Cold Therapy Seminar Level 1 Lecture Notes

Cold Therapy

Developed by Sam Vaknin, Cold Therapy is based on two premises: (1) That narcissistic disorders are actually forms of complex post-traumatic conditions; and (2) That narcissists are the outcomes of arrested development and attachment dysfunctions. Consequently, Cold Therapy borrows techniques from child psychology and from treatment modalities used to deal with PTSD.

Cold Therapy consists of the re-traumatization of the narcissistic client in a hostile, non-holding environment which resembles the ambience of the original trauma. The adult patient successfully tackles this second round of hurt and thus resolves early childhood conflicts and achieves closure rendering his now maladaptive narcissistic defenses redundant, unnecessary, and obsolete.

Cold Therapy makes use of proprietary techniques such as erasure (suppressing the client's speech and free expression and gaining clinical information and insights from his reactions to being so stifled). Other techniques include: grandiosity reframing, guided imagery, negative iteration, other-scoring, happiness map, mirroring, escalation, role play, assimilative confabulation, hypervigilant referencing, and re-parenting.

Pathological Narcissism

1. Four misconceptions about pathological narcissism:

    a. It is not only regression to an earlier childhood developmental phase

    b. It is not merely a psychological defense

    c. It is not simply an organizing principle or a schema

    d. It is not a personality disorder

It is a post-traumatic condition, amenable to trauma therapies

Concepts: cold empathy, CPTSD, GAD, mood/affect disorders, alexythimia/hypochondriasis.

It is not an adult disorder but an attachment dysfunction coupled with arrested development.

Amenable to techniques borrowed from child psychology.

It is also not a disorder of the self, but an interpersonal disorder.

Concepts: critical period, safe base, internal working model (IWM), mentalization/intersubjectivity, attachment styles, basic trust (Erikson), dead mother complex/syndrome, emotional dysregulation/lability, impulse control, betrayal/trauma bonding, externalized disorder (AsPD/NPD), trauma model of mental disorders (Colin Ross), dissociation, depersonalization, derealisation, developmental trauma disorder, Bartholomew and Horowitz attachment model, external locus of control, alloplastic defenses, cognitive distortions and deficits (example: grandiosity, Dunning-Kruger effect).

“When alarmed, child seeks proximity to caregiver (safe base). But proximity to frightening caregiver increases alarm” (Hazen and McFarland, 2010). Child attaches to imaginary caregiver (False Self = god and narcissism = private religion).

Re-traumatization

Foa and Kozak, 1985

(a) Resolves early conflicts;

(b) Achieves closure;

(c) Counters avoidance, helplessness, and depression

Via

Controlled/tiered:

(A) Triggering (trauma simulation, stressing)

(B) A hostile, non-holding environment

Generating a facsimile of the environment of the Primary or Originating Trauma

The adult patient emerges alive (survives the re-traumatization) and successfully copes with it

The patient’s maladaptive narcissism (cognitions, beliefs, emotions) is rendered redundant, unnecessary, and obsolete

Concepts: Unthought known (Bollas), True and False Self (Winnicott), Apprehensive vs. Comprehensive Knowing (systems therapy)

The False Self is godlike (private religion), an inverted and compensatory self-image, a signal (it elicits supply), a decoy. It re-interprets the narcissist's behaviors and actions in a socially-acceptable light, emulates (Combines cold empathy with emotional resonance tables).

The Goals of Cold Therapy

Process trauma via skilled reliving

Foster more adaptive functioning

Replace negative with positive coping

Integrate distressing materials (thoughts, feelings, memories)

Lead to internal resolution and homeostasis

Aid the growth of skills: resilience, ego regulation, empathy

The Narcissist in Therapy

Introduction to Narcissistic Personality Disorder (NPD) in the DSM-IV-TR and DSM-V, including the Alternate Model.

Typology of narcissists: Overt/classic/grandiose, covert/shy/fragile/vulnerable, inverted, somatic, cerebral, acquired situational, high-functioning/exhibitionist, malignant.

