

WPA/ISSPD
Educational Program
on Personality Disorders
Module II
Personality Disorders

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INTERNATIONAL SOCIETY
for the STUDY of
PERSONALITY DISORDERS

Antisocial personality disorder

Steven D. Hart and David J. Cooke

A pervasive pattern of disregard for and violation of the rights of others
(DSM-IV-TR)

- Behavioural symptoms: Lack of perseverance, unreliability, recklessness, restlessness, disruptiveness and aggression
- Emotional symptoms: Lack of: anxiety, remorse, emotional depth and emotional stability
- Interpersonal symptoms: detachment, lack of commitment, and lack of empathy or concern, antagonism, arrogance, deceitfulness, manipulateness, insincerity and glibness
- Cognitive symptoms: suspiciousness, inflexibility, intolerance, lack of planfulness and concentration
- Self-symptoms: self-centeredness, self-aggrandizement, self-justification, entitlement, uniqueness and invulnerability

ASPD (2)

Dissocial Personality Disorder, ICD 10

Gross disparity between behaviour and prevailing social norms

- Callous unconcern
- Irresponsibility and disregard
- Incapacity for enduring relationships
- Low frustration tolerance, low threshold for aggression and violence
- Incapacity for feeling guilt
- Proneness to blame and rationalize

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ASPD (3)

Prevalence:

(lifetime)

General population:	2-3 %
Psychiatric population:	1-2 %
Forensic and substance abuse population	> 50 %
Correctional and forensic psychiatric population	15-25 %

Gender:

Male-female ratio 3:1

Age:

Higher life time prevalence in younger generation

ASPD (4)

Course

- Manifestations in young age –
Antecedents of conduct disorder, oppositional defiant disorder or attention deficit disorder
- Symptoms may or may not persist into middle or late adulthood
- Increased rate of mortality

ASPD (5)

Comorbidity

- Highest comorbidity with substance-use disorder
- Highest comorbidity with borderline, narcissistic and histrionic personality disorder (DSM-IV-TR) and emotionally unstable and histrionic personality disorder (ICD 10)

ASPD (6)

Etiology

- Biological factors I: prenatal trauma, neurotransmitter dysfunctions, structural abnormalities in the frontal lobe
- Biological factors II: impaired ability to experience emotions and integrate them into executive functions => failure to attach, inattention and/or insensitivity to punishment
- Sociocultural factors: Certain cultural norms and values may foster extreme manifestations of antisocial character traits. Subcultural expressions of antisocial behaviour can also be found.

ASPD (7)

Treatment

- Treatment resistance: Disruptive behaviour, early drop-out and continuing criminal behaviour during and after treatment
- Structured psychosocial treatment: focused on acquisition of communication, assertiveness and anger management skills
- Pharmacological treatment: focused on extreme hostility and impulsivity

ASPD (8)

Contemporary controversies

- The role and origin of criminal behaviour in diagnosing ASPD
 - a) a primary symptom
 - b) a consequence or complication of ASPD
- Relative significance of early childhood experiences as opposed to biological dispositions

Avoidant personality disorder

Yutaka Uno

Pervasive pattern of social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation (DSM-IV-TR)

- Avoids occupation involving interpersonal contact, new relationships and activities, and personal risk taking because of fear of criticism, disapproval, embarrassment, rejection or not being liked
- Is inhibited in social situations and intimate relationships because of fear of being shamed, ridiculed or feeling inadequacy
- Is preoccupied with being criticized and rejected, or feeling socially inept, unappealing or inferior vis-à-vis others

AVPD (2)

Anxious personality disorder (ICD 10)

- Tension, self-consciousness, insecurity
- Yearning to be liked and accepted
- Hypersensitivity to rejection and criticism
- Needing uncritical relationships
- Exaggerating potential dangers
- Restrict lifestyle to feel secure

AVPD (3)

Prevalence:

General population: 0.5 – 5.0 %

Clinical population: 5 – 35 %

Gender:

Equal to greater risk in females

Both prevalence and gender distribution in general population is also highly influenced by cultural differences

Age:

Early signs may begin childhood, can appear in adolescents and young adults.

