Schizoid Personality Disorder

Description/Etiology

Schizoid personality disorder (SPD) is one of ten diagnosable personality disorders that appear in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*); it is grouped with paranoid personality disorder and schizotypal personality disorder to form the Cluster A personality disorders, which share the appearance of eccentricity and oddness. The *DSM-5* general criteria for all 10 personality disorders include significant variation in behavior and internal life experience from one’s own cultural norms in at least two of the following areas: cognition, affectivity, interpersonal functioning, and impulse control; a long-term and consistent history across a variety of life situations apparent since at least adolescence that has caused significant disturbances in functioning in important areas of life and which could be described as an abiding pattern; and the abiding pattern is not caused by another mental health disorder, including substance use disorder(s), impact of medications, or a medical condition. The specific criteria for SPD are an absolute lack of interest or concern about social relations and a severely limited display of emotions when with people. An individual must have four of the seven specific criteria that enumerate examples of social detachment and emotional flatness (e.g., does not seek or enjoy close relationships, prefers a limited number of solo activities, does not have intimate relationships, seems to not care what other people think of him or her, shows little or no emotion). Also, these criteria do not occur in association with a diagnosis of schizophrenia, bipolar or depressive disorders, other psychotic disorders, or the autism spectrum. The absence of delusions and hallucinations distinguishes SPD from psychotic disorders. Individuals with SPD may appear aimless, directionless, or disinterested, behave inappropriately (by underreacting) in social situations, have a notable absence of friends and have disrupted relationships with family, and have difficulty functioning in workplaces that require interpersonal interactions. Many of the signs and symptoms of SPD overlap the negative signs and symptoms of schizophrenia. (For more information on schizophrenia, see *Quick Lesson … Schizophrenia in Adults*.)

Personality is generally agreed to refer to the internal organization and evolution of an individual’s psychobiological and social inheritance and learning that enable him or her to live in, and adapt to, a constantly changing world. To make evaluation easier, personality can be broken down into three components: temperament (i.e., how one responds to outside stimuli), character (i.e., one’s self-concept, motivation, and object relations), and psyche (i.e., intuitive self-awareness, consciousness, and spirit). An individual’s personality is a complex arrangement (and continuous rearrangement) of elements of temperament such as harm avoidance, novelty seeking, reward dependence, and persistence; of character such as self-directedness, cooperativeness, and self-transcendence; and of psyche such as memory or recollection, awareness, hopefulness, aesthetic sense, and spirituality. To be considered disordered the sum of these elements must be dysfunctional on both an individual level and a social level and the personality elements usually are inflexible. Furthermore, persons with personality disorders lack awareness that there are problems in their personal or social functioning.

Controversy surrounds the personality disorders and is reflected by the inclusion in the *DSM-5* of a chapter entitled “Alternative DSM-5 Model for Personality Disorders” in Section 3, “Emerging Measures and Models.” The alternative model was introduced to address shortcomings in the current model, including that many individuals simultaneously...
meet the criteria for several personality disorders and that the general categories of “other specified” or “unspecified” are the most often diagnosed and are uninformative about the individual. A larger question about the personality disorder diagnosis is its categorical nature (meaning either the criteria are met and there is a disorder/diagnosis, or the criteria are not met and there is no disorder/diagnosis) as opposed the dimensional nature (meaning that personality traits occur along a continuum from not present at all to having overwhelming impact) of actual human behavior and lives. The DSM-5 personality disorders remain categorical, yet the alternative model introduces the concept of dimensional assessment. Another issue of contention is the theory that personality disorders are actually a point on the continuum of a larger mental health disorder, usually at the less impactful end of a dimensional model. In particular, some researchers contend that SPD is the early stages of schizophrenia rather than the discrete disorder described in the DSM, or a stable variant of schizophrenia that does not include delusions or hallucinations.

The etiology of SPD is unresolved, with most literature attributing it to an interaction of genetically inherited traits and environmental influences. Because SPD is diagnosed in few persons, and because the diagnosis can be unreliable due to subjective and vague criteria as well as errors due to limited experience with SPD by assessors, the progression and prognosis of the disorder are not well understood. Additionally, individuals with SPD rarely seek treatment unless there is another other mental health disorder present, which complicates assessment, treatment, and research into SPD. The viability of treatment for personality disorders is the subject of debate, with some literature claiming that individuals with personality disorders are unreceptive to treatment and other literature asserting that the problem with treatment lies with professionals who blame their countertransference and lack of success on the individuals with personality disorders.

**Facts and Figures**

Given the negative nature of many of the criteria (i.e., the criteria cite absence, lack, indifference), which makes diagnosis and measurement difficult, and the fact that individuals with SPD rarely seek treatment, there are few generally agreed upon facts and figures about SPD. Different studies have found prevalence rates of SPD in the general population ranging from 0.5% to 7%. Two generally agreed facts are that SPD is among the least often diagnosed personality disorders and that when it does occur it is more often found in men. An analysis of data about 2,619 patients in the Norwegian Network of Personality-Focused Treatment Programs revealed 19 (0.7%) with SPD, the second least-occurring after histrionic personality disorder; a higher rate for men (1.3%) than for women (0.5%); and only two patients with a diagnosis of SPD alone, with the paranoid and obsessive-compulsive personality disorders those most frequently co-occurring with SPD (Hummelen et al., 2015).

**Risk Factors**

As with all other aspects of SPD, risk factors are complicated by the debate around the nature of the disorder and the relatively few cases. However, there is a generally agreed higher risk for individuals with first-degree relatives in whom schizophrenia or schizotypal personality disorder has been diagnosed. Various environmental factors have been researched without conclusive findings, including emotionally inadequate parenting and childhoods marked by neglect.

