NAADAC

Working with Antisocial Personality: Etiology Through Treatment Interventions

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>> JESSIE O'BRIEN: Hello everyone and welcome to the webinar, Working with Antisocial Personality: Ideology through Treatment Interventions, presented by Dr. Malcolm Horn. My name is Jesse O'Brien. I am the training and professional development content manager here at NAADAC. And I will be the organizer for this training experience.

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We are using GoTo Webinar for today's live event and you will notice the GoTo Webinar panel that looks like the one here on my side and you can use the orange arrow to minimize or maximize the control panel. If you have any questions to the presenter protect them into the questions box and we will gather all those questions and give them to our presenter towards the end of the webinar for our live Q&A.

Any questions that we do not get to we will collect directly from the presenter and post the questions and answers on the website. Lastly, under the questions tab you will see the another tab that says handouts and you can download the PowerPoint slides from that handout tab venues are very user-friendly instructional guide on how to access our online CE quiz and immediately earn your CE certificate so make sure to use the instructions in the handout tab when you are ready to take the quiz.

let's get to the presentation, I want to introduce you to Malcolm Horn received her master's degree in social work from Walla Walla College. She is a licensed clinical social worker and is the president of the Montana chapter of the NASW as well as the regional Vice President of NAADAC of the Northwest region. She's director of special services for Rimrock Foundation and she coordinates the continuing education for license staff, supervises and coordinates the internship program and provides educational outreach to the region and conducts an adjunct of family and individual therapy she also teaches two courses at Montana State University, Billings in their addiction specific program for which he recently attained her doctorate degree in psychology. NAADAC is really delighted provide this webinar presented by such an amazing leader in our field so Malcolm, Dr. Horn, if you are ready I will hand this over to you.

>> DR. MALCOM HORN: Great. thank you, Jesse, I am ready, this is one of my favorite topics so thank you everybody for joining me. I love talking about personality disorders and I find them to be complicated and fascinating all at the same time. So thank you everybody for joining me. I always look forward to the questions at the end because I find that I learn as well when you guys asked me questions. So I look forward to today and we will jump into it.

As we go through these slides please do not hesitate to write down your questions and put them in the chat box and it looks like Jesse -- I cannot advance the slides. They don't want to go.

>> JESSIE O'BRIEN: fish It looks like you have control if you click on the slide again -- there you go.

>> DR. MALCOM HORN: It wanted me to ask for help, that is what it wanted me to do. So antisocial personality disorder, we will just go through these and let's go.

Maybe I'm just getting too trigger-happy on the keyboard but so will do a brief overview of the diagnostic criteria looking a little bit at some of the assessment tools. But we want to focus on the skills to use and one of the things I find when it comes personality disorders particularly in the field of substance use is there's a lot of overlap between the actual personality disorder criteria and the substance use.

's to some degree I don't really care about the diagnosis. What I care about are the behaviors and what I do with them. So that is really important to keep in mind. Particularly if you only patience for a short period of time, I typically don't want for myself or any of the people that I am mentoring and teaching, I don't want to do a diagnosis of a personality disorder unless I've worked with a person for a really long time. Particularly if they are complicated issues, substance use or mental health issue, multiple personality disorder issue, there's a lot of overlap in the personality disorders tend to be pejorative negative type diagnosis and so not really want to make a diagnosis and wasn't really sure about it. For the most part if you're working with the patient in an inpatient residential setting you may not have among so you may not long enough or even want to put that diagnosis in the chart.

But what you do want to look at are the behaviors and what are the things you are saying and then how do you address those? That is what we want to be focused on, the behaviors but so some basic definitions to keep in mind. And a lot of these definitions people use them interchangeably particularly psychopath and sociopath, people tend to use them interchangeably even though they are distinct and there are some differences present actually, and a few slides I have a grid where I broke them out because my visual person and I broke them out to give you a better idea of what the differences are. But a narcissist is the inflated sense of their own importance. A need for admiration, lack of empathy, I think the important thing to keep in mind with a narcissist is that even though we assume that narcissist means they think they are great, they do but they don't.

Thinking of that porcupine that I had on one of those slides, two slides ago, occupies look all scary, but they have a soft underbelly. The narcissist don't have a whole lot of ego strength. If you are working with someone who is a narcissist or has a lot of narcissistic behaviors, you need to be pretty aware that they are really -- they don't have enough that ego strength to take feedback and guidance. They need admiration. They can't take anything negative.

Working with a narcissist and I give them feedback, I have to be very careful about how I do it. They don't have the ego strength to take that feedback whereas this I think of the -- I'm a pretty good presenter. I would much know what I'm doing most of the time. But if you wanted to give me feedback at the end of this that I sucked, why did I do this? That would hurt. I wouldn't like it, but I could take it. A narcissist can't do that which is why they demand from the people around them that those people give them praise. Because

they need that. They don't have a good sense of that balance.

Psychopaths, all of the antisocial personality disorder traits but they are not limited to criminal behavior. They can be manipulative. There's a lack of guilt. Think about white-collar criminals. Those are the ones you would attach that definition psychopaths two. Sociopaths have low or no conscious. Most professional skill is a learned trait. It's not necessarily genetic. Sociopaths are learning that from their environment versus a strict leap genetic perspective and there's a little overlap there. A lot of the same trades you would see in the psychopath but sociopaths tend to be the consensus is it's a social learning and something they learn based on their environment. I get a little annoyed with some of this in the sense that some of my patients I did an assessment on a gentleman last week who grew up in a part of Los Angeles where there was lots of gangs, lots of violence.

If you just look at his behaviors, yes, he would look like a sociopath or psychopath for that matter.  Very antisocial. But when you really talk to him and look at those behaviors, it's survival. I don't want to pathology eyes behaviors that really how else would he develop? We really want to take that as something I think it's important to remember that. Sometimes we can use that to help the patient change. We can help them -- you don't have to stay that way just because you grew up that way. You don't have to stay that way. Then the antisocial definition. There's the external criminal behaviors, failure to can sport to social norms, impulsivity. Going back to the gentleman I did the assessment on, he meets every criteria for antisocial personality disorder.

I didn't put that diagnosis on his chart and I didn't because when I talked to him and I looked at him, he's got all those behaviors were things that he learned growing up for survival and it was a way for him to keep going in life. We want to be careful with some of the definitions of what we do with them. The personality traits that we really see what you see on the surface, vanity, temper outbursts, boredom cause devastation in the face of criticism. The devastation is not said depression. It's usually anger, lashing out. Failures of empathy. They don't do well when you say how would you think that would make me feel? That really is not relevant. That is not even on their radar. They might be cruel. They mightcrave others control.

There's inability to adjust their behavior based on the situation they are in. Most of us can change our behavior based on environment. Depending on whether we are talking to our boss or family, we can adjust our behavior to meet the situation. These folks struggle with doing that. They don't see they need to change their behavior. They want the world or people around them to adjust to what they do instead of having their own internal shift and change.

I love this picture. Why would this girl burn her house down? But it was a great plan to avoid broccoli for dinner. All of the antisocial personality to just -- traits but not limited to criminal behavior. Manipulative, lack of guilt. We think of lawyers, doctors, CEOs, politicians, a lot of them have this traits. They fall on the psychopath spectrum. So keep as and psychopaths is not a diagnosis. It is a system of behaviors. When you think

about it, in some ways it is adaptive. Think about a surgeon, and doctor. I don't necessarily want him to have a whole lot of emotion in some ways. I don't want him during surgery on me into thinking oh my goodness, what if I make a mistake and kill this patient? That would be so saddened devastating and her family would be so sad. That would be so traffic. I don't want him thinking that. I want him thinking I'm going to do this, I'm going to save this life.

