ARTICLE

# Deconstructing detachment: a clinical guide for psychiatrists

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## SUMMARY

This article aims to help clinicians better assess and manage patients who show 'problematic detachment': interpersonal distancing that is resulting in functional impairment or distress. It considers both the possible relevant social contextual factors and the wide range of possible underlying psychopathologies that can result in problematic detachment, including mental illnesses, neurodevelopmental disorders and personality pathology. After giving a practical framework for diagnostic formulation, it summarises key aspects of best practice when working with such individuals. The article covers four key questions that the clinician must address. Is problematic detachment present? If so, what specific challenges underlie and maintain it in this person? Based on that, what diagnostic formulation makes sense for this individual? Finally, using this understanding, how can they best treat this individual?

## LEARNING OBJECTIVES

After reading this article you will be able to:

- develop a comprehensive clinical formulation of patients presenting with problematic levels of detachment
- describe the various psychopathological and social contextual factors that may underpin problematic detachment
- devise a logical, evidence-based management plan that addresses problematic detachment.

## KEYWORDS

Personality disorders; psychotic disorders/schizophrenia; autism spectrum disorders; neurodevelopmental disorders; trauma and stressor-related disorders.

There is a small but challenging subset of patients presenting to psychiatrists who show an unusually high degree of interpersonal distancing – intuitively experienced by the clinician as a profound sense of emotional disconnection. This phenomenon attracts various value-laden terms, including 'lack of warmth', 'oddness', 'eccentricity', 'aloofness', 'social awkwardness' and 'coldness'. All such terms imply significant detachment (Box 1); where there is also functional impairment and/or distress, it can reasonably be called problematic detachment. This article aims to help psychiatrists to understand and treat such individuals, using problematic detachment as an umbrella term to cover a range of underlying psychopathologies. Effective care of such patients requires not only an understanding of possible associated pathologies of personality, but also an appreciation of how problematic detachment may arise secondary to other mental disorders and/or environmental factors.

**BOX 1** ICD-11 and DSM-5 definitions of detachment

**ICD-11 (World Health Organization 2025)**

> 'The core feature of the Detachment trait domain is the tendency to maintain interpersonal distance (social detachment) and emotional distance (emotional detachment). Common manifestations of Detachment, not all of which may be present in a given individual at a given time, include: social detachment (avoidance of social interactions, lack of friendships, and avoidance of intimacy); and emotional detachment (reserve, aloofness, and limited emotional expression and experience).'

**DSM-5 Alternative Model for Personality Disorders (American Psychiatric Association 2013)**

> Detachment (versus Extraversion): 'Avoidance of socioemotional experience, including both withdrawal from interpersonal interactions, ranging from casual, daily interactions to friendships to intimate relationships, as well as restricted affective experience and expression, particularly limited hedonic capacity.'

Facets (not all of which need to be present):

- withdrawal
- intimacy avoidance
- anhedonia
- depressivity
- restricted affectivity
- suspiciousness.



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The article will outline a simple heuristic guide to problematic detachment, structured in terms of four key questions addressing whether problematic detachment is present, what challenges underlie and maintain it in a particular individual, what diagnostic formulation makes sense for the individual and what is the best therapeutic approach for them.

## Is problematic detachment present?

It is rare for problematic detachment to be a presenting complaint. More commonly, it is encountered in persons coming to clinical attention because:

- they have co-occurring psychopathology, and/or
- they were pressured into seeking help by others, and/or
- they have been referred for assessment in forensic contexts.

The detection of problematic detachment therefore requires particular vigilance: mental state examination, history-taking and psychometric testing may each flag its possible presence. As always, robust formulation requires spending time with the patient and key informants to obtain a comprehensive history. Problems with detachment may have a relatively rapid onset, in which case personality dysfunction is an unlikely explanation; not uncommonly however, they arise from a complex admixture of personality vulnerabilities and other co-occurring psychopathology. Teasing apart the relative contributions of dynamic state factors versus slowly changeable trait factors requires careful attention to longitudinal history, including early development. User-friendly psychometric tools can, however, assist with screening for problematic detachment (Kim 2021) even in busy clinical contexts.

