

SCHIZOTYPAL PERSONALITY STYLE AND DISORDER

THE SCHIZOTYPAL PERSONALITY TYPE IN A NUTSHELL

“The essential feature of *SCHIZOTYPAL PERSONALITY DISORDER* is a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior.”¹

These individuals are characterized by excessive paranoia, especially in social and interpersonal situations. They are hypervigilant, and hypersensitive and fearful. They are prone to various anxiety states. Cognitively, they have automatic thoughts and beliefs about their environment that seem to “protect” them from the harm that they believe others might bring on them.

A CLOSER LOOK

The *SCHIZOTYPAL PERSONALITY TYPE* is most likely the product of a serious and consistent parental behavior in an individual’s childhood. Minimally, the parental behavior indicates a significant form of neglect. There may have been some form of fragmented communication. Other issues may have caused this problem include such extreme issues as death of a parent or both parents, torture of the individual, abuse (especially physical or sexual), or consistent emotional abuse that might be construed as nearing a torturous situation.

As a method to “protect” themselves from the outside social world, these individuals have a series of automatic thoughts that they use to insulate themselves against the potential of being harmed by other people. These automatic thoughts are all associated with beliefs that others are conspiring against them, watching them, talking about them, or in some other way plotting against them.

They use these beliefs as a shield that protects them against social interaction. Since everyone (from their viewpoint) is malevolent toward them, they use those beliefs to eject from any possibility of stable interpersonal relationships.

¹ American Psychiatric Association: *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION, TEXT REVISION*. Washington D.C., American Psychiatric Association. 2000, p. 697.

THE BOTTOM LINE

In order to counsel this individual, the therapist must help the individual “test” their beliefs regarding others. The therapist must help the individual reconstruct their cognitive processes so that the automatic thinking is stopped.

A therapist should only attempt to counsel this individual if they are a higher functioning schizotypal. A lower functioning schizotypal will likely need medical attention, possible hospitalization (if a crisis is presented) and significant medication.

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

The official DSM-IV-TR diagnostic criteria for *SCHIZOTYPAL PERSONALITY DISORDER* are:²

- A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early childhood and present in a variety of contexts, as indicated by five (or more) of the following:
 - 1. Ideas of reference (excluding delusions of reference)
 - 2. Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g. superstitiousness, belief in clairvoyance, telepathy, or “sixth sense” in children and adolescents, bizarre fantasies or preoccupations)
 - 3. Unusual perceptual experiences, including bodily illusions
 - 4. Odd thinking and speech (e.g. vague, circumstantial, metaphorical, over elaborate, or stereotyped)
 - 5. Suspiciousness or paranoid ideation
 - 6. Inappropriate or constricted affect
 - 7. Behavior or appearance that is odd, eccentric, or peculiar
 - 8. Lack of close friends or confidants other than first-degree relatives
 - 9. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgment about self
- B. Does not occur exclusively during the course of *Schizophrenia*, a *Mood Disorder With Psychotic Features*, another *Psychotic Disorder*, or a *Pervasive Development Disorder*.

[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.]

² *DSM-IV-TR*, p. 701.

DIFFERENTIAL DIAGNOSIS

There are a number of other disorders that contain similar characteristics to *SCHIZOTYPAL 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. Psychotic symptomology is associated with all three of the differential diagnoses. Psychotic symptomology, however, is not present with *SCHIZOTYPAL PERSONALITY DISORDER*. While dual diagnosis can be made, *SCHIZOTYPAL PERSONALITY DISORDER* must be present prior to diagnosis of the differentials.

PERSONALITY CHANGE DUE TO GENERAL MEDICAL CONDITION. Both diagnoses can be made. However, *SCHIZOTYPAL PERSONALITY DISORDER* must be present first.

CHRONIC SUBSTANCE ABUSE. Both diagnoses can be made. However, *SCHIZOTYPAL PERSONALITY DISORDER* must be present first.

PARANOID PERSONALITY DISORDER, SCHIZOID PERSONALITY DISORDER. The two differential disorders are not characterized by the odd, eccentric behaviors and the cognitive and perceptual distortions characterized by *SCHIZOTYPAL PERSONALITY DISORDER* are not present.

AVOIDANT PERSONALITY DISORDER. The primary reason for lack of relationship with *AVOIDANT PERSONALITY DISORDER* is fear of rejection whereas the reason for such with *SCHIZOTYPAL PERSONALITY DISORDER* is a lack of desire for relationships generally.

NARCISSISTIC PERSONALITY DISORDER. The primary reason for lack of relationships with *NARCISSISTIC PERSONALITY DISORDER* is due to the fear of having imperfections exposed while the reason for lack of relationships with *SCHIZOTYPAL PERSONALITY DISORDER* is due to lack of desire for relationships generally.

COMMONLY ASSOCIATED AXIS I DISORDERS

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

ANXIETY DISORDERS. Since this individual is hypervigilant and hypersensitive to social and interpersonal settings, there is always the possibility that demands for social or interpersonal interaction can result in various anxiety states or syndromes.

BRIEF PSYCHOTIC DISORDER. Since the *SCHIZOTYPAL PERSONALITY TYPE* involves cognitive or perceptual distortions the prospect for a *Brief Psychotic Disorder* is elevated.

