

The Dual Diagnosis Pages: "From Our Desk"

Revised 25 March, 2000



Dual Diagnosis and The Schizotypal Personality Disorder (StPD)

Table of Contents

- [Essential Feature](#)
- [Treating the Schizotypal Personality Disorder](#)
- [Dual Diagnosis Treatment: Treating the Addicted Schizotypal Personality Disorder](#)

For references, see the [Bibliography](#) page

The Schizotypal Personality Disorder (StPD)

Essential Feature

The essential feature of StPD is a "pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior" (DSM-IV™, 1994, p. 641).

The schizotypal personality disorder was introduced in the DSM-III in 1980. The term schizotype was first used by Sandor Rado in 1953 as a combination of schizophrenic and genotype. The concept came from the awareness that there were nonpsychotic but eccentric and dysfunctional personalities who were considered to have attenuated expressions of the constitutional defect that underlay schizophrenia (Akhtar, 1992, pp. 260-261). Rado hypothesized that these schizotypal individuals had the same two constitutional defects that were found in schizophrenia, i.e., deficiency in integrating pleasurable experiences and a distorted awareness of the bodily self. The symptoms of StPD came from these two defects and included: chronic anhedonia and poor development of the pleasurable emotions; continual engulfment in emergency emotions, e.g. fear and rage; extreme sensitivity to rejection and loss of affection; feelings of alienation; a rudimentary sexual life; and, a propensity for cognitive disorganization under stress (Akhtar, 1992, p. 263).

Individuals with StPD:

- may have ideas of reference;
- be superstitious or preoccupied with paranormal phenomena;
- feel they have special powers;
- believe they have magical control over others;
- experience perceptual alterations;
- have loose and vague speech (without being incoherent);
- be suspicious and have paranoid ideation;
- be affectively inappropriate;
- have odd and eccentric mannerisms;
- experience interpersonal problems;
- have few close friends; and,
- have social anxiety that does not abate with time (DSM-IV™, 1994, pp. 641-642).

Schizotypal personality disorder encompasses a combination of peculiar behavior, speech, thought, and perception. Individuals with StPD are usually withdrawn and display eccentric beliefs, paranoid tendencies, idiosyncratic speech, perceptual illusion, unusual appearance, inappropriate affect, and social anxiety (Frances, 1995, p. 368).

The ICD-10 definition of StPD is similar to that found in the DSM-IV™. However, this personality disorder has been removed from Axis II and placed with the schizophrenia spectrum disorders. According to the ICD-10, StPD is a disorder characterized by eccentric behavior with anomalies of affect and cognition similar to those seen in schizophrenia. In the ICD-10, an individual diagnosed with StPD must have manifested over a period of two years at least four of the following:

- inappropriate or constricted affect;

- odd, eccentric, or peculiar behavior or appearance;
- poor interpersonal rapport and social withdrawal;
- odd beliefs or magical thinking;
- suspiciousness or paranoid ideas;
- ruminations;
- unusual perceptual experiences;
- vague, circumstantial, metaphorical thinking manifested in odd speech without gross incoherence;
- occasional transient quasipsychotic episodes.

Further, the individual must never have met the criteria for any other schizophrenic disorder (ICD-10, 1994, pp. 103-105).

Beck (1990, pp. 136-137) proposes that the most striking feature of StPD is odd cognition. He describes four types of peculiar StPD cognition: suspicious or paranoid ideation; ideas of reference; odd beliefs and magical thinking; and illusions. He notes that indications of hallucinations, delusions, or loose associations should prompt a consideration of the diagnosis of schizophrenia.

The DSM-IV™ indicates that StPD is more prevalent among the first-degree relatives of individuals with schizophrenia than among the general population (DSM-IV™, 1994, p. 643). Seiver also notes that many family members of schizophrenic patients are eccentric and socially isolated; he states that research supports the idea of familial transmission of schizotypal personality disorder similar to that of other schizophrenia-related disorders (Seiver, Livesley, ed., 1995, p. 77). StPD has a relatively stable course; only a small proportion of individuals with StPD go on to develop schizophrenia or other psychotic disorders (DSM-IV, 1994, p. 643).

