Schizotypal personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis

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Literature review current through: **Oct 2023.**
This topic last updated: **Sep 15, 2023.**

INTRODUCTION

Schizotypal personality disorder is a chronic disorder with manifestations beginning in childhood and adolescence. Phenomenological characteristics of the disorder include cognitive-perceptual problems (such as magical thinking or paranoia), oddness or disorganization, and interpersonal problems such as social anxiety and a lack of close friends.

Schizotypal personality disorder is under-recognized and understudied. Its lifetime prevalence in the general United States population has been estimated at just under 4 percent. The disorder is associated with significant disability, as well as a wide range of psychiatric comorbidities. Schizotypal personality disorder is challenging to treat.

This topic reviews the epidemiology, pathogenesis, clinical manifestations, course, and diagnosis of schizotypal personality disorder. Psychotherapy, pharmacotherapy, and our approach to selecting treatments for schizotypal personality disorder are reviewed separately. The clinical presentation and treatment of other personality disorders are also reviewed separately. Establishing and maintaining a therapeutic relationship in patients with personality disorders are also reviewed separately.

- (See "Schizotypal personality disorder: Psychotherapy".)

- (See "Schizotypal personality disorder: Treatment overview".)
- (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis".)
- (See "Borderline personality disorder: Psychotherapy".)
- (See "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis".)
- (See "Antisocial personality disorder: Treatment overview".)
- (See "Narcissistic personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)
- (See "Narcissistic personality disorder: Treatment overview".)
- (See "Overview of personality disorders".)
- (See "Approaches to the therapeutic relationship in patients with personality disorders".)
- (See "Personality disorders: Overview of pharmacotherapy".)

EPIDEMIOLOGY

Not studied as extensively as many mental disorders, estimates of the prevalence of schizotypal personality disorder have ranged from less than 1 percent to nearly 4 percent:

- Based on face-to-face interviews of a nationally representative sample of 34,653 adults, the United States National Epidemiologic Survey of Alcohol and Related Disorders (NESARC) estimated the lifetime prevalence of schizotypal personality disorder to be 3.9 percent (4.2 percent in men and 3.7 percent women) [1].

- In smaller community adult samples internationally, lower estimates of point prevalence of schizotypal personality disorder have been found, from 0.06 to 1.7:

  - 0.06 percent in sample of 626 people age 16 to 74 in Great Britain living in households [2];

  - 0.6 percent in 742 people age 34 to 94 in Baltimore, Maryland [3];

  - 0.6 percent in a representative cohort of 2053 individuals age 18 to 65 in Oslo, Norway [4];

  - 1.7 percent in a sample of 768 women age 25 and up in Australia [5].

It is not known whether the differences in prevalence across geographic regions and studies reflect geographic variation in schizotypal personality disorder prevalence or methodological differences among studies.

Findings from the NESARC study suggest schizotypal personality disorder is more common among people with lower incomes and those never married, divorced, separated, or widowed [1]. No relationship was seen between the prevalence of schizotypal personality disorder and subject's education or residence in an urban (versus rural) area or in different regions of the United States.

Co-occurring conditions — The NESARC study found higher rates of schizotypal personality disorder in subjects with a lifetime history of other mental disorders compared with the general population [1]:

- Bipolar I disorder – 22.1 percent
- Panic disorder with agoraphobia – 25.9 percent
- Drug dependence – 19.4 percent
- Any personality disorder – 15.6 percent

Borderline personality disorder had the highest prevalence among personality disorders co-occurring with schizotypal personality disorder, with a rate of 36.7 percent. The NESARC study similarly found that patients with schizotypal personality disorder had higher rates of co-occurring classes of mental disorders [1]:

- Substance use disorders (most commonly alcohol, nicotine) – 67.5 percent
- Mood disorders (major depression, bipolar I) – 67.6 percent
- Anxiety disorders (social anxiety disorder, specific phobia) – 72.3 percent
- Personality disorders (borderline, narcissistic personality disorder) – 82.7 percent

Other research indicates that antisocial and paranoid personality disorder may co-occur in people with schizotypal personality disorder more commonly than in those with other personality disorders [6].

