapist.

General Comments

- There will be no guidelines for any modality for Personality Disorder for customers 0 to 12 years old. For assistance planning treatment of difficult behaviors and personality traits in this age range, see the guidelines for Parenting and for Disruptive Disorders
- We will have guidelines for customer 13 to 18 years old although they cannot be officially diagnosed with a personality disorder.
- For any group to function effectively, all staff members involved must have an excellent rapport to ensure consistent treatment.
- Therapist and client relationship is crucial factor in the treatment of personality disorders.
- Communication with all medical staff is important.

Types of Personality Disorder

Cluster A:
- Paranoid
- Schizoid
- Schizotypal

Cluster B:
- Antisocial
- Borderline
- Histrionic
- Narcissistic

Cluster C:
- Avoidant
- Dependent
- Obsessive-Compulsive

Personality Disorder Not Otherwise Specified.

Flow Diagram

Assessment Completed

Review DSM-IV criteria for this disorder

Does customer meet criteria for this disorder?

UNCERTAIN

Reference Assessment in the Treatment Guidelines

Review case at your clinical team meeting and with your clinical supervisor.

Recommend customer for psychiatric Assessment, Psychological Testing and/or utilize screening scales to aid your in our assessment.

NO

Review other diagnoses and/or treatment guidelines

YES

Are manifestations of this disorder the most pressing aspect of the clinical presentation?

NO

Review other diagnoses and/or treatment guidelines

YES

Does customer want treatment for this disorder?

NO

Ensure Patient Safety

Recommend 4 PM Gatherings, PsyhoEd groups and/or Primary Care (BHC)

YES

Reference Treatment Guidelines

Read Executive Summary

Review each treatment modality

Determine treatment indicated for this customer.

Customize standard treatment plans for this customer.

Assessment

The Diagnostic Testing team will be reviewing and commenting on the Psychological Testing column for every disorder.

	Psychiatric Assessment	Psychological Testing	Screening/Scales
Indications	▪ Diagnostic dilemma or clarification of co-morbidity ▪ Unmanageable behavior or other symptoms that have not improved with standard interventions ▪ Patients is already on psychotropic medication and is requesting continuation ▪ Patient or guardian requests a second opinion or wishes to consider pharmacologic intervention ▪ Rule out organic cause and/or contributions to symptoms	▪ Diagnostic clarification following assessment by PCP or ANP. ▪ Question only answerable by psychological testing ▪ Appropriate physical assessment completed	• Establish baseline and/or monitor treatment effectiveness • Clarify symptoms
Contraindications	▪ Diagnosed severe cognitive disorder or developmental delay and collateral source not available ▪ Consent not available (if patient has guardian) ▪ Patient or guardian has forensic rather than therapeutic goal (i.e. compliance with court or parole requirements, disability determination, etc.)	▪ Extremely dangerous to self and/or others ▪ Untreated psychosis ▪ Initial evaluation / assessment is not done ▪ Referral question not answerable and/or not clear ▪ Any physical causes of the disorder have not been ruled out ▪ Attention span inadequate ▪ School or other source has already conducted psychological testing within the last year ▪ Severely depressed	▪ Limited English proficiency. ▪ Attention span inadequate ▪ Lack of cooperation
Structure	In patients with cognitive impairment who cannot give adequate history, parent or guardian with knowledge of the patient's history must be available for assessment.	▪ Depends on the referral question	▪ Self-administered for adults and adolescents ▪ Completed by Parent and/or care giver for children or incompetent adults.

