1999

Paranoid Personality Disorder.

Nancy S. Thurston
George Fox University, nthursto@georgefox.edu

Paranoid Personality Disorder.

The core feature of a paranoid personality disorder (PPD) is a longstanding, pervasive pattern of mistrust in the motives of others. Persons with this disorder assume that others have malevolent intentions to harm, exploit, or deceive them, even when no objective evidence exists. They ruminate over unfounded suspicions that their family and friends are disloyal and will scrutinize these relationships for evidence of untrustworthiness. In particular they are prone to pathological jealousy of their spouse or lover. They are often reluctant to confide in others out of fear that anything they say will be used against them. This makes them appear interpersonally cold and aloof. They also tend to distort benign remarks into hidden meanings that are threatening and insulting. For example, they might respond to an offer for help with, "So you think I'm incapable of doing it myself!" People with this disorder often stubbornly refuse to forgive others for insults or injuries that they think they have received. They are swift to counterattack with hostility for such imagined offenses. In order to meet the criteria for a diagnosis of PPD, these symptoms must not occur as part of a psychotic disorder and must not be directly caused by a medical illness. PPD begins by early adulthood and typically endures for life.

It is widely believed that PPD is caused by an experience of severe rejection by one's parents very early in life. As a result the young child internalizes a belief that she is profoundly inadequate. Such a belief raises intolerable anxiety, which is defended against with a paranoid projection that one's self is worthy but that the world is hostile and critical.

Treatment of PPD is particularly difficult for several reasons. First, the lack of subjective distress felt by such persons does not motivate them to seek relief in treatment. Second, they may experience a therapy office as an inquisition chamber or as a laboratory for scrutinizing them as if they were rats in a maze. The most effective treatment of PPD begins with supportive therapy aimed at gaining the person's trust. The therapist must refrain from challenging the paranoid beliefs while at the same time refraining from seeming too sympathetic. Confronting the paranoia before a therapeutic alliance is forged will usually backfire and provoke the patient to strengthen her defenses. Too much kindness and intimacy extended by the therapist will likely backfire as well, causing the patient to feel invaded or frightful uf symbiotic merger. The best approach to take with such patients is one of professionalism, in which the therapist interacts in a reserved and straightforward manner.

Therapy at this early stage should focus on empathic reflection of the person's experience of the world as a threatening place. As the therapist validates the patient's feelings of hostility and vigilance, gradually the patient may feel safe enough to access more vulnerable underlying feelings such as fear, rejection, and loneliness. If supportive therapy successfully uncovers such feelings, the patient may be ready to tolerate the anxiety of deeper reparative treatments such as cognitive retraining or insight-oriented psychotherapy. Unlike supportive therapy, which has a goal of symptom relief, these two treatments aim at personality reconstruction and healing the root causes of the disorder.

Cognitive retraining seeks to alter the faulty beliefs that underlie the patient's suspiciousness. The therapist helps the patient to label and challenge such logical errors as overgeneralization (e.g., "A motorist cut me off on the freeway today. It only goes to show that all motorists are out to get me.") and drawing incorrect inferences (e.g., to point out to the patient that the motorist may have been late for work and not maliciously "out to get her").

Psychodynamic (insight-oriented) therapy focuses on helping the patient to uncover deeply repressed feelings of parental rejection early in life. Such therapy is like a tunnel, in

which the only way out is through. For the patient, this means allowing herself to remember and work through excruciating feelings of inadequacy and depression. As the early parental losses are grieved, the patient finds that she is able to regain some of the lost parental nurturance through a corrective emotional experience with the empathic therapist. Finally, she discovers that she can become a nurturing parent to herself and function as a whole, autonomous person.

For the Christian therapist, treatment of PPD carries a redemptive metaphor. The therapist serves as an ambassador of Christ and gradually helps the patient to view herself as Christ views her. Her critical and unforgiving response to the world is but a mirror of her unconscious conviction that she herself is unlovable and unforgivable. Therapeutic healing comes as she grows to internalize the therapist's model of Christ's acceptance of her.

N. S. THURSTON