**Title:** Fathering Emotions: The Relationship between Fathering and Emotional Development  
**Author(s):** Anthony J. Ferrer

**Abstract**

The study of child development is an ever growing and consistently important area of psychology. Research suggests that parenting starts as early as conception and that a developing fetus can be affected by maternal and parental bonding in addition to biological influences. However there is a lack of research regarding the effect fathering has on the child’s development and there is a surplus of research regarding the effect of mothers parenting on the child’s development. Currently research neglects families raised by single fathers, two fathers, and other cis-male and trans-male caregivers. This paper will provide an in-depth review of emotional development in children, “parenting”, and will highlight the limited literature on the effects of fathering on emotional development.

**Title:** Brain Impairments in Maltreated Children  
**Author(s):** Carl C. Papandreau

**Abstract**

The purpose of this paper is to explore the brain development in typically developing and maltreated children as noted by neuroimaging technology. The use of magnetic resonance imaging (MRI) provides insight into how early experiences affect the developing brain, and provides biological implications for what practitioners identified through behavioral, psychological, and emotional terms. Neurobiological impairments have been seen in children who experience adverse childhood experiences, this paper reviews literature that identifies and explains these findings.

**Title:** Common Personality Traits in Youth and Connection with Antisocial Personality  
**Author(s):** Carl C. Papandreau

**Abstract**

The purpose of this paper is to explore the links between common maladaptive personality traits in youth with conduct problems and their connection to Antisocial Personality Disorder. Current treatment interventions for youth and families, and their effectiveness will be reviewed. Justification of the need for future research to improve treatment interventions and how counseling psychologists may use evidenced based measures to reach minority groups. Social justice concerns surrounding the lack of resources, differences in treatment interventions and outcomes for minority families will be discussed.
Title: Sexual Sadism Disorder
Author(s): Carl C. Papandrea

Abstract

Sexual sadism is a sexual disorder associated with pain and humiliation. An individual said to be sadistic enjoys inflicting pain and humiliation, whereas, a masochistic individual enjoys being on the receiving end of the pain and humiliation. There is also sexual arousal associated with each disorder and both are classified under Paraphilic Disorders. This paper will review the symptomatology, etiology, prognosis, psychosocial and psychopharmacological treatment, as well as the biopsychosocial factors involved in Sexual Sadism Disorder.

Title: Narcissism
Author(s): Breyanna Sanders

Abstract

Narcissistic personality disorder is a personality disorder defined by the DSM-IV as a persuasive pattern of grandiosity which means fantasy or behavior, and is described as someone requiring admiration, and lack of empathy towards others. It is recognized as an important condition and involves a long term pattern of behaviors, thoughts, and can cause complications with work, family, and friends. This paper reviews the history, prevalence, etiology, symptomology, prognosis and treatment of this disorder.
Fathering Emotions: The Relationship between Fathering and Emotional Development

Anthony J. Ferrer

the College of Saint Elizabeth
Fathering Emotions: The Relationship between Fathering and Emotional Development

The study of child development is an ever-growing and consistently important area of the field of psychology (Anderson et al., 2003; Efenvbera et al., 2018). Childhood is an amalgam of moments of development and learning (Newman & Newman, 2018). Many behaviors and attitudes learned along the way of early development are carried over to adulthood (Colman et al., 2013; Szepsenwol et al., 2015; Henry et al., 2018). Some of the most important contributing moments in child development are parental and familial interactions (Ooi et al., 2015; Orth, 2018; Scott et al., 2018). Recent research (Glover & Capron, 2017) suggests that parenting starts as early as conception. Glover and Capron (2017) reviewed the most current literature and found that a developing fetus can be affected by maternal and paternal bonding, as well as, biological considerations. Various factors affect the developing fetus including the mother and the father’s mental health (Vänskä et al., 2017; Schechter et al., 2017). From the womb to infancy and beyond interactions with caregivers play an important role in all areas of development, including emotional development (Glover & Capron, 2017; Van Lissa et al., 2019).

“Parenting” can play a strong role in a child’s emotional development (Lima et al, 2010; Marusak et al., 2018). However, there is a discrepancy in a high volume of research on emotional development and parenting, as well as, the research on overall child development and parenting. An overwhelming majority of the literature uses the term “parenting” however, samples and data refer to mothers (Giallo et al., 2014; Treyvaud et al., 2016; Serrano-Villar et al., 2017). The research on mothering is equally as apparent, as is the shortage of research on fathering. This lack of research on the effects that fathering has on child development is a void in the field that ne-
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glects multiple populations and has the potential to impede best practices. The current paper will provide an in-depth review of emotional development in children (Marusak et al., 2018; Hammer et al., 2018), “parenting” (Russell et al., 2016; Henry et al., 2018), and will highlight the limited literature on the effects of fathering on emotional development (Bocknek et al., 2017; Van Lissa et al., 2019).

Critically analyzing the limited research on fathers is imperative. Currently, without a sufficient amount of literature on the topic, multiple populations are being neglected. Current research neglects families raised by single fathers, two fathers, and other cis-male and trans-male caregivers (e.g. extended family or adopted parents). Additionally, the current paper will note, based on the limited research (Cabrera et al., 2017; St George et al., 2017; Van Lissa et al., 2019), the differences between gendered social-normative parenting techniques of male caregivers compared to female caregivers and the importance of each. These proposed differences make it equally important to study when considering single mothers, as well as, children with two mothers, and additional scenarios without a father role (e.g. active military duty). Lastly, caregivers who do not subscribe to a socially dictated gender binary label will benefit from more research to extend the knowledge on best parenting practices for their children’s healthy emotional development.

As a practical frame to standardize the discussion of children’s developmental stages, the current paper will rely on Erikson’s psychosocial development as presented by Newman and Newman (2018). The current paper will look at emotional development in children (in the infancy stage and the toddlerhood stage; Newman & Newman, 2018), parenting (through behaviors and attitudes), parenting and development, fathering and emotional development, and clinical
relevance in working with parents of all genders. Lastly, future directions will be discussed and a plan of action will be proposed to further progress the conversation and the study of the effects of fathering on developing children.

**Emotional Development in Infants and Toddlers**

While great depths can be spent discussing development before birth (prenatal development; Glover & Capron, 2017; Väskä et al., 2017), for precision in detail, the current review will begin in infancy.

**Emotional Development in Infants**

During infancy, young humans’ capacity for emotion begins to blossom. Infants begin to develop emotions at an intense rate during these first 24 months (Newman & Newman, 2018). Along with these emotions comes varying severity. Infants have the ability to express their emotions with varying degrees of intensity (e.g. a smile compared to a laugh; Newman & Newman, 2018). Emotions at this stage are developed by necessity. At this stage of development infants are learning how to effectively communicate their needs (Newman & Newman, 2018). Infants as early as four weeks old are able to utilize emotions and expressions of emotions (e.g. smiling) to communicate and achieve a goal (Lavelli et al., 2019). Through the process of expressing emotions infants are able to engage in dyadic communication with caregivers and create a sense of “intersubjectivity” (Newman & Newman, 2018) to reach their general goal of attention and tender interaction (Lavelli et al., 2019). Infants look for stimulating responses from their parents rather than a neutral expression and will change their emotional response and intensity based on the situation (Ekas et al., 2013). This is further supported neurologically (Sampaio & Lifter, 2014). In a 2014 study, researchers Sampaio and Lifter studied the infant brain and found neuro-
logical responses in key areas (lateralized responses) to emotional stimuli. This functional finding further supports the psychological, and physiological (neurological) impact of interactions with caregivers.

Emotionally driven interactions between caregivers and infants support stimulation and promote children’s growth in multiple areas (e.g. emotional stimulation, and trust). (1) Emotional stimulation is one of the drivers behind the development of attachment style, prosocial behavior (Newman & Newman, 2018). McElwain and Booth-LaForce (2006, p. 5) noted that parental (specifically, maternal) emotional stimulation, responsivity, and sensitivity to infant needs were found to be predictive of secure attachment in infants. (2) Similarly, Hammond and Drummond (2019) compiled the literature on prosocial behavior and came to a supported and impactful conclusion. They argued that infants further along in emotional development engage in more prosocial behavior (Hammond & Drummond, 2019). (3) Lastly, it can be seen that the ability to communicate through emotions for infants is at the heart of the trust versus mistrust crisis (Erikson 1963; as cited in Newman & Newman, 2018). As aforementioned, through infants’ expression of emotions they are able to communicate with their caregivers (McElwain & Booth-LaForce, 2006; Ekas et al., 2013). This communication through expression of emotion allows the infant to express their needs, and for parents to meet their needs, given they properly interpret the child’s emotional interaction (i.e. intersubjectivity; Newman & Newman, 2018). These three aspects, stemming from various types of development, necessitate the development of emotions and emotion expression. Infants attune their emotional proficiency to meet their needs in other areas of development.
Beyond parental interaction, infant emotional development is often affected by several other factors. One factor that appears to have an impact on infants’ social-emotional development is sleep (Mindell et al., 2017). Mindell and colleagues studied over 100 infants, as well as, data collected from their mothers, to critically analyze the relationship between sleep and social-emotional development. The most significant finding that was supported was the connection between being put to bed late and social-emotional difficulties in the form of dysregulation, as well as, internalizing, and externalizing disorders (Mindell et al., 2017, p. 8). While the quasi-independent variable is bedtime (Mindell et al., 2017) and the variation may appear to stem from “sleep” the variation once again leads back to the parents, and what time the child is put to bed. Making parents aware of this finding could impact their parenting techniques to establish an earlier bedtime. A second, potentially more evident, factor that affects emotional development in infants is time. Researchers (Ruba et al., 2017) studied two groups of infants, ages 10 months and 18 months. Results indicated that both groups were able to perceive two emotions (anger and disgust), identify them, and categorize them (Ruba et al., 2017). Moreover, it was found that the 18 month old infants overall performed better in the task (Ruba et al., 2017). While there are clear confounding variables to be considered, including the individual differences between each child, and differences in history of parent interactions, the general findings support that with time, and therefore experience, infants display continual development (Ruba et al., 2017).

**Emotional Development in Toddlers**

Staying true to Ruba and colleagues (2017), to look at further development of emotions the focus must be shifted to the next phase, toddlerhood (Newman & Newman, 2017). As children age into this next phase (ages 2 to 4; Newman & Newman, 2017), the research continues to
highlight the importance of parent interaction, no matter the culture. For example, Frankel and colleagues (2014) uncovered the importance of Native American mothers’ interactions with their infants and toddlers, specifically in a tribe from the Northern Plains. Researchers (Frankel et al., 2014) found that mothers with their own emotional challenges comorbid with difficulty in their relationship with their young children, had children with emotional dysregulation and their own difficulties. It was unclear which aspects of the parenting (mothering) techniques contributed to the children’s dysregulation (Frankel et al., 2014). This absence of clarity was due to a lack of understanding of the culture’s common parenting practices, as well as, a shortage of measures created with this specific culture (tribe) in mind (Frankel et al., 2014). However, the data was collected with the measure best fit for the culture and significant findings were established between mothering and their children’s socioemotional behavior, despite being fully certain as to why.