Self-Image

Millon and Davis state that individuals with StPD evidence an estranged self-image; they see themselves as forlorn and alienated from the world. They ruminate about life's emptiness and meaninglessness. Many people with StPD see themselves as more dead than alive and threatened by nonbeing. To themselves, they seem insubstantial, foreign and disembodied (Millon & Davis, 1996, p. 626).

These individuals know that their relationships and their vocational experiences are prone to disruption and failure. They begin to isolate and increasingly see themselves as not fitting into the society in which they live. Feedback from others usually confirms that they do not experience the world as others do. They rarely can find affirmation or validation for themselves in their interactions with others.

View of Others: Relationships

Kantor notes that both the schizoid and schizotypal personality disorders show interpersonal reserve and semi-isolation. However, individuals with schizotypal personality disorder demonstrate strange and eccentric beliefs and habit patterns. The schizotypal personality disorder has a "schizoid" tree trunk with odd, quirky branches (Kantor, 1992, p. 75). Walker and Gale (Rain, editor, 1995, p. 57) note that the ideational and perceptual abnormalities of StPD must not cross the clinical threshold into delusions and hallucinations. However, the negative symptoms of social withdrawal and constricted affect may be as pronounced as those observed in many patients with schizophrenia.

Oldham describes individuals with StPD as shy, aloof, and withdrawn; they have difficulty communicating and are estranged from people (Oldham, 1990, p. 260). They are loners who experience intense social anxiety associated with distrust rather than a negative self-appraisal (Sperry, 1995, p. 191). These individuals fear being controlled by others but imagine that they can magically influence people directly or indirectly. They want to be left alone; their interpersonal baseline position is one of hostile withdrawal and self-neglect (Benjamin, 1993, p. 356).

Individuals with StPD have poorly regulated cognitive controls that are particularly vulnerable to disruption when experiencing affective interpersonal stimuli. Cognitive slippage can occur even with low levels of anxiety; when this happens, their speech becomes digressive, vague, and difficult to follow (Seiver, Lion, Editor, p. 49). Unable to achieve interpersonal comfort and satisfaction, they drift into isolation and increasingly peripheral vocational roles (Millon & Davis, 1996, pp. 624-625).

Interpersonal isolation and peculiarity become mutually exacerbating conditions. The more isolated persons with StPD are, the more peculiar they become. The more peculiar they become, the more they are interpersonally maladroit and isolated.

Issues With Authority

Because individuals with StPD are interpersonally more unusual, with eccentric mannerisms, unusual dress, peculiar behavior, and distrust of being controlled, they are less able to manage their behavior than are those with schizoid personality disorder. Accordingly, they are more likely to be able to function only in marginal jobs with limited oversight by anxiety-inducing supervisors. They are also more likely than the schizoid personality disordered individuals to be unable to manage their behavior in public settings and may find themselves in more difficulty with the police. Authority figures are distrusted and intensely anxiety-provoking; their presence may lead to even more bizarre and socially unacceptable behavior.

Schizotypal Personality Disorder Behavior

Individuals with StPD show a variety of persistent and prominent eccentricities of behavior, thought, and perception that mirror, but fall short of, clinical schizophrenia (Millon & Davis, 1996, p. 613). They are socially gauche and are perceived by others as bizarre, odd, or aberrant. Many individuals with StPD dress in an unusual manner that attracts attention (sometimes bewilderment, sometimes amusement) (Millon & Davis, 1996, p. 624).

