

# SCHIZOID PERSONALITY STYLE AND DISORDER

## THE SCHIZOID PERSONALITY TYPE IN A NUTSHELL

“The essential feature of *SCHIZOID PERSONALITY DISORDER* is a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings.”<sup>1</sup>

This individual will appear as self-contained, emotionally under control, and in need of little or no social interaction.

### A CLOSER LOOK

The schizoid individual chooses not to engage in deep and intimate social or interpersonal relationships. This is not usually done out of fear (as is the case with the avoidant individual). It is simply the choice of the individual not to interact with others deeply. They are indifferent to close interpersonal relationships.

And, it is that prospect that will likely result in a significant crisis in the life of an individual with a schizoid personality. When they do engage in a relationship and that relationship presents them with a crisis, they will be subject to an adverse reaction.

The crisis in a relationship might be the prospect of a close relationship ending. It might be, however, something of lesser significance – something like the need to resolve significant conflicts in the relationship. This individual doesn't typically like to face strong emotions or social situations that demand expression of emotion. They would rather stay away from strong emotion (sometimes at all cost).

### THE BOTTOM LINE

The therapist will find this situation to be a real challenge to counsel. The individual may use silence on a regular basis. They will also refrain from expressing pent-up emotions that are likely buried deep inside. The surfacing of those emotions may result in significant arousal of *Axis I Disorders*. Among those *Disorders* there may be some delusional indications, if the crisis is severe enough. The therapist needs to ensure that the client does not decompensate into a more maladaptive personality style such as *SCHIZOTYPAL PERSONALITY TYPE*.

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<sup>1</sup> American Psychiatric Association: *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION, TEXT REVISION*. Washington D.C., American Psychiatric Association. 2000., p. 694.

## **TECHNICAL DSM-IV-TR CRITERIA FOR DIAGNOSIS OF A FULL PERSONALITY DISORDER**

The official DSM-IV-TR diagnostic criteria for *SCHIZOID PERSONALITY DISORDER* are:<sup>2</sup>

- A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
  - 1. Neither desires nor enjoys close relationships, including being part of a family.
  - 2. Almost always chooses solitary activities.
  - 3. Has little, if any, interest in having sexual experiences with another person.
  - 4. Take pleasure in few, if any, activities.
  - 5. Lacks close friends or confidants other than first-degree relatives.
  - 6. Appears indifferent to the praise or criticism of others.
  - 7. Shows emotional coldness, detachment, or flattened affectivity.
- B. Does not occur exclusively during the course of *SCHIZOPHRENIA*, a *MOOD DISORDER WITH PSYCHOTIC FEATURES*, another *PSYCHOTIC DISORDER*, or a *PERVASIVE DEVELOPMENT DISORDER* and is not due to the direct physiological effects of a general medical condition.

[The therapist is reminded that the above criteria must be (1) a pervasive pattern, (2) and must begin by early adulthood. If those main criteria cannot be met, a personality disorder cannot be diagnosed (technically). If many of the other criteria are present, the therapist should understand that the personality style has drifted toward undesirable and maladaptive behaviors associated with the disorder. Treatment techniques described below should be used to move the personality toward style rather than disorder.]

### **DIFFERENTIAL DIAGNOSIS**

There are a number of other disorders that contain similar characteristics to *SCHIZOID PERSONALITY DISORDER*. This list contains some of those disorders. The therapist is encouraged to research these similar disorders using the DSM-IV-TR.

**DELUSIONAL DISORDER, SCHIZOPHRENIA, MOOD DISORDER WITH PSYCHOTIC FEATURES.** The difference between *SCHIZOID PERSONALITY DISORDER* and these three disorders is that these three disorders include persistent psychotic symptoms while *SCHIZOID PERSONALITY DISORDER* does not.

**AUTISTIC DISORDER, ASPERGER'S DISORDER.** *SCHIZOID PERSONALITY DISORDER* is often difficult to differentiate from these two disorders. These two disorders, however, usually have more profound impairment of social interaction.

**PERSONALITY CHANGE DUE TO A GENERAL MEDICAL CHANGE.** This diagnosis should be used if symptomology appears directly related to the general medical change.

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<sup>2</sup> *DSM-IV-TR*, p. 697.

**SCHIZOTYPAL PERSONALITY DISORDER.** *SCHIZOID PERSONALITY DISORDER* does not contain cognitive nor perceptual distortions while *SCHIZOTYPAL PERSONALITY DISORDER* does.

**PARANOID PERSONALITY DISORDER.** *SCHIZOID PERSONALITY DISORDER* does not contain suspiciousness and paranoid ideation while *PARANOID PERSONALITY DISORDER* does.

