"I am not Complaining"—Ambivalence Construct in Schizoid Personality Disorder

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Patients with schizoid personality disorders (SPD) often challenge clinicians because of their seemingly detached and restricted affective behaviour, which may be interpreted as lack of motivation for treatment and lifestyle changes. However, Bleuler indicated the intrapsychic dynamics of ambivalence in schizoid disorder, and it has been discussed in later literature on psychopathology. Schizoid ambivalence refers to contrasting feelings in patients of a seemingly emotionally detached appearance that may curtain an inner, heightened sensitivity and longing for closeness. This article introduces different diagnostic and theoretical descriptions of the ambivalence construct in the schizoid personality disorder. The discussion is elaborated by means of a case example, presenting both the patient's and professionals' points of view on the treatment process. We use the concepts of treatment alliance and countertransference as explanatory models in the discussion of how the schizoid ambivalence may affect the treatment relationship.

KEYWORDS: schizoid personality disorder; ambivalence; treatment relations; case example

INTRODUCTION

In our work with patients with substance use disorders, we have frequently noted that over the years some patients tend to be "forgotten" by their therapists and caseworkers. These patients initially present as awkward, yet friendly and compliant. As the patient is not very problematic, he (usually, it is a male patient) does not come up in regular supervision; little or no progress is noted by the caseworker or therapist, and as time goes by, the therapist tends to lose "interest" in the patient, directing focus and attention to other more challenging or engaged patients. When we teach psychopathology at workshops for caseworkers

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and therapists, we suggest that often this pattern emerges when patients suffer from schizoid personality disorder. We suggest that this pattern emerges because the patients are unable to communicate their difficult feelings and inner worlds, but we also stress that a substantial proportion of patients with this disorder may experience more benefit from treatment than they are able to communicate. Most participants in such workshops tend to react with a mixture of relief and shame to these descriptions: They recognize that one of their patients might have a schizoid disorder, and they have indeed either lost interest or distanced themselves from him, reasoning that he was friendly, maybe strange, and probably lonely, but because he did not complain or cause ruptures in the treatment setting, he was also a patient with whom they did not feel very involved.

The American Psychiatric Association (2000) reports that the prevalence in the general population of schizoid personality disorder (SPD) in the general population is less than 1%. Other studies have found a community prevalence of 3.1% in the United States (Grant et al., 2004) and a higher prevalence in substance abusing and primary care and medical samples (Kosson et al., 2008). In surveys with a more general focus on personality disorders, schizoid personality disorder is associated with a childhood history that includes a lack of positive parenting (Cohen, Brown, & Smailes, 2001), and is associated with alcohol and drug dependence, but not abuse, and with depression and anxiety disorders (Grant, Hasin et al., 2005; Grant, Stinson, Dawson, Chou, & Ruan, 2005). Prototypic cases of SPD are rare and often blended with avoidant or schizotypal disorders (APA, 2000).

The literature is rich with descriptions of SPD. Eugen Bleuler coined the term schizoid in 1908, describing persons with schizoid features as 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). Bleuler argued that ambivalence was 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, for example, experiencing love and hatred for the same person (Bleuler, 1976). In the 1920s clinical investigations confirmed some kind of relationship between SPD and schizophrenia (Wolff, 1996). Despite Bleuler's and others' focus on the ambivalence in SPD, the construct was not incorporated in the experimental and developmental psychopathology literature. Recent studies attempted to operationalize ambivalence and assess its relations to

schizophrenia and schizotypy. For instance, a study by Kwapil, Mann, and Raulin (2002) assessed psychometric properties and concurrent validity of the Schizotypal Ambivalence Scale (SAS) in 997 American college students, finding that high SAS scores were associated with schizoid as well as schizotypal and paranoid symptoms.

The focus on behavioural manifestations in diagnostic manuals does not incorporate emotional ambivalence as a core schizoid construct. According to the *International Classification of Diseases-10 (ICD-10)*, SPD is characterised by emotional coldness, detachment or reduced affection, withdrawal from affectional, social, and sexual contacts, preference for fantasy, solitary activities and introspection, limited capacity to express feelings and to experience pleasure, indifference to either praise or criticism and to social norms and conventions (World Health Organization (WHO), 1992).