Modalities & Treatment Models

Group Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Customer is 3 years old or older ▪ Mild to moderate severity ▪ Able to tolerate affect without behavior destructive to group ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible. ▪ Must be concurrent with Individual Therapy ▪ Ability to contract for safety and deal with it in a constructive manner	▪ Dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Sexually acting out behaviors ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Severe untreated hyperactivity ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Acute intoxication or withdrawal from alcohol or other substances	• Diagnosed social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services

STRUCTURE

- Groups will be facilitated by 2 Master's Level Therapist and Case Manager
- For 17 years old and below, some age grouping recommended
- For 18 years old and above consider adult services
- Customer must be referred
- Customer must participate in group orientation

Duration	60 to 90 minutes for 4 to 12 weeks
Frequency	Once a week
Size	3 to 4 customers per clinician
Open vs. Closed	▪ Modified Open ▪ We can accommodate occasional and/or infrequent participation

TREATMENT MODEL

Modified DBT

Individual Therapy

Literature indicates that 1 year minimum is recommended for individual therapy concurrent with Group Therapy for most personality disorders.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
• Sufficient verbal and/or cognitive ability to benefit from treatment • Moderate to Severe severity ▪ Customer is 3 years old or older • For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Imminent dangerousness to self or others requiring hospitalization ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Untreated Psychosis or mania ▪ Acute intoxication or withdrawal from alcohol or other substances	

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly ▪ Up to 8 sessions for treatment

TREATMENT MODEL

- DBT for Borderlines
- Psychodynamic or CBT
- Symptom driven depending on primary diagnosis

Family Therapy / Couples Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Disorder is impacting the family and/or relationship ▪ Family dynamic exacerbating or triggering symptoms ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ No buy-in to group and/or individual therapy ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible. ▪ Concurrent with group and/or individual treatment for children or adults with severe mental illness ▪ Adjunct with Individual Therapy and/or Group Therapy	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Current Domestic violence or abuse of child ▪ Custody dispute ▪ Untreated Psychosis ▪ Acute intoxication or withdrawal from alcohol or other substances	

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly ▪ Up to 8 sessions for treatment

TREATMENT MODEL

There should be a psycho educational component on the personality disorder, as well as an understanding of how the personality disorder impacts relational issues.

Eclectic approach including but not limited to:

- Structural
- Strategic
- Systems Family Therapy (SFT)
- Interpersonal Family Therapy (IFT)
- Solutions Focus Therapy
- For couples, Imago Therapy

Medication Management

There is no single medication to treat Personality Disorders but almost every category of psychoactive medication has been used to mitigate some manifestation of various personality disorders. A few medications have been systematically studied in borderline personality disorder demonstrating limited but potentially significant improvements with SSRIs, and possibly with mood stabilizers and the second generation antipsychotics. Refer to American Psychiatric Association Guideline on the treatment of borderline personality disorder with links to relevant studies.

Psycho Educational Groups

Psycho Education Groups are recommended for skills building, such as communication, social skills, and problem solving skills. For example, the Wellness Action in Recovery Group (WRAP) provides a structured set of skill to manage daily problems and increase emotional regulation, Emotional disregulation is a hallmark of the Cluster B disorders, most specifically Borderline Personality Disorders.

Case Management

All Ages	
Assessment	▪ Collect psychosocial history ▪ Collect collateral history and/or past treatment records ▪ Obtain patient and/or guardian consent ▪ Liaison with outside agencies and/or link to community resources ▪ Administer standardized scales ▪ Lead orientation to services ▪ Review and/or conduct client initial screening and triage
Treatment	▪ Psychosocial education ▪ Maintain supportive contact ▪ Triage current clients in crisis ▪ Crisis management (e.g. triage, risk assessment, skills coaching, referrals when needed) ▪ Community liaison work and coordination of care ▪ Manage charts ▪ Provide aspects of treatment ▪ Assist with group preparation ▪ Draft treatment plans ▪ Follow-up when customer fails to keep appointments. ▪ Encourage medication and treatment compliance
Follow-up	▪ Liaison with outside agencies ▪ Link to community resources ▪ Gather and disseminate information from external referral sources

Referral

INDICATIONS

- Services needed are not available within the Behavioral Health department.
- Meets CMI criteria and not receiving rehab services
- Legal custody or other issues predominate
- Needed treatment is available elsewhere.