PATHOGENESIS

Schizotypal personality disorder is a heritable, complex psychiatric condition whose etiology may be multifactorial. Genetic and environmental factors play a role in a general vulnerability for schizotypal personality disorder [7]. These factors mediate their effects at specific developmental vulnerability periods, such as prenatal and early and late adolescence. Evidence indicates that schizotypal personality disorder is in fact a pathological entity, as opposed to simply representing the extreme end of a continuous schizotypy dimension [8]. Some studies

have suggested there are different classes of schizotypal personality disorder. There may be multiple paths to schizotypal personality disorder. (See 'Symptom domains' below.)

Genetic factors — A number of genes have been identified that appear to be involved in specific schizotypal personality disorder traits such as paranoia and anhedonia. These genes are also risk alleles for schizophrenia. These genes include:

- Catechol-O-methyltransferase – Involved in the degradation of synaptic dopamine [9]
- Disrupted in schizophrenia 1 – Regulates neuronal proliferation and differentiation and may contribute to social anhedonia [10]
- Zinc finger protein gene (ZNF804A) – Involved in brain development, may promote suspiciousness and referential thinking [11]
- p250GAP gene – Associated with N-methyl-D-aspartate receptor function, is associated with schizophrenia, as well as schizotypal personality traits (particularly, social anxiety and lack of close relationships) in individuals without schizophrenia [12]

Environmental factors — Psychologically traumatic experiences and early psychosocial adversity have been implicated in the development of schizotypal personality disorder, as well as other personality disorders. The contribution of trauma to the development of schizotypal personality disorder may depend on genetic risk alleles [9] or family psychiatric history [13].

In a study of 225 patients with schizotypal personality disorder and 127 healthy comparison participants, multiple forms of childhood trauma were found to be associated with the severity of schizotypal personality disorder; and specific types of trauma were related to particular schizotypal symptoms domains [14]. For example, severe sexual abuse was most strongly associated with cognitive-perceptual disturbances (eg, magical thinking, perceptual aberrations, ideas of reference, and suspiciousness/paranoia). Emotional neglect, however, appeared to be more closely linked to the interpersonal domain of schizotypal symptoms (eg, excessive social anxiety). Finally, greater impairments in cognitive function (eg, working memory, verbal/visual learning and memory, and verbal fluency) were also related to more severe trauma in patients with schizotypal personality disorder.

Some evidence, however, has brought into question the extent to which trauma plays a causative role in the development of personality disorder traits [15]. Achievement and positive interpersonal experiences, as well as contexts that promote autonomy, may mitigate schizotypal symptomatology during adolescence. Finally, cluster A personality disorders may be

linked primarily by a shared environmental pathogenic factor, rather than similar genetics [16]. The nature of this "cluster A" pathogenic environmental factor remains uncharacterized.

Brain morphology — Direct neurobiological comparisons between schizotypal personality disorder and schizophrenia have helped put the pathogenesis of schizotypal personality disorder within a "schizophrenia-spectrum" framework. Characterization of structural abnormalities of the cerebral cortex, particularly the temporal and prefrontal lobes, in both these conditions have been particularly illustrative [17].

Both schizotypal personality disorder and schizophrenia have been shown to exhibit significant atrophy of the (predominantly left) lateral temporal lobe. A narrower set of temporal lobe subregions are involved in schizotypal personality disorder than in schizophrenia, and temporal lobe atrophy in schizotypal personality disorder does not appear to worsen over time as it does in schizophrenia [17-19].

The prefrontal cortex, which also exhibits significant atrophy in schizophrenia, is relatively spared, structurally, in schizotypal personality disorder [20]. This is not to suggest, however, that abnormalities in prefrontal cortical function are not involved in schizotypal personality disorder. Certain subregions of the prefrontal cortex have been shown to be enlarged in schizotypal personality disorder relative to schizophrenia and healthy comparison participants. Such increases have been considered to be compensatory or "protective" against the development of an illness with frank psychosis [21].

There is some evidence that volume decreases of specific temporal lobe subregions may be predictive of having schizotypal personality disorder compared with a healthy comparison participant. Certain prefrontal cortex volumes may be inversely proportional to the severity of schizotypal personality disorder symptoms [22].

CLINICAL MANIFESTATIONS

The three schizotypal symptom domains determined by factor analysis studies are [6]:

- Cognitive-perceptual
- Oddness/disorganized
- Interpersonal

As described below, the nine criteria of schizotypal personality disorder are each associated with one of these symptom domains or factors. Although these higher-order symptom domains are not described in the American Psychiatric Association's Diagnostic and Statistical Manual of

Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR; nor previous DSM versions), they are clinically useful to systematize the criteria in a psychometrically valid way.

