A Stubborn Problem

• Suicide rates have not decreased in the last decade, or in the last 110 years. It is one of only three of the top ten reasons for death in the United States that is increasing, rather than decreasing. (The other two are overdoses and Alzheimer’s disease.)
• The increase has occurred in every state except Nevada. More than half of the deaths were among people with no known mental health problem. Coroners’ reports suggest relationship problems, substance use and financial crises were the proximate cause.
• This is more than a mental health problem.

No Personalized Predictors

• The base rate of suicide is low, creating a number of statistical and research problems. Our current approach of using epidemiologic risk factors has no clinical utility at an individual level. (This is called the “ecological fallacy” – assuming social characteristics of groups are applicable to particular individuals in those groups.)
• Decades of research have failed to identify any new personalized predictors. We have no biological markers.
“Suicide Risk Assessment Doesn’t Work”

Scientific American, 3/28/17

- 95% of high risk patients will not die of suicide at all. 50% of the lower risk categories will die of suicide. Suicide risk scales using multiple factors are no better than just using one factor. There has been no improvement in the accuracy of suicide risk assessment in the last 40 years. (Large, M, et al. PLOS one, June 10, 2016)

“Suicide Risk Assessment Doesn’t Work”

- The four most strongest risk factors (previous episodes of self-harm, suicidal intent, physical health problems, male gender) are so common they are no help in assessing risk. There is no evidence to support the use of risk assessment scales. (Chan M, et al. Brit J Psych Oct 2016)

“Suicide Risk Assessment Doesn’t Work”

- The attention paid to suicide risk assessment instruments diverts clinicians from really engaging with patients. Guidelines in the UK state that tools and scales that give a crude indication of the level of risk (high, medium, low) should not be used.
Best Practice

• At present, the consensus among mental health leaders is that a good suicide risk assessment involves a clinical interview augmented by structured assessment data and clinical judgement.

Columbia-Suicide Severity Rating Scale (C-SSRS)

• The C-SSRS is the current “gold standard” of suicide risk assessment instruments. It was selected by the FDA as the preferred instrument to be used in research studies. It is hoped that it will be universally used in suicide research, so that data can easily be compared from one study to another, as in the case with the Hamilton Depression Scale.

The C-SSRS: A Good Beginning

• There are some variations of the instrument useful for different settings available at their website. There are also a number of literature citations given.
• The C-SSRS has not been compared to other instruments and may have some serious flaws (Giddens 2014.)
• Clinicians should not rely on the C-SSRS alone to do suicide risk assessments.
Forms don’t do suicide risk assessments.

People do.

Social Media
(Christensen, JAMA May 2016)

• Social media has the power to study vast numbers of people in very short time frames. Software is being developed by Facebook and Google to track suicidal language and videos and mark them for possible intervention.
• Data mining can uncover previously unknown risk factors (use of certain phrases and personal pronouns on blogs and Twitter, facial or voice characteristics on videos)
• Social media can facilitate help seeking and peer support through smart phone apps.

Warning Signs vs. Risk Factors

• Risk factors are epidemiologically derived, often distant in time and unchangeable (age, gender, previous attempts, etc...) They may mean nothing.
• Warning signs are behavioral signs of precipitating conditions in an individual. They are observable and current.
• Risk factors make warning signs more ominous.
### Simplified Risk Assessment: 5 Risk Factors, 5 Warning Signs, 5 Steps

<table>
<thead>
<tr>
<th>Five Warning Signs</th>
<th>Five Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Suicidal intention (rumination, planning, preparation, access, giving items away) <strong>ACUTE</strong></td>
<td>1) Previous attempts or exposure to violence, self-injury, impulsive aggression <strong>CHRONIC</strong></td>
</tr>
<tr>
<td>2) Sudden change in mood with no known reason <strong>ACUTE</strong></td>
<td>2) Mental illness, substance abuse <strong>CHRONIC</strong></td>
</tr>
<tr>
<td>3) Anxiety, agitation, insomnia, despair, hopelessness <strong>ACUTE</strong></td>
<td>3) Social isolation, stress, loss <strong>ACUTE or CHRONIC</strong></td>
</tr>
<tr>
<td>4) Feeling like a burden to others, disconnected <strong>ACUTE</strong></td>
<td>4) Family history or exposure to suicide <strong>CHRONIC</strong></td>
</tr>
<tr>
<td>5) Poor treatment alliance <strong>ACUTE</strong></td>
<td>5) Native-American or white male</td>
</tr>
</tbody>
</table>