These individuals are unable to differentiate the salient from the tangential causing them to attend to a different aspect of an event or interpret events differently than others, e.g., they may digress into a discussion of Mexican political corruption when another guest compliments the hostess on the chili served for dinner. They will also ascribe special significance to incidental events, e.g. the Mexican dinner theme might indicate some significant event about to occur in that country. The overall impact of this variance in attention, interpretation, or attribution of meaning to everyday events renders them odd and peculiar to observers (Millon & Davis, 1996, p. 625).

Affective Issues

Sperry (1995, p. 193) describes the StPD emotional style as cold, aloof, and unemotional but hypersensitive to slights. They are generally suspicious and mistrustful. Millon & Davis (1996, p. 627) state that individuals with StPD tend to display one of two predominant affective states. The first is insipid, drab, apathetic, sluggish, and joyless. The second is timorous, excessively apprehensive, ill at ease, agitated, and anxious (Millon & Davis, 1996, p. 627).

Kantor notes that StPD inappropriateness of affect may also result from missing a primary idea and reacting to a secondary or peripheral matter. As in the examples above, if an event is perceived or interpreted in a tangential manner, the accompanying affect will also be dislocated from the central point of what is taking place. The more irrelevant or peripheral the focus, the more unusual (and interpersonally disconcerting) the affective and cognitive responses will be (Kantor, 1992, pp. 78-84).

Defensive Structure

All of the personality disorders have an inherent tendency to live in the past, or in fantasy, with too little input from the here and now. This produces a characteristic infantile quality in these individuals (Kantor, 1992, p. 36). To this, in StPD, is added an inclination to create illogical theories that are wishful, capricious, magical, and mysterious. These odd beliefs are "soft" delusions in that they are modest, trivial, low key, and surrealistic; they create a dreamy eccentricity in individuals with StPD (Kantor, p. 75). Oldham (1990, p. 260) suggests that people with StPD need to believe that they have extraordinary, supernatural powers in order to give meaning to their impoverished sense of self. Millon & Davis (1996, p. 626) propose that StPDs are overwhelmed by the dread of total disintegration and nonexistence; the self-made reality of superstition, suspicion, and illusion counter the threat of non-being.

Millon & Davis (1996, p. 626) describe individuals with StPD as ineffective and uncoordinated in regulating their needs, tensions, and goals. Their inadequate defenses lead to a disorganized and often direct discharge of primitive thoughts and impulses. They are unable to effectively sublimate their energy into reality-based activity and have few successful achievements in life. The disorganized and ineffective defenses further leave StPDs vulnerable to being overwhelmed by excess stimulation.

[Table of Contents](#)

Treating the Schizotypal Personality Disorder

The Schizotypal Personality Disorder Coming Into Treatment:

Few individuals with a Cluster A personality disorder are particularly inclined to seek treatment. They are often forced into therapy by family or the legal system. However, once there, individuals with StPD may respond positively to an environment structured to allow them greater personal and interpersonal success than they can achieve outside of the treatment setting. They are not inclined to prefer isolation; they frequently move to greater and greater isolation via social distress and rejection. They may value a setting where they can enjoy some connection to others.

Medication Issues

Personality disorders are medicated for target symptoms rather than for the personality disorder itself. Joseph (1997, pp. 58-61) believes that, from a symptomatic approach, schizotypal personality disorder can be considered a mild form of schizophrenia with the same characteristics accompanied by mild perceptual and affective symptoms. The difference he describes is quantitative, not qualitative. Therefore, treatment employs similar medications in lower dosages. He notes that StPD can be effectively treated with risperidone, olanzapine, and sertindole for both positive and negative symptoms. SSRIs can improve obsessive, compulsive, and depressive symptoms. However, antidepressants in the absence of antipsychotic medication can make any underlying psychosis worse.

Ellison & Adler (Adler, ed., 1990, p. 49) also note that individuals with StPD have responded positively to low dose neuroleptics which can reduce the tendency to blame others, unwarranted suspicion, outbursts of rage, and repeated interpersonal conflict. These individuals are inclined, however, to experience medication as causing odd side effects and compliance can become a problem (Ellison & Adler, Adler, ed., 1990, p. 59).