Comorbidity (with other personality, eating, mood disorders and autism).

Treatment modalities: CBT/CEBT/REBT, DBT, Schema, Dynamic, psychoanalysis, Gestalt, Group

Presenting signs and symptoms

Clinical interview (anamnesis), diagnosis, prognosis

Psychological tests and their interpretation: NPI, MMPI-2, PCL-R, others

The patient's narcissistic defenses and resistances

Working without a therapeutic alliance or contract

Realistic therapy goals: behavior modification, reconciling lifestyle and choices with pathological/secondary narcissism, setting an extended timeframe, measurement of outcomes

The Therapist

Idealization-devaluation cycles

Transference and countertransference

Vicarious traumatisation

Own narcissistic defenses

Resentment, alienation, burnout, emotional exhaustion, trauma

Cooptation and collusion

Victimization

Concepts: Shared psychosis/shared psychotic disorder (folies a deux), paranoia as narcissism, cult settings

Problems in Cold Therapy

Leveraging the False Self's grandiosity

Overcoming psychological defense mechanisms (like splitting) and magical thinking

Tackling cognitive deficits and distortions, thinking errors, fallacies, and failed reality test (e.g., Dunning-Kruger grandiosity)

Victim stance and internal working model

Grandiose, paranoid, and schizoid automatic thoughts

Contracting and alliancing

Managing and containing transference

Role of medication and placebos

Confrontation in hostile environment fosters persecutory delusions

Narcissistic Rage and Shame

Distinguishing primary/originating traumas from secondary one and CPTSD (using the Erasure and Hypervigilant Referencing techniques)

Comfort zone: Hostile, non-holding, unsafe environment leads to repetition compulsion, not to decompensation

Cold Therapy Techniques

Only Level 1 techniques are listed but not in order of use!

Erasure

Foa and Kozak (1985): fear memory combined with absent info

Metaphors: Cut cake provides more information that whole cake, reading between the lines in authoritarian regimes

Keywords selection guidelines

Keywords selection process (filtering for originating or primary trauma)

Speech suppression techniques: active (hushing) and passive (irrelevancing)

Speech recovery and interpretation of silences: gaps patterns, distribution, contextual gaps

Deconstructive/reconstructive narratives

Foa, E. B. And Kozak, M. L. (1985) Treatment of Anxiety Disorders: Implications for Psychopathology (In: A. H. Tuma and J. D. Master (eds.) Anxiety and Anxiety Disorders. Hillsdale, NY: Lawrence Erlbaum Associates)

Hypervigilant Referencing

Trauma and Abuse as narcissistic injury lead to hypervigilance: obsessive-compulsive behaviors and rituals, irritability and rage, sensory sensitivity, anxiety, arousal, exhaustion, scanning for threats and insults.

Referential ideation

Learn from the content of the delusional thinking about the locus of the primary/originating trauma.

Deconstruct the disparity between emotional and reality states

Grandiosity Reframing

Grandiosity as a cognitive distortion (Dunning-Kruger effect)

Grandiosity justified only inasmuch as it is an adaptation or a survival strategy.

Grandiosity provides capabilities to overcome traumas (it is a skill)

Grandiosity results in winning over the abuser

Leveraging grandiosity to get rid of it by telling the patient, for example: “When you are grandiose you are not acting optimally or efficiently, you are not a perfect machine.”