AVPD (4)

Comorbidity

- Co-occur with mood disorder – major depression dysthymia and mania
- Co-occur with anxiety disorder – panic disorder with agoraphobia and social phobia
- Co-occur with dependent, paranoid and schizoid personality disorders

AVPD (5)

Etiology

- Heritability – introversion and neuroticism
- Biological influence – sensitivity to interpersonal relationships and social experiences
- Interpersonal influence – seeking and fearing closeness
- Cognitive theory – negative cognitive schema

AVPD (6)

Course and Prognosis

- Symptom can worsen in adolescence
- Relatively stable course in adulthood
- Behavioural symptoms rather than avoidant traits can remit more quickly with treatment
- Comorbidity associated to worsening prognosis

AVPD (7)

Treatment

- Low self-esteem and hypersensitivity to rejection tend to increase resistance to therapy
- Gain and change can be obtained in short term and long term treatment
- Useful treatment modalities:
 - Short term dynamic or cognitive psychotherapy
 - Group therapy
 - Social skills and systematic desensitization
 - Exploratory and supportive group therapy
 - Psychopharmacological treatment

AVPD (8)

Contemporary controversies

- Relationship between avoidant personality disorder and social anxiety disorder/generalized social phobia: are they the same disorder?
- Differentiation between avoidant personality disorder and anxiety disorder: phobic avoidant behaviour versus anxious feelings

Borderline Personality Disorder

Anthony W. Bateman

Pervasive pattern of instability of interpersonal relationships and self-image, emotional dysregulation and impulsivity (DSM-IV-TR)

- frantic efforts to avoid abandonment
- unstable and intense interpersonal relationships
- identity disturbance
- impulsivity, affect instability
- recurrent suicidal or self mutilating behaviour
- chronic feelings of emptiness, intense anger
- transient stress-related paranoid ideations or severe dissociative symptoms

BPD (2)

Emotionally unstable disorder (ICD 10)

- **Impulsive type:** emotional instability, lack of impulse control, implicit paranoid sensitivity
- **Borderline type:** emotional instability, problems with self-image, lack of personal clarity about preferences, chronic feelings of emptiness

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BPD (3)

Prevalence:

General population: 0.2 – 1.8 %

Psychiatric population: 10 – 20 %

Gender:

75% female

Age:

Early adulthood

BPD (4)

Etiology

- Heritability
- Genetic influence
 - low serotonin => impulsive aggression
- Psychosocial factors
 - early separations and losses
 - conflictual parental relationships
 - childhood physical or sexual abuse
 - affective disorder in first degree relatives
- Neurobiological development
 - frontal lobe abnormality => impulsivity and emotional dysregulation
 - sensitivity to stress => over arousal

BPD (5)

Course and Prognosis

- Symptomatic improvement over time
- History of sexual abuse => poor prognosis
- Predictors of poor prognosis:
 - affect instability
 - magical thinking
 - aggression in relationships
 - impulsivity
 - substance abuse
 - comorbid schizotypal, antisocial and paranoid features

BPD (6)

Comorbidity

- Major depressive disorder 60 %
- Panic disorder with agoraphobia 30 %
- Substance abuse 12 %
- Bipolar I 10 %
- Bipolar II 4 %

BPD (7)

Treatment

Evidence base for psychotherapy

- Dynamic psychotherapy – moderate support
- Psychoanalytic psychotherapy – robust support
- Transference focused psychotherapy - promising
- Cognitive therapy – mixed results, more research needed
- Dialectical Behavioural Therapy – superior in reducing self-mutilation and self-destructive acting
- Therapeutic community treatment – limited support

BPD (8)

Treatment

Evidence base for medication

- Antipsychotic drugs – mixed results, can reduce irritability
- Serotonin reuptake inhibitors (SSRI's) – effective in reducing aggressive, impulsive and angry behaviour
- Mood stabilizers – supported effects on reducing aggression

Dependent personality disorder

Robert F. Bornstein

A pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation (DSM-IV-TR)

- difficulties making decisions, expressing disagreements and initiating own projects
- excessively seeking nurturing and support and needing others to assume responsibility
- uncomfortable and helpless when left alone, seeking support when relationships end, and preoccupied with fear of being left alone

DPD (2)

Dependent Personality disorder, ICD 10

- Encouraging others to make decision
- Subordination of ones own needs to those of others
- Unwilling to make demands on people one depends on
- Feeling uncomfortable or helpless when alone
- Fears of being abandoned
- Limited capacity to make decisions

DPD (3)

Etiology

- Genetic influence
- Overprotective or authoritarian parenting
- Sociocultural emphasis on close interpersonal relationships and strong community belongingness

DPD (4)