Cognitive-perceptual — Cognitive-perceptual symptoms are generally chronic traits but can become more pronounced and problematic under stress. The cognitive-perceptual domain of schizotypal personality disorder consists of:

- **Odd beliefs/magical thinking** – Magical thinking connotes attribution of causality that is not consistent with mechanisms accepted by the individual's subculture. These commonly include a belief in paranormal or supernatural phenomena, such as control of external events with one's mind, belief in the ability to sense events before they occur, the influence of reality by the spirit of a deceased family member, and mind reading/thought transfer. As an example, a patient described that he believed that thinking about someone would often soon lead to receiving a phone call from that person, and that his thoughts actually, "through forces we can't see," caused the phone call to occur.

Disturbed beliefs in schizotypal personality disorder can manifest as an overvalued appraisal of the ideational content such as feelings of inadequacy, guilt, and obsessions. As an example, an individual with schizotypal disorder with comorbid obsessive-compulsive disorder (OCD) may believe that their intrusive, unwanted worry that they, "might accidentally push someone in front of a train," is because they might have murdered someone in a past life (rather than it being an irrational obsession due to OCD). Aberrant beliefs may also underlie the striking capacity of individuals with schizotypal personality disorder to deny certain external realities, such as a diagnosis with a medical condition.

- **Unusual perceptual experiences and bodily illusions** – Unusual perceptual experiences in patients with schizotypal personality disorder include seeing a halo or aura surrounding someone; experiencing the presence of an unseen force or being; bodily illusions (eg, one's body appears to be changing in shape or proportion); déjà vu; and bizarre dissociative experiences (feeling one is falling into a "different dimension"). Perceptual disturbances are often accompanied by a complementary magical or odd belief (eg, the perception of a "glowing aura" surrounding someone is accompanied by a belief that the aura indicates that the individual is evil or good).

- **Ideas of reference** – This refers to misinterpretation of incidents and events as having direct personal reference to oneself. These can range from a patient's excessive concern about brief eye contact with a stranger to beliefs that an external event such as a natural disaster is a sign indicating how the patient should make an important life decision. As example, a patient who was staying with friends while trying to find an apartment believed

that seeing a moving truck outside a friend's apartment building meant that he was outstaying his welcome, and it was time to stay with a different friend.

Paranoia/suspiciousness — Suspiciousness and paranoia can vary widely. They can range from persistent and overt hostility, guardedness, and evasiveness to pleasant and agreeable compliance and deference intended to avert potential reprisal.

Oddness/disorganized — The oddness/disorganized domain consists of phenomena that can primarily be observed. Patients with schizotypal personality disorder can have hygiene, attire, and social behaviors that are eccentric, unconventional, idiosyncratic, or somewhat neglected or impoverished. Speech and thought process can be vague, unelaborate, circumstantial, metaphorical, or stereotyped but not grossly incoherent or blocked. Psychomotor expressions of affect are commonly constricted.

Interpersonal — The two main criteria of the interpersonal domain consist of:

- **Chronic social anxiety** – The social anxiety of schizotypal personality disorder is, unrelenting, situationally generalized, unconditional, and does not tend to lessen with familiarity.

- **Social anhedonia** – The lack of close friends or confidantes of patients with schizotypal personality disorder is believed to stem partly from a deficit in finding social interactions gratifying. It may be conceptualized as a form of social anhedonia. A factor analysis suggested that social anhedonia may consist of at least two independent factors: social apathy/aversion and social withdrawal [23]. Social anhedonia is believed to be distinct from introversion, a nonpathological personality dimension that also involves relatively lower levels of both sociability and trait positive affect. Social anhedonia may in fact be more closely related to alexithymia, a personality trait associated with difficulties identifying and describing emotions, than introversion [24]. The social isolation of schizotypal personality disorder may, therefore, not simply reflect an affinity for an internally oriented cognitive style and lower trait positive affect, but rather, distress related to "making sense" of the range of affects elicited by social interaction and interpersonal closeness.

Cognitive deficits — Patients with schizotypal personality disorder have consistently been shown to exhibit cognitive deficits consistent with other schizophrenia-spectrum disorders, affecting a range of domains, including attention, executive function, verbal learning and memory, working memory, and context processing. The cognitive deficits of schizotypal personality disorder are narrower in scope and less severe compared with schizophrenia. These

cognitive deficits are specific to schizotypal personality disorder (and possibly paranoid personality disorder), and not seen in other personality disorders.