### Acute Risk
- **High:** Person with risk factors and warning signs, inability to maintain safety, access to means, acute stressors – needs hospitalization
- **Medium:** As above, but able to maintain safety, intent is ambivalent, no preparation – needs frequent contact, safety plan, regular re-assessment
- **Low:** No intent, plan or preparation, capable of following coping strategies – primary care

### Chronic Risk
- **High:** Ongoing mental disorder/personality disorder, prior attempts, limited coping skills, instability. Requires skill building, safety plan, routine re-assessment
- **Medium:** As above but with stronger protective factors and coping skills. Requires safety plan, routine mental health care
- **Low:** No chronic suicidality or previous attempts, strong coping and resources. Requires mental health care as needed.
Don’t Worry Alone.

Main Points
• Personality Disorder diagnosis is deeply flawed. There is considerable overlap. Most clinicians are unable to choose which personality disorder a person has and end up diagnosing “mixed” personality disorder in one way or another.
• Suicide risk, like violence risk, is not determined by a diagnostic label. It is determined by the particular traits that the individual is exhibiting and the relationship of those traits to the context of what is happening at the moment.

Borderline Personality Disorder
• BPD is the only disorder that includes recurrent suicidal behavior as part of the disorder.
• 70% will attempt suicide with an average of 3 attempts per person. 3-10% will die of suicide, 40% men.
• Most attempts occur early in the 20’s, but most deaths will happen later in the illness (mean age of 37), so during the most alarming stage of the illness, there is less chance of death.
Description
• Interpersonal problems
  • Turbulence, fear of abandonment, self-esteem dependent on important others
• Affective instability
  • Reactivity, intense negative emotions, pervasive dysphoria
• Behavioral difficulties
  • Impulsive, self-destructive, addictions, recklessness
• Cognitive problems
  • Lack of stable sense of self, psychosis and dissociation
• Comorbidity
  • Substance abuse, impulse control disorders, mood disorders, eating disorders, anxiety disorders, PTSD, ADHD

Clinical Consensus Summary
• Severe emotion dysregulation
• Strong impulsivity
• Social-interpersonal dysfunction

Natural History
• Diagnosis is unstable, improvement over time is the norm, hospitalization is uncommon after the first few years of illness.
• Most individuals with borderline personality eventually get a life, find a place in the world, and stop wanting to kill themselves.
• However, complete recovery (good social and vocational functioning, in addition to symptomatic improvement) is difficult to obtain.
Recovery

• Engaging in meaningful work, or at least meaningful activity, is an important part of the recovery from borderline personality disorder.

Interpersonal Agenda of the Borderline Personality

• The person’s primary concern is to find someone who can understand them perfectly enough so that their sense of isolation will abate and their misery will stop. It is a kind of “Golden Fantasy” – by finding the one person who can help them, all of their needs will be met.

• A strong fear of abandonment arises when something seems to disrupt the developing relationship. Abandonment fear is expressed with “rage” as a kind of hostile dependence.

Some Reasons for SIB

• Affect regulation
  • Reconnection with the body
  • Calming the body during periods of arousal
  • Validating inner pain
  • Avoiding suicide

• Communication
  • Express things which cannot be said out loud

• Control/punishment
  • Trauma re-enactment
  • Bargaining and magical thinking
  • Self-control/manipulation
SIB and Suicide
• Psychotic and affective disorder clients: may be a prodrome to suicide.
• Personality disordered clients: to reduce tension and communicate
• Those who self-injure without suicidal intent:
  • Do less damage
  • Use multiple methods
  • Have intermittent psychic pain, not constant
  • Show more affect
  • Show rapid improvement after hurting themselves
  • Show optimism and sense of control

Suicide and SIB in Borderline Personality
• SIB is reported by 43-78%.
• The act of self-injury usually has little overt suicidal ideation, but the probability of suicide is increased 2x in the future.
• Clinicians and family members see self-harm as manipulative (about us), but BPD’s see the acts as an attempt to control their inner experience (about them.)