The utilization of emotions as a means of communication of needs (e.g. feeding, general attention, tender touch) remain important. However, with the development of speech during late infancy and into toddlerhood, emotional expression as communication becomes second to verbal communication (Newman & Newman, 2017). During toddlerhood, children begin to express their true form of communication, play (Axline, 2011). Children begin to utilize their emotional expression and verbal communication to engage in pretend or fantasy play (Newman & Newman, 2017). For further development of emotional prowess, caregivers have the potential to be an excellent choice for playmates (Kochanska et al., 2013). In brief, researchers (Kochanska et al., 2013) found that play between mothers and their children have a positive effect for the child’s socioemotional competence. Any form of play can result in improvements for the chil-
The research (Kochanska et al., 2013) did suggest a slight favoring toward child-lead play, as compared to the mother and child’s typical play “regiment” or play fully lead by the mother. Kochanska and colleagues (2013) sampled low-income mothers for these findings and found two additional correlations. (1) Mothers who were unmarried engaged in less child-lead play. (2) Mothers of multiple children engaged in less child lead-play (Kochanska et al., 2013). It was hypothesized that this was due to multiple cognitive hardships (Kochanska et al., 2013); however, it is also possible that mothers in these two situations have adapted to be self-sufficient and effective at leading for their child/children. When considering practical applications of this research (Kochanska et al., 2013), these findings support a non-directive, client/child centered form of play therapy (CCPT) an adaptation of the Rogerian Person-Centered Therapy (Axline, 2011; Axline, 1964).

Additionally, many toddlers experience a transition into spending a portion of their day away from their primary caregivers and are instead with teachers (Conners-Burrow et al., 2017). This highlights the need for programs like Reaching Educators and Children (REACH); Conners-Burrow, et al., 2017). The REACH program is a model for teachers to follow to educate their young students about a social and emotional intelligence, as well as, support their own autonomous development (Conners-Burrow et al., 2017). Conners-Burrow and colleagues offer their full REACH Workshop to the field as part of their program evaluation study (2017, pp. 5-6). Conners-Burrow and colleagues (2017) noted that the teachers who participated in their study did not have a degree and had not received formal training on social-emotional intelligence. The teachers included in the study enjoyed multiple aspects of the program suggesting that it could be a helpful tool for teachers and, therefore, for their students (Conners-Burrow, et al., 2017). Further
study is warranted to see if this specific program’s (REACH; Conners-Burrow et al., 2017) success for teacher holds a high external validity and can be generalized and used for the general public.

“Parenting” Behaviors and Attitudes

Despite societal pressure to be a “good parent,” even greater in parents of children with mental health concerns, parenting is not as easy as some portray it to be (Eaton et al., 2016). There are some parents who are candid and report lower levels of confidence in their parenting (Peterson et al., 2017) or feel they do not meet the “good-parent” paradigm (Eaton et al., 2016; O’Reilly & Lester, 2016). These parents who do not feel confident in their abilities can increase their confidence (Khajehei & Finch, 2016). With considerations to their confidence in their abilities; parents engage socially determined, culturally perpetuated, and individually determined behaviors and attitudes. Generally, parenting attitudes and behaviors are depicted in literature through the lens of parenting styles, extremities of parenting, and parental mental health. The following literature reviewed is reflective of current research, seeking diverse examples of a range of parenting behaviors and attitudes; however, due to the lack of diverse research it is not reflective of all ethnicities, races, and various cultures.

Behaviors and Attitudes

Parenting attitudes are specific to each parent and based on a culmination of factors in their lives. However, there are several qualities that have been identified to be important for consideration when parenting infants (Arnott & Brown, 2013). In a 2013 exploratory study, Arnott and Brown identified the following key qualities: discipline, routine, anxiety, nurturance, and involvement (p. 1). Notably from this list is anxiety. It was further supported that maternal anxi-
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ty play a role on the developing infants and effectively dealing with their anxiety is important for their child’s psychological development (Arnott & Brown, 2013). Maternal and paternal mental health are discussed in subsequent sections of the current review. From these suggested key attitudes stem a set of behaviors. Common parenting behaviors are, expression of warmth, distribution of structure and discipline, control, and management of anxiety (Arnott & Brown, 2013). Managing maternal anxiety is a parenting behavior unique to first time parents of infants (Arnott & Brown, 2013). This may be due to insecurities or lack of confidence. Future study is warranted to look at the relationship between parental anxiety and confidence in parenting.

In addition to these qualities (Arnott & Brown, 2013, p. 1), parenting attitudes can be viewed through the lens of parenting styles; authoritative, authoritarian, permissive, or neglectful (Baumrind, 1971; as cited in Cerezo et al., 2018). Authoritative parenting takes a democratic attitude with the child. Similarly, authoritarian parenting can be compared to a stricter form of government; discussed in the vernacular as the “because I said so” parenting style. Permissive parenting is the most liberal and relaxed form of parenting; encouraging of the self. Lastly, neglectful parenting is a hands off parenting style comparable to child neglect. These parenting styles have an effect on their children. The effects can be seen in children’s patterns of socializing with others and their reactions to discipline, to modeling behavior, as well as, in aspects of children’s play (Cevher-Kalburan & Ivrendi, 2016). In a Turkish study, researchers (Cevher-Kalburan & Ivrendi, 2016) found that authoritative parents were more likely to support their children in “risky play.” This form of play leaves risk for injury; it is possible that authoritative parents see a benefit in allowing their children to make their own decisions and learn from the outcome.
Specific groups such as feminists bring in a set of values and attitudes to their parenting. In a 2012 study, researchers (Liss & Erchull) surveyed a sample of feminists and found that compared to non-feminists, the feminist participants valued bringing close attachment styles into their parenting. Additionally, these feminist mothers considered themselves atypical from other feminists (i.e. they felt their focus on attachment in parenting was uncommon; Liss & Erchull, 2012).

Additionally, there is another group in the parenting community that is underrepresented in research, stepparents. Step-parents bring in a different relationship for children; however, each experience with a step-parent, and the involved circumstances, are unique and therefore difficult to generalize (Jensen et al., 2014). Jensen and colleagues (2014) for example, found that with two single parents combining families (i.e. children from their previous spouse and new stepchildren) parents have an expectancy for obedience from their new step children. This paradigm warrants further research to determine if this attitude of expectancy reflects on any stepparent specific behaviors.

Polarities of Parenting

There are certain parental behaviors and attitudes that can have a long-term effect on children. The most apparent of these behaviors is corporal punishment. Regardless of the studies and facts published and made available to the public, corporal punishment is still practiced in the United States (Taylor et al., 2017). This practice continues to be used in the United States and its use is perpetuated when they believed others approved of using corporal punishment (Taylor et al., 2017). In their survey, Taylor and colleagues (2017) found that parents were more likely to engage in corporal punishment when they perceived professionals, family members, and friends
approved of using it themselves. From this perception, there are many who engage in this dangerous physical form of punishment despite the negative effects. In a sample of 111 single teenage Hispanic mothers the participants were questioned about their use of corporal punishment and other parenting behaviors (Smith et al., 2017). It was seen that this sample of mothers engaged in the highest levels on the measures utilized testing for use of corporal punishment and other negative parenting behaviors and attitudes (e.g. minimizing children’s independence; Smith et al., 2017). It is unclear due to the vast amount of confounding variable what is at the root of these behaviors (Smith et al., 2017). There may be some cultural basis for this type of punishment; there could be common factors with the participants as single parents or their age (Smith et al., 2017). Further research is needed to clarify what is at the root of this behavior in order to take the next step to move away from its use.

**Parent Mental Health**

As aforementioned, parental mental health is an important consideration, clearly for the individuals (the parents) as well as their children, no matter how young. From the earliest moments in the womb children can be affected by parental stress, anxiety, and depression (Glover & Capron, 2017). This does not change outside the womb, in fact, there is research that suggests that expecting parents be screened for mental health problems early to resolve or prevent possible damaging effects pre- and post-partum (Väskä et al., 2017). In a separate study, researchers looked at expecting Latina mothers with a history of interpersonal trauma (Waters et al., 2015). This sample of Latina mothers took a survey during their pregnancy to test their predicted levels of sensitivity towards their child (Waters et al., 2015). The sample of mothers had a high level of predicted sensitivity during the pre-test (Waters et al., 2015). The post-test, six months later,
highlighted results after using the experimental intervention (Waters et al., 2015). This highlights both the possibility for improvement in parenting techniques and the need for these types of treatments for families at risk (Waters et al., 2015).

“Parenting” and Development

With a comprehensive detailing of both child development and parenting independently, it is now possible to explore where the two intersect -- an area of abundance, or at least it seems. The literature covers varying areas from behavioral development to effects of parenting on schooling. Treyvaud and colleagues (2016) studied the effects of parenting behavior on the development of 2 year old children. They found that parents who intervened and engaged in efficient parenting behaviors for their very preterm children had a significant impact on the child’s school performance later on (Treyvaud et al., 2016). These findings (Treyvaud et al., 2016) could be vital for parents and their children’s future. Looking at behavioral development, d’Apice and colleagues (2019) studied behavioral, cognitive, and language development in children aged 2 to 4 (toddlerhood). Their results suggest that parenting plays a significant role in behavioral development, but it is the language input and not the parenting directly that has an effect on cognitive and language development (d’Apice et al., 2019). Another aspect “parenting” plays a role in is emotional development, the focus on the current review.

“Parenting” and Emotional Development

As aforementioned, children utilize their emotional prowess in infancy to communicate their needs to their caregivers (Lavelli et al., 2019) and in toddlerhood their emotional needs are met through moments of play (Kochanska et al., 2013). Looking further into the effects of parenting, Mingo and Easterbrooks (2015) studied infant mother dyads to gauge patterns of emo-
tional availability. They found four different patterns that could be plotted on a scale from healthy to unhealthy (Mingo & Easterbrooks, 2015). Notably the “low functioning” group was the most concerning (Mingo & Easterbrooks, 2015, p. 9). This group was characterized by low emotional availability, hostile behaviors, and conflict (Mingo & Easterbrooks, 2015). Clearly, this is not the optimal example of healthy emotional development, but it is a potential reality.