Cognitive impairments clinically manifest as problems such as poor sustained attention and day dreaming; trouble with verbal learning and memory; moment-to-moment forgetting (eg, forgetting a thought one was about say); poor time management; losing/misplacing items; challenges with prioritizing and organizing during complex work or academic problems. Working memory deficits in schizotypal personality disorder are predictive of functional impairment [25].

Patients with schizotypal personality disorder can also exhibit a remarkable capacity to deny or minimize certain external realities. This can manifest as nonadherence to treatment, poor hygiene and living conditions, and severe neglect of academic or work responsibilities. In patients without schizotypal personality disorder, worries about external realities such as illness typically serve as motivators for treatment.

Despite that cognitive deficits are common in this disorder, impairments in cognitive function are not described in the current or past versions of the DSM.

Defense mechanisms — Similar to other severe personality disorders, schizotypal personality disorder is associated with significant use of numerous immature defense mechanisms [26]. Specific immature defenses do not appear to predict the presence of schizotypal personality disorder as strongly as they do in other personality disorders, such as borderline and narcissistic personality disorders. Schizotypal personality disorder can be considered to be predominantly a deficit-disorder, rather than one determined by specific conflict/defense constellations.

The deficit(s) of schizotypal personality disorder may attenuate the ability of patients to manage unconscious dynamic conflict, broadly speaking. In other words, the “dangerousness” of unconscious conflicts may be heightened in schizotypal patients, leading to the deployment of more primitive and less adaptive defenses.

Commonly used defenses in patients with schizotypal personality disorder include projection and passive aggression. Defenses that predicted schizotypal personality disorder included autistic fantasy, displacement, passive-aggression, and help-rejecting-complaining.

COURSE

Manifestations of schizotypal personality disorder can begin in childhood or adolescence. Magical thinking and odd beliefs manifest in children as bizarre fantasies and preoccupation with make-believe characters, creatures, or worlds; a belief that mythical or characters from stories or visual media are real; and a belief in having magical or superpowers. Schizotypal traits also affect school performance. Children who later go on to develop schizotypal personality disorder are more passive/unengaged and hypersensitive to criticism as per teacher reports. Various problematic school behaviors have been shown to be predictive of later adult schizotypal symptoms. This effect appeared to be specific primarily for the oddness/disorganized domain of schizotypal traits, and cognitive-perceptual symptoms to a somewhat lesser extent.

There is a moderate degree of stability of schizotypal traits from early to late adolescence, and this level of temporal consistency may be greater than that of other personality disorder traits during adolescence (eg, borderline or narcissistic traits) [27]. Follow-up of children diagnosed with schizotypal personality disorder has indicated that at least half continue to meet criteria for schizotypal personality disorder in later adolescence, and 10 to 20 percent develop schizophrenia or schizoaffective disorder [28]. Temporal stability of schizotypal personality disorder appears greater in adulthood compared with adolescence, and stability in adulthood seems to be primarily determined by genetic as opposed to environmental pathogenic influences.

Schizotypal personality disorder is a chronic condition that at baseline is associated with some form of functional impairment and/or subjective distress. During periods of heightened psychosocial stress, acute symptomatic exacerbations occur in the form of heightened paranoid ideation (which does not reach the level of complexity or elaborate systematization as seen in schizophrenia), intensified perceptual disturbances and bodily illusions, worsened social anxiety and/or social withdrawal, and deterioration of self-care. These exacerbations can last as long as the stressor occurs. Schizotypal personality disorder symptomatology attenuates slightly with age, but usually not significantly until mid-life [1]. Comparative studies have consistently shown schizotypal personality disorder to one of the most impairing personality disorders with respect to quality of life, vocational, and psychosocial functioning [25,29,30].

The prognosis for schizotypal personality disorder can vary depending on a number of factors, but generally speaking, it is a difficult-to-treat condition, and in our clinical experience, is associated with an indolent course albeit with incremental improvements with consistent treatment. Schizotypal personality disorder significantly aggravates the prognosis of other syndromal or personality disorders that are of clinical focus.

DIAGNOSIS

DSM-5-TR diagnostic criteria — The DSM-5-TR diagnostic criteria for schizotypal personality disorder are described below [31].