Note that even an unusually high degree of detachment is not necessarily problematic: in certain environmental contexts, detachment may be adaptive; even high degrees of introversion are not pathological per se, notwithstanding the challenges associated with such traits in contemporary society (Cain 2012). Also, given the extent to which interpersonal connections are nowadays virtual, the question of what constitutes problematic detachment may be increasingly contested: for example, should the term apply to a person who rarely meets another human 'in real life' but whose productive work life is conducted online and whose favoured recreation largely comprises interacting through video games and social media?

## What specific challenges underlie and maintain this patient's problematic detachment?

If problematic detachment is assessed as being present, the specific barriers to achieving more functional levels of attachment need to be clarified. These can be considered under three distinct domains.

- Motivation:
  - How much does the patient care about interpersonal and emotional connection?
  - Does connecting with others yield sufficient reward (pleasure) to sustain motivation to connect over time?
- Interpersonal safety appraisal:
  - Does the patient have sufficient confidence that interpersonal and emotional connections will not threaten their safety (psychologically or physically)?
- Capacity to communicate:
  - Is capacity for reciprocally fulfilling and effective social communication impaired?
  - Can the patient adequately understand social communications made by others?
  - Can they make themselves properly understood in social contexts? Central to communication is adequate understanding and appreciation of others' perspectives, both cognitive and emotional – a capacity captured by a range of overlapping constructs, including cognitive empathy, cognitive theory of mind, social cognition and mentalisation.

Problems in any one of the above domains may result in problematic detachment. Furthermore, the three domains interact in mutually reinforcing ways, so challenges in one domain frequently bring problems in one or both of the others (Fig. 1).

For example, an autistic person who struggles to follow the complex group dynamics of their neurotypical peers (a communication challenge) may lose the confidence to socialise with them (owing to an appraisal that their psychological safety is threatened, a fear that may be reinforced if their peers engage in rejection or ridicule) and subsequently lose the motivation to do so (because it is no longer pleasurable). Or a previously gregarious person who is seriously assaulted may develop post-traumatic stress disorder (PTSD) with features that include hyperarousal and hypervigilance (heightened preoccupation with physical safety). Leaving the home, even to socialise with friends, may become an exhausting and unrewarding chore (leading to reduced motivation to do so). After a prolonged period of withdrawal, social skills (capacity to



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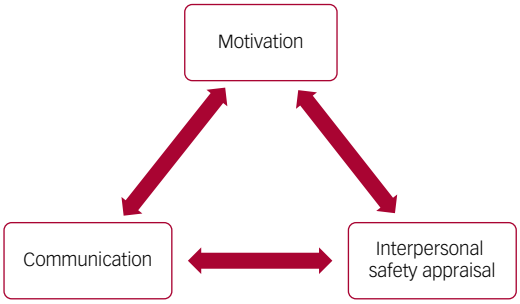



**FIG 1** The three interacting domains.

communicate with others) may begin to deteriorate.

## What diagnostic formulation makes sense for this patient?

Problematic detachment may have its origins in:

- relatively normative and possibly adaptive responses to contextual circumstances
- personality spectrum pathology
- other psychopathology
- a mixture of some or all of the above.

### *Contextual barriers as a source of problematic detachment*

Contextual variables can have a profound impact on each of the three domains that underpin social attachment:

- motivation: the environment sets the contingencies of reward and punishment that drive motivation to attach or to detach;
- interpersonal safety appraisal: the optimal level of trust versus mistrust in any given interpersonal encounter is influenced by context – what is adaptive in one situation may be unsafe or may impede healthy relationships in another;
- communication: effective social communication is a bidirectional process – contingent on both the person who communicates and the messages that they are able to receive from others.

Hence, before diagnosing problematic detachment as primarily indicating individual-level psychopathology (whether personality-based or otherwise), it is essential to consider the environment in which the person finds themselves embedded.

