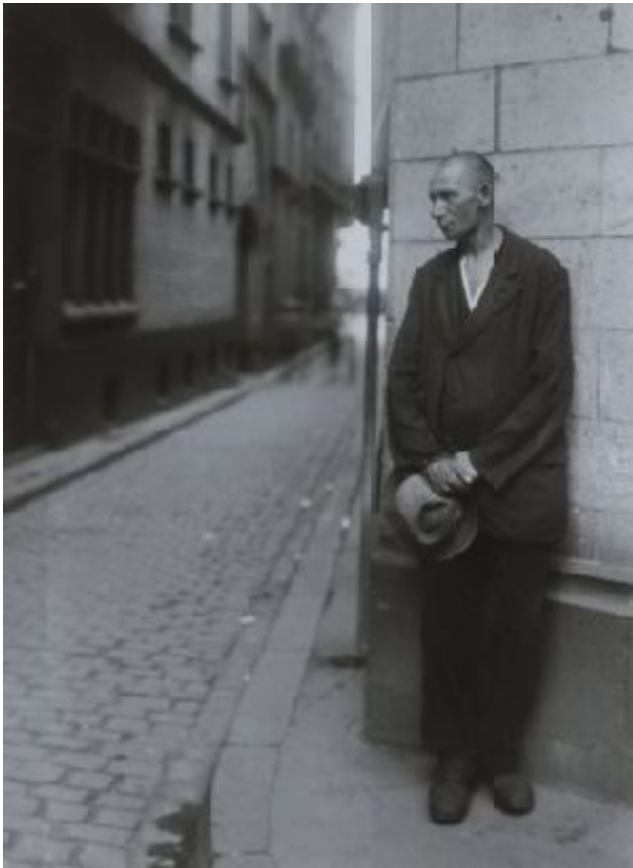


”I am not complaining”

**- AMBIVALENCE CONSTRUCT IN SCHIZOID
PERSONALITY DISORDER**

SCHIZOID PD (SPD)



- › Background
- › Case
- › Central dynamics and focus points
- › Discussion

SETTING

- › Outpatient psychiatric treatment offer to DD patients in Odsherred, DK
- › Open Dialogue (OD), family and network approach in treating psychosis, schizophrenia, other severe psychiatric crisis (Seikkula & Trimble, 2005)
- › Supports change by means of reflective interaction and dialogue among patients, family and significant others, case-specific treatment team (2-4 from social, district, and general psychiatry)
- › Operates within a social-constructionist framework and integrates various psychotherapeutic traditions and elements

OWN EXPERIENCE

- › Some patients tend to be "forgotten"
- › Awkward, friendly, compliant, unproblematic
- › Seldom come up in regular supervision
- › Little or no progress is noted
- › Loss of interest
- › Attention directed to more "loud" or engaged patients

AT WORKSHOPS

- › Patients unable to communicate difficult feelings and inner worlds
- › ...but may experience more benefit from treatment than they are able to communicate
- › Most staff members recognize one of their patients
- › ...and their own loss of interest or distance
- › Patient was friendly, maybe strange, probably lonely
- › ...but because few complaints or ruptures, there was lack of involvement