- A. 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, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
  - 1. Ideas of reference (excluding delusions of reference).
  - 2. Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (eg, superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations).
  - 3. Unusual perceptual experiences, including bodily illusions.
  - 4. Odd thinking and speech (eg, vague, circumstantial, metaphorical, overelaborate, or stereotyped).
  - 5. Suspiciousness or paranoid ideation.
  - 6. Inappropriate or constricted affect.
  - 7. Behavior or appearance that is odd, eccentric, or peculiar.
  - 8. Lack of close friends or confidants other than first-degree relatives.
  - 9. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self.
- B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder.

Note: If criteria are met prior to the onset of schizophrenia, add "premorbid"; for example, schizotypal personality disorder (premorbid).

Symptom domains — It can be helpful to keep in mind that the nine DSM-5-TR criteria can be organized into three factors: Cognitive-perceptual (criteria 1, 2, 3, and 5); oddness (criteria 4, 6, and 7), and interpersonal (criteria 8 and 9). These factors are not described in DSM-5-TR,

however, and the presence of any of the five criteria can lead to a diagnosis of schizotypal personality disorder. It is not uncommon, however, that a significant burden of one to four schizotypal personality disorder traits may nevertheless be present and require clinical attention.

Although not formally represented in the diagnostic criteria, cognitive deficits, namely working memory and other executive function impairments, are a key feature of schizotypal personality disorder that are a major determinant of functional disability.

The nine schizotypal personality disorder DSM-5-TR criteria differ with respect to their diagnostic utility [6]. If a patient has schizotypal personality disorder, then cognitive-perceptual symptoms are very likely to be present, and if cognitive-perceptual symptoms are manifest in an individual (particularly, magical thinking/odd beliefs, unusual perceptual experiences, and ideas of reference), then there is a moderately high likelihood of schizotypal personality disorder being present. If oddness symptoms are present then there is a very high likelihood of schizotypal personality disorder; however, oddness criteria may be absent with schizotypal personality disorder.

Differential diagnosis — There are a wide range of other mental disorders and personality disorders to be considered as part of the differential diagnosis of schizotypal personality disorder.

- **Schizophrenia** – The course of schizophrenia differs from that of schizotypal personality disorder as the former is typically associated with a premorbid period, a decline in level of function relative to the premorbid period, and acute episodes of frank psychosis. Delusions and hallucinations differ from the cognitive-perceptual symptoms of schizotypal personality disorder, as the former are more well-formed, systematized, and persistent. Whereas insight and conviction about delusions in schizophrenia are generally limited, patients with schizotypal personality disorder commonly oscillate between awareness of the potential implausibility of their magical or odd beliefs on the one hand and an active endorsement of them.

  Awareness of the implausibility will commonly manifest as the patient stating, “You must think that sounds crazy." Patients with schizotypal personality disorder are prone to brief psychotic episodes; however, there is typically an identifiable psychosocial stressor, and once the episode resolves, level of function, typically, returns to baseline. Hallucinations in schizophrenia are characteristically auditory, whereas the modality of perceptual disturbances in schizotypal personality disorder is broader and often are bodily, somatic, or a “feeling.”

- **Bipolar disorder** – When patients with schizotypal personality disorder manifest prominent cognitive-perceptual symptoms, digressive thought process, and comorbid borderline personality traits such as affective instability, impulsivity, and intense anger, the clinical presentation could be attributed to a manic episode with rapid cycling. Schizotypal personality disorder with comorbid borderline traits can be distinguished from bipolar disorder by its acute symptomatology's dependence on an interpersonal stressor. The rapidity of fluctuations in affect, behavior, and cognition disturbances in schizotypal personality disorder occur on an hour-to-hour or day-to-day basis, as opposed to on the order of weeks-to-months in bipolar disorder.

- **Autism spectrum** – High functioning autism-spectrum conditions are particularly difficult to differentiate from schizotypal personality disorder. Global measures of schizotypy and the autism-spectrum are highly correlated in nonclinical participants [32]. The interpersonal and oddness schizotypal symptom domains are strongly associated with the social skills and communication deficits of the autism-spectrum. Therefore, anxiety in social situations, avoidance of or lack of interest in interpersonal relationships, and awkwardness or deficits in social, nonverbal communication, are suggestive of either schizotypal personality disorder or autism-spectrum conditions.