Social contextual factors that may especially heighten the risk of detachment include (Mirowsky 1983; Haynes 1986):

- feeling different from the rest of a social group (such as in school, college or workplace) because of, for example, gender, race, level of experience;
- feeling under the evaluative scrutiny of others with more power, such as professional seniors;
- subjective uncertainty regarding social status, for example when new to a group;
- actual powerlessness, victimisation or bullying;
- acute disruption of social networks;
- environments in which previously learned social skills may be less useful, for example following imprisonment or emigration (especially in the early stages);
- environments involving sensory deprivation, for example prolonged darkness.

It has been suggested (Kramer 1998) that such situations promote 'dysphoric self-consciousness' and thence hypervigilance, rumination, mistrust, a reduced motivation to socialise and interpersonal detachment. Resulting behaviours, such as withdrawal and impaired communication, may in turn exacerbate self-consciousness, resulting in a vicious cycle.

Thus, a degree of detachment due to mistrust and/or communication challenges and/or reduced motivation to mix with others is normal in some contexts. The boundary between an understandable and 'normal' response to challenging situations versus diagnosable psychopathology is a contested and value-laden issue: false positives may stigmatise the individual and may endorse an iniquitous status quo that entrenches unfair power differentials; false negatives may mean that the opportunity to properly address an individual's suffering is missed. Clearly, this is not an either/or proposition: frank mental illness can be generated by pathogenic environments and there may be an interaction between such environments and pre-existing personal vulnerabilities.

### *Personality spectrum pathology as a source of problematic detachment*

A range of distinct but overlapping personality pathologies are associated with problematic detachment.

'Avoidant' refers to individuals with elevated sensitivity to interpersonal rejection and consequent avoidance of social interaction. Beneath the detached exterior may lie an anguished desire to relate to others, suffocated by fears for their own psychological safety: an anticipation of humiliation or rejection. It is not that they view others as malevolent, but rather that they view themselves as inadequate and hence likely to be negatively judged by others. Not surprisingly, negative affectivity, clinical depression, substance use and suicidal ideation are overrepresented in such individuals (Lampe 2018). Early neglect and emotional abuse may be risk factors for avoidant pathology



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(Lampe 2018), but it should not be assumed that all such individuals have suffered such childhood experiences.

'Paranoid' refers to individuals presenting with fear of harm that is attributed to purposeful malevolence on the part of others. Their appraisal of interpersonal safety is hypersensitive, manifest as suspiciousness and mistrust. Such individuals tend to also show elevated negative affectivity and may display pathological hostility: a tendency to react angrily to perceived attacks and to hold grudges. Paranoid traits have also been linked with deficits in cognitive empathy (Lee 2017). Unsurprisingly, childhood emotional and physical abuse are associated with such traits (Triebwasser 2013). (Note that many patients use the word 'paranoid' to describe any fears that underpin their withdrawal from the world; it behoves the assessing clinician to clarify precisely what a given patient means by the word.)

'Schizoid' refers to individuals who are preoccupied with their own inner world, keeping their feelings inaccessible to others and presenting as asocial, reserved, without warmth or humour and sometimes frankly odd (Kretschmer 1936). It has long been recognised that some such individuals have a rich inner world ('fantasy life') in which they evidently prefer to dwell, to the neglect of their interpersonal milieu. Detachment results from the person simply not deriving usual levels of pleasure from interpersonal connections and thus lacking motivation to develop them. Individuals with schizoid personality pathology generally show such features from childhood onwards (Wolff 1980). As with paranoid traits, those with schizoid traits commonly show deficits in cognitive empathy (Booules-Katri 2019). Adverse childhood experiences (such as institutionalisation) are a risk factor (Yang 2007) and some have posited that emotionally cold early caregiving engenders such traits (Choi-Kain 2021). However, the evidence is insufficient to make any assumptions about the developmental history of any given individual based purely on their presenting with schizoid features.

