

Schizotypal Personality Disorder

Authored by
mohammad looti

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Schizotypal personality disorder, or simply schizotypal disorder, is a personality disorder that is characterized by a need for social isolation, anxiety in social situations, odd behavior and thinking, and often unconventional beliefs.

Causes

Genetic

Although listed in the DSM-IV-TR on Axis II, schizotypal personality disorder is widely understood to be a "schizophrenia spectrum" disorder. Rates of schizotypal PD are much higher in relatives of individuals with schizophrenia than in the relatives of people with other mental illnesses or in people without mentally ill relatives. Technically speaking, schizotypal PD is an "extended phenotype" that helps geneticists track the familial or genetic transmission of the genes that are implicated in schizophrenia.

There are dozens of studies showing that individuals with schizotypal PD score similar to individuals with schizophrenia on a very wide range of neuropsychological tests. Cognitive deficits in patients with schizotypal PD are very similar to, but somewhat milder than, those for patients with schizophrenia.

Social and environmental

People with schizotypal PD, like patients with schizophrenia, may be quite sensitive to interpersonal criticism and hostility, and there is now evidence to suggest that parenting styles, early separation, and early childhood neglect can lead to the development of schizotypal traits.

Diagnosis

World Health Organization

The World Health Organization's ICD-10 lists schizotypal personality disorder as (F21.) Schizotypal disorder. (Note that in ICD-10, Schizotypal disorder is classified as a mental disorder associated with schizophrenia rather than a personality disorder as with DSM-IV. The DSM-IV designation of schizotypal as a personality disorder is controversial.)

It is characterized as:

A disorder characterized by eccentric behaviour and anomalies of thinking and affect which resemble those seen in schizophrenia, though no definite and characteristic schizophrenic anomalies have occurred at any stage. There is no dominant or typical disturbance, but any of the following may be present:

Inappropriate or constricted affect (the individual appears cold and aloof);
Behaviour or appearance that is odd, eccentric, or peculiar;
Poor rapport with others and a tendency to social withdrawal;
Odd beliefs or magical thinking, influencing behaviour and inconsistent with subcultural norms;
Suspiciousness or paranoid ideas;
Obsessive ruminations without inner resistance, often with dysmorphophobic, sexual or aggressive contents;
Unusual perceptual experiences including somatosensory (bodily) or other illusions, depersonalization or derealization;
Vague, circumstantial, metaphorical, overelaborate, or stereotyped thinking, manifested by odd speech or in other ways, without gross incoherence;
Occasional transient quasi-psychotic episodes with intense illusions, auditory or other hallucinations, and delusion-like ideas, usually occurring without external provocation.

The disorder runs a chronic course with fluctuations of intensity. Occasionally it evolves into overt schizophrenia. There is no definite onset and its evolution and course are usually those of a personality disorder. It is more common in individuals related to people with schizophrenia and is believed to be part of the genetic "spectrum" of schizophrenia.

Diagnostic Guidelines

This diagnostic rubric is not recommended for general use because it is not clearly demarcated either from simple schizophrenia or from schizoid or paranoid personality disorders. If the term is used, three or four of the typical features listed above should have been present, continuously or episodically, for at least 2 years. The individual must never have met criteria for schizophrenia itself. A history of schizophrenia in a first-degree relative gives additional weight to the diagnosis but is not a prerequisite.

Includes

borderline schizophrenia
latent schizophrenia
latent schizophrenic reaction
prepsychotic schizophrenia
prodromal schizophrenia
pseudoneurotic schizophrenia
pseudopsychopathic schizophrenia
schizotypal personality disorder

Excludes

Asperger's syndrome
Schizoid personality disorder

Millon's subtypes

Theodore Millon identified two subtypes of schizotypal . Any individual schizotypal may exhibit none or one of the following:

insipid schizotypal - a structural exaggeration of the passive-detached pattern. They include schizoid, depressive, dependent features.

timorous schizotypal - a structural exaggeration of the active-detached pattern. They include avoidant, negativistic (passive-aggressive) features.

