Understanding Personality Disorders

Presented by

Joseph W. Shannon, Ph.D.
Psychologist

Disclosure

Neither Dr. Joseph W. Shannon, the presenting speaker, nor the activity planners of this program are aware of any actual, potential or perceived conflict of interest

Sponsored by

Institute for Brain Potential

PO Box 2238
Los Banos, CA 93635

COURSE OBJECTIVES

Participants completing this 6-hour seminar should be able to:

1. List key brain regions influencing social reasoning and conduct.

2. Identify features of and effective treatments for paranoid, schizoid and schizotypal, antisocial, borderline and narcissistic disorders; and OCD personality disorders.

3. Describe personality disorders that may underlie hypochondriasis, body-dysmorphic disorder, selected eating disorders, and substance abuse.

4. Review principles that facilitate the transformation of personality.

Policies and Procedures

1. Questions are encouraged. However, please try to ask questions related to the topic being discussed. You may ask your question by clicking on "chat." Your questions will be communicated to the presenter during the breaks. Dr. Shannon will be providing registrants with information as to how to reach him by email for questions after the day of the live broadcast.

2. If you enjoyed this lecture and wish to recommend it to a friend or colleague, please feel free to invite your associates to call our registration division at 866-652-7414 or visit our website at www.IBPceu.com to register for a rebroadcast of the program or to purchase a copy of the DVD.

3. If you are unable to view the live web broadcast, you have two options:
a) You may elect to download the webinar through February 9th, 2015. IBP will automatically provide you with a new link to receive the program.
b) You may request a free copy of the DVD set of this program and the instructional materials. Send an email to IBP at ceu@4brain.org, fax us at 209-710-8306 or mail the IBP Home Study Division at 245 W Pacheco Blvd, Suite C, Los Banos, CA 93635. Please provide us with your mailing address.

If you are not fully satisfied with the DVD and instructional materials, return them to IBP and receive a credit for a future seminar or webinar offered within the next 12 months.

4. For American Disability Act accommodations or for addressing a grievance, please contact customer service at 888-202-2938 or write to IBP at PO Box 2238, Los Banos, CA 93635.

5. **Post webcast materials are available for each participant at the following URLs:**
Live Webcast Evaluation: http://www.ibpceu.com/content/pdf/personality-s16-eval.pdf
On-Demand Webcast Evaluation: http://www.ibpceu.com/content/pdf/personality-s16-dl-eval.pdf
All licensed health professionals are required to complete all pages. Please transmit by February 9th, 2015.

6. **IMPORTANT: Your certificate of completion will be available by email, mail or fax following receipt of your fully completed evaluation form.** If you request the certificate by mail, it will be mailed within 2 business days upon receipt of your fully completed evaluation form.

In the unlikely event that you lose your certificate, please send your request in writing and a check for $15 payable to IBP at PO Box 2238, Los Banos, CA 93635 or call 866-652-7414.

IBP is a nonprofit scientific and educational organization dedicated to promoting advances in behavioral medicine. IBP is entirely supported by the tuition it charges for its seminars and the sale of educational materials. Neither IBP, its planning committee, nor any of its instructors has a material or financial interest with any entity, product, or service mentioned in the seminar unless such relationship is disclosed at the beginning of the program. The information presented is of a general nature. For specific advice, please consult a specialist in your area.

JOSEPH W. SHANNON, Ph.D.
Psychologist
1155 West Third Avenue
Columbus, Ohio 43212
Telephone: (614) 297-0422

UNDERSTANDING AND TREATING PERSONALITY DISORDERS

Personality-disordered individuals comprise 20 percent of the general population and are seeking or being referred for professional counseling services at an increasing rate each year. And yet there is much confusion and debate over the definition of "personality disorder," the classification of personality types and the distinction between healthy and disordered personalities.

In this highly practical program, helping professionals will learn how to quickly recognize the signs and symptoms of personality pathology and how to treat personality-disordered patients in an effective and ethical manner. Categories of personality disorders will be discussed in great detail. Film clips from major motion pictures which feature personality-disordered characters or real-life case histories will be used to illuminate the unique aspects of each sub-type of personality disorder. The etiology of personality pathology will be discussed. The latter will lead to a lengthy discussion of strategic treatment approaches. Guidelines for assessing and addressing patient resistance will also be discussed throughout the program.

As a result of attending this program, participants will be able to:

1. Define and describe the parameters of personality pathology;
2. Discuss the prominent theories regarding the causes/evolution of personality pathology;
3. List and describe 12 distinct types of personality disorders;
4. List and describe sources of resistance commonly seen with personality-disordered patients; and
5. Describe a short and long-term treatment model for addressing personality pathology in an efficient, effective and ethical fashion.