Psychopharmacological treatment may also be directed to dimensions that underlie the personality: cognitive/perceptual organization (low-dose antipsychotics); impulsivity and aggression (serotonin blockers); affective instability (cyclic antidepressants or serotonin blockers); and anxiety/inhibition (serotonin blockers and MAOI agents) (Sperry, 1995, p. 7).

For individuals with StPD, anxiolytics in small doses have been effective for anxiety; antipsychotics have been useful for psychotic symptoms; SSRIs have reduced symptoms of interpersonal sensitivity, anxiety, paranoid ideation, and self-injury (Sperry, 1995, p. 205).

Better functioning individuals with StPD who display oddities of speech but who do not have psychotic episodes may not require medication (Stone, Gabbard & Atkinson, editors, 1996, p. 955). Treatment Provider Guidelines

Because of the autistic nature of StPD ideation and cognitive style, it is important to establish a sound psychotherapeutic relationship with these clients. This relationship can then serve as a basis for reality testing for individuals with StPD. Their impaired social interaction and lack of social connection results in ongoing loss of contact with reality. Their connection with treatment providers can serve as a corrective opportunity for their increasing eccentricity and bizarre thinking. Their peculiar thoughts can be treated as symptoms which they can identify and correct within the context of a therapeutic setting, e.g. individual or socialization group sessions (Will, Retzlaff, ed., 1995, p. 105).

One experienced clinician noted that working with clients with StPD requires flexibility and a focus on behavior. She described one StPD client who could not bring himself to speak to his therapist but was able to write her notes on envelopes or toilet paper. It was painful work but he was able to connect in his own unusual manner. He was described as a man who wore three-piece suits and appeared to be more intact than was actually the fact.

Countertransference Issues

Clients with StPD are inclined to engage treatment providers in circuitous, belabored, odd, and meaningless discourses on subjects like: "artistic endeavor and the use of drugs" or "mental health treatment providers as agents of social control." Treatment providers may become overwhelmed, bored, or frustrated and begin to withdraw. Individuals with StPD will not be able to structure treatment sessions; the focus and content will need to come from service providers so that the therapeutic tasks can be achieved and neither client nor clinician become overwhelmed and defeated.

Service providers, in response to these individuals' tenuous boundaries, may begin to feel as if they do not exist in the clients' reality. Clinicians may feel disconnected or, alternately, joined in an idiosyncratic insight that is not based in reality but in the clients' defense system. Clinicians need to form a holding environment that can allow clients with StPD to integrate their feelings and perceptions without getting lost in the circuitous and disjointed cognitions expressed by these individuals (Kubacki & Smith, Retzlaff, ed., 1995, pp. 176-177).

Treatment Techniques

Zimmerman (1994, pp. 92-95) suggests the following questions when assessing for schizotypal personality disorder:

- Have you ever found that people around you -- who seem to be talking in general -- are actually making comments meant for you? If so, how did you find out they were talking about you?
- When you walk into a room, do people stop talking or begin acting differently? Does this happen often?
- Have you ever experienced someone in charge changing the rules specifically because of you but would not admit it?

- Do you sometimes feel like strangers in public places are looking at you or are talking about you? Why do you think they are taking particular notice of you?
- Some people talk about having ESP or mental telepathy; they feel like they can sense what is in someone's mind or predict the future. Have you had experiences like this? Very often? Have these experiences become important in your life?
- Are you superstitious? In what way? Does this influence decisions you make? Do your friends or family share these superstitions?
- Some people believe they can influence the weather or the outcome of ball games just by thinking about them. Do you believe that you can make things happen just by thinking about them?
- Do you believe in curses, omens, hexes, voodoo, witchcraft, magic, or other similar things?
- Have you ever sensed that there was some unusual force or presence close to you? What do you think caused this? Has it happened often?
- Have you ever experienced the world around you looking different than it usually does? Can you describe what it was like? What do you think caused this to happen?
- Do your eyes play tricks on you? For example, have you ever seen someone's face or body suddenly change in shape or form?
- Do you ever mistake noises for voices or shadows for people? Does this happen often?
- Have you ever experienced people who pretended to be your friends taking advantage of you? What happened?
- Do you find yourself trying to figure out what people really mean instead of taking what they said at face value?
- Do people tell you that you read too much into things?
- Do people tell you that you take offense at things that were not meant to be critical?
- Not counting your immediate family, do you have any close friends in whom you can confide?
- Do you generally feel anxious around people? What makes you nervous? How bad does it get for you?