CONTRAINDICATIONS

Meets criteria for treatment within the Behavioral Health department system

Primary Care

INDICATIONS

- Refuses specialty mental health care
- Specialty Mental Health care not available
- Uncomplicated Medication Management
- Maintenance Medication Management

CONTRAINDICATIONS

Higher intensity services needed to ensure safety to patient or others

Special consideration for the treatment of personality disorders in the primary care setting

Appendix A: Glossary

Term or Acronym	Term Definition
Acute Intoxication	A reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Clinically significant maladaptive behavior or psychological changes that are due to the effect of the substance on the central nervous system and develop during or shortly after use of the substance. (Adapted from DSM-IV)
Acute Withdrawal	A substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged. (Adapted from DSM-IV)
CBT	Cognitive Behavioral Therapy
Closed Group	Customers may enter only at initial formation of group.
Closed Group with Windows	Customer enrollment available intermittently
Eclipse	Overshadow, for example, when the symptoms and dysfunction related to one disorder overshadow another making treatment of one more pressing.
Exposure Therapy	Exposure therapy (Haug et al, 2003) with or without response inhibition is most cited as effective for specific phobia, obsessive compulsive disorder and PTSD. Generally, these run 10 -12 sessions with each session targeting a specific skill, exposure level and cognitive reframing. Manuals are available to guide clinical work.
Intervention	Any thoughtful action taken by a clinician or customer with the purpose of addressing a perceived problem or therapeutic goal
IPT	Interpersonal Therapy
NOS	Not Otherwise Specified
Open Group	Participants can enter at any time.
PDD	Pervasive Developmental Disorder
Play Therapy	Play therapy is a form of psychotherapy for children who have been traumatized. It encourages children to explore their emotions and conflicts through play, rather than verbal expression.
Psychiatric Assessment	Formal assessment by a psychiatrist or ANP
Psychoeducation	teaching and training about the disease or problem for which the customer or family member is seeking treatment. Psychoeducation is frequently presumed to be part of all forms of assessment and treatment, yet additional interventions that emphasize education about an illness are often shown to improve outcomes over treatment as usual. Psychoeducation can be incorporated into many treatments, but can be viewed as an intervention in its own right and can be delivered by non-professional staff such as case managers or health educators.
Psychological Testing	Formal psychological assessment which includes clinical interview and appropriate tests conducted by a psychologist and/or psychometrician. This testing is standardized and normed.
Screening/Scales	Brief, easily administered screening and scales which do not require advance training to interpret.
Social Rhythm Therapy	A structured psychotherapy combining elements of behavioral therapy and psychoeducation and shown to reduce rates of relapse and rehospitalization in bipolar disorder

Term or Acronym	Term Definition
Structural Family Therapy (SFT)	Structural Family Therapy is model of treatment in which a family is viewed as a system with interdependent parts. In this treatment model, the family system is understood in terms of the repetitive patterns of interaction between the parts. From such a perspective, the goal of structural family therapy is to identify maladaptive or ineffective patterns of interactions, then alter them to improve functioning of the subparts and the whole.
TBI	Traumatic Brain Injury
Treatment Modality	For purposes of this guideline, we have defined "modality" as the structure in which the customer receives treatment, for example, individual psychotherapy, group psychotherapy, or psychoeducation.
Treatment Model	For purposes of this guideline, we have defined the "model" of care as the underlying theoretical approach to clinical intervention, for example, Cognitive Behavioral Therapy, Insight Oriented Therapy, Interpersonal Therapy.
Untreated Psychosis	For the purposes of this treatment guideline, we define untreated psychosis as psychotic symptoms that are prominent, disruptive in some way, and for which the customer is not accepting or engaging in care that would mitigate such symptoms. The diagnosis of a psychotic disorder or the presence of psychotic symptoms at some point in the course of illness or treatment should not be a barrier to participation in treatment that might be helpful. However, nor should a customer with a significant psychotic disorder be treated with some forms of psychotherapy from which they are not likely to benefit. Clinical judgment will be needed in selecting appropriate treatment for each customer.
Untreated Substance Dependence	Because "dual diagnosis" is the norm, rather than the exception in behavioral health settings, customers with substance abuse problems should not be excluded, a priori, from participation in treatment for other mental health conditions. However, the impact of their substance use on their capacity to participate in treatment must be assessed on an ongoing basis. Customers with current substance dependence may not be appropriate candidates for some forms of treatment.