Etiology - competing theoretical models

Psychodynamic models

Unconscious conflicts between

- a) competing urges - e.g., to be cared for and to compete
- b) impulse-defence – e.g., to be cared for versus societal expectations

Mental representations of self as weak and ineffectual

Cognitive models

Autonomic thoughts combined with negative self-statements => sense of being vulnerable and weak => helplessness

Behavioural and Social learning models

rewarded dependent behaviour => problematic dependency

Trait models

high level of trait dependency associate with increased levels of neuroticism and low level of openness

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DPD (5)

Prevalence:

General population: 0.2 – 1.8 %

Psychiatric population:

hospital and rehab 15 – 25 %

outpatient 0 – 10 %

Cultural influence is prominent

Gender:

40 % higher in women

Age:

increase in later adulthood

DPD (6)

Comorbidity

Axis I

- Mood disorder
- Anxiety Disorder
- Adjustment disorder
- Eating disorder
- Somatization disorder

Axis II

- Borderline, avoidant and histrionic

DPD (7)

Course and Prognosis

No studies has specifically focused on the course and prognosis of dependent personality disorder

DPD (8)

Treatment

- Dependent behaviour both facilitate and undermine treatment
- Recommended treatment
 - cognitive
 - psychodynamic
 - behavioural
 - experiential
- Psychopharmacological treatment may or may not be efficient

DPD (9)

Contemporary controversies

- Variable or no empirical support for some diagnostic criteria
- Usefulness of a dimensional model
- Temporal and situational stability versus longitudinal variability in dependent symptoms

Histrionic Personality Disorder

Bruce Pfohl

A pervasive pattern of excessive emotionality and attention seeking
(DSM IV-TR)

- Seeking to be the centre of attention and uses physical appearance to draw attention
- Inappropriate sexually seductive or provocative behaviour
- Expressions of emotions are rapidly shifting, shallow and dramatically or theatrically exaggerated
- Impressionistic speech lacking in detail
- Is suggestible and easily influenced
- Considers relationships more intimate than they are

HPD (2)

Additional criteria for histrionic personality disorder in ICD 10

- Continual seeking excitement and activities in which the patient is the centre of attention
- Over concern with physical attractiveness

HPD (3)

Prevalence:

General population: 1.8 – 3 %

Psychiatric population: 5 – 10 %

Gender:

Not necessarily higher in women

Possible cultural bias and stereotyping

Age:

Decrease in middle and late adulthood

HPD (4)

Comorbidity

- Overlap with borderline, narcissistic antisocial and dependent personality disorders
- High overlap with somatoform disorder
- Comorbid Major depression: 15 - 30%

HPD (5)

Etiology

- Heritability and biological constitution
- Repression of strong emotions

HPD (6)

Treatment

Obstacles for treatment

- Rarely seek therapy
- Prematurely terminate treatment
- Self-serving therapeutic goals

Treatment strategies and goals (Millon 1995)

- Specific treatment goals
- Develop own identity
- Change patterns of interactions

HPD (7)

Contemporary controversies

- Relationship to borderline and antisocial personality disorders
- Gender bias versus cultural differences

Obsessive Compulsive personality disorder

Vicente E. Caballo

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness and efficiency (DSM-IV-TR)

- preoccupied with details, rules order etc.
- perfectionism, rigidity and stubbornness
- excessive devotion to work and productivity
- overconscientious, scrupulous and inflexible
- unable to discard, reluctant to delegate, hoarding money
- rigidity and stubbornness

OCPD (2)

Anankastic personality disorder (ICD 10)

Additional criteria:

- excessive doubt and caution
- excessive pedantry and adherence to social conventions
- intrusion of insistent and unwelcome thoughts or impulses
- unreasonable insistence of others' submission

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OCPD (3)

Prevalence:

General population: 1.6-6.4 %

Psychiatric population: 3-10 %

Gender:

Twice as often in men than women

Age:

Start in adolescence or young adulthood, and increase with age

Sociocultural factors:

More frequent in Western cultures

OCPD (4)

Etiology

Environmental factors are influential

- Parental over control
- Learned compulsive behaviour
- Learned responsibilities

OCPD (5)

Course and Prognosis

- Onset in adolescence and early adult life
- Increases with age
- Stable course
- Poor prognosis

OCDP (6)

Comorbidity

Axis I

- Mood and anxiety disorder

Axis II

- Avoidant
- Borderline
- Narcissistic
- Paranoid
- Histrionic

OCPD (7)

Treatment

- Vocational ineffectiveness, marital problems and health problems related to obsessive compulsive behaviour increase awareness of problems and motivation to seek help.
- CBT treatment successful to modify:
self-efficacy, time management, problem solving, dichotomous thinking, relaxation activities programming, self-instructional training, subjacent beliefs and increased empathic ability.