I don't necessarily want him in touch with some of those emotions. When we think about some of these traits and behaviors, it's important if you're going to work with a subset finding their strengths. Finding how maybe this trait can be useful for them. It might be good for them. CEOs, politicians, a lot of them get to the top because they don't have a lot of concern for your emotions. I look at some of the things that my CEO has had to do in times of COVID to keep our doors open to make payroll and people say gosh, all she cares about is money. Yeah. That is her job to care about the money. Why? Because she can keep the doors open. She can keep the business going. Does that mean some people emotionally don't like the way she asked? Sure. But her job is not necessarily to make you like her. Her job is to keep the business going.So it's helpful for us to think about those perspectives in some ways.

You want to think about what are their social norms. Go back to the assessment of the gentleman I did last week. He grew up in a very dangerous part of Los Angeles. Social norms for him were violent. If I say to him you are not conforming with social norms, in his culture, in his neighborhood, yes he was. The neighborhood or the society as a whole, of course, he's falling outside of social norms. But in his immediate environment, his behavior is not abnormal. His behavior was seen as survival, even something to be admired. You want to take that into account.

There's several authors that I like to point to when I'm talking about this topic. Dutton is one of them. He says antisocial personality disorder is psychopathy without emotion. Psychopathy is an emotionless void.  So there is a slight nuance. This really does lag. Here's a little grid I was talking about. It broke out antisocial personality disorder, sociopathy, psychopathy. It broke out where there might be distinctions. At the end of the day, I probably wouldn't get too hung up on the definitions. Honestly, unless you are working in a criminal justice setting where it's really important to have the right definition there, I don't care too much. I care more about the behaviors and what it represents for the patient and how do I work with that.

That's what I'm really going to try to focus on in the hour and a half list that we have now.Research. When we talk about some of the work -- this is dead and again -- EEG responses of psycho and non-sociopaths. -- Psychopaths. Normal brains emotional -- identify emotionally charged words quicker than not emotionally charged words. So we think about things that affect us, cancer, rate cut might have an emotional effect on some of us. But these folks that meet the definition of psychopathy, those emotionally charged words don't measure the same way we do in us. Go back to that surgeon that I was talking about. Call him, cool and collected. That can be an adaptive trait for some folks. When they talk about how for people like a surgeon or a CEO that this trait might

be adaptive for them, it's because they can screen out those emotional things that might be really distracting to some of us.

If you are a counselor or work in the field, maybe something happens and it sticks with you emotionally. I know this has happened to me where a patient might share something that's really sad or devastating and I walk through that with them and that emotion sits with me a while. It kind of colors the rest of my day. If I was a psychopath, I wouldn't have the empathy. Their emotional state would not impact me. And at the end of the session, I'm done with it. I move on. It doesn't color the rest of my day. It's an important distinction when we think about those emotions.

The advantage. What professions might be an advantage to not be as in touch with your emotions? There might be times where it is adaptive. I think sometimes these folks, they find careers where they find jobs that they can actually fit into society. There is obviously you get too far in one end of the spectrum where they really get into trouble, but there are those that can really have that functional psychopathy. Whether they become a doctor or CEO or whatever it might be. If they are able to channel that trait that they have and they are able to be functional with it. That might be something to keep in the back of your mind as well.

The actual diagnostic craze Terri. I'm not going to spend a whole lot of time about this because we care about behaviors. This is the only personality disorder where they specifically say occurrences age 15 years. They really look back into adolescence and say we want to have this there. You have to have three or more of the following. Failure to conform to social norms. Again, what is their social norm? What if what is their cultural perspective? Deceitfulness. Indicated by repeated lying, use of an alias, conning others for personal profit or pleasure. They are deceiving you because they want to get something out of you. They have an agenda. They might be very impulsive.

They may be irritable or aggressive. Reckless disregard for the safety of self or others. Consistent irresponsibility so they don't show up for work. They don't pay their bills. They may not honor their parental duties. There's a lack of remorse and they don't necessarily feel that while, that may have been hurtful. Criteria B, the individual is at least 18 years of age. Unlike borderline personality disorder, you technically can diagnose prior to age 18 as long as the behavior has been there for at least a year. Antisocial personality disorder you have to be 18 years old.

Then there's evidence of conduct disorder with onset before age 15. The occurrence is not exclusively happening during schizophrenia or bipolar disorder episodes. Then you have those four categories of behaviors. There's aggression to people and animals, destruction of property, deceitfulness or theft and serious violation of rules.

If you work with the substance use disorder population, when evil or active in addiction they made a lot of these criteria. See want to make sure you separate that out. That's one place where I do want to pay attention to the diagnosis with a person who is active in their alcohol use disorder or methamphetamine use, they probablyDestroying

property that  repeatedly leads to arrest. The illegal upgrade patients. Dealing drugs, embezzlement. Deceitfulness. There's lying, manipulation. They are malingering, use of an alias. Always to gain power versus attention. When you think about the other personality disorders such as histrionic personality disorder or borderline personality disorder look, borderline may lie or manipulate to a get attention. Versus antisocial, they are doing it to gain power. That is their objective not necessarily attention. Impulsivity condos consideration for consequences to self or others. Not thinking to those behaviors. If you look at some people or patients that maybe have a high score with adverse childhood experiences where they have a lot of childhood trauma, they can be very impulsive. The part of their brain that helps them regulate emotion gets damaged by develop mental trauma. That might also be something to think about if you are making a diagnosis. Is it truly antisocial or is it some form of trauma that you might want to be able to explore?

Irritability, aggressiveness, reckless disregard cusp even, driving under the influence, constant consistent irresponsibility and then of course the lack of remorse. Lack of remorse comes into play when you talk about treatment, when you talk about treatment. We will talk about it in a little bit. It's important to be able to say, does this person have insight or not? If they have remorse, then they have a little bit of insight even if their remorse is I got caught and I got to go to jail. At least they are recognizing they had a behavior some packet impacted going to jail. If they truly don't see that, then you have an uphill battle. If the patient has a little bit of insight, even just a little nugget, you can start to work and play with that. So thinking about that lack of remorse and how that might relate to their insight.

Additional components. They might be callous or cynical. They may be very arrogant. I've seen this in some folks that really don't feel -- I remember one guy in particular he needed to get a job. He was in our drug court program. The only jobs he would qualify forward jobs at fast food restaurants and he really felt that all of those jobs were beneath him. He felt like he should have a much better job, something with more power, control, money. We were like you don't qualify for anything. The judge is saying you need to get a job even if it's not -- at McDonald's. He felt like any of those jobs were way beneath him. That was something that okay, I can see that in him.

