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Paranoid Personality Disorder

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Paranoid personality disorder is an enduring pattern of maladaptive behavior, thinking, and personality traits exhibited in a wide range of social and personal situations. Patients with this disorder are not psychotic, but some evidence suggests a weak genetic link to schizophrenic spectrum disorders (Heston 1970; W. Reich 1976). The characteristic personality traits may be already established by adolescence and may have been present in some modified or precursory form even in childhood.

General Considerations

Common Difficulties

Paranoid personality disorder is well established in the catalogue of personality disorders, but even so, the clinical literature on its specific treatment is rather sparse, as is the research. Most discussions of treatment deal more or less exclusively with psychotic forms of paranoid pathology; personality disorder is rarely seen clinically. The rigidity of paranoid defenses does not augur well for effective treatment, so that diagnosis should include an assessment of the patient's motivation and receptivity for psychotherapy as well as the capacity to tolerate the therapeutic process.

Individual Psychotherapy

From the perspective of the paranoid process (Meissner 1978, 1986), the symptoms of the patient with paranoid personality disorder can be seen as expressing attitudes and feelings that derive from the patient's pathological sense of self. Consequently, the emphasis in therapy falls on the inner attitudes and feelings toward the self rather than on the projective system. This internal focus serves as the basis for certain principles that can serve to set priorities and provide sense of direction for the therapeutic work.

The following recommendations pertain primarily to patients who are seeking therapy, and secondly, in whom the paranoid defenses have weakened to an extent that

would allow therapeutic intervention. Patients who seek treatment are usually suffering from some degree of anxiety or depression resulting from the failure of paranoid defenses; such patients are deserving of therapeutic effort, and some will respond, whereas others will reclaim their paranoid stance. To the extent that coming to therapy is motivated by the distress caused by their symptoms and little else, prospects for effective therapy are dim. Patients seeking change in themselves and their pathological feelings have better prospects.

Therapeutic Alliance

The first principle in treatable cases of personality disorders concerns establishing and maintaining a meaningful therapeutic alliance. The basic therapeutic issues center on questions of trust and autonomy. The alliance is stabilized to the degree that the patient can develop a meaningful trust in the therapist and to the extent that the patient is also increasingly able to build and sustain a sense of autonomy within the therapeutic relationship. Important contributions on the therapist's part include empathic responsiveness to the idiosyncratic needs (largely narcissistic), anxieties, and inner tensions felt by the patient, so that the therapist responds to the patient in terms of the latter's own individuality rather than in terms of the therapist's needs or in terms of some preexisting therapeutic or theoretical stereotype.

Conversion of Paranoia to Depression

A second principle is that the direction of the therapy is toward converting the paranoid stance into depression. As the therapy progresses, projective and externalizing defenses are gradually eroded, so that the patient comes more directly and immediately in touch with the form and content of feelings of vulnerability, weakness, inferiority, and inadequacy connected with a defective sense of self. These feelings will find expression, because they are so much a part of the patient's sense of self, but useful therapeutic work with them is facilitated by the therapist's consistent empathy and tolerance for, and nonjudgmental acceptance of, these feelings as part of the patient's self-experience. The therapeutic focus remains on accepting the validity of these feelings and understanding their meaning. The patient begins to experience more immediately those hidden elements of himself or herself against which the paranoid system has served as an elaborate defense.

If the patient becomes depressed, he or she must come to terms with, understand, work through, and resolve the depressive elements contained in his or her pathological sense of self as victim. The therapeutic effort is directed toward focusing, understanding, and resolving the elements of weakness, vulnerability, and impotence embedded in the sense of victimhood, along with the feelings of worthlessness, inferiority, and shamefulness that reflect the underlying narcissistically inferior aspect of the patient's sense of self. The sense of vulnerability, victimization, and fear of injury may have developmental links to early experiences in which the roles of victimizer and victim were directly enacted, or in which these unconscious schemata were experienced and internalized from interactions with parental figures (Meissner 1978).