This is important to consider when looking to the future as the development learned at this young age are built upon in the future. Russell and colleagues (2016) highlighted this in their article with results that pointed to social-emotional competencies learned at this young age (infancy and toddlerhood) carry out into later stages of childhood. This is also why intervention methods are important. One parenting attitude to adopt that may help is a mindful parenting attitude. Aspects of mindful parenting are based loosely off of Jon Kabat Zin’s mindfulness meditation course (Kabat-Zinn, 1990). Mindfulness is a state of being present, having a non-judgmental attitude, and, being alert (Kabat-Zinn, 1990). In support of mindful parenting, one set of researchers looked at how mindful concepts would affect parent and child dyads (McKee et al., 2018). They conducted research to see what would happen if caregivers express parenting that is nonjudgmental. They found that parents who were more willing to express a non-judgmental state were also more likely to encourage their children’s emotional expression (McKee et al., 2018, p. 10).

Parenting vs Mothering

Before delving into more specific instances of emotional development and parenting, it has become vital to mention the difference between the phrase “parenting” and “mothering.” “Parenting” has been listed multiple times throughout the current review with quotation marks because even though the studies are titled or described as parenting research, majority have focused on
female clients and have left fathers out of the data (Giallo et al., 2014; Serrano-Villar et al., 2017). This causes several issues, first this is unjust for women. By titling research on mothers as parenting research, the role of the mother becomes minimalized. Second, this false labeling of research makes it appear that there is more research on fathers than there truly is. When there are males included in parenting research, often times scales need to be adapted or testing results need to be explained that the measure was originally designed solely for mothers (Schiffrin et al., 2014).

**Fathering and Emotional Development**

In reviewing the current literature it is apparent across the discipline of “parenting” that there is little research on fathering and development at large. This disparity neglects families raised by single fathers, two fathers, and other male caregivers (e.g. extended family or adopted parents). This is a clear source of hindrance for best practices in parenting, parent education, and counseling when working with these populations. Critically analyzing the existing research on fathers is necessary to determine the course of action needed to close the gap.

**Emotional Development and Play**

Within the specific field of fathering and emotional development, there are still aspects of mothering that arise. In one 2017 study, researchers, Kim and Min Kim, found that when father’s engaged in more levels of play with their children this had a positive effect on lowering the mother’s depression, which in turn, had a positive effect on the child’s emotional development. The goal of this study was to test how father involvement with the child affects the mother in heterosexual married couples (Kim & Min Kim, 2017). While this may be discouraging to the field that even when studying fathering behavior the mediation of the mother-child relationship
becomes the focus, there is some research on father-child play that attest to the father’s involvement affecting the child’s emotional development.

In a father-play specific, researchers found data that is a vital addition to the study of fathering behavior (Bocknek et al., 2017). It was found that moderate levels of physical play with fathers was beneficial for toddlers’ emotional development. Toddlers who spend a moderate time engaged in physically active play with fathers had the best emotional regulation, as compared to toddlers who spent too little or too much time engaged in physical play (Bocknek et al., 2017). Bocknek and colleagues stated that their data evidenced greater differences in toddler development than several other forms of parent involvement (2017, p. 19). Additionally, the emphasis on the routine of this play was noted (Bocknek et al., 2017).

In another study of play fathers engaged their children in similar fashions regardless of gender (Ahnert et al., 2017). Additionally, it was seen that the father’s play was not affected by their own personality nor their levels of stress (Ahnert et al., 2017). When looking at the quality of father’s play, fathers play held more quality for male toddlers, as compared to other children (i.e. female toddlers, infants; Ahnert et al., 2017). Finally, this research provided more evidence of benefits to emotional development in correlation to paternal play. Higher amount of quality play with fathers was correlated to lower amount of internalizing behaviors (Ahnert et al., 2017). It appears that physical play or as some describe it “rough and tumble” play mediate these positive results (St George et al., 2017). An Austrailian study revealed that rough and tumble play was correlated to fewer emotional difficulties, improved self-regulation, as well as, some behavioral benefits (St George et al., 2017). Rough and tumble play was compared to playing with toys, a form of imaginary play more typical of mother-child play (Ahnert et al., 2017). Re-
searchers noted that while toy play with fathers was correlated with lower levels of self-regulation (St George et al., 2017). This may have been due to a lack of challenge involved in the toy play and father’s observed difficulty engaging (St George et al., 2017).

However, contrary to these findings, Cabrera and colleagues (2017) found there was a link between paternal play and toddlers’ vocabulary skills, while it was maternal play correlated to toddler emotional development. However, it was also noted that when fathers engaged effectively in pretend play both correlations were strengthened (i.e. vocabulary skills and emotional skills; Cabrera et al., 2017). This highlights the impact effective paternal forms of play can have, as well as, notes the difference in play between mothers and fathers.

**The Difference in Play**

Studying the difference between parents’ willingness, skills, and overall ability to engage in play (different types, quality, frequency, etc.) is important in understanding the effects on child emotional development. These considerations in play derive from general elements of parenting. As previously noted, routine, nurturance, and involvement are some of the key elements of parenting and can be applied specifically to play (Arnott & Brown, 2013, p. 1). Generally, fathers engage in higher degrees of rough and tumble, physical, play compared to mothers who tend to engage in pretend and educational play (Ahnert et al., 2017). Mothers and fathers engaging in play engage their children equally, but what they brought to the play, personally, was different (Ahnert et al., 2017). As noted, fathers do not bring their stress and personality into play; however, mothers tend to (Ahnert et al., 2017). Additionally, mother’s play was of higher quality than that of fathers for infants. Researchers attributed this, again, to the type of play parents tend to engage in.
**Diverse Considerations**

These differences between fathers and mothers fit gender social-normative beliefs about physical play with fathers and non-physical play forms, such as pretend play, with mothers (Ahnert et al., 2017). These differences and those aforementioned are blatantly important to consider for fathers in heterosexual couples, homosexual couples, single fathers (temporary single fathers (e.g. military deployed partners), but there are others who benefit from this knowledge. With the knowledge of the positive effects of play delivered by fathers on children’s emotional development, some mothers need to make appropriate adjustments. Single mothers, two mother families, and additional families without a father (permanent or temporary; military deployed partners) may find it beneficial to include physical play into their parenting techniques. Conversely, all fathers may equally benefit from working towards incorporating pretend play into their parenting. Lastly, caregivers who do not subscribe to a socially dictated gender binary label can benefit from this new knowledge on the importance of physical play (presented by Ahnert et al., 2017).

**Fathering Education**

It is important to note that a majority of fathering education research appears to originate in Australia and New Zealand. For example, Frank and colleagues (2014) found that in a sample (study total: n = 176) fathers were not aware of nor had experience with programs for fathering. Additionally, they found that a percentage of the fathers surveyed believed their children had emotional problems and behavioral problems (Frank et al., 2014). These perceptions were correlated with higher stress in the fathers. Additionally, their study took a detailed surveying of father’s preferences for delivery of a fathering education program (Frank et al., 2014). This survey’s results could be highly beneficial, if capitalized, to create effective programs with fathers’
needs and preferences in mind. The population’s needs and preferences are important to consider when designing a program; however, it is also important to consider the current barriers. Sicouri and colleagues (2018) found fathers view gender roles, the social stigma on help seeking behavior, and the lack of content specific to fathers to all be barriers from attending parenting workshops/education. Creating workshops with preferences in mind and working on these barriers of attendance are key steps to move forward in the field.

Clinical Applications

Although children’s emotional development and the relationship to fathering is a minute area in the overall field of fathering, there is a need to start somewhere. The apparent lack of research in this specific area is a microcosm for the discipline of fathering at large. Having information on fathering available for clientele in a psychoeducational setting, general parenting course setting, and a newly developed fathering workshop. Additionally, within a counseling setting, having an abundance of information for clients is pertinent for fathers coming experiencing lack of confidence in their ability to parent, or concerns about becoming a parent, or how to aid their children through emotional (or other) hardships. Looking specifically to the current paper and the known knowledge, providing clients information regarding their play style with their children is valuable information for their child’s emotional development. Promoting ingrained play behaviors parents naturally engage in, and working on the play behaviors that individual parents (of any gender) struggle with may be an effective approach in helping parents engage with their young children.

Future Direction
The future direction of research in this field is an aggressive call for research. With limited research on fathering classes (especially in the United States; Frank et al., 2014; Sicouri et al., 2018), fathering and emotional development (in and out of the scope of play), and fathering in general, any and all father specific research is welcome and warranted. Perhaps the most valuable place to start is clarifications of father’s needs and preferences in fathers in the United States, to determine what fathers are lacking knowledge or confidence in to be effective parents for their infants and toddlers to assure positive development throughout their lives.
References


Brain Impairments in Maltreated Children

Carl C. Papandrea

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This paper begins with a brief review of brain development in typically developed and maltreated children. Neurobiological impairments that have been found in children who experience adverse childhood experiences are identified and explained.

In recent years, mostly due to the advancement in technologies such as neuroimaging, there has been a surge of research into early brain development and understanding how early adverse experiences impact development (Teicher et al., 2003; Caspi & Moffitt, 2006; Lupien, McEwen, Gunnar, & Heim, 2009). The use of magnetic resonance imaging (MRI) provides insight into how early experiences affect the developing brain. This type of research now provides biological explanations for what practitioners identified through behavioral, psychological, and emotional terms. The evidence is becoming overwhelming in support of altered brain functioning in individuals that have experienced early abuse and neglect.

What is known now is that our experiences, including interactions with other people, significantly impact how our genetic predispositions are expressed. It was once believed that infants were born with several fixed capabilities, however, it is now understood that these capabilities are dependent on the infant’s sequence of experiences and genetic makeup. For optimum development, both factors are essential (Shonkoff & Phillips, 2000).

Some background information about the developing brain is will be helpful before exploring the impairments found amongst abuse and/or neglect victims. One of the most important components of the brain is the neuron, which, during fetal development begin to form the various parts of the brain. Neurons differentiate and become specialized to a specific function in the body (Perry, 2002). This process occurs in a "bottom-up" sequence, that is, it begins in areas of the brain that control the bodies most basic functions (e.g., heart rate, breathing) to the
most high-level functions (e.g., complex thought; Perry, 2000a). The autonomic functions which manage the necessary bodily functions for life, develop first. The higher regions, or the limbic system and cerebral cortex that involve regulating emotions, language, and abstract thinking, grow rapidly during the first 3 years of life (ZERO TO THREE, 2012). The process of learning or brain development is the creation and discarding of neural connections called synapses. The forming of the brain through synaptic pathways is the essence of postnatal brain development. When born, very few synapses have already been formed. Through experiences, a child's synapses occur at an amazing rate. A healthy toddler’s cerebral cortex can, at its peak, create 2 million synapses per second and by the time a child is 2 years old, approximately 100 trillion synapses have already been made (ZERO TO THREE, 2012). Through experiences, a child's synapses are strengthened, but many are slowly discarded through a process called pruning (Shonkoff & Phillips, 2000). Another process that occurs is myelination. Myelin is the white fatty tissue that insulates the mature brain cells to ensure the transmission of neurotransmitters through synapses. In youth, there is a lack of myelin, which is why they process information more slowly than adults (ZERO TO THREE, 2012). As with the other areas of brain development, a child’s experiences also affect the rate and growth of myelination (Shonkoff & Phillips, 2000). If a baby’s brain is stimulated properly, it can reach almost 90 percent of its adult size by the age of 3.

