Schizotypal personality disorder: Psychotherapy

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INTRODUCTION

Schizotypal personality disorder is a chronic disorder with manifestations beginning in childhood and adolescence. Characteristics of the disorder include cognitive-perceptual problems (eg, magical thinking or paranoia), oddness (eg, odd rapport, affect, and speech), and interpersonal problems (eg, social anxiety and a lack of close friends).

Schizotypal personality disorder is underrecognized and its treatment is understudied. The lifetime prevalence of schizotypal personality disorder 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.

Psychotherapy for schizotypal personality disorder is reviewed here. The epidemiology, pathogenesis, clinical manifestations, course, diagnosis, and treatment overview of schizotypal personality disorder are described separately. The clinical presentation and treatment of other personality disorders, establishing and maintaining a therapeutic relationship, and pharmacotherapy of individuals with personality disorders are also reviewed elsewhere.

- (See "Schizotypal personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis".)
- (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".)

PSYCHOTHERAPY AS PRIMARY INTERVENTION

For most individuals with schizotypal personality disorder, we initiate treatment with psychotherapy. We use pharmacotherapy as an adjunct to psychotherapy to target specific core symptoms as needed. Our approach to selecting treatment for schizotypal personality disorder, our rationale for choosing psychodynamic psychotherapy, and the pharmacologic management of target core symptoms are discussed separately. (See "Schizotypal personality disorder: Treatment overview".)

INITIATING A PSYCHOTHERAPEUTIC RELATIONSHIP

The initial treatment period usually takes place over two to four sessions. During this period, the clinician develops a more nuanced understanding of the quality of the patient's cognitive appraisals and reasoning, and how amenable the patient is to have distorted thinking examined and challenged. This will help the clinician to further assess suitability for treatment and the type of psychotherapy best suited to the individual.

Engaging the patient — In general, it is necessary to engage the patient in an active and relatable manner, focusing on material that is readily accessible to the patient (ie, closest to consciousness). A professional, secure, and assured therapist whose primary goal is to allow the individual to be listened to and feel interpersonally connected is an essential element of psychotherapy with patients with schizotypal personality disorder. However, clinicians should be mindful that they are not too informal or over accommodating and that they do not disclose excessive personal information.

As an example, the therapist might approach an individual's reluctance to discuss work problems as follows: "I notice when I asked you about how your job is going, my sense is that you feel that I'm putting pressure on you or that I'm prying. But you've also told me that you really want me to help you not to lose this job. So I find myself feeling like I'm sort of in a bind."

This approach de-emphasizes making an objective observation of the patient's behavior by sharing the therapist's observations of their own reaction to the patient. An approach in which boundaries and limits are inconsistently maintained is likely to lead to patient regression, disorganization, and weakening of the alliance. (See 'Establishing an alliance' below.)

In the example above, a different tactic might be to say, "I can see that it is difficult for you to discuss work-related issues. However, discussing these issues will likely lead to a better understanding of them and ultimately help us to work together to develop more adaptive ways of dealing with it."

Some patients may be amenable to or more comfortable with a less active and more reserved approach. This should be determined on a case-by-case basis.

Establishing an alliance — Establishing an alliance is a critical goal and often an ongoing challenge in the treatment of patients with schizotypal personality disorder.

Symptoms of schizotypal personality disorder, such as paranoia, suspiciousness, interpersonal ambivalence, and poor hygiene can make establishing and maintaining a therapeutic alliance difficult. Working collaboratively with the individual to establish the treatment approach and goals can help to overcome these difficulties. (See 'Addressing specific symptoms' below and 'Engaging the patient' above.)

Tactics for enhancing the alliance include active listening (eg, openly acknowledging what the patient is saying), prompting for elaboration and clarification, and, tactfully, pointing out the patient's implausible, erroneous, odd, or contradictory assumptions.

At certain points, the clinician may state their understanding of the patient's difficulties and what type of treatment or approach is recommended, as well as a supporting rationale; however, it is important to examine the patient's reaction and understanding of these recommendations.

Establish treatment expectations — It is essential to establish a mutual understanding of the goals, expectations and format of the treatment including:

- Clearly identifying the main issues that need to be addressed in treatment. Clearly stating the goals of treatment.