**AVOIDANT PERSONALITY DISORDER.** *AVOIDANT PERSONALITY DISORDER* contains the element of profound fear of being embarrassed or found inadequate and excessive anticipation of rejection. *SCHIZOID PERSONALITY DISORDER* does not.

**OBSESSIVE-COMPULSIVE PERSONALITY DISORDER.** *OBSESSIVE-COMPULSIVE PERSONALITY DISORDER* contains many of the same traits as *SCHIZOID PERSONALITY DISORDER*, but *OBSESSIVE-COMPULSIVE PERSONALITY DISORDER* has an underlying capacity and desire for intimacy.

### COMMONLY ASSOCIATED AXIS I DISORDERS

There are a number of *DSM-IV Axis I Disorders* that are commonly associated with the *SCHIZOID PERSONALITY TYPE*. The therapist should be aware of each of these *Axis I Disorders* and screen for them, if such screening seems appropriate.

**DELUSIONAL DISORDER.** *Delusional Disorder* is associated with nonbizarre delusions involving situations that could potentially occur in real life. These include the feeling that one is being followed, poisoned, infected by disease, or deceived by a significant person. This follows course with the detachment from social relationships and the expression of emotions associated with the *SCHIZOID PERSONALITY TYPE*.

**SCHIZOPHRENIA.** *Delusional Disorder* is a potential *Axis I Disorder* associated with the *SCHIZOID PERSONALITY TYPE*. *Schizophrenia* is similar to *Delusional Disorder* except that the delusions are bizarre rather than nonbizarre. Furthermore, *Schizophrenia* contains the possibility of *hallucinations, disorganized speech, and catatonic behavior*. This is probably associated with the same reasons as *Delusional Disorder*.

**MAJOR DEPRESSIVE DISORDER.** The *Major Depressive Disorder* associated with *SCHIZOID PERSONALITY TYPE* may be a result of the social detachment and isolation that is part of the personality type.

### THE SCHIZOID PERSONALITY CONTINUUM

All personality flows on a continuum from order to disorder – from function to dysfunction. Internal and external stressing events are the “triggers” that motivate a personality that is functioning in an orderly fashion to move toward disorder. Since each personality is different, not all stressing events hold the same impacting “value” for each person. A stressor that might cause significant personality disruption in one person might not effect another at all.

Each clinically recognizable *Personality Disorder* has its corresponding *Personality Style*. The goal of the therapist should be to move a disordered personality from a state of disorder to a state of homeostasis – the corresponding *Personality Style*.

According to Sperry,<sup>3</sup> the optimally functioning *SCHIZOID PERSONALITY STYLE* contains five elements. Correspondingly, there are five elements that indicate the breakdown of each of those five optimally functioning elements. As an individual “trades off” each of the optimally functioning elements for a maladaptation, they are moving closer to a clinical assessment of full *SCHIZOID PERSONALITY DISORDER*. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *SCHIZOID PERSONALITY STYLE* without allowing for diminution toward more maladaptive traits.

Sperry’s continuum includes the five following elements:

Optimal Functioning	Maladaptation
<ul style="list-style-type: none"> <li>• The individual exhibits little need of companionship and is most comfortable when alone</li> <li>• The person tends to be self-contained and does not require interaction with others in order to enjoy experiences or to live their lives</li> <li>• The person is even-tempered and dispassionate. They are usually calm and rarely sentimental.</li> <li>• The individual is not driven by sexual needs. While they can enjoy sex, they do not suffer without it.</li> <li>• The person tends to be unswayed by either praise or criticism and can confidently come to terms with their own behavior.</li> </ul>	<ul style="list-style-type: none"> <li>• The person does not desire nor enjoy close relationships. This includes being part of a family. They have no close friends or confidants</li> <li>• The individual almost always chooses solitary activities.</li> <li>• The individual rarely if ever claims to have or appears to experience strong emotion such as anger or joy.</li> <li>• The person experiences only an indirect battle or desire (if any) to have sexual experiences with another person.</li> <li>• The person is indifferent to praise and criticism of others. They display constricted affects. They are aloof, cold, and rarely do they ever reciprocate gestures made by others or exhibit facial expressions.</li> </ul>

<sup>3</sup> Sperry, Len, M.D., Ph.D. *HANDBOOK OF DIAGNOSIS AND TREATMENT OF DSM-IV-TR PERSONALITY DISORDERS* (Second Edition). Brunner-Routledge. New York, NY. 2003. P. 221.