In assessing individuals with StPD, consider possible psychotic processes; determine whether or not there is evidence of hallucinations, delusions, and/or a thought disorder. If symptoms of psychosis are present, treatment must be designed for the seriously mentally ill.

Even if there are no indications of psychosis, treatment is most effective when structured, supportive, and focused on teaching social skills. Individuals with StPD are in danger of increasing loss of contact with reality without social connection (Beck, 1990, p. 140). When these individuals relinquish their activities, they regress into an amotivated state; they often deteriorate and become increasingly less functional without the feedback process that accompanies interpersonal interaction (Millon & Davis, 1996, p. 640). Treatment providers must set limits on aberrant behavior and avoid placing too many demands on clients' fragmented defenses. Instead, support must be provided for existing mechanisms for regulation and control; assistance should be provided to these individuals to order their thoughts by clarification and educative techniques (Dorr, Retzlaff, ed., 1995, p. 203).

Individuals with StPD often experience social isolation as painful; increasing their capacity to develop and maintain a social network is an effective therapeutic strategy (Beck, 1990, p. 140). Institutionalization, when necessary, should be brief; hospital settings breed isolation, reward withdrawal, and lead to increased detachment and bizarre preoccupations (Millon & Davis, 1996, p. 642).

Interviews with individuals with StPD usually elicit surprising statements and peculiar ideas; the clinician must be empathic and show understanding to share their secret and autistic world (Sperry, 1995, p. 199). One source of the cognitive peculiarity for individuals with StPD is what cognitive-behaviorists describe as emotional reasoning. This is a process wherein these individuals believe that a negative external situation exists because they have a negative emotion, e.g. if they are uncomfortable with another person that person must be hostile or dangerous (Sperry, 1995, p. 196). These individuals can be taught to recognize when they are distorting reality. Just because they "feel it" does not necessarily mean "it" is true, e.g. feeling fear does not automatically mean danger exists (Beck, 1990, p. 141). They need to learn to evaluate their thoughts against environmental evidence, not against their feelings. This reduces emotional reasoning and the drawing of incorrect conclusions about interpersonal situations (Millon & Davis, 1996, pp. 640-641).

Individuals with StPD also personalize, i.e., they believe that they are responsible for external situations when this is not the case (Sperry, 1995, p. 196). Therapy time, then, is often spent in education and therapists find themselves functioning as the clients' auxiliary ego (Stone, 1993, p. 187). Structured, focused reframing of environmental cues that normalize the interpretations these individuals make in regard to the behavior of others allows them to function with greater stability, both socially and vocationally. Hypochondriasis is another problem for people with StPD. However, if they can become more successful interpersonally, many of the bodily symptoms will diminish automatically (Stone, 1993, p. 189).

Not pushing individuals with StPD too hard in treatment can prevent their experiencing severe anxiety and having

paranoid reactions. Group or individual sessions must be well structured; the rambling cognitive style of these individuals makes it difficult for them to focus. A supportive approach is often the only kind of therapeutic intervention that they can tolerate in early treatment (Millon & Davis, 1996, pp. 640-641). In fact, for many individuals with StPD, supportive interventions remain the mainstay of treatment. Supportive therapy utilizes sympathetic listening, education about the world, giving advice, problem solving, exhortation, and the quiet establishment of relatedness which relies upon regular contact and nonjudgmental acceptance. The most effective treatment is one in which service providers remain active and involved but avoid becoming overly ambitious or impatient. Expectations must be in harmony with the clients' capabilities. . . even though these fall far short of an ideal life (Stone, Gabbard & Atkinson, editors, 1996, p. 955).

