MANAGING NARCISSISTIC, BORDERLINE AND ANTISOCIAL PERSONALITY DISORDERS

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PERSONALITY DISORDERS

• TOTALITY OF EMOTIONAL AND BEHAVIORAL TRAITS
• ONSET TEENS
• ENDURING, INFLEXIBLE, CONSISTENT, AND MALADAPTIVE
• CAUSES SIGNIFICANT IMPAIRMENT AND/OR DISTRESS
• SOME SEEM TO GET BETTER IN THE 30 AND 40 YEAR OLD RANGE
• TRAITS VS. DISORDER

PSYCHOBIOLOGICAL MODEL OF PERSONALITY

• PERSONALITY (CLONINGER, 1993)
  – TEMPERAMENT -50% HEAVILY INFLUENCED BY GENETICS
    • AFFECTIVE TONE
    • INTENSITY AND REACTIVITY
  – CHARACTER -50% HEAVILY INFLUENCED BY ENVIRONMENT
    • MORAL AND VALUE SYSTEM

PSYCHOBIOLOGICAL MODEL OF PERSONALITY

• TEMPERAMENT
  – NOVELTY-SEEKING
  – HARM-AVOIDANCE
  – REWARD-DEPENDENCE
  – PERSISTENCE
• CHARACTER
  – SELF-DIRECTEDNESS (RESPONSIBLE, PURPOSEFUL & RESOURCEFUL)
  – COOPERATIVENESS
  – SELF-TRANSCENDENCE
  – ALTRUISM
PSYCHOBIOLOGICAL MODEL OF PERSONALITY

• GENETICS
  • EXAMPLE-ANTISOCIAL PERSONALITY DISORDER
    • INCREASED IMPULSIVITY
    • DECREASED EMPATHY
    • LOW FRUSTRATION TOLERANCE
    • HIGH DRIVE
    • HIGH SENSATION SEEKING

TREATMENT CONSIDERATIONS

• EGOSYNTONIC AND CHARACTEROLOGICAL
• CHARACTER TRAITS MORE AMENABLE TO TREATMENT
• TRANSFERENCE/COUNTERTRANSFERENCE
• STRESS A VARIABLE IN INTENSITY

TREATMENT CONSIDERATIONS

• PSYCHOTHERAPEUTIC TREATMENT STRATEGIES
  – INCREASE ACCEPTANCE AND TOLERANCE
  – REDUCE INTENSITY OF TRAIT EXPRESSION
  – PROMOTE ADAPTIVE TRAIT-BASED BEHAVIOR
  – REDUCE STRESS (REAL AND PERCEIVED)
  – CREATE CONDUCIVE ENVIRONMENTS

PSYCHOTHERAPEUTIC TREATMENT STRATEGIES

• INCREASE ACCEPTANCE AND TOLERANCE
  – PSYCHO-EDUCATION
  – IDENTIFY ADAPTIVE FEATURES
• REDUCE INTENSITY OF TRAIT EXPRESSION
  – RESTRUCTURE TRIGGERING SITUATIONS
  – MODIFY AMPLIFYING COGNITIONS
  – ENHANCE INCOMPATIBLE BEHAVIORS
  – MEDICATION
PSYCHOTHERAPEUTIC TREATMENT STRATEGIES
• PROMOTE ADAPTIVE TRAIT-BASED BEHAVIOR
  – HOW AND WHEN TO ASK FOR HELP
• CREATE CONDUCIVE ENVIRONMENTS
  – MODIFY ENVIRONMENT TO MATCH CLIENT INSTEAD OF ASKING THE CLIENT TO ADAPT TO THE ENVIRONMENT THAT HAS BEEN PROBLEMATIC

CREATE CONDUCIVE ENVIRONMENT
• HELP THEM FIND AN ENVIRONMENT THEY CAN FLOURISH IN
  • ESPECIALLY TRUE WITH BORDERLINE PD
• SET APPROPRIATE LIMITS
• ENVIRONMENTAL ENRICHMENT

SETTING LIMITS
TOO STRICT
TOO LOOSE

A “GOOD PARENT” SETS “GOOD LIMITS”
FAIR
CONSISTENT
AVAILABLE
PERSONALITY DISORDERS

- LACK OF EMPATHY DISORDERS
  - NARCISSISTIC PERSONALITY DISORDER
  - ANTISOCIAL PERSONALITY DISORDER

- IMPULSIVE DISORDERS
  - ANTISOCIAL PERSONALITY DISORDER
  - BORDERLINE PERSONALITY DISORDER

EMPATHY

- THREE TYPES OF EMPATHY
  - EMOTIONAL EMPATHY
    - SHARING ANOTHER'S FEELINGS
  - COGNITIVE EMPATHY
    - PERSPECTIVE TAKING OR THEORY OF MIND
    - THINK ABOUT AND UNDERSTAND ANOTHER'S FEELINGS
  - EMPATHIC CONCERN OR COMPASSION
    - MOTIVATION TO DO SOMETHING ABOUT ANOTHER'S SUFFERING

WHEN ONE MEMBER OF A HUSBAND/WIFE TEAM EXPERIENCES PAIN...

- EMPATHY ACTIVATES THE EMOTIONAL OR AFFECTIVE PARTS OF THE PAIN NETWORK BUT NOT THE PHYSICAL SENSATION OF PAIN
- COGNITIVE EMPATHY IS AN ATTEMPT TO UNDERSTAND AND REASON ABOUT THE STATE OF ANOTHER. IT IS A CAPACITY CALLED MENTALIZING OR THEORY OF MIND
  - INVOLVES THE SUPERIOR TEMPORAL SULCUS, TEMPORAL POLES AND TEMPOROPARIETAL JUNCTION. ALSO THE MEDIAL PREFRONTAL CORTEX WHICH IS ASSOCIATED WITH THINKING ABOUT ONESELF

- PSYCHOPATHS UNDERSTAND WHAT OTHERS ARE FEELING BUT HAVE A PROFOUNDED LACK OF EMPATHIC CONCERN
- IMAGING REVEALS ABNORMAL CONNECTIONS AND NEURAL ACTIVITY IN AREAS ASSOCIATED WITH EMPATHY
- COGNITIVE EMPATHY BUT NOT EMOTIONAL EMPATHY PREDICTS A SENSE OF JUSTICE FOR OTHERS
  - THOSE HIGH IN "COLDHEARTEDNESS" WERE LEAST MOTIVATED BY A SENSE OF JUSTICE

DENNORTH, LYDIA. *I FEEL YOUR PAIN*. SCIENTIFIC AMERICAN. DECEMBER 2017, PG 58-61
**Impulsivity**

- Impulsivity has been variously defined as behavior without adequate thought, the tendency to act with less forethought than do most individuals of equal ability and knowledge, or a predisposition toward rapid, unplanned reactions to internal or external stimuli without regard to the negative consequences of these reactions.

- Impulsivity is implicated in a number of psychiatric disorders including mania, personality disorders, and substance use disorders.

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**Impulsivity**

- Lithium has long been considered a potential medication for reducing impulsivity. Its effectiveness in bipolar mania is due, in part, to its ability to reduce the impulsivity associated with grandiosity.

- In addition, lithium may be effective in reducing impulsive aggression. The use of lithium is somewhat limited because of tolerability problems and its adverse effects (e.g., tremor, nausea, diarrhea, nephrotoxicity).

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**Impulsivity**

- SSRIs are some of the most frequently prescribed psychiatric medications. Basic research has long shown that low levels of the serotonin metabolite 5-hydroxyindoleacetic acid and blunted serotonergic response within the ventromedial prefrontal cortex are associated with impulsive behaviors, especially aggression.

- Animal research supports an emerging role for the noradrenaline system in impulse control. Given their potential to modulate prefrontal inhibitory processes, SNRIs may hold promise for the treatment of some types of impulsivity.

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**Impulsivity**

- Several clinical conclusions can be drawn from the data regarding pharmacological treatment of impulsive behaviors:

  - SSRIs appear most helpful for impulsive aggression
  - Stimulants can worsen some types of impulsive behavior even though they are helpful in ADHD; in such cases, other treatment options, such as SNRIs, merit consideration
  - Glutamatergic agents, N-acetylcysteine and memantine, have shown early promise for a range of impulsive behaviors and particularly merit further investigation given their high tolerability and minimal adverse-event profiles
  - Atypical antipsychotics may also be promising for a range of impulse behaviors, but their adverse-effect profile and the need for occasional blood monitoring must be seriously considered before use; aripiprazole may worsen impulsivity in some individuals
  - Lithium may be most effective for the impulsivity seen in conduct disorder, but its utility is hindered by the need for blood monitoring
NARCISSISM-TRAITS
• INCREASING IN COLLEGE STUDENTS FOR PAST FEW DECADES
• BECOMING A MORE NARCISSISTIC CULTURE
• NARCISSISTS ARE OBSESSED WITH THEIR LOOKS
• THEY LIKE TO TALK ABOUT THEMSELVES
  • USE WORD “I” MUCH MORE THAN “WE”

NARCISSISM-TRAITS
• WE LIVE IN A WORLD OF DUALITY BY COMPARISON
  • GRADES
  • MONEY
  • POSITION
• THAT PERPETUATES INFANTILE NARCISSISM (EGO)
• SECONDARY GAIN OF THE EGO

NARCISSISM AND PRIDE
ENTITLEMENT COMES FROM UNRESOLVED INFANTILE NARCISSISTIC EGOCENTRICITY (“BABY”)
  – PRODUCES LACK OF REMORSE
  – JUSTIFIES RESENTMENTS
  – REAL OR PERCEIVED SLIGHT CAN CAUSE INCREDIBLE RAGE
  – CREATES A “BETTER THAN” ATTITUDE SUCH THAT IT IS NOW OK TO HOLD NEGATIVE JUDGMENT