Issues of Autonomy

A third principle in the treatment of paranoid patients involves respect for the patient's autonomy and efforts to build and reinforce it in the therapeutic relationship. The patient

sense of autonomy is fragile and threatened, so that issues related to establishing and maintaining it permeate all aspects of the therapy. This fragile autonomy is associated with fantasies of magical connection and even merger with the projective object, so that weakening of boundaries in projection may not be an unfortunate side effect, but the intent of the projective process. The paranoid cognitive style (D. Shapiro 1965) of environmental scanning may serve as more than an early warning system of attack; it may also reflect the need for connectedness and the intolerance of indifference from the object (Auchincloss and Weiss 1992). The therapist directs his or her effort to fostering and maintaining the patient's autonomy at all points possible within the therapeutic work. Complete openness, honesty, and confidentiality are essential in all dealings with the patient. Any decisions that need to be made must be explored with the patient, and insofar as possible, the ultimate choice should be left in the patient's hands—even decisions about taking drugs, if their use seems indicated.

Therapeutic Techniques

Working with patients who have projective defenses calls for special techniques. Confrontation, challenge, or even reality testing of projective defenses can create a situation of opposition and run the risk of turning the therapist into an enemy or persecutor. More progress can be made through empathically eliciting the details of the patient's projective system, bringing into focus the patient's feelings, particularly those of doubt, insecurity, vulnerability, weakness, inadequacy, or inferiority, that lie behind the paranoid facade. An additional technique is so-called counterprojection: this involves acknowledging and accepting the patient's feelings and perceptions, without disputing or reinforcing them. Temporarily accepting the patient's perceptions avoids confrontation and allows access to real underlying feelings.

Countertransference Issues

Countertransference, reflecting the therapist's unconsciously derived and motivated reactions to the patient, is an area of special concern in therapy with paranoid patients. These patients can often be difficult, resistant, provocative, and contentious.

The therapist may find himself or herself reacting with annoyance or impatience. In the face of the patient's insistent argumentativeness, the therapist may come to play the aggressor to the patient's victim, becoming more forceful, argumentative, or confrontational. In other instances, the therapist may become frustrated and discouraged, feeling inadequate, helpless, and worthless, thus playing out the role of victim to the patient's aggressor.

Litigiousness

An additional matter of concern is the threat of legal action by litigious patients. Given the hostile, defended, suspicious, and overly sensitive disposition of paranoid patients, legal threats against the therapist are not uncommon. A litigious stance can generally be avoided by careful attention to the therapeutic alliance and the arrangements for dealing with matters of privacy and confidentiality. If threats of legal action arise, they reflect a disruption of the alliance and should be worked with accordingly. If restitution of the alliance fails and the patient moves toward legal action, the therapy should probably be terminated. Appropriate arrangements should be made for referral of the

patient to other treatment resources, if indicated, and the therapist should take steps to protect his or her own legal interest. This is a course of last resort, implemented only when efforts to deal therapeutically with the patient's threatening attitude have failed. Psychotherapy cannot be conducted under conditions of threat.

Other Psychotherapies

The primary and preferred approach to the treatment of the paranoid personality is long-term, relatively intensive (two or more sessions weekly) individual psychotherapy. If this level of intensity proves too threatening, the scheduling can be modified to meet the patient's needs. The patient's pathology is embedded in his or her character structure and yields to therapeutic influence only gradually over an extended period of time. In specific cases, however, adjunctive therapeutic interventions may prove useful and productive.

Short-Term Psychotherapy

Some therapists have undertaken short-term psychotherapy with paranoid patients. For many paranoid patients this may be the preferred modality, because they may not be able to tolerate much more. A rapid relief of symptoms and a return to their prior defensive status are preferred to longer-term and difficult treatment.

Family Therapy

In the long-term treatment of a patient with paranoid personality, occasion may arise for combining individual psychotherapy with other therapeutic modalities, such as family therapy. Family therapy may be indicated particularly for adolescent patients whose family dynamics and patterns of interaction may be interfering with or contributing to the patient's difficulties. Such approaches, however, should remain secondary to the primary psychotherapeutic approach. Because of the paranoid patient's hypersensitivity and vulnerability, there is always a risk that family work can undermine individual therapy.

Group Therapy

Group therapy may also be considered as an adjunctive modality in selected cases. The resources of a group situation may enable a relatively healthy paranoid patient to sort out and resolve difficulties in socialization, thereby facilitating the course of therapeutic improvement. Paranoid patients generally do not do well in group settings of any kind, because of their hypersensitivity, suspiciousness, and tendency to misinterpret comments or contributions from other group members.

Behavior Therapy

Behavioral therapies have little demonstrable role in the treatment of paranoid personality, although at times secondary symptoms (e.g., phobic anxiety) may be modified by behavioral techniques. Usually the patient's suspiciousness, guardedness, distrust, and easily threatened autonomy contraindicate a behavioral approach.