Lack of insight. To how their behavior leads leads to negative consequences. Insight is important. Insight is important for anybody. Whether you are working with someone with anxiety or alcohol use disorder, do they have insight? Are they able to do that? If there's no insight, it's really hard to work with that person because they don't necessarily see that they need to change anything. Insight can be very relevant with this population in particular. They may be charming, charismatic. Lack of empathy. They may be exploitive in sexual or other relationships. There's often comorbidity,, substance use, other mental health issues. I don't care about the diagnoses, but if you are in a setting where you do need to have a specific diagnosis, you might need to do some differential diagnoses in terms of is it a trauma disorder, substance use disorder, another personality disorder? Maybe need to think about that. They may struggle with tolerating boredom. They feel like they need to have life laid out to them and they always need to be stimulated and

engaged. They can't handle that type of boredom of normal life so to speak.These are components of personality disorder diagnosis. There is quite a bit of debate about whether it truly is enduring and rigid. Whether it really does remain consistent over time. Some of my colleagues and I have discussions about personality disorders. Even though it says they are persistent and consistent over time, I don't know that I fully agree that. I've had patients that have true borderline personality disorder. They meet every criteria. And they can change. Maybe they have insight and they want to do things to Philly. I had one particular patient who essentially she grew out of it in many ways.

As she got older she was like this is not working for me anymore. I need to do things differently. She was able to grow out of some of those behaviors. I don't necessarily agree with the personality disorders being an enduring pattern that they are consistent. Sometimes the change. They can change. They may not seem problematic to the individual. If you do have to make this diagnosis, you absolutely need to get collateral information. We see that with substance use disorder as well. If I say to someone do you think your drinking is a problem? No, drinking is fine. My wife is the problem. Okay. What do they perceive the problem is being? Then when you get to that treatment side of it, that's pretty relevant. The problem is your wife. Let's talk about your wife. The problem is never about them. So knowing what their perspective of the problem is is relevant when it comes to treatment. Behaviors may become less evident with age.

This is where DSM conflicts with itself because it says it's endured, out rigid, fixed over time but it may become less prevalent. And it really is not rigid and fixed over time but whatever. Lack of expressed anxiety or fear. I bold that expressed. These folks quite often have a lot of anxiety and fear but that's not what they would name it. That's not what they would call it. They would call it something else or they might even not identify they have it at all. In these folks, go back to the porcupine analogy. They have that soft underbelly and so they have to have those quills up because of the acknowledge they are scared or wrong or bold, that's not safe so they don't really want to do that so it might take a lot of time and work with them to help them feel safe enough to start identifying what anxiety and fear feel like for them and what they do with it.

Of course with substance use, you really need to look at the antisocial personality disorder criteria as different than the substance use. You want to have collateral and of course you want to pay attention to the age because DSM does toss this at age 18. Additional components. Is there a family connection? This can also be a point of contention. Is it nature versus nurture? If I grope an environment where everyone in my family is out for themselves only. They don't show empathy. They don't show courtesy or respect for others, I'm going to learn these behaviors. Thinking about if I grew up in that family, I'm going to learn those behaviors. Is that part of my social upbringing? Even though antisocial personality disorders is more common in males, I question that simply because men tend to be more aggressive. Women may have the exact same experiences are the same environment and they tend to behave differently. They react differently to that setting whereas men tend to be more aggressive so men are more likely to get the diagnosis of antisocial personality disorders.

Adoption studies indicate genetic and of our mental factors. Just like a lot of our disorders that we look at it's what we call epigenetics. Epigenetics says there's a genetic foundation or underpinning for a disorder and the environment influences it. That's really relevant for these folks. It may also be associated with that low socioeconomic status. If I grew up in that setting where it really is a survival setting, I'm going to develop these behaviors in order to survive. So I need to take that into in -- account when assessing someone.

Core structures of personality. There's the surface structure, life of the party, don't respond to friends. Then there's that core structure. Abandonment, emptiness. I don't know how to share that. I don't know how to say that so I'm going to have surface behavior. When I think about it with patience, I asked patients give me a list of your behaviors or tell me about the times when you feel good. When you feel happy. I'm not going to necessarily identify those beh.. Just that they are behaviors. I want to explore that with the patient.If you are working with this population, you need to make sure you have the ability to work with them long-term because that's the only way you're going to be able to motivate them to change. Some differential diagnoses for personal… The disorders. There's a lot of overlap with antisocial narcissistic and histrionic. This is just a nice grid as well to look at you have the antisocial personality disorder. It's usually a precursor of contact -- conduct disorder or oppositional defiant disorder. So see up at the end of psychopathy or behaviors within that. They are not diagnoses. But they are behaviors. I like to think of sociopathy and psychopathy on a spectrum. You have the extreme ends.

There's a few screening tools. If you decide that maybe I want to do some screening tools. I want to get a handle on if this is relevant, Doctor Robert Hare if you've read any of his materials, he's sort of the guru of this field and he actually developed a psychopathy checklist R PCL-R. It's a rating scale 20 items. It assesses lifestyle, pathological lying etc. Scores are used to predict criminal re-offense and rehabilitation likelihood. He does a lot of work in prison in the prison setting and I love this quote. If I wasn't studying psychopaths in prison, I would do it at the stock exchange. He really points out that there is this spectrum of behaviors. You go from one into the other.

I appreciate that with him. He also sees it as a trait versus a disorder. Someone may have the full out disorder or they may have some of those traits. If you look at DSM, DSM does have a proposal in the back for an adjusted way to look at personality disorders. I agree with that. I wish they would do that and say that you have those four core traits of a personality disorder and then we can identify with borderline features or with antisocial features. We can identify there are certain traits within it because there is so much overlap in personality disorders. I would really rather that they have a general personality disorder and certain features that go along with it. He also identifies there's limited prosocial behaviors and emotions.

I think about childhood trauma, develop mental trauma. It from growing up in a really traumatic, sad, scary, not safe place, it is really life preserving for me to be able to detach from my emotions. It's really adaptive for me to shut down those emotions and

not feel them. I need to take that into account if I'm working with this population. Identifying and feeling those vulnerable feelings can be very difficult. Truly Doctor Harris says that really only about 1% of the population meets full criteria. It's estimated about 80% of the prison population meets criteria but only 20% of those meet Doctor Harris criteria. The majority of psychopaths are not incarcerated. Scary but true. There's 20 items on his tool.

The Acme is another tool and I should've written out what it is. The effective -- I should remember this because this is what I used for my dissertation. It's a tool to assess their emotional states. It's my ability to identify and have empathy for those around me. It really is a 36 items, Likert scale 1 to 5 with strongly agree to strongly disagree. 10 items or reverse scored so that means that if a person just goes through and fills in the same little bubble on everyone it's going to throw off the results. It's designed to reverse scored. The high score is 180. The closer to 180, the more empathy they have. These are just -- it's my right hand side of the slide just a list of some of the items on the Acme.

I have a hard time reading people's emotions. I think it's fun to push people around once in a while. This is just a simple tool that you can pull off the Internet and get an idea of where's your patient? How do they feel with that? Do they seem to care about emotional states of others? Can they recognize that? The thing with the Acme to keep in mind. Depending on the person's mood of the day, it's going to impact their responses. If you think about when my friends are having a good time, I often get angry. Probably depends on what kind of mood I'm in. If I'm cranky to begin with, if you arm having a good time it makes me mad. But if I made a good mood it doesn't bother me. So it can be subjective there.The PPI. Eight independent traits. It's worked -- based on the work of Doctor hare and Doctor quickly. There is a four point Likert scale. Levenson Self-Report Scale and I put the website. You can go ahead and pull it off. Success is based on survival of the fittest. I'm not concerned with losers. That's one of the authors of that tool said so that can really help you identify I agree with that or no I don't agree with that. All those tools are not necessarily diagnostic but they are tools that might help you gain insight into what's going on within your patient.