NARCISSISM AND PRIDE
ENTITLEMENT
• TENACIOUS, RIGIDLY DEFENDED AND SOMETIMES UNCORRECTABLE (ASPD). THE MORE THE ENTITLEMENT THE LESS THE LEVEL OF EMPATHY.
• THIS ATTITUDE IS BASICALLY PSYCHOTIC AS THE INNER GRANDIOSITY IS DELUSIONAL.
NARCISSISM AND PRIDE

• PSYCHOANALYTIC VIEW
  • GRANDIOSE VIEW BUCKERS A PERSON FROM UNCONSCIOUS INSECURITIES
  • HUBRISTIC PRIDE AND ITS ASSOCIATED AGGRESSIVENESS AND MANIPULATIVE TENDENCIES ALLOW NARCISSIST TO MAINTAIN AN ARTIFICIALLY POSITIVE SENSE OF SELF (BULLY WHETHER ON PLAY GROUND OR CONFERENCE ROOM)

NARCISSISM AND PRIDE

• PRIDE IS A PLEASURABLE SELF-CONSCIOUS EMOTION ARISING WHEN PEOPLE FEEL GOOD ABOUT THEMSELVES
  • THERE APPEARS TO BE TWO FACETS OF THE SAME EMOTION
    • AUTHENTIC PRIDE
    • HUBRISTIC PRIDE
  • BOTH ARE ADAPTIVE-SECURE SOCIAL STATUS

TRACEY, JESSICA. “PRIDE AND POWER”. SCIENTIFIC AMERICAN MIND. NOV/DEC 2013, PGS. 64-68.

NARCISSISM AND PRIDE

• AUTHENTIC PRIDE
  • MOTIVATES HARD WORK AND ACHIEVEMENT-EXAMPLE MIGHT BE BILL GATES
  • GENERALLY ASSOCIATED WITH HIGH SELF-ESTEEM
  • TEND TO BE EXTROVERTED, AGREEABLE, CREATIVE AND POPULAR
  • COMMUNALLY ORIENTED (VOLUNTEER WORK)
  • ASSOCIATED WITH LONG-TERM SUCCESS
  • MOTIVATES ACHIEVEMENT AND CONCERN FOR OTHERS

NARCISSISM AND PRIDE

• HUBRISTIC PRIDE
  • INVOKES ARROGANCE AND EGOTISM-EXAMPLE MIGHT BE KIM JONG UN
  • NARCISSISM AS A CLASSIC DEFENSE SYSTEM TO WARD OFF UNCONSCIOUS INSECURITIES AND SHAME
  • GENERALLY ASSOCIATED WITH LOW SELF-ESTEEM
  • TEND TO BE DISAGREEABLE, AGGRESSIVE, MANIPULATIVE, SOCIALLY ANXIOUS AND EVEN CLINICALLY DEPRESSED
NARCISSISM AND PRIDE

• HUBRISTIC PRIDE (CONTINUED)
  • MORE INTERESTED IN DEROGATING OTHERS THAN HELPING THEM
  • SERVES AS A CRUTCH FOR OUR SENSE OF SELF
  • SHORT-TERM SUCCESS WITH LONGER-TERM NEGATIVE EFFECT ON RELATIONSHIPS AND WORK
  • FACILITATES ALL OF THE BEHAVIORS NEEDED TO BE DOMINANT-ARROGANCE, SENSE OF SUPERIORITY AND WILLINGNESS TO INTIMIDATE AND DEROGATE OTHERS

NARCISSISTIC PERSONALITY DISORDER

• THREE LEVELS OF SEVERITY
  • MILD
    • INTERPERSONAL PROBLEMS IN LONG-TERM INTERACTIONS
    • GENERALLY FUNCTIONAL
  • MODERATE
    • TYPICAL SYNDROME
      • GRANDIOSITY
      • SENSITIVITY TO CRITICISM
      • LACK EMPATHY

NARCISSISTIC PERSONALITY DISORDER

• THREE LEVELS OF SEVERITY (CONTINUED)
  • SEVERE OR MALIGNANT
    • ANTISOCIAL BEHAVIOR WITH LACK OF IMPULSE CONTROL AND TOLERANCE
    • SELF-DIRECTED OR OTHER-DIRECTED AGGRESSION
    • MAY HAVE SIGNIFICANT PARANOID IDEATION

NARCISSISTIC PERSONALITY DISORDER

• SUBTYPES
  • GRANDIOSE, THICK-SKINNED AND OVERT
    • OVERT GRANDIOSITY
    • ATTENTION-SEEKING
    • ENTITLEMENT
    • ARROGANT
    • LITTLE OBSERVABLE ANXIETY
    • SOCIALLY CHARMING BUT OBLIVIOUS TO THE NEEDS OF OTHERS
    • INTERPERSONALLY EXPLOITIVE
    • SELF-ABSORBED
NARCISSISTIC PERSONALITY DISORDER

- Fragile, thin-skinned and covert
  - Inhibited
  - Manifestly distressed
  - Hypersensitive to criticism
  - Chronically envious
  - Constant evaluation of self and others
  - Interpersonally shy
  - Outwardly self-effacing
  - Harbors secret grandiosity
  - Self-absorbed

NARCISSISTIC PERSONALITY DISORDER

- High-functioning, exhibitionistic or autonomous
  - Grandiose
  - Competitive
  - Attention seeking
  - Sexually provocative
  - Demonstrate adaptive functioning using traits to succeed

NARCISSISTIC PERSONALITY DISORDER

- Depression, anxiety, self-injurious behavior and suicide more common in vulnerable subtype
- Grandiose traits related to substance abuse and comorbidity with ASPD and paranoid PD

NARCISSISTIC PERSONALITY DISORDER

- No known cause
  - One theory holds they are compensating for low self-esteem by becoming egotistical (weak scientific support)
  - Another theory suggests only vulnerable narcissists lack a sense of self-worth
  - Self-destructive behavior may result from despair. Recent data suggests the vulnerable but not the grandiose narcissist is linked to suicidal thinking and self-harm
NARCISSISTIC PERSONALITY DISORDER

• NOT A UNITARY CONSTRUCT
• COMBINATION OF AGENTIC AND ANTAGONISTIC ASPECTS
  • AGENTIC-ASSERTIVENESS, DOMINANCE AND CHARM
  • ANTAGONISTIC-AGGRESSIVENESS AND DEVALUATION OF OTHERS
• BOTH ASPECTS INVOLVED IN MAINTAINING POSITIVE SELF-ESTEEM

NARCISSISTIC PERSONALITY DISORDER

• SELF-PROMOTION DRAWS PRAISE (TO BE ADMIRED)
• SELF-DEFENSE DEMEANS OTHERS TO FEND OFF CRITICISM

NARCISSISTIC PERSONALITY DISORDER

• READILY EMERGE AS LEADERS IN GROUP DISCUSSIONS AND ARE MORE LIKELY TO RISE TO TOP POSITIONS IN BUSINESS
  AMY BRUNELL, OHIO STATE UNIVERSITY AT NEWARK, 2009.
• PERFORMED WELL IN JOB INTERVIEWS BECAUSE THEY ARE GOOD AT SELF-PROMOTION

NARCISSISTIC PERSONALITY DISORDER

• ASSESSMENT
  • FOCUS ON MORAL FUNCTIONING (DISHONESTY AND EXPLOITATION)
  • FOCUS ON DESCRIPTION OF SIGNIFICANT OTHERS
    • DISMISSIVE OR DEROGATORY OR ALTERNATELY IDEALIZING
    • SUPERFICIAL AND VAGUE
    • TEND TO DESCRIBE OTHERS AS SIMILAR TO OR DIFFERENT FROM THEMSELVES
NARCISSISTIC PERSONALITY DISORDER

- In a series of 11 experiments involving more than 2,200 people of all ages, the researchers found they could reliably identify narcissistic people by asking them this exact question (including the note):

  - To what extent do you agree with this statement: "I am a narcissist." (Note: The word "narcissist" means egotistical, self-focused, and vain.)

- Participants rated themselves on a scale of 1 (not very true of me) to 7 (very true of me).

- Results showed that people's answer to this question lined up very closely with several other validated measures of narcissism, including the widely used Narcissistic Personality Inventory.

NARCISSISTIC PERSONALITY DISORDER

- The difference is that this new survey -- which the researchers call the Single Item Narcissism Scale (SINS) -- has one question, while the NPI has 40 questions to answer.


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NARCISSISTIC PERSONALITY DISORDER

- Therapist's reaction
  - Idealized
  - Pressured to provide cure
  - Belittled and devalued
  - Treated like an incompetent
  - Ignored
NARCISSISTIC PERSONALITY DISORDER

• TREATMENT
  • PHARMACOLOGICAL-SYMPTOM DRIVEN
  • TREAT CO-OCcurring DISORDERS
  • ENGAGEMENT IS DIFFICULT DUE TO GRANDIOSITY AND DEFENSIVENESS
  • DBT (IF BORDERLINE TRAITS ARE PRESENT)
  • TRANSFERENCE FOCUSED

NARCISSISTIC PERSONALITY DISORDER

• TREATMENT (CONTINUED)
  • USE PATIENTS OWN WORDS TO INCREASE ENGAGEMENT
  • DON'T CONFRONT GRANDIOSITY DIRECTLY
    • NON-JUDGMENTAL AND INQUIStIVE
    • MONITOR COUNTERTRANSFERENCE
  • DON'T GET DEFENSIVE OR REACT AGGRESSIVELY
  • PAY ATTENTION TO NEGATIVE FEELINGS PATIENT HAS ABOUT TREATMENT AND CLINICIAN

NARCISSISTIC PERSONALITY DISORDER

• SYMPTOMS OF NARCISSISTIC PERSONALITY DISORDER
  – GRANDIOSITY
  – SENSITIVE TO CRITICISM
  – LACK OF EMPATHy
• GRANDIOSITY IS A WORLD VIEW THAT PROTECTS THE EGO FROM EXPERIENCING THE HURT, LONELINESS AND ISOLATION OF EXISTENCE.