In certain other kinds of personality pathology, motivation to engage in interpersonal relationships may be overridden by competing motivations to engage in other sources of gratification:

- individuals with prominent anankastic features may value work and productivity at the expense of personal relationships;
- those with prominent narcissistic features may lack interest in others except insofar as they can bolster their own self-esteem; they may also be pathologically oblivious to others' perspectives and/or hypervigilant about the possibility of being influenced by others.

## *Other psychopathology as a source of problematic detachment*

### Psychotic spectrum pathology

Psychotic disorders, whether primary in nature or secondary to triggers such as stress or the effects of substances, commonly result in persecutory delusions, with a consequent response of relatively abrupt detachment from other people. The longitudinal history of a clear-cut change from premorbid functioning, along with associated positive symptoms, will generally make the diagnosis, including the distinction from personality disorder, quite clear.

Problematic detachment may also arise in individuals with schizophrenia secondary to enduring negative and/or neurocognitive symptoms, even after positive symptoms have resolved. As well as these motivational changes, social communication deficits due to impaired perspective-taking are overrepresented in people with schizophrenia (Bora 2009).

Historically, 'delusional disorder: persecutory type' (previously termed paranoia) was viewed as an offspring of pre-existing personality vulnerabilities. Thus, Kraepelin (Kendler 2016) promulgated continuity between personality pathology and paranoia, which he described as a 'sort of psychic malformation [...] the root of [which] is to be sought in a particular "paranoid" predisposition. [However,] to produce [paranoia] especially unfavourable external and internal conditions have to work in combination' (Kraepelin 1916). The condition thus seems to 'develop on the fertile soil of certain personality types' (Kendler 1995: p. 369).

Consistent with this idea of predispositions existing on a spectrum, empirical research into paranoid symptoms in the general population (Bebbington 2013) supports a continuum of increasing interpersonal sensitivity from simple mistrust, to ideas of reference, to frank fixed delusions. Consistent with this, paranoid personality pathology and delusional disorder show shared genetic vulnerabilities (Bernstein 1995).

Thus, the boundary between delusional disorder (persecutory type) – a form of psychosis – and personality disorder with prominent paranoid features appears to be 'fuzzy', and the relationship between the two constructs may be one of consanguinity resulting in a 'Galenic syndrome': 'a combination of personality disorder and clinical symptom complex so frequently associated that the two conditions should be considered as a single disorder' (Tyrer 2022a). In such cases, psychiatrists may more usefully focus on assessment of specific, dynamic phenomenological features such as current degree of conviction, preoccupation and functional



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impairment rather than hunting the Snark of diagnostic clarity. The often associated question of the appropriateness or otherwise of involuntary treatment then may turn on matters such as decision-making capacity and least restrictive care required to manage risk of harm, rather than on an overly simplistic dichotomy between illness and personality.

Schizotypal disorder sits within the 'Schizophrenia and other primary psychotic disorders' chapter in ICD-11 (World Health Organization 2025), rather than being construed (as it is in DSM-5; American Psychiatric Association 2013) as a personality disorder. It has been viewed as a neurodevelopmental disorder with genetic, prenatal and early postnatal origins, conferring vulnerabilities that affect both neurobiological and psychosocial functioning (Raine 2006). However, many who score significantly on schizotypal personality traits (or the similar construct of psychoticism) would not quite meet criteria for schizotypal disorder (Chapman 1994); therefore, there is also value in the dimensional concept of schizotypy, which may exist as a non-pathological personality trait.

However conceived, along with the oddities of belief and thinking that are intrinsic to the condition, prominent detachment is a core feature of schizotypy; associated features may include:

- misappraisals of interpersonal safety, whether at the level of social anxiety or paranoid mistrust;
- aloofness, with limited motivation to engage at an interpersonal level (social anhedonia);
- impairments in perspective-taking, predisposing to deficient reciprocal communication (Pflum 2013).

## Trauma-related pathology

Diminished social functioning is a common part of post-traumatic psychopathology: post-traumatic hypervigilance regarding safety (physical and/or psychological) in social contexts may result in problematic detachment. This can be severely distressing, disabling and at times 'indistinguishable from paranoia' (Triebwasser 2013).