AGENDA

7:30 - 9:00 AM	Registration
9:00 - 10:30 AM	INTRODUCTION → Basic concepts → Prominent theories re: etiology → Common properties
10:30 - 10:45 AM	Morning Break
10:45 AM - 12:15 PM	Cluster A and Cluster B
12:15 - 1:15 PM	LUNCH
1:15 - 2:30 PM	Cluster C Short-term Treatment Model
2:30 - 2:45 PM	Afternoon Break
2:45 - 3:45 PM	Long-term Treatment Model Resistance
3:45 - 4:00 PM	Questions, Closure

UNDERSTANDING AND TREATING PERSONALITY DISORDERS

I. INTRODUCTION:

A. Definition of "personality":

1. A construct
2. Comprised of traits and habits .
3. Impacts everything we think, feel and do.
4. "How we characteristically view ourselves and the world and how we characteristically interact with the world to get our needs met...."
5. "Normal" or healthy personality functioning:

    a. Capacity to function autonomously and competently;
    b. Ability to adjust to the changing demands of life effectively; and
    c. Personal sense of contentment and satisfaction with one's life

B. Definition of "personality disorder":

1. The traits and habits that comprise the personality are inflexible and damaging.
2. The individual will be impaired in his/her capacity for love and work.
3. The pathology/impairment will affect the individual and those who interact with the individual.

C. Demographics:

1. Democratic phenomenon
2. Cut-off age: 17/18
3. 20% of general population
4. Incurable but treatable in some cases

II. Etiology: Theories and Recommendations

A. Psychodynamic/Developmental:

→ e.g., "developmental fixation"

II. Etiology: Theories and Recommendations continued:

B. Cognitive-Behavioral:

1. All beliefs/behaviors are learned.
2. Personality disordered patients have developed an inordinate number of maladaptive beliefs and behaviors.
3. Anything that is learned can be unlearned.
4. Maladaptive ways of thinking and behaving can be discarded and healthier, more adaptive coping styles can be learned.
5. With improved coping will come improved affect.

C. Biological/ Neurochemical:

1. Personality-disordered patients have an atypical brain chemistry.
2. The atypical brain chemistry may be the result of a biogenetic predisposition, pre-birth trauma, birth trauma, post-birth psychological or physical trauma, physical or emotional neglect, medical conditions or a combination of these factors.
3. While many areas of the brain may be affected, the primary locus of the imbalance will be in the cerebral cortex, the prefrontal cortex and sections of the limbic system, notably the amygdala and the hippocampus. (see Appendix A)
4. Neurotransmitters, notably serotonin, dopamine and norepinephrine, will figure prominently in the chemical imbalance which underlies the personality pathology. These neurotransmitter excesses or deficits will have profound effects on the patient's mood, motivation, interpersonal behavior, impulse control and affect regulation/modulation.
5. Effective treatment will need to include a pharmacological intervention targeted to specific symptoms along with strategic psychotherapy and other treatment modalities.
6. Diet and exercise will also be critical components of treatment:
   a. High protein, low- carb, low- fat diet
   b. Aerobic exercise
   c. Omega III fatty acids
7. Behavioral change will result in neurochemical change: "neuroplasticity."

III. Personality Disorders: Common Patterns

A. Adaptive inflexibility (i.e., they are rigid.)
B. Tendency to foster vicious cycles (e.g., "crisis orientation")
C. Tenuous stability (chronicity of problem)

III. Personality Disorders: Common Patterns continued:

D. "Cluelessness" (e.g., self-consonant nature problem)
E. Pathological problem-solving (i.e., they create psychodramas)
F. Treatment non-compliance/questionable motivation for treatment
G. Difficulty translating therapeutic insights into specific, concrete behavioral changes
H. Intense transference/counter-transference reactions

IV. Personality Disorders: Twelve delicious flavors, 3 happy clusters

A. Cluster A: Odd or Eccentric:

1. Paranoid - they are tense, guarded, suspicious, self-righteous, rigid, petty, vengeful and litigious. They bear grudges and are prone to primitive, overt violent acts of aggression. They rarely seek treatment voluntarily: are typically court-ordered into treatment or are "sent" to treatment by their physicians; they are highly somatic, hypochondriacal. Especially prone to G.I. problems of psychogenic nature.
   E.g., Richard M. Nixon;
   Film: "The Caine Mutiny" (1953)
2. Schizoid - they are affectively blunted, socially isolated, socially awkward, somewhat robotic, individuals. They can be drawn to emotional intensity in partners but will eventually feel overwhelmed by it. They have little or no desire to be with people and are typically content to live a routine, orderly, quiet life.
   E.g., TV: "Mr. Spock" in the original "Star Trek" series (1966-69).
   Film: "Napolean Dynamite" (2005)
3. Schizotypal - they are peculiar, highly eccentric, often bizarre in thought, appearance or behavior; they may look schizophrenic but will not meet a sufficient number of diagnostic criteria for full-blown psychosis; they typically are not helped all that much by anti-psychotic medications
   E.g., T.V.: "Kramer" on "Seinfeld"
   "Phoebe" on "Friends"
   Film: "Psycho" (1960)
   Real Life: Andy Warhol; Michael Jackson

