THE CARLAT REPORT
PSYCHIATRY
A CME Publication

AN UNBIASED MONTHLY COVERING ALL THINGS PSYCHIATRIC

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Learning Objectives
After reading these articles, you should be able to:
1. Diagnose borderline personality disorder using DSM-5 criteria.
2. Identify ways for clinicians to diagnose and treat narcissism in patients.
3. Summarize some of the current findings in the literature regarding psychiatric treatment.

Diagnosing and Treating Borderline Personality Disorder

Joel Paris, MD, professor, Department of Psychiatry, McGill University. Daniel Carlat, MD, editor-in-chief, The Carlat Psychiatry Report

Dr. Paris and Dr. Carlat have disclosed that they have no relevant financial or other interests in any commercial companies pertaining to this educational activity.

In Summary

- Some of the nine DSM-5 criteria for diagnosing borderline personality disorder (BPD) include identity disturbance, unstable mood, abandonment intolerance, and relationship problems.
- The mood instability in BPD is generally triggered by relationship problems, whereas this is not a characteristic for bipolar disorder.
- Psychotherapies such as dialectic behavior therapy, transference focused therapy, mentalization based therapy, and general psychiatric management are the most effective treatments for BPD.

By and large, psychiatrists aren't terribly comfortable when it comes to diagnosing and treating borderline personality disorder (BPD). The clinical picture is challenging, and the stigma attached to the term makes it difficult for patients to hear—in fact, many clinicians end up not making the

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Q&A With the Expert

Diagnosing and Treating Narcissism
Craig Malkin, PhD

Clinical psychologist. Lecturer, Harvard Medical School. Author of Rethinking Narcissism, *published by HarperCollins*

Dr. Malkin has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

TCPR: Dr. Malkin, it seems to me that in psychiatry we've gotten out of the habit of diagnosing narcissistic character traits in our patients, yet many patients do have these traits, and this can cause a lot of distress. I'd like to start by asking you to define narcissism.

Dr. Malkin: At its heart, pathological narcissism is a desperate need to feel special—in fact, you can call it an addiction to feeling special. The confusing thing is that we tend to focus on one presentation, which is the loud, arrogant, conceited narcissist, but that's only one type. The reality is many narcissists couldn't care less about looks or fame or money and can be very quiet. There are plenty of introverted narcissists (often called vulnerable or covert in the research), and these are the patients who often show up in our office.

TCPR: Tell me more about this addiction to feeling special.

Dr. Malkin: Extroverted narcissists feel special by possessing things, by amassing power, by fancying themselves the smartest person in the room. Others may believe themselves to be the most helpful person they know, and will corner you and tell you about all the altruistic things they've done. This version is called communal

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Diagnosing and Treating Borderline Personality Disorder
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diagnosis at all! But BPD, characterized by DSM-5 as "a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity," is curable. It's also more common than you might think. Estimates state that 1%–2% of adults have BPD, yet among clinical samples—ie, people who will actually show up in your practice—the clinical prevalence is about 9% (Zimmerman M et al, *Am J Psychiatry* 2005;162(10):1911–1918).

With those numbers in mind, and because with DSM-5 all personality disorders were "promoted" to Axis 1 disorders, we thought it would be good to review the basics of diagnosis and treatment so you can feel more confident in helping these patients.

Fortunately, diagnosing BPD is relatively easy and can often be done in 20–30 minutes. The key is to have a systematic approach, to ask high-yield questions, and to know how to efficiently follow up on responses. In the corresponding table, we go through each of the nine DSM criteria in turn, organized by the "IDESPAIRR" mnemonic (Carlat D. *The Psychiatric Interview,* 4th ed. The Netherlands: Wolters Kluwer; 2017).