- Clarifying how the patient understands the nature of these problems.
- Identify potential obstacles to the treatment (ie, excessive distress or guardedness when examining underlying beliefs; difficulty recognizing implausibility or considering alternative views).
- Evaluating the individual's understanding of their symptoms with an emphasis on identifying and addressing the role illogical or idiosyncratic beliefs and assumptions.
- Developing a framework for the treatment including frequency and length of sessions. Discuss how progress will be assessed. (See 'Frequency and length of sessions' below and 'Duration of psychotherapy' below.)

CHOOSING PSYCHOTHERAPY

The choice among psychodynamically informed psychotherapy in individuals with schizotypal personality disorder is based on the patient's level of introspection (ie, ability to critically examine thoughts and feelings) and level of functioning. However, other factors such as capacity to trust, degree of overall psychopathology, and motivation are also taken into account.

Our approach is based on clinical experience as there are limited data informing the choice of psychotherapy. The type of therapy we typically use for individuals based on their level of introspection and functioning are discussed below. (See 'Efficacy' below.)

Less introspective, lower functioning individuals — We favor supportive psychotherapy for individuals with schizotypal personality disorder who are less introspective (ie, less able to critically examine thoughts) and lower functioning. These individuals typically have multiple symptoms that are chronic in nature, are sensitive to stressors, often have impaired verbal communication or comprehension (ie, tangential thought process, impoverished abstract thinking), have difficulty tolerating closeness, and are more prone to suspiciousness.

- **Goals** – The goals for supportive treatment are optimizing and maintaining the baseline clinical state, adhering to psychiatric and medical treatment, promoting a greater ability to tolerate negative emotions and distressing thoughts, and improving capacity for trust and interpersonal relatedness.
- **Technique** – We establish a therapeutic relationship and provide an environment that is comforting and consistent through empathic, attentive listening. Pointing out self-defeating (or treatment-interfering) behaviors and their consequences and formulating

more adaptive behaviors with the individual often mitigates less adaptive behavior and encourages the individual to take ownership of them. As an example, an individual who believes coworkers and supervisors perceive them as “slow” or “incapable” despite no objective evidence should be encouraged to review their work and productivity with supervisors more regularly rather than accepting their perception as factual.

While we encourage individuals to speak freely about what is on their mind, we typically avoid exploratory or insight-oriented interventions (eg, exploring subconscious meaning to behaviors or situations). When individuals express more affectively charged subjects we typically listen empathically to avoid the individual feeling dismissed, but gently redirect to less conflictual material.

In most cases, a regular and continuous treatment schedule should be established, as opposed to an ad hoc schedule that resolves crises as they arise.

Intermediate introspection and functioning — We favor supportive expressive psychotherapy for individuals with intermediate capacity to critically examine thoughts. Typically, these individuals are modestly functioning, living independently, and may be sustaining gainful employment. They often have some success with friendships or long-term relations. Candidates for this form of psychotherapy should be amenable to verbally processing confusing or troublesome thoughts, emotions and behaviors and superficially well-adjusted to social norms. Additionally, these individuals should have intact reality testing and be motivated for change.

- **Goals** – The goals of supportive-expressive psychotherapy for schizotypal personality disorder are developing more positive expectations about interpersonal interactions, and promoting the individual’s ability to tolerate beliefs that may be conflicting with their own.

  Additionally, a common goal is for the individual to learn that verbally expressing and acknowledging certain thoughts, emotions, or wishes are not dangerous (ie, that thinking something is not the same as doing something; that thinking something does not make it true.) This will allow for patients to tolerate a fuller range of thoughts and emotions with less distress leading to an improved quality of relationships and work satisfaction [1]. (See 'Addressing specific symptoms' below.)

- **Technique** – Similar to the supportive treatment for lower functioning individuals described above, supportive-expressive psychotherapy employs an engaged and active psychotherapeutic relationship, a consistent and supportive therapeutic environment, and empathic, attentive listening.

We promote a greater emphasis on encouraging the patient to elaborate their thought process, and offer timely and tactful confrontation of inconsistent, implausible, or contradictory thoughts or beliefs. It is useful for the patient to gently explore how likely their belief of a specific circumstance is to be true (eg, how likely is their thought that their supervisor believes they are unable to do their job in the context of good productivity reports.) However, interpretations of behaviors should be restricted to conscious rather than unconscious motives. The goal of such surface interpretations is supportive in nature (ie, to promote the patient's ability to tolerate ambivalence of the unknown and question their false beliefs as opposed to investigating unconscious motives in others.)