B. Cluster B: Dramatic or Highly Emotional

4. Sociopathic (anti-social) - they are pervasively dishonest, manipulative, exploitative and disloyal individuals; they lack a well-developed super ego and experience little or no guilt when they break rules, violate laws, and shatter the lives of others. They are capable of experiencing intense insecurity and anxiety and tend to assuage their insecurity and anxiety by raising it in others.
   E.g., Career criminals, criminal lawyers, politicians, clergy
   Films: "Public Enemy" (1932)

"Public Enemies" (2009)
"The Treasure of the Sierra Madre" (1948)
"White Heat" (1949)
"The Godfather" (1972)
"Wallstreet" (1988)

5. Borderline - they straddle the border between sanity and psychosis; "they have egos as fragile as spun sugar, psyches that are irretrievably fragmented, like a jigsaw puzzle with crucial pieces missing;" they have intense and unstable moods, chaotic personal relationships, self-destructive eating, drinking, and sexual patterns and periodic feelings of numbness, emptiness and dissociation. They are intolerant of being alone; as much as they crave intimacy they ultimately repel it by being childish, overly demanding, jealous, possessive and verbally and physically abusive with significant others. They have primitive defenses, most notably splitting, projection and denial. They tend to self-mutilate and are a high risk for suicide.

E.g., Marilyn Monroe, Jim Morrison, Princess Diana, Maria Callas,

Films: "Of Human Bondage" (1934)
"These Three" (1936)
"Wuthering Heights" (1939)
"Leave Her to Heaven" (1945)
"Sunset Boulevard" (1950)
"Play Misty For Me" (1971)
"Equus" (1978)
"Fatal Attraction" (1987)
"Misery" (1990)
"The Talented Mr. Ripley" (2002)

6. Histrionic - they are seductive and flirtatious but rarely enjoy sex - they use it to manipulate others or to get attention from others; they have an insatiable need to be the center of attention and will demand constant reassurance and immediate gratification. They have rapidly changing but ultimately shallow moods; they also are pathologically vain individuals who tend to be phobic about aging. They can be very quick-witted, talented, beautiful and a "must" at any party.

E.g., Judy Garland, Liza Minnelli, Robin Williams, Jim Carey
T.V.: the characters of "Jack" and "Karen" on "Will and Grace"
Films: "Dark Victory" (1939)
Films: "Gone With The Wind" (1939)
"All About Eve" (1950)
"A Streetcar Named Desire" (1951)
"Auntie Mame" (1958)
"Annie Hall" (1977)

7. Narcissistic - two sub-types (Masterson, 1981):

a. "Closeted" Narcissist - they are superficially nice and aim to please but have a narcissistic wound that drives them; they tend

to be passive-aggressive, inordinately sensitive to criticism and have an intense need to be mirrored by others. While capable of empathy, they tend to be pretty self-absorbed and self-centered; high risk for addictions to assuage low self-esteem and periodic feelings of depression; prone to envy, jealousy.

E.g., many career politicians and political leaders (e.g., Bill Clinton)

Many celebrities in film, T.V. and sports (e.g., Bing Crosby).
Many surgeons; psychotherapists who have sex with their patients, etc.

T.V.: "Ralph Kramden" on "The Honeymooners"
"Frazier Crane" on "Frazier"
"Murphy Brown" on "Murphy Brown"
"Jerry Seinfeld" on "Seinfeld"

b. "Malignant" Narcissist - these people truly believe they are superior to just about everybody else on the planet. Accordingly, they demand constant adulation and "special" treatment everywhere they go. They have fantasies of perfection, may be preoccupied with envy and typically have an insatiable need for power, wealth, prestige and attention. They are excessively sensitive to shame and embarrassment. If you work for them, they will take credit for your successes and blame you for their failures. When confronted with their shortcomings, they will quickly become hostile and defensive and will project blame onto people and circumstances outside themself. High risk for addictions, sado-masochistic sex and white-collar crime; may even have psychopathic tendencies.