IDESPAIRR: A Mnemonic for Diagnosing BPD

DSM-5 Criteria	Suggested Diagnostic Questions
Identity disturbance	"Do you have a sense of where you're going in life?"
Disordered mood	"Do you find that your mood changes a lot in the course of the day?"
Emptiness	"Do you feel empty inside, as if there's nothing there?"
Suicidality	"Have you ever thought of suicide, and have you made an attempt?"
Paranoia	"Do you feel when you're outside that strangers are looking at you, commenting on you, and probably criticizing you?"
Abandonment intolerance	"When you start a relationship, do you feel that you're going to be dumped from day one?"
Impulsivity	"Have you engaged in reckless behavior involving money, sex, driving, drugs or alcohol, or eating?"
Rage	"Would people describe you as having a short temper?" "Do you lose control when you get mad?"
Relationship problems	"What happens to you in a close relationship?"

Identity disturbance

How do you ask about something as vague as an identity disturbance? Asking something like, "Do you know who you are?" may not get you anywhere. Instead, ask, "Do you have a sense of where you're going in life?" Probe for whether your patient has a dream, a purpose, or an ambition—all of which are inextricably tied to one's sense of identity. The BPD patient's response is often, "No, I don't have an ambition; I'm just caught up in my pain." Patients with BPD who are working toward a goal, such as college students, tend to do better in treatment. Having goals helps strengthen the wish to continue living.

Disordered mood

Disordered mood is what DSM calls mood instability, and it is one of the key features of BPD. Ask, "Do you find that your mood changes a lot in the course of the day?" Typically patients will reply with, "My emotional life is a roller coaster."

Emptiness

Ask patients, "Do you feel empty inside, as if there's nothing there?" Among BPD patients, a common answer is, "Definitely." The emptiness of BPD is different from depression. Patients with depression feel sad, like they've lost something, and can usually describe a time when they *didn't* feel depressed. BPD patients, on the other hand, will often say, "I've never been happy; my life is pointless."

Suicidality

BPD patients often have chronic suicidal ideation, though the rate of actual suicides is lower than many think—most estimates are in the 5%–10% range (Soloff P and Chiapetta L, *J Pers Dis* 2012,26(3):468–480).

Often patients have urges to inflict self-harm by means such as cutting, burning themselves, or banging their heads against the wall. People have varying motivations for these actions, but they often feel overwhelmed by their lives and are unable to regulate their emotional responses; if they harm themselves, they feel the act breaks the cycle and serves as a distraction. One of our patients said, "When I see the blood dripping out, I immediately feel better."

As you should do for any patient in whom you suspect suicidal ideation, be straightforward in your questions: "Have you ever thought of committing suicide? Have you ever tried? What have you done? Have you done it more than once? Do you cut yourself? If so, how long have you been doing it and how often?" Ask patients whether they have ever threatened to harm themselves during an argument—a common practice in BPD.

Our preferred intervention for BPD patients discussing suicide is to

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EDITORIAL INFORMATION

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Diagnosing and Treating Borderline Personality Disorder
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acknowledge their pain and to assure them that their condition *can* be treated: "You must have unbearable pain if you're thinking about suicide. But know this is something I can help you with." The reality is that most people who commit suicide do so when they are not in active treatment. Patients who are in your office trying to get help are demonstrating that they would prefer to get better rather than kill themselves.

Note that sometimes, BPD patients don't think clinicians will listen to them unless they turn up the volume and talk about suicide in an attempt to scare the clinician. Don't get scared; instead, let patients know that you hear them.

Paranoia

This DSM criterion refers to "transient, stress-induced paranoid ideation" and includes "severe dissociative symptoms." In our experience, some degree of paranoia is very common in BPD patients.

If you were to ask, "Do you feel when you're outside that strangers are looking at you, commenting on you, and probably criticizing you?" most patients will respond, "Yes, I've been like that as long as I can remember." Some will say they have trouble getting onto a bus or engaging in other activities because of that feeling. These symptoms are not usually amenable to antipsychotic treatment. However, some patients experience transient auditory hallucinations when they get upset, and antipsychotics may be helpful in these cases.