The *Diagnostic Statistical Manual of Mental Disorders-IV-Text Revision* (DSM-IV-TR) lists SPD under cluster A, the odd-eccentric cluster of personality disorders, along with paranoid and schizotypal personality disorder. Schizoid personality disorder is defined as a pervasive pattern of interpersonal detachment and restricted affective expression, manifested in 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, and lacking desire for sexual experiences with another person (APA, 2000). While both the ICD-10 and the DSM-IV-TR focus on emotionally detached features and inner life in the schizoid disorder, *the Psychodynamic Diagnostic Manual* (PDM, 2006) points to the emotional ambivalence of the schizoid disturbance. The PDM stresses that the patient with SPD tends to be highly sensitive, shy, and easily over-stimulated, fearing closeness but simultaneously longing for closeness and experiencing general emotional pain when over-stimulated, which calls for the defence of emotional suppression.

In his article "Schizoid Personality Disorder: A Synthesis of Developmental, Dynamic, and Descriptive Features," Akhtar (1987) describes the contradictory aspects of the schizoid disturbance in descriptions of the overt and covert manifestations of the disorder. According to Akhtar, the person with schizoid disorder often manifests an overtly aloof and self-sufficient appearance in his outer persona, while he internally experiences feelings of heightened sensitivity and emotional neediness. Akhtar also 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" (1987, p. 515). His description of the discrepancy between the overt and covert manifestations of the schizoid disorder suggests that the patient with schizoid disorder may have an inner world in which experiences, thoughts, and feelings that are not immediate accessible for the clinician.

Recent research on SPD has been very limited, and recent treatment reports of patients with schizoid personality disorder have been rare. One of the reasons is that patients with SPD are not particularly likely to seek treatment (Frances & Ross, 2001), and therefore, obtaining a substantial number of patients with the disorder for a treatment study is a challenge in itself. In the following, we shall describe issues that we find central in the treatment of patients with SPD, and elaborate on these issues by means of a case example.

TREATING SCHIZOID PERSONALITY DISORDER

Few clinical descriptions, and even fewer research reports, have characterised treatment processes with schizoid patients in psychotherapeutic treatment from both the patient's and the professional's points of view. 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). While these null findings may suggest that clinicians are proficient in maintaining a professional attitude with schizoid patients, the absence of emotional reactions may also 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 somehow forced to do so.

Our observations from supervision of clinicians, our own work with patients, and experiences from training clinicians in working with personality-disordered patients suggest that that may very well be what takes place in treatment. As time goes by in the treatment process, clinicians tend to tire because of lack of visible changes in schizoid patients; the clinicians lose interest in the treatment, which they find is not progressing. The patients on the other hand, may value the therapeutic relationship far more than the clinicians realize, and may even benefit from the treatment in ways that the clinicians may miss altogether, or disregard as insignificant. In our experience, schizoid patients make a poor match with treatment offers that are very goal oriented, short term, and focused on obtaining an atmosphere conducive to change. The short-term treatments

focus on changing symptoms rapidly, and some of them are very effective at obtaining this objective (Millon & Davis, 1997).

However, these treatments tend to disregard change at more fundamental levels. If anything, rapid changes rarely occur in truly schizoid patients, since very fundamental issues are at stake in the treatment of such patients. Indeed, many patients with schizoid personalities have very little motivation for symptomatic change, and their main concern is whether or not they will even be able to cope with being close-up and personal with the psychotherapist, considering the therapeutic alliance a difficult task (Lingiardi, Filipucci, & Baiocco, 2005). At one level, the patients can be surprisingly compliant, and rarely miss an appointment with a therapist over long stretches of time. At another level, they are often not even able to explain what they want with the treatment or to define specific goals that they wish to achieve. Furthermore, many of these patients appear very ambivalent in the way they participate in treatment. Emotionally, they do not communicate with their clinicians, rarely showing their emotions, such as grief, anger, fear, frustration, happiness, or motivation. Their body language and facial expression does not show what they feel, and even when they talk about events that would normally elicit a reaction in most people, such as very traumatic childhood events, they tend to appear indifferent to the events they report and to talk in a casual way about these events.

METHODS

Qualitative data can give an in-depth understanding of what has been called "the patient's morbid subjectivity" (Stanghellini & Ballerini, 2008, p. 161). Rather than splitting the research problem into isolated variables, qualitative data allows the researcher to construct a holistic transpersonal account of the psychopathological processes and the therapeutic interventions. Thereby, qualitative data allow an integrated understanding of the treatment process as a whole, encompassing how the psychopathological processes and the therapeutic relationship interacts. Especially important in this context is the use of multiple perspectives on treatment. Each participant's unique experience contributes to a fuller understanding of the treatment process (Dreier, 2008).