E.g., Sadam; Hitler, Studio bosses, such as Jack Warner and Harry Cohn

Films: "Citizen Kane" (1941)
"Laura" (1944)
"The Picture of Dorian Gray" (1945)
"The Roman Spring of Mrs. Stone" (1961)
"American Gigolo" (1979)
Any Tom Cruise movie from 1988 to the present
Any Woody Allen move from 1966 to the present

C. "Cluster C : Anxious/Fearful

8. Avoidant - they are painfully, pathologically shy creatures who long for human contact but fear being judged and criticized; they often experience debilitating fear or panic in social situations. They are "thin-skinned" individuals who are easily hurt and embarrassed; they tend to live lonely, sad, very routinized sorts of lives.

Films: "Johnny Belinda" (1948)
"Separate Tables" (1958)
"Bells are Ringing" (1960)

"The Accidental Tourist" (1988)

9. Dependant - they see themselves as inadequate and have pervasive feelings of low self-esteem and insecurity. They overcompensate for their perceived short-comings by encouraging others to develop a strong dependency on them for emotional nurturance. They then depend on that person for just about everything else. They are profoundly passive creatures and are seemingly contented to be in the passenger seat of life. They have a terrifying fear of abandonment but are not as manipulative, self-destructive or otherwise annoying as Borderlines can be when faced with the threat of abandonment.

T.V.: "Edith Bunker" on "All In The Family"
Films: "Gaslight" (1944)
"Rebecca" (1940)
"Come Back Little Sheba" (1953)
"Rocky" (1976)
"Polyester" (1979)

10. Compulsive - they can be stiff, perfectionistic, aloof, unemotional, unemphathic, overly conscientious and controlling; they often have difficulty seeing the bigger picture" and can become pre-occupied with details. They are riddled with free-floating anxiety and tend to keep this at bay by creating a meticulously-ordered, efficient and, at times, beautiful environment which belies their internal pain/distress. They can be rigid, unforgiving and unyielding when dealing with interpersonal conflict; they don't like or tolerate "mess".

T.V.: "Niles" on "Frasier"
"Martha Stewart" on "Martha Stewart's Living"
Films: "Ordinary People" (1979)
"Sleeping With The Enemy" (1991)
"The Remains of the Day" (1999)

11. Passive-Aggressive - they are inordinately fearful of anger and conflict and tend to deal with their own angry/hurt feelings in covert, often "sneaky" ways; they are exquisitely sensitive to being manipulated or controlled: any request you make of them will likely be seen as an attempt to manipulate/control them and will be resented. They are notoriously late for appointments and other time commitments. They frequently express irritation by brooding, complaining, sulking or by being deliberately inefficient. In more intimate relationships they will withhold affection or sex to "punish" the loved one, but never be open/clear about the source of their upset.

T.V. "George" on "Seinfeld"
"Sue Ann Nivens" on "The Mary Tyler Moore Show"

12. Depressive - these individuals have moderately severe depressive symptoms that typically date back to early childhood and are treatment-resistant; they are also pervasively pessimistic, negative and riddled with self-doubt, self-reproach and guilt.

T.V.: "Dr. House" on "House"

Films: "Annie Hall" (1977)
"Manhattan" (1979)

V. What is likely to bring the personality-disordered patient into treatment:

A. Losses (e.g., pathological grieving)
B. Major affective disorder/anxiety disorder (e.g., depression/panic).
C. Developmental dysynchronies (e.g., "I have never been able to actualize my potential"...).
D. Interpersonal conflict (e.g., abusive relationship history)
E. Somatic problems
F. Referred by employer, spouse, court.
G. Alcoholism/chemical dependency

*** key question to ask: "Why are you coming into treatment now?"**

VI. Undergraduate-level treatment (3-9 months)

A. Address the presenting problem; this facilitates the development of rapport and trust and may set the stage for more advanced treatment later. Basic listening skills, problem-solving strategies and cognitive-behavioral interventions could prove most helpful at this stage of treatment.
B. Assess/address any Axis I pathology via cognitive-behavioral strategies and/or pharmacotherapy.
C. Help the patient identify patterns of thinking, feeling and behaving that seem to be causing problems for them or others;
    1. How are these patterns adaptive?
    2. What is the patient losing? What are the costs of maintaining these patterns?
    3. "Is this getting you what you want?"
D. Draw a connection between the patient's presenting problem(s) and the more pervasive patterns identified in step "c"
E. Invite the patient to explore with you ways to challenge and change these more enduring, maladaptive patterns.

VII. Graduate-level Treatment (1 year to 18 months; periodic "tune-ups" thereafter)

A. Identify core schema that may underlie maladaptive behavior and painful feelings (see appendix B).
B. Use orthodox cognitive-behavioral strategies to challenge and change these core beliefs, (e.g., Burns, 1980).
C. Identify maladaptive patterns of behavior and/or behavioral skill deficits.
D. Use orthodox cognitive-behavioral strategies to challenge/change these behaviors, (e.g., Dialectical Behavioral Therapy, Linehan, 1993).
E. Encourage the patient to test out new patterns of thinking and behaving in real-life situations; therapist may serve as "coach" via telephone coaching/consultation sessions.