To assess dissociation, ask, "When you get upset, do you feel outside your body, like everything looks peculiar or different?"

Abandonment intolerance

Ask patients, "When you start a relationship, do you feel that you're going to be dumped from day one?" Most say yes and go on to explain that every rejection throws them into a crisis.

Impulsivity

Impulsivity includes a range of behaviors, such as over-spending, substance abuse, reckless sexual behavior often associated with drinking, reckless driving, and bulimia. You can ask about each of these behaviors in turn: "Do you ever spend so much money that you go deeply into debt? Do you get drunk, and have you done things you're sorry for while you're drunk? Do you binge eat? Have you ever forced yourself to throw up after binge eating?"

Rage

Ask patients, "Would people describe you as having a short temper? When you get angry, do you lose it completely? Do you yell, scream, break things, or throw things?" Rage is one of the most characteristic features of BPD.

Relationship problems

Finally, ask patients, "Have you had the experience that when somebody disappoints you, you just can't stand them?" One of our patients responded, "The moment somebody disappoints me—even in the smallest way—I never want to see them again."

Relationships, particularly intimate relationships, play a key role in getting BPD patients into psychiatric trouble, so you should spend some time understanding patients' relationship history. Ask questions like, "Are you in a relationship? What happens to you in a relationship? Are there a lot of quarrels?"

Most BPD patients have not been able to sustain relationships for long periods. One reason is their inability to tolerate their fear of abandonment, or less extreme forms of rejection or criticism.

Distinguishing between BPD and bipolar disorder

Given that both borderline and bipolar disorder are characterized by mood instability, it's no wonder the two conditions can easily be confused. According to research, 40% of patients with BPD have been diagnosed as bipolar at some point (Ruggero VJ et al, *J Psychiatr Res* 2010;44(6):405–408).

It's critical to distinguish the two for several reasons. Meds are the cornerstone treatment for bipolar, whereas therapy is the cornerstone for borderline. Contrary to popular opinion, prognosis is much better for borderline personality disorder than for bipolar. Most people don't meet diagnostic criteria for borderline 10 years after first diagnosis. In addition, the suicide rate for borderline is 5%–10% vs 6%–20% for bipolar (Goodwin FK & Jamison KR. *Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression,* Vol. 1. Oxford University Press; 2007).

How to differentiate between the two in an interview? In patients with bipolar II, you must document a hypomanic episode that lasts at least 4 days, after which patients return to their baseline mood. Borderline patients also have mood swings, but they are usually brought on by difficult interpersonal events, and the fluctuations happen more quickly—sometimes several times throughout the day.

Communicating the diagnosis to patients

Because of the stigma attached to the term "borderline personality disorder," some clinicians find themselves tongue-tied when trying to explain the diagnosis to their patients.

It's best to simply describe the symptoms and behaviors as you heard them from the patient and repeat them. This deemphasizes the idea that the patient has some deep-seated defect, which is a common misinterpretation of the term "personality disorder." For example: "You described to me that your emotions are very unstable; you often lose control of your temper; you cut yourself; you have made suicide attempts; you use too many drugs; and your relationships are conflictual and don't work—that's borderline personality disorder. "

A brief note on treatment

Psychopharmacology treatment can be helpful when targeted carefully. We recommend you check out this thoughtful review of current treatment options published this year: Choi-Kain WL et al, What Works in the Treatment of Borderline Personality Disorder. *Curr Behav Neurosci Rep* 2017;4(1):21–30. The bottom line is that antidepressants, while very commonly prescribed for

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narcissism. The quieter narcissist may depend on being the most deeply misunderstood person in the room. They tell themselves, "I'm more sensitive; most people don't understand my problems," focusing on a sense of uniqueness based on their pain and their problems. In both extroverted and quiet narcissism, instead of turning to other people for mutual caring and support to soothe themselves, they depend on feeling special; narcissists soothe themselves with this feeling much like substance abusers might turn to alcohol or heroin.