Alternatively or additionally, emotional numbing and/or shame may inhibit the normal pleasure response in interpersonal contexts, sapping motivation for social contact. In some, the level of detachment is sufficiently severe and prolonged as to amount to an enduring change of personality functioning, a notion previously captured in ICD-10 by 'Enduring personality changes after catastrophic events' and now, in some at least, in ICD-11 by 'Complex post-traumatic stress disorder'.

## Affective disorders

Various pathways link mood disturbance with state-related problematic detachment. Individuals suffering depressive disorders, as part of a generalised loss of hedonic tone may show diminished motivation for social connection. In some, depressed mood may result in excessive concern about negative evaluation in social contexts, resulting in social withdrawal. This may reach the level of 'bad-me paranoia' (Chadwick 2005), wherein the sufferer believes that they are being persecuted in some way, but that this is deserved.

Less commonly, manic elevation may present with detachment, as the individual becomes absorbed in their own thought processes and/or loses motivation to connect with others, who are deemed unworthy, secondary to manic grandiosity.

## Anxiety disorders

Social withdrawal is a common feature of clinical anxiety, irrespective of precise diagnosis. Sufferers may long for interpersonal connection, but struggle to attain it owing to pathological fear of negative evaluation and consequent withdrawal. Eventually, symptoms of social exhaustion may supervene, wherein any motivation to engage with other people is lost.

Clinically, the distinction between agoraphobia and social anxiety disorder has important implications for treatment. Superficially, they may present similarly – with withdrawal from the outside world. However, agoraphobia is not predicated on interpersonal detachment as such: rather, it involves an excessive fear of being in a situation from which escape may be difficult or help might not be available. However, in the longer term, diminution in social skills and social exhaustion may complicate the picture.

## Neurocognitive disorders

The accurate appraisal of safety in interpersonal contexts is a complex task, involving both cognitive and emotional processes, contingent on higher-order cortical functioning working in tandem with subcortical threat-detection systems. Similarly, social cognition (decoding social cues, understanding the perspective of others and communicating effectively with others) and motivation to engage socially also have complex neurobiological underpinnings. Unsurprisingly therefore, neurocognitive disorders may present with problematic detachment.

The abrupt onset (over days or hours) of problematic detachment should prompt consideration of possible delirium. More slowly emerging social withdrawal, over a period of months or longer, may herald a neurodegenerative condition.



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Acquired brain injuries are a well-recognised risk factor for the development of paranoid thinking, with evidence that up to a quarter of individuals with these injuries develop such symptoms (Munro 1988); others may develop pathological apathy with associated problematic detachment.

More circumscribed deficits affecting sensory functioning, notably hearing, have long been associated with impaired reciprocal communication and, in some, paranoid thinking (Triebwasser 2013).

### Neurodevelopmental disorders

The relationship between autism spectrum disorder and personality pathologies characterised by detachment is complex, with various theories as to their nosological relationship (Vuijk 2018). It has been suggested that in some there may be consanguineous relationship: a 'true Diogenes syndrome [that] combines one part of autism spectrum disorder [. . .] with the personality profiles of detachment and anankastia' (Tyrer 2022b).

In general, although autistic individuals may have intact motivation for social interaction, they face various challenges in reciprocal social communication with neurotypical individuals that may result in problematic detachment, including (Vicker 2009):

- difficulty comprehending others' perspectives (emotional and/or cognitive) when these differ from their own, with a resulting tendency to social naivety and an assumption that others know what they are thinking;
- reduced use of bidirectional eye contact as non-verbal communication;
- difficulties with intuitively adhering to unwritten social rules that govern relations between neurotypical individuals;
- difficulties engaging in to-and-fro reciprocal conversation; and
- difficulty recognising subtle expressions of emotions.