NARCISSISTIC PERSONALITY DISORDER

• OTHER SYMPTOMS
  • EXPECTATION OF PREFERENTIAL TREATMENT
  • ENTITLEMENT
  • EXAGGERATED SELF-IMPORTANCE
  • ARROGANCE
  • EXPLOITATION OF OTHERS
  • CONTROLLING
  • LIKELY TO ENGAGE IN POWER STRUGGLES
  • COMPETITIVE
NARCISSISTIC PERSONALITY DISORDER

- Pathology of Self
  - Excessive self-centeredness
  - Overdependence on admiration from others
  - Fantasies of success
  - Grandiosity
  - Bouts of insecurity and avoidance of reality
- Pathology of the relationship with others
  - Intolerance of criticism
  - Narcissistic rage

NARCISSISTIC PERSONALITY DISORDER

- Difficult to treat
  - Unable to admit personal weaknesses
  - Inability to appreciate the effect their behavior has on others
  - Lack of empathy
  - Failure to incorporate feedback
  - High drop out rate

MANAGEMENT CONSIDERATIONS

- Goal: To reduce the intensity and hue of the acting out
- Prerequisites- “Level playing field”
- Business like, non-confrontational yet assertive while assuaging the sensitive ego
- Behavioral
- “Hook” the grandiosity

MANAGEMENT CONSIDERATIONS

- Countertransference
  - Clinicians tend to feel bored, distracted, and annoyed in sessions with these patients. They do not feel engaged when working with them and often feel frustrated. Therapists also sometimes feel interchangeable, as if they could be anyone to the patient. They can feel ineffectual, invisible, and deskillled.
TACTICS NARCISSISTS USE TO CONFUSE AND DOMINATE YOU

• **EMOTIONAL APPEALS**: Attempting to play on emotions such as fear, guilt and loyalty rather than using logic and reasoning.
  
  • Narcissists use emotional appeals to disguise false or outrageous claims. Since many narcissists tend to be drama kings or queens, using over-the-top emotionality to control others comes naturally for them.
  
  • Example: “How dare you question me! After all I’ve done for you.”

• **BANDWAGON**: An attempt to pressure another to go along because “everybody is doing it.”
  
  • Narcissists know the power of numbers. They slavishly follow their “likes” on social media and other measures of attention. Having lots of followers reassures them of their worth. They use the power of group-think and peer pressure to play on others’ fears of missing out, being ostracized or being in the wrong.
  
  • Example: “All your friends agree with me.”

• **BLACK-AND-WHITE / EITHER-OR**: Pretending there are only two choices when there are several.
  
  • Narcissists view the world in either-or terms. Nuance is lost on them. They derive a feeling of power from this divide-and-conquer approach.
  
  • Example: “You’re either with me or against me.”

• **BURDEN OF PROOF**: Asserting that the speaker does not need to prove his points but, rather, that the burden is on the listener to disprove them.
  
  • Narcissists love to take credit but have little interest in taking responsibility. They hate to be wrong, so putting the burden on others is a stonewalling strategy that makes it especially difficult to disprove them.
  
  • Example: “I know I am right. What I say stands until you can prove otherwise.”
TACTICS NARCISSISTS USE TO CONFUSE AND DOMINATE YOU

• **FALSE FLATTERY**: Buttering others up to make them more receptive.
  - Narcissists rarely meet a compliment they don’t like. They think others are as susceptible to flattery as they are. They ply listeners with pseudo-compliments, hoping to get things in return.
  - Example: “I couldn’t possibly be manipulating you, you’re way too smart for that.”

• **INCREDULITY**: Acting as though what someone said is unbelievable.
  - Rather than admit they are confused, they pretend that what the other person is saying is beyond belief. This is an attempt to dismiss valid concerns.
  - Example: “You seriously think there are other husbands who are better than me? You really think other wives get anywhere near what I have given you? You are not living in the real world.”

• **LABELING**: Applying a negative phrase or attributing negative characteristics to a person or position.
  - Narcissists love labels. Having a single word to invalidate or humiliate another feels like an ultimate power for narcissists.
  - Example: “You’re too needy. You’re a loser.”

• **FALSE COMPROMISE**: Offering to meet half way on matters in which there is clearly a fair and unfair choice.
  - If a narcissist has a choice to treat another person fairly or unfairly, a “compromise” that still treats the other unfairly is no compromise – it’s still wrong.
  - Example: “Okay, you win, I’ll pay you back $50 of the $100 you gave me and we’ll call it even. Hey, it’s better than nothing.”
TACTICS NARCISSISTS USE TO CONFUSE AND DOMINATE YOU

• **EMPTY PROMISES**: Promising to give others what they want without any plan or intention of fulfilling the promise.
  
  **EXAMPLE**: “You’ll get your turn. I promise.”

TACTICS NARCISSISTS USE TO CONFUSE AND DOMINATE YOU

• **QUOTING OUT OF CONTEXT**: Repeating only part of what another person said or using another’s words completely out of context.
  
  **EXAMPLE**: “You always said people have to take responsibility for themselves so I didn’t think you needed my help when you had to go to the ER.”

TACTICS NARCISSISTS USE TO CONFUSE AND DOMINATE YOU

• **RIDICULE**: Mocking or humiliating another person or their requests or feelings.
  
  **EXAMPLE**: “That’s the dumbest thing I’ve ever heard. You’re just embarrassing yourself.”

TACTICS NARCISSISTS USE TO CONFUSE AND DOMINATE YOU

• **SLIPPERY SLOPE**: An appeal to fear which takes a small problem and predicts that it will lead to an escalating series of worst-case scenarios.
  
  **EXAMPLE**: “If I do this for you, you will think you can get whatever you want from me. I’ll become your slave and have no life.”

• **NARCISSISTS DEVALUE OTHERS THROUGH DISMISSIVE REMARKS, SARCASM, OR HOSTILE HUMOR INSTEAD OF TAKING THE OTHER PERSON SERIOUSLY.**

  **EXAMPLE**: “The goal is to use an extreme hypothetical to distract from a reasonable complaint or argument.”
TACTICS NARCISSISTS USE TO CONFUSE AND DOMINATE YOU

• **SLOGANS**: A SIMPLISTIC PHRASE THAT IS A CATCH-ALL DESIGNED TO SHUT DOWN DISSENT.
• NARCISSISTS OFTEN HAVE PAT PHRASES THEY EMPLOY WHEN THEY FEEL THREATENED.
• EXAMPLE: “I'M YOUR LAST BEST HOPE. I'M ALL YOU'VE GOT.”

DEHUMANIZING:
CLASSIFYING OTHERS AS INFERIOR, DANGEROUS OR EVIL TOjustify OPPRESSING OR ELIMINATING THEM.
• THIS ENDS-JUSTIFIES-THE-MEANS TACTIC IS SECOND NATURE FOR NARCISSISTS, WHO SEE MOST OTHER PEOPLE AS INFERIOR.
• EXAMPLE: “THEY'RE BRINGING DRUGS. THEY'RE BRINGING CRIME. THEY'RE RAPISTS.”

BORDERLINE PERSONALITY DISORDER

• 2% OF GENERAL POPULATION
• 10% IN AN OUTPATIENT SETTING
• 20% OR HIGHER IN A PSYCHIATRIC INPATIENT SETTING
• 80% HAVE HISTORY OF TRAUMA (ESPECIALLY EARLY LIFE TRAUMA)
• SELF DESTRUCTIVE BEHAVIOR CAN PRECIPITATE DOPAMINE REWARD LIKE AN ADDICTIVE SUBSTANCE
• CRISIS MAY PRECIPITATE ENDORPHIN RELEASE
• HIGH INCIDENCE OF SUBSTANCE-USE DISORDER (OPIATES, COCAINE AND ALCOHOL), EATING DISORDER, DISSOCIATIVE DISORDER, AND SEXUAL AND IDENTITY DISORDERS.

FOUR PRESENTATIONS

• HYSTEROID DEPRESSIVE
• OBSERVED DEPRESSED
• SCHIZOTYPAL
• IMPULSIVE
BORDERLINE PERSONALITY DISORDER

• Clinical presentation of 2 syndromes (depression and mania) that can be characterized as a unitary psychiatric entity (bipolar disorder) and a third syndrome (borderline personality disorder) that is often comorbid with bipolar disorder

• The findings converge in suggesting that bipolar disorder and borderline personality disorder are overlapping but different pathologies,

BORDERLINE PERSONALITY DISORDER

• These findings align with previous results that indicate shared genetic variance between BD and BPD, as well as shared environmental risk factors such as childhood parental loss, various types of early trauma, and a dysfunctional family environment


BORDERLINE PERSONALITY DISORDER

• Kiera Van Gelder in her memoir, The Buddha and the Borderline, of her own evolution, "Am I recovered? I no longer struggle with the urge to hurt or kill myself, but other symptoms persist: my impulsivity, my sensitivity, my shifting moods, and my inherent fragility when I'm under stress or begin to feel connected to someone. I still have difficulty being alone, a deep need for security, and a gnawing dissatisfaction with what is."