Differential diagnosis

There is a high rate of comorbidity with other personality disorders. McGlashan et al. (2000) stated that this may be due to overlapping criteria with other personality disorders, such as avoidant personality disorder, paranoid personality disorder and borderline personality disorder.

There are many similarities between the schizotypal and schizoid personalities. Most notable of the similarities is the inability to initiate or maintain relationships (both friendly and romantic). The difference between the two seems to be that those labeled as schizotypal avoid social interaction because of a deep-seated fear of people. The schizoid individuals simply feel no desire to form relationships, because they see no point in sharing their time with others.

Prevalence (epidemiology)

Schizotypal personality disorder occurs in 3% of the general population and occurs slightly more commonly in males.

History

The specific term schizotype was coined by Sandor Rado in 1956 as an abbreviation of schizophrenic phenotype.

Schizoid Personality Disorder: Summarized

Schizoid Personality Disorder is characterized by a long-standing pattern of detachment from social relationships. A person with schizoid personality disorder often has difficulty expression emotions and does so typically in very restricted range, especially when communicating with others.

A person with this disorder may appear to lack a desire for intimacy, and will avoid close relationships with others. They may often prefer to spend time with themselves rather than socialize or be in a group of people. In laypeople terms, a person with schizoid personality disorder might be thought of as the typical "loner."

Individuals with Schizoid Personality Disorder may have particular difficulty expressing anger, even in response to direct provocation, which contributes to the impression that they lack emotion. Their lives sometimes seem directionless, and they may appear to "drift" in their goals. Such individuals often react passively to adverse circumstances and have difficulty responding appropriately to important life events. Because of their lack of social skills and lack of desire for sexual experiences, individuals with this disorder have few friendships, date infrequently, and often do not marry. Employment or work functioning may be impaired, particularly if interpersonal involvement is required, but individuals with this disorder may do well when they work under conditions of social isolation.

Symptoms of Schizoid Personality Disorder

Schizoid personality disorder is characterized by a pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

Neither desires nor enjoys close relationships, including being part of a family

Almost always chooses solitary activities

Has little, if any, interest in having sexual experiences with another person

Takes pleasure in few, if any, activities

Lacks close friends or confidants other than first-degree relatives

Appears indifferent to the praise or criticism of others

Shows emotional coldness, detachment, or flattened affectivity

As with all personality disorders, the person must be at least 18 years old before they can be diagnosed with it.

Schizoid personality disorder is more prevalent in males than females. Its prevalence in the general population is not known.

Like most personality disorders, schizoid personality disorder typically will decrease in intensity with age, with many people experiencing few of the most extreme symptoms by the time they are in the 40s or 50s.

How is Schizoid Personality Disorder Diagnosed?

Personality disorders such as schizoid personality disorder are typically diagnosed by a trained mental health professional, such as a psychologist or psychiatrist. Family physicians and general practitioners are generally not trained or well-equipped to make this type of psychological diagnosis. So while you can initially consult a family physician about this problem, they should refer you to a mental health professional for diagnosis and treatment. There are no laboratory, blood or genetic tests that are used to diagnose schizoid personality disorder.

Many people with schizoid personality disorder don't seek out treatment. People with personality disorders, in general, do not often seek out treatment until the disorder starts to significantly interfere or otherwise impact a person's life. This most often happens when a person's coping resources are stretched too thin to deal with stress or other life events.

A diagnosis for schizoid personality disorder is made by a mental health professional comparing your symptoms and life history with those listed here. They will make a determination whether your symptoms meet the criteria necessary for a personality disorder diagnosis.

Causes of Schizoid Personality Disorder

Researchers today don't know what causes schizoid personality disorder. There are many theories, however, about the possible causes of schizoid personality disorder. Most professionals subscribe to a biopsychosocial model of causation -- that is, the causes of are likely due to biological and genetic factors, social factors (such as how a person interacts in their early development with their family and friends and other children), and psychological factors (the individual's personality and temperament, shaped by their environment and learned coping skills to deal with stress). This suggests that no single factor is responsible -- rather, it is the complex and likely intertwined nature of all three factors that are important. If a person has this personality disorder, research suggests that there is a slightly increased risk for this disorder to be "passed down" to their children.