## THE SCHIZOID PERSONALITY STYLE UNDER STRESS

The following behaviors will likely manifest when an individual with a *SCHIZOID PERSONALITY TYPE* faces a triggering event. In the case of the *SCHIZOID PERSONALITY TYPE*, triggering events will be associated with close interpersonal relationships. Both demands from close interpersonal relationships and crisis situations involving close interpersonal relationships may act as triggers.

- The individual may feel defective or engage in self devaluation.
- Social isolation is a distinct possibility especially when the individual was hurt in a relationship.
- Depressive symptomology, especially *Dysthymic Disorder*.
- Outward “flattening” of emotions as the individual attempts to control their social and interpersonal environment.
- *Major Depressive Episode*. This is especially a possibility in cases where the individual had engaged in a close interpersonal relationship and got hurt in that relationship. It is not unlikely that the individual will feel that they were deceived in the relationship.
- In extreme cases, the individual may suffer from *Delusional Disorder*.
- In extreme cases, the individual’s personality structure may decompensate into the *SCHIZOTYPAL PERSONALITY TYPE*.

## DISORDER ETIOLOGY AND TRIGGERS

Etiology is the study of causes and origins for a malady. The list of etiological causes and origins for this personality type have been compiled from accepted psychological research. Each personality type also has a number of triggers that will likely be associated with movement from optimal functioning toward maladaptation. While this list of triggers is not all-inclusive, this list does contain the most commonly accepted reasons that trigger a maladaptive episode in an individual with a *SCHIZOID PERSONALITY TYPE*.

### PSYCHOSOCIAL ETIOLOGY FOR THE SCHIZOID PERSONALITY TYPE

The formulation of personality (and, consequently, the potential for disorder) occurs during child development. No parent and no family environment is perfect. Thus, the imperfections of that home environment will lead to the development of some personality “skew.” That skew is called a personality style.

In cases where the home environment was significantly maladaptive, traumatic, or damaging to the psyche of the child, the potential for development of a full-blown personality disorder increases with the onset of early adulthood.

The following list contains likely issues that arose during childhood that precipitated the formulation of the *SCHIZOID PERSONALITY TYPE*. Many of these issues will not be cognitively accessible to the client and there is a likelihood that many of these issues will be denied by the client. In spite of client denial (which is very common) these are the most commonly accepted reasons for the development of the *SCHIZOID PERSONALITY TYPE*.

The therapist must recognize the difference between an optimally functioning personality style and a personality that is moving (or has moved) toward disorder. The personality that is not in a state of disorder but skews toward the personality style may contain a few of the events from this list, some items may be repressed, or less severe family behaviors that follow the same “theme” may have existed (but not necessarily with the same intensity).

The therapist should not “automatically” assume that each of these items was a reality in the person’s home of origin. This list should be used for investigation and exploration in order that the therapist might understand the dynamics of the home of origin.

- Perceived inadequate mothering. The child projects the belief that they did not receive appropriate emotional nurturance to sufficiently meet their needs. This covers a very broad scope and the perception may not indicate either neglect or indifference on the part of the mother (or the parents). While it may be that the mother did not adequately nurture the child, another facet of nurturance may have been the realistic inability of the mother (or the father) to nurture due to circumstances that were out of their control. This is sometimes the case when children are injured or when they suffer from some physical malady that the parents cannot control. The child may experience an “emotional void” that allows for the development of the belief that they cannot expect to receive emotional nurturance from any place in their environment.<sup>4</sup>
- Parental indifference to emotional issues. This would be indicated as a secondary cause of schizoid tendencies. This might be the cause when there was significant interpersonal reserve, formality, superficial and cold emotions in the home of origin. This would cause a constricted emotional state in the child and may cause the child to isolate themselves from social situations that could cause emotional states they were not familiar or comfortable with.
- Family behavior patterns to investigate at the disorder level include an orderly home; a formal home; possibility of colorless home life; over protection from the “world out there”; and no significant parental attempts to socialize the child.<sup>5</sup>

[The above list does not contain biochemical considerations associated with the etiology of the *SCHIZOID PERSONALITY TYPE*. The therapist should understand that there may be biochemical issues associated with this disorder. Those issues are best addressed by a medical doctor or a Psychiatrist.]

## **DISORDER TRIGGERS**

The following list contains the most common triggers that precipitate a crisis event or a full disorder in someone with a *SCHIZOID PERSONALITY STYLE*.

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<sup>4</sup> An example of such a physical case would be early onset of seizure disorder. That physical malady may imprint on the child that the mother was indifferent or unable to provide emotional nurturance when in fact that may not have been the case. The trauma of the situation might override the reality of maternal nurturance.