BORDERLINE PERSONALITY DISORDER

• These individuals suffer from profound feelings ofaloneness or annihilatory panic and worthlessness, having failed to achieve a solid sense of self because their emotional boundaries are fluid, the inevitable ups and downs of everyday life often crush them. In practice, it is rare for one clinician and one individual to have the opportunity to work together over the long haul. Therefore clinicians' understanding is necessarily influenced by shorter-term perspectives
**BORDERLINE PERSONALITY DISORDER**

- **WHY DO BPD CLIENTS HAVE MORE EMOTIONAL FLARE-UPS?**
  - One possible answer is how they read facial expressions (Thomas Lynch, Duke, 2006)
    - On average people with BPD recognized both pleasant and unpleasant facial expressions at a much early stage
    - They are hyperaware of even subtle emotive faces which is problematic when one is intensely reactive to other people’s mood states

- **WHY ARE BPD CLIENTS SO SOCIALLY SENSITIVE AND MOODY?**
  - Subjects studied photos of people crying, acting violently and making sexual gestures (Harold Koenigsberg, Mount Sinai School of Medicine, 2009)
    - Using fMRI found that the unpleasant images elicited more activity in several regions of the brain in BPD patients including the amygdala which governs emotional reactivity and memory and the superior temporal gyri which is involved in “reflexive” processing
    - React more strongly and more rapidly to disagreeable images with less time to reflect

- **PEOPLE WITH BPD LACK THE BRAIN ACTIVITY THAT INTERPRETS SOCIAL GESTURES SUCH AS THOSE SIGNALING TRUST (Brooks King-Casas, Baylor, 2008)**
  - Found a problem with the insula which ordinarily monitors uncomfortable interactions with others such as those stemming from the violation of trust and other social norms. BPD patients tend to lack this ability to gauge leading to a difficulty in trusting others
**BORDERLINE PERSONALITY DISORDER**

- Neuroimaging research published since 2010 finds "structural and functional abnormalities in a fronto-limbic network including regions involved in emotion processing (e.g., amygdala, insula) and frontal brain regions implicated in regulatory control processes (e.g., anterior cingulate cortex, medial frontal cortex, orbitofrontal cortex, and dorsolateral prefrontal cortex)."

- The same review also suggests patients may have "altered function in neurotransmitter systems including the serotonin, glutamate, and GABA systems." Commonly it is believed serotonin contributes to feelings of well-being, glutamate is involved more generally in brain function and cognition, while GABA is a chemical messenger that calms over-excited neurons.

**BORDERLINE PERSONALITY DISORDER**

- Emotional dysregulation of BPD appears to be a biological vulnerability that includes both increased emotional reactivity (limbic system over activity), as well as, an impaired capacity to employ effortful control (deficits in prefrontal regulatory regions). The impairment in emotional modulation results in a slow return to the baseline emotional state.

**BORDERLINE PERSONALITY DISORDER**

- DBT is an empirically validated treatment approach emphasizing the role of emotion regulation in the treatment of suicidal and self-destructive behaviors in BPD.

- This approach stresses skills and techniques for emotional regulation, and encourages cognitive control over maladaptive behavioral patterns.
**BORDERLINE PERSONALITY DISORDER**

- Dialectical Behavior Therapy (Marsha Linehan)
- An innovative form of CBT
  - Helps detect and combat distorted thoughts
  - Counteract problematic behaviors and associated emotions
  - Incorporates meditative practices—mindfulness
  - Self-soothing techniques to manage mood swings (deep breathing, taking walks, listening to music, etc.)
  - Building healthy relationships

**MANAGEMENT CONSIDERATIONS**

- Time consuming
  - Fewer resources
  - Fewer alternative
- Powerful wishes to create clinician into a friend, lover, parent or enemy
- "Therapeutic rupture"
- Impulsivity—limit setting
- Affective storm—calmness and unflappability
- Polarization of thought and attitude—integration and finding middle ground

**MANAGEMENT CONSIDERATIONS**

If a patient has experienced neglect and abuse in childhood, he or she may wish for the therapist to provide the love the patient missed from parents. Therapists may have rescue fantasies that lead them to collude with the patient’s wish for the therapist to offer that love. This collusion in some cases leads to physical contact and even inappropriate physical contact between therapist and patient. Clinicians should be alert to these dynamics and seek consultation or personal psychotherapy or both whenever there is a risk of a boundary.

**MANAGEMENT CONSIDERATIONS**

Clinical experience suggests that effective therapy for patients with borderline personality disorder also involves promoting reflection rather than impulsive action. Therapists should encourage the patient to engage in a process of self-observation to generate a greater understanding of how behaviors originate from internal motivations and affect states rather than coming from "out of the blue." Similarly, psychotherapy involves helping patients think through the consequences of their actions so that their judgment improves.
MANAGEMENT CONSIDERATIONS

• As previously noted, splitting is a major defense mechanism of patients with borderline personality disorder. The self and others are often regarded as "all good" or "all bad." This phenomenon is closely related to what Beck and Freeman call "dichotomous thinking" and what Linehan (17) refers to as "all or none thinking." Psychotherapy must be geared to helping the patient begin to experience the shades of gray between the extremes and integrate the positive and negative aspects of the self and others. A major thrust of psychotherapy is to help patients recognize that their perception of others, including the therapist, is a representation rather than how they really are.

MANAGEMENT CONSIDERATIONS

• No pharmacologic treatment has received regulatory approval for borderline personality disorder, in the United States or elsewhere. According to a 2010 Cochrane systematic review, 27 randomized clinical trials of pharmacologic agents had been conducted in borderline personality disorder up to 2008.

MANAGEMENT CONSIDERATIONS

• In the past 5 years, most such trials have focused on mood stabilizers and second-generation antipsychotics.
• Among the second-generation antipsychotics, there has been one study with positive findings for aripiprazole, one study with negative findings for ziprasidone, and three studies with mixed results for olanzapine.

MANAGEMENT CONSIDERATIONS

• Studies have suggested efficacy for several anticonvulsants, including valproate, lamotrigine, and topiramate. There have also been a number of negative studies for antidepressants, including fluoxetine, fluvoxamine and phenelzine.
Management Considerations

- A well-designed clinical trial that provides evidence that low-dosage quetiapine (150 mg) is effective in the short-term treatment of some of the core symptoms of borderline personality disorder.


Management Considerations

- Goal
- Prerequisites
  - Structure
  - Therapy
  - Threatening
  - Life Threatening
- Medication if Needed
- Behavioral
  - Limit Setting
  - Treatment Plan
- Closure

Management Considerations

- Countertransference
  - Clinicians tend to feel overwhelmed by strong emotions and intense needs. In particular, more than with most patients, therapists feel like they have been pulled into things but do not realize it until after the session is over. Borderline patients can "frighten” clinicians, who experience high levels of anxiety, tension, and concern.

Management Considerations

- Countertransference
  - Therapists can also feel incompetent or inadequate and often experience a sense of confusion and frustration in sessions. They are afraid they are failing to help these patients and can sometimes feel guilty. Therapists can do things for them, or go the extra mile for them, in ways that they do not do for other patients.
TREATMENT PLANNING BASED ON SYMPTOM CLUSTERS

• IDENTITY CLUSTER (PROJECTION)
  – ABANDONMENT FEARS
  – UNSTABLE SELF-IMAGE
  – RELATIONSHIP PROBLEMS

• AFFECTIVE CLUSTER (SPLITTING)
  – REACTIVITY OF MOOD
  – INAPPROPRIATE, INTENSE ANGER

• IMPULSIVE CLUSTER (DENIAL, DISTORTION)
  – SUICIDAL BEHAVIOR
  – POTENTIALLY SELF-HARMING BEHAVIOR (SUBSTANCE ABUSE, SEX, BINGE EATING, SPENDING)

IDENTITY CLUSTER

• TREATMENT
  – BEHAVIORAL
    • STRUCTURE
    • IMMEDIATE REWARD
  – MEDICATION
    • NEUROLEPTICS
    • SSRI'S

SELF AND IDENTITY

• INSECURE ATTACHMENT-LACK OF CONFIDENCE IN “OTHERS” AVAILABILITY
  • DISORGANIZED TYPE
  • DISORGANIZED ATTACHMENT THEMES
• COHERSIVE CONTROL
  • BLAME
  • REJECTION
  • INTRUSION
  • HOSTILITY

SELF AND IDENTITY

• HELPLESSNESS
  • ABANDONMENT
  • BETRAYAL
  • FAILURE
  • DEJECTION
ABANDONMENT FEAR

TRAUMA ➔ ATTACHMENT PROBLEMS

ABANDONMENT ➔ INCREASED FEAR ➔ INCREASED ANXIETY ➔ INCREASED IMPULSIVITY

ABANDONMENT FEAR

• MANY PEOPLE GROW UP WITH FEARS AROUND ABANDONMENT. SOME ARE PLAGUED BY THESE FEARS PRETTY CONSISTENTLY THROUGHOUT THEIR LIVES. THEY WORRY THEY'LL BE REJECTED BY PEERS, PARTNERS, SCHOOLS, COMPANIES, OR ENTIRE SOCIAL CIRCLES. FOR MANY OTHERS, THESE FEARS AREN'T FULLY REALIZED UNTIL THEY ENTER INTO A ROMANTIC RELATIONSHIP. THINGS WILL BE GOING ALONG SMOOTHLY, AND ALL OF A SUDDEN, THEY FEEL INUNDATED WITH INSECURITY AND DREAD THAT THEIR PARTNER WILL DISTANCE THEMSELVES, IGNORE, OR LEAVE THEM.

• IN EXTREME CASES, PEOPLE MAY STRUGGLE WITH “AUTOPHOBIA,” AN OVERWHELMING FEAR OF BEING ALONE OR ISOLATED, IN WHICH THEY PERCEIVE THEMSELVES AS BEING IGNORED, OR UNCARED FOR EVEN WHEN THEY'RE WITH ANOTHER PERSON. THEY MAY ALSO EXPERIENCE A FEAR OF ABANDONMENT PHOBIA, WHICH IS CHARACTERIZED BY EXTREME DEPENDENCY ON OTHERS.