  The presence of cognitive-perceptual symptoms (namely magical/odd beliefs and perceptual disturbances, as well as make-believe characters, creatures, and events in children/adolescents) are suggestive of schizotypal personality disorder [33]. More characteristic of an autism spectrum disorder are the presence of an impoverished capacity for imagination, repetitive/stereotypical behaviors; and an excessive focus on details, objects and their components, and mechanistic processes) favors an autism-spectrum diagnosis.

- **Persistent depressive disorder (dysthymia)** – The restricted affect, diminished interest in social interactions and impoverished rapport, attenuated hygiene, attire, and limited speech productivity of schizotypal personality disorder can be lead to a confusion of schizotypal personality disorder for dysthymia. Dysthymia is not associated with cognitive-perceptual symptoms, severe social isolation, and oddness symptoms (other than restricted affect). Patients with schizotypal personality disorder do not characteristically endorse that their mood is depressed on a daily basis.

- **Social anxiety disorder** – Schizotypal personality disorder can very easily be confused with social anxiety disorder. In social anxiety disorder, patients are much more likely to find some social situations that do not provoke anxiety (eg, a social gathering of close friends or family members whom the patient does not view as sources of scrutiny or

criticism). In patients with schizotypal personality disorder, intensity of anxiety does not lessen with time or greater familiarity. Patients with social anxiety are much more likely to recognize the disproportionate or undue nature of their concerns. Although the presence of fear of humiliation or embarrassment in situations that involve scrutiny does not rule out a diagnosis of schizotypal personality disorder, its presence is necessary for a diagnosis of social anxiety disorder.

- **Obsessive-compulsive disorder** – The differential diagnosis between schizotypal personality disorder and obsessive-compulsive disorder (OCD) is particularly challenging. OCD commonly co-occurs in patients with schizotypal personality disorder [6], and schizotypal traits frequently occur in patients with OCD [34,35]. (See 'Co-occurring conditions' above.)

  The differential diagnosis between schizotypal personality disorder and OCD is also complicated by the fact that a subgroup of OCD may represent a schizotypal-variant, which has important therapeutic and prognostic implications. Schizotypal-OCD is associated with “autogenous” obsessions, which consist of intrusive fears about thoughts, urges, or impulses regarding immoral, aggressive, or sexual acts and are not elicited by a clear external stimulus. This is in contrast to OCD marked by “reactive” obsessions, which are provoked by identifiable, reality-based external stimuli, and are related to contamination, errors/mistakes, and symmetry concerns.

- **Borderline personality disorder** – The differential between schizotypal personality disorder and borderline personality disorder (BPD) is complicated by their frequent co-occurrence, and some overlap in their phenomenology. Cognitive-perceptual symptoms are present in both schizotypal personality disorder and BPD. Cognitive-perceptual symptoms in BPD tend to be primarily stressor-related, particularly in the context of heightened conflict with an attachment figure. Cognitive-perceptual symptoms are exacerbated under stress in schizotypal personality disorder; however, in contrast to BPD, they also commonly occur under more routine circumstances, and are not as interpersonally related.

- **Posttraumatic stress disorder** – In patients with a trauma history, posttraumatic stress disorder (PTSD) and schizotypal personality disorder can manifest similarly. Dissociative experiences related to traumatic cues, severe hypervigilance leading to suspiciousness, social avoidance, diminished interest and participation in activities, feelings of detachment or estrangement, and inability to experience positive emotions may be present in either case. Differentiating between PTSD and schizotypal personality disorder can be particularly difficult when the PTSD-associated trauma is not a single identifiable event

occurring during adulthood, but rather was ongoing or continuous during childhood. Assessment should focus on the presence of a trauma history, the dependence of symptoms on re-experiencing, avoiding, or reacting to trauma-related stimuli.

- **Attention deficit hyperactivity disorder** – Patients with schizotypal personality disorder can meet criteria for attention deficit hyperactivity disorder; however, symptoms generally are more oriented towards difficulty organizing tasks, forgetfulness, and losing things, and less so regarding distractibility, hyperactivity, and impulsivity.

- **Other personality disorders** – Social isolation, seen in other personality disorders, may be distinguishable from that seen in schizotypal personality disorder. There is less of an ideational component associated with the social isolation and social anxiety in schizotypal personality disorder, although there is a tendency towards a paranoia or suspiciousness. The underlying factors seems to be affective rather than cognitive. Either there is an indifference to relationships, or despite there being a desire for closeness, there is a discomfort associated with the positive and negative feelings that are elicited in relationships.