IN STUDIES

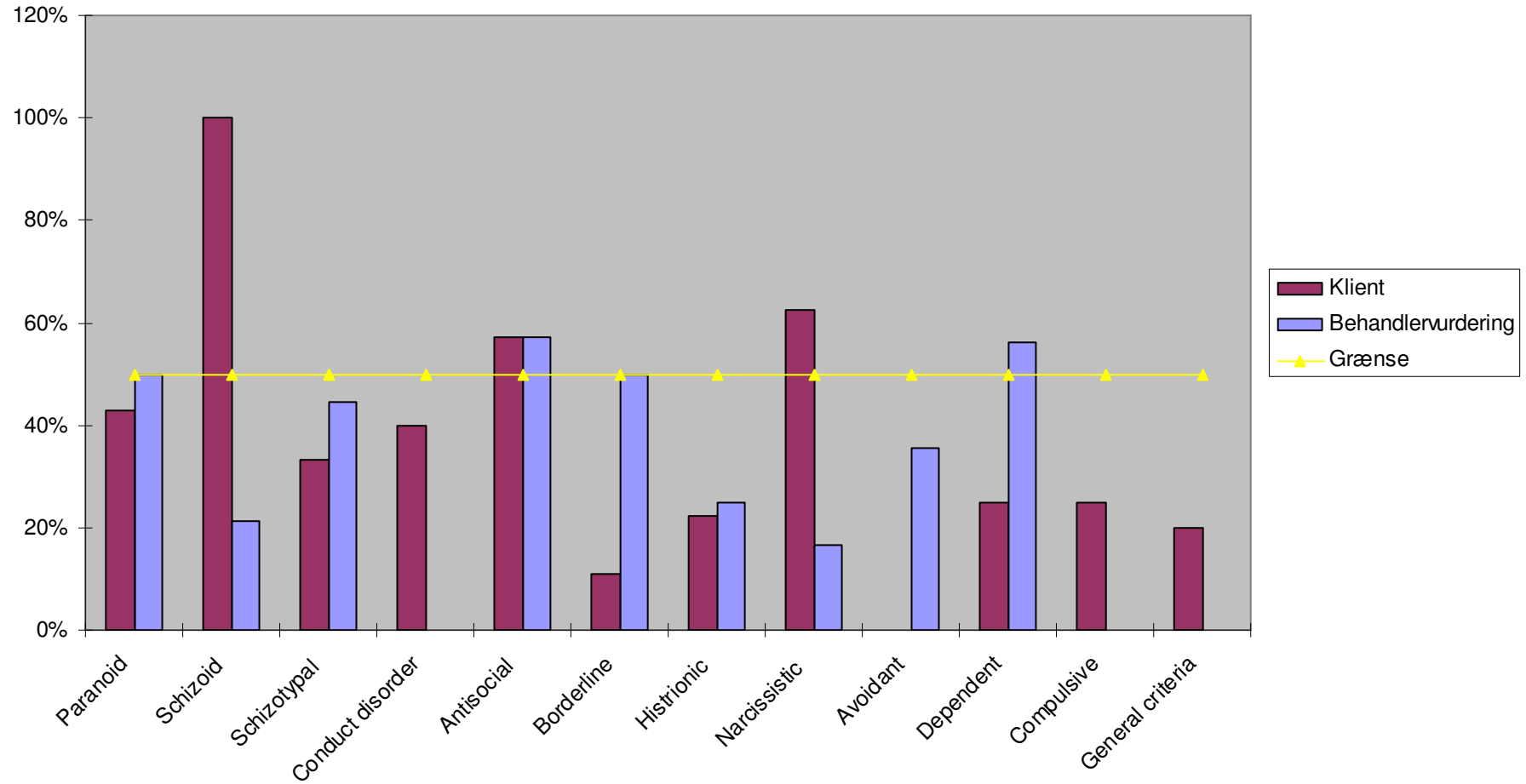
- › Studies of personality disorder features and clinicians' emotional reactions to patients have generally found that odd-eccentric disorder cluster A features do not elicit particular emotional reactions among staff members (Betan, Heim, Zittel Conklin, & Westen, 2005; Thylstrup & Hesse, 2008)

SCHIZOID PD (SPD)