This is what we really want to focus on. How do I treat them? I don't necessarily care about the diagnosis. I really care about the behaviors. I'm going to treat the behaviors whether they meet full criteria for a diagnosis or not. It's the behaviors that are bringing them into my office and landed them in drug court or I want to look at. There's two courses of treatment. If the client has insight, you are going to expand on that insight. You are going to work with MBT, CBT. You want to create change, sustain change. You are going to be building skills to help them adapt to their world. You are going to help them identify what goals they have and how they are going to get those goals met.

If your client does not have insight, it's going to be a little more challenging. You are going to want to really try to improve their insight by using MAT. Maybe they need to be in what they call thinking errors course. Looking at some of those thinking errors they may have. If they really don't have insight, if they can't build insight, treatment really becomes more about harm reduction. How do I keep you out of the prison system? How

do I keep you from reoffending? They may not care about that. They may say, that is relevant to me. I think sometimes counselors struggle when a patient says you know what? That goal is not one that I endorse. It's not one that I want. They really don't have insight. They don't seem to have the ability to change. It's going to be more about harm reduction and behavior reduction. You are going to have to get their buy-in.

If you didn't have to hold yourself accountable, empathize with other, feel guilt or remorse, would you change? For the folks that don't have the insight and some that do have it, there are days where being up -- I like to think of myself as a semi-functional person in society -- being accountable, paying my bills, being kind to others, following the rules of the road. I have to stop at the stop sign. Sometimes that can be annoying. If I didn't have to do any of that, life would be a lot easier. If you think about some of the folks that might be in this population, if they didn't have to be accountable, they don't have to have those uncomfortable feeling things, didn't have guilt, didn't have remorse, would you change? Would you be motivated to change? You might not be. That's a question you have to ask yourself if you are going to be thinking about it with them.

This next slide, this picture, it can be kind of inflammatory and scary. You think about Adolf Hitler.. At the time, this was his belief. His belief was this is what I need to do. This is what God wants me to do. Now we look back at Adolf Hitler and we are like wow, that was not okay. But at the moment, that was his perception. It's really important that even if we don't agree with it, even if it makes us really, really uncomfortable, we have to be willing to identify or at least validate the patient's perspective. Even if we don't like it and don't agree with it. That's one of the best ways to get their buy and. That's one of the ways to come alongside them. Albert Ellis said people don't react emotionally or behaviorally to the events they encounter. Rather people cause their own reactions to the way they interpret or evaluate the events they experience. Really being aware of that.

Go back to the patient that I was referring to last week. The environment he grew up in, the behaviors he engaged in at the time, totally normal and acceptable. It was not until he got much older and moved out of that environment and some other things happen in his life he could look back at his childhood and go wow, something was not right. Just toying with that. Change requires safety. But what if you don't know what safe feels like we all of us would only change if we feel safe. We only change we are doing if we somehow feel it's okay and safe for us to change. Our patients don't know what safety feels like. How do we do that? As a part of the programming at the facility that I work in, I do a lecture on aces, adverse childhood experiences. I have a discussion with the patient about safety. If you grew up in a household that was not safe, how do you then find safety? It amazes me every month when I do this lecture how many of them will say that rehab, being in treatment is their safe place.

That makes me sad. Rehab? That is your safe place? Not with family, not at home, not in childhood. That was not safe. We really need to say how do I create a sense of safety for this patient? In order to do that, I really have to explore with them what is not safe. What would it mean to be safe? What is their definition of safe? I want to somehow do

some motivational interviewing to create their awareness of the problem, to help them identify what they want to do with it. What do they want to do about that problem? How do they want to change? Confrontation of the problem and confrontation is not attacking. It's simply identifying behaviors and saying how does that behavior impact you?

People think that confrontation is aggressive and scary and it really truly does not have to be. I think about my husband and if he doesn't do the dishes or does something I don't like, if I go home and I say you lazy so be good for nothing. I can tell you what kind of response he's going to have. He is not going to be impressed versus if I go home and I say sweetie, when you didn't do the dishes I was frustrated. When you do the dishes, I feel valued. Oh, okay. That's a different message. I'm still saying essentially the same thing but I'm doing it differently. I want to be able to practice how I confront the problem. I want to be able to create effort towards change. Hope for change and support for change. Whatever that might look like for them.Collaboration checklist.. Questions to ask yourself and the patient. Are they motivated to change? Do they see value in change? It can be simple. They may say the only thing I want out of treatment is I want to get out of being on probation. I want to get off probation. Okay. If that's what's going to motivate them, I'm fine with that. In my head I'm being much more like you're going to have the goal of being a happy, healthy, balanced, whole person human being. They are like I don't care about that. I just want to get off probation. I have to start where they are. What do they want to change? What  is the value they attach to that? Can they see your perspective?

Let's say I say how do you think that your husband felt when you did XYZ? Can they see that perspective? Are they willing to even look at that? If I've done my job and created a safe setting, they are more willing to listen to me giving them that perspective. They may not like it, but they are willing to listen. A good example. One of my patients that I've worked with for a while, he definitely has scores seven. Mom and dad are still active alcoholics. He's living with them because he's in drug court and has no place else to live. It's really not a great setting for him. Because of COVID 19 all of our drug court said it -- services are over telehealth. He was watching television one day during group. The counselor can see his face and see he's not paying attention. And he says I'm watching TV. I have a movie going. The counselor got mad at him. So he comes in to the session with me and he's super mad. They wrote me up and the judge got mad at me and I don't see why that was a problem. Let's talk to that because I think it's a problem. Would you do that if you were in the group room with everybody? No. Okay. Do you think that your group mates appreciated it? I don't know. Okay. Let's think about it.

Over the course of a 20 minute conversation, he was able to go okay I guess I kind of see why maybe it wasn't okay to watch TV during group. But it was only because I set up that setting where it was a safe place. I'm not judging you. I'm not against you. Let's just talk to this. He was able to then go okay. I can see why maybe it wasn't okay for me to do that. Do they have a history of using cruelty to gain power? Remember that for this population, they are engaging in some of those behaviors. It's for power, not for

attention. If their goal is to get attention, then I lean more on the borderline personality spectrum or a lean more on the histrionic spectrum. If they are doing it just to gain power, then it's probably more on the antisocial or sociopath psychopath spectrum.

Is their external motivation -- if -- I don't care if it's external. I'm willing to work with external motivation. I hope it moves to internal motivation, but if it starts off as external, that's fine with me. Do they trust you? What does trust look like? That might be something that they are not sure what trust looks like. Trust looks like you don't rat out your brother. That's trust? Trust means different to me. So I might be able to get have a conversation about what does trust look like? Are they able to take responsibility for their behavior and outcomes? They may or may not be. That's something that you can talk to them about and ask them. Are they able to respect others boundaries and do they understand why other people might have boundaries?

Causes of pathology. I don't usually spend time on this with the patient unless I think the patient might benefit in understanding why they are the way they are. Like the gentleman watching TV in group, he really benefits and has -- I don't want to say enjoy, but he has found it very helpful to understand what aces are. It has done him a world of good to understand the reason I do XYZ is because I saw my dad do that over and over and over again. As a little kid I felt scared and sad and powerless so I do these things because of the way I was raised. He can understand that. Then eventually he can maybe work towards a don't know if forgiveness is the right word, but maybe just having less resentment towards his dad. But there's three ways to do these disorders.