Appendix B: Literature Summary

Evidence Based Clinical Guidelines
Southcentral Foundation Research Project
Summary Sheet
Personality Disorders

Diagnosis: Broad application of symptoms and interactive/interpersonal processes clustered into three general categories. Cluster A are internalized disordered personalities, Cluster B are strongly externalized or reactive disordered personalities and Cluster C are enduring patterns of social inhibition and interpersonally-based disordered personalities. There are 10 Personality Disorders in total. See the DSM for each description. Diagnostic criteria require 18 years of age therefore precluding children population groups.

General Information: This review searched the following data bases: Cochrane Reviews, American Psychological Association, American Psychiatric Association, The Journal of Empirical Mental Health, The National Guideline Clearinghouse, The Texas Algorithm Project, The Harvard Algorithm Project and SAMHSA, NIMH and Mental Health Today. The keywords for this search were: Personality Disorders, Borderline Personality Disorder, Group Therapy, Evidence Based Therapy/Treatment/Interventions, Empirically Supported Therapy/Treatment/Interventions, Treatment Guidelines, Psychotherapy with Personality Disorders.

The search provided limited evidence-based protocols or guidelines. The nature of each of the clusters and subtypes of personality disorders raises concerns too large to address in a quick summary. The fact that personality disorders are relatively common (one in eleven people) Samuels et al. (2002) raises the need for a more in-depth review of each subtype and the attending literature. In general, working with personality disorders requires common factor approaches that maintain therapeutic relationship and apportioned technical and supportive skills.

Group Therapy and Personality Disorders: The limited literature search produced one strong reference to adolescent Borderline Personality Disorders and Integrative Borderline Adolescent Family Therapy (I-BAFT) (Santisteban, et al 2003). This article utilized the Dialectic Behavioral Treatment (DBT) (Linehan 1993) components applied in a group (family) setting. By extension, the principles and techniques of the DBT could be utilized therefore in group settings. NIDA sponsored the I-BAFT studies and has a manual available. According to the Am. Psychiatric Assoc. guidelines, group therapy is helpful but offers no clear advantage over individual therapy. They recommend group therapy be used in combination with individual therapy, be relatively homogeneous in make up and exclude untreated substance abuse, antisocial personalities and psychotic patients. Group therapy that offers support and understanding especially from other clients that share trauma background has shown effectiveness in BPD. The use of psychoeducation groups has been shown to be universally beneficial across diagnostic categories; one could surmise the same for personality disorders. In my opinion, there is some clinical caution to group work with antisocial personality disorders. Cluster A disorders might have a difficult time engaging and finding connection and alliance with a group due to the symptomology but there is some limited literature noting success of groups with schizophrenia that might apply. Cluster C, in my opinion of the diagnoses, would benefit more readily to group interventions. Some literature does suggest that individuals routinely have more "personality disorders" than officially diagnosed.

Individual Therapy and PTSD: Psychotherapy is seen as beneficial to personality disordered individuals (Perry et al, 1999) with psychodynamic and cognitive behavioral therapy garnering evidences of their effectiveness (Leichsenring and Leibing, 2003). The American Psychiatric Association has a specific treatment guideline for borderline personality disorder. Much of this summary will use extrapolations for this reference guide. Benjamin and Karpiak (2001) noted that Linehan's (1993) dialectical behavioral therapy is effective as well as Piper et als (1996) Therapeutic Community Model of treatment.

Brief Therapy Models and Personality Disorders: The consensus of the literature reviewed does not espouse a brief, less than 20 session, therapy modality. The most common cited reason was the difficulty in establishing but essential role of therapeutic alliance, the teaching and experiencing process of DBT and

Therapeutic Community Models and the diagnostic assumption of trait endurance. Longer term therapy is recommended.