TCPR: How does this need to feel special become a pathology?

Dr. Malkin: It becomes pathological when patients engage in destructive behaviors, like arrogantly insulting people, constantly blaming others, or becoming enraged when they feel criticized. A convenient way of remembering the core of pathological narcissism is to use the mnemonic "triple E"—exploitation, entitlement, and empathy impairment. Exploitation is getting your needs met by taking advantage of and manipulating others, entitlement is acting as though other people owe you something, and impaired empathy is disregarding others in your quest to feel special. When people become so addicted to feeling special that they'd lie, steal, cheat, and even hurt others to get their "high," they've tipped into pathology.

TCPR: What do these patients present with when they come to see a clinician for treatment?

Dr. Malkin: There are two common scenarios. Sometimes they see us because someone else, like a partner or the courts, insisted that they come. In other cases, they come willingly because they're in distress; their defenses are breaking down.

TCPR: How so?

Dr. Malkin: If you are dependent on feeling special, the world is going to prove you wrong at some point. People with the core of pathological narcissism (triple E) suffer deeply when their belief that they're exceptional or unique in some way is challenged. In fact, high levels of exploitation and entitlement are tied to just about every negative behavior we see with pathological narcissism—the rage when criticized, the tendency to blame others for their failings, the intense envy of others. Extreme exploitation and entitlement are strongly linked to increased suicidality and lowered or fluctuating self-esteem (Ackerman at al, *Assessment* 2011;18(1):67–87).

> **"At its heart, pathological narcissism is a desperate need to feel special—in fact, you can call it an addiction to feeling special."**
>
> Craig Malkin, PhD

TCPR: Do you have any case examples you could share?

Dr. Malkin: Sure. A dean at a local university referred a young man to me who was failing classes because he was staying up late with a classmate working on a get-rich-quick scheme. He showed up at my office, and his first question was, "Are you any good at this?" He didn't want to be there, and he was completely oblivious to the seriousness of the situation he was in—namely, that he was about to be kicked out of school. He wanted to simply walk out the door. My challenge was to help him to acknowledge that his behavior, if unchanged, could very well ruin his plans for the future, beginning with expulsion.

TCPR: Interesting. Can you expand on some of the clinical presentations?

Dr. Malkin: Another common presentation is the patient who comes in and says, "I'm having panic attacks, I'm depressed, and I've been thinking about suicide. My wife has left; my kids won't speak to me—am I a monster? Can I change?" You'll hear certain typical themes. Patients often describe a history of infidelity and broken friendships, caused by volatility and fighting. They often feel mistreated at every turn, like they're not getting their due. "I should have had that raise." "Everyone else was a jerk." "They didn't see my talents." Other people, in their minds, don't recognize their greatness. These interpersonal ruptures eventually cause depression because the patients become ashamed and lonely. Their failure doesn't mesh with their sense of grandiosity. I call this narcissistic personality disorder (NPD) in shame mode.

TCPR: Do you have a sense of what causes this kind of pathology?

Dr. Malkin: We don't know for sure, but we can get a hint of the core problem underlying pathological narcissism from some fascinating longitudinal research published by Phebe Cramer (Cramer P, *J Res Pers* 2011:45(1):19–28). She followed children who showed early signs of pathological narcissism for over 20 years, using validated indicators such as aggressiveness, melodrama, and "showing off." She found that the kids who were more likely to demonstrate pathological narcissism later in life were those whose parents failed to demonstrate a warm structuring style, also known as authoritative parenting. These kids had attachment insecurity characterized by an enduring stance: "When I'm sad or scared, I don't feel safe turning to the people I love; I'm going to feel good by finding different ways of feeling special." So at the core you get people with a negative view of self, and they're afraid to allow themselves to experience connection with others. Their defenses, like grandiose fantasies, haughtiness, or relentless criticism of others, kick in to prevent themselves from believing the negative things they feel about themselves: "I can feel great about myself by having power and influence and possessions or secretly believing I'm an undiscovered genius."