The case study is taken from a larger study conducted by both authors in an outpatient treatment offer to psychiatric and dual-diagnosed patients in Odsherred, Zealand, Denmark. The first author did not participate in the treatment interventions and did not engage in supervision feedback with the staff. The treatment model is Open Dialogue (OD), a family and

network oriented approach in treating psychosis, schizophrenia, and other severe psychiatric crisis, which has demonstrated utility and effectiveness in outcome studies, especially in treating psychotic crisis (Seikkula & Trimble, 2005). Focus is primarily on supporting change by means of reflective interaction and dialogue among patients, family and significant others, and a case-specific treatment team. In OD in Odsherred the team consists of 2 to 4 professionals from social, district, and general psychiatry. The OD intervention takes place at treatment meetings with the case-specific team, and services may be integrated in the intervention if needed (Seikkula & Trimble, 2005). The dialogical approaeh operates within a social-constructionist framework with integration of different psychotherapeutic traditions and elements (i.e. traditional family therapy, family consultation, and network therapy), aiming at constructing a joint dialogue with the participants at the treatment meetings to generate a new understanding of the presented problems (Seikkula & Olson, 2003). A primary aim of the dialogical exchange is to construct a caring personal community (Seikkula & Olson, 2003). For the new meanings to emerge, the professionals must exercise emotional attunement in the reflective dialogue and allow the therapeutic process to be slow ". . . in order to provide for the rhythm and style of each participant's speech, and to ensure that each person has a place created in which he or she is invited and supported to have his or her say" (Seikkula & Olson, 2003, p. 463).

We selected Fred from the case series of patients from the OD-treatment unit, as he was a "critical case" (Yin, 1994, p. 38). That is, a case that provides specific insight into central dynamics and issues relating to a problem of theoretical and clinical interest. Fred's case gave an in-depth picture of the interpersonal dynamics in the treatment of a patient with schizoid personality features, giving an opportunity to study these feature in detail.

Data in the case study are based on two semistructured interviews with the patient and two of the three case-specific team members 3 and 6 months after start of OD, for a total of six interviews. The two interviews with the third team member are not included in the case study, since these mostly concerned other patients in OD treatment.

Both the first and second interview consisted of three overall research questions and focus points: (1) experience of treatment meetings, (2) relations among participants at treatment meetings, (3) changes in the patients' life situation after onset of treatment. Interview data were recorded on an Olympus DSS Player Pro Dictation Module and coded in Qualitative Media Analyser (QMA) (Skou, 2004). The case study data was

analysed using an explanatory analytic strategy; the case example was used as a constituent part of a hypothesis-generating process to stipulate causal links between chosen theoretical and clinical propositions on the schizoid ambivalence construct in the later discussion (Yin, 1994). We chose the interview extracts to examine how the patient and team members perceived the treatment process in relation to treatment goals and the interpersonal aspects of treatment, with special attention given to extracts reflecting how schizoid ambivalence affected the treatment process.

Quotations are verbatim. The symbol . . .( ). . . in the interview extracts indicates that the interviewee either is repeating the content of the answer, that the utterances are unintelligible, or the interviewee sidetracks into matters that the authors considered irrelevant for the content of the answer.

We changed some details of the case to ensure patient anonymity. Fred and the treatment professionals gave full consent to use all data collected in the study for research purposes. Danish institutional review boards do not assess ethics in studies except those involving invasive medical procedures or experimental manipulation of drug treatment. However, we can think of no way in which the present case report can be harmful to Fred or in any way violate the Declaration of Helsinki.

We used the Ten-Item Personality Inventory (TIPI) to assess the patient's personality dimensions. The TIPI Questionnaire is based on the Big-Five personality model, which is a hierarchical model of personality traits with five broad personality factor dimensions (Costa & McCrae, 1992). The Big-Five factors are bipolar and consist of extraversion, agreeableness, conscientiousness, emotional stability, and openness to experience. The TIPI, developed by Gosling and colleagues, has shown adequate levels in convergent and discriminant validity and test-retest validity (Gosling, Rentfrow, & Swann, 2003). The informant is asked to rate 10 items, with one item representing each pole of the five dimensions. The rating is done on a 7-point Likert scale from 1 (disagree strongly) to 7 (agree strongly). The questionnaire was translated into Danish and retranslated by the authors and a native English speaker.

CASE DESCRIPTION

Fred is in his 40s, is unemployed, and reports he has been in contact with the social psychiatry for over 10 years. He has been diagnosed with paranoid schizophrenia, and has long-standing cannabis dependence. For the past 20 years, he has smoked regularly throughout the day, smoking

two pipes of hashish in the morning before leaving his home. He supplements the hash with a fluctuating beer intake. During the first interview, he reports that he suffers from anxiety and depression. Although paranoid delusions may be present, from a clinical perspective, we suggest that Fred is an excellent model of how a patient with schizoid personality interacts with clinicians. If he were to abstain from cannabis for a lengthy period of time, he might change in a number of ways. We do not focus the following on whether Fred is "truly" a schizoid patient, but on the schizoid features showing in his way of interacting with the staff members.