The brain continues to grow and develop through adolescence and into adulthood (at least to the mid-twenties). Lebel & Beaulieu (2011) were able to show that white matter volume increases in adults as old as 32. During the adolescence and teenage years, the brain goes through a process of pruning, somewhat like in the infant and toddler brain, and sees an increase in white
matter and changes to neurotransmitter systems (Konrad, Firk, & Uhlhaas, 2013). As a teenager grows into young adulthood, myelination occurs last in the frontal lobe. When the brains of teenagers and young adults were compared through the use of MRI’s, it was discovered that most areas were the same. Meaning, during this time the brain reaches maturity in areas that control such abilities as speech and sensory capabilities. The biggest difference was in frontal lobe development (National Institute of Mental Health, 2001). In adolescence, puberty occurs and leads to the physical development of the body, however, the brain lags, particularly in areas that allow them to reason and think logically. Most teenagers present with impulsive behavior, poor decision making, and heightened risk-taking behavior due to having to use the lower parts of their brain. The limbic system, which is responsible for our emotions, also develops during the adolescent years. Teenagers rely on their primitive limbic systems when interpreting emotions since they lack maturation in the cortex which can override the limbic response (Chamberlain, 2009).

Plasticity, which is the brain's ability to change in response to repeated stimulation, is dependent on the stage of development along with the particular brain system or region affected (Perry, 2006). Plasticity decreases as a child gets older, though some degree of plasticity remains throughout our lives. The brains development throughout life depends on both genetics and experiences. Children adapt to their environments e.g. growing up in a large family, children learn to function in that setting. Regardless of the environment, to promote the healthy development of the brain, a child requires stimulation and nurturance. If those things are lacking (e.g. due to abuse or neglect), development can be impaired. If exposed to a toxic or negative environment, the brain will adapt as readily as it would to a positive environment.
Research posits that there are sensitive periods for the development of certain capabilities. If healthy development is not promoted during these sensitive periods, neural pathways can be discarded, and capabilities diminished. Smyke, Zeanah, Fox, & Guthrie (2010) studied children from Romanian institutions that were severely neglected. Before they were 24 months old, the children that were placed in foster care had much better attachment responses compared to those that were not placed in foster care. This research shows that there is a sensitive period for attachment, however, there is likely a general sensitive period not a true cut-off point for recovery (Zeanah, Gunnar, McCall, Kreppner, & Fox, 2011).

Memories are another important component of development. Memories are what shape our experiences and interpret the way we perceive the world. Applegate & Shapiro (2005) found that babies are born with the capacity for implicit memory. This means that they can perceive their environments and recall it in unconscious ways. Explicit memories develop around the age of two and refer to the conscious memories that are tied to language development. At this point, children can talk about themselves in the past or future and in different places and/or circumstances. An effect of abuse or trauma in children is that they may retain implicit memories of the physical or emotional sensations, which results in uncontrollable reactions like flashbacks or nightmares.

Now that we have a brief synopsis of brain development in children, let’s take a look at some of the impairments identified in the structure and chemical activity in the brains of maltreated children. The effects of maltreatment depend on many factors such as the age of the child, number of times, length, type and severity of maltreatment, the identity of the abuser,
whether or not the child had a dependable nurturing individual in his or her life, and other individual and environmental characteristics.

McCrory, De Brito, & Viding (2010) and Wilson, Hansen, & Li (2011) found that adults who were maltreated may have reduced volume in the hippocampus. The hippocampus plays a central role in learning and memory. Shonkoff (2012) also found that toxic stress can reduce the hippocampus’s capacity to bring cortisol levels back to normal after stressful events. The corpus callosum, which is responsible for processes such as arousal, emotion, and higher cognitive abilities, can also be affected due to maltreatment. McCrory (2010) found that maltreated adolescents tend to have decreased volume in the corpus callosum and cerebellum. The cerebellum helps coordinate motor behavior and executive function-related tasks. Other studies on both adults and adolescents that were abused and/or neglected as children identified the prefrontal cortex as being smaller when compared to their typically developed peers (National Scientific Council on the Developing Child, 2012). On the other hand, some studies contest this claim and found no difference at all (McCrory, 201). Hanson et al., (2010) located reduced volume in the orbitofrontal cortex which is part of the prefrontal cortex. The orbitofrontal cortex is vital to emotion and social regulation. Most studies found no differences in amygdala volume of maltreated children, however, the National Scientific Council on the Developing Child (2010b) found abuse and neglect can cause overactivity in that area of the brain. This area helps determine whether a specific stimulus or situation, is threatening and triggers the appropriate emotional response. Cortisol levels can also be affected within the brain of abused and/or neglected children. Children typically have a sharp increase in cortisol in the morning followed by a steady decrease throughout the day, however, in both institutional and family settings,
Bruce, Fisher, Pears, & Levine (2009) found lower than normal cortisol levels in the mornings along with flatter release levels throughout the day. Also, they found that maltreated children in foster care had higher than normal morning cortisol levels. A reason for the differences in morning levels could be due to the body reacting differently to varying stressors. Abnormal cortisol levels can have many negative effects e.g. lower levels can result in decreased energy, which in children specifically, can impact both learning and socialization. Higher levels of cortisol can affect cognitive processes and reduce inflammatory reactions. Other affected areas include decreased electrical activity, decreased brain metabolism, and poorer neural connections between brain areas that integrate complex information (National Scientific Council on the Developing Child, 2012). Additionally, malnutrition can impair both brain development (e.g., slowed growth of neurons, axons, and synapses) and function (e.g., neurotransmitter syntheses, the maintenance of brain tissue; Prado & Dewey, 2012). De Bellis et al. (2002) found decreased volume in the corpus callosum, prefrontal cortices, and temporal lobe and increased volume in the superior temporal gyrus in maltreated children with PTSD as opposed to those without PTSD.

The results of maltreatment on brain structure and chemical activity can have a range of effects on a child’s behavioral, social, and emotional functioning. Individuals exposed to chronic stress or repeated trauma can result in several reactions, including a persistent fear response (National Scientific Council on the Developing Child, 2010b). A child may adapt in a way that is necessary for survival in a hostile environment, which can be the result of chronic activation of neural pathways involved in fear. Children who suffer from persistent fear response lose their ability to distinguish between danger and safety. An example of this would be a child that has
been maltreated by a close male figure may be fearful of other male figures that pose no threat. Hyperarousal is another potential consequence of maltreatment in children. Hyperarousal is when the brain sensitizes the pathways for fear response and create memories that trigger a specific response without conscious thought. Children suffering from hyperarousal can be sensitive to nonverbal cues such as eye contact or touch. A child can become consumed with the need to monitor nonverbal threats, resulting in their brains being less able to interpret and respond to appropriate verbal cues (National Scientific Council on the Developing Child, 2010b).

Emotion and stress regulation can become difficult in maltreated children as the result of chemical changes in the amygdala and hippocampus, which can initiate the development of depression and/or anxiety (Herringa et al., 2013). Early emotional abuse or severe deprivation may affect the brain's ability to use serotonin. Serotonin helps produce feelings of emotional stability and well-being (Healy, 2004). As stated early, brain impairments can also lead to diminished executive functioning. Executive functioning generally includes three components: working memory, inhibitory control, and cognitive or mental flexibility. Maltreatment can cause deficits in all areas of executive functioning (Hostinar, Stellern, Schaefer, Carlson, & Gunnar, 2012). Maltreatment of children can also be a parent/caregivers failure to meet a child’s cognitive, emotional, or social needs. A failure to do so can lead to delayed developmental milestones. Scannapieco (2008) posits that for a baby’s brain to develop appropriately, he/she needs to experience face to face baby talk and hear countless repetitions of sounds. In a study of young adults that were maltreated, Dillon et al., (2009) found them to be less responsive to positive stimuli. For example, they rated monetary rewards less positively than their typically
developed peers and demonstrated weaker responses to reward cues in the basil ganglia areas of the brain.

As you can see, abuse and/or neglect can have serious consequences for an individual’s development. In 2012, 686,000 children were reported to be victims of abuse and/or neglect (U.S. Department of Health and Human Services, 2013). These are just the reported numbers of abuse and/or neglect, so this number is likely higher. More broadly, adverse childhood experiences or ACEs affect basic biological and neural processes during development (Heim & Nemeroff, 2002). ACEs come from the ongoing Adverse Childhood Experiences (ACEs) Study (Dube et al., 2003; Felitti, 1998). ACEs can be childhood emotional, physical, sexual abuse, parental psychopathology, substance abuse, and early parental loss due to death/abandonment, or parental incarceration. A lot of evidence has been collected demonstrating that child abuse and neglect is linked to a marked increase in risk for major psychiatric disorders e.g. major depression, bipolar disorder, post-traumatic stress disorder, substance and alcohol abuse, etc., and medical disorders such as cardiovascular disease, diabetes, irritable bowel syndrome, asthma, and others (Nemeroff, 2016). What should be learned from all of this, is that a child’s brain development is heavily dependent upon their environment. Providing a child with a stable, nurturing environment can have a significant positive impact on their development. Exposure to an abusive, hostile or neglectful environment can have a significant negative impact on their development as well.
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Common Personality Traits in Youth and Connection with Antisocial Personality

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Personality Traits, Conduct Disorder and Their Connection to Antisocial Personality Disorder

The study of personality traits in youth and is controversial due to the potential for labeling, stigma and/or inappropriate diagnosis, however, researchers have started to study the development of conduct problems and the personality traits that accompany them. Conduct problems in youth can take a toll on families and greatly impact the community, which is why more specific, earlier, evidenced based treatment interventions need to be developed; especially those that reach minority groups. Research has been able to show that the early on-set of behavioral problems in youth increases the risk for behavioral issues in adulthood, though not all children that exhibit such behavioral issues warrant a diagnosis of Antisocial Personality Disorder (Loeber & Farrington, 2000). It is imperative then, that those in the field of counseling psychology have access to tools and measures that help identify youth whom are at greater risk of developing conduct problems. In doing so, appropriate diagnosis can be made and specific, evidenced based interventions utilized.