F. Supplement formal treatment with participation in self-help groups, such as AA and Al-Anon.

G. For cluster B patients, pharmacotherapy to enhance impulse control and affect regulation may be in order. Consider S.S.R.I.'s and/or mood stabilizers.

H. The therapist will need to monitor/address transference and resistance on-goingly; countertransference will also need to be addressed via peer super-vision.

VIII. Do's and Don'ts with Personality-Disordered Patients

A. What You Should Do:

1. Use the patient's language.
2. Be empathetic, honest and direct. Focus on feelings at first, not on ex-plaining the behaviors/patterns that are dysfunctional.
3. Set limits in a clear, respectful manner; written contract/treatment plan is essential.
4. Offer the patient an explanation of their diagnosis and for the treatment plan you intend to employ.
5. Explain any major treatment interventions - if you spring an intervention on a patient without explaining it, it will raise resistance and anxiety.
6. Help the patient identify resources (i.e., people and coping responses) already available to them; reinforce positive coping mechanisms.
7. Review treatment plan from time to time and ask the patient for feedback-enhance collaboration; value the patient's feedback and don't assume patient is being manipulative or "gamey".
8. Make diagnostic and therapeutic use of negative interactions with patient; confront rather than interpret defensive behaviors; identify ap-propriate behaviors and reward these when they occur.
9. Be aware of your countertransference reactions but say nothing to the patient; maintain therapeutic neutrality.
10. Help patient identify consequences of actions. "What are you trying to accomplish? Is there a more effective way to do this?"

B. What You Should Not Do:

1. Do not listen to stock, repetitive complaints.
2. Do not try to save face or feel ashamed if fooled by the patient.
3. Do not try to rescue or encourage dependency.
4. Do not blame or punish the patient - require responsibility; offer choices and clarify consequences.
5. Do not offer interpretations or insights early in treatment, if at all.
6. Do not present self as an emotionless blank screen.

***** Never lie or offer conflicting non-verbal messages. *****

IX. Short-Term Treatment Model:

A. Data Collection; critical to do a thorough history of the presenting problem as well as gather information about previous treatment.

B. Change vague complaints into specific problem statement.

1. Problem categories (4 types):
   a. Problematic situations
   b. Uncomfortable emotions (feelings/symptoms)
   c. Dysfunctional behavior
   d. Troubling, re-curing thoughts
2. Give up notion of "cure".
3. Move from "cure' to "coping" model.
4. Focus on "what" instead of "why".
5. Focus on skill deficits - e.g., problems with modulation.
6. Identify targets for therapy, e.g., specific attitudes, behaviors, etc.

C. Prioritize problems; (limit to 3 or 4 issues and form hierarchy).

D. Develop a working alliance by explaining your approach to treatment and what each person will be responsible for.

E. Initiating treatment; focus on the most pressing issue.

F. Developing and revising hypotheses; revise treatment program as you get to know the patient.

G. Testing hypotheses; e.g., homework

H. Getting and giving feedback

I. Involving significant others; e.g., spouse/partner.

J. Homework: to reinforce in-treatment learning and to measure progress.

K. Evaluating progress; bottom line: attitudinal/behavioral change.

L. Setting goals for termination/follow-up; "How will you know when this is no longer a problem?"

M. Evaluating potential for danger; e.g., assessing lethality.

N. Planning termination.

O. Relapse prevention - identify vulnerability factors and develop plan for addressing these:

1. Acute physical distress.
2. Chronic illness/pain.
3. Gradual deterioration of health (aging).
4. Hunger.
5. Anger.
6. Fatigue.
7. Loneliness
8. Major life loss.
9. Poor problem solving ability.
10. Substance abuse.
11. Poor impulse control.
12. New life circumstance.
13. PTSD.

14. Rigidity (neurotic).

X. Sources of Non-Compliance - see Appendix C

XI. Questions, Closure

REFERENCES

Beck, A.T., Freeman, A. and Davis, D.D. (2003). Cognitive therapy of personality disorders. New York: Guilford.

Beutler, L.E. and Clarkin, J.F. (1990). Systematic treatment selection. New York: Bruner/Mazel.

Burns, D.D. (1980). Feeling good: The new mood therapy. New York: Morrow.

Burns, D.D. (1990). The feeling good handbook. New York: Penguin.

Carter, S. and Sokol, J. (2005). Help! I'm in love with a narcissist. New York: Evans.

Darby, D. and Walsh, K. (2005). Walsh's Neuropsychology: A clinical approach. New York: Elsevier/Churchill/Livingstone.

Duncan, B., Hubble, M. and Miller, S. (1997). Psychotherapy with impossible cases: An efficient treatment of therapy veterans. New York: Norton.