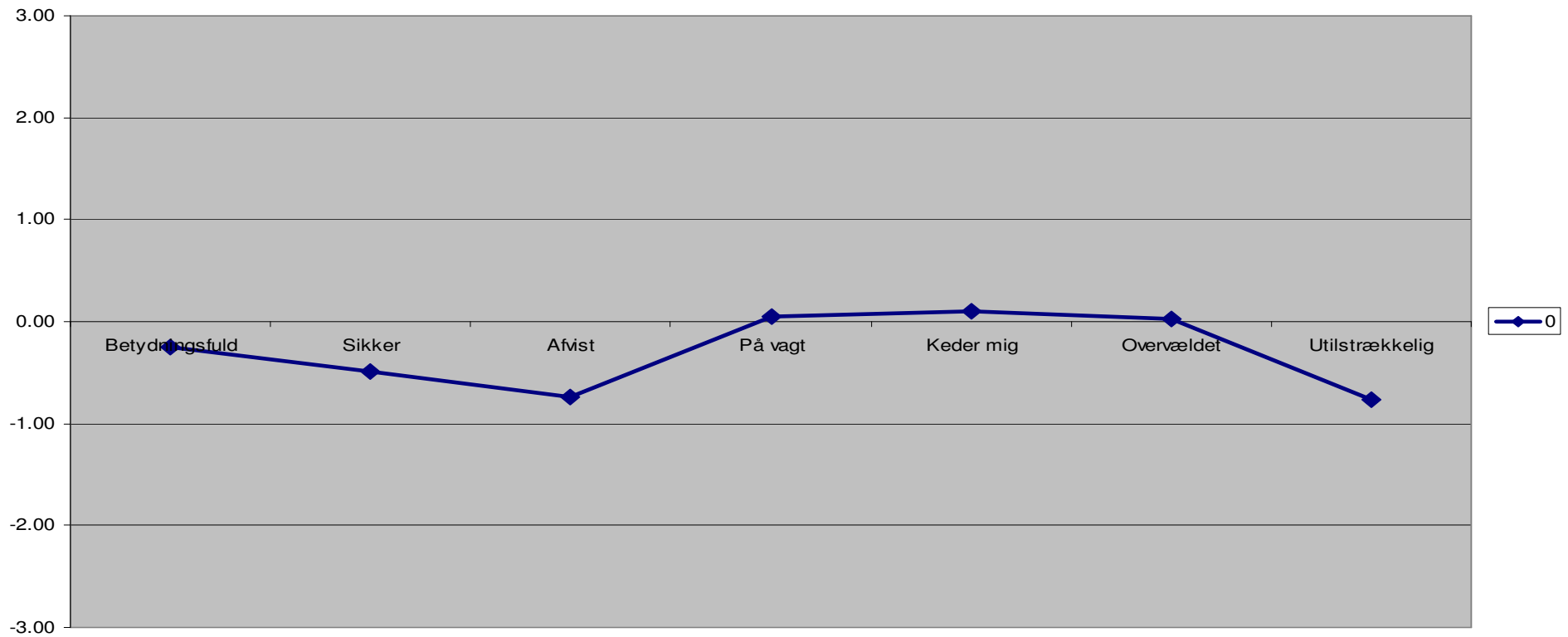
- › Absence of emotional reactions may mirror what happens in the lives of schizoid patients more generally
- › Other people tend not to react to them, or even notice them, unless they are forced to do so

DSM-IV graf

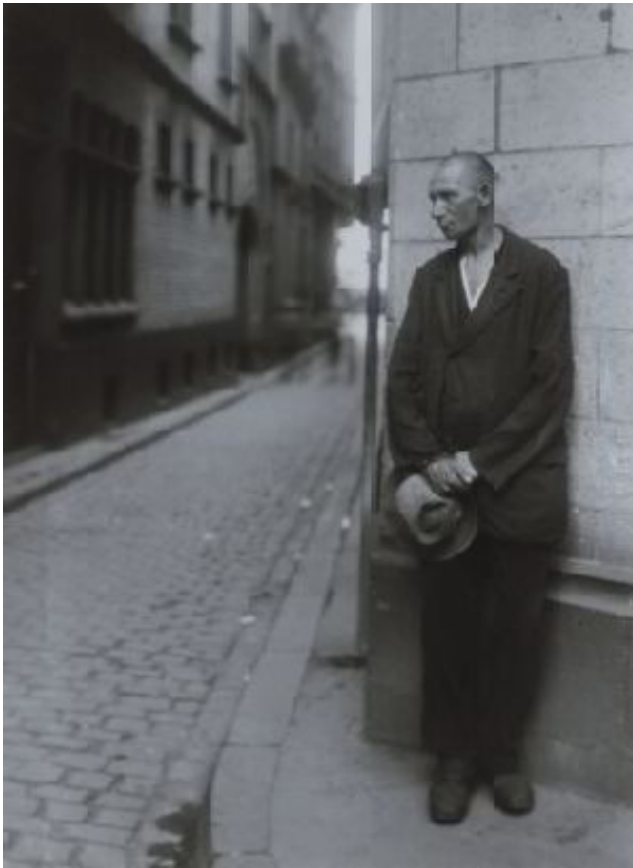


STAFF MEMBER REACTION MEASURED BY FWC

0



SCHIZOID PERSONALITY



- › "Light autism"
- › Lack of interest for others
- › Lack of interest in general
- › Flattened detached affect
- › Seeks isolation