Early onset of conduct problems in youth typically results in a diagnosis of Conduct Disorder (CD). CD is a behavioral and emotional disorder which is defined in the DSM-5 as “a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated” (5th ed.; DSM–5; American Psychiatric Association, 2013). These behaviors can include threatening others, bullying, physical fights, weapon use/possession, cruelty to animals, theft/break ins, forced sex, fire setting, destruction of property, lying, and running away, which can be identified as early as the preschool years. The DSM-5 introduced a specifier for the more severe subtype of CD, the Limited Prosocial
Emotions (LPE). The LPE is supported by a body of research suggesting that children with conduct problems and callous–unemotional traits (CU) are at greater risk for more severe conduct problems in adulthood, increasing the likelihood of a diagnosis of Antisocial Personality Disorder (ASPD). CU traits such as a absence of remorse, guilt and empathy, and shallow emotions, and are important to consider in the diagnosis of CD and the development of ones personality (Latzman, Lilienfeld, Latzman, & Clark, 2013).

Frick, Bodin, & Barry (2000); Kotler & McMahon (2005) and Colins, Andershed, Frogner, Lopez-Romero, Veen, & Andershed, A.-K. (2014) examined the development of antisocial traits in adulthood when children exhibited conduct problems earlier in life and found a moderate correlation between the two. Research has focused on a combination of conduct problems and psychopathic traits in youth; which in combination can manifest into severe behavioral dysfunction and greater risk for antisocial personality disorder (Frogner, Gibson, & Andersed, 2018). Frogner (2018) also suggest that there is a developmental trend of conduct problems, in that a diagnosis of Oppositional Defiant Disorder (ODD) increases the risk for a diagnosis of CD, and CD increases the risk for ASPD.

Assessment Tools and the Five-Factor Model of Developmental Personality Pathology

Colins (2014) developed the Child Problematic Traits Inventory (CPTI) to assess a three-dimensional psychopathic personality construct. The CPTI measures a Grandiose–Deceitful (GD) dimension, a Callous–Unemotional (CU) dimension, and an Impulsivity and Need for Stimulation (INS) dimension. Included in the GD dimension are narcissism, lying, an inflated
sense of self-worth and manipulative behavior. The INS dimension assesses impulsivity, and the child’s need for pleasure and change.

Verbeke, De Caluwé, & De Clercq (2017) tested whether the Dimensional Personality Symptom Itempool (DIPSI), which was originally created to measure personality traits in adults could be modified to measure traits in youth and across developmental stages. The DIPSI originally measured four maladaptive personality traits of Disagreeableness, Emotional Instability, Introversion and Compulsivity. Verbeke (2017) tested whether a fifth factor, maladaptive Openness to Experience, would be useful. The results of their study concluded that the DIPSI, including the fifth factor, is a useful measurement for youth and can be used to assess the personality pathology in childhood.

**Treatment Interventions and Social Justice Implications**

Few studies have explored the etiology of maladaptive personality traits, or conduct problems in youth, and even less have explored the differences between boys and girls. Ficks, Dong, & Waldman (2014) tested the etiology of three traits (narcissism, impulsivity, callous-unemotional), all of which have been linked to ASPD. The study failed to detect any differences in the etiology of maladaptive personality traits between males and females, suggesting that genes and environmental influences affect both similarly. Other studies have shown that with the appropriate treatment, maladaptive traits, just as any other trait, change over time (Klingzell, Fanti, Colins, Frogner, Andershed, & Andershed, 2016).

With research supporting the effectiveness of treatment to address maladaptive traits and/or conduct problems in youth, it would behoove researchers in the field of counseling to identify
which, if any, interventions are most effective. Also, which have the ability to be used across cultural and socio-economic backgrounds. In doing so, counseling psychologists can better address the needs of youth and work with families to reduce conduct problems and potentially lessen the likelihood even further of developing ASPD. Though there is no single identified treatment option for CD, research suggests utilizing multiple treatment options such as Cognitive Therapy, Behavioral Therapy, and Cognitive-Behavioral Therapy (Nuckols & Nuckols, 2004).

Hawes, Price & Dadds (2014) found that parent training based on social learning theory was an effective form of treatment. Ronan, Davies, Wikman, Canoy & Evans (2016) evaluated the efficacy of Family-Centered, Feedback-Informed Therapy (FC-FIT) in youth exhibiting conduct problems and found FC-FIT is an efficient, and effective treatment for families. The study elaborated on the use of benchmarking strategies, which will be useful for counseling psychologists. During treatment, counseling professionals should focus on promoting the disengagement from deviant peers, building stronger bonds with family members, community supports such as schools, athletic leagues and faith-based communities, improve monitoring and disciplining with guardians, develop social skills and improve academic performance.

Most importantly, research and counseling professionals should not overlook social justice concerns, particularly the social-structural inequalities faced by minority youth. Unfortunately, many of the leading interventions today fail to account for such disadvantages experienced by minority groups. These groups of youth experience adversity in many forms, including poverty, social marginalization and neighborhood violence. Case (2017) discusses a Positive Youth Development (PYD) model for working with youth. As a strength-based model, it looks to foster the skills and knowledge needed by youth in their progression to adulthood. Like
other strength-based models, PYD asserts that given the right supports and environment, all youth have the potential to succeed. In adapting the PYD, Case (2017) Critical-Theory pays close attention to the social-structural barriers faced by minority youth. More specifically, the assumption is that the ability of minority youth to act in the face of social-structural inequalities is crucial and should be developed through interventions. To do this, the PYD-Critical Theory combines a strength-based approach (PYD) and a social justice approach (Critical-Theory) that can be offered to a broader range of youth and families. In doing so, counseling psychologist can better serve those in need of treatment, including minority groups and communities.

To expand upon the availability of treatment interventions useful for youth with conduct problems, and to have a significant impact on public health, adaptions to current treatment solutions need to be made. To address issues surrounding the development of interventions that can reach youth of all ethnic, cultural and socio-economic backgrounds, Niec, Barnett, Prewett, & Shanley, Chatham (2016) explored the efficacy of Parent–Child Interaction Therapy (PCIT) and Group PCIT in addressing conduct problems in youth. The study posits that utilizing a group treatment format is useful due to its ability to reach more families in need. The study found that both Group and Individual PCIT were similar in their effectiveness, meaning that Group PCIT can and should be made available to families of youth with conduct problems.

**Conclusion**

This paper explored the links between common maladaptive personality traits in youth with conduct problems and their connection to Antisocial Personality Disorder. Research supports the fact that early identification of conduct problems is advantageous, in that common
maladaptive traits seen in this group of youth can change over time. The use of evidenced based treatment interventions has helped youth and families re-direct the course of maladaptive behaviors so that youth can thrive into adulthood. Measurement tools such as the DIPSIP help counseling professionals identify maladaptive traits. Positive Youth Development Critical-Theory (PYD-CT) and Group Parent–Child Interaction Therapy (PCIT) have shown to be effective in not only addressing conduct problems, but also at reaching a broader range of youth and families from different cultural, ethnic and socio-economic backgrounds. Counseling psychologists should look to utilize treatments that are far reaching and effective, which can have a greater impact on overall public health.
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Sexual Sadism Disorder

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Paraphilic Disorders:

The term paraphilia in the DSM-5 is defined as any intense and persistent sexual interest other than sexual interest in genital stimulation or preliminary fondling with phenotypically normal, physically mature consenting partners. Paraphilia’s are abnormal sexual behaviors or impulses that involve intense and persistent sexual interest in unusual objects, activities, or situations. Paraphilias can center around children, non-humans (animals, objects, materials), or the harming of self or others. As with other disorders in the DSM-5, to be diagnosed with a Paraphilic Disorder, the paraphilia needs to be causing significant distress or impairment or is a risk to self or others. It is important to understand that individuals can have a paraphilia, but not the disorder. For example, if an adult male’s paraphilia is center around an attraction to prepubescent boys, a diagnosis of Pedophilia is not warranted if it is not causing significant distress, impairment and there is no risk to self or others. Meaning, this individual can be attracted to prepubescent boys but never act out on this attraction. Some of the other more commonly known Paraphilic Disorders in the DSM-5 are Voyeuristic Disorder (spying on others in private activities), Exhibitionistic Disorder (exposing the genitals), Frotteuristic Disorder (touching or rubbing against a nonconsenting individual), and Sexual Masochism Disorder (undergoing humiliation, bondage, or suffering) (American Psychiatric Association, 2013).

Sexual Sadism Disorder Symptomology:

To receive a diagnosis of Sexual Sadism Disorder, an individual must experience, over a period of at least 6 months, recurrent and intense sexual arousal from physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviors. The individual must
have acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2013). A sadistic individual obtains sexual gratification by exerting power over another through acts of cruelty or degradation. Although aspects of power may be part of consensual sadomasochistic role play, severe sexual sadism refers to forensically relevant instances in which someone else is being victimized against his or her own will. Such instances may lead to sexual offenses like rape or sexual homicide (Mokros, Schilling, Eher, & Nitschke, 2012). Sexual Sadism can be either physical or psychological in nature. Sadistic acts range from behaviors that do not physically harm others to those that are purely humiliating. For example, being urinated or defecated on is more an act of humiliation than an act of physical violence. Sadistic acts that are more physical in nature are those that are more violent and potentially deadly behaviors such as whipping, shocking, burning, beating, stabbing, strangling, raping, mutilation and murder. Sexually sadistic acts need to be differentiated from normal sexually arousing behaviors and experimentation between two consenting adults. For example, mildly aggressive acts such as love bites, pats or scratching would fall within the normal range of behaviors during intimacy between two consenting adults. Consenting couples that experiment with sadism generally only include activities that cause mild pain or stimulation, with the intent of mutual excitement. A sexually sadistic individual engages in behaviors that are degrading, cause high levels of pain and humiliation. During a severe sadistic episode, Juni (2009) found that the perpetrator is in fact detached from reality and psychically living in a past horror scene. A sadistic episode is not part of their regular day-to-day behaviors, rather, it consists of a intermittent pattern of highly structured rituals where the
individual is thought to be re-enacting a past traumatic event. These episodes are generally more
violent and gruesome. Juni (2009) also found that sadistic individuals, though very much
psychologically like a psychopath (anti-social personality disorder), differ in many ways. It was
found that sadistic individuals do experience responsibility and show guilt and superego indices
in specific family relations. The sadistic activities are dissociated from the perpetrator’s
conscientious interpersonal experiences.

**Etiology:**

While there have been no specific causes identified for sexual sadism, several theories
have emerged including escapism, suppressed sexual fantasies, drive theory and object relations
perspectives, along with psychosexual components. Psychopathy, which is one of the most
controversial disorders (Lilienfeld, 1998) presents similarly, however, distinct differences can be
made between the two. Sadism is a severe form of hostile psychopathy. Juni (2009) posits that
negative childhood and traumatic events seem to enhance the likelihood of the development of
psychopathy in adulthood and that this predisposition is most significant in the development of
sadism. A history generally emerges amongst sadists of horrific tales of victimization or
molestation. The predispositional childhood diagnosis of oppositional defiant disorder (ODD),
which emphasizes the early pattern of consistent negativity toward authority, is predictive of the
type of sadism that is anchored in object-relational disturbances.