Both Fred's and staff members' descriptions of him involve personality traits that encompass nearly all the ICD-10 and DSM-IV criteria for schizoid personality disorder. He comes across as a friendly and mild person, and one professional describes him as a "warm teddy bear." But Fred displays a marked level of detachment and restricted affect when telling about his life situation, problems, and treatment process in the interviews. Even when he talks about his anxieties, his appearance is remarkably neutral. He describes uneasiness in social situations, and clearly has a limited capacity to express either positive or negative feelings towards others. Fred also tells that he has no conflicts with other people. Besides the people he occasionally drinks with at the local pub, and the people whom he meets at his visits at the DIC, he has one friend, a neighbour. Fred is liked by his family, has regular contact with his mother and father, whom he visits regularly and who provide him material and emotional support. Fred does not mention any close relationships with whom he shares intimate thoughts, feelings, or sexuality. His life is for a large part, solitary, either drawing, reading, or daydreaming in a parallel fantasy world. However, Fred has a covert desire to able to engage in closer relations. He feels lonely but cannot do anything about the loneliness due to the schizoid disorder. Thus, his communication is a strange mixture of longing for closeness and social indifference (Akhtar, 1987). Fred's ratings in the Ten-Item Personality Inventory (Gosling et al., 2003) show that he sees himself as an extremely introverted person, who feels responsible and thorough, displays less openness to experiences than most patients in the larger study sample, and has difficulties trusting others.

Treatment Process

Fred began participating in OD treatment in February 2005 at the suggestion of a social worker affiliated with OD treatment and working at

the local Drop-In Centre (DIC) that Fred visited. The case-specific team consisted of two professionals from project OD in Odsherred who already knew Fred, the social worker from the DIC, a nurse, who had known Fred for around a year, and a social worker who had been Fred's contact person for more than ten years.

The first interview with Fred took place after four OD meetings. When asked about the meetings, Fred said he found them very useful for shedding light on his problems, that they make him feel safe and calm, that his thoughts became healthier with fewer interfering thoughts, and that his delusions were "kind of put in place." Still, the treatment set-up, involving three professionals, presented a challenge to him, resulting in ambivalence:

> *I find it is very tense, because it is now and here, because we 'are on.' How can you put it, 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 among people, especially not when I am the centre . . .( ). . . I have also been the small one in this group . . .( ). . . I am so awfully insecure . . . (excerpt of the first interview).*

Despite these difficulties, Fred attended the OD meetings because he found them helpful, and explained that he considered his daily actions more constructively, for example, decreasing his hash and beer intake two to three days after a meeting. He told how meetings increased his demands on himself and gave him hope and a taste for life:

> *[The demands that Fred finds he puts on himself, BT&MH] are more troublesome than good, but somehow I don't think you should refrain from thinking and considering what you want from life . . .( ). . . I think the meetings kind of encourage a positive outlook on life and not only think black all the time, because somewhere there is also the desire for hope for an improvement of my self-development somehow . . .( ). . . I have three tools actually . . .( ). . . three persons I can work with or they can work with me . . . (excerpt of the first interview).*

Fred finds the discussion of behavioural change and goals difficult:

> *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. It's an incredibly big challenge, because I also get more confident meeting others in that way . . .( ). . . I am not one who kind of engage in conversations . . . (excerpt of the first interview).*

WHY DID TREATMENT END?

The meetings of OD team and Fred ended after four sessions, and Fred returned to social psychiatric care. In the second interview, conducted three months after treatment termination, Fred said he did not know why the meetings stopped. He believed the termination was caused in part by the team assigning him low priority compared to other more urgent work assignments and referred to difficulty in scheduling meetings all could attend and to meeting cancellations. Fred wondered if treatment termination might have to do with him not showing enough results, even though the meetings had great value for him:

> *. . . they might have felt that it didn't go anywhere, but I haven't talked with them about it. I would really like to hear why they also gave up . . .( ). . . I tried to be bloody serious . . .( ). . . It gave me so many personal feelings of well-being, because we talked cross ways so I actually could live several days without [smoking cannabis BT&MH]. It gave me peace of mind . . . (excerpt of the second interview).*

The team members explained the termination was partly their lack of prioritising the meetings with Fred and partly with difficulties attending the scheduled meetings. One team member described an incident in which Fred chose to go shopping instead of attending a specific meeting and of a fellow team member's loss of motivation in the project. He also described how lack of positive change in Fred led to his own loss of motivation:

> *The engagement kind of goes when you find out that you can't move him an inch . . .( ). . . He didn't get anything out of the meetings except from getting two hours of extra attention every fortnight . . .( ). . . he could use us for many hours every day, but when it suited him . . .( ). . . and we can't give him that with our work burden these days . . .( ). . . it was a pity, we should have ended it properly and told Fred what happened. And somehow, I think it doesn't matter anymore. But there is no doubt that Fred is left with some frustrations . . . . (excerpt of the second interview).*

Thus, two different problems with Fred emerged: He did not appear to benefit sufficiently, and he was not able to make the staff members feel that his problems were sufficiently urgent to warrant their help. The other team member wondered whether the fact that the meetings took place every second week was too sparse for Fred. Also, the team member described how all three professionals wanted to engage themselves in the intervention, but that the lack of openness between Fred and the team members concerning treatment focus caused the meetings to fade out:

. . . it kind of faded out . . .( ). . . the official agenda . . .( ). . . probably was that he wanted to be more social and get out more, and in any case begin to visit the DIC more often. Implicitly, it also meant that he could get out without using substances . . .( ). . . there were cancellations partly from him and X and I think also from Y, and then it became like 'too much time has passed' . . .( ). . . I think we cancelled more than Fred when it comes down to it . . .( ). . . 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 . . . (excerpt of the second interview).

In this case, it seems as if the team members did not perceive Fred's problems as critical and urgent enough to prioritise a continuation of the OD meetings, partly because Fred did not make his needs clear. It also seems as if the lack of mutual understanding and agreement on treatment focus had an impact on the team members' engagement in the treatment.

Life After Treatment

How did the experience of starting and ending OD meetings leave Fred and the staff members? In the second interview, Fred describes his lifestyle:

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 is probably why I returned to it. But it doesn't mean I get to meet other people . . .( ). . . it does not create openness to other people that grind . . .( ). . . I do go [to the Drop in Centre, BT&MH] to eat, . . .( ). . . but a week can pass before I go there . . .(omission). . . then I see how people treat each other in ways that are very different [compared to the local pub, BT&MH]. As for togetherness, there are more benefits in the DIC than in a café and pub environment, but now I know them there [in the pub], and it's easier to get contact with that group rather than coming over there [to the DIC] and just be alone and say Hi . . . (excerpt of the second interview).

It is clear that his return to his former lifestyle presents mixed emotions in Fred. Even though the grind represents a safe comfort zone, he also finds it leaves him in a socially isolated position. In this interview, Fred clearly states a desire and motivation for changing his substance use:

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 . . . (excerpt of the second interview).

A team member described changes in the way that he related to Fred after participating in OD meetings:

I am probably more open towards him . . .( ). . . if I find he has messed up, I confront him . . .( ). . . I have probably become more tough and said, 'but you must also learn to take a responsibility' right, where he often just places the responsibility with me . . .( ). . . 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 . . . (excerpt of the second interview)

Another team member remarked that while Fred's social situation showed no changes, Fred seems to participate more frequently in larger family gatherings. He also found that Fred's overall functioning had worsened, taking a more accepting stance towards Fred. He also wonders whether the termination of treatment has affected Fred negatively:

He smokes more cannabis . . .( ). . . and he also drinks more . . .(omission). . . he is more clouded in his talk . . .( ). . . he is more quiet . . .( ). . . It's harder for him to get up in the mornings, and physically he is also more enfeebled . . .( ). . . I can't get him out for a ride . . .( ). . . 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. So it gets more like accepting him . . . (excerpt of the second interview)

Maybe it has actually been negative, because there was a let down from our side . . .( ). . . I talked with him about it when it happened—that it didn't really amount to anything. But it probably had more to do with me trying to pour oil on troubled waters and excuse it somehow . . . (excerpt of the second interview)

COMPARISON OF DESCRIPTIONS

There are both remarkable similarities and remarkable differences between Fred's and the team members' descriptions of his treatment. They all agree that the team members' interest decreased over time. They also agree that both the relative lack of urgency of his concerns and ambivalence about treatment goals contributed to the gradual decline in interest.

But how were his problems less urgent compared with other work assignments? Were his concerns trivial? He complained of anxiety, depression, delusions, serious substance dependence, and social isolation. These complaints do not appear trivial. What was striking abont Fred was the limited expression of distress in relation to these concerns. It is also somewhat striking that Fred described the importance of goals concerning his own substance use, though with some ambivalence. At the same time, his caseworkers noted the absence of change in Fred or described their concern with his substance use as their own "hidden agenda" rather than area with which he expressed concern.

