A Review on Schizotypal Personality Disorder

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Abstract. Schizotypal personality disorder (SPD) is a severe mental disease that brings about serious difficulties and impairments in the lives of those affected by it. Those with SPD might be described as strange or unusual by other people. They are highly likely to have few intimate or close relationships. The purpose of this paper is to examine and discuss the etiology, individual and social impact, prognosis, and treatments for SPD. These details are important to study because SPD has been reported to be linked to violent behavior. A review of pertinent literature, mostly peer-reviewed journal articles, is carried out. The findings show that SPD has no known specific cause(s), results in severe physical, psychological, and social disabilities, and does not have any specific treatment. Further research on psychotherapeutic and pharmacological treatments is needed to improve prognosis for SPD, especially as regards its connection to violent behavior. Additional studies are also needed to conclusively identify SPD in all ages, which would help more effectively tailor psychotherapeutic and pharmacological interventions to the specific symptoms being presented.

Keywords: Personality; Disorder; Schizophrenia; Schizotypal.

1. Introduction

Schizotypal personality disorder (SPD) is a form of peculiar or unusual personality disorder. If a person has this disorder, his/her mannerisms, behavior, and thoughts may seem odd to other people. Although the disorder is on the spectrum of schizophrenia, those with SPD do not often develop psychosis [1]. As defined in DSM-5, SPD is mostly distinguished by a person's chronic social impairments characterized by severe cognitive perversions or disruptions of behavior and distress with interpersonal relationships [2]. One of the controversies surrounding SPD is its link to aggression and violence. For instance, schizotypal attributes in children cause victimization, which consequently set off reactive vengeful violence [3]. Apostolopoulos and colleagues (2018) reported that SPD is linked to antisocial behavior [4]. This correlation is reproduced in studies connecting SPD with violent crime and antisocial behavior [5]. According to Apostolopoulos and colleagues (2018), perhaps there is a neurobiological aspect to the relationship between SPD and violent crimes or homicides [4]. In empirical studies, schizotypal traits are linked to increased aggression, violence, or hostility. Thus, the purpose of this paper is to examine and discuss the etiology, impact, prognosis, and treatment(s) of SPD.

2. Methodology

This paper conducts a review of pertinent literature to examine and discuss SPD, particularly all the pertinent background information about it. The databases that are used to obtain the primary literature are Proquest, Psychiatry Online, PsycINFO, and PubMed. Majority of the references used for this paper are from peer-reviewed journal articles, such as Personality and Individual Differences, Annals of General Psychiatry, Current Psychiatry Reports, and Frontiers in Psychology. The primary emphases of this paper as specified in these references are the causes and risk factors, symptoms, individual and societal impact, and treatments.

3. Results and Discussion

3.1. Etiology

Individuals with an immediate family member(s) with schizophrenia are highly at risk of acquiring the disorder. For those with a genetic predisposition to SPD, being subjected to chronic stress or psychological trauma can also raise the likelihood of experiencing the symptoms [6]. Schizotypy's genetic transmissibility has been appraised roughly 30 to 50 percent within first-degree family members or relatives. Studies on patients with schizophrenia have shown that, in comparison to healthy individuals, those with SPD exhibit decreases in gray matter volume in several areas of the brain [6, 7]. These reductions in volume are most prominent in the cerebellum, amygdala, hippocampus, frontal cortical, parietal, and temporal areas. Moreover, there are findings showing ventricular swelling. Generally, these findings suggest structural changes that are non-localized, consistent with the theory that schizophrenia is a dysconnectivity disorder [7]. There is also evidence suggesting that childhood neglect, trauma, early separation, and parenting styles can result in the emergence of schizotypal attributes. During childhood, family dysfunction could raise the possibility of acquiring SPD [8].

Actually, researchers are still not certain about what precisely causes SPD, but, according to their findings, it is a combination of environmental and genetic factors. The disorder is also culture-bound, which implies that cultural differences can affect how it becomes evident. Western cultures generally believe that symptoms of SPD are a medical condition, whereas Eastern cultures view it as a supernatural or spiritual occurrence [9]. Mostly, more men than females are affected by SPD. Symptoms in various cultural domains do prefer men than women as more schizotypal, perhaps due to women's tendency to communicate or relate to others allowing them to have more positive, beneficial relationships [9]. Hence, several distortions should be assessed within the cultural setting of the individual, since several cultural features could be erroneously identified as schizotypal.