Aggression and sadism were first conceptualized by Freud (1905) as a subsidiary to the
basic sex drive. As the development of the psychoanalytic theory continued, Freud adopted the
view that aggression was a reactive response to the frustration of libidinal drives, however,
digressed from this viewpoint when he proposed Thanatos, a self-destructive death instinct that is not oriented at pleasure, rather at self-destruction (Freud, 1920). Freud suggested aggression might be interpreted as natural inner-directed destructiveness channeled outward as a defensive maneuver. Interestingly, Juni (2009) suggests that the etiological linkage of sadism and masochism is actually reversed and is instead self-destructiveness deriving from aggression that is turned inward.

**Object Relations Theory Perspective:**

Sadism as a mode of object relations theory hypothesizes psychopathic offenses as repetitive re-enactments of an irresolvable trauma. The victims are players who have been designated to “stand-in” for key figures in the past, in a drama intended to repair severe attachment and interpersonal damage. This can be understood as a special form of transference. While re-enacting a scenario, a sadist may call the victim by another’s name, someone with whom the sadist was him or herself victimized by during childhood, whether real or imagined. Projecting aggression onto others is the primary mode of object relations in sadistic psychopathy. An early attachment to an abusive caregiver results in a perverse linkage between abuse and feelings of closeness. The abuse produces guilt, prompting self-loathing, which is then projected onto others (Juni, 2009). From a deterministic perspective, aggression as a primary mode of object relations results from early emotional neglect, causing the person to resort to sadism or aggression “in an effort to deny the loss and to buttress a failing sense of self” (Bach, 1994, p. 5). Thus, the developmental link between poor attachment styles and criminality (Allen, Hauser, and Borman-Spurrell, 1996; Stoller, 1987) is not surprising.

**Drive Theory Perspective:**
From a drive theory perspective, individuals are born with certain psychological needs and if those needs are not satisfied, a negative state of tension is created. The aim of an individual’s instinct then is the satisfaction of one's needs, or more precisely “the very specific discharge action which dispels the physical condition of excitement and thus brings about satisfaction” (Fenichel, 1945, p. 55). Drives originate from the energy that pushes for the release, and there are different types of drives e.g. sexual instinct, a need for food, anal stimulation, or aggression. Regardless of the underlying drive, each involves a state of tension whose release feels good. In sadistic individuals, the aggressive drives thought to be experienced are indistinct from any other drive and involve drive discharge. Healthy functioning individuals are able to keep these aggressive drives within normal bounds because society has established appropriate socialization processes beginning in childhood. The aggressive tendencies that cannot be expressed directly are expressed indirectly in socially sanctioned sublimations. Healthy functioning is very much dependent on the sublimation of aggression in constructive ways such as sports (Juni, 2009).

**Psychosexual Components:**

As postulated by Freud (1905), psychological development in childhood occurs in a series of psychosexual developmental stages: oral, anal, phallic, latency, and genital. As the body progresses through a series of physical sensitivities and modes, there is a similar development of psychological and interpersonal modes that are adapted. Developmentally, sadism bridges the two stages of orality and anality. According to Junis (2009):

There is a developmental continuum in the evolution of sadism as the child matures from early infancy. As the oral dependent phase yields to the oral sadistic phase, frustrations
often pit the child against the potential provider. Aggression (biting) can now evolve from its archaic incorporative mode, which is designed to ensure closeness into an aggressive adversarial tool facilitating sustenance. As oral sadism progresses toward anal sadism, the oppositional mode begins to characterize more and more of the interaction. Yet, the aim of the child is to get sustenance (drive satisfaction) despite the impediments of the (sometimes) frustrating object. It is only as anality evolves from expulsiveness toward retentiveness that there is a shift from the stance of getting satisfaction in spite of opposition, to the point at which “spite” actually becomes the central aim. Dynamically, the tenor of this continuum entails a role progression of the object from first being a source of drive satisfaction, then a likely impediment to satisfaction, and finally a relational adversary. At the final stage, the child’s perspective is not only to win the battle in order to gain drive satisfaction; he or she now has the additional caveat that the defeat of the frustrator is now an aim in itself (p. 16).

Other Theories:

The link between psychopathy and sadism is strong, though there are distinct differences as stated above. Research on the etiology of sadism is limited, so a look at other theories regarding the manifestation of psychopathy is reasonable. There are theorists that argue it is the emotional absence of a parent that leads to psychopathy and others believe actual abuse forms the foundation of future psychopathy (Bach, 1994). Early maternal deprivation is believed to result in sadism and self-loathing that is projected outward. As a result of this deprivation, the criminal unconsciously projects his sense of deserving punishment by punishing others, as a means of negating his own punishment (Glover, 1960; McDougall, 1972). Hartmann, Kris, and
Lowenstein (1964) describe sadism as an adaptation of personality that serves the purpose of self-preservation. The theory of Escapism, where an individual purposely engages in behavior to escape unpleasantness in their life (Hirschman, 1983) is yet another theory for why an individual engages in sadistic behaviors.

**Prognosis:**

Music (2016) showed numerous examples of children and adolescents with psychopathic and sadistic behavioral characteristics. Although sadistic sexual fantasies may begin during childhood, the onset of active sexual sadism typically occurs during early adulthood and is most commonly found in males. A representative sample in Australia reported that 2.2% of men and 1.3% of women said they have been involved in some form of bondage, sadomasochism, dominance, or submission. One study found that women became aware of their sadomasochistic orientation as young adults, and another reported that the mean age of onset in a group of males was 19.3 (American Psychiatric Association, 2013). When sadistic behaviors begin, they will most often continue on a chronic course, particularly in those that don’t seek help. What may begin as a compulsion, can become an addiction for defensive reasons. The cause may be to manage core complex anxieties, stress, trauma or inadequacies. Whichever the case, such defenses can become addictive in similar ways to drugs, pornography or gambling (Music, 2016). As with other addictions or maladaptive behaviors, successful functioning as an adult can be achieved with the appropriate interventions, albeit difficult at times. What makes addressing and treating sadistic behaviors difficult is the fact that because many sadistic fantasies are socially unacceptable, individuals who may have the disorder avoid treatment or drop out.

Sexual sadism acts tend to grow more violent or bizarre over time, though in men, as they grow
older, their desire and ability to commit such acts decreases. In fact, a diagnosis of sexual sadism is unlikely to be made in men over 50 (Ebert, Loosen, & Nurcombe, 2000). In the most dangerous cases of sexual sadism, the prognosis is poor, however, in less extreme forms it is fair.

**Psychosocial and Psychopharmacological Treatment:**

Due to the uncertainty of its cause and chronic course, sexual sadism can be difficult to diagnose and treat because little is known about its psychopathology and etiology (Yates et al., 2008). Treatment is typically long term rather than short because it attempts to change personality traits like beliefs, coping mechanisms, and behavioral patterns which took several years to form. To be effective, it is necessary that treatment providers have unconditional positive regard and a trusting relationship with the sadistic patient. A strong therapeutic alliance will assist in making treatment outcomes more effective. Treatment should allow for flexibility and not utilize a “one size fits all” model. Researchers have demonstrated an important process for treatment. Marshall and his colleagues (Marshall, Serran, Moulden, et al., 2002; Marshall, Fernandez, et al., 2003; Marshall, Serran, Fernandez, et al., 2003; Marshall & Serran, 2004; Marshall, 2005) have shown that a therapist's display of features such as empathy, warmth, directiveness, and encouragement is predictive of the clients' attainment of the goals set forth in the treatment of sexual sadistic individuals. In many patients there is a pleasurable, addictive and sometimes sexual excitement in inflicting pain (Bower et al., 2013), making it more difficult to treat. Treating sexual sadism or a paraphilia, in general, is often a sensitive subject even amongst professionals, and more extreme cases should be referred to experienced and specialized mental health professionals.
Over time, researchers have developed sophisticated methods for assessing sexual arousal (Wincze, 2009; Ponseti et al., 2012; Wincze & Weisberg, 2015). Such methods are useful, particularly because those presenting with a problem may be unaware, they have a problem. Assessors should not only focus on the paraphilic disorder but also biopsychosocial factors as well. For example, useful information can be found in identifying a patient’s ability to make and maintain relationships and/or social skills. A common form of treatment for sexual sadism and other paraphilic disorders are behavioral treatments. These approaches may include the management and conditioning of arousal patterns and masturbation. The use of CBT’s cognitive restructuring exercises and social skills training are also utilized. Another procedure, covert sensitization is carried out by the patient by associating sexually arousing images with some reasons why the behavior is harmful or dangers (Cautela, 1967). In a case study, Davison (1968) was the first report to report the elimination of a sadistic fantasy by conditioning methods. It was also the first to describe a client-controlled technique for counterconditioning sexual responses. Another intervention, orgasmic reconditioning, is a technique that requires the strengthening of appropriate desired patterns of arousal. Patients are instructed to masturbate to their usual fantasies but substitute more socially appropriate ones before ejaculation. When repeated, the patient should be able to begin the desired fantasy earlier in the masturbatory process and still maintain their arousal. This technique was first described by Gerald Davison (1968) and has been used with some success in a variety of settings (Brownell et al., 1977; Maletzky, 2002). Due to the beliefs that sadistic tendencies stem from the unconscious, long term psychoanalysis may be beneficial once the immediate, more at-risk symptoms and behaviors have subsided. This could help address any underlying unconscious issues triggering the sadistic behaviors. Stress
can be a trigger for sadistic episodes, so treatment focused on alleviating stress and managing
anxiety may be useful. Individual, group, inpatient or residential settings, family therapy can all
be effective treatment modalities depending on the severity of symptoms. A patient’s
commitment to change the socially undesirable behavioral patterns they exhibit is necessary for
treatment to be successful.

A number of treatment manuals are available to be used with sex offenders that specify
the necessary process conditions (therapist style and skills, group climate) and also allow
therapists to determine necessary flexibility for successful treatment. These models include the
Risk/Needs Model, Good Lives Model, and model which combine the two (Marshall, Anderson,
Marshall, Marshall, & Serran (2006) identified the following treatment targets: Life History,
Self-Esteem, Acceptance, and Responsibility, Coping and Mood Management, Social Skills,
Sexual Interests, Self-Management Plans, and After Care.

Medication may be used in general for paraphilias, but especially with those who exhibit
sadistic behaviors. The most popular drug used is an antiandrogen called cyproterone acetate,
which is often referred to as a “chemical castration” because it eliminates sexual desire and
fantasy by reducing testosterone levels. If the drug is stopped, the fantasies and arousal will
return. (Bradford, 1997). Another drug used is medroxyprogesterone, or the injectable form is a
Depo-Preveral, a hormonal agent that also reduces testosterone (Assumpção et al., 2014). These
types of drugs are more useful for dangerous sex offenders who do not respond to other forms of
treatment or to temporarily suppress sexual arousal. Also used are selective reuptake inhibitors or SSRIs.