They are born that way so it's genetic. Environment had nothing to do with it. Or they were not born that way it was environment or they were born that way and the environment made it worse. That's epigenetics and most of us feel like it's that. There's probably an underlying genetic susceptibility to certain behaviors and traits and the environment triggers them. If you really want to get to the diagnosis, two possible antecedents of antisocial personality disorder, conduct disorder and oppositional defiant disorder. Those are precursors. 90% of children that have a diagnosis of conduct disorder also have a diagnosis of oppositional defiant disorder. I don't play with kids. That's not my wheelhouse. But when I have talked with kids and work with them, anytime they have that diagnosis, I'm like wow. They have trauma.

To me I don't like coloring them with this negative diagnosis of oppositional defiant and conduct disorder. No, this kid has trauma. We need to address that. There is no one pathway to antisocial personality disorder only research Bequt trend. Then there's this thinking point. Is it a personality disorder or thought processing disorder? I don't like the whole chapter on personality disorders. It makes me twitchy. I really see a lot of this is rooted in trauma, anxiety, other disorders so I don't like how personality disorders are so pejorative. But when I think about one of my gals who has borderline personality disorder, I don't like that definition necessarily. I think of it more as a thought processing disorder. When the world happens around her, she perceives it as unsafe and so she reacts accordingly. She lashes out. She does manipulation. She does those things because her thinking process about the world around her is different than mine.

The personally disorder has such a negative connotation and so sometimes I tried to walk patients through that. There's that ultimate attachment disorder. If you are familiar with the attachment period, that might be a tax to take if you're going to work with this population helping them understand what attachment is, helping them understand the -- what did you have as a child?The general and I was working out last week, I asked him what do you think you needed when I -- when you were growing up? He needed to feel safe. He needed to know that his mom loved him. And that her drugs were not more important than him. I referred him to a therapist and gave him the background and said this is what I think you need to work on. You need to work on how to weigh need -- get my needs met as a health away because as a kid, they were not met. Sociologists believe that that low consciousness person is largely due to negative and emotionally toxic environment in childhood. Sociopath is a social disease. Due to social upbringing. That's another way to think about it and maybe even explain it to patients that way.

Uncompleted develop mental tasks. I was talking to a group of my supervisees yesterday about personality disorders and one set a lot of these techniques sounds like what I do with my four-year-old. I'm like yeah, in some ways. If you are going to work with this population, you are going to do a lot of parenting type tasks that you are going to do give them structure. Giving them safety. Giving them consistency. Giving them unconditional positive regard. No matter what name you call me or those things that you do, I am still going to say, I care about you as a person. Thinking about that if that's in your wheelhouse, that might be a perspective to take on it.

Other causes. There probably are some other experiences. Malcolm's take, events and emotional responses. When you think about how did they respond to these events? That's where I want to dig and check it from going to work with these patients long term, hopefully they can learn to trust me enough to talk about some of these things and then how their responses were adaptive in survival. Even though maybe society has told them those crimes you committed were bad. I would say well, yeah. Maybe they were illegal. However, you were stealing all that food to survive. You stole that person's money so that you had money to buy food. To me, you survived. I'm glad you survived.

There are various protective factors and there's probably actually a combination of environmental and genetic factors to take into account. These are risk and protective factors you can identify. You can go through these with your patients. You can identify -- give them the education. These oaks are typically very, very smart and if they have inside and are willing to look at stuff, they might be very willing to look at and want to have a better understanding of what their risk factors are, what their's score might be. Protective factors they may have around them that may have helped them get to the place they are at. A little bit more neuroscience. The orbital central -- frontal cortex which regulates emotions and decision-making.

When you look at these screens, pet scans of 41 murderers revealed reduced activity in those frontal lobes. The frontal lobe activity certainly that is indicative of that's different. I have said this to anybody who's attended any of my educational sessions, I've probably

said this in more ways than one. At some point you will look at how we address mental health and substance use issues as archaic. We will say Malcolm's list of traits and criteria, that's nice. But we are going to do a brain scan so we really know what's wrong. We are going to do a brain scan so we know what this looks like. Psychology is really the only field where we don't take a look at the organ we are treating. Cardiologists look at the heart. Liver doctors look at the liver. We don't look at the brain. We go with a bunch of sometimes relatively subjective behaviors and traits.

I think that in the future, whether it's a brain scan or something else, we will have a better way of diagnosing and having treatment for folks with substance use and mental health issues. We will look at what we do now as archaic. We will have such a different perspective but we are not there yet. The techniques to take away from this. Finding their strength. What are their strengths? You may have to get creative with that. I had one patient and she identified her strength as being a drug dealer. She said -- I said that's not something to be proud of, dealing. I said yeah, however, what do you need to be a good drug dealer? You've got to know your market. You've got to be a good business person. So we were able to find some strength in that. You want to be able to find their strengths and build on that. You want to have a strengths perspective in working with this population. You want to be nonthreatening and nonjudgmental. That might mean that you need to have your own supervision in the sense of sometimes the things that these folks may tell you can be very triggering, very emotional.

You need to be able to take care of yourself. If you are recognizing some of this stuff is really sticking with me, you need to be able to do clinical supervision, whether that someone in your organization or whatever you need to do. You may need to have your own place to digest some of this. Active listening. I want to have that active listening skill.Ask yourself and them what the goal is. The goal is getting off probation, that's the goal. Let's talk about how you are continuing to break the law and that's getting in the way of your goal. Whatever that might look like. Being silent and nondirective is sometimes seen as a weakness. This would be a population where the use of silence -- that is a therapeutic technique. I would not use it with this population. Stylistic of behavioral therapy might be relevant particularly if they have -- identified and a ruling to work on I need to learn some interpersonal communication. Eileen need to learn grounding. I need to learn distress tolerance. That's the DBT skill that I really like to work on with folks is distress tolerance. Anybody. We can all use that. How do I tolerate uncomfortable emotional situations? How do I deal with that?

We all could benefit from that. Motivational interviewing. Fabulous technic. It takes a lot of work on the end of the clinician but with this population it's relevant. You would do well to learn more about motivation interviewing. Solution focused there peak. In graduate school it was the modality elect because you identify a problem, create a plan and go. Let's do it. We don't get into the emotional quagmire surrounding it. Some of these folks might like that particularly if getting emotional might be too scary. Being emotional might not be something they feel fully comfortable doing so sometimes solution focused reef therapy where it's very action oriented might be something that they can readily accept.

You might have to admire some negative traits. Like I said admiring the drug dealing. You are a good businessperson. Let's figure out how we can reframe that into some skills that can be very useful for you. Finding out their values. I like to do this with a lot of my patients when they are struggling with what to do. I like to look at values. What do they value? And how do they define that. With one of my patients, I think of a value as being a good mom. That is a value that I want to be a good mom. Then we talk about what behaviors do you need to do in order to meet that value? To be a good mom, what does that look like?