Some may develop motivational and confidence problems in engaging with others, especially with neurotypical individuals, as a consequence of such difficulties. A further challenge for the clinician seeking to formulate such issues is the complex, value-laden question as to whether neurodiverse ways of functioning in the social world ought to be labelled as pathological at all (Fletcher-Watson 2020). It is increasingly recognised, for example, that there is a 'double empathy problem' (Fletcher-Watson 2020) of bidirectional communication challenges across the autistic/neurotypical divide: autistic individuals may be better at interpreting social signals of other autistic individuals as compared with neurotypicals and vice versa.

### Addiction disorders

As with most clinical presentations, the possible confounding effects of addictions need to be considered. Personality traits that predispose to problematic detachment, such as excessive harm avoidance, have been shown to relate to elevated risk of some addictions (Matosic 2016). Also, addictive behaviour itself – whether involving intake of substances or behavioural addictions – entail a source of reward (whether pharmacological or behavioural) becoming pathologically prominent in a person's reward repertoire. As a result, the normative degree of pleasure afforded by interpersonal contact may become so constricted that problematic detachment may result.

## How can we best treat this patient?

Although the research base for working with problematic detachment is thin, some useful guidance can nonetheless be provided for psychiatrists. In addition, there are some specific therapeutic approaches that claim special value for the treatment of underlying personality pathologies (Young 2003; Renton 2015; Lampe 2018; Bach 2020; Cheli 2021). Some useful general principles for treatment are widely accepted and are summarised below.

### *Develop a shared understanding*

The collaborative development of a shared understanding may be an especially slow process requiring patience and diligence. More often than not, even when co-occurring psychopathology is identified, some personality difficulties will form a core part of the formulation. Shared understandings, however, require shared language: clinicians must be mindful that terminology may alienate rather than engage. The public discourse around terminology relevant to mental health is fluid and at times turbulent: the term personality disorder remains heavily stigmatised (perhaps with the exception of borderline personality disorder). A useful approach is to tailor language sensitively and flexibly in a way that works for the individual patient, but to acknowledge that it may be 'still necessary for medicolegal, technical and procedural reasons, to keep the term, personality disorder' (Tyrer 2022a: p. 111).

When developing a shared understanding, discussing dimensional models of personality pathology that explicate its relationship to normal personality traits can be very helpful. A focus on traits (rather than diagnostic categories), along with



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the idea that such traits exist on a spectrum of severity and usually only become problematic in some circumstances (while perhaps being adaptive in other situations), can help to convince a hesitant patient that positive change is possible.

Furthermore, it can be helpful to conceptualise personality traits not as intrinsically maladaptive symptoms of disease, but as part of the person's unique psychological make-up, to be worked with rather than eliminated. The distinction between basic tendencies (i.e. core personality traits) and characteristic adaptations (i.e. how traits manifest as thoughts, feelings and behaviours, sometimes in unhelpful ways, in certain contexts) can be therapeutic gold. Although basic tendencies underlying detachment may resist change, characteristic adaptations and related functional impairments and distress are amenable to therapeutic intervention (Tyrer 2022a: p. 85). Adaptations involving inflexible, unhelpful learned patterns of expressing core traits may be agreed on as a target for treatment, with a goal of discovering new, adaptive ways of being in the interpersonal world, in harmony with the underlying personality. Individuals presenting with detachment that is initially problematic may thus be helped to 'create a way of living that is consistent with their basic stylistic traits and needs rather than attempting to become even mildly extroverted' (Tyrer 2022a: p. 86). This strengths-based approach recognises that detachment (as with all traits) may be a relative strength in some contexts, for example when sustained focused work conducted in solitude is required. The clinician thus helps the patient to discover 'a niche in society that provides some degree of involvement and social status' (Paris 2020: p. 86).

The extent to which exploration of putative historical antecedents of interpersonal detachment is a useful part of developing a shared understanding will vary. Where there is a clear, established history of trauma (with or without co-occurring personality pathology), this may be an important consideration when making sense of problematic detachment. However, it should not be assumed that significant past trauma is always part of the aetiological underpinnings of problematic detachment or that trauma-focused therapy is always an essential element of treatment.