ABANDONMENT FEAR

• IN ORDER TO FEEL SECURE, CHILDREN HAVE TO FEEL SAFE, SEEN, AND SOOTHED WHEN THEY'RE UPSET. HOWEVER, IT'S BEEN SAID THAT EVEN THE BEST OF PARENTS ARE ONLY FULLY ATTUNED TO THEIR CHILDREN AROUND 30 PERCENT OF THE TIME. EXPLORING THEIR EARLY ATTACHMENT PATTERNS CAN OFFER INDIVIDUALS' INSIGHT INTO THEIR FEARS AROUND ABANDONMENT AND REJECTION. UNDERSTANDING HOW THEIR PARENTS RELATED TO THEM AND WHETHER THEY EXPERIENCED A SECURE ATTACHMENT VERSUS AN INSECURE ONE, CAN GIVE PEOPLE CLUES INTO HOW THEY VIEW RELATIONSHIPS IN THE PRESENT.
ABANDONMENT FEAR

- **A PARENT WHO MAY AT ONE MOMENT BE PRESENT AND MEETING THE CHILD’S NEEDS, THEN AT ANOTHER MOMENT BE ENTIRELY UNAVAILABLE AND REJECTING OR, ON THE OPPOSITE END, INTRUSIVE AND “EMOTIONALLY HUNGRY” CAN LEAD THE CHILD TO FORM AN AMBIGUOUS/ANXIOUS ATTACHMENT PATTERN. CHILDREN WHO EXPERIENCE THIS TYPE OF ATTACHMENT TEND TO FEEL INSECURE. THEY MAY CLING TO THE PARENT IN AN EFFORT TO GET THEIR NEEDS MET; HOWEVER, THEY MAY ALSO STRUGGLE TO FEEL SOOTHE BY THE PARENT.**

ABANDONMENT FEAR

- **CHILDREN WHO EXPERIENCE AN AMBIGUOUS ATTACHMENT PATTERN MAY GROW TO HAVE A PREOCCUPIED ATTACHMENT PATTERN AS ADULTS, IN WHICH THEY CONTINUE TO FEEL INSECURE IN THEIR RELATIONSHIPS. THEY “OFTEN FEEL DESPERATE AND ASSUME THE ROLE OF THE “PURSUER” IN A RELATIONSHIP,” WROTE JOYCE CATLETT, CO-AUTHOR OF COMPASSIONATE CHILD REARING. “THEY RELY HEAVILY ON THEIR PARTNER TO VALIDATE THEIR SELF-WORTH. BECAUSE THEY Grew UP INSECURE BASED ON THE INCONSISTENT AVAILABILITY OF THEIR CAREGIVERS, THEY ARE “REJECTION-SENSITIVE.” THEY ANTICIPATE REJECTION OR ABANDONMENT AND LOOK FOR SIGNS THAT THEIR PARTNER IS LOSING INTEREST.”

ABANDONMENT FEAR

- **ADULTS WHO EXPERIENCE A FEAR OF ABANDONMENT MAY STRUGGLE WITH A PREOCCUPIED ATTACHMENT STYLE. THEY FREQUENTLY ANTICIPATE REJECTION AND SEARCH FOR SIGNS OF DISINTEREST FROM THEIR PARTNER. THEY MAY FEEL TRIGGERED BY EVEN SUBTLE OR IMAGINED SIGNS OF REJECTION FROM THEIR PARTNER BASED ON THE REAL REJECTIONS THEY EXPERIENCED IN THEIR CHILDHOOD. AS A RESULT, THEY MAY ACT POSSESSIVE, CONTROLLING, JEALOUS, OR CLINGY TOWARD THEIR PARTNER. THEY MAY OFTEN SEEK REASSURANCE OR DISPLAY DISTRUST. “HOWEVER, THEIR EXCESSIVE DEPENDENCY, DEMANDS AND POSSESSIVENESS TEND TO BACKFIRE AND PRECIPITATE THE VERY ABANDONMENT THAT THEY FEAR,**

ABANDONMENT FEAR

- **ABANDONMENT BEHAVE IN WAYS THAT ARE PUNISHING, RESENTFUL, AND ANGRY WHEN THEIR PARTNER DOESN’T GIVE THEM THE ATTENTION AND REASSURANCE THEY BELIEVE THEY NEED TO FEEL SECURE. “THEY OFTEN BELIEVE THAT UNLESS THEY DRAMATICALLY EXPRESS THEIR ANXIETY AND ANGER, IT IS UNLIKELY THAT THE OTHER PERSON WILL RESPOND TO THEM,” WROTE CATLETT. HOWEVER, SOME PEOPLE WITH PREOCCUPIED ATTACHMENTS ARE MORE “RESENTFUL TO EXPRESS THEIR ANGRY FEELINGS TOWARD A PARTNER FOR FEAR OF POTENTIAL LOSS OR REJECTION.” THIS CAN LEAD THEM TO SUPPRESS THEIR FEELINGS, WHICH CAN CAUSE THEM TO BUILD UP, AND EVENTUALLY, SPILL OUT IN OUTBURSTS OF STRONG EMOTION.**
**ABANDONMENT FEAR**

- EXPERIENCING A SECURE ATTACHMENT CAN OFFER SOMEONE A NEW MODEL FOR RELATIONSHIPS AND HOW PEOPLE BEHAVE IN THEM. IF A PERSON IS ABLE TO FORM A RELATIONSHIP WITH SOMEONE WHO HAS A LONG HISTORY OF BEING SECURELY ATTACHED, THAT PERSON CAN LEARN THAT HE OR SHE DOESN'T HAVE TO DESPERATELY CLING TO A PERSON TO GET HIS OR HER NEEDS MET. ANOTHER WAY FOR INDIVIDUALS TO DEVELOP MORE SECURITY WITHIN THEMSELVES IS THROUGH THERAPY. EXPERIENCING A SECURE RELATIONSHIP WITH A THERAPIST CAN HELP A PERSON FORM EARNED SECURE ATTACHMENT.

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**ABANDONMENT FEAR**

- ONE OF THE MOST EFFECTIVE WAYS FOR A PERSON TO DEVELOP SECURE ATTACHMENT IS BY MAKING SENSE OF HIS OR HER STORY. DR. DANIEL SIEGEL TALKS ABOUT THE IMPORTANCE OF CREATING A COHERENT NARRATIVE IN HELPING INDIVIDUALS FEEL MORE SECURE AND STRENGTHENED WITHIN THEMSELVES. WHEN PEOPLE MAKE SENSE OF AND CONVEY THEIR STORY, THEY GET TO KNOW THEIR PATTERNS AND TRIGGERS, AND THEY AREN'T AS INSTINCTIVELY REACTIVE IN A RELATIONSHIP – BE IT WITH A ROMANTIC PARTNER OR WITH THEIR CHILDREN. WHEN PEOPLE MAKE SENSE OF THEIR PAST, THEY MAY BE LESS LIKELY TO FEEL SUCH INTENSE, KNEE-JERK FEAR OF ABANDONMENT. HOWEVER, EVEN WHEN THEY DO FEEL FEAR, THEY ARE FAR BETTER ABLE TO CALM THEMSELVES DOWN. THEY CAN IDENTIFY WHERE THEIR FEAR COMES FROM AND WHERE IT BELONGS, AND THEY CAN TAKE ACTIONS THAT ARE MORE RATIONAL AND APPROPRIATE TO THE REALITY OF THEIR PRESENT LIVES.

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**ABANDONMENT FEAR**

- ENHANCING SELF-COMPASSION IS ACTUALLY FAVORABLE TO BUILDING SELF-ESTEEM, BECAUSE SELF-COMPASSION DOESN'T FOCUS AS MUCH ON JUDGMENT AND EVALUATION. RATHER, IT INVOLVES THREE MAIN ELEMENTS:

  1. **SELF-KINDNESS**: THIS REFERS TO THE IDEA THAT PEOPLE SHOULD BE KIND, AS OPPOSED TO JUDGMENTAL, TOWARD THEMSELVES. THIS SOUNDS SIMPLE IN THEORY BUT IS MUCH MORE DIFFICULT IN PRACTICE. THE MORE PEOPLE CAN HAVE A WARM, ACCEPTING ATTITUDE TOWARD THEMSELVES AND THEIR STRUGGLES, THE STRONGER THEY'LL FEEL IN THE FACE OF DIFFICULT CIRCUMSTANCES. WE CAN ALL BE A BETTER FRIEND TO OURSELVES, EVEN IF WE FEEL HURT OR ABANDONED BY SOMEONE ELSE.

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**ABANDONMENT FEAR**

- 2. **MINDFULNESS**: BEING MINDFUL IS HELPFUL, BECAUSE IT HELPS PEOPLE NOT TO OVER-IDENTIFY WITH THEIR THOUGHTS AND FEELINGS IN WAYS THAT ALLOW THEM TO GET CARRIED AWAY. WHEN PEOPLE FEEL AFRAID OF SOMETHING LIKE BEING ABANDONED, THEY TEND TO HAVE A LOT OF MEAN THOUGHTS TOWARD THEMSELVES PERPETUATING THIS FEAR. IMAGINE IF YOU COULD ACKNOWLEDGE THESE THOUGHTS AND FEELINGS WITHOUT LETTING THEM OVERTAKE YOU. COULD YOU TAKE A GENTLER ATTITUDE TOWARD YOURSELF AND LET THESE THOUGHTS PASS LIKE CLOUDS IN THE SKY INSTEAD OF FLOATING OFF WITH THEM – WITHOUT LOSING YOUR SENSE OF YOURSELF AND, OFTEN, REALITY?
ABANDONMENT FEAR

COMMON HUMANITY: THE MORE EACH OF US CAN ACCEPT THAT WE ARE HUMAN AND, LIKE ALL HUMANS, WE WILL STRUGGLE IN OUR LIVES, THE MORE SELF-COMPASSION AND STRENGTH WE CAN CULTIVATE. IF INDIVIDUALS CAN CONSISTENTLY REMEMBER THAT THEY ARE NOT ALONE AND THAT THEY ARE WORTHY, THEY CAN HELP THEMSELVES AVOID BELIEVING THOSE CRUEL AND INCORRECT MESSAGES, TELLING THEM THAT THEY WILL BE ABANDONED OR THAT THEY’RE UNWANTED.