More introspective, higher functioning individuals — We favor exploratory, insight-oriented psychotherapy for individuals who are more introspective and higher functioning. Candidates for this form of psychotherapy are generally superficially well-adjusted to the demands of life and may have success with relationships, work, or education. They are typically able to establish an alliance. These individuals exhibit both the capacity and need to resolve unconscious conflicts that are contributing to self-esteem, relationship, or career difficulties. Additionally, some individuals with schizotypal personality disorder commonly have feelings of shame or introversion and may have identity disturbances. However, unlike individuals with borderline personality disorder, they do not typically have affective instability, impulsivity, or self-injurious behaviors.

- **Goals** – The goal of this treatment is promoting a greater understanding of conscious thoughts, behaviors, and motives; and lessening regressive reactions that may occur when individuals with schizotypal personality disorder are in distress (eg, disorganization, paranoia, or dissociations).

- **Technique** – We place a greater emphasis on exploring, in a deliberate and incremental manner, the individual's conscious thoughts rather than interpreting their unconscious meaning; however, gentle exploration of motives and meaning to conscious thoughts may be appropriate. Additionally, the therapist will more readily share their thought process with the individual to provide examples and enhance the individuals understanding of situations.

  To determine whether an exploratory/insight-oriented approach is appropriate, it is best to begin treatment with a supportive/expressive approach, and after a therapeutic alliance has been established, assess the individual's capacity to explore motives that may be outside of the individual's awareness.

ADMINISTERING PSYCHOTHERAPY

Frequency and length of sessions — The frequency of psychotherapy is be determined on an individualized basis.

- Individuals with schizotypal personality who have a greater capacity for interpersonal closeness and goals beyond maintaining stability may benefit from once or twice weekly treatment. (See 'Intermediate introspection and functioning' above and 'More introspective, higher functioning individuals' above.)

- For nonacute patients for whom maintenance of stability is the goal, particularly those who are not highly expressive and/or would have difficulty tolerating greater intensity, regularly scheduled, monthly sessions may be adequate. (See 'Less introspective, lower functioning individuals' above.)

After the initial treatment period, we generally continue psychotherapy on a weekly or twice monthly basis depending on the needs of each patient. We establish a consistent schedule as the clinical status of individuals with schizotypal personality disorder can change abruptly. A structured schedule can bring about a sense of order by offering the patient a set period during which they can expect to voice their concerns. Scheduling inconsistency can be misinterpreted by the patient as, for example, lack of concern or therapist anger.

Duration of psychotherapy — The duration of psychotherapy for schizotypal personality disorder is typically more open ended. It is dependent on the progress of the therapy, and determined on a case-by-case basis. Effective psychotherapy of the insight-oriented, exploratory type often takes from one to five years of once to twice weekly sessions to develop an alliance, explore maladaptive beliefs, prioritize treatment goals and develop adaptive interpretations and effective coping skills.

Supportive psychotherapy with a highly impaired patient may be needed less frequently (eg, monthly), but due to the severity and chronicity of the impairment, the therapy may be needed long term without discontinuation to prevent decompensation.

Addressing specific symptoms — Symptoms and thoughts that individuals with schizotypal personality disorder commonly experience and which may present as obstacles to development of an alliance include:

Patient discomfort, interpersonal ambivalence — Individuals with schizotypal personality disorder may avoid closeness or find feelings of closeness to be conflictual or confusing. To

minimize this, we allow the therapy to progress at the pace that the patient is comfortable with. Additionally, we allow the depth of the material addressed to be at the level the patient is conscious of. For example, we allow the individual to develop their own insights rather than suggesting associations or interpreting thoughts.

Unclear interventions made by the therapist may lead to distress, confusion, detachment, or paranoia in individuals with schizotypal personality disorder. A clear, explicit rationale for verbal interventions should be given by the therapist. This will minimize ambiguity and the possibility of misinterpretation and will help the patient to better incorporate the therapist's ideas about psychological material. Additionally, it may lessen the shame often associated with the patient feeling the therapist "made a connection" that the patient hadn't. Feelings of shame and guilt may be disruptive to the therapeutic alliance.