Suicide and NSSI
• NSSI usually follows suicidal ideation, rather than vice versa or no relationship.
• NSSI may delay suicidal behavior – it is a window of opportunity.
• “Do you have fleeting thoughts of suicide when you self-injure?”
• NSSI may lead to acquired capability and body disregard.
SSI and Suicide Risk Increase

• Greater versatility (cutting has a unique relationship to risk) 1-2x vs 5+x
• Frequency (lifetime): 1-10 vs. 21-50. More than 50 times is related to lower risk!
• Motivation: more reasons, more risk. Greatest risk is “to prevent suicide” followed by self-hate.
• Location of injury (non-arm.) Is it more dangerous behavior because it is more hidden?

SSI and Suicide Risk

• “Not working as well” is an ominous statement
• Severity of self-harm – not as important as other factors

Study Predicting Suicidal Behavior in BPD, 6+ years

• Most suicide attempts occurred in the first two years of the study (24.8%)  
• The first 12 months: major depressive disorder. Outpatient treatment reduced attempts
• 4 years: illness severity (hospitalizations)  
• 6 years: absence of outpatient treatment, low socioeconomic status
• All intervals: poor psychosocial and global functioning. Family history.
• Symptomatic improvement did not prevent poor psychosocial outcomes.
Suicide Risk and BPD

- Impulsivity is associated with number of attempts but not lethality.
- Manipulative suicide attempts decrease from 56.4% at year 2 to 4.2% by year 10.
- Suicide death occurs after many years of illness, failure to benefit from treatment, loss of supportive relationships, and social isolation. Patients were no longer involved in active treatment.
- Borderline symptoms did not have any predictive value for suicidal behavior over the long term.

Long-Term Risk

- This is confirmed by a recent study that shows in borderline personality, acute stressors such as depression may contribute to a short-term risk of suicidal behavior, but long-term risk is more related to poor psychosocial outcomes.

Treatment Dilemmas (Gunderson 2009)

- Dramatic fluctuations in capacities will challenge diagnostic certainty.
- Urgent appeals for an exclusive helping relationship will generate strong counter-transference responses, including inadequate rescue efforts.
- Treaters and others will have intense and distinct reactions, seeing the patient as a helpless victim or angry bully.
- Separation will prompt regressions
- Medication will not help significantly and will often be harmful.
Pharmacological Treatment

- No medication has been approved by the FDA for BPD or BPD traits, although MSAD showed 40% of clients on 3+ medications, 20% taking 4+ medications, 10% taking 5+ or more medications.
- Medication is hard to use with these clients because of their extreme reactivity, transference problems, suicidality, comorbidity, and variety of symptoms among clients.
- Clients with impulse disorders often exhibit a strong initial transient response to placebo treatment.

Gunderson, 2018

- The group of patients with borderline personality constitute more than 20% of all psychiatric inpatients and 10% of psychiatric outpatients.
- Patients usually receive the diagnosis only after they have received multiple trials with psychoactive medications. Medication then continues over many more years.
- The use of mood stabilizers began with the view that borderline personality was part of a bipolar spectrum disorder.

Cont.

- We now know that the actual co-occurrence of borderline personality and any bipolar disorder is only 15%. The two disorders have little impact on each other’s course and rarely occur in together in other family member. Medications can help build an alliance, relieve states of stress, and be helpful for comorbid disorders, but they should be prescribed with skepticism.
Psychotherapy and Borderline Personality Disorder

• A 2012 study (McMain 2012) shows that well-structured general psychiatric treatment, focusing on interpersonal issues and emotion regulation, targeting the acute symptoms of borderline personality disorder, was as effective and dialectical behavior therapy at 2-year follow-up.