BEHAVIORAL FOUNDATION PROGRAM

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IDENTITY CLUSTER

- SECURE ATTACHMENT WITH THERAPIST
  - CAN BE ACCOMPLISHED VERBALLY
  - IN A SAFE ENVIRONMENT
  - LIBERATES CLIENT FROM PAST CONSTRAINTS OF RIGID PERSONALITY
  - FACILITATES SELF-OBSERVATION (ACTIVE SCANNING OF INNER-WORLD)
  - OBSERVE WITHOUT CRITICISM OR EVALUATION
  - ENHANCES CAPACITY FOR INTROSPECTION
  - REDUCES PREDICTION ERROR
AFFECTIVE CLUSTER

• TREATMENT
  – BEHAVIORAL
    • STRUCTURE
    • SETTING LIMITS
      • FAIR
      • CONSISTENT
      • AVAILABLE
  – MEDICATIONS
    • MOOD STABILIZERS
    • ANTIDEPRESSANTS

LABELING OUR FEELINGS

• THE MORE MINDFUL YOU ARE, THE MORE ACTIVATION YOU HAVE IN THE RIGHT VENTROLATERAL PREFRONTAL CORTEX AND THE LESS ACTIVATION YOU HAVE IN THE AMYGDALA. WE ALSO SAW ACTIVATION IN WIDESPREAD CENTERS OF THE PREFRONTAL CORTEX FOR PEOPLE WHO ARE HIGH IN MINDFULNESS. THIS SUGGESTS PEOPLE WHO ARE MORE MINDFUL BRING ALL SORTS OF PREFRONTAL RESOURCES TO TURN DOWN THE AMYGDALA.

LABELING OUR FEELINGS

• VERBALIZING OUR FEELINGS AND LABELING EMOTIONS MAKES THEM LESS INTENSE.

• PHOTOGRAPH OF AN ANGRY OR FEARFUL FACE CAUSES INCREASED ACTIVITY IN THE AMYGDALA
  – CREATES A CASCADE OF EVENTS RESULTING IN “FIGHT OR FLIGHT” RESPONSE

• LABELING THE ANGRY FACE CHANGES THE BRAIN RESPONSE

LABELING OUR FEELINGS

• LABELING THE RESPONSE CAUSED THE AMYGDALA TO BE LESS ACTIVE AND THE RIGHT VENTROLATERAL PREFRONTAL CORTEX TO ACTIVATE.

• USING MINDFULNESS AND LABELING THE FEELINGS ONE EXPERIENCES ALLOWS THE PREFRONTAL CORTEX TO OVERRIDE THE AMYGDALA.
  – MATTHEW LIEBERMAN, UCLA, PSYCHOLOGICAL SCIENCE, MAY 2007
**IMPULSIVE CLUSTER**

- **SELF-DESTRUCTIVE BEHAVIOR**
  - A/D USE
  - SUICIDAL AND PARASUICIDAL BEHAVIOR
    - HURT SELF
    - DISSOCIATION
    - REDUCE ANXIETY
  - EATING DISORDERS

**IMPULSIVE CLUSTER**

- **ASSESSMENT**
  - ELABORATE
- **TREATMENT**
  - CONTRACTS
    - SETTING
    - PATIENT'S RESPONSIBILITY
    - ALTERNATIVES
  - MEDICATIONS

**NON-SUICIDAL SELF INJURY**

- WHAT IS THE FUNCTION OF SELF-INJURY?
  - DID PATIENT WANT TO DIE?
    - USUALLY “NO”
  - A WAY TO TOLERATE INESCAPABLE AND UNBEARABLE EMOTIONS, MOST OFTEN INTENSE ANXIETY
    - STUCK IN A BAD SITUATION AND CANNOT FIND ANOTHER WAY TO COPE
  - SELF-INJURY IS REINFORCED TO THE EXTENT THE BEHAVIOR IS EFFECTIVE

**NON-SUICIDAL SELF INJURY**

- BOTH POSITIVE AND NEGATIVE REINFORCEMENT
  - NEGATIVE REINFORCEMENT IS REWARDING BY MAKING AND UNPLEASANT SITUATION STOP
  - POSITIVE REINFORCEMENT IS REWARDING BY GAINING SOMETHING AFTER THE BEHAVIOR
  - WHEN NEGATIVE REINFORCEMENT GENERALLY RELIEVES UNCOMFORTABLE EMOTIONS LIKE ANGER, ANXIETY, GUILT AND NUMBNESS
  - WHEN POSITIVE REINFORCEMENT INCLUDES “FEELING SOMETHING EVEN IF IT IS PAIN”, PUNISHING ONESELF AND FEELING RELAXED
NON-SUICIDAL SELF INJURY

- Males more likely to want to "make others angry"
- Females more likely to want to "punish myself"
- Endogenous opioids
  - Hypothesized that injury induces the release of endogenous opioids which creates reward
    - B-enдорphins comfort negative emotions (Stanley B et al., J AFFECT DISORD 2010:124 (1-2012:140))
  - Early childhood trauma changes the density of opiate receptors and level of B-endorphin baseline

NON-SUICIDAL SELF INJURY

- Early childhood trauma changes the density of opiate receptors and level of B-endorphin baseline (continued)
  - May find injuring less painful and subsequent opioid release more pleasurable
  - Patients with only one episode of self-injurious behavior say "it hurt" and didn't repeat behavior
  - Non-suicidal self injury (NSSI) may be the best predictor of suicide attempt (Wilkinson P et al, AM J PSYCHIATRY 2011; FEBRUARY 1)
    - 70% of people who engage in NSSI eventually attempt suicide

RISK ASSESSMENT

- Safety plan
  - Contracting for safety has no evidence base and asking the patient to sign a document stating they will not harm themselves can be problematic
    - Promise without "how to not harm self"
    - May feel they cannot talk about being suicidal
    - May give clinical team a false sense of security
  - Develop a plan for "what to do" when patient feels suicidal
  - Safety Planning Intervention (SPI) is a brief intervention with ongoing clinical trial but is a suicide prevention resource center/American Foundation for Suicide Prevention best practice

SAFETY-PLANNING INTERVENTION

1. Recognizing warning signs.
2. Employing internal coping strategies without needing to contact another person.
3. Socializing with family members or others who may offer support as well as distraction from the crisis (external strategies)
4. Contacting family members or friends who may help to resolve a crisis (seeking support).
5. Contacting mental health professionals or agencies.
6. Reducing the potential use of lethal means
STEP ONE: RECOGNIZING WARNING SIGNS

SAFETY PLAN IS ONLY USEFUL IF THE PATIENT CAN RECOGNIZE THE WARNING SIGNS.

• THE CLINICIAN SHOULD OBTAIN AN ACCURATE ACCOUNT OF THE EVENTS THAT TRANSPRIED BEFORE, DURING, AND AFTER THE MOST RECENT SUICIDAL CRISIS.

ASK “HOW WILL YOU KNOW WHEN THE SAFETY PLAN SHOULD BE USED?”
ASK “WHAT DO YOU EXPERIENCE WHEN YOU START TO THINK ABOUT SUICIDE OR FEEL EXTREMELY DISTRESSED?”

• WRITE DOWN THE WARNING SIGNS (THOUGHTS, IMAGES, THINKING PROCESSES, MOOD, AND/OR BEHAVIORS) USING THE PATIENTS’ OWN WORDS

STEP ONE: RECOGNIZING WARNING SIGNS

AUTOMATIC THOUGHTS
“I AM A NOBODY”
IMAGES
FLASHBACKS
MOOD
FEELING DEPRESSED
BEHAVIOR
CRYING
ISOLATING MYSELF
USING DRUGS

STEP TWO: EMPLOYING INTERNAL COPING STRATEGIES

LIST ACTIVITIES THAT PATIENTS CAN DO WITHOUT CONTACTING ANOTHER PERSON.
• ACTIVITIES FUNCTION AS A WAY TO HELP PATIENTS TAKE THEIR MINDS OFF THEIR PROBLEMS AND PROMOTE MEANING IN THE PATIENT’S LIFE.
• COPING STRATEGIES PREVENT SUICIDE IDEATION FROM ESCALATING

EXAMPLES: GO FOR A WALK, LISTEN TO INSPIRATIONAL MUSIC, TAKE A HOT SHOWER, WALK THE DOG

• AUTOMATIC THOUGHTS
  • THEY ARE SHORT, SNAPPY AND SPONTANEOUS
    • “I AM GOING TO DIE”
    • “I LOOK LIKE AN IDIOT”
  • THEY ARE OVERGENERALIZATIONS MAKING THE STATEMENT FALSE
    • ALWAYS
    • NEVER
    • NOBODY
    • EVERYBODY
    • EVERYTHING
    • NO ONE

• THEY ARE SHORT, SNAPPY AND SPONTANEOUS
  • “I AM GOING TO DIE”
  • “I LOOK LIKE AN IDIOT”
• THEY ARE OVERGENERALIZATIONS MAKING THE STATEMENT FALSE
  • ALWAYS
  • NEVER
  • NOBODY
  • EVERYBODY
  • EVERYTHING
  • NO ONE
**STEP TWO: EMPLOYING INTERNAL COPING STRATEGIES**

Ask,"How likely do you think you would be able to do this step during a time of crisis?"

Ask,"What might stand in the way of you thinking of these activities or doing them if you think of them?"

Use a collaborative, problem solving approach to address potential roadblocks.

**STEP THREE: EXTERNAL STRATEGIES**

Coach patients to use step 3 if step 2 does not resolve the crisis or lower risk.