**Biopsychosocial Factors:**

**Biological:**

Considering the biopsychosocial factors amongst those diagnosed with sexual sadism disorder is important, however, a lot still needs to be learned about the disorder. Regarding biological aspects, the increased usage of neuroimaging techniques such as MRIs and fMRIs provide researchers with information about any abnormalities in their brains. Knowing which, if any, areas of the brain are over or under-activated in sexual sadists will provide treatment professionals a better understanding of how patient’s brains are “wired.” Research conducted by Harenski, Thornton, Harenski, Decety, & Kiehl (2012) on 17 adult males who were committed under Wisconsin’s sexually violent persons law, did just that. Harenski et al., (2012) explored whether sexual sadists differ from non-sadists in neural systems underlying pain observation. While taking images of the brain using MRI and fMRIs, researchers showed participants pictures depicting someone causing another pain e.g. one person stabbing another’s hand with scissors, and non-pain pictures for comparison. Results indicate that sexual sadists showed a greater pain vs. no-pain picture distinction in the left amygdala relative to non-sadists. This was consistent with the researcher's prediction that only sadists would find pain pictures sexually arousing. In addition, sexual sadists also rated pain pictures higher on pain severity than non-sadists, which is consistent with sadists’ heightened sensitivity to others’ pain. Also, sadists showed a positive correlation between pain severity ratings and activity in the left anterior insula, meaning that
increased activity was associated with higher subsequent pain ratings. Sexual sadists also showed increased right temporo-parietal activity relative to non-sadists in response to both pain and no-pain pictures. The role of the temporo-parietal junction in mentalizing (attribution of mental states such as beliefs and intentions to others) has been previously established (Frith & Frith, 2003). Also, relative to non-sadists, sexual sadists showed greater functional connectivity between the left amygdala and right anterior insula during pain observation. This result suggests covariation between the perception of others’ pain and sexual arousal in sadists but not non-sadists. Continued research such as Harenski et al., (2012) will prove valuable to the understanding and treatment of sexual sadism disorder. Similar biological research is being conducted throughout psychology and will eventually guide treatment professionals as it does medical doctors when treating injuries, viruses and/or other curable diseases. Biological aspects of psychological disorders are an area where an in-depth understanding has been limited but has become increasingly researched. Certainly, biological factors alone cannot predict whether an individual will develop sadistic behaviors or act out in general on sexual impulses, though they will continue to provide useful information to treatment professionals.

**Psychological:**

Much of the research presented above has to do with exploring the psychological aspects of Sexual Sadism Disorder. The behaviors exhibited by sadists can be bizarre and is poorly understood. Many psychological factors play a role in the development of such a disorder; from an individual’s family history, the environment they were raised in, sex abuse and/or child abuse trauma, and/or even substance use. Since there are a limited number of openly sadistic individuals, developing appropriate assessment tools and treatment planning is difficult. There
are, however, people that enjoy sadism and find it sexually gratifying without it causing any distress or impairment. Perhaps, if researchers were able to incentivize or entice these individuals to assist in research, treatment providers would better understand the more extreme cases of the disorder. Those that enjoy sadism in a safe manner are free to do so, so long as they have a consenting partner.

**Social:**

Socially, sadistic behaviors are perceived as strange and are generally unacceptable to society even when it is known the two parties consented. The stigma attached to such behaviors has led those who suffer to keep quiet about their thoughts, feelings, fantasies, and behaviors. Whether you agree or disagree with what another person likes or dislikes, it is their right to do so. The media, movies, and books have glorified sexual sadists in ways that have created this perception of them being violent, crazy or disgusting. When nonconsensual sadistic behavior leads to problems with the criminal justice system, society should be concerned, though there are individuals that consent and enjoy milder forms of sadism. As helpful as the legal system here in the United States of America can be, issues related to legal problems may impair or delay a patient's treatment. Persons with sexual sadism may be reluctant to seek or continue treatment because they fear being reported to the police. Just like any other illness, those suffering from this type of disorder are deserving of proper treatment. If a sadist were raised in an environment where he/she was severely sexually abused as a child, and then as an adult acts out sadistically, should they be locked up in a cell and left to die? Or should treatment be provided so that we can better understand the disorder while also helping others live a safe and productive life? This in
no way minimizes anyone’s violent actions against others, it is pointing out that society can be socially just to both victim and perpetrator.
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Narcissism

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Introduction

Narcissistic personality disorder is a personality disorder defined by the DSM-IV as a persuasive pattern of grandiosity which means fantasy or behavior, (DSM-IV, 2013 [APA, 2013]). This personality disorder is described as someone requiring admiration, and lack of empathy towards others. Narcissistic personality disorder is a mental condition in which someone has an inflated sense of themselves and their importance, they crave attention, and have extreme confidence and self-esteem but also take offense to criticism from others. To describe someone with narcissistic personality disorder we refer to the person as a narcissist or being narcissistic, (Barlow, 2018).

Someone with narcissistic personality disorder may have troubled relationships with others, for example at work or school, if the individual with narcissistic personality disorder doesn’t receive the attention they crave they will become unhappy, and will then begin to find their relationships unfulfilling which can cause others not to want to be around them. It is very easy for those with NPD to build relationships; they tend to come off as charming at first by understanding what people look for in the early stages of any relationship. Over time their charming ways are put to an end and they begin to speak down on others and look for admiration in themselves which then causes their relationships with others to end.

History

NPD is recognized as an important condition and involves a long term pattern of behaviors and thoughts and can cause complications through work, family, and friends. This mental illness has become recognized within the last 50 years, (Afek, 2019). The story evolves from the Greek mythology; the myth goes as a man named Narcissus who was a handsome man
of pride saw his reflection in the water for the first time, he became so fascinated that he would not stop staring at his reflection, and continued to stare at his reflection until his death. According to this personality, disorder self-admiration has been described to be known as narcissism. The topic of narcissism came into play in the early 1900s through psychoanalysis. Otto Rank an Austrian Psychoanalyst published the description of narcissism in 1911 and described it as self-admiration and vanity, (Afek, 2019).

Freud also came together with a collective set of ideas that connected to the causes of narcissism. He explained that a person’s libido which is also our survival instincts towards our self and others was directed only towards oneself if the person showed signs and symptoms of narcissism. This fixed amount of energy that Freud described as if the person libido was directed outward towards others then it would create satisfaction to one’s self, he believed that if a narcissistic person gave away love at first and then received the same love and affection from the world then it satisfied the individual, which also sounds like the sign of “charming”, when an individual with NPD is charming at first they manipulate someone else so they can get what they want from the other person. Freud also mentioned that as the child interacts with their environment they begin to develop an ego ideal or perfect image that the ego strives to attain leading to a sense of them self, (Afek, 2019).

In 1967 psychoanalyst Otto Kernberg and Heinz Kohut described these characteristics of this self-centered illness as narcissist personality structure and developed three major types: normal adult narcissism, normal infantile narcissism, and pathological narcissism which can be four types (Afek, 2019). In 1968 it was then changed to narcissistic personality disorder as Kohut came to the understanding of this illness. He took some ideas from Freud and expanded his
theory, he came to term that narcissism played an important role in his theory of self-psychology which suggest that narcissism was a normal part of someone’s development, but the difficulties arise when self-object relationships lead to the challenge of maintaining one's self-esteem which then leads to narcissistic disorders. After this theory presented by Kohut in 1980 NPD was recognized in the third edition of the DSM and was also considered to be a diagnosis, (Afek, 2019)

**Prevalence**

There are different traits of narcissist in adolescents, during these years adolescents are self-centered, this characteristic is a part of their healthy personal development, (Barlow, 2018). Throughout their adolescent years, the stages include, self-definition, and separation from one's parents and can involve narcissistic assertiveness, this can be confused with NPD. As the individual with NPD grows older they may suffer from physical, mental, and occupational restrictions. NPD can often be diagnosed with other mental disorders such as eating disorders and substance-related disorders. Individuals with NPD are more prone to show signs of abuse towards themselves and engage in reckless behavior. The comorbidity of NPD is associated with histrionic, borderline, and antisocial personality disorder and can often be misdiagnosed as bipolar disorder or generalized anxiety disorder, (DSM-IV, 2013).

**Etiology**

The causes of NPD are not exactly known. Researchers identified some factors that may contribute to personality disorder. They believe that narcissism begins during childhood and the relationship that the parent indulges in with their child. The parent may excessively praise their child or lack an authentically validating environment that may cause NPD (Barry, 2019). As
children grow they are naturally considered selfish and this is a normal part of a child developing. They present behaviors to get their needs met and can’t understand the needs and desires of others. This then carries into teenage years where they are still self-centered but are also searching for their independence. The older the child gets these self-centered behaviors should decline and they should be able to not only care for themselves but also others, and have healthy connected relationships. If the child is raised in a healthy household they will gain the ability to see other people’s viewpoints while also having empathy for others. If the child lacks empathy for others this is a warning sign that the person may have a personality disorder as an adult (Barry, 2019).

Parents should teach their child empathy if they consistently teach their child to be tough or dominant verse teaching them kindness and honesty this can cause narcissism. The parent should make their child aware that their selfish behavior is not okay, the parent should be building healthy self-esteem for their child. If the parent presents unhealthy parenting styles to their children such as neglect, or spoiling with privilege and promoting entitled attitudes this can cause narcissistic behavior. Cold parenting, over-controlling, or someone who shows perfection can cause their child to become self-indulged and lack empathy towards others (Barr, 2011).

**Symptomology**

If someone notices signs and symptoms of NPD early on in life such as children or adolescents they will be able to detect the illness. Some signs may be the child showing persistent bullying behaviors such as teasing someone; they will need to always win no matter what. The child will lie to benefit themselves such as lying on someone else to take the blame off of them and will blame others for bad outcomes and won’t take responsibility for themselves.
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(Barry, 2019). For adults the signs and symptoms of NPD can vary, the individual will have an inflated feeling of self-importance, and feel entitled to receive admiration from others.

The individual will present characteristics of grandiosity which is more than just arrogance but it is an unrealistic sense of being superior, where they feel they can only associate themselves with other people of power. Someone with NPD will try to present superiority over others even without achievement. They will preoccupy themselves with fantasies about their success and power. They need constant admiration from others and surround themselves with others who cater to their every need, and their relationships are one-sided. People with NPD will start as what is considered to be “charming” but they take advantage of the person they have a relationship with to get what they want. A narcissist lacks empathy for others, and has difficulty regulating emotions and behavior (Jana, 2019).