OCPD (8)

Contemporary controversies

No evidence based treatment or empirical proof of effectiveness of treatment strategies for OCPD

Narcissistic personality disorder

Elsa F. Ronningstam

Pervasive pattern of grandiosity, need for admiration, and lack of empathy (DSM-IV-TR)

- Grandiose sense of self importance, grandiose fantasies, special and unique, need for admiring attention
- Unempathic, entitled, exploitive, arrogant, envious
- Vulnerable self esteem, inhibitions, shame, sensitivity to humiliation, intense reactions to criticism

Narcissistic personality disorder is not included in ICD 10

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NPD (2)

Prevalence:

General population	0-5.3 %
Clinical population	2-16 %

Gender:

50-75 % male

Age:

Can begin in childhood

Developmentally influenced increase in narcissistic traits in adolescence and young adults

Can persist in middle and old age

NPD (3)

Comorbidity

High overlap with histrionic, antisocial, paranoid and borderline personality disorders

- Major depression: 42-50 %
- Bipolar disorder: 5-11 %
- Substance abuse disorder: 6-37 %

NPD (4)

Etiology

Heritability and generic influence

hypersensitivity, aggression, anxiety and frustration tolerance and affect regulation

Environmental influence

parental overvaluation

early parent-child insufficient attachment and inconsistent attunement

age inappropriate role assignments and expectations

adult traumatic experiences

NPD (5)

Course and Prognosis

- High resistance to change
- Individuals with less severely disturbed object relations have better prognosis
- Improvement through corrective life events:
 achievements, relationships and disillusion
- May not remit with age

NPD (6)

Treatment

Low to variable motivation. Urgency, ultimatums and reaching middle age increase motivation

Treatment modalities:

- Psychoanalysis and psychoanalytic psychotherapy
- Cognitive, short-term and couples/family therapy
- Group therapy

Specific challenges:

- Comorbid Axis I disorder – low treatment compliance, reluctance to symptom reduction
- Psychopharmacological treatment – sensitivity to side effects

NPD (7)

Contemporary controversies

- One or several types of narcissistic personalities, i.e., the arrogant, the shy, the antisocial
- Narcissism as a continuum ranging from healthy to disturbed to pathological

Paranoid Personality Disorder

Elisabeth Iskander, Larry Siever

A pattern of pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent.
(DSM-IV-TR)

- suspects harm exploitation or deception
- doubts loyalty and trustworthiness
- reluctant to confide, reads hidden meanings
- bear grudges, has recurrent suspicions
- perceives attacks on own character or reputation

PPD (2)

Paranoid personality disorder ICD 10

- sensitivity to setbacks, bear grudges
- suspiciousness, misconstruing others actions
- combative and tenacious sense of personal rights
- suspicions regarding sexual fidelity of spouse
- self-importance, self referential attitude
- unsubstantiated “conspiratorial” explanations of events

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PPD (3)

Prevalence:

0.5–4.41% in general population

Gender:

significantly more common among women

Age:

appear in childhood and adolescent. More common in younger age (18 – 29)

Sociocultural factors:

Minority groups, immigrants and refugees could mistakenly be labelled with paranoid traits. Higher risk for PPD in blacks, Hispanics and Native Americans. More common among those with lower income, divorced or never married

PPD (4)

Comorbidity

Axis I:

- depression, agoraphobia, obsessive compulsive disorder, and alcohol or substance abuse/dependence

Axis II:

- schizotypal, narcissistic, passive aggressive, obsessive compulsive, histrionic and antisocial

PPD (5)

Course and Prognosis

- Noted first in childhood
- Tends to be stable throughout adulthood
- Rarely worsen or goes into remission

PPD (6)

Etiology

Heritability –

Risk of PPD in first degree relatives with

schizophrenia	0.8 %
delusional disorder	4.8 %

PPD (7)

Treatment

- Mistrust and suspiciousness makes people with this disorder less likely to seek treatment
- No specific treatment or medication exists for paranoid personality disorder

PPD (8)

Contemporary Perspectives

- Relationship between post-traumatic stress disorder and PPD => possible link between early trauma and subsequent and subsequent paranoid behaviour
- Relationship between violence and PPD: paranoid traits can increase risk for violence