Pharmacotherapy

Slight improvement has been noted in some cases with low-dose neuroleptics, but for all practical purposes the role of drugs with such patients is more or less limited to modifying specific target symptoms that may occur because of the failure of characterological defenses. Thus, at certain times in the course of treatment, limited use of minor tranquilizers for the treatment of anxiety, or of tricyclic or antiserotonergic antidepressants or monoamine oxidase inhibitors for the treatment of phobic anxieties or depression, might be indicated.

One difficulty in the management of paranoid patients is that they are often extremely resistant to taking medications of any kind, often seeing them in terms of issues of control, powerlessness, and loss of autonomy. In the face of such resistance, the clinician must often make a difficult decision as to whether the potential advantages of the pharmacotherapy outweigh the consequences of insisting on the medication and possibly harming the therapeutic relationship and process.

Conclusions

Some paranoid personalities are treatable. Often, such patients lead reasonably adaptive and productive lives but encounter difficulties in circumstances of loss or under specific forms of life stress. Their treatment, however, is not easy and requires patience, empathy, and great sensitivity to the vulnerability and hypersensitivity that are inexorably part of the pathology. The therapist must be willing to work slowly toward minimal, long-term goals, foregoing any illusion of quick or easy resolution of the patient's difficulties and aiming for a more enduring and fundamental change in the patient's personality structure.

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Schizoid and Schizotypal Personality Disorders

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Schizoid and schizotypal personality disorders have enjoyed separate status in DSM-III and DSM-IV (American Psychiatric Association 1980, 1994) as distinct categories, their chief attributes being "aloofness" (in schizoid) and "eccentricity" (in schizotypal). Before DSM-III, as Gabbard (1994a) mentions, the concepts embodied in these two categories were conflated in the notions of "schizoid" abnormalities that were understood as attenuated manifestations of schizophrenia.

Another important issue concerns the schizoid person's shyness. Some have argued for a fundamental difference between the schizoid and the avoidant patient, in that the former has little or no interest in getting close to others, whereas the avoidant person longs for closeness but is too afraid of social encounters. Others, including Gabbard (1994a) and Akhtar (1987), see schizoid persons as yearning secretly for closeness but adopting a facade of aloofness or indifference out of an even more extreme fear of closeness. In this view, schizoid adaptation is the more severe abnormality, of which avoidant adaptation is the milder variant. The truth may lie in the middle of these positions: schizoid persons who accept "patienthood" and seek help spontaneously are probably those whose desire for closeness lies nearer the surface and who are more readily disposed to form a good therapeutic alliance. Those who come to treatment begrudgingly and only under pressure from family may be less accessible. Schizoid patients, for example, who are truly comfortable with hermit-like solitariness experience little or no discomfort at being alone and thus do not seek treatment.

Outcome

What can be reasonably expected of therapeutic efforts depends greatly upon the complexion of the personality as a whole. Most commonly, therapists will encounter schizotypal patients with some schizoid and paranoid features. If the paranoid features are not prominent, the therapist's task will be easier and the outlook better. Improvement is apt to be more rapid and impressive in the occupational sphere than in the area of social, let alone intimate, relationships.

Although brief psychotherapy can be effective in resolving specific problems, there is no "quick fix" of any thoroughgoing kind for any personality disorder. This is doubly

true within the eccentric cluster. Many schizotypal patients habitually misinterpret the social field, misreading other people's intentions and then behaving in an unrealistic manner. They may, in the process, alienate co-workers and potential friends. To help remedy this situation, therapists will often find themselves functioning as an "auxiliary ego," enlightening the schizotypal patient about what might be more probable interpretations concerning the various interpersonal events in the patient's current life. With help of this sort, the schizotypal patient may be kept sufficiently "on the track" whether at work or in social settings, so as to fit in better with other people and be more readily accepted by them.

Treatment

For didactic purposes, it is easier to address the issue of treatment in the realm of personality disorders as though patients manifested "prototypic" or textbook instances of the disorder whose DSM criteria they (predominantly) meet. In actual practice, schizoid and schizotypal are better seen, when present, as central tendencies whose ultimate clinical coloration and response to therapy are both modified by the existence of various coexisting traits that would arbitrarily be assigned to different DSM categories.