• In fact, no specialized treatment for BPD has ever been shown to be better than general psychiatric treatment, as described above. Unstructured treatments fare poorly.

Common Ingredients of Successful Therapies (Paris 2008)

• Emphasize getting a life in the present – a job, going to school, having a relationship, etc

• Manage emotional dysregulation – learn and label feelings, then modify them through mindfulness, distress tolerance, problem solving

• Deal with impulsivity – use behavioral analysis, teaching patients to slow down before reacting

• Manage bad interpersonal relationships – get patients to broaden their sources of satisfaction and support

Excellent Video About Talking to Clients about Borderline PD

• [https://vimeo.com/185015649](https://vimeo.com/185015649)
Treatment of SIB

• There is no good evidence base for using medications.
• The best non-evidence based recommendations would be: if SIB occurs in the context of an affective or obsessive/compulsive disorder, treatment should begin with an antidepressant or mood stabilizer. If psychosis, tics, seizures, akathisia or pain contribute, treat with an antipsychotic, anticonvulsant, tranquilizer or analgesic respectively. In the remaining subtypes, initiate treatment with an SSRI. If that is ineffective, add or substitute naltrexone. Then try lithium, beta blockers, pindolol, clonidine, guanfacine, or an MAOI.

Treatment for SIB

• Therapeutic approaches that have been tried include cognitive restructuring (dialectical behavior therapy), behavior modification, assertiveness training, teaching alternative coping mechanisms, and psychodynamic long-term partial hospitalization programs. DBT is the only well-replicated successful treatment. Targeting emotion dysregulation may be a useful focus.

Treatment

• Improving stress tolerance addresses most of the internal reasons for self harm. Improving interpersonal effectiveness addresses most of the interpersonal reasons.
• Cognitive behavior therapy can help adolescents stay out of the ruminative negativity that drives the overwhelming distress.
• Developing alternatives to self-injury is important.
Treatment - A CBT Approach

Current Psych (Aug 2014)

• Aaron Beck proposed in 1979 that a person’s biopsychosocial vulnerabilities interact with suicidal thoughts to produce a state called “suicide mode.” This mode can be activated by cognitive, affective, or behavioral systems. It can also become chronically active.

• CBT aims to
  • Deactivate the suicide mode
  • Modify its structure and content
  • Construct a more adaptive mode

---

Treatment - A CBT Approach

Current Psych (Aug 2014)

• Phase 1: Tell the suicide story
  • Engage the client in treatment
  • Generate a safety plan
  • Develop a cognitive-behavioral conceptualization
    • Automatic thoughts (I am going to get fired today.)
    • Conditional assumptions (If I get fired, my life is over.)
    • Core beliefs (I am a failure.)

---

Treatment - A CBT Approach

Current Psych (Aug 2014)

• Phase 2: Build skills to prevent episodes of suicidal behavior, manage underdeveloped and overdeveloped skills (virtual hope box, coping cards, etc.)
  • Self-soothing vs. self-blame
  • Modulate emotions vs. dissociate
  • Optimism vs. catastrophizing
  • Assertiveness vs. social avoidance
  • Inhibition of suicidal behavior vs. pain endurance
  • Talking to caregivers vs. skipping appointments
Treatment - A CBT Approach

- Phase 3: prevent relapse
  - Psychoeducation
  - Problem solving
  - Rehearsal
  - Debriefing

Treatment

- The clinician should recognize the influence of cognitive distortions (suicide would be a better outcome for everybody, the pain is interminable, there is no hope...)
- The clinician should remember that depression causes an insurmountable isolation in clients. Emotional communication is impaired.
- The focus of sessions should be on lists of symptoms and their relationship to the recurrent suicidal thoughts.

Other Principles of Treatment

- Provide support to family members and friends. Parents will often react with anger and denial, as well as anxiety and embarrassment. They will need help understanding their responsibilities and limits. Help them not to feel isolated in the crisis.
Other Principles of Treatment

- Enhance protective factors
  - Perspective “Do you want to die or do you just want to stop the pain?”
  - Environmental supports
  - Ethical beliefs
  - Future orientation
  - Reinforcing positive memories
  - Exercise
  - Sense of purpose

Other Principles of Treatment

- Monitor and reassess each appointment.
- Document your thinking.
- Assure coverage when you are absent.
- Do not let the matter drop without a resolution, including a crisis plan and a long-term treatment plan.