They will exploit others without any guilt, they do not have the tendency to put themselves in other people’s shoes, they can present malicious behavior to hurt someone purposely to make themselves feel better or they may be simply oblivious that their words are hurtful to others because of their lack of empathy and because they only understand their own needs and no one else’s. While they seem to present the qualities of self-centeredness and arrogance they are also not subject to change and can become stressed, they can become moody if they feel like they are not aiming at perfection and this personality disorder can also be a cover-up under much feelings of insecurity and shame. Their grandiosity and delusion thinking are considered a cover-up of their feelings of emptiness so they try to rationalize it away (Rhomann, 2019).
Someone with NPD can also feel easily threatened by others and challenge them and present a defense mechanism by putting other people down, they may attack someone else they feel threatened by, with insults, or threats to the person. People can overlook the signs and symptoms of NPD and think these symptoms can be described as arrogance or a mood disorder or someone being histrionic and looking for attention (Jana, 2019).

Health care providers can make the diagnosis of narcissistic personality disorder. They will do an examination and laboratory test to rule out any other medical condition that may bring out the symptoms described. The person who presents with signs and symptoms of NPD will be asked questions from a standardized self-test to help detect the illness. The health care provider may also get information from the individual’s family as part of the assessment and they will look into the history or the presence of other mental health symptoms that correlate with NPD such as histrionic or borderline (DSM-IV, 2013).

**Prognosis**

The outcome of well or how poor someone with NPD progresses over time depends on the severity of the disorder at the time that person is treated. Once the health care provider can determine the historical factors that might have led to this mental illness such as child abuse, they will then be treated. Along with history, the individual should also be checked to make sure they are not suffering from other disorders such as major depression. The individual who suffers from NPD should understand that their problems aren’t caused by others rather than their self-centered tendencies. Even though the severity does show in great detail of how well off a person with NPD will live, they must also understand this mental illness is typically lifelong. There is a
chance that the individual can show improvement if they are subjective to treatment. They should be willing to present corrective life events such as stable relationships with others and manage their disappointments. For someone with NPD to show improvement, they must be properly educated about their signs and symptoms of their disorder. Once they are educated this should help the individual with reading material so they can see what factors apply to them. Educating the family is also important because the family members can be affected by the illness as well. With the proper education family, members will be able to take a different approach to the individual with NPD (Jana, 2019).

While the progress depends on the severity of the illness, most times the prognosis of NPD is poor. The individual will have to submit themselves and be open and willing to learn about their illness, it may be difficult to educate someone about their illness if they feel they are superior and the one who is there to help them is beneath them. The symptoms may even become worse as time goes on and their signs and symptoms of grandiosity and contempt will increase. Those who present less severe symptoms are a greater chance of a healthier life outcome. The improvement depends on the amount of effort the individual puts into understanding their illness (Jana, 2019).

If there is no improvement in the person’s illness the person may have a higher risk of becoming depressed, or socially isolated, due to their problematic relationships with others. They may indulge in self-injury behaviors; engage in substance abuse such as alcoholism or drug use. Their behavior may cause problems in their personal life because they cannot get along with others. This illness can cause health issues as a relation to stress such as cardiovascular illness,
which can result in death. These issues related to NPD can also lead to suicidal thoughts or increased risk of suicide.

**Psychosocial and Psychopharmacological Treatment**

As mentioned in the prognosis section, the severity of the signs and symptoms of an individual determines the outcome of the progress they can make according to their illness. It can be very difficult to treat someone with NPD because they do not think they have a problem so they would be less likely to seek treatment. For the individual to seek the treatment they must take the first step in becoming aware of their behavior and recognize how their behavior is a problem in their life and their relationships with others. If the individual is open to being treated for their illness some forms of therapy can be helpful.

Psychotherapy or talking to a therapist can be useful; with this the patient can learn to develop a realistic self-image of them and learn to relate to other people. With psychodynamic therapy, the patient can learn to understand their behaviors and moods, and thoughts which can help them relate to other people. CBT Cognitive Behavior Therapy is also efficient in helping the patient identify their negative thoughts and replace them with more adaptive positive thoughts. Including the family in therapy is also important for individuals with NPD. Having a session for the family can help everyone deal with their relationship, problem solve and communicate effectively (Bogaard, 2014).

Practicing mindfulness is also an effective strategy for someone with NPD. Mindfulness helps help the individual access self-knowledge because there is an assumption that narcissist builds a self-centered image of them self as an underlying sense of low self-esteem. If the individual is successful in practicing mindfulness they can observe their behavior without the
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need to trigger self-inflating behaviors. The individual should be having less reason to judge themselves about who they are. Group therapy is also a great step in helping someone with NPD. Since these individuals do not have intimate relationships, because they view others who see past their image they try to present as a threat. If the individual is in social interaction such as group therapy they can develop a healthy sense of themselves within the group, they are forced to interact with people on an intimate level which can create the humanness of others and themselves in group therapy, (Brogaard, 2014).

As far as psychopharmacological treatment for NPD it has not been shown as effective. Because of the individuals, severe grandiosity and defensiveness due to their illness can cause problems and make engagement in psychotherapy difficult. If the individual presents themselves with other disorders that co-occur with NPD this may lead to an increase in dropping out of therapy treatment (Brogaard, 2014).

If the therapist is successful in getting the individual to attend therapy they should engage the client in talk therapy rather than medication. Medication is effective for other comorbid disorders such as depression or anxiety. With therapy the focus is on how the client with the illness interacts with their therapist and examine the client's change of their grandiose thinking, the goal is to teach the client how to regulate their own emotions and correct their self-centered behavior and teach them healthier ways of interacting with other people. Another source of therapy that might help is re-parenting which can be effective in the parent-child relationship. The parent will then learn to help the child emotional mature and behave like a mature adult. Narcissism can be prevented at earlier stages in life. The parent can learn to help their child with their self-esteem in a healthier way. The parent should have the child recognize that they don’t
always have to be put on a pedestal in life and that it’s okay to not always be on top. If the parent can recognize the early signs and symptoms of NPD they can help their child recognize their behavior and help them adapt to their environment as they grow older. Not only is it important for the parent to make changes in their child’s life when recognizing the signs and symptoms of NPD, but it is also important for the family and others to recognize an individual with NPD (Broggaard, 2014).

Being able to recognize an individual with NPD can avoid others from toxic harm and learning to deal with it. They should understand how to think critically about what the person says or does. Thinking critical is a helpful skill that can help others determining the truth from a lie or whether someone is trying to manipulate them or take advantage. It is important for those who are dealing with someone who has NPD to have life-skills that protect them from any form of this kind of abuse. It is very important that others can understand and educate themselves on the sign and symptoms of someone with NPD and to be able to protect themselves when they are dealing with NPD. These skills can be effective for the family members and can create a more efficient relationship between them and the person who is suffering from this mental illness.

BIOPSYCHOSOCIAL

As we know that NPD is the need for admiration, fantasy thoughts, and lacking empathy for others researchers estimate that 1% of the population had NPD as a lifelong illness (Twenge et al, 2014). NPD as a whole is not always pathological, many people present with the characteristics of narcissistic behaviors more or less frequently than the actual illness. The biopsychosocial model of NPD is a mixture of different factors that contribute to the individual’s daily living.
The biological aspect that researchers have found is that there is a part of the brain that associates itself with empathy which is called the left anterior insula that has less grey matter found in those who have NPD. This part of the brain is related to empathy, emotional regulation, compassion, and cognitive functioning. The grey matter that is in the insula is made of neuron cell bodies and non-neuron brain cells, these cells provide energy and nutrients. The neurons send and receive information in the individual's nervous system, and if the person has less grey matter this can determine to which degree they will empathize with others or not (Brogaard, 2014). The psychological aspect of the actual disease itself can be a problem, if the individual is practicing self-absorbed thinking, then they will be more likely to continue having these self-absorbed thoughts in the future. If the person with NPD cannot empathize with other's feelings and interests, then they are not even trying to make empathy apart from their normal habit. Socially researchers have found that parents or any guardian can be an early cause of NPD in children. Childhood experiences can have an impact on how they developmentally for example if the parent overindulges on their child, or praises their child excessively, or if the parent neglects their child this can cause the child to grow with self-esteem issues which the child later o replace with more self-absorbed behavior (Brogaard, 2014). Parenting style is not always the societal factor of NPD, but culture can also have an impact on someone developing NPD, for example in the United States, people are coached to strive to be the best or better than our peers. Many different factors can lead to this illness.

**Conclusion**

As we have looked into the mental illness of NPD there are steps that people can take to be aware that they are dealing with someone who is a narcissist and how to protect themselves
from being hurt or manipulated. We are aware that narcissists can be charming and create a perfect self-image to draw you in. People must be aware that it is a fantasy they are creating for you in the beginning and that their needs won’t be fulfilled, it’s important to understand that someone with NPD is looking for someone else to admire them, and recognize that the other person does not matter. When dealing with someone with NPD it is good to recognize how they treat others because there is a chance that they will not treat you any different, so do not make excuses for their behavior nor deny their behavior (Smith, 2018).

If you are dealing with someone who has NPD remember to always make a plan for yourself first and always put yourself first, do not fall into manipulation to attend to their needs. You cannot point out their behaviors because they become easily offended so it’s important to tread lightly and deliver how you are feeling about their behavior calmly affects you. it is important to understand that the relationship you have with a narcissist may change because they may feel threatened by you, and they may begin to distance themselves, so it’s best to expect and don’t take personally(Smith,2018).

While there are many cons about NPD there are also pros to this illness. Past the fact that those with NPD can attention seeker and not empathetic, they are usually more successful than the average person. They are more likely to succeed and do well in education, work, and intimate relationships. The benefits of having NPs are that you have a "mental toughness" that can give them the drive and confidence to succeed. Because they have the mindset that they are better than others and deserve nothing but the best they have more of an ability to strive for different challenges and see it as growth. People who have NPD are more likely to be considered good leaders because they have tough skin, they can also enjoy leadership opportunities because they
have they will be able to dominate others, and also allowed to provide their skills and task without the need for explanation. They are good for making rational decisions and show great authority over others. If someone with NPD is in a leadership position they are feared by others because they do what they need to do to get their job done, but they are also loved by others because they are great at entertaining others, which creates a love-hate relationship. Those who are narcissistic know what they want out of life and they are focused on getting what they want and doing what they love, they are great at using their dominance and arrogance to get to the top (Roberts, 2019).

Narcissism is a very rare but very extreme disorder there are both pros and cons to this illness. People who are dealing with someone who have NPD should be aware of the signs and symptoms they should be able to understand what might be the cause of this illness whether it is biological or societal. Not everyone with narcissism has grown up self-absorbed, but there may also be issues with self-esteem which can be used as a cover-up to make themselves feel better and put others down. Those with NPD should be aware of or their limitations and understand how their behavior can put a strain on their relationships.
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