### *Treat coexisting psychopathology*

Depending on the formulation, in some individuals it will be essential to treat mental illness as a first step. In some, for example where a treatment-responsive major depressive episode drives social withdrawal, this may be all that is required. In others, there will be a significant residuum of problematic detachment, often due to co-occurring personality pathology.

As well as being part of the presenting problem, mental illness may later emerge as a new problem to be addressed during treatment. For example, depression and even suicidal thinking may emerge when previous rigid psychological defences are challenged in someone with avoidant or paranoid traits. This emergent psychopathology will then require treatment in its own right; this risk, of course, further highlights the need for an appropriately measured pace of therapy in such individuals.

### *Be very sensitive to the dynamics of the clinical relationship*

Unsurprisingly, problematic detachment is likely to play out in the dynamics of the clinical encounter. When it is driven by the patient's concerns about interpersonal safety, the power dynamics inherent in clinical encounters will require more than the usual degree of sensitivity and attention. A patient's expectations of mistreatment and/or rejection may otherwise be readily confirmed by even a minor oversight or careless remark on the part of a well-intentioned clinician. Specific ways of managing issues of power dynamics include:

- conveying genuine desire to understand (curiosity) rather than judge;
- avoiding rushed or overly confrontative approaches;
- starting with 'safe' areas of conversation and not diving into the problem head-on;
- taking special care to avoid fomenting suspicion, for example by informing the patient if contact occurs with other clinicians involved in their care;
- documenting the source of any information in the clinical file;
- empowering the patient to maximise their sense of control over their treatment;
- being open, honest and firm when necessary, explaining why particular decisions have been made, particularly decisions that may be unwelcome.

The risks of an overly warm therapeutic style with patients with paranoid personality pathology are recognised: they may misunderstand acts of kindness or words of encouragement as a cover for malevolent intention; even overly close seating may be counterproductive. Conversely, patients with avoidant personality pathology may benefit from a warmer approach, with more in the way of supportive, explicit encouragement.



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### Promote change, but slowly

Notwithstanding the therapeutic pessimism often engendered by problematic detachment, the promotion of positive change by clarifying collaborative treatment aims and goals has been emphasised (Lampe 2018). In keeping with the ICD-11 framework that prioritises severity rather than category of personality dysfunction, measurement of the functional impact of interpersonal detachment (for example by assessment on the DSM-5 Level of Personality Functioning Scale at suitably spaced intervals) may help to track slow but enduring therapeutic change over time.

### Acknowledge and manage countertransference

The value of managing and making use of common countertransference reactions, such as frustration, irritability, impotence and despair, is recognised: it has been suggested (Stone 2014: p. 1002) that 'provided that the patient is not grossly delusional and that some working alliance has been formed, the therapist in becoming cognisant of these feelings may then suggest that the patient may also be saddled with these same feelings': clearly, the timing of such interpretative suggestions will be a matter of careful clinical judgement.

### Address behavioural cycles that maintain problematic detachment

Detachment, whether primarily attributable to challenges in motivation, interpersonal safety appraisal or reciprocal communication, can readily become a self-reinforcing problem. Whether at the level of social anxiety or frank paranoia, a downward spiral can develop, whereby psychological drivers underpinning detachment 'group together because they mutually influence each other' (Fonseca-Pedrero 2017). Thus, withdrawal and isolation that has developed for any reason can promote:

- further deterioration in social skills;
- aggravation of interpersonal anxiety, as the individual never learns that the world is safer than they fear;
- further diminished motivation as withdrawal becomes an ingrained habit; and
- abandonment by previously important social attachment figures, who sense that they are no longer wanted as part of the person's life.

The exploration of such behavioural cycles with the patient can provide a useful framework for individualised cognitive–behavioural work. There is also evidence that such maintaining cycles can even be ameliorated by self-help therapy (Freeman 2016). I explored their role in paranoid thinking in more detail in an earlier article in this journal (Carroll 2009).