The balance in any given schizoid patient between "inherent deficit" (a shyness rooted in innate temperament) versus "conflict" ("I want to be close to others, but I fear they will hurt me") informs the major thrust of therapy. The greater the extent to which intrapsychic conflict dominates the scene, the more the clinical picture will resemble that of the *avoidant* personality, and the more appropriate will be a "dynamic" (psychoanalytically oriented or "expressive") approach. The more deficit factors appear to be operative (impoverishment of thought, lack of experience in the realms of social intercourse or intimacy, impediments in the ability to "read" other people's feelings and intentions—i.e., poor empathy), the greater use therapists will find in supportive, particularly educative, interventions.

A number of treatment modalities may be applicable to schizoid and schizotypal patients, depending on their individual characteristics. These include dynamic, supportive, and behavioral-cognitive therapies in individual, as well as group, family, and pharmacotherapies. These modalities may be used singly or in combination, in accordance with the nature and special needs of each prospective patient.

Individual Psychotherapy

Dynamic Psychotherapy

Because schizoid patients are generally uncomfortable with emotional closeness, dynamic therapy is best carried out on a once- or twice-weekly schedule, rather than on the more frequent basis that is customary in classical psychoanalysis. This stricture might not apply to archetypical schizotypal patients, although, as noted above, admixture with paranoid traits is very common in this group.

The overarching goal of helping the patient achieve stability in a close personal relationship (Abel 1960) will more often be feasible with schizotypal than with schizoid patients. For many schizoid patients, the more reasonable goal is to help make their solitary life more endurable and rewarding.

Several analysts have reported good outcomes using dynamic therapy with schizoid patients (Grinberg and Rodriguez-Perez 1982; Kernberg 1982). The focus in these studies

was on the patients' compensatory, omnipotent fantasies (as defenses against futility and feelings of ineffectiveness or low self-esteem [Nachmani 1984]) and on their use of splitting and projective identification.

Dynamic psychotherapy is indicated, and best limited, to those schizoid and schizotypal patients who, in relation to their shyness, show themselves to be predominantly "avoidant" (Gabbard 1994a), rather than innately indifferent to the possibility of human contact. Other prerequisites include high motivation for therapy and a good degree of psychological mindedness (i.e., an openness to self-awareness and to working with symbolism, dream material, double entendres, and the like).

Supportive Psychotherapy

Supportive interventions will be useful in work with most schizoid and schizotypal patients; for many, these interventions will constitute the mainstay of treatment. Supportive therapy relies on measures such as sympathetic listening, education about the world, giving advice, problem solving, exhortation, and also the quiet establishment of relatedness enhanced by the regularity of visits and nonjudgmental acceptance of the therapist. Problem-solving techniques may include role-playing, in which the therapist might, for example, simulate an interviewer screening an applicant for a job. Some therapists go a step further and accompany a schizotypal patient who is out of touch with societal conventions to a clothing store, helping the patient select the apparel most appropriate to an upcoming interview

Psychotherapy, of whatever sort, with schizoid to schizotypal patients should usually proceed at a slow pace. With most schizoid and schizotypal patients, an effective path to pursue is one in which the therapist, while remaining active and involved, avoids becoming overly ambitious or impatient. Expectations need to be tailored so as to be in harmony with the patient's capabilities, which may fall well short of some hypothetical "ideal life."

One must respect the emotional distance customarily required by patients with these disorders. Many embarrassing topics may have to remain under wraps for a long time or even permanently, especially where grotesque sexual or aggressive fantasies or memories dominate the patient's inner life. An overeager therapist may succeed only in frightening or altogether alienating patients of this sort, who may be exquisitely sensitive and prone to feelings of shame if such fantasies were forced out into the open prematurely.

Cognitive-Behavior Therapy

Beck and Freeman (1990) have recently offered an overview of the cognitive-behavioral approach to the whole roster of disorders in DSM Axis II, including schizoid and schizotypal personality disorders. Their orientation emphasizes, first, the isolation of the important set of basic assumptions maintained by persons with these character types, and then the palette of clinical strategies and techniques that therapists can bring to bear in ameliorating these (uncomfortable and self-defeating) assumptions. The ultimate goal is, via substitution of these old assumptions with more life-positive ones, to enable the patient, by becoming more at ease and socially better adapted, to lead a more fulfilling life.