TCPR: How can we help these patients?

Dr. Malkin: We need to tune into their more vulnerable feelings. For example, I had a patient who was in a rage at his wife because she'd gained weight. He wanted her to lose the weight and complained, "Why can't she do this for me?" As is common with NPD, on the surface it seemed to be a criticism of someone else. But there's always a sense of personal pain underneath.

TCPR: So how did you handle this?

Dr. Malkin: I said to him, "I get that you're angry. It's frustrating when you have expectations of someone that aren't met. But what are you missing that feels so important? What is it that feels so painful?" He responded, "If my wife cared enough for me,

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News of Note

FDA Approves First Drug to Treat Tardive Dyskinesia

On April 11, the U.S. Food and Drug Administration approved Ingrezza (valbenazine) for the treatment of tardive dyskinesia (TD), a disabling movement disorder that afflicts 10%–20% of people on chronic antipsychotic medication.

The approval was based on a clinical trial in which 234 patients with moderate to severe TD were randomly assigned to a higher or lower dose of valbenazine or placebo. After 6 weeks, patients on 80 mg, but not 40 mg, of valbenazine had a statistically significant greater improvement in Abnormal Involuntary Movement Scale (AIMS) score than those in the placebo arm (-3.2 for valbenazine 80 mg vs -1.9 for 40 mg and -0.1 for placebo). Patients on both doses of valbenazine also had higher AIMS response rates at 6 weeks (defined as a 50% reduction in the AIMS score) than those on placebo (80 mg, 40% response rate; 40 mg, 23.8%; placebo, 8.7%).

Because TD is a serious disorder and no other medication has been approved for its treatment, the FDA fast-tracked its approval, leading to sooner-than-normal market arrival.

How does the drug work? It's classified as a VMAT2 inhibitor (vesicular monoamine transporter type 2 inhibitor). VMAT2 is a protein that regulates the packaging and release of dopamine from synaptic vesicles. Inhibiting it essentially decreases dopamine release. Since TD is probably caused by dopamine hypersensitivity, inhibiting dopamine release logically decreases these symptoms.

If you want to prescribe the new medication, start it at 40 mg/day and increase to 80 mg/day after a week. The most common side effects are sedation, somnolence, and akathisia. Additionally, valbenazine may increase the QT interval (mean of 11.7 msec in CYP2D6 poor metabolizers and 6.7 msec in healthy volunteers). This degree of prolongation may be clinically significant, albeit rarely, in those at risk (eg, poor metabolizers, congenital QT syndrome, or concomitant meds that increase QT). Longer-term studies will help determine whether there is an associated increase in risk for depression or suicidality as has been reported with other VMAT inhibitors.

For now, the major side effect may be sticker shock. Manufacturer Neurocrine Biosciences is asking $5,275 for a 30-day supply (that's $63,300 per year). Another company, Teva, is seeking a TD indication for their own VMAT2 inhibitor deutetrabenazine (Austedo, now approved for Huntington's). But don't expect the price to come down with the added competition: the projected price for Austedo will be $70,000 per year.

While it's great to finally have a drug for TD, the best policy is to prevent it in the first place by avoiding drugs most likely to cause it (first-generation high-potency drugs like haloperidol), and by monitoring for TD (using the AIMS scale: www.cqaimh.org/pdf/tool_aims.pdf).

—Talia Puzantian, deputy editor, *The Carlat Psychiatry Report*

Expert Interview
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she would care about what I'm looking for in a relationship. I want a wife who looks good—that's important to me." The weight issue appeared to be important, but he was hinting at the underlying issue, which is that he wanted closeness with his wife. I pointed that out to him, and eventually it made sense to him and helped him to reduce the fixation on his wife's weight. So in cases like this, you want to get patients to talk about what is so painful about a given situation. Help them name their feelings. We need to move people with NPD and pathological narcissism in all its forms away from talking about other people and what's wrong with them to talking about what's going on inside of themselves emotionally.