<sup>5</sup> Some of these family behavior patterns are indicated with a full disorder. In the case of a stable and optimally functioning personality style, the therapist may not locate these family behavior patterns, the behaviors may be repressed, only a few behaviors may exist, or less severe family behaviors that follow the same “theme” may be indicated.

**Close Interpersonal Relationships.** Since the *SCHIZOID PERSONALITY TYPE* exhibits a pervasive pattern of detachment from social relationships and a restricted range of emotional expression in interpersonal relationships, any significant prospect for a close interpersonal relationship could bring about a crisis event in this individual. This prospect is greatly increased when the demand for a close interpersonal relationship is mandated by circumstances out of the individual's control. Also, when the schizoid individual does engage in a close interpersonal relationship and the relationship ends, they are likely to experience a significant crisis including the potential for *Axis I Disorders*.

### **TREATMENT COURSE FOR SCHIZOID PERSONALITY ISSUES**

The following is a summary of treatment objectives when a therapist is dealing with a *SCHIZOID PERSONALITY TYPE*. As is the case with any client engagement, when the therapist feels that they are not capable of dealing with a specific case, the case should be referred to another therapist. Also, in the event that a therapist takes on a specific case and after an appropriate time period does not see progress, the case should also be referred.

#### **POTENTIAL MALADAPTIVE DEFENSE MECHANISMS**

While it is possible for any individual in crisis to use any of the maladaptive defense mechanisms, there are maladaptive defense mechanisms that certain personality styles "favor" over others. The therapist should thoroughly research all defense mechanisms that the client might be using.

There are three major defense mechanisms that are commonly used by individuals with the *SCHIZOID PERSONALITY TYPE*. Two of those involve some type of image distortion and may indicate a significant problem leading toward psychosis (any defense mechanism above Level #2).

**Intellectualization.** The client uses excessive abstract thinking, intellectual reasoning, or generalizations to control or minimize the emotional discomfort associated with an internal or external stressor. This is an effort on the part of the client to "shut off" the emotions associated with the stressor. [Level #2 – Mental Inhibitions Level]

**Denial.** The client refuses to acknowledge some painful aspect of external relative or subjective experience that is apparent to others. [Level #4 – Disavowal Level]

**Projection.** The client falsely attributes their own unacceptable feelings, impulses, or thought onto another person without justification. This is usually a guilt-based reaction to their own perceived negative aspects. [Level #4 – Disavowal Level]

## **THE TREATMENT PROCESS**

### **Prior to Therapeutic Intervention**

The first course in treatment for the *SCHIZOID PERSONALITY TYPE* is to get a broader conceptualization of the individual. In cases of significant personality dysfunction or maladaptation, there are undoubtedly family structure and home of origin issues that are important. Thus, the *Foundations Assessment* is a vital tool for the therapist to administer prior to actual therapeutic intervention. The client's current levels of anxiety and depression are also important. Therefore, either *QuikTest* or the *Personal Crisis Inventory* should be administered. The *Addictions and Dependency Scale* may also be an important tool since it will reveal a broad range of both addictions and codependent behaviors.

The therapist should begin by reviewing all Assessment results. That includes review of other elevated personality styles included in this report. In all likelihood, the therapist will find that more than one personality type will be elevated above the 50% threshold. This is not abnormal.<sup>6</sup> Each personality type that is elevated should be analyzed and cross-correlated. The therapist should look for common elements among all of the elevated personality types. Those elements that are common to all personality type elevations will likely be significant issues for the client

### **Objectives of Therapy**

During the initial interview phase of therapy the therapist must determine the reason that the client has been presented to therapy. Current home issues should also be discussed. The potential for *Axis I Disorders* should be considered during the interview. Finally, prior to the actual treatment phase of therapy, the therapist should conduct an investigation of the client's home of origin. This information should be gathered in hopes of correlating the results of the *Foundations Assessment* and the personality type elevations.

The therapist must recognize the fact that the whole demeanor of the schizoid individual is functional and not relational. They do what has to be done to function – not to relate. In higher functioning individuals, their relational interactions will likely be associated with functioning and not the pleasures of interacting with others.

While therapy with lower functioning individuals can be challenging and difficult, counseling individuals who are higher functioning can be quite productive. Reframing persistent negative self-beliefs is essential. The minimum goal of therapy should be to greatly reduce anxiety and apprehension related to social and interpersonal situations.

The therapist should thoroughly investigate the possibility of *Axis I Disorders*. The propensity of this client will be toward depressive symptomology (although other *Axis I Disorders* are a distinct possibility). The therapist is warned that this personality type may decompensate into a more serious condition, including *SCHIZOTYPAL PERSONALITY TYPE*.