Other Principles of Treatment

- Deal with countertransference
  - Taking responsibility for a patient’s care is not the same as taking responsibility for his life. Over-involvement (love and save) can lead to boundary crossings, poor judgment, and setting up unrealistic hopes and expectations. The result can be hostility, anger, and a sense of hopelessness. Also, countertransference can cause the clinician to be swept away by the client’s own ambivalence (“Don’t tell my roommates what I did!” “I can’t miss any more work.”)
  - Consultation is essential.
Hospitalization

- Borderline personality disorder is the predominant personality disorder on inpatient services. Hospitalization is useful for clients who are acutely suicidal or destabilized, but hospitalization should rarely be used for SIB, and does not decrease the risk for future suicide attempts in chronically suicidal people.
- Hospitalization usually results in regression in borderline clients (e.g. renewed and intransigent focus on their internal life and misery.)

DSM 5 Definition Antisocial

- DSM 5 requires a disregard of the rights of others since 15, indicated by 3 or more of these:
  - Getting arrested
  - Lying
  - Conning
  - Impulsivity
  - Aggression
  - Reckless
  - Irresponsibility
  - No remorse.
- For adults who are simply criminal, we diagnose Adult Antisocial Behavior.

Primary Interpersonal Features

- Preoccupation with control: insist on being right and rarely concede an issue
- Rebelliousness: contempt for authority
Psychopathy

• To meet criteria for psychopathy, a person must exhibit evidence of emotional dysfunction (reduced, empathy), features unnecessary for a diagnosis of antisocial personality. In addition, while antisocial personality disorders often present with comorbid mood and anxiety disorders, psychopaths do not.

The Hare Psychopathy Scale

• The Hare definition of psychopathy includes two factors: 1) emotional detachment (extreme self-centeredness, exploitation, indifference to the feelings of others, willingness to hurt others for one's own purposes, etc.) and 2) antisocial behavior.
• There is no impairment in sociality. Psychopaths can read other people quite well.
• The mix can vary considerably in psychopaths.

The Hare Psychopathy Scale

• Factor 1 is labelled "selfish, callous and remorseless use of others". This factor is correlated with narcissistic personality disorder. It is associated with extraversion and positive mood.
• Factor 2 is labelled as "chronically unstable, antisocial and socially deviant lifestyle". This is particularly strongly correlated to antisocial and borderline personality and is associated with reactive anger, criminality, and impulsive violence.
Description of Psychopaths

- Aggressive narcissism
  - Devalues others, retaliates for insults
- Chronic emotional detachment
  - Unable to bond, uses power instead
  - Emotions are shallow, easily irritated, no loyalty or passion, may commit horrible crimes on a whim
- Chronic lying
  - Delights in deceiving others
- Cognitive problems
  - Can’t plan ahead, impulsive, language processing deficits (unresponsive to emotional words, difficulty with metaphors), poor aversive learning, attention

Suicide and Antisocial Personality

- There is a known relationship between juvenile delinquency, violent crime, and suicidal behavior. Most experts agree that there is a relationship between depression/antisocial behavior and suicide attempts in youth.
- DSM-5 reports that individuals with antisocial personality can suffer from depression and anxiety, and are more likely to die prematurely by violent means such as accidents or suicide.
- Base rates of suicide may be ~5% (0.01% in the general population.)