Freeman, A. Simon, K.M., Fleming, B., and Pretzer, J. (1991). Clinical applications of cognitive therapy. New York: Plenum.

Goldberg, S. (2003). Clinical neuroanatomy made ridiculously simple. Miami, Fl: MedMaster, Inc.

Linehan, M. (1993). Cognitive-behavioral treatment for borderline personality disorder. New York: Guilford.

Linehan M. (1993). Skills training manual for treating borderline personality disorder. New York: Guilford.

Livesley, W.J. (Ed.) (2001). Handbook of personality disorders: Theory, research and treatment. New York: Guilford.

Magnavita, J. (1997). Restructuring personality disorders: A short-term, dynamic approach. New York: Guilford.

Mason, P.T. and Kreger, R. (1998). Stop walking on eggshells: Taking your life back when someone you care about has borderline personality disorder. Oakland, CA: New Harbinger Publications, Inc.

Masterson, J. (1981). The narcissistic and borderline disorders. New York: Bruner/Mazel.

Masterson, J. (1983). Countertransference and psychotherapeutic technique. New York: Bruner/Mazel.

REFERENCES continued:

Miller, M.C. (Ed.) (2005). The biology of child maltreatment. Harvard Mental Health Letter. 21, (12), 1-3.

Millon, T. (1981). Disorders of personality. New York: Wiley.

Moskovitz, R. (2001). Lost in the mirror: An inside look at borderline personality disorder. New York: Taylor Trade Publishing.

Piacentini, J. and Langley, A.K. (2004). Cognitive-behavioral therapy for children who have obsessive-compulsive disorder. Journal of Clinical Psychology, 60, (11), 1181-1194.

Robinson, D.J. (2003). Reel psychiatry: Movie portrayals of psychiatric conditions. Port Huron, MI: Rapid Psychler Press.

Rodham, K. Hawton, K. and Evans, E. (2004). Reasons for deliberate self-harm: Comparisons of self-poisoners and self-cutters in a community sample of adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 43, (1), 80-87.

Schwartz, J.M. and Begley, S. (2002). The mind and the brain: Neuroplasticity and the power of mental force. New York: Harper/Collins.

Stout, M. (2005). The sociopath next door. New York: Broadway Books.

Strong, M. (1998). A bright red scream: Self-mutilation and the language of pain. New York: Penguin.

Vaknin, S. (2005). Malignant self love: Narcissism revisited. Prague: Narcissis Publications.

Wilhelm, S., Tolin, D.F., and Stakatea, G. (2004). Challenges in treating obsessive-compulsive disorder: Introduction. Journal of Clinical Psychology, 60, (11), 11270-1132

Williams, J.M.G. (1995). The psychological treatment of depression: A guide to the theory and practice of cognitive-behavior therapy. New York: Routledge.

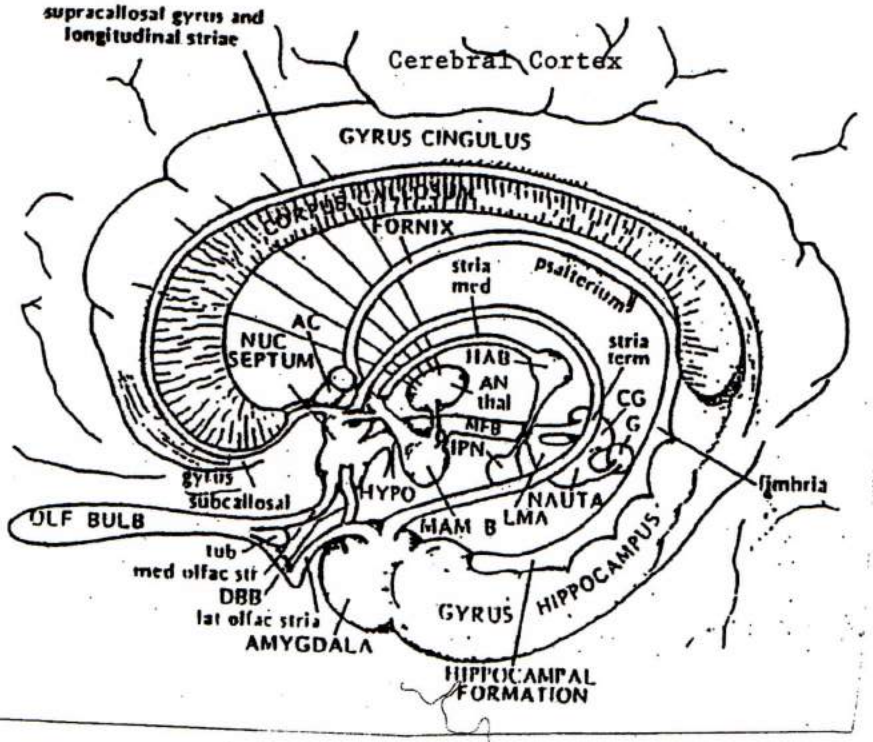
Yen, S., Shea, M.J., Sanislow, C.N., Grilo, C. et al. (2004). Borderline personality disorder criteria associated with prospectively observed suicidal behavior. American Journal of Psychiatry, 161, (7), 1296-1298.