Professional Status in Brief Therapy: Training and model understanding are essential components of professional practice. Techniques and on the fly real time decision making, especially in Cluster B and Paranoid Personality disorders were underscored in the articles cited and others reviewed. This calls for training for the practice of any therapy with personality disorders.

Structure of most (Brief) Therapy: None found. The DBT and Therapeutic Community as well as cognitive behavioral therapy have structured model and stepwise decision points in the application of their respective models.

Multi-Cultural Considerations: The literature on multi-cultural adaptation of evidence based treatments was less than complimentary. Nagayama Hall, 2001, reviewing the empirically supported literature plainly states: "there is not adequate empirical evidence that any of these empirically support therapies is effective with ethnic minority populations" (p.502). Bernal and Scharron-Del-Rio, (2001) earlier noted the same conclusion and called for a more "pluralistic" methodology in developing evidence based and culturally sensitive treatments. The overall consensus is that, even lacking specific cultural treatments, the application of evidence supported interventions is better than using non-supported techniques. Caution must be exercised to not over-diagnose personality trait problems in cross-cultural settings. The manifestation of the symptomology of many personality disorders would be considered appropriate. For example, Asian female client might display Cluster C, dependent traits and features that are only to be interpreted within the American culture. See Rethinking Psychiatry by Kleinman (1988)

Pharmacological Interventions: Am. Psychiatric Assoc treatment guide for Borderline suggest SSRIs for most symptoms. It provides a decision tree for the Rx. Due to the nature of characterological or personality disorders, medication management is not about "curing" the cause but rather ameliorating and addressing related symptoms. Affective disturbances are the primary issue in many of the disorders. General knowledge suggests SSRIs or the newer combination medications like Effexor. Aggression is sometimes controlled with newer antipsychotics or antiseizure/mania medications.

Manuals: Integrative- Borderline Adolescent Family Therapy (I-BAFT) through NIDA

References:

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Samuels, J., Eaton, W., Bienvenu, J., et al. Prevalence and correlates of personality disorders in a community sample. *Brit J of Psychiatry*, 2002, June, 180: 536-42

Santistenban, DA., Muir, JA., Mena, MP., and Mitrani, VB., Integrative Borderline Adolescent Family Therapy: meeting the challenges of treating adolescents with borderline personality disorders. *Psychotherapy: Theory, Research, Practice, Training,* 2003, Vol 40 No.4 251-254

Treating Borderline Personality Disorder: A Quick Reference Guide, Oct 2001 Published by the American Psychiatric Association. http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm

Appendix C: Sample Treatment Plans

Treatment Plan for Borderline Personality Disorder

Problem #1
Borderline Personality Disorder

As evidenced by:
1. Frantic effort to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationship
3. Identity disturbance
4. Impulsivity in at least two areas that are potentially self-damaging.
5. Recurrent suicidal behavior

Goals:
1. Develop and demonstrate coping skills to deal with mood swings.
2. Develop the ability to control impulsive behavior.
3. Learn and practice interpersonal relationship skills
4. Eliminate self-damaging behaviors

Objectives:
1. Verbalize situations that may trigger feelings of depression and/or anger
2. Identify distorted cognitions that mediate negative emotions
3. Practice verbalizing realistic, positive self-talk to replace negativity
4. Identify a list of negative consequences to self and others regarding self-defeating behaviors
5. Practice cognitive methods to control impulsive behavior.
6. Implement assertiveness and the use of "I" messages to communicate both without aggression.
7. Verbalize childhood experiences of abuse, neglect and/or abandonment and how they impact present feelings.
8. Identify coping strategies to deal with fear and abandonment
9. Initiate productive, enjoyable activities
10. Take medication as prescribed by psychiatrist.
11. Establish a crisis plan with therapist that will be utilized if there is an urge to harm self or others.