> It is equally critical to implicitly mention that interpersonal discomfort that may occur during brief periods of silence is not abnormal.

Odd, illogical, or unwanted thoughts, feeling, or beliefs — Individuals with schizotypal personality disorder are prone to feeling that a "bad thought" is the equivalent of performing a bad act and that putting something into words will make it true or real. We promote the verbal expression of thoughts, feelings, and anxieties in psychotherapy, hoping to enhance the ability of the patient to recognize and tolerate unwanted thoughts.

> Additionally, individuals with schizotypal personality disorder may have odd, magical, or illogical ideas that affect their understanding of their problem and how it should be addressed. For example, seemingly ordinary concerns may be based on illogical reasoning. These beliefs are more likely to be mentioned if the therapeutic alliance is well established and the individual believes that they can trust the therapist. If these ideas are not discussed, a disconnect between the patient and the clinician in terms of the type of problem being addressed may occur. This may lead to an impasse in the treatment or early termination.
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> Patients will often oscillate between acknowledging cognitive perceptual symptoms as illogical or aberrant on the one hand and as reality on the other. We encourage the therapist to focus on helping patients tolerate their perceptions by acknowledging their presence and offering suggestions to cope with them. We do not avoid addressing what is obviously implausible about certain beliefs; however, we also do not attempt to convince the patient one way or the other. We employ empathic, attentive listening and supporting healthy coping skills, while avoiding the validation of false beliefs. (See "Schizotypal

personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis", section on 'Cognitive-perceptual'.)

Paranoia and suspiciousness — Paranoia and suspiciousness can limit the patient's development of trust and openness, as well as forgiveness of real or imagined missteps by the provider. Paranoia may manifest towards the therapist covertly, for example, by excessively ingratiating themselves or by offering deferential gestures. Paranoia may increase during periods of heightened tension or stress. Open communication between the patient and therapist, for example, by frequently encouraging the individual to express their feelings and responding in a supportive, nonjudgmental fashion can help to mitigate these symptoms.

Poor hygiene — Poor hygiene is not uncommon and could potentially be severe enough as to make treatment impossible. Poor hygiene can be a thorny clinical matter, as it places the therapist in the position of addressing a problem early in the initial period, which the patient could find insulting. It should be addressed in a nonjudgmental, empathic manner, for example by commenting on the health and social benefits of good hygiene.

Chronicity of symptoms, indolent course — Some individuals may be unable to attain certain goals, such as the ability to fully support oneself or establish long-term relationships. This can lead to overinvolvement on the part of the therapist to move things forward, or giving up on the patient due to frustration. Additionally, the indolent course may lead to excessive reliance on medication. The latter is a particular risk for individuals with schizotypal personality disorder whose chronic symptoms and indolent course may lead to a belief that medications are indicated. In these cases, we typically obtain a consultation from a provider with expertise in personality disorders to determine whether medication is in fact indicated.

EFFICACY

Efficacy data on psychotherapy for schizotypal personality disorder comes from small trials or case series as there are no controlled clinical trials examining its effect either with or without medication [2-5].

In our clinical experience, psychotherapy emphasizing a supportive approach can have significant stabilizing effects, while in appropriately selected patients, a more-expressive approach can achieve sustainable, albeit modest and slowly developing improvements in personality functioning.

Factors appearing to contribute to effectiveness of supportive-expressive psychotherapy included patient motivation, and ability to trust and to tolerate dependency. Hostile, rigid

paranoia and lack of close friends or confidants appears to be associated with poor psychotherapy outcomes [2,3,6-8].

While to date there are no clinical trials of psychodynamically oriented psychotherapy for schizotypal personality disorder, studies of metacognitively oriented psychotherapy for this disorder have been described. Metacognitively oriented psychotherapy is a manualized treatment that, like psychodynamic therapy, focuses on improving one's ability to understand thoughts, feelings and motivations while identifying recurrent, maladaptive interpersonal patterns. This is intended to mitigate symptoms of schizotypal personality disorder while enhancing one's sense of identity and interpersonal relatedness.