3.2. Individual and Social Impact

SPD is a long-term condition that needs lifetime treatment/therapy. If not treated, the outlook for the illness is mostly poor. Those suffering from the condition are at a higher risk of suicide attempts, drug or alcohol problems, short-term psychotic episodes (often as a reaction to stress), schizophrenia, other personality disorders, anxiety, and depression [8]. Once diagnosed with the disorder, roughly 30 to 50 percent develop major depressive disorder (MDD). It is vital that those with SPD obtain treatment/therapy for these illnesses [8]. Moreover, individuals with SPD experience heightened or extreme distress, discomfort, and anxiety in social situations. It is extremely challenging for them to form and maintain close relationships, partly because of an inaccurate or perverted view of social interactions [2].

Someone with SPD could have impaired social relationships and heightened social anxiety; lack close companions or friends; have odd or atypical mannerisms, behaviors, and habits; have strange speech and thoughts, like making use of too much concrete or abstract expressions or making use of words or phrases in strange ways; have supernatural beliefs and sensitive experiences, like believing they possess magical powers; inaccurately perceive usual events or circumstances as having unique value or significance for them; be doubtful and paranoid of the intentions or motives of others; have troubles responding properly to eye contact and other social cues; and, poorly perform in work and educational settings [1]. People with SPD are largely unaware of how their behaviors and thoughts affect others.

Pattamanusorn and colleagues hypothesized in their study that individuals with SPD experience more 'pathogenic beliefs' than those suffering from other forms of personality disorders due to the severely impaired personality functioning of SPD [10]. Pathogenic beliefs are defined as the dysfunctional and debilitating perceptions of others and oneself that disrupt normal interpersonal activities or endeavors. Using a retrospective cross-sectional design, the researchers examined the dissimilarities in the frequency of pathogenic beliefs among patients with SPD, other personality

disorders, and those who do not suffer from any personality disorders. The participants for the study were patients diagnosed with psychiatric disorder and were receiving psychotherapy between 2007 and 2019 [10]. No confounding variables were controlled in the study. The research used the Structured Clinical Interview for DSM-IV to assess the different personality types, including schizotypal, paranoid, depressive, borderline, antisocial, and so on, and the Pathogenic belief scale (PBS), a self-report tool, to identify and explain the pathogenic beliefs that the participants might have. The researchers chose these research tools and scales because of their evidence-based reliability and internal consistency. Descriptive data were used to present the overall PBS scores, clinical psychiatric disorders, and socio-demographic data (e. g. level of education, age, sex) [10].

As expected, patients with SPD showed more pathogenic beliefs than the other personality disorders. Pathogenic beliefs were more pervasive and severe in the SPD group compared to others, suggesting more diminished personality functioning. Pattamanusorn and colleagues (2020) concluded that impaired cognitive skills, alongside several pathogenic beliefs, might explain why patients with SPD need longer and more intensive treatments than other personality disorders [10]. They also concluded that pathogenic beliefs observed in individuals with SPD could assist clinicians or mental health professionals in working with patients to enhance their social, emotional, and psychological functioning through contradicting or refuting their pathogenic beliefs, instead of ignoring them and dismissing these beliefs as a component of a wider cluster of cognitive-perceptual distortions [11]. However, this research has some limitations, which include the non-differentiation of every personality disorder within the non-schizotypal group, and thus treated as heterogeneous in order to conduct a comparative analysis. Furthermore, the researchers did not assess or quantify the seriousness of personality disorder and the seriousness of clinical symptoms or disorder. Therefore, the effects of pathogenic beliefs on the seriousness of personality disorder and clinical symptoms were not identified. This must be thoroughly examined in future studies [10]. Despite these limitations, the research successfully highlighted the need to clinically investigate SPD, since it is poorly understood, usually misdiagnosed, difficult to treat or manage, and linked to severe functional deficiencies.