Young, J.E. (1990). Cognitive therapy for personality disorders: A schema-focused approach. Sarasota, FL: Professional Resource Exchange.

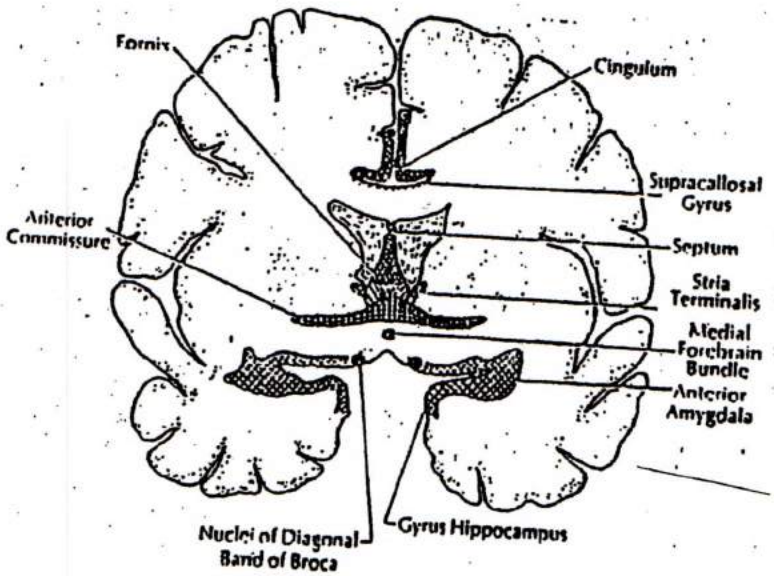
Yudofsky, S. C. (2005). Fatal flaws: Navigating destructive relationships with people with disorders of personality and character. Washington, D.C. : American Psychiatric Publishing, Inc.

APPENDIX A

Key Neurological Structures:



THE LIMBIC SYSTEM:
ANTERIOR CORONAL SECTION

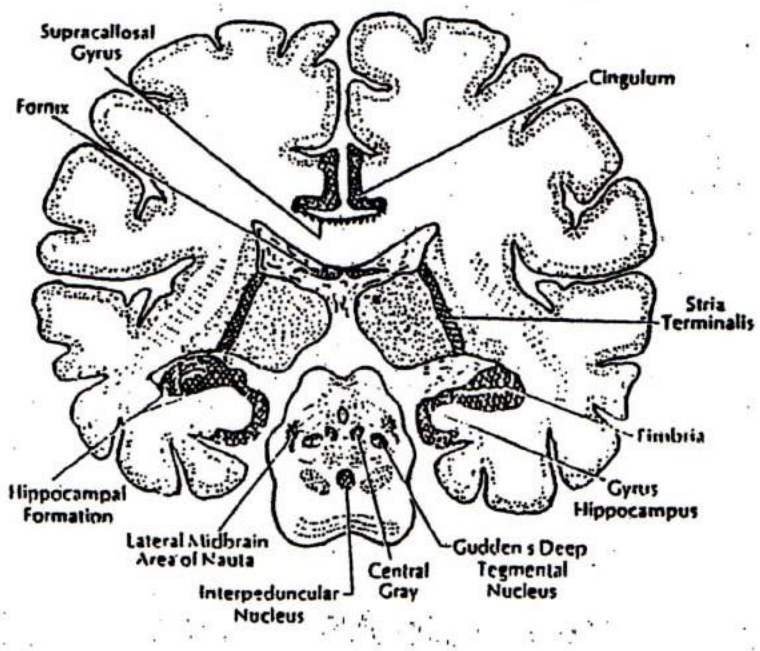


THE LIMBIC SYSTEM:
ANTERIOR CORONAL SECTION

APPENDIX A (cont.)

FIGURE 3

THE LIMBIC SYSTEM:
POSTERIOR CORONAL SECTION



APPENDIX B

Schema for Personality Disorders

PARANOID PERSONALITY DISORDER

1. People will eventually try to hurt me.
2. People cannot be trusted. They will always take advantage of me.
3. People will try to bother or annoy me.
4. Don't get mad, get even.
5. Any insult, no matter how slight, directed at me should be punished.
6. Always be prepared for the worst.
7. To compromise is to surrender.
8. Avoid intimacy.
9. If I get close to people they can find out my weaknesses.
10. Keep alert for anyone who has power. They can hurt me.