Psychopathy and Suicide Risk (Verona E et al. 2001)

- This study looked at 313 male prison inmates to determine the relationship between psychopathy, antisocial personality, and suicide. The conclusion was that a history of suicidal behavior was closely correlated to the Hare Psychopathy Scale, Factor 2, but not Factor 1.
- Recall Factor 2 is labelled as “chronically unstable, antisocial and socially deviant lifestyle”. This is particularly strongly correlated to antisocial and borderline personality and is associated with reactive anger, criminality, and impulsive violence.
Antisocial Personality/ Borderline Personality

- There is a lot of comorbidity with BPD and APD
- Related genetically
- Impulsive aggression is significant in both
- Family dysfunction is significant in both
- A study looking at four factors of impulsivity found the following:
  - Antisocial: more likely to show sensation seeking and lack of premeditation
  - Borderline: negative urgency and lack of perseverance

APD and BPD

- A 2017 article (Howard R 2017) reviewed the relationship between antisocial and borderline personality and found that individuals with this particular comorbidity are most often found in criminal populations with the most severe violent and sexual offenses (~60-70% of severely personality disordered offenders.) Lower figures are found is less dangerous populations.

Suicide Risk

- In Verona, et al. it was found that suicide risk in antisocial personality was correlated with impulsivity and neuroticism (anxiety) rather than other antisocial traits.
- Given that there is frequent comorbidity between antisocial and borderline personality disorders, it is an interesting question as to how that might affect suicidality.
- One study (McConigal 2017) found that when controlling for BPD, those with APD showed no significant increase in suicidal behavior.
Transference and Boundaries

- APD’s are better at manipulating than therapists are at being on guard.
- Therapists need to beware of feeling that the client is getting a bad deal from legal system, family members, etc.
- Expect manipulation and dishonesty.
- Therapists need to understand principles of violence risk assessment and management.

Typical Countertransference
(Colli A et al. Am J Psych 2014)

- Clinician feels mistreated, criticized, or repulsed, and can experience intense anger.
- As they are pushed to set firm limits, they can feel mean or cruel.
- They often wish they had never taken this client into therapy.

Treatment

- Results for all forms of treatment for APD are generally dismal. Clients are not usually interested in treatment. Their dishonesty, sensitivity to power issues, and constant manipulating make them poor candidates for therapy.
- There is no evidence for the efficacy of any medications.
- Other treatments such as milieu, empathy, self-esteem training, or anger management, are problematic or have not shown any consistent benefit.
Treatment

• There is a spectrum of antisocial clients, some less damaged than others, who may be willing and able to form a treatment alliance.
• Any worthwhile treatment must include strict limits and no opportunity for deception. Compassion and flexibility will usually be interpreted as weakness.

Treatment

• The structure is part of the treatment. Patients need to accept the necessity of following rules in order to get what they want. Strong coercion is a prerequisite and such tools are not usually available for outpatients.
• Doren suggests that therapy can only address 3 issues:
  • Learning that behavior has consequences
  • Increasing frustration tolerance
  • Increasing behavioral repertoire

Narcissism: Demographics and Natural History

• 1% of the general population, 60-75% are male
• Less common in married individuals, less common in older adults, more common in black men and women and Hispanic women than other groups.
• Narcissistic traits are common in adolescence, but most commonly disappear in adulthood. Those who continue to be narcissistic generally have a great deal of trouble with aging. They fall behind in acquiring skills. Over time, they become very socially isolated from others who tire of their selfishness.
Natural History

• One study found 60% improvement in grandiosity over a 3 year period, although the need for admiration and envy of others remained. The curative factor was corrective life events.

• Corrective Life events:
  • Having actual, not imagined, achievements
  • Relationships with others who provide gentle correction
  • Disillusionment with one’s grandiose view of self

Comorbidity

• Feelings of shame and self-criticism may be accompanied by depression. Sustained periods of grandiosity may be associated with hypomania.
• There are associations with anorexia, substance abuse, histrionic, borderline, antisocial, and paranoid personality disorders.
• Suicide risk is unclear. It is possible that narcissistic injury may precipitate a suicidal crisis.

Comments

• A 2008 survey of clinicians indicated the following as most important in diagnosis:
  • Exaggerated self-importance
  • Expecting preferential treatment
  • Anger and hostility
  • Being critical of others
  • Getting into power struggles
• Clinicians identify the following as important traits that are not included in DSM-5:
  • Tendency to be controlling and competitive
  • Feelings of being misunderstood and mistreated
  • Externalizing blame
  • Unrealistic standards of perfection
A Diagnosis of Contrasts

• Grandiose – self-loathing
• Extraverted – socially isolated
• Leaders of the team – unable to find steady employment
• Model citizens – antisocial
• Narcissism may span the largest spectrum of severity and functionality.