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<sup>6</sup> If an individual displays four or more elevated personality styles, this may present a problem. The therapist should understand that the more personality styles the individual displays, the more the personality tends to become disassociated from a unified and consistent core. A personality that contains more than three personality types will likely score on the *DSM Personality Cluster* score in the *MARET COUNSELING AND ASSESSMENT PERSONALITY STYLE ANALYSIS*. The therapist should carefully examine those results.

*Delusions* and *Schizophrenia* is a distinct possibility in extreme crisis situations, especially for lower functioning schizoid individuals.

These individuals usually enter therapy due to unacceptable *Axis I Disorder* symptomology. Internally, they usually have a “plan” to only stay around until the most discomforting symptomology is resolved. This is a safe and acceptable treatment plan for them. Anything else presents fears that are not acceptable. The therapist must realize that early exit from therapy after elimination of persistent negative emotions is a real possibility. Structuring a treatment plan early with the acceptance of the client may prevent early withdrawal.

The following suggestions are included as appropriate treatment objectives during the course of counseling.

- The therapist should understand that silence is a non-verbal form of relating rather than as treatment resistance. This may be unacceptable to the therapist but resistance to silence must be controlled or eliminated.
- It is important during the therapy process to help the client correct their emotional experience. The emotions of the client will be very controlled. They must learn to deal with stronger emotions that may seem threatening. Internalizing these emotions will only result in other adverse reactions including *Axis I Disorders* (e.g. *Mood Disorders*, *Delusional Disorders* (in extreme cases), and *Somatic Disorders*).
- If the therapist believes it is warranted, the therapist should role-play social skills development. This can easily be done in the course of counseling and employed as homework assignments.
- As therapy progresses, the therapist should carefully increase social interaction on the part of the client. It is important that this increase in interaction should be carefully discussed with the individual. The therapist must be sensitive to the emotional reactions of the client regarding this progress. Also, when the client is successful in engaging in increased social interaction the therapist must note the progress that the client has made. Complete assessment of increased social interaction must be made and both the positive and negative accomplishments must be noted. The negative issues must be analyzed and any residual emotional hesitancy must be eliminated.
- It is important in this process that the therapist completely involves the client. The therapist should get the client “excited” about the potential for growth in interpersonal communication. Prior to homework assignments, the therapist and the client must be in full agreement regarding the exercise.
- All social interactions should be appropriate to the growth level of the client. The client should never be “pushed” beyond their emotional limits. This could cause sudden cessation of therapy and relapse.
- The therapist must defuse and eliminate the client’s belief that they are defective, bad, unwanted, or inferior to others.
- The client must be moved away from social isolation. They may feel that they are alienated, different from others, or not part of any group.
- The individual must enlarge their acceptance of emotions. They will typically refrain from emotions that are “charged,” especially in interpersonal situations. This issue

must be resolved and those “charged” emotions must be made acceptable to the individual. This will be a challenge to the therapist.

- The client’s belief that they must suppress their own desires, needs, and feelings in order to meet the needs of others must be corrected. To some degree, this will be part of the social training that the therapist does.

### **Dangers of the Therapeutic Process**

There are significant obstacles and potential dangers associated with the therapeutic process for the *SCHIZOID PERSONALITY TYPE*. The therapist must understand that the more the client tends toward true personality disorder, the more possible these dangers become. The obstacles and dangers include the following:

- Exiting treatment due to the anxiety of treatment.
- Total social isolation.
- Decompensation into schizotypal personality traits *Delusional Disorder*, or *Schizophrenia*.

### **Successful Completion of Treatment**

Termination of treatment for the *SCHIZOID PERSONALITY TYPE* is indicated when the therapist has moved the individual substantially or completely to the optimal functioning side of the personality structure.

The key elements that must be accomplished are:

- The client must restructure their frame of reference regarding social isolation. The client feels alienated from other people. This prevents interaction in social and interpersonal situations.
- The client’s belief that they are defective, bad, unwanted, or inferior to others must be reversed.
- The client must understand that others can meet their emotional needs in consistent interpersonal relationships.
- The client’s belief that they must be emotionally close with others at the expense of their own individualization must be reconciled.
- The client must realize that they do not need to meet the needs of other people at their own expense.

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This document is a small portion of the MARET Educational Series textbook titled *UNDERSTANDING PERSONALITY STYLE AND DISORDER FOR PASTORAL COUNSELING*. The textbook is highly recommended for pastors who engage in counseling. It is available for purchase on the MARET web site or from Amazon.com.