Especially with folks when we talk about defeating beliefs or negative core beliefs, people talk about using affirmations. I don't mind affirmations. But I find -- I feel when you do behaviors, it's a much stronger change. If I feel like I'm a bad mom, a horrible mom. My alcohol use may be a bad mom. I can do the affirmations and Sam a good mom. But I don't believe I'm a good mom and now I'm lying to myself and feeling worse. Whereas if I can say I am a bad mom. I failed my children. A want to be a good mom. That is a value I want to have. What are the behaviors I can do to be a good mom? If I can engage in those behaviors, whether it means I'm reading stories to my kids or I'm making a nutritious meal or whatever I'm doing, if I can do those behaviors, self-esteem is going to improve. I'm going to see a lot of different behavior changes in other areas because I'm aligning myself with a healthy value system.

Identifying values with this population can be a great technique and you might have to work at it a little bit. They may say value is being honest. What does honesty mean? Does that mean that you tell the cops that someone did something? Or does that mean that you are writing them out? Really trying to play with what auths their values and what does it look like? You might also have to do some praise. It takes courage to confront these issues. You are very resilient to have survived that. I'm continuously floored when I have one of these forks and they say something like I'm proud of you. I know that what you just did was difficult and I'm proud of you. They will tell me I'm the only person that has ever said I am proud of them. Me? I'm the only one? We want to give them that praise. Like being a parent, we want to be able to do that.Techniques for change. Leave your ego at the door. If they are into criminal pathology, you may need to make sure you are very safe so you are going to leave your personality out of it. You are not going to have pictures of your family in your office. You really want to just be the counselor, not anything else when you are in front of them. Empathizing when it hurts to do so. They may tell you some things and inside you are like oh my gosh. That's nuts. Don't say that. I might have to empathize even when it's like that's hard to do. I need to be able to do that.

Establish empathy prior to confronting. I'm not going to confront behavior until it established that foundation of safety. Established on something -- I'm going to say things to you because I truly care about what happens to you. Courtesy and permission. This is the one population where I do actually ask permission to give feedback. Most other folks I just tell them I'm going to give you some feedback because that's why they are there and paying the money. That's why they come to my office. They want my

feedback. This population him going to be a little more careful. I'm probably going to say, wow. You just told me some amazing things. Gosh, I'm so glad you told me that. Can I give you a little feedbackI may phrase it differently. Maybe I say I have some thoughts on that.can I share them with you? I might say something like that. Rolling with the resistance. That's a motivational interviewing skill. I'm not going to fight with them. Narcissists in particular do a really good job of what I call poking. They just poke poke poke poke. They keep going. You can't get a word in edge wise. They get very emotional and reactive which makes most of us emotional reactive so I'm not even going to have a fight. I'm pretty clear that if you are going to yell at me or say those things, we are going to end the session and we can meet again next week.

They get mad. We can meet again next week. Or if you want to go hang out in the lobby for a few minutes and calm down, if you want to take 15 minutes, you can do that. I'm not going to have a fight with them. I'm not going to get into that. I have a little bit of feedback going on. We are good? Setting those boundaries, making sure you establish that prior to engaging in counseling with them.All things to do and make sure to keep in mind. We crave resistance. When we confront them and spend a lot of time doing that -- I'm not going to get into a fight with them. They may have a certain perspective or view. I'm not going to convince them otherwise. I'm not going to spend a lot of time fighting them on that. I may find if I accept their you and say okay, I see why you see it that way. I'm going to validate that. I may not agree with it, but I'm going to validate that that is your perspective. I'm not going to fight with you about it. Rapport is going to look very different with this population. I'm also not going to get into fact-finding discussions with them.

If you work with the substance use population, I'm sure you've had a discussion where you say gosh, your drug screen came up positive. I didn't use anything. Okay. But your drug screen came back positive. I don't know how it came back positive! The drug screen came back positive and I'm not going to spend time on it. We're going to move on. I'm going to note that you disagree with it. That's fine. I'm not going to spend the entire session talking about it because for me is usually a deflection. They want to fight about the drug screen because that way we spend our time doing that instead of talking about what might be really going on. If they are heightened, activated, reactive like that, that tells me they are in fight, flight, freeze. They are not feeling safe. What do I need to do to keep them feeling safe and get them back to a safe place.

Questions to ask them. This is a great way to build engagement and for you to get a good perspectival where they are at. Tell me what does trust look like? People are trustworthy when. You can make this into a handout. Fox the citation down there I will show you the reference at the end of this. He is a great workbook. I love it. He is a board book where it's handouts. You can use these so having the patient fill it out. What does trustworthy look like? How do people show that they are trustworthy? How can I show you that I am trustworthy? You know you can connect with someone else when. People care when. You can show someone you care by. These are all ways to get insight as to where they are at, what they think and how do I align myself with that. Those are good techniques.

Also thinking about primary and secondary gain. There's almost always a secondary gain. For those with antisocial personality disorder, secondary gain is probably going to be something about avoiding the emotional discomfort. It's probably something about I don't have to deal with I feel vulnerable right now. Thinking about that primary and secondary gain. When you work with personality disorders in general, this is something to keep in mind. I know I had a patient with borderline personality disorder and she was one of those where making suicidal gestures was something she did frequently. She would end up in the psych center. We talked about what's the benefit? She finally said it's really nice because I go there. Everyone's really happy to see me. Everyone knows me. They know my name and my story. I feel accepted and I get out of life for a week. I don't have to go to work. I don't have to pay bills. I don't have to be with my family. Everyone leaves me alone for a week.

That is your secondary gain. Having to come around to how can we make it not so comfortable there for you? How can I make it where the psych center isn't just a place to go for a week long vacation? Exploring that. If you want to look at those secondary gain -- I call them defense mechanisms. It may be violent or aggressive. They have repeated unresolved complaint over and over every day in your office. They say the same thing over and over again. They might have lots of complaints. I'm going to spend time as a counselor trying to resolve their complaints instead of saying okay, what do you want to do about it? Let's move on from the complaints and figure out today we were going to talk about your life history. Let's focus on that. Complaints am not going to deal with. However you want to navigate that. There may be a lot of anxiety in there. Like I said earlier, they may not express anxiety. They may not express fear.

But they probably have it. But they don't know what that feels like. They don't know what it looks like. They don't know how to express it appropriately. So they come across with aggression, fighting, being uncooperative. Because those are behaviors they know and feel safe with. You need to ask the client, how do you benefit? What is the unmet need? I say to all my patients, over and over again, life is about what are my needs? How do I get the Met? That's it. That is life. What do I need? How do I get my needs met? For a lot of these patients, they really don't know what they need. Their needs are more superficial. One of my patients I said that to her, what do you really need? She said I need a beer. Okay. I'm not going to get you a beer. She needed to not feel so uncomfortable and beer is how she feels good now. I get a little social lubricant going on. What do you need? And how can you get that need met? You may have to spend a lot of time really helping them identify -- most of us have those core needs of safety, belonging, acceptance. Those may be foreign to them. You may talk about what does that look like. How does that look like? Where can you find that?Do they have insight into the behavior? How do they see the behavior is meeting a need? I make a suicidal gesture, I get to go to the psych center and it -- I get taken care of for a while. Do they have a long pattern of this? Can you identify with that? Can they talk about it? Are there ways to limit the secondary gain? For the patient with borderline personality disorder, it meant I would talk to her psychologist and say next time she checks in, can we do a few things to make it not so comfortable for her? He was like yeah, we can probably do that.

That's what we did and it was not as comfortable for her to go to the psych center.. There were ways that we changed that gain. Sometimes you can do that and sometimes you can't.