Family, friends (buddy from the service), or acquaintances who may offer support and distraction from the crisis.

Ask,"Who helps you take your mind off your problems at least for a little while?"

Ask,"Who do you enjoy socializing with?"

Ask patients to list several people, in case they cannot reach the first person on the list.

**STEP FOUR: SEEKING SUPPORT**

Coach patients to use step 4 if step 3 does not resolve the crisis or lower risk.

Seeking support from friends and/or family.

Ask,"How likely would you be willing to contact these individuals?"

Identify potential obstacles and problem solve ways to overcome them.

**STEP FIVE: CONTACTING PROFESSIONALS AND AGENCIES**

Coach patients to use step 5 if step 4 does not resolve the crisis or lower risk.

Ask,"Which clinicians should be on your safety plan?"

Identify potential obstacles and develop ways to overcome them.

List names, numbers and/or locations of:

- Clinicians
- Local urgent care services
- Suicide prevention hotline
BEHAVIORAL SAFETY PLAN ON 3X5 INDEX CARD

MY PERSONAL SAFETY PLAN

• Remember that craving go away
• I can write in my journal
• I can call my sponsor (299-289-5555)
• I can call my lover (299-426-1776)
• I can read from my favorite recovery book
• I can read affirmations

ANTISOCIAL PERSONALITY DISORDER AND CONDUCT DISORDER

• DIAGNOSTIC CRITERIA-CONDUCT DISORDER
  – AGGRESSION TO PEOPLE OR ANIMALS
  – DESTRUCTION OF PROPERTY
  – DECEITFULNESS OR THEFT
  – SERIOUS VIOLATIONS OF RULES

• SUBTYPES
  – CHILDHOOD-ONSET
  – ADOLESCENT-ONSET
  – UNSPECIFIED (UNABLE TO DETERMINE WHETHER ONSET WAS PRIOR TO AGE 10)

CONDUCT DISORDER

• CHILDHOOD-ONSET
  – NON-NORMATIVE PEER RELATIONS
  – MOSTLY MALE
  – ONSET PRIOR TO 10 YO
  – AGGRESSIVE STYLE MAY BE PREDATORY
  – GENETICS INVOLVED
  – MAY ALSO HAVE OPPOSITIONAL DEFIANT DISORDER OR ATTENTION-DEFICIT DISORDER
  – MORE LIKELY TO PRECEDE ANTISOCIAL PD

• ADOLESCENT-ONSET
  – NORMATIVE PEER RELATIONS
  – ONSET AFTER 10 YO
  – LESS LIKELY TO DISPLAY AGGRESSION ALTHOUGH MAY DISPLAY CONDUCT PROBLEMS IN GROUPS
  – EMOTIONAL OR PASSIVE-AGGRESSIVE ACTING-OUT
  – MALE/FEMALE RATIO MORE BALANCED
  – LESS LIKELY TO DEVELOP ANTISOCIAL PD
CONDUCT DISORDER

- SPECIFIERS
  - WITH LIMITED PROSOCIAL EMOTION
    - LACK OF REMORSE OR GUILT
    - CALLOUS-LACK OF EMPATHY
    - UNCONCERNED ABOUT PERFORMANCE (SCHOOL, WORK OR OTHER ACTIVITIES)
    - SHALLOW OR DEFICIENT AFFECT

ANTISOCIAL PERSONALITY DISORDER

- DSM-I CATEGORIZED ALCOHOLISM UNDER ANTISOCIALITY
- MAY HAVE ASSOCIATED IMPULSE CONTROL PROBLEMS
- HIGHER INCIDENCE OF SUBSTANCE-RELATED DISORDERS AND PATHOLOGICAL GAMBLING

ANTISOCIAL PERSONALITY DISORDER

- PSYCHOPATHIC INDIVIDUALS CAN FEEL FEAR, BUT HAVE TROUBLE IN THE AUTOMATIC DETECTION AND RESPONSIVITY TO THREAT.

SYLCO S. HOPPENBROUWERS, BEREND H. BULTEN, INTI A. BRAZIL. PARSING FEAR: A REASSESSMENT OF THE EVIDENCE FOR FEAR DEFICITS IN PSYCHOPATHY. PSYCHOLOGICAL BULLETIN, 2016; 142 (6): 573 DOI: 10.1037/BUL0000040

ANTISOCIAL PERSONALITY DISORDER

- WHEN INDIVIDUALS WITH PSYCHOPATHY IMAGINE OTHERS IN PAIN, BRAIN AREAS NECESSARY FOR FEELING EMPATHY AND CONCERN FOR OTHERS FAIL TO BECOME ACTIVE AND BE CONNECTED TO OTHER IMPORTANT REGIONS INVOLVED IN AFFECTIVE PROCESSING AND DECISION-MAKING
1. When highly psychopathic participants imagined pain to themselves, they showed a typical neural response within the brain regions involved in empathy for pain, including the anterior insula, the anterior midcingulate cortex, somatosensory cortex, and the right amygdala. The increase in brain activity in these regions was unusually pronounced, suggesting that psychopathic people are sensitive to the thought of pain.

2. But when participants imagined pain to others, these regions failed to become active in high psychopaths. Moreover, psychopaths showed an increased response in the ventral striatum, an area known to be involved in pleasure, when imagining others in pain.

3. This atypical activation combined with a negative functional connectivity between the insula and the ventromedial prefrontal cortex may suggest that individuals with high scores on psychopathy actually enjoyed imagining pain inflicted on others and did not care for them. The ventromedial prefrontal cortex is a region that plays a critical role in empathetic decision-making, such as caring for the wellbeing of others.

4. Altered connectivity may constitute novel targets for intervention. Imagining oneself in pain or in distress may trigger a stronger affective reaction than imagining what another person would feel, and this could be used with some psychopaths in cognitive-behavior therapies as a kick-starting technique.

ANTISOCIAL PERSONALITY DISORDER

- Never develop a sense of attachment to others and the world
- Have low orbitofrontal cortex activity
- Involved in ethical behavior
- Moral decision making
- Impulse control
- Combination of genetic patterns, brain patterns and early life trauma

PARALIMBIC SYSTEM AND ASPD

- Paralimbic system is a circuit of interconnected brain regions that may well be the area of malfunction in ASPD
- These interconnected brain regions register feelings and other sensations and assign emotional value to experiences, as well as, being involved in decision making, high level reasoning and impulse control
- Area is underdeveloped in ASPD and damage to these areas can create psychopathic traits

PHINEAS GAGE
PHINEAS GAGE
• 43 INCHES LONG, 1.25 INCHES IN DIAMETER AND WEIGHING 13.25 POUNDS
  • THE TAMPPING IRON PENETRATED THE LEFT CHEEK AND EXCITING THROUGH THE SKULL
  • LOST A PART OF HIS BRAIN CALLED THE VENTROMEDIAL PREFRONTAL CORTEX (VMPFC) AN AREA STRUCTURALLY SIMILAR TO THE ORBITOFRONTAL CORTEX (OFC)

PHINEAS GAGE
• OFC INVOLVED IN SOPHISTICATED DECISION-MAKING TASKS THAT INVOLVE SENSITIVITY TO RISK, REWARD AND PUNISHMENT
  • LEADS TO PROBLEMS OF IMPULSIVITY AND INSIGHT AND LASH OUT IN RESPONSE TO PERCEIVED AFFRONTS
  • THESE WERE GAGE'S PREDOMINANT SYMPTOMS ALTHOUGH HE STILL POSSESSED EMPATHY

PHINEAS GAGE
• EMPATHY INVOLVES MANY AREAS OF THE BRAIN BUT THE AMYGDALA SEEMS TO BE A CENTRAL PLAYER AS IT GENERATES EMOTIONS SUCH AS FEAR-CREATES FEARLESSNESS
  • ASPD NOTED FOR FEARLESSNESS-WHEN CONFRONTED WITH AN ATTACKER THEY DO NOT BLINK
  • THEIR EEG READINGS ARE CONSISTENT WHEN SHOWN WORDS LIKE “BLOOD” AND “HOUSE” (A NEUTRAL WORD), THE PATTERNS ARE ALSO DIFFERENT THAN CONTROLS

PARALIMBIC SYSTEM AND ASPD
PARALIMBIC SYSTEM AND ASPD

- Empathy involves other areas of brain such as
  - Orbifrontal cortex
  - Anterior cingulate
  - Dorsolateral prefrontal cortex
- Anterior cingulate regulates emotional states and helps people control their impulses and monitor their behavior for mistakes
- The insula plays a key role in the recognition of violation of social norms, as well as, the experiencing of anger, fear, empathy and disgust
- Insula also involved in pain perception and psychopaths are strikingly unfazed by threat of pain

PARALIMBIC SYSTEM AND ASPD

- FMRI images of brains (Kiehl) show pronounced thinning of paralimbic tissue indicating the area is underdeveloped

ANTISOCIAL PERSONALITY DISORDER

- Delinquent adolescents from the Netherlands aged between 15 and 21 years who had been diagnosed with an antisocial personality disorder
- The delinquent adolescents showed less activation than the control group in the temporoparietal junction and in the inferior frontal gyrus (FMRI).
ANTISOCIAL PERSONALITY DISORDER

• These areas of the brain are responsible for functions including the ability to put oneself in another person’s position and impulse control. In both groups, the researchers observed similar levels of activation in the dorsal anterior cingulate cortex and in the anterior insula -- areas of the brain associated with affective processes.


ANTISOCIAL PERSONALITY DISORDER

• The findings indicate that although both groups showed the same levels of emotional reactivity to unfair offers, the delinquent adolescents rejected these offers more often. In contrast to the control group, they did not take account of their opponent’s intention – or of whether their opponent had no alternative.

IS ASPD MADE OR BORN?

• Combination of nature and nurture - genes and environment
  • Some are scared by early environment
  • Others are “black sheep” of stable families

ARE THEY TREATABLE?