Similar to strengthening the host in the treatment of DID (Dissociative Identity Disorder)

Guided Imagery (Imaginal technique)

Controlled catastrophizing (imagine the worst)

Controlled malignant optimism (imagine the fantastic)

Middling: locate the middle ground and render the adult the winner (by meeting the reality test)

Controlled depersonalization (deconstructing the False Self)

Controlled derealisation (life as a movie)

Validating reality: acknowledging transference and using the client’s own language (echoing) while acknowledging his state of mind

Based on: **Exposure and Response Therapy**

Concepts: The uncanny, uncanny valley

Negative Iteration

Reframe situations and events as traumas

Design: coping strategies, winning strategies, defenses

Observe, hold (freeze), Rate distress (hot spotting), maintain (equilibrium), deconstruct, reframe (cognitive restructuring), dispose

Based on: **Cognitive Processing Therapy**

Engender: personal safety, trust, power/control, esteem, intimacy by reconsidering or reframing negative thoughts about self, others, and the world/environment

Assertiveness, communication, and social support

Repetition compulsion brought to awareness, mastered, obtains different outcomes, leads to resolution and reconciliation.

Example: Approach-avoidance Repetition Complex (Or Compulsion)

Happiness Map

Happiness Space

Happiness Mapping: common denominator accomplished by reduction (drilling down)

Counterintuitive Reactivity and Denial

Intuitive Reactivity

Mirroring

Client requested to play the Devil’s Advocate via a dialectic: thesis (abuse, trauma), antithesis (not abuse, not trauma), synthesis (trauma is not an objective, “scientific” fact or event, but a subjective exegesis and reactive).

Escalation

Scenario construction: what could have been worse, what could have gone wrong

Reality check/testing leads to gaining perspective and placing in proportion

Based on: **Cognitive Processing Therapy**

Role Play

Be an abuser (overt and covert techniques)

Be an abuser: identifying vulnerabilities

Patient as a therapist, parent, child, and adult

NPD as DID: the False Self on the chair. Moderator role shuttles between therapist and patient.

Based on: **Internal Family systems (IFS)**

Other-scoring

Part I

1. Self-evaluated thoughts

2. Thoughts about evaluation of others

3. Evaluative thoughts about others

What...

Do I think that s/he thinks about me?

Does s/he think that I think about him/her?

Do I think about him/her?

Does s/he think that I think that s/he thinks about me?

Do I think that s/he thinks about himself/herself?

Does s/he think that I think that s/he thinks about himself/herself?

Part II

4. Thoughts about coping strategies and behavioral plans

5. Thoughts of avoidance

In times of stress and crisis, what ...

Do I think that s/he thinks I do best/I shirk or avoid/I fail in?

Does s/he think that I think s/he does best/shirks or avoids/fails in?

Do I think s/he does best/shirks or avoids/fails in?

Does s/he think that I think that s/he thinks I do best/I shirk or avoid/I fail in?

Do I think that s/he thinks that s/he does best/shirks or avoids/fails in?

Does s/he think that I think that s/he thinks that s/he does best/shirks or avoids/fails in?

Assimilative Confabulation

Identify: repressive gaps and dissociative gaps

Construct confabulations to bridge the gaps

Rank the plausibility of such confabulations

Demand the patient’s ownership (assimilation) Patient reacts with dystony or syntony

Dystony: Eg-discrepancy, discontinuity (disjointedness)

Syntony: Congruence, narrative coherence

Assemble core healthy, narratives about functioning and happiness

Share therapy notes with the patient

Reparenting

Transference and shared psychosis fostered and encouraged

Shift the parental locus of trauma to the therapist

Therapist owns the bad object

Splitting encouraged and leveraged and patient now owns the good object

Projective identification and introjective identification

Therapist picks up and contains via projective identification what patient cannot think about (unthought known)

Emotional Reregulation

From externalizing to internalizing

From grievance to task orientation

From counterdependence (contumacious defiance) to codependence

From social withdrawal to social functioning

Techniques from child psychology:

Emotional intensity control

Behavioral control (termination)

Interpretational of emotional cues (including own cues)

Interpretation of social cues

Avoidance and regression balancing

Focusing on the positive

Attention and focus control

Impulse control

Modelling (not demanding) desired behavior

Freedom vs. constraint and self-regulation

No over-stimulation

No excessive frustration

Identifying and countering discriminating thoughts and emotions

From internal construction to external representation