TCPR: That makes sense. What other things did you say in sessions with that patient?

Dr. Malkin: I said something like, "It hurts when we want something but it's not coming to us. What happens for you when you experience the pain of not feeling like your wife is meeting your needs?" He responded, "I feel like I'm not important," and I said, "What does that feel like emotionally?" At this point, we were going deeper into his vulnerability. He began to cry, and when I see tears, I'll say, "I really admire your courage here." And he responded with, "I feel like my wife and I aren't close enough." The crux was the loneliness he felt in the relationship. The weight issue was actually a cover, a way of blaming her for the distance he felt in their relationship. People with NPD can overlook perceived issues or other criticisms when they feel connected to their loved ones.

TCPR: Any other techniques that you've had success with?

Dr. Malkin: I use a technique called "communal activation." It involves using language with clients that reminds them of their connection to others and the importance of people in their lives. For example, you'd make a conscious effort to use words like "we," "our," "us," and other collaborative language. You'd also actively explore feelings of sadness, loneliness, fear, and other attachment-related emotions. And you'd use your interactions with the client to try to create corrective emotional experiences, by saying things like, "That took so much courage for you to share. What's it like for you emotionally to share with me how sad you feel when people turn away?" The latest research suggests that these techniques reduce all narcissistic traits—as if they light up

Triple E: The Core Pathology of Narcissism

1. Exploitation: Getting needs met by exploiting others
2. Entitlement: Acting as though people owe you something
3. Empathy impairment: Disregarding others in the quest to feel special

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Research Updates IN PSYCHIATRY

ANTIDEPRESSANTS

Which Are the Most Dangerous Antidepressants?

REVIEW OF: Nelson JC and Spyker DA, *Am J Psychiatry* 2017;174(5):438–450
STUDY TYPE: Retrospective cohort

We often prescribe antidepressants to patients who are suicidal, and unfortunately, some people use these very medications to try to kill themselves. It's been known for some time that tricyclic antidepressants are among the most toxic in overdose, so we embraced the SSRIs and later medications in part because they are considered to be safer. But how safe are they? A new study attempts to answer that question.

METHODS
Researchers identified all 48 FDA-approved medications likely to be prescribed for depression, and then searched for these drugs in the National Poison Data System, which lists all reports of poisoning in the U.S. There were more than 950,000 poisoning reports involving these medicines from 2000 through 2014.

The hazard level of the drugs was measured in two ways: a morbidity index, which described the proportion of exposures that led to an injury serious enough to require hospitalization (like an ICU admission for cardiac monitoring after a tricyclic ingestion); and a mortality index, which is the proportion of exposures that led to death. The people involved in these events had a mean age of 35.8 years, and 62.8% were female.

RESULTS
This study reports a cornucopia of interesting results, and there's no way to cover them all in this synopsis. Here are some of the highlights that we found especially clinically relevant.

1. The two most dangerous drugs of all 48 studied were the tricyclic amitriptyline (morbidity index of 345/1,000 and mortality index of 3.8/1,000) and lithium (325/1,000 and 1.3/1,000).
2. Not surprisingly, tricyclics and MAOIs as classes had the highest morbidity and mortality rates.
3. Clomipramine was the safest of all tricyclics and was similarly safe in overdose as drugs like citalopram and mirtazapine.
4. The "second generation" ADs were generally much safer than tricyclics and MAOIs (these included SSRIs, SNRIs, and others such as bupropion and mirtazapine). Within this group of safer drugs, here were some outliers:

   — Bupropion and venlafaxine were ranked #1 and #2 respectively in highest mortality rates among the second-generation ADs; bupropion had the highest morbidity rate.