• ASPD is a disorder of range, the far end is the psychopath who is difficult, if not impossible, to treat with today’s technology.

ONE WAY OF CONSIDERING TREATMENT IS TO THINK OF DEVELOPMENT AS OCCURRING EASIEST DURING CERTAIN PERIODS OF LIFE OFTEN CALLED “CRITICAL PERIODS”

• Childhood and early adolescence may be a window for developing social and cognitive skills we call “conscience”
ANTISOCIAL PERSONALITY DISORDER

- Hare’s studies show that group therapy for psychopaths in prison results in more crimes than if they had no therapy.
- Notoriously good at learning and exploiting the weaknesses of others.
- They have trouble absorbing abstract ideas so lectures about personal responsibility are unlikely to be helpful.
- Insight oriented therapy also ineffective.

TREATMENT OF INTRACTABLE JUVENILE OFFENDERS WITH PSYCHOPATHIC TENDENCIES AT MENDOTA JUVENILE TREATMENT CENTER IN MADISON, WI. (WWW.NREPP.SAMHSA.GOV/VIEWINTERVENTION.ASPX?ID=38)

- Intensive one-on-one therapy known as decompression aimed ending the vicious cycle in which punishment for bad behavior inspires more bad behavior.
- 150 youths were 50% less likely to engage in violent crime than a comparable group treated at regular juvenile corrections facilities.

SIGNS YOU ARE DEALING WITH ASPD

- Shallow affect and limited emotional responsiveness.
- Research indicates that psychopaths have reduced affective responses and an absence of a startle response (Patrick et. al, 1993). In fact, lab experiments indicate that they lack the physiological responses associated with fear (Lykken, 1995; Ogloff & Wong, 1990).

- Such findings suggest that psychopaths have a greater ability than others to engage in cruel and callous behavior without considering the emotional consequences or even punishment for their actions.
- When psychopaths are in their natural state, there is an eerie sense of calm, quiet and nonchalance about them.
SIGNS YOU ARE DEALING WITH ASPD

• THEIR PREDATORY GAZE ZOOMS IN ON POTENTIAL PREY.
  • WHEN THEY ARE MANIPULATING SOMEONE, THOSE WITH ANTISOCIAL TRAITS ARE KNOWN FOR THEIR INTENSE "PREDATORY GAZE" WHEN THEY FIXATE ON A SPECIFIC VICTIM. THIS CAN BE AN ALMOST REPTILIAN GAZE THAT IS DESCRIBED AS "DEAD" AND "DARK" OR EVEN SEDUCTIVE IF THE PSYCHOPATH IS ATTEMPTING TO LURE SOMEONE IN SEXUALLY. AS ROBERT HARE (1993) WRITES IN WITHOUT CONSCIENCE:

SIGNS YOU ARE DEALING WITH ASPD

• "MANY PEOPLE FIND IT DIFFICULT TO DEAL WITH INTENSE, EMOTIONLESS, OR "PREDATORY" STARE OF THE PSYCHOPATH. NORMAL PEOPLE MAINTAIN CLOSE EYE CONTACT WITH OTHERS FOR A VARIETY OF REASONS, BUT THE FIXATED STARE OF THE PSYCHOPATH IS MORE OF A PRELUDE TO SELF-GRATIFICATION AND THE EXERCISE OF POWER THAN SIMPLE INTEREST OR EMPATHIC CARING...SOME PEOPLE RESPOND TO THE EMOTIONLESS STARE OF THE PSYCHOPATH, WITH CONSIDERABLE DISCOMFORT, ALMOST AS IF THEY FEEL LIKE POTENTIAL PREY IN THE PRESENCE OF A PREDATOR."

SIGNS YOU ARE DEALING WITH ASPD

• THEY REQUIRE HIGH LEVELS OF STIMULATION BECAUSE OF PERPETUAL BOREDOM.
  • THE PSYCHOPATHY CHECKLIST DEVELOPED BY ROBERT HARE (2008) LISTS "PRONE TO BOREDOM" AS ONE OF THE TRAITS OF BEING A PSYCHOPATH. SOMEONE WHO IS PERPETUALLY BORED IS UNBELIEVABLY RESTLESS AND CAN BE IMPULSIVE WHEN IT COMES TO HIGH-RISK BEHAVIOR. IT IS UNSURPRISING THAT DUE TO THEIR CHRONIC BOREDOM, PSYCHOPATHS GAIN THE MOST EXCITEMENT FROM CONNING OTHERS OR ENGAGING IN CRIMINAL ACTIVITIES OF ALL KINDS.

SIGNS YOU ARE DEALING WITH ASPD

• THEIR EXCESSIVE NEED FOR STIMULATION AND ENTERTAINMENT, COMBINED WITH THEIR LACK OF REMORSE, IS ALSO WHAT ENABLES THEM TO ENGAGE IN MULTIPLE RELATIONSHIPS AND SEXUAL LIAISONS SIMULTANEOUSLY.
  • FOR PSYCHOPATHS, THE NOVEL IS WHAT IS MOST EXCITING AND THEY QUICKLY GET BORED WITH THEIR CURRENT PURSUITS IN SEARCH OF SOMETHING "BETTER."
SIGNS YOU ARE DEALING WITH ASPD

• They demonstrate a haughty, superior and contemptuous attitude.

• As natural braggarts, psychopaths tend to oversell themselves and their abilities. They self-aggrandize and believe the world must cater to their ego. They take pride in whatever qualities make them special and they believe themselves to be the exception to every rule.

• This form of grandiosity isn’t just your garden-variety arrogance, but rather, a core belief the psychopath holds about himself or herself that shapes everything they do. No amount of theft, criminal activity, con artistry, infidelity, or pathological lying may be out of bounds for them; they are contemptuous of the “mere mortals” who allow their values or morals to interfere with achieving their goals.

SIGNS YOU ARE DEALING WITH ASPD

• Their curiosity is limited to what they can gain.

• Psychopaths and other similarly empathy-challenged individuals do not care about someone else’s successes, goals, interests, hobbies or needs unless those very things can be used to serve them. For example, a wealthier partner can be “useful” to a predator so long as he or she can financially depend on them for a place to stay or funds. Psychopaths are known for leading parasitic lifestyles.

• The study found that the blood flow among murderers in the prefrontal cortex (PFC) of the brain was significantly decreased. This area of the brain is implicated in anger management and deficits here indicate a relative inability to utilize resources involved with inhibition, self-censorship, planning, and future consequences. The results suggest that murderers who commit acts of impulsive violence show a marked inability to utilize important cognitive resources when challenged by emotionally neutral tasks.
LOWER LEVELS OF PFC VOLUME AND ACTIVITY
• LOWER LEVELS OF PFC ACTIVITY AND VOLUME FOUND IN IMPULSIVE MURDERERS BUT NOT IN COLD, CALCULATING CRIMINALS
• PFC VOLUME OF GRAY MATTER 22.3% DEFICIENT IN UNSUCCESSFUL OFFENDERS BUT PFC VOLUME IN NORMAL RANGE FOR SUCCESSFUL OFFENDERS (AVOIDING CAPTURE AS CRITERIA FOR SUCCESS)


ANTISOCIAL PERSONALITY DISORDER
• HARE PSYCPATHY CHECKLIST-REVISED
  • 20 CRITERIA EACH GRADED 0, 1, OR 2
  • AVG. GENERAL POPULATION SCORE IS 4
  • OVER 30 IS PSYCHOPATHIC RANGE
  • MEASURES
    • ANTISOCIAL BEHAVIOR
      • NEED FOR STIMULATION AND PRONENESS TO BOREDOM
      • PARASITIC LIFESTYLE
      • POOR BEHAVIORAL CONTROL
      • SEXUAL PROMISCUITY
      • LACK OF REALISTIC LONG-TERM GOALS

• MEASURES
  • ANTISOCIAL BEHAVIOR (CONTINUED)
    • IMPULSIVITY
    • IRRESPONSIBILITY
    • EARLY BEHAVIOR PROBLEMS
    • JUVENILE DELINQUENCY
    • PAROLE OR PROBATION VIOLATIONS
  • EMOTIONAL/INTERPERSONAL TRAITS
    • GLIBNESS AND SUPERFICIAL CHARM
    • GRANDIOSE SENSE OF SELF-WORTH
    • PATHOLOGICAL LYING

• MEASURES
  • EMOTIONAL/INTERPERSONAL TRAITS (CONTINUED)
    • CONNING AND MANIPULATIVENESS
    • LACK OF REMORSE OR GUILT
    • SHALLOW AFFECT
    • CALLOUSNESS AND LACK OF EMPATHY
    • FAILURE TO ACCEPT RESPONSIBILITY FOR ACTIONS
  • OTHER FACTORS
    • COMMITTING A WIDE VARIETY OF CRIMES
    • HAVING MANY SHORT-TERM MARITAL RELATIONSHIPS
MANAGEMENT CONSIDERATIONS - ASPD

• GOAL
• PREREQUISITES
• BUSINESS-LIKE
• BEHAVIORAL
  – LIMIT SETTING
  – TREATMENT PLAN
• INCORPORATE “OBSERVERS”

COUNTERTRANSFERENCE

• CLINICIANS TEND TO FEEL MISTREATED, CRITICIZED, OR REPULSED AND CAN EXPERIENCE AN INTENSE ANGER AND IRRITATION WORKING WITH ANTISOCIAL PATIENTS. THEY OFTEN FEEL USED OR MANIPULATED BY THEM AND PUSHED TO SET FIRM LIMITS IN THE CLINICAL SETTING. THEY CAN SOMETIMES FEEL THEY ARE BEING CRUEL, MEAN, OR AGGRESSIVE WHEN WORKING WITH THESE PATIENTS AND WISH THEY HAD NEVER TAKEN THEM ON IN THERAPY.

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