Schizoid Personality Disorder Treatment

Psychotherapy

While there are many suggested treatment approaches one could make for this disorder, none of them are likely to be easily effective. As with all personality disorders, the treatment of choice is individual psychotherapy. However, people with this disorder are unlikely to seek treatment unless they are under increased stress or pressure in their life. Treatment will usually be short-term in nature to help the individual solve the immediate crisis or problem. The patient will then likely terminate therapy. Goals of treatment most often are solution-focused using brief therapy approaches.

The development of rapport and a trusting therapeutic relationship will likely be a slow, gradual process that may not ever fully develop as in seeing people with other disorders. Because people who suffer from this disorder often maintain a social distance with people in their lives, even those close to them, the clinician should work to help ensure the client's security in the therapeutic relationship. Acknowledging the client's boundaries are important and the therapist should not look to confront the client on these types of issues.

Long-term psychotherapy should be avoided because of its poor treatment outcomes and the financial hardships inherent in length therapy. Instead, psychotherapy should focus on simple treatment goals to alleviate current pressing concerns or stressors within the individual's life. Cognitive-restructuring exercises may be appropriate for certain types of clear, irrational thoughts which are negatively influencing the patient's behaviors. The therapeutic framework should be clearly defined at the onset. Stability and support are the keys to good treatment with someone who suffers from schizoid personality disorder. The therapist must be careful not to "smother" the client and be able to tolerate some possible "acting-out" behaviors.

Group therapy may be an alternative treatment modality to examine, although it is usually not a good initial treatment choice. A person who suffers from this disorder who is assigned to group therapy at the onset of therapy will likely terminate treatment prematurely because he or she will be unable to tolerate the effects of being in a social group. If, however, the person is graduating from individual to group therapy, they may have enough minimal social skills and abilities to tolerate group much better. People who suffer from this disorder see little to no reason for social interactions and often will be quite quiet in group, contributing little to others and offering little of themselves. This is to be expected and the individual who has schizoid personality disorder should not be pushed into participating more fully group until he or she is ready and on their own terms. Group leaders must be careful to help protect the individual from criticism from other group members for their lack of participation. Eventually, if the group can tolerate the initially-silent member with this disorder, the individual may gradually participate more and more, although this process will be very slow and drawn out over months.

Clinicians should be wary of too much isolation and introspection on the part of the patient. The goal is not to keep the individual in therapy as long as possible (although they may appreciate, if not fully utilize, therapy). As in group therapy, the individual who suffers from this disorder may engage in long periods of not talking and silence in session. These may be difficult to bear for the clinician. Phillip W. Long, M.D., also notes that the patient may eventually, "reveal a plethora of fantasies, imaginary friends, and fears of unbearable dependency - even of merging with the therapist. Oscillation between fear of clinging to the therapist may be followed by fleeing through fantasy and withdrawal." These types of feelings must be normalized by the clinician and brought into proper focus in the therapeutic relationship.

Medications

Medication is usually not an issue for someone who suffers from this disorder, unless they also have an additional Axis I disorder, such as major depression. Most patients show no additional improvement with the addition of an antidepressant medication, though, unless they are also suffering from suicidal ideation or a major depressive episode. Long-term treatment of this disorder with medication should be avoided; medication should be prescribed only for acute symptom relief. Additionally, prescription of medication may interfere with the effectiveness of certain psychotherapeutic approaches. Consideration of this effect should be taken into account when arriving at a treatment recommendation.

Self-Help

Self-help methods for the treatment of this disorder are often overlooked by the medical profession because very few professionals are involved in them. The social network provided within a self-help support group can be a very important component of increased, higher life functioning and a decrease in an inability to function in the face of unexpected stressors. A supportive and non-invasive group can help a person who suffers from schizoid personality disorder overcome fears of closeness and feelings of isolation. Many support groups exist within communities throughout the world which are devoted to helping individuals with this disorder share their common experiences and feelings.

Patients can be encouraged to try out new coping skills and learn that social attachments to others don't have to be fraught with fear or rejection. They can be an important part of expanding the individual's skill set and develop new, healthier social relationships.