   — Among the SSRIs, citalopram was the most dangerous, and in one comparison, it was four times more likely to be fatal than sertraline and escitalopram.
5. Among atypical antipsychotics, olanzapine and quetiapine had the highest morbidity rates, with respiratory depression being a particularly common problem with these agents.

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Diagnosing and Treating Borderline Personality Disorder
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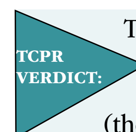
BPD in the community, don't appear to help much with core BPD symptoms such as the feeling of emptiness and the fear of abandonment. Antipsychotics can be effective for symptoms including affective dysregulation, impulsivity, and hallucinations. The efficacy of mood stabilizers is more controversial. Some meta-analyses have concluded that meds like lamotrigine and valproate are helpful for impulsivity and anger. But a recent large-scale study (Crawford MJ et al, *Trials* 2015;16:308) presented at the North American Association for the Study of Personality Disorders found no benefit of lamotrigine.

Psychotherapy is the most effective treatment for BPD. While many associate dialectic behavior therapy (DBT) with specific efficacy for BPD, it turns out that in head-to-head trials, DBT is no more effective than several other manualized therapies, such as transference focused therapy (TFT), mentalization based therapy (MBT), and others. The trend now is to devise treatments that don't require as many sessions and can more easily be led by clinicians who don't have training in specific structured techniques. For example, general psychiatric management (GPM) involves no more than one session per week. The individual therapist coordinates treatment between the psychopharmacologist and a family therapist, if needed. A randomized comparison of GPM with DBT found that both techniques were effective at 2-year follow-up, with less patient dropout in the GPM group (McMain SF, *Am J Psychiatry* 2009;166(12):1365–1374).

Dr. Paris, one of this article's authors, has used a form of therapy called "DBT-light" for many years. It incorporates some elements of standard DBT but is less time-consuming. The essence of the treatment is a combination of psychoeducation and skills development. The goal is to teach patients to regulate their emotions and to gain the skills needed to improve their relationships. Getting along better with people helps patients be less impulsive, since much of their impulsivity has to do with relationship issues. Most patients can be treated in just a few months, making treatment more accessible and less expensive (Paris J. *Stepped Care for Borderline Personality Disorder.* New York: Academic Press; 2017).



Time to sharpen your BPD diagnostic skills. Use meds conservatively (they don't work very well), and focus on helping patients learn the skills needed to form lasting relationships.

CME Post-Test

To earn CME or CE credit, you must read the articles and log on to www.TheCarlatReport.com to take the post-test. You must answer 75% of the questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be completed within a year from each issue's publication date. As a subscriber to *TCPR*, you already have a username and password to log onto www.TheCarlatReport.com. To obtain your username and password, please email info@thecarlatreport.com or call 978-499-0583.

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For those seeking ABPN Self-Assessment (MOC) credit, a pre- and post-test must be taken online at http://thecarlatcmeinstitute.com/self-assessment/

Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning Objectives are listed on page 1.

1. A patient says to you, "I'm more sensitive than other people; no one understands my problems." This declaration is characteristic of what type of narcissistic personality? (LO #2)
   [ ] a. Extroverted narcissist [ ] b. Quiet narcissist
   [ ] c. Communal narcissist [ ] d. Combination of extroverted and communal narcissist

2. Which of the following statements about borderline personality disorder (BPD) and bipolar disorder is true? (LO #1)
   [ ] a. Therapy is the cornerstone treatment for BPD; prognosis is about the same for BPD and bipolar
   [ ] b. Medication is the cornerstone treatment for both BPD and bipolar; prognosis is about the same
   [ ] c. Medication is the cornerstone treatment for BPD; prognosis is better than for bipolar
   [ ] d. Therapy is the cornerstone treatment for BPD; prognosis is better than for bipolar

3. The estimated range of actual suicides in BPD patients is ______________. (LO #1)
   [ ] a. Between 1% and 5% [ ] b. Between 5% and 10% [ ] c. Between 10% and 15% [ ] d. Between 15% and 20%