Keep in mind. Personality disorders. Before DSM-5 when we had the five axes under DSM-IV personality disorders were put on the same axis as mental retardation, develop mental disabilities. They were seen as clinical issues you can't do anything about. Axis II. If you think about that, would you ask a developmentally disabled person to be fixed? The first job out of college I worked with adults with disabilities. Many of them had brain injuries. They were in wheelchairs. I would never ask them to be fixed. We simply said how do we help you navigate your life as best as you can, best as we can? Given the circumstances, given the traits that you have, how do we help you navigate the world as best as we can? That's really what I try to do when I'm working with someone with a personality disorder.

How do I help you navigate your world? I'm not going to ask you to quote unquote be fixed. I'm going to say how do I help you adjust to the world that you were in? It's incredibly relevant for us to remember people that have problems hope that they can solve them. Whereas people who are problems see themselves as fundamentally flawed and unchangeable. I really want my patients to say I am a person and I have some problems. Maybe I've had some adversity in my life. I've had -- made some bad choices. But I can still do something. I'm not powerless. I'm not powerless over this.. I can make some changes in my life and I want them to be able to focus on that.

You want to be able to keep yourself safe. If you are working with those antisocial population where they are high on the psychopathy sociopathy scale, you have to make sure you are keeping yourself safe. Sit closest to the door. Some of them may not like that especially if they have their own trauma. They may not be comfortable with that and they might want to sit closest to the door. Depending on your setting, if you know that you have a patient that might be potentially reactive, you may need to let people in the offices around you know. I have a session with Joe at two. Do you think you could stand by and make sure that you are listening? Yes. Do you have a panic button? Something like that that you might need to use. Make sure there are others nearby to help you if you needed. So you wouldn't want to schedule a session in the evening on the weekend where there may not be other people available to help if need be.

You want to have a safety plan. Do you text or email staff at the beginning and end of session so they know you are okay? Do you have a panic button? Avoiding power struggles. I don't want to get into power struggles with these folks. That's just a way to distract from the actual reason they're seeing me. You may need to screen clients. You may need to be able to say I'm not actually going to be able to see this patient. I'm not comfortable with it. Then who do you refer them to? Could you send them to? To the personal items visible in your office?

If you're working with this population, you may not want to have pictures of your family, personal items in your office. Do they know where you parked? Do they know where --

what your car looks like? You may want to be aware of that. You also want to look at what's on the Internet about you? It's not hard to find information on people on the Internet. You may want to be aware that these folks may find ways to abuse or exploit you so be careful what's on the Internet about you. Also you want to monitor your social media. You don't want to give them information that you would be uncomfortable with them having so just keep in the back of your mind.

These are some of my favorite resources.The book on the far left-hand side. That is the one by Mr. Fox. It is my favorite book. On my bookshelf it has all sorts of tags and flags on it. It has a lot of great worksheets and insights. Women who love sociopaths is a great book. I've had women read that where they tend to consistently get into unhealthy and abusive relationships. It can help them understand what they are doing. Then of course the sociopath next door and the wisdom of psychopaths. I love these two just because it's a different spin on sociopathy and psychopathy. We tend to think of them as bad and different. Yeah, okay. But again, there's some adaptive traits in there so these two books put a whole different spin on it. I find that to be very eye-opening and good. Those are some resources if you want to play with those.

There we go. My title just recently changed. I realized that on the first slide I have my title change very recently. It doesn't matter. I still do the same thing. There is my contact information. Feel free to email me. I love having these discussions with people. Having said all that, I'm going to turn it back over to Jesse. I hope I got that in time. Sometimes I keep going. Going to turn it back over to Jesse.

>> JESSICA O'BRIEN: You did. We have time for questions and we have a lot of questions. Get ready. The first is from Evan who asks can you talk about cultural influences to antisocial traits?

>> MALCOLM HORN: Yes. I believe so. I guess I maybe need to ask a clarifying question. A culture such as the gentleman that I did the assessment with last month who grew up in Los Angeles in a gang community. His culture was a violent culture. So that would be his culture. We also think of culture as Native American or Hispanic or other ethnic areas so I would ask which culture he is referring to. I've talked about the violent culture. But yes, if we think about the other -- whether it's -- there's two Native American reservations I them close to where I live. There's often violence on this reservations. It may be commonplace for them. I really want to get a perspective from the patient. Tell me about that? What does safety look like, violence look like? How did that affect you? I find that sometimes if they've had a lot of violence in their life, whether it's been perpetrated on them, whether they witnessed it, I really want to help them understand what trauma does to the brain and how that can impact their behaviors.

Looking at the cultural perspective. DSM does talk a little bit about cultural perspectives in the diagnoses. You would want to redo that. Then I start with my patient. I care less about DSM and more about the patient's perspective. On how their culture influenced their behaviors and perspective of the world. I hope that was helpful.

>> JESSICA O'BRIEN: I think it was. I think that answered it. Penny asks can people be diagnosed with more than one personality disorder?

>> MALCOLM HORN: Yes, you can technically. I don't like that. I feel like one is plenty. Why would you want more than one? Technically you can.I feel like if you have more than one personality disorder in your chart, I feel like some one has done you would do service. I think it's easy for people to say you are borderline and be done with it as opposed to peeling back the layers. I can probably count on one hand the number of patients where say the borderline personality disorder is the diagnosis. Most of the time it sounds like complex trauma or something different. You can you have more than one. I honestly feel one is too many. I tried to find a different diagnosis if I can. Simply because it's so pejorative. I've known clinicians that find it on the file and said not touching that. That person probably needs a counselor so let's try to break it a little bit.

>> JESSICA O'BRIEN:Elizabeth from Minneapolis. Do you see clients really changing? If behaviors lesson as they get  older, have testosterone levels in men ever been studied?

>> MALCOLM HORN: Yes. With men with testosterone yes. They are less aggressive. So you may see those behaviors come down. I have seen patients that their behaviors become less significant particularly most of the time when they come into my office, they have substance use as well as whatever else they have. So I do see once they get sober, some of those behaviors go away. They are able to work through it. I want to be able to say do I get them sober? Do I see the behaviors change then? Yes, a lot of times I do see the behaviors get better. However, unfortunately I'm thinking of a couple folks in our drug program, they are in their early 50s. They are probably not going to do a lot of changing. They've had 40+ years of dysfunction, abuse, trauma. They are probably not going to do a whole lot of changing. They are probably stuck in the criminal justice system for a long time.

Might be doing some changing. They might. But unfortunately sometimes I see that by the time they get to that -- late 40s early 50s, it's become very ingrained. A lot of us are like that. If you think about your parents. They've been doing that for 60 some years. They are not going to change. Then it goes back to is this a problem or not? Is this something that -- can we look at harm reduction? Can I help the patient do things differently? If they have inside, they might be willing to make some changes.

>> JESSICA O'BRIEN: Very helpful answer. Janice from Kentucky. Other than behavior, individuals responding to their environment, what do you use to determine a specific diagnosis? It seems the environment could be the catalyst to many diagnoses?

>> MALCOLM HORN: Yes. Environment is huge catalyst for diagnoses.What do I see besides the behaviors?

>> JESSICA O'BRIEN: Other than behavior, what do you use to determine specific diagnosis?