**Signs and Symptoms/Clinical Presentation**

Signs and symptoms include a preference for solitary activities, lack of friendships or relationships of any kind with the possible exception of immediate family, social detachment, limited and restricted emotional expression, appearing distant and aloof, being difficult to engage, and a lack of awareness or concern about any of these traits.

**Social Work Assessment**

› **Client History**
  * Standard biopsychosocialspiritual history, including risk for suicide
  * Observations of functioning and demeanor during interview
  * Collateral information from family, friends, and coworkers is especially important because individuals frequently have limited insight into the oddness of their behavior and rarely believe there is any disruption of functioning

› **Relevant Diagnostic Assessments and Screening Tools**
  * Care should be used with self-reporting screening tools due to the client’s general lack of insight. The tools listed are not specific to SPD, but are used for general measurement of personality dysfunction
    – Structured Interview for DSM-IV Personality (SIDP-IV)
    – Personality Diagnostic Questionnaire-Revised (PDQ-R)
    – Minnesota Multiphasic Personality Inventory (MMPI)
    – Millon Clinical Multiaxial Inventory (MCMI)
Laboratory and Diagnostic Tests of Interest to the Social Worker

- At present there are no laboratory or medical diagnostic tests available
- Tests for the presence of alcohol or other substances at levels indicating abuse may be useful

Social Work Treatment Summary

Individuals with SPD rarely seek treatment, and if they do it is likely that another mental health disorder or a need for social services has prompted them to seek treatment. Usually it is difficult to engage individuals in whom SPD has been diagnosed in treatment because of the nature of the disorder: an absolute lack of interest in interpersonal interactions and relationships. Also, lack of insight and concern about dysfunction further complicates engagement and progress in treatment, which may cause clinicians to lose interest in treatment. A commonly repeated myth holds that individuals with personality disorders are untreatable, or that personality disorders are inflexible and cannot be treated. In fact research shows that progress can be made if barriers to treatment are not erected. The three most common barriers are strong and counterproductive feelings of countertransference, belief (and covert communication of that belief to the individual being treated) in the myth of untreatability, and giving direct and specific advice on social functioning or personal problems, which usually produces dependence, noncompliance, or resentment.

Countertransference during treatment with an individual with SPD may be rooted in the individual’s disconnection and disinterest in personal relationships, which is directly contrary to most professional caregivers’ beliefs about relationship. Clinicians may feel inadequate, incompetent, hopeless, frustrated, and pessimistic about the outcome of treatment and may feel that the client might be better off with a different clinician. A first step in treatment of SPD is collaborative goal-setting about treatment. There is no consensus on the use of medications in the treatment of SPD, although since other mental health disorders usually are present medications may be used to treat them.

Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice.

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<tr>
<th>Problem</th>
<th>Goal</th>
<th>Intervention</th>
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<td>Inappropriate social interactions and difficulty in situations requiring interpersonal interactions, such as at work</td>
<td>Learn social and cognitive skills to successfully interact with people</td>
<td>Cognitive-behavioral and social skills training using thought recording, role-playing, group social-skills training, or cognitive-behavioral therapies as appropriate. All interventions for SPD will depend on initial establishment of a therapeutic relationship</td>
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<td>Lack of engagement in or pleasure from the daily activities of life</td>
<td>Engage in daily activities and relationships and pleasure of life</td>
<td>Existential therapy to engage in discussion about the meaning of life and seek insight into one’s existence. Or psychodynamic therapy to address unresolved issues from childhood</td>
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Applicable Laws and Regulations

- Each jurisdiction (e.g., nation, state, province) has its own standards, procedures, and laws for involuntary restraint and detention of persons who may be a danger to themselves or others. Individuals with SPD generally are not at higher risk of this danger; however, because there frequently are other mental health disorders present, and some theories hold that SPD
is an early stage of schizophrenia, assessment should include this danger. Local and professional reporting requirements for neglect and abuse should also be known and observed.

Each country has its own standards for cultural competency and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (e.g., National Association of Social Workers in the United States, British Association of Social Workers in England) and practice accordingly.

Available Services and Resources

Enter “schizoid” or “personality disorder” in the search box to access relevant information available on each website.

› National Alliance on Mental Illness (NAMI), http://www.nami.org/
› U.S. National Institutes of Health (NIH), http://www.nih.gov/
› National Association of Social Workers (NASW), http://www.socialworkers.org/

Food for Thought

› Different cultures value different levels of engagement and interaction in social situations. In fact, in some contexts an individual displaying the traits of SPD might be considered to be at a higher state of being. For example, Buddhist monks practice meditation in part to experience freedom from emotions, attachment, and striving, all of which could be observed while assessing for SPD. Cultural as well as professional expectations about acceptable levels of interpersonal interaction and affective demonstration vary greatly.

Red Flags

› Individuals with SPD may engender strong positive or negative feelings that may lead to countertransference.
› SPD may be difficult to diagnose because it is hard to distinguish from other Cluster A personality disorders, from prodromal schizophrenia, and from avoidant personality disorder.
› The myth that personality disorders are untreatable can be self-reinforcing when repeated among professionals involved in treatment of SPD.

Discharge Planning

› Review medication regimen and make follow-up appointment with agency issuing prescription.
› Assess stability of employment and living situation.
› Refer to appropriate treatment modality.
› Provide referrals for support and education for family members.

Personality disorders

References