### Manage risks

Notwithstanding what is often a calm and superficially 'behaviourally settled' veneer, individuals with problematic detachment – especially those with paranoid features – may ruminate on perceived slights and may have a low threshold for feeling deliberately provoked by others. As well as violence, risks of suicide, complaint and litigation, and stalking are hence relevant concerns in treatment (Carroll 2009). Therapeutic work needs to be undertaken with these concerns in mind and appropriate risk management implemented from the start: a collaborative crisis plan should be developed early on in therapeutic work; for those with prominent mistrust, clinical encounters should not take place in environments where emergency help cannot be summoned.

### Consider judicious use of pharmacology

Clearly, co-occurring mental illnesses such as PTSD, psychosis or major depression may require pharmacotherapy. This may be a necessary step to clarify and thence to effectively address underlying, co-existing personality pathology.

The use of medication where personality pathology alone is diagnosed is much less straightforward. Although the evidence base for pharmacological treatment of personality disorder per se is not strong, at a pharmacological and neurobiological level, a clean line between personality pathology and mental illness pathology is unlikely (Goldberg 2022).

Although low doses of potent antipsychotic agents have been recommended for individuals with prominent paranoid symptoms, those very symptoms may promote suspiciousness of pharmacotherapy and hence non-adherence (Stone 2014). Certainly, it would be unwise to overemphasise the role of such treatment with such individuals, particularly early on in therapy before a trusting alliance of some degree has been established.

Where schizotypal disorder is diagnosed, the antipsychotic risperidone may improve global functioning; antipsychotics may also reduce the likelihood of transition to frank schizophrenia (Kirchner 2018).

Importantly, clinicians should beware that an underlying personality trait of detachment may shape the outward manifestations of any mental illness, such that the illness may present in an atypical fashion. Where lowered mood is a feature therefore, even if many of the usual markers of



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major depressive disorder are absent, an empirical trial of antidepressant medication may be indicated.

## Conclusions

The success and survival of our species is contingent on our capacity for interpersonal attachment. It is hence appropriate that diminution in this capacity is a focus of clinical concern. Although problematic detachment (where such a diminution is associated with distress and/or functional impairment) may in some people be best conceptualised as part of personality pathology, there are a range of other psychopathological mechanisms and environmental factors that may lead to, or at least contribute to, the same problem. Working with patients who present with problematic detachment therefore requires the exercise of psychiatric skills that integrate a nuanced understanding of the unique mix of intra-individual and contextual variables that will be involved. This article provides a pragmatic conceptual map that may assist by facilitating a management plan based on comprehensive formulation that considers not just individual psychopathology, but also the potentially critical role of contextual factors. Such work is likely to be challenging, sometimes frustrating, but always fascinating.

## Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

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## MCQs

Select the single best option for each question stem

**1 In DSM-5, which of these is *not* a possible facet of detachment?**

a withdrawal
b intimacy avoidance
c anhedonia
d anankastia
e restricted affectivity.

**2 Avoidant personality pathology:**

a refers to a tendency to procrastinate
b always indicates a history of childhood abuse
c is another term for schizoid
d involves high sensitivity to interpersonal rejection
e requires antipsychotic medication.

**3 Kraepelin's model of paranoia:**

a viewed it as related to pre-existing personality vulnerabilities
b has been disproven by modern research
c stated that it was another term for schizophrenia
d related suspiciousness to manic–depressive insanity
e links closely to the modern concept of neurodiversity.

**4 In assessment of patients with problematic detachment, which of the following is *not* essential?**

a consideration of possible social factors driving detachment
b a careful longitudinal history
c an empirical trial of antidepressant medication
d consideration of the person's capacity for appraisal of their own psychological and physical safety
e consideration of possible past trauma.

**5 Schizotypal disorder:**

a is defined similarly in both ICD-11 and DSM-5
b implies the presence of severe psychotic symptoms
c is an episodic condition, characterised by sleep disturbance
d is caused by maternal alcohol use
e is a risk factor for subsequent development of schizophrenia.



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