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 *cognitive or perceptual distortions* of the *SCHIZOTYPAL PERSONALITY TYPE*.

SCHIZOPHRENIA. *Delusional Disorder* is a potential *Axis I Disorder* associated with the *SCHIZOTYPAL 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 follows course with the *cognitive or perceptual distortions* of the *SCHIZOTYPAL PERSONALITY TYPE*.

SCHIZOPHRENIFORM DISORDER. *Schizophreniform Disorder* contains the same criteria for *Schizophrenia* except for the duration of the symptomology and the level of impairment suffered by the individual. This follows course with the *cognitive or perceptual distortions* of the *SCHIZOTYPAL PERSONALITY TYPE*.

MAJOR DEPRESSIVE DISORDER. The potential for a *Major Depressive Disorder* with the *SCHIZOTYPAL PERSONALITY TYPE* is probably related to the severe interpersonal and relational deficits associated with the personality type.

THE SCHIZOTYPAL 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,³ the optimally functioning *SCHIZOTYPAL PERSONALITY STYLE* contains six elements. Correspondingly, there are six elements that indicate the breakdown of each of those six 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 *SCHIZOTYPAL PERSONALITY DISORDER*. The effort, therefore, must be to establish and maintain the optimally functioning elements of the *SCHIZOTYPAL PERSONALITY STYLE* without allowing for diminution toward more maladaptive traits.

³ 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. 199.

Sperry's continuum includes the following six elements:

| Optimal Functioning | Maladaptation |
|---|--|
| <ul style="list-style-type: none"> • This individual tends to be tuned into and sustained by their own feelings and belief. • This person has a keen observation of others and are particularly sensitive to how others react to them. • This person tends to be drawn to abstract and speculative thinking. • This person is receptive and interested in the occult, the extrasensory, and the supernatural. • This individual tends to be indifferent to social convention and they lead interesting and unusual lifestyles. • This individual is usually self-directed and independent, requiring few close relationships. | <ul style="list-style-type: none"> • This individual has ideas of reference, suspicious or paranoid ideation, and inappropriate or constricted affect. • This individual has excessive social anxiety (extreme discomfort in social situations involving unfamiliar people). • This person has odd beliefs or magical thinking influencing behavior and inconsistent with subcultural norms. • This person has unusual perceptual experiences (illusions, sensing the presence of a force, etc). • This person exhibits odd or eccentric behavior or appearance. • This individual has no close friends or confidants (or only one) other than first-degree relatives. |

THE SCHIZOTYPAL PERSONALITY STYLE UNDER STRESS

The following behaviors will likely manifest when an individual with a *SCHIZOTYPAL PERSONALITY TYPE* faces a triggering event. In the case of the *SCHIZOTYPAL PERSONALITY TYPE*, triggering events will be situations related to the individual's paranoid ideations about interpersonal relationships. When the client is overwhelmed with the presence of automatic thoughts regarding the malevolent intentions of others, a crisis may result.

- Extreme irritability.
- Excessive states of anxiety, anxiety disorders and anxiety syndromes.
- Significant and nearly consistent paranoia, especially related to social or interpersonal demands.
- Obsession with automatic thoughts and the behaviors that are a response to them. Most of these automatic thoughts will be associated with their beliefs concerning the malevolent nature of their social or interpersonal environment.
- Diminution toward morbid psychotic or pseudo-psychotic symptomology. These states may include auditory and/or visual hallucinations as well as other psychotic ideations.
- Psychotic *Axis I* incident.
- Social isolation due to perceived threats.

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 *SCHIZOTYPAL PERSONALITY TYPE*.

PSYCHOSOCIAL ETIOLOGY FOR THE SCHIZOTYPAL 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 *SCHIZOTYPAL 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 *SCHIZOTYPAL 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.

- Extreme trauma in the home. This may range from the death of one or both parents (especially traumatic death), abandonment of the child by parental figures, abuse of all types including physical abuse and/or torture, emotional abuse and/or torture,⁴ as well as sexual abuse (including *Ritual Sexual Abuse*).
- Insufficient emotional warmth in the home. The home was likely a cold and formal place with little or no emotional safety. The environment was probably hypercritical and charged with guilt.

⁴ Incidents of physical torture would include acts on the part of a caretaker such as burning the child with cigarettes or other physical acts of “punishment” that are outside of the socially-accepted means of child correction. Incidents of emotional torture might include extreme isolation and stimulation reduction such as locking a child in a dark basement or closet for any period of time.

- Fragmented parental communication. The parent typically condemned the child for behaviors that the parent consistently exhibited. There was an obvious and extreme parental depreciation of the child.
- Impoverished infantile stimulation. This was due to parental indifference to the stimulatory needs of the child. This may be one of the causes for the fantasy life of the adult. Punitiveness and social control might also be a factor in the development of the fantasy life.
- “Magical knowledge” on the part of the parent. The parent instills within the child the belief (usually early on in childhood) that they “know” what the child was thinking or doing while the parent were not there. The purpose of this parental behavior appears to be an effort to control both thinking and behavior from a distance. The parent implants