>> MALCOLM HORN: The patient's history. Collateral information from other providers. When I do an assessment very rarely do I just take the patient's word. I usually will say okay, Kenna get your medical records? You told me you saw a counselor five years ago. Can I get those records? If I can't get any professional records, I like to talk to family all the family again sometimes they have their own slant. If it is a dysfunctional relationship, I'm thinking about domestic violence situations, the partner or family member is not going to want to talk to because that might put this person in an unsafe situation. I want to get collateral information. I try to use a combination of collateral information and what the patient says. Those are typically the things I use. I don't like just behaviors unless I understand the whole context. If the patient tells me they've done something. Say they beat somebody up. Tell me the context. It was a gang fight or something else happened. Okay. It still doesn't mean it's okay that you beat somebody else but I can understand you didn't just do that for fun. There was something else going on.

>> JESSICA O'BRIEN: If a client shows up for their appointment, doesn't that done -- demonstrate some motivation even if it might be external such as a court order? How does harm reduction playing with someone who is at least partially externally motivated?

>> MALCOLM HORN: Harm reduction is probably going to be how do we keep them from committing another crime? Adding another crime is going to be harm even if we aren't thinking physical harm. You commit another crime. How do I figure out the harm for society? Harm reduction for society not necessarily the individual. Even though I would rather be person centers. Sometimes thinking of it that way. I think also whether it's external motivation or not, they showed up. Tell me why you showed up. I didn't want to go back to jail. Okay. Tell me more about that. Three hot Senokot. Maybe that's okay. At least you shut up. What do you want from it? I was try to ask the patient and I tried to say how do I know that at the end of this hour or the end of this assessment that I've done my job? What do you need for me?

Especially when they're court-ordered, it's a little disarming for them. They are not used to that. I put it in their lap. I'm here to help you. You tell me what that looks like. Oh. That puts them off a little bit. Okay, you actually care a little bit about what I might think. Interesting. They showed up. I'm going to go with that. You may be getting into unsafe territory. I never want to put a family member in an unsafe situation. Are they willing to work on it? Are they willing to make things different? We may get to the point where we realize, this relationship is not healthy. Do you guys want to continue this relationship? You can get into another realm. "You broke us up!" I wasn't trying to. Be careful. Does this fall in line with what they need?

You will find with their partner, or spouse, may be equally unhealthy. Unhealthy people do not deal with unhealthy people. If you have an unhealthy person, and they have an extreme case, they are probably not with a healthy person to begin with. You may be inviting another circus. It will be bearing down, what are the goals for the individual, and

would therapy with the family member help meet the goals? You also need to say that "I reserve the right to terminate this at any time."

>> Okay. Steve from Colorado. Is family therapy a good modality for this?

>> If the person with the disorder is insightful and aware of their behaviors, yes. You may be getting into unsafe territory. I never want to put a family member in an unsafe situation. Are they willing to work on it? Are they willing to make things different? We may get to the point where we realize, this relationship is not healthy. Do you guys want to continue this relationship? You can get into another realm. "You broke us up!" I wasn't trying to. Be careful. Does this fall in line with what they need?

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>> Can you speak more about how you may teach one to respect ones boundaries, especially if the person lacks insight?

>> I hate role playing, but this is good for that. The patient may feel it's weird, but no feeling, doing nothing different. If you are in a group setting, it may be helpful that the patient can do role playing and can watch. Peers will say "they do this, this, and this." The patient doesn't know they do that. If they can role play, maybe they have more insight on what it is.

You can role play with a patient. You can ask them, what do you think this would feel like? If someone did this, how would it make you feel? If you know their history, you may be able to find other times in their life where it's been mirrored. If they are consistently breaking someone else's boundary, was there a time in their life when their boundary was consistently broken? "I hear so and so is mad at you. Remember you were telling me about when you were 20, and someone broke your boundary? How did that make you feel?" Connecting them with an event that happened to them is a good way to identify it.

>> Rebecca from Idaho.

>> Colorado, Idaho . . .

>> Everywhere. Do you know where we clinicians can get this training?

>> Good question. I don't know off the top of my head. NAADAC, do we have any

webinars about it? PESI does some. If you email me, I do a lot of trainings. I do them for our organization here. I teach motivation reviewing, focus therapy, and I'd be happy to talk to you individually. I'd be happy to do that.

>> Great answers. Email Malcolm, or us.

>> I think, in the NAADAC on demand webinars, there are solution focused webinar.

>> I feel like I should know the answer! I don't, off the top of my head. I will look.

>> Canada. How do we show empathy to those who have vulnerability?

>> Before you show any empathy to the patient, make sure you have the foundation of safety. Feel they can trust you a bit. By sharing that empathy . . . "when you shared that story with me, that resonated with me. Thank you for sharing." Don't dwell on it. It makes it uncomfortable.

Know their information is safe. I let them know I appreciate them being vulnerable to talk to me. I ask them, is there anything else I can do for you? Is there anything I can do to help you understand? I see you shared that with me, and I'm honored. Thank you. I find that's helpful, simply acknowledge it.

I'm blunt. I will say something, but I will be blunt and gentle. I may be the only person they told some of those things to. I want to respect that honor.

>> I think that's great. Great words. It's really useful. I hope everyone got that one.

Christy from Colorado. We are running out of time. When you were supervising clinical staff, what are some things you do to help them with self care when working with difficult populations?

>> When they have a difficult population, I can tell. I need to know my staff. Some do well, some don't. I need to check in with them. "I know you had a session with joe. He can be challenging. How are you? Do you want to talk about it?" I had a staff member who was struggling with a patient with personality disorder. Since I'm a supervisor, it's appropriate for me to set in. The patient loved it. "I get two counselors!" It was helpful. My staff said "that felt good." The patient feels supported.

Also, they need to say "help me terminate this relationship." We need to be able to do that. If we know it's not a good fit, because of my own stuff or theirs, I need to be able to terminate that safely and appropriately.

>> You need to team!

Alright, guys. There's a few more. The ones we didn't get to, they will be sent to Malcolm. No one is getting ignored. You are a pleasure. Thank you for being here!

Let's see. For those who have been with us before, a reminder. You probably know this. All the information you need about this webinar is on the web page where you signed in. Right after this, when this ends, you can go there. Click and take the online CE quiz on the exact same website, on top of the slide.

We have some really great upcoming webinars. This a busy week for us. I hope you can be at every one! Tomorrow we have Dr. Eric presenting. I'm getting exciting. [On screen.]

This is the outline for Thursday and Friday. [On screen.]

If you haven't already, bookmark this page. [On screen.] You can stay up to date on the latest in this series. All eight trainings are free. Believe it or not, we are going to have more to come. Stay tuned!

As an additional resource, NAADAC has provided a COVID 19 resources page. It includes six free webinars, presenting by leading professionals in the field.

We also offer two specialty online trainings. [On screen.] You can find it on the website here. This goes along with the book. These are wonderful webinars. Check out.

Our second series is addiction treatment in military and veteran culture. This is a great series.

As a NAADAC member, here are the benefits. You have access to over 145 CEs. This is huge. We all have to take them. These are good ones. Become a member. NAADAC members receive free access to the addiction and recovery magazine, also eligible for CEs.

A short survey will pop up. We go through your feedback. It helps us with our webinars in the future. Please do it. We appreciate it. Thank you for participating. Thank you Malcolm for your leadership and personality. Take time to browse our website. Stay connected with us on social media. Have a great day, everybody. Take care of yourselves.

[End of webinar.]