FREQUENCY

- › Less than 1% in general population (APA, 2000)
- › Community prevalence of 3.1% in US (Grant et al., 2004)
- › Higher prevalence in substance abusing, primary care and medical samples (Kosson et al., 2008)
- › Associated with alcohol and drug dependence (not abuse), depression, anxiety disorders (Grant, Hasin et al., 2005; Grant, Stinson, Dawson, Chou, & Rúan, 2005)
- › Prototypic cases of SPD are rare and often blended with avoidant or schizotypal disorders (APA, 2000)

THIS STUDY

- › Interest in Fred's case
- › Psychiatric diagnoses and personality disorders co-exist
- › Research on SPD has been limited
- › Few treatment reports of patients with schizoid
- › Few clinical descriptions and research reports have characterised treatment processes with schizoid patients in psychotherapeutic treatment from both patient's and professional's points of view

MANUALS: DETACHED FEATURES/INNER LIFE

- › Limited capacity to express feelings and to experience pleasure
- › Emotional coldness, detachment or reduced affection
- › Indifference to praise or criticism and to social norms and conventions
- › Preference for fantasy, solitary activities and introspection
- › Withdrawal from affectional, social, and sexual contacts
- › Pervasive pattern of interpersonal detachment
- › Restricted affective expression
- › Emotional coldness, detachment and flattened affectivity
- › Indifference to praise or criticism of others
- › Predominantly choosing solitary activities
- › Lacking desire for close and confident relationships other than first-degree relatives & sexual experiences with another person

(ICD-10, WHO, 1992)

(DSM-IV,-TR, APA, 2000)

WHAT ABOUT THE AMBIVALENCE?

- › Manuals focus on behavioural manifestations
- › Absence of emotional ambivalence as core construct
- › The Psychodynamic Diagnostic Manual (PDM, 2006) describes the emotional ambivalence
- › Patients tend to be highly sensitive, shy, and easily overstimulated, fearing closeness but simultaneously longing for closeness and experiencing general emotional pain when over-stimulated, which calls for the defence of emotional suppression

BLEULER

- › ...coined the term schizoid in 1908
- › Shut-in, suspicious, and comfortably dull, while simultaneously sensitive and in pursuit of vague purposes, frequently occurring in the prepsychotic personality of schizophrenic illness (Bleuler, 1976)
- › Ambivalence as a consequence of the schizophrenic association disturbance, representing a tendency to experience contrasting feelings (affective ambivalence), intentions (ambivalence of the will), and thoughts (intellectual ambivalence) to situations, objects or people

AKHTAR

- › ...describes the contradictory aspects in descriptions of overt and covert manifestations (Akhtar, 1987)
- › Suggests that the overt manifestation is a defence against *“Anxieties emanating from the underlying sensitive and hungry self-representation that is still hoping, albeit passively, for a loving rescue by an omnipotent, all-good symbiotic object”*
- › Overtly aloof and self-sufficient appearance, while internally heightened sensitivity and emotional neediness

METHOD – CRITICAL CASE

- › Critical case (Yin, 1994) - specific insight into central dynamics and issues of theoretical and clinical interest
- › Qualitative data - in-depth understanding of “patient's morbid subjectivity” (Stanghellini & Ballerini, 2008)
- › Multiple perspectives - each participant's experience contributes to a fuller understanding of treatment (Dreier, 2008)
- › Integrated understanding of treatment process – how psychopathological processes and therapeutic relationship interacts

INTERVIEWS

- › Focus: Perceptions of treatment process & goals, interpersonal aspects of treatment, how schizoid ambivalence affects treatment process - combined with discussions of alliance and countertransference
- › 3 key questions:
 - › (1) experience of treatment meetings
 - › (2) relations among participants at treatment meetings
 - › (3) changes in patients' life situation after onset of treatment
- › Semi-structured interviews with Fred and 2/3 case-specific TM 3 and 6 months after start of OD (6 interviews, app. 1/2 hour)