Treatment for individuals with StPD is most effective when family members are involved. Service providers should try to join with the family to engage them in the treatment process. There is the possibility that these clients are meeting pathological needs in the home environment and will not be able to make progress in their own lives without assistance to detach from their family. On the other hand, if the family is supportive, their help can make an enormous difference.

Treatment Goals

Personality disorders derive in part from patterns of behavior and thought that would appear to be hard-wired into the central nervous system during the first six years of life. It is understandable that personality disorders are hard to modify and slow to change. However, studies suggest that positive changes can occur. The treatment goal in working with all of the personality disorders is the same: gradually exchanging new, more adaptive habits of thought and behavior for pre-existing, maladaptive habits (Stone, 1993, p. 152).

In treatment settings, it is most common to encounter schizotypal clients with some schizoid and paranoid features. Improvement is most likely in the occupational areas; it is much more difficult to see progress in social or intimate relationships (Stone, Gabbard & Atkinson, editors, 1996, p. 953). Millon & Davis propose that change is most likely for these individuals in nonintimate interactions, in reality testing, and participation in enjoyable activities. Treatment can help individuals with StPD identify those spheres of life toward which some positive inclination exists. While they may not be able to be enthusiastically involved, increased participation in activities can provide a window of reality-based experiences that may reduce the need for bizarre internal gratifications (Millon & Davis, 1996, pp. 639-640). Beck proposes that treatment should teach individuals with StPD that bizarre thoughts are symptoms and do not have to be responded to behaviorally or emotionally (Beck, 1990, p. 141).

Another treatment objective for individuals with StPD is to develop and maintain social relationships through social skills training, cognitive reorientation, and environmental management (Millon & Davis, 1996, p. 640).

In an outpatient treatment setting, this author has seen individuals with StPD develop connections to others that, while impoverished and rather fragile, were of considerable value to the individuals involved. Their investment in the social contact provided the impetus needed for them to learn and practice social skills and appropriate interpersonal behavior.

[Table of Contents](#)

Dual Diagnosis Treatment: Treating The Addicted Schizotypal Personality Disorder

Cluster A: Incidence of Co-Occurring Substance Abuse Disorders

The schizotypal personality disorder is in Cluster A, the "odd or eccentric" personality disorders (DSM-IV, 1994). Cluster A represents the lowest incidence of co-occurring substance abuse disorders of the three DSM-IV™ personality disorder clusters (Nace, 1990).

Individuals with StPD may have difficulty establishing connections to obtain illegal drugs. If they are able to connect to sources for drugs, they are extremely vulnerable to exploitation and abuse or violence.

Drugs of Choice for the Schizotypal Personality Disorder

While no single pattern of substance use or abuse can be identified for any of the personality disorders, individuals with StPD may well be attracted to psychedelics. Milkman and Sunderwirth (1987, p. xiv) suggest that, from a psychological perspective, drug choice depends on a positive "fit" with individuals' usual style of coping. The drug of choice can function as a pharmacologic defense mechanism. For individuals with StPD, there is the possibility of an addiction to compulsive fantasy and an inclination to seek drug experiences with the psychedelics

that provide imaginative transport such as with LSD, psilocybin, and peyote. Marijuana is also a favored drug for these individuals.

Walant (1995, pp. 146-147) notes that LSD give some individuals a false sense of control. The drug allows escape from reality to a drug-induced mental chaos that seems to be in the control of the users. Weird perceptual distortions can actually alleviate anxiety about personal strangeness that is not drug induced.