3.3. Prognosis/Treatment/Societal Implications

The prognosis for SPD differs and depends on several aspects, like the symptoms' severity and the person's eagerness to receive professional help or make a change in his/her life. Largely, this is regarded as a lifelong and chronic disease. The prognosis becomes better when continuous treatment is received and when useful resources for support like finances, transportation, work skills, housing, and family assistance exist [2]. The usual treatment for SPD is similar to that given to other personality disorders. It is often treated with medications, namely, antidepressants (alleviate anxiety in people with SPD) and antipsychotics (reduce symptoms of psychosis and anxiety) [3]. Cognitive-behavioral therapy (CBT) that places emphasis on ways to effectively manage anxiety and develop social skills can also be helpful. This intervention can also enhance the awareness of patients of how their attitudes and behaviors could be understood. Supportive psychotherapy is beneficial and effective as well [8]. The objective is to build a supportive, positive, and emotional relationship with the patients and hence guide them in acquiring useful defense or coping mechanisms [8].

The major components of treatment for SPD are medication and therapy. There are no particular or exact medicines for it, yet psychiatrists could recommend drugs for specific symptoms. Antipsychotic drugs, for example, can be effectively in managing paranoia and other psychosis-like symptoms [2]. Symptoms of anxiety and depression can be managed as well with proper medications, which include antidepressants or anti-anxiety drugs. Therapy is necessary for treatment since there is no one medication that is effective for each and every patient or alter problematic thought patterns and behavior [1]. Behavioral therapists can assist those with SPD in recognizing when they are experiencing or having episodes of adverse thoughts. Moreover, they can assist patients in developing improved social skills and learning how to more productively identify and decode social

prompts/signals, how to respond to other people, and how to modify and manage suspicious and paranoid thoughts [9].

Studies show that treatment outcomes are poorer for SPD patients with no solid or strong social support system. The active involvement of the family members in the treatment process significantly contribute to its success [12]. Family therapy could effectively inform family members regarding SPD, enhance communication, and treat or manage patterns that worsen depression or anxiety. Also, studies show that although therapy is the best form of treatment for SPD, residential care for a family member suffering from the disorder could also be beneficial as it would give them access to several complementary treatments. These could comprise fitness and nutrition, alternative therapies, holistic treatments, medical care, and so on [2]. These can boost the effectiveness of psychotherapy and make patients more involved and motivated.

Although SPD is lifelong, several of its symptoms could lessen or diminish over time if the person suffering from it develops helpful traits, like confidence in his/her capability to surpass difficulties/challenges and a positive self-image. Some major aspects that were reported in studies to most likely contribute to the reduction of several SPD symptoms are a sense of fulfillment at work, school, or personal life; healthy routines, like constancy or regularity in taking required medications, exercise, and a consistent sleep schedule; and, positive interpersonal relationships (e.g. family, friends) [2]. Clinical studies verify that when significant others are engaged and are informed about the disorder, and when clinicians show trust and confidence in them, the effectiveness of treatment improves and there is a lower likelihood of hospitalization (or re-hospitalization) and consequent psychotic spells [13].

Generally, from a clinical point of view, SPD is poorly or inadequately known relative to other personality disorders, and much about SPD is unclear and uncertain, especially as regards psychotherapeutic and pharmacological treatments. SPD is extremely difficult to identify because other major occurrences, specifically, cognitive impairments (working memory, executive function, and attentional deficits), could not decisively imply an SPD diagnosis since they are not officially embodied within the diagnostic and statistical manual (DSM) [13]. Therefore, future research should focus on characterizing SPD in all ages, as well as identifying therapeutics and neural links of cognitive deficiency, psychotherapeutic and pharmacological interventions, and correlation with autism-spectrum disorders. Given empirical findings indicating that antipsychotic drugs could alleviate symptoms of SPD, one can anticipate further studies on the psychopharmacologic interventions for SPD [12]. This pattern indicates the need for additional research on the differences in the indicators of risks for SPD and mere adjustment issues which will disappear even with no treatment/intervention.

4. Conclusion

Studying SPD is necessary and crucial clinically speaking, since it is poorly understood, linked to serious functional deficiency, usually misdiagnosed or under-recognized, and difficult to treat. SPD is a mental/psychological illness wherein an individual has difficulties with relationships and disruptions in behavior, appearance, and thought patterns. The specific cause of the disorder is not yet known. Numerous aspects could be involved, including environmental (e. g. chronic stress, emotional trauma), psychological (e. g. individual personality, capability to cope with stress), and genetic. Areas that have to be focused on in the future for improvements include research on psychotherapeutic and psychopharmacological treatments and features of SPD in adolescents and children. In spite of widespread belief, those with SPD are not naturally violent or aggressive, yet it can be threatening or risky personally. There are no immediate links between SPD and violent behavior, although comorbid illnesses may raise the possibility of self-harm.

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