SCHIZOID PERSONALITY DISORDER

1. There are few reasons to be close to people.
2. I am my own best friend.
3. Stay calm.
4. Displays of emotion are unnecessary and embarrassing.
5. What others say is of little interest or importance to me.
6. Sex is okay, but just for release.

ANTISOCIAL PERSONALITY DISORDER

1. Rules are meant for others.
2. Only fools follow all of the rules.
3. Rules are meant to be broken.
4. Look out for Number 1.
5. My pleasure comes first.
6. If others are hurt, offended, or inconvenienced by my behavior, that is their problem.
7. Do it now!
8. I will not allow myself to be frustrated.
9. I will do whatever I must to get whatever I want.
10. I am really smarter than most everybody else.

BORDERLINE PERSONALITY DISORDER

1. I am not sure who I am.
2. I will eventually be abandoned.
3. My (psychic) pain is so intense that I cannot bear it.
4. My anger controls me. I am incapable of modulating my behavior.
5. My feelings control me. I cannot modulate my feelings.
6. He/she is so very, very good that I am so lucky.

Schema for Personality Disorders continued:

7. He/she is so very, very awful that I cannot bear them.
8. When I am overwhelmed I must escape (by flight or suicide).

HISTRIONIC PERSONALITY DISORDER

1. Appearances are important.
2. People are judged on external appearance.
3. I must be noticed.
4. I must never be frustrated in life.
5. I must get everything I think that I want.
6. Emotions should be expressed quickly and directly.
7. Beauty is the most important consideration in judging someone.

NARCISSISTIC PERSONALITY DISORDER

1. I must have my way in every interaction.
2. I must not be, in any way, foiled in seeking pleasure or status.
3. I am more special than anyone else.
4. I should only have to relate to people like me.
5. I must be admired.
6. No one should have more of anything that I have.

AVOIDANT PERSONALITY DISORDER

1. I must be liked.
2. I must not look foolish to myself or others at any time.
3. The world is a dangerous place.
4. I must depend on others to take care of me.
5. All criticism -- massive condemnation.
6. People must offer me unconditional guarantees of acceptance before I commit to other person.
7. Isolation is preferable to being put at risk of being hurt.

DEPENDANT PERSONALITY DISORDER

1. I cannot function without the support of others.

DEPENDANT PERSONALITY DISORDER

2. Without the advice and reassurance of others I cannot exist.
3. In any situation, I am probably wrong.
4. Anger expression -- people will abandon me.
5. If I am abandoned, I will be destroyed.
6. I must keep people near me.
7. If I am alone, I may be hurt.

Schema for Personality Disorders continued:

8. Working with others is far better than working by myself.

OBSESSIVE COMPULSIVE PERSONALITY DISORDER

1. There are strict rules in life.
2. By focusing on the details of a situation, one will reduce the chances of making errors.
3. A person is defined by what they do.
4. The better the job you do the better person you are.
5. Rules must be adhered to without alteration.
6. Never discard anything that may be of some value.
7. Emotions must be controlled.

PASSIVE AGGRESSSIVE PERSONALITY DISORDER

1. I should only have to do what I want to do.
2. People should not make demands on me.
3. Others undervalue my work and worth.
4. People in authority are generally unfair.
5. I should not be asked to do so much work.
6. Deadlines and pressures are unfair and should be resisted.
7. Anger cannot be directly expressed.
8. Anger is dangerous and must be avoided.
9. Whatever can be put aside for tomorrow can be left for tomorrow.
10. Get away with whatever you can.

* From: Beck, Freeman, & Davis, (2003).

APPENDIX C

TREATMENT OF NON-COMPLIANCE

1. Lack of patient skill to collaborate.
2. Lack of clinician skill to develop collaboration.
3. Environmental stress ors preclude changing or reinforce behavior.
4. The patient's ideas and beliefs regarding potential failure in treatment.
5. Patient ideas and beliefs regarding consequences of the patient changing to others.
6. Patient ideas and beliefs regarding changing and the "new" self.
7. Patient and clinician distortions are congruent.
8. Poor socialization to the treatment model.
9. Secondary gain from maintaining the dysfunctional pattern.
10. Lack of treatment-collaboration and alliance.
11. Poor timing of interventions.
12. Lack of patient motivation.
13. Patient's rigidity foils compliance.
14. Patient has poor impulse control.
15. The goals of treatment are unrealistic, amorphous or vague.
16. The goals of treatment are unstated.
17. There has been no agreement relative to treatment goals.
18. The patient may attempt to assert power.
19. Patient frustration related to lack of treatment progress.
20. Patient's perception of lowered status or self-esteem.