Type	Paranoid
General	The whole personality is organized around the theme of **power**, either the persecutory power of others or the megalomaniac powers of self. **Core theme**: attacking/being attacked by humiliating others; Core defense: dealing with one s felt negative qualities by**projecting** them; the disowned attributes then feel like external threats. Mostly in the borderline range
Affect, Drive, Temper ament	**Temperament** High degree of innate aggression or irritability Active symptomatic style in infancy - irregularity, nonadaptability, intensity or reaction, negative mood Hyperexcitability **Affect** **Combination of Fear and Shame** Shame use of denial/projection are very powerful so that no sense of shame is accessible to the Self; they foil the efforts of those trying to humiliate them Differential the shame of narcissist is that they can be unmasked **Anger, vindictiveness, resentment** **Envy** increased vulnerability; is dealt with by projection; the others are out to get me because things about me that they envy. **Unconscious yearning for closeness with a person of the same sex.** Unbearable burden of unconscious guilt **terrorized of being unmasked by the therapist** transform this fear into constant efforts to discern the evil intent behind anyone s else behavior towards them.
Defenses	**Projection** can be at psychotic, borderline or neurotic level **Psychotic** e.g I am followed by homosexual Romanian agents wish for same-sex closeness, power, ethnocentrism **Borderline** projective identification they try to make the projection fit **Neurotic** internal issues are projected in a potentially ego-alien way they describe themselves as paranoid **Denial, reaction formation - correlates of projection** Freud s example of reaction formation and projection I don t love you, I hate you (reaction formation); projection I don t hate you, You hate me! Other examples of projection/displacement: I don t love him, she loves him; I don t love him, I love her;
Object relations/ interpersonal	Repeatedly felt **overpowered/humiliated** through criticism, capricious punishment by adults who cannot be pleased, utter mortification. **Psychotic, borderline ridicule, scapegoats** **Neurotic teasing, sarcasm combined with warmth** **Unmanageable anxiety in a primary caregiver who is incapable of comforting** inducing the idea that pt s private feelings have a dangerous power. **Modeling of a paranoid parent.** Steps First both feelings and reality were disavowed by primary care giver instilling fear, shame rather than the feeling of being understood. Second denial, projection modeled.

	Third Primitive omnipotent fantasies reinforced leading to guilt Final interaction with external world anger. I will hit you before you get a chance to hit me!
Self	Belief that hatred, aggression and dependency are dangerous. Polarity **impotent/humiliated/despised** self-image vs. **omnipotent/vindicated/triumphant** one First engenders terror and shame Second engenders guilt Combination of sexual identity confusion, longings for the same sex closeness, preoccupations with homosexuality. **Homosexuality** longing for a peer, safe way to get away from solitude and isolation
Transference/ Counter-transference	**Transference** In most cases is swift, negative and intense. Therapist seen as potentially disconfirming and humiliating (rarely as a savior). They may fix their eyes on the therapist paranoid stare . **Countertransference** Either anxious or hostile. Because of powerful defenses of denial/projection therapist may feel the emotional reaction that the patient has exiled from the consciousness. E.g. patient may feel full of hostility while therapist feel fear or patient may feel vulnerable/helpless while therapist feels sadistic/powerful.
Therapeutic implications	Interpretation from surface to depth is usually impossible because of multiple defense operations denial, projection, displacement (a man who longs for the support of someone of his gender, misreads it as sexual desire, denies it, projects it into someone else and displaces it becomes overwhelmed with fears that his wife is having an affair with his friend). Analysis of denial and projection brings more defenses of the same kin. Exploration and pointing out unconscious manifestations boomerang. 1) **use of humor**/attitude of self-mockery, amusement at world s irrationalities and other nonbelittling forms of wit jokes are a time-honored way to discharge aggression safely. They also tell that the therapist is real and not playing a role or pursuing a secret game plan. 2) **Avoid the content, engage with the disowned, projected feeling** 3) Identify what was the **recent trigger** of upset 4) **Avoid direct confrontation of the content of a paranoid idea**; do not offer alternative explanations but only when the paranoid client asks outright if the clinician agrees with their understanding. 5) Avoid interventions that invite them to explicitly accept or reject therapist s ideas. From their perspective acceptance equals a humiliating submission and rejection invites retribution. 6) **Make repeated distinctions between thoughts and acts**. Go beyond interpretation of feelings and fantasies to the recommendation that one enjoys them. Bad thoughts are a lot of fun especially when one could do good deeds in spite of them . 7) One must be **hyperattentive to boundaries** consistency is critical to a paranoid s sense of security; 8) Therapist should convey both **personal strength and unequivocal frankness** sometimes what matters more than what is said is how confidently, fortrightly and fearlessly the therapist delivers the message.

	Respect, integrity, tact, patience
Differential Diagnosis	**Paranoid vs. Psychopathic** Significant overlap many have strong tendencies in both directions Both are concerned with issues of power but from different perspectives. Projective processes are common in antisocial people, but where psychopaths are fundamentally unempathic, paranoid people are deeply object related. Unlike psychopaths, people with essential paranoid structure have profound guilt the analysis of which is critical to their recovery from suffering. The main threat to long term attachment in paranoid people is not lack of feeling for others but rather experience of betrayal. They connect with others on the basis of similar moral sensibilities and hence they and their love objects are united on the basis of what is good and right, any perceived moral failing by the person with whom they are identified feels like a flaw in the self that must be eradicated by banishing the offending object. **Paranoid vs. Obsessive** They share a sensitivity to issues of justice and rules, a rigidity and denial around softer emotions, a preoccupation with issues of control, a vulnerability to shame, and a penchant for righteous indignation. They also scrutinize details and may misunderstood the big picture because of their fixation on minutia. Furthermore, obsessional people in the process of decompensation into psychosis may slide from irrational obsessions into paranoid delusions. They differ in the role of humiliation in their histories and sensitivities; the obsessive person is afraid of being controlled but lacks the paranoid person s fear of physical harm and emotional mortification. Obsessional people are much more likely to cooperate with the interviewer despite their oppositional qualities; therapists working with them do not suffer from the same degree of anxiety that paranoid patients induce. Rage reactions to conventional clarifications and interpretations in a patient one has believed to be obsessional may be the first sign that his or her paranoid qualities predominate.