TEAM

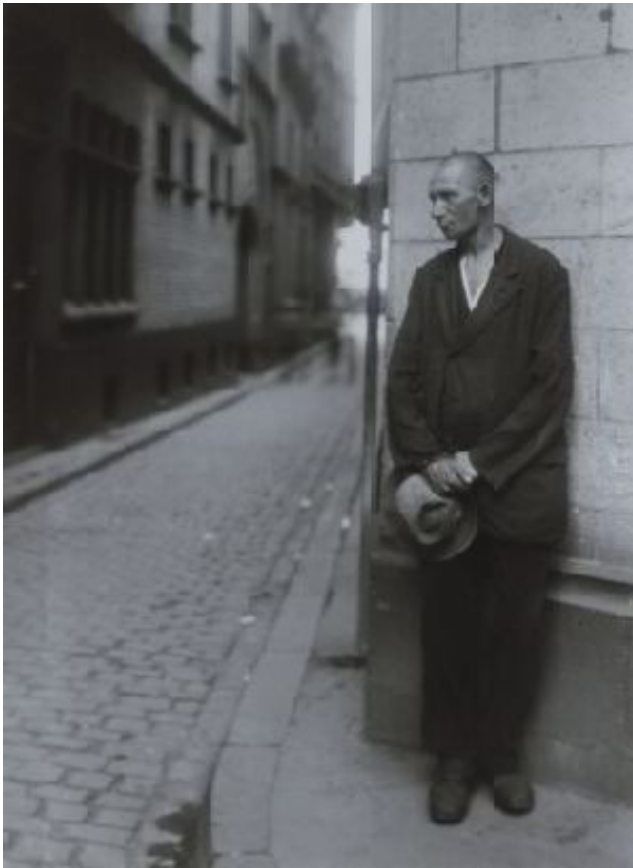


- › Two professionals from project OD in Odsherred who already knew Fred
- › Social worker from the DIC
- › Nurse - known Fred for around a year
- › Social worker - Fred's contact person more than 10 years

FRED – WHO IS HE?

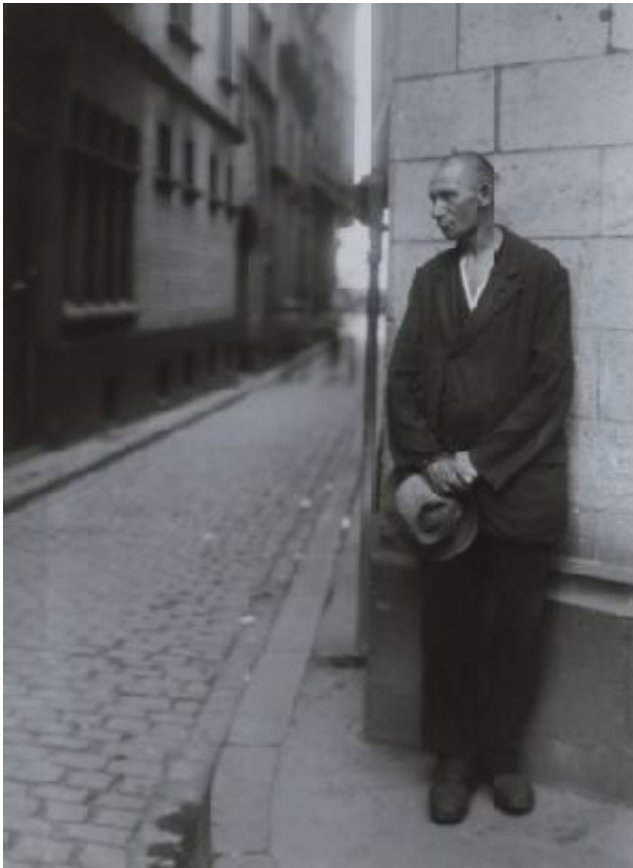
- › 40'ies, unemployed
- › Social psychiatry (>10 yrs)
- › Hashish (daily) and beer (>20 yrs)
- › Diagnosed with paranoid schizophrenia
- › Schizoid features (DIP-Q,)
- › Anxiety and depression

APPEARANCE



- › Fred's and staff' descriptions involve all traits in ICD-10 & DSM-IV
- › Comes across as friendly and mild - a "warm teddy bear."
- › Displays a marked level of detachment and restricted affect when he tells about his life, problems, and treatment process
- › Even when he talks about his anxieties, his appearance is remarkably neutral