4. Which of the following is an example of a technique called "communal activation," which, according to research, can reduce narcissistic traits in patients? (LO #2)
   [ ] a. Using language that reminds patients of their connection to others
   [ ] b. Discussing past challenges in individual, marital, and/or group therapy
   [ ] c. Asking patients about their physical and emotional responses to potentially stressful statements
   [ ] d. Asking patients for permission to tape or record sessions so you can identify when they respond angrily or shut down

5. According to a study of the dangers of overdose, which two atypical antipsychotics had the highest morbidity rates? (LO #3)
   [ ] a. Aripiprazole and quetiapine [ ] b. Aripiprazole and olanzapine
   [ ] c. Olanzapine and quetiapine [ ] d. Olanzapine and risperidone

Expert Interview
Continued from page 5

the centers of the brain devoted to caring and closeness (Giacomin M and Jordan CH, *Pers Soc Psychol Bull* 2014;40(4):488–500).

TCPR: Have you found that it works well with most patients?

Dr. Malkin: Naturally, any therapeutic tip is more easily said than done. Introverted narcissists who elevate the importance of their pain and emotional struggles are apt to jump on you or shut down angrily when you try to speak, feeling you've interrupted their flow of thought. Or they'll reject your summary of what they said no matter how closely you stick to their words, because if you can understand and reflect their pain, then perhaps it isn't as exceptional as they thought.

TCPR: Yes, I think any of us who have worked with narcissists have had that frustrating experience of having our comments ignored, as though they are irritated that we are even there in the room with them!

Dr. Malkin: Absolutely, and for that reason I have a standard prompt from the beginning for people with NPD: "To the extent that we're talking about what other people do and not what happens inside you emotionally, we're not working therapeutically. How would it be for you if I slow you down at times to bring you back to what happens inside you emotionally? Would you be open to trying that?" And you might have to repeat that sort of request for permission more than once.

TCPR: Can you give another example of a therapeutic intervention?

Dr. Malkin: Let's say our patient is getting in touch with his depression and loneliness and says, "I've pushed everybody away from me," and feels sad about what he's made of his life. This is gold, therapeutically, because you can say, "People have these survival strategies. Let's try to understand why you coped with life this way, so you can cope with it in another way." Secure attachment transforms our view of ourselves—and others—into a more positive image. As their view of self becomes more positive, people with NPD aren't so strongly driven to feel special because they can learn to feel valued in relationships. We're essentially replacing the need to feel special *for* others (which is more performative) with the enjoyment of feeling special *to* others. That's the key corrective emotional experience that people with NPD need.

TCPR: Thank you very much for your time, Dr. Malkin.

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This Month's Focus:
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Next month in *The Carlat Psychiatry Report:* Antidepressant Update 2017

Research Update

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TCPR'S TAKE

Before making wholesale changes in your prescribing habits, you should step back and realize how uncommon these bad events actually are. For example, bupropion, the "most lethal" of the second-generation ADs, led to 47 deaths out of over 62,000 overdoses over 15 years. The chance that one of your patients will OD on bupropion is already very scant, and then, among those rare overdose victims, less than 1 person out of 1,000 will die.

Nonetheless, there are a lot of thought-provoking data points in this paper that might affect our practices. If you're deciding between amitriptyline and duloxetine for fibromyalgia, go with the much safer duloxetine. Bupropion and venlafaxine are the most likely to be hazardous among the newer ADs—which is unfortunate, since bupropion is on the list of first-line ADs for many clinicians. Citalopram really is more dangerous than its racemic cousin escitalopram, meaning that the FDA warning about citalopram dosing is sounding more reasonable than before.

The bottom line is that you should add these data to the many other factors you consider in deciding which antidepressant to prescribe. And don't forget the basics, such as limiting refills to a weekly supply in patients at high risk of overdosing.

—Daniel Carlat, MD, editor-in-chief, *The Carlat Psychiatry Report*

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