Thaddeus Golas, the author of *The Lazy Man's Guide to Enlightenment*, said that each of us declares the state of consciousness we prefer by the drugs we choose. He saw LSD as a means to spiritual levels of consciousness; it will show the user all of the divine intelligence he/she can handle; LSD "speaks from a timeless place" (From the Internet: <http://www.highvib.org/archive1/lsd.htm>). For individuals with StPD, how much more appealing must transcendence to a higher level of consciousness be to feeling or being seen as weird or bizarre.

Alcohol is readily available and may become the drug of choice because of its accessibility. With the capacity of alcohol to disinhibit, individuals with StPD may be able to drink to release an already heightened capacity for fantasy and unusual beliefs about who they are and what they can do.

Dual Diagnosis Treatment for the Schizotypal Personality Disorder

Pattern of drug use and consequent destabilization for individuals with StPD can be similar to the seriously mentally ill/dually diagnosed population, i.e., destabilization may be triggered by use rather than abuse. On the other hand, when there is sufficient psychiatric stability to sustain considerable alcohol or other drug use, these individuals often do not have enough social or interpersonal support to effectively interrupt early drug use or to support an abstinent life style. Treatment therefore must address the development of sufficient social support to foster abstinence without overpowering these individuals with an intolerable level of intimate contact. They may well thrive in Twelve Step Meetings if their behavior is socially appropriate enough to be accepted in the self-help community. If not, they may need Dual Recovery Anonymous meetings or AA/NA meetings attached to community mental health centers where there is often greater tolerance for unusual behavior or disquieting personal appearance. Treatment providers can also watch for community 12-Step Groups that can accept these individuals. Psychoeducation is an essential and effective tool in substance abuse treatment. Individuals with StPD need to learn basic information about drugs and alcohol as well as have their misinformation or misbeliefs challenged. This needs to be done with minimal pressure as individuals with StPD will not prosper in confrontative treatment. They are effective in withdrawing from, distracting themselves from, or disrupting the process of uncomfortable situations. They will not receive or profit from any approach that assumes greater interpersonal strength than they have. Similarly, abstinence cannot be a prerequisite for treatment. Based upon personality dynamics in StPD, abstinence must be a goal. It cannot be achieved with coercion.

In spite of their interpersonal vulnerability, individuals with StPD often have an internal, rather quirky, resistance to what they may perceive as pressure from others. If, for example, they are not convinced that drug and alcohol use have significant negative consequences for them, they may well consider family, friends, and service provider admonitions for abstinence as (perhaps) well-meaning but misguided attempts to make individuals with StPD become conforming, boring, and dull. This will be particularly true if these individuals entertain ideas of transcendence as a result of psychedelic use, e.g. they transcend the ordinary and become wise, spiritual, or special in some manner. It is also likely that individuals with StPD may feel, or actually be, socially adept only when using and when they are with their drug-using friends.

If individuals with StPD are sent to jail, they will be easy prey and will need protection from the general population. They do not pick up interpersonal cues well enough nor are they interpersonally dominant enough to avoid victimization by more aggressive inmates. In a setting of such serious threat, opportunities for substance abuse or dual diagnosis treatment may be well received -- particularly if they involve separation from dangerous others. Similarly, in either inpatient or outpatient dual diagnosis treatment settings, whether in a substance abuse or mental health facility, individuals with StPD may need some protection from other more predatory and exploitive clients. It is in these settings that individuals with StPD can discover, experiment with, or learn to obtain drugs with which they had no previous familiarity.

Dually diagnosed individuals with StPD are quite vulnerable to relapse. If stress increases in their lives, they may well return to drugs or alcohol to manage an increase in symptoms or the failure of their fragile defenses to cope with problems. The pattern of behaviors related to relapse are not different from non-dually diagnosed individuals with addiction. However, the level of support or intervention needed to reverse the process is likely to be more intense as individuals with StPD have few internal resources to resist a full-blown return to addiction.

[Table of Contents](#)

Sharon C. Ekleberry, 2000