Among the negative attitudes and assumptions characteristic of the schizoid person are the following (Beck and Freeman 1990):

- "Life is less complicated without other people."
- "I'm a social misfit."
- "It is better for me to keep my distance and keep a low profile."

Those characteristic of the schizotypal person include the following (Beck and Freeman 1990):

- "I feel like an alien in a frightening environment."
- "Things don't happen by chance."
- "Relationships are threatening."

In working with the schizoid patient, the therapist will, at a suitable point, encourage the patient to develop a social network within which other persons can be found who will be reassuring and supportive. Even the discovery of one such person helps to overturn the assumption that people do not care about the patient. Beck and Freeman (1990) recommend the use of the dysfunctional thought record, in which, as a homework device, the patient is asked to list major assumptions and typical negative thoughts. These then become grist for the mill in subsequent sessions.

Small talk is often inordinately difficult for schizoid or schizotypal patients, who find it next to impossible to banter with co-workers or exchange pleasantries with store attendants. This contributes to the impression of oddness that they create. Improvements may come about in this realm through the therapist's efforts to make the patient less anxious in social situations (via exploration of the negative assumptions) and to educate the patient about the kinds of comments people ordinarily make and expect in these casual encounters.

Schizoid and schizotypal patients both have a tendency to concretize negative feelings about their psychological self and their personalities via assumptions about their bodies. Symbolization is used and may become deeply entrenched in the manner of a somatic delusion. Dynamic therapy with such patients can also be made to include cognitive interventions of this sort. Certain interventions with schizoid and schizotypal patients cannot, in other words, be considered the exclusive preserve of one or another competing school of thought.

Group Therapy

Group therapy may play an invaluable role in the overall treatment approach for many schizoid and schizotypal patients. Their characteristic fearfulness and mistrust of others make most schizoid and schizotypal patients reluctant to participate in group therapy. Some preparatory work by the therapist in one-to-one sessions is often necessary. During this period, the therapist will have the opportunity to hear out and to allay the particular anxieties voiced by the patient.

Depending on the needs and psychological mindedness of the patient, either a chiefly supportive or a dynamic orientation may be preferable. The group can serve as an excellent crucible for the melting down of negative assumptions ("people won't like me," "nobody has as shameful fantasies and impulses as I do") and for the formation of more realistic ones.

Guidelines for group therapy of schizoid and schizotypal patients are to be found in the papers of Roth (1982) or Mosher and Gunderson (1979); Appel (1974) and Azima (1983) concentrate on dynamic group therapy for schizoid patients. It will be true in some instances, as Gabbard (1994a) and Leszcz (1989a) point out, that schizotypal patients with extreme eccentricities may push the other group members beyond their flexibility, leading to dropping out or to expulsion by the rest of the group. This is more likely if very bizarre (and possibly repugnant) behavior is involved, rather than merely bizarre thoughts, because the other group members tend to be less tolerant and forgiving of certain behaviors.

Family Therapy

Young schizoid and schizotypal patients are often caught in tense family situations similar to those arising in the families of certain schizophrenic patients. The parents may maintain unrealistically high expectations—in some instances because of a child's precocious intelligence, and in others because of a child's seeming normality in early life—without taking sufficiently into consideration the handicap imposed by the chronic emotional disorder as it becomes manifest in adolescence. Therapy with the family as a whole, or with just the parents alone, may help educate the parents about their child's lower ceiling of potential. This in turn may reduce the family's impatience and intolerance (Anderson 1983).

Pharmacotherapy

The closer the clinical picture resembles "pure" schizoid personality, the less the likelihood there will be any target symptoms responsive to medication. Schizotypal patients, in contrast, may present with considerable levels of anxiety and may benefit from small doses of anxiolytics (Serban and Siegel 1984). Schizotypal patients with illusions, ideas of reference, and proneness to psychotic ideation have been noted to respond favorably to neuroleptics such as thiothixene (Goldberg et al. 1986), usually in lower doses than required in ambulatory schizophrenic patients. In a study by Hymowitz et al. (1986), half of schizotypal outpatients responded to low-dose haloperidol (2–12 mg per day), especially on measures of ideas of reference and odd communication. Patients with marked paranoid traits may react negatively to sedation, however, because of the lowering of their alertness to imagined dangers (Stone 1985). Better-functioning schizotypal patients who display some oddities of speech but who are not prone to brief psychotic episodes may not require medication at any phase of their treatment.