Passive-Aggressive Personality Disorder

J. Christopher Perry

A pervasive pattern of negativistic attitudes and passive resistance to demands for adequate performance (DSM-IV-TR, appendix B)

- passive resistance to fulfilling tasks
- feeling misunderstood, unappreciated
- sullen, argumentative; criticizes and scorn authorities
- envy and resentment; complaints of personal misfortune
- alternate between defiance and contrition

Passive Aggressive Personality Disorder is not included in ICD 10

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PAPD (2)

Prevalence:

1.7 % in general population

Gender:

More common in women (ratio: 2.4 to 1)

Age and socio economic factors:

More common among younger people, who are living alone in urban areas

Sociocultural factors:

Passive aggressive behaviour can be learned or reinforced in hierarchical, authoritarian societies or institutions that demand compliance and discourage expressions of needs.

PAPD (3)

Comorbidity

Axis I:

- anxiety 41%
- depression 25% - 30%
- alcohol dependence 18 %
- psycho physiological 11%

Axis II:

- Antisocial, borderline, depressive,
- dependent and self-defeating

PAPD (4)

Course and prognosis

Follow-up study showed:

- persistent difficulties (79 %) including irritability, anxiousness, depression
- hospital readmission (28 %)
- occupational impairment (44 % full-time employment)

PAPD (5)

Treatment

- Treatment of patients with PAPD is prone to raptures and early termination due to conflict between dependency and control
- PAPD shows various signs of treatment resistance
- Passivity and complaining prevent self-reflection
- Easily feeling wronged; expression of anger inhibited and shame accompanies passivity and demandingness

PAPD (6)

Treatment Modalities

- Psychoanalysis and Psychoanalytic psychotherapy
- Psychodynamic psychotherapy
- Assertiveness training
- Cognitive Behavior Therapy, CBT
- Group therapy

PAPD (7)

Contemporary controversies

- Does PAPD exist as a specific personality disorder or as a set of traits found in several other disorders?
- What are the underlying causes: biological, temperamental, psychological, familial or sociocultural?

Sadistic Personality Disorder

Michael H. Stone

A pervasive pattern of cruel, demeaning and aggressive behaviour directed toward other people. DSM-III-R

- Use of physical cruelty or violence for dominance
- Humiliates, demeans, disciplines harshley
- Takes pleasure in others' suffering
- Lies, intimidates, restricts others' autonomy
- Is fascinated by violence, weapons, torture

Not included in DSM-IV-TR and ICD 10

SdPD (2)

Additional descriptive features (Millon, 2004)

- abrupt and abrasive
- dogmatic and combative
- isolated
- eruptive – explosive, aggressive, irritable
- malicious
- hostile

SdPD (3)

Differential Diagnosis

- No actual overlap between SdPD and antisocial or narcissistic personality disorders or psychopathic personality
- Certain overlap between SdPD and Sexual sadism. However, in SdPD the main motive of sadistic behaviour is aggressive or retaliatory, not sexual arousal or gratification

SdPD (4)

Etiology

- Genetic predisposition for low compassion and high impulsivity
- Being brutalized during childhood => compulsion to repeat earlier trauma
- Head injury with temporal lobe damage

SdPD (5)

Comorbidity

- Comorbid Schizoid personality disorder => indifference to others' feelings may cause added risk for violence
- Comorbid psychopathy => increased violence among sex offenders

SdPD (6)

Treatment

- Resistance to treatment due to externalization of conflicts and blaming of others
- Absence of motivation to change
- Ability to feel remorse => benefits from psychotherapy
- Group therapy can lead to change in wife-batters
- Libido-lowering psychopharmacological treatment for chronic sex offenders

Schizoid Personality Disorder

Henning Sass and Reinhild Schwarte

A pervasive pattern of detachment from social relationships and a restricted range of expressions of emotions in interpersonal settings.
DSM-IV-TR

- neither desires nor enjoys close relationships and lacks close friends and chooses solitary activities;
- little pleasure in activities and interest in sexual experiences with another
- indifference to praise or criticism
- emotional coldness, detachment, flat affect

SPD (2)

Additional criteria for schizoid personality disorder in ICD 10

- limited capacity to express warm, tender feelings or anger
- excessive preoccupation with fantasy and introspection
- insensitivity to prevailing social norms and conventions

SPD (3)

Prevalence:

general population 0.5 -7 %

Gender:

more frequent and may cause more severe impairment in males

Sociocultural factors:

Individuals from different cultural background may exhibit defensive behaviour in new sociocultural contexts that may resemble schizoid functioning

SPD (4)

Differential Diagnosis

- Schizophrenia
- Schizotypal, Paranoid, Avoidant and obsessive compulsive Personality Disorders
- Autistic disorder and Asperger's syndrome
- Personality changes due to medical conditions e.g. temporal lobe epilepsy
- Personality symptoms derived from chronic substance use

SPD (5)

Comorbidity

Axis I:

- Social phobia
- Agoraphobia
- Substance abuse

Axis II:

- | | |
|-------------------------|-----------|
| • Schizotypal PD | 2% - 80% |
| • Avoidant PD | 23% - 88% |
| • Paranoid PD | 4% - 62% |
| • Antisocial PD | 3% - 40% |
| • Borderline PD | 19% - 60% |
| • Passive Aggressive PD | 4% - 50% |

SPD (6)

Etiology

- Heritability
 - possible relationship to schizophrenia
 - Inherited introversion
 - dopaminergic abnormalities
- Developmental sources
 - inadequate early relationships to parents
 - incorrect attributions from others

SPD (7)

Treatment

- Low motivation for seeking treatment
- Reasons for entering treatment
 - medical conditions
 - family or legal enforcement
 - stressful experiences or crises
- Major resistance:
 - absence of response
- Goals for treatment:
 - reduce social isolation
 - promote adjustment to new circumstances, experiences and changes

SPD (8)

Treatment modalities I

- Behavioural therapy
 - psychoeducational strategies focusing on problem solving and social skills
- Cognitive therapy
 - exploring self-concept, and socio-cultural and interpersonal belongingness;
- Psychoanalytic psychotherapy
 - focus on discomfort with intimacy, provide new experiences of relatedness with self-disclosure and interpersonal interactions
- Family therapy
 - improve understanding and foster stability and support

SPD (9)

Treatment modalities II

Psychopharmacological treatment

- treatment of comorbid disorders: depression and anxiousness
- Schizoid symptoms responding to medication
 - emotional apathy
 - social withdrawal
 - constricted affect
 - anhedonia, dysphoria
 - poverty of speech and thought, slow thinking

SDP (10)

Contemporary Controversies

- Similarities to residual and prodromal phases of schizophrenia
- Comorbidity with avoidant personality disorder raise the question whether schizoid and avoidant PD are same or distinct disorders

Schizotypal Personality Disorder

Svenn Torgersen

A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive and perceptual distortions and eccentric behaviour

DSM-IV-TR

- ideas of reference; odd beliefs or magical thinking that influence behaviour
- unusual perceptual experiences, odd thinking and speech
- suspiciousness, paranoid ideations
- odd, eccentric, peculiar behaviour or appearance
- inappropriate or constricted affect, excessive social anxiety
- lack of close friends or confidants

STPD (2)

Additional criteria for schizotypal personality disorder in ICD 10

- obsessive rumination
- micro-psychosis

Included among psychotic disorders in ICD 10

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STPD (3)

Prevalence:

general population 1 - 3%

Gender:

slightly more common in males

Age:

may appear in childhood

Sociocultural factors:

Cultural or religious rituals and beliefs can appear schizotypal

STPD (4)

Comorbidity

Axis I:

- Schizophrenia
- obsessive compulsive disorder
- phobic disorder
- dysthymic disorder
- panic disorder
- somatoform disorder
- eating disorder

Axis II:

- Schizoid personality disorder most strongly correlated
- Avoidant, borderline and paranoid PD also related

STPD (5)

Etiology

Genetic influence

- relationship to psychotic disorder spectrum
- specific relationship to schizophrenia
- two inherited syndromes:
 - constricted/eccentric and psychotic-like

Environmental influence

- neglectful parenting from both parents

STPD (6)

Treatment

Psychotherapy

- Learn social skills and common appropriate behaviour, and to avoid difficult situations
- Dedramatize strange thoughts and images
- Increase understanding of and learn from interpersonal failures

Psychopharmacological treatment

- psychotic like symptoms – neuroleptic drugs
- constricted/eccentric symptoms – amphetamine functioning drugs

STPD (7)

Contemporary controversies

- Equivocal relationship to personality dimensions and categories
- Complicated genetic relationship to schizophrenia
- Neuropsychological and biological aspects split between eccentric/constricted and psychotic-like syndromes