A Common Core

• From a psychodynamic perspective, narcissists have a fragile view of self that requires maintaining a view of oneself as exceptional. The cost of maintaining this stable self is a denial of certain realities. It is hard for them to engage with others since others may outshine them in some areas.
• In short, there is a desperate need to feel special. Extraverted narcissists amass things, or power, or regard themselves as smarter than anyone. Communal narcissists believe they are the most helpful person they know. The quiet narcissist is the most deeply misunderstood person in the room.

A Common Core

• Instead of turning to other people for mutual caring and support to soothe themselves, they depend on feeling “special.”
• It becomes pathological when they engage in destructive behaviors: insulting and blaming others, becoming enraged – exploitation, entitlement, and empathy impairment.
Diagnostic Challenges

*Am J Psych 5/15*

- There is a highly variable presentation and a wide range of severity for this condition. This group can be some of the highest-functioning patients, and some of the most damaged and impaired.
- It would be useful to focus on how the person describes significant others during your interview. These descriptions are usually dismissive, or at times, idealizing. They will generally be quite superficial, however, and the client will tend to describe others in terms of themselves.

Three Variants

- **The High Functioning Narcissist**: exhibitionistic, self-important, but energetic, articulate, outgoing, and achievement oriented. They show good adaptive functioning and use their narcissism as a motivation to succeed.
- Studies show that narcissistic individuals readily emerge as leaders in group discussion, and in graduate business programs, and are likely to rise to top positions. They do well in job interviews, in part, because they are skilled at self-promotion.

Three Variants

- **The Vulnerable Narcissist**: grandiosity that serves a defensive function, warding off painful feelings of inadequacy, anxiety, and loneliness. They have fragile self-esteem requiring constant overcompensation. When defenses fail, there is a powerful undercurrent of inadequacy, often accompanied by rage. This group suffers the most and has the most comorbidity with depression and anxiety.
Three Variants

• **Malignant Narcissism:** intense grandiosity and belief in self-perfection - feels privileged, exploits others, lusts after power. These clients seethe with anger and lack remorse. They do not suffer from underlying feelings of inadequacy. They have no insight and blame others for their problems. This is the description of DSM-5. This group has the most problems with substance abuse and violence.

Suicide Risk

• In a study of 446 suicide attempters (Blasco-Fontecilla et al. 2009), those with personality disorders were compared with each other and other groups. It was found that those with narcissistic personality disorder had **higher lethality** than those with histrionic, borderline, and antisocial personality.
• Surprisingly, narcissistic suicide attempters were **less impulsive** than any of the other suicide attempters with personality disorders (antisocial, borderline, histrionic.)

Psychotherapy

• Although narcissism has been a pathology of choice for many decades in psychoanalysis, a 2015 systematic review of the literature found no studies that meet current epidemiologic standards. We know very little how to work with this personality trait.
• Supportive therapy seems to get nowhere.
• Group therapy does not work because these clients lack empathy, hunger for admiration, and hold others in contempt.
Treatment

• Look for signs of moral dysfunction in order to assess for antisocial personality.
• Focus on self-esteem regulation, problems in interpersonal relationships.
• Help them name their feelings rather than focus on what’s wrong with everyone else.
• Use language that reminds them of their connection to others “we, our, us”.
• Help them replace the need to be special to others to being special for others.

Treatment of Variants

• High functioning: may benefit from interpretive, insight-oriented approach to improve interpersonal relationships
• Fragile: may respond best to empathic understanding and interventions that acknowledge underlying pain and vulnerability
• Grandiose: have the poorest outcome since they do not experience any discomfort with their condition and are so manipulative. They are the most like antisocial personality.

Interpersonal Psychotherapy

• A useful focus may be helping the client become a bit more empathic. Role playing may be useful, or watching movies.
• The modest goal is to help the narcissist be a little more sensitive to the people in his life.