  Examples include of personality disorders with prominent social isolation and the features that may distinguish them from schizotypal personality disorder include:

  - Avoidant personality disorder – The social isolation in avoidant personality disorder has less to do with ambivalence about interpersonal closeness, and much more to do with a sense of inadequacy, and anticipation of shame or embarrassment. The social isolation is related to and in avoidance of the irritability engendered by the needs, wishes, or demands of other people. The social anxiety of schizotypal personality disorder persists even with friends and family, is usually not well concealed. Additionally, individuals with avoidant personality disorder are capable of feeling at ease with those they are confident will not be critical of them whereas this is not typical in schizotypal personality disorder.

  - Narcissistic personality disorder – Social isolation in narcissistic personality disorder often owes to a desire to avoid situations in which one may have to contend with the reality other people's strengths, accomplishments, or importance.

  - Paranoid personality disorder – Social avoidance in individuals with paranoid personality disorder is typically motivated by the underlying fear that others will use information about them for malicious purposes. In schizoid personality disorder, there is essentially an absence of a desire for interpersonal closeness.

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Psychotic disorders" and "Society guideline links: Personality disorders".)

SUMMARY AND RECOMMENDATIONS

- **Epidemiology** – Schizotypal personality disorder is a chronic disorder with manifestations beginning in childhood and adolescence. It is underrecognized and understudied. The disorder is associated with significant disability and a wide range of psychiatric comorbidities.

  Not studied as extensively as many mental disorders, estimates of the prevalence of schizotypal personality disorder vary. It is not known whether the differences in prevalence across geographic regions and studies reflect geographic variation in schizotypal personality disorder prevalence or methodological differences among studies. (See 'Epidemiology' above.)

- **Co-occurring conditions** – Commonly co-occurring in patients with schizotypal personality disorder are mood, anxiety, substance use, and personality disorders. Major depression and bipolar I disorder are the most common mood disorders, which have been seen in 67.6 percent of schizotypal personality disorder patients. (See 'Co-occurring conditions' above.)

- **Pathogenesis** – Schizotypal personality disorder is increasingly seen as a schizophrenia spectrum disorder, based on phenomenological similarities with the more severe schizophrenia, as well as findings from multiple lines of evidence – family/twin studies, neuropsychological and cognitive deficits, molecular genetics, and neuroimaging. (See 'Pathogenesis' above.)

- **Clinical manifestations** – The three schizotypal symptom domains as determined by factor analysis include cognitive-perceptual, odd/disorganized, and interpersonal domains. (See 'Clinical manifestations' above.)

  - Cognitive-perceptual features of schizotypal personality disorder include odd beliefs, unusual perceptual experiences, bodily illusions, ideas of reference, paranoia, and suspiciousness. (See 'Cognitive-perceptual' above.)

- Oddness/disorganized domain include hygiene, attire, and social behaviors that are eccentric, unconventional, idiosyncratic, or somewhat neglected or impoverished. Speech and thought process can be vague, unelaborate, circumstantial, metaphorical, or stereotyped. Expression of affect is commonly constricted. (See 'Oddness/disorganized' above.)

- Interpersonal features include unrelenting social anxiety and a paucity of close social relationships. (See 'Interpersonal' above.)

Individuals with schizotypal personality disorder have consistently been shown to exhibit cognitive deficits consistent with schizophrenia-spectrum disorders. These include deficits in attention, executive function, verbal learning, and memory, working memory, and context processing.

- **Course** – Manifestations of schizotypal personality disorder can begin in childhood or adolescence. Various problematic school behaviors have been shown to be predictive of later adult schizotypal symptoms. Schizotypal personality disorder is a chronic condition that is associated with some form of functional impairment and/or subjective distress, with periodic brief psychotic exacerbations. (See 'Course' above.)

- **Differential diagnosis** – There is a wide range of other psychiatric disorders that should be considered in making a diagnosis of schizotypal personality disorder. These include, schizophrenia, bipolar disorder, autism spectrum disorder, social anxiety disorder, dysthymia, obsessive-compulsive disorder, borderline personality disorder, posttraumatic stress disorder and attention deficit hyperactivity disorder.

Topic 14771 Version 11.0

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