SOCIAL



- › Uneasiness in social situations
- › Limited capacity to express positive or negative feelings towards others
- › No conflicts with others
- › Small social network
 - › Liked by his family
 - › Regular contact with mother and father - material/emotional support
- › No mentions of relationships where he shares intimate thoughts, feelings, or sexuality

INNER WORLD



- › Life is solitary
- › Drawing, reading, or daydreaming in a parallel fantasy world
- › Covert desire to be able to engage in closer relations
- › Communication is a strange mixture of longing for closeness and social indifference

FRED'S PERCEPTION OF TREATMENT

› Positive

- › Helpful
- › Makes him feel safe and calm
- › Healthier thoughts with less interference
- › Delusions "put in place"
- › Considers his daily actions more constructively
- › Decrease in hash and beer intake two to three days after a meeting

› Challenge

- › Socialise with other people
- › Nervous and insecure

AMBIVALENCE - LONGING AND UNEASE

- › *I find it is very tense, because it is now and here, because we 'are on'...()...it's also nice to know that there are some people who are interested in you, and who want to try to help. I find it warms my heart. I don't know what to say. I find it constructive and good...()... I am not used to being around people, especially not when I am the centre...()... I have also been the small one in this group...()... I am so awfully insecure...*

AMBIVALENCE – INCREASE IN DEMANDS & HOPE

- › *I have three tools actually...(). . . three persons I can work with or they can work with me...*
- › *We talk much about that I should go on walks on Thursdays and so on ...()... It's easier for them, because they are living life. I stopped my life in 1985 ...()... I think it's great, it's also part of what I have to learn concerning how the meetings work ...()... how you actually communicate with others and so on*

CONTINUED

- › *The demands are more troublesome than good, but somehow I don't think you should refrain from thinking and considering what you want from life ...().. . somewhere there is also the desire for hope for an improvement of my self-development somehow...*

TREATMENT ENDS

- › After 4 sessions
- › Fred returns to social psychiatry
- › Second interview 3 months later

FRED'S EXPLANATION

› *...they might have felt that it didn't go as planned. I would really also give up ...()... I tried to be bloody honest with me so many personal feelings of well-being. I talked cross ways so I actually could live without (smoking cannabis). It gave me*

**Low priority
compared to more
urgent matters**

**Difficulty in
scheduling**

Meeting cancelations

**Lack of positive
changes**

TEAM MEMBERS' EXPLANATION

› *The engagement kind of goes when can't move him an inch ...()... . He did the meetings except from getting twice every fortnight...()... .he could use us every day, but when it suited him ...()... and that with our work burden these days should have ended it properly and then. And somehow, I think it doesn't make no doubt that Fred is left with some*

Low priority compared to more urgent matters

Difficulty in scheduling

Meeting cancellations

Lack of positive changes

SAFE BUT ISOLATED

- › *I am just hanging in the same grind as always ...()... Well that grind I have, it also consists of comfort and enjoying life, and that's probably why I returned to it. But it doesn't mean I get to meet other people ...()... It doesn't create openness to other people that grind ...()... I do go (to the DIC) to eat ...()... but a week can pass before I go.. .()... then I see how people treat each other in ways that are very different (compared to the local pub). As for togetherness, there are more benefits in the DIC than in a café and pub environment, but now I know them there, and it's easier to get contact with that group rather than coming over there and just be alone and say Hi...*

...STILL THINKING ABOUT DRUGS

- › *Now nothing came of the detoxification, I didn't get that far...().. I had contemplated on at least reducing my needs. Because sometimes I think that smoking cannabis is just a compulsive idea for me . . .*

TEAM MEMBERS' REACTIONS

- › More direct
- › *I am probably more open towards him ...()... if I find he has messed up, I confront him ...(). .. If he wants to stop drinking, if he wants to go out for a walk...()... I will support him, but he has to take it on himself. . .*

- › More accepting
- › *He smokes more cannabis...()... and he also drinks more.. he is more clouded in his talk ...(). . . he is more quiet...(). . . It can be difficult to get him going as in getting a smile and some facial expressions. ...(). . . He doesn't want to open up, and then you shouldn't try...Maybe it has actually been negative, because there was a let down from our side...*

WHAT HAPPENED

- › Fred did not appear to benefit sufficiently
- › Were Fred's concerns trivial? He complained of anxiety, depression, delusions, serious substance dependence, and social isolation
- › Fred's limited expression of distress -> not able to make TM feel his problems were urgent enough
- › .. *the will and desire was present in all...()... well I probably had Fred's substance abuse in the back of my head, and Fred didn't see it as a substance abuse ...()... I don't think we mentioned substance abuse at any time ...*

AGREEMENTS & DISAGREEMENTS

Fred

Low priority
Difficulty in scheduling
Meeting cancelations
Lack of positive changes

Motivated

Ambivalent feelings about
social dimension of
treatment sessions

Describes goals concerning
his substance use

Team members

Low priority
Difficulty in scheduling
Meeting cancelations
Lack of positive changes

Not motivated

Fred primarily sought sessions
as
social occasions

No mentions of substance
abuse - or hidden agenda

ALLIANCE

- › Agreement on goals,
- › Agreement on therapeutic tasks
- › Quality of the interpersonal bond (Bordin, 1979)

- › Interactive and dyadic

- › Likely to evoke overt or covert ambivalence in the patient

CHALLENGE- NO COMPLAINTS BUT MANY PROBLEMS

- › **Development of interpersonal collaborative bond**
 - › Lack of patient ability to express contrasting feelings
 - › Therapist perceive the patient as emotionally detached and unengaged
 - › Treatment relationship nonexisting?

- › **Agreement on goals**
 - › Patient's ambivalence regarding life style changes challenge existing comfort zones
 - › Difficulties in expressing specific treatment goals cause confusion

- › **Collaborative effort**
 - › Agreeing on a topic and devising a strategy for dealing with this topic is a great challenge
 - › Patients may drift from the topic or be very difficult to communicate with

CHALLENGE- TIME AND PATIENCE

- › Access to inner longing for closeness and change
- › Challenges treatment engagement
- › Challenges therapists' feeling of treatment progress and ability to make a positive difference

COUNTERTRANSFERENCE

- › Professionals' emotional reactions to patients as important part of psychiatric treatment (Freud)
- › Emotional reactions interfere with treatment and have diagnostic and therapeutic relevance
- › Presence or lack of empathic attunement affects outcome
- › Absence of emotional reaction as informative as presence of reactions to cluster B disorders

CONSCIOUS AND CONSCIOUS

- › No emotional reactions
- › Unconscious creating a distance from feelings of discomfort related to patient's ambivalence
- › Parallel coping strategy to patient's emotional suppression of hidden feelings, eg. fearing and longing for closeness, emotional pain, heightened sensitivity
- › Clinicians may react with splitting: some accept and resign, some become demanding and invasive. In Fred's case both reactions occurred

SUM UP

- › Treatment offers opportunities for the patient to engage in dialogues that support capacities to form, recognize, and challenge understanding of self and others
- › A sufficient conceptual understanding with SPD patients?
- › Schizoid ambivalence challenges engagement
- › Focus on how ambivalence affect treatment alliance and countertransference reactions
- › Useful in understanding what takes place and how to support patient in treatment engagement

GUIDELINES

- › Respect need of emotional space and time to develop trust in therapist
- › Balance between temptations to abandon or control patient
- › Allow fascination with the patient's world
- › Focus on overt and covert expressions
 - › Not evaluate the patient's treatment motivation based on visible expressions of treatment engagement
 - › Not oversee underlying key processes
 - › Increase patient awareness of SPD by using simple questions related to the DSM-IV criteria
 - › Focus on non-communicated aspects of treatment relationship
- › Reflect on emotional reactions
 - › Diagnostic and therapeutic relevance
 - › Provide information about covert patient ambivalence and problems

CUE QUESTIONS

- › "Do I feel like my patient is not improving, even though he or she appears to be content with treatment?"
- › "Do I consider cancelling appointments with my socially isolated patient, thinking it won't hurt him or her?"
- › "Do I think of the patient as lacking in motivation, even though he or she rarely cancels or misses appointments?"
- › "Do I find myself wondering if this patient has any problems at all, even in spite of clear evidence that he does?"

THANK YOU

- › If there is any questions, you are welcome to contact me at bt@crf.au.dk
- › Reference:
- › Thylstrup, B & Hesse, M (2009). "I am not Complaining"—Ambivalence Construct in Schizoid Personality Disorder, *American Journal of Psychotherapy*, Vol. 63, No. 2, 2009