In two studies totaling 14 individuals with schizotypal personality disorder, treatment with metacognitively oriented psychotherapy (either individually or as a component of comprehensive psychiatric rehabilitation), led to improvement in overall symptoms as measured by the Symptom Checklist-90-R, a measure of global severity of illness [2,3]. In one of the two studies [3], patients demonstrated increases in the global level of personality functioning [9] and metacognitive ability (ie, awareness and understanding of ones thought process) as measured by the metacognition assessment scale [10]. In each study, individuals tolerated treatment with no adverse side effects and few missed appointments over the 6- to 12-month length of treatment.

These findings support the notion that a psychotherapeutic approach that focuses on the quality of how one makes sense of one's thoughts, feelings, and interpersonal is efficacious in treating schizotypal personality disorder.

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

- **Approach to treatment** – In our approach, psychodynamically informed psychotherapy is the primary treatment modality for schizotypal personality disorder. Adjunctive pharmacotherapy is used to address specific symptoms if present. This is discussed elsewhere (See 'Psychotherapy as primary intervention' above.)

- **Initiating treatment** – During the initial treatment period, the clinician develops a more nuanced understanding of the individuals cognitive appraisals and reasoning and how amenable the patient is to have distorted thinking examined and challenged. This will help choose the individuals suitability for treatment and the type of psychotherapy best suited to them. (See 'Initiating a psychotherapeutic relationship' above.)

  - **Engaging the patient** – It is necessary to engage the patient in an active, relatable manner, focusing on material that is closest to consciousness. It is essential that the therapist is a professional, secure, and assured listener whose primary goal is to allow the patient to feel interpersonally connected. (See 'Engaging the patient' above.)

  - **Establishing an alliance** – Establishing an alliance is often an ongoing challenge in the treatment of patients with this disorder. The primary tactics are active listening, prompts for elaboration and clarification, and tactfully drawing the patient's attention to implausible, odd, or contradictory assumptions. (See 'Establishing an alliance' above.)

  - **Establish treatment expectations** – This includes establishing a mutual and clear understanding of the goals and format of treatment. (See 'Establish treatment expectations' above.)

- **Choosing psychotherapy** – Our choice among psychotherapy for individuals with schizotypal personality disorder is based on the patient's ability to critically examine thoughts and feelings, level of functioning, capacity to trust and establish rapport, and motivation.

  - **Less introspective, lower functioning individuals** – For individuals who are less able to critically examine thoughts, affects or motives, are chronically symptomatic, and have lower overall functioning, we favor supportive psychotherapy. (See 'Less introspective, lower functioning individuals' above and "Schizotypal personality disorder: Treatment overview", section on 'Selection of psychotherapy'.)

  - **Intermediate and introspection and functioning** – For individuals who have some capacity to critically examine thoughts and behaviors, and are functioning modestly, we favor supportive-expressive psychotherapy. Candidates for this psychotherapy should be amenable to verbally processing confusing or troublesome thoughts and emotions. (See 'Intermediate introspection and functioning' above and "Schizotypal personality disorder: Treatment overview", section on 'Selection of psychotherapy'.)

- **More introspective, higher functioning individuals** – For individuals who have good ability to critically examine thoughts, we favor exploratory insight-oriented psychotherapy. Candidates for this form of psychotherapy are generally superficially well-adjusted to the demands of life, have had basic success with relationships, work or education and have capacity and need to resolve unconscious conflicts that may be affecting them. (See 'More introspective, higher functioning individuals' above and "Schizotypal personality disorder: Treatment overview", section on 'Selection of psychotherapy'.)

- **Administering psychotherapy** – The frequency and duration of psychotherapy is determined on a case-by-case basis but is typically at least every month for several years. Symptoms or thoughts that the individual with schizotypal personality experience and which may present as obstacles to developing an alliance include interpersonal ambivalence, odd, unwanted or illogical thoughts or beliefs, paranoia and suspiciousness, and patient hygiene. (See 'Addressing specific symptoms' above.)

- **Efficacy** – There are no clinical trials of psychotherapy for schizotypal personality disorder, either versus an inactive control, comparing different psychotherapeutic approaches, or comparing psychotherapy with and without adjunctive medications. Our approach is based on our clinical experience. (See 'Efficacy' above.)

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