The team members also agreed that Fred primarily sought the treatment sessions as social occasions, and that the social interaction in the sessions was at least as important to Fred as the topics discussed. However, while the team members described Fred as longing for and enjoying the attention, Fred described strongly ambivalent feelings about the social dimension of going to treatment sessions. The tension he described, his awareness of his own lack of experience with social situations, and his feeling of being the "little one," are not reflected in the team members' descriptions of the sessions as being two hours of positive attention.

Finally, why did Fred describe changes in his substance use as a valuable goal while the professionals either failed to mention that his substance use as a common goal of treatment or described it as their hidden agenda?

Most people with substance use disorders experience some degree of ambivalence about their substance use, and for this reason, substance use is frequently a sensitive subject in the treatment of patients with substance use problems. Moreover, the OD treatment model does not directly emphasize addressing substance use and discussing treatment goals in relation to the patients' substance use. Even considering this, there is a substantial contradiction between Fred's experience of changing his use of cannabis being a valuable and difficult goal directly linked with the usefulness of the treatment sessions and the team members' description of his lack of motivation for changing his substance use. One member even stated that Fred did not see his use of cannabis as a substance abuse.

According to the team members, the treatment process was not discussed at the meetings, nor was it reflected on at the weekly OD staff member meetings.

DISCUSSION

The differences in Fred's and the team members' descriptions of what took place in treatment are highly typical of some of the challenges that we have come across, either when treating patients with SPD or when supervising others. The following discussion will focus on how problems in the treatment of schizoid patients may be understood, based on the concepts of treatment alliance as coined by Bordin (1979) and countertransference in the psychodynamic tradition.

Treatment Alliance and SPD

The concept of the treatment alliance is widely recognized as a common and important dimension of psychotherapeutic work. Bordin describes the

working alliance as the cooperation between the person who seeks change and the one who offers to be a change agent (Bordin, 1979). He presents three interdependent components of the working alliance:

- agreement on goals,
- agreement on therapeutic tasks, and
- the quality of the interpersonal bond.

The components are interactive and dyadic, and therefore, likely to evoke ambivalence in the schizoid patient. The ambivalence may be felt or expressed openly in treatment, but is usually, as in Fred's case, more likely hidden from the therapist.

The development of an interpersonal, collaborative bond with the therapist is a key challenge to both the patient and the therapist. Often the patient does not have the ability to express his contrasting feelings, and the therapist may perceive the patient as emotionally detached, and the treatment relationship as either nonexisting or lacking patient engagement.

Attaining an agreement between the patient with SPD and the therapist can meet obstacles caused by the patient's ambivalence regarding life style changes that challenge existing comfort zones. The patient's difficulties in expressing specific treatment goals may cause confusion in both the patient and the therapist, and impede the collaborative effort required when formulating treatment objectives. The patient does not have any complains to start with—even if he has numerous problems. Following Akhtar (1987), we suggest that having concerns, complaints, or problems is part of the covert side of the patient with schizoid personality.

Obtaining an agreement on specific therapeutic tasks in treatment can be as difficult as formulating the therapeutic goals. To attain the goals, the patient and therapist must obtain an overall agreement on behaviours and cognitions that form the substance of the therapeutic process (Horvath, Gaston, & Luborsky, 1993). Agreeing on a topic and devising a strategy for dealing with this topic is often a great challenge with patients who have SPD, even in the minute-to-minute interactions with the therapist. The patients may drift from the topic or be very difficult to communicate with, especially when the therapist tries to engage the patient in exploration or problem solving.

The case example illustrates how the patient's feelings of ambivalence may affect different aspects of the treatment relation and interfere with the treatment process. Some of the challenges in creating a working alliance with patients with SPD may be explained by Bordin's description of the treatment alliance being a "real relationship", that is, a cooperation between the rational ego of the patient and the therapist (Bordin, 1979).

Here the identity fusion and the ambivalence in the schizoid disorder are likely to cause misunderstandings in the treatment alliance between patient and therapist.

The development of a treatment alliance with the patient with SPD is often a long process that demands time and patience from both the patient and the therapist, and is likely to challenge both the patient's and the therapist's treatment engagement. Bordin described the positive working alliance as a key ingredient for engaging the patient in the therapeutic change process (Bordin, 1979). We suggest that a positive working alliance is also related to therapist engagement in treatment, because obtaining agreement on therapeutic goals and tasks gives the therapist a feeling of treatment progress and an ability to make a positive difference for the patient (Hatcher, Barends, Hansell, & Gutfreund, 1995). Assuming that the therapist's feelings about treatment progress are linked to the collaboration with the patient, the patients' active investment in treatment becomes an important factor for therapist engagement (Hatcher, 1999). The therapist should not feel tempted to evaluate the patient's treatment motivation based on visible expressions of treatment engagement: Such evaluation carries a risk of dismissing the underlying key processes taking place in treatment. The concept of the therapeutic alliance does not necessarily direct therapeutic focus on the noncommunicated aspects of the treatment relationship—the covert longing for closeness and desire for change. A search for stated common goals, agreement on the strategy to obtain these goals, and expressed bond between the patient and therapist may misguide the therapist's understanding of what is going on in the treatment of patients with SPD.

COUNTERTRANSFERENCE AND SPD

The concept of countertransference from psychodynamic theory offers another explanatory model of what might take place when treating patients with schizoid disorders. Freud introduced the concept to describe professionals' emotional reactions to patients, which he viewed as an important part of psychiatric treatment. Freud observed that the patient's influence on the analyst's unconscious feelings might interfere with treatment. Later observations tend to support the view that emotional reactions are able not only to interfere with treatment, but also have diagnostic and therapeutic relevance and in many situations, even facilitate rather than interfere with treatment (Holmes & Perrin, 1997; Kernberg, 1965; Winnicot, 1949). The therapeutic and diagnostic relevance might be information to the therapists about problems with which the patients are struggling. It may affect

the outcome through the presence, or lack of, empathic attunement (Rossberg, Karterud, Pedersen, & Friis, 2007).

Today, the definition of countertransference is broader and defines all feelings evoked in professionals working with patients, emphasizing the counter aspect of transference (Sattar, Pinals, & Gutheil, 2004). While countertransference reaction refers to reactions that occur within the therapeutic alliance, Sattar and colleagues point out that many other factors outside the therapeutic alliance influence staff members' emotional reactions (Sattar et al., 2004). As mentioned earlier, patients with SPD may evoke few emotional reactions from the therapist (Betan et al., 2005; Thylstrup & Hesse, 2008). However, the absence of emotional reaction may be as informative of SPD, as is the presence of reaction to cluster B disorders.

Emotional reactions include both the therapist's conscious and unconscious reactions to the patient (Rossberg et al., 2007) and can take place both in and outside the therapeutic setting. Eliciting no emotional reactions to the patient with schizoid disorder may illustrate how the countertransference can take place on a conscious and unconscious level. Sensing no emotional reactions, the therapist unconsciously creates a distance from feelings of discomfort related to the patient's ambivalence. The feelings may mirror hidden feelings in the patient, for example, the discomfort in both fearing and longing for closeness and the experience of emotional pain and heightened sensitivity, calling for a defence of emotional suppression (Akhtar, 1987; PDM, 2006). Thus, the distancing stance, taken by the therapists, becomes a parallel coping strategy to the patient's emotional suppression.

Kernberg and Caligor have recently suggested that the splitting described in borderline personality disorder is equally present in schizoid personality disorder, but that patients with SPD tend to withdraw rather than seek contact (PDM, 2006). When clinicians react to patients with SPD, they too react with splitting: on the one hand, some accept and resign, on the other, some become demanding and invasive. In the case described above both reactions occurred, and neither was in accord with the patient.

It is possible that when clinicians reflect on their emotional reactions they may generate diagnostic and therapeutic relevance of their emotional reactions and provide information about the ambivalence and problems with which the patients covertly struggle. As is clear from the case example, sympathy is not sufficient for providing therapeutic help to a patient who is not communicating.

Using countertransference as a diagnostic tool has relevance in psychotherapeutic treatment. However, the absence of therapist emotional reactions requires careful attention, since the absence of reactions may be at least as informative as any strong emotional reaction. A disregard of these reactions may lead to misunderstandings of the patients' treatment desires and needs, especially when treating those with schizoid disorders.

CONCERNS IN THE TREATMENT OF PATIENTS WITH SCHIZOID DISORDERS

This article discusses how a therapeutic focus on the ambivalence construct in the schizoid disorder might be useful when treating patients with SPD. According to Lysaker and colleagues, psychotherapeutic treatment offers opportunities for the patient to engage in dialogues that support the patient's capacities to form, recognize, and challenge understanding of themselves and others, possibly spurring growth in those abilities (Lysaker, Buck, & Ringer, 2007). When treating patients with SPD, the question is whether such a conceptual understanding of therapeutic treatment is sufficient, as the nature of the schizoid ambivalence challenges engagement. A therapeutic focus on how ambivalence may affect the treatment alliance and cause distancing countertransference reactions in the professionals might prove useful in the understanding of what takes place in treatment and how the professionals are able to support the patient in engaging in the treatment process.

Discussing some of the therapeutic challenges when treating patients with SPD leads to the next question: What are the practical guidelines for engaging the schizoid patient in the treatment process? Although books have been written on treatment of personality disorders, clinical guidelines on how to approach the patient with SPD are sparse.

Building a therapeutic relationship with the schizoid patient requires respect for the patient's need of emotional space and time to develop trust in the therapist. Adequate treatment of a patient with schizoid personality disorder involves balancing between the temptations to abandon the patient or to control him. The chance of establishing a good treatment relationship with the schizoid patient is enhanced if the therapist is fascinated with the patient's world, and allows himself to get involved in the process of working with the patient.

Even if treatment needs and length of therapy may alter, initial treatment sessions benefit from a rational nonconfrontational treatment approach. Such an approach creates the emotional space and distance needed to avert the patient feeling interpersonally crowded or anxious. In

the beginning of treatment, it may be helpful to increase the patient's awareness of how the schizoid personality features may cause problems in his life. This might be accomplished with simple questions related to the diagnostic criteria, in much the same way as is done in a semi-structured diagnostic interview:

- Do you have close friends or family? If yes, with whom? If no, does it bother you?
- Do you wish you had closer relations with others? Some people prefer to spend time alone. Others prefer to be with people.
- How would you describe yourself? Do you frequently choose to do things by yourself?
- Do you confide in anyone who is not in your immediate family?
- How do you react when someone criticizes you? How do you react when someone compliments you? (Zimmermann, 1994).

Additionally, professionals should consider their own reactions. We recommend that clinicians working with patients who are socially isolated regularly ask themselves these questions, which we find are useful in identifying counter-transference reactions to schizoid patients:

- "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?"

Treating the patient with schizoid disorder according to the patient's range of psychotic symptoms is also critical. The assessment of these symptoms can be made by the therapist addressing psychotic processes, for example, by establishing whether the patient has hallucinations or delusions (and to what degree), paying attention to the presence or absence of disordered thinking, and evaluating the patient's capacity to distinguish ideas from actions (McWilliams, 1994, p. 202).

Adequate treatment may involve more than the dyadic relationship. Often, others are also involved with the patient. Here it can be helpful to educate the significant others how schizoid personality features may cause interpersonal problems. An increased understanding of SPD may result in others having a better understanding of and more respect for the patient's need for solitude and distance, and may result in less distress in all parties. In our experience, educating social workers and nurses about the nature of

patients with SPD has been very helpful in assuring that they maintain an adequate balance between control and abandonment. It is crucial that those involved in the care of the schizoid patient are able to accept the patient's lack of communication and need to withdraw, without resigning from treatment.

Participation in group therapy is another potential treatment approach, since the patient with SPD may experience less fear of intimacy by making social contact in a supportive, therapeutic environment. Although participation within a therapy group may be overwhelming at first (causing the patient to withdraw from the interaction in the group), the patient often becomes a more active participant as the level of comfort is gradually established. Within this treatment context it is also, if not more, important, that the therapist respects the patient's difficulties in closer personal interaction, and protects the patient from criticism by others in the group (Ekleberry, 2009).

A number of medications help reduce social anxiety. Although schizoid personallty disorder is the result of a deficiency in socialization urges, medical prescription for acute symptom relief should be considered. Unless in the presence of possible psychosis, the recommendation for medication should consider whether the medication might interfere with the effectiveness of the psychotherapeutic treatment.

STRENGTHS AND LIMITATIONS OF THE USE OF A CASE EXAMPLE

The use of a case example in the discussion of treatment challenges of patients with SPD adds to the limited research on treatment reports. A methodological strength of the case example is the description of the treatment process from both the patient's and the professionals' points of view. Another strength is the first-person experience of the patient's subpersonal schizoid impairments.

We can argue that the patient in this study, due to his mental disorder, presents an impaired awareness of his situation and treatment. Indeed, there were important issues of which Fred was not aware, such as his lack of communicative skills. He did not seem to be aware that he had to present his complaints and desires to get help from treatment.

Because of ethical considerations, the patient and the professionals did not validate the case analysis. However, the case was used as a critical case study to demonstrate how schizoid features in a patient may affect treatment relations and treatment process. Thus, the analysis was based on embedded units from the case, illustrating how transpersonal dynamics

can take place when treating schizoid patients, rather than studying the treatment process in itself (Yin, 1994).

CONCLUSION

The presence of schizoid features in a patient presenting for treatment requires special attention from treatment staff. In particular, the patient's inability to communicate his complaints may be mistaken for a lack of problems or lack of motivation. The patient's engagement in treatment may be underestimated and lead to a gradual decline in the professional engagement, which, for the patient, may create a sense of treatment failure, leading to discouragement about treatment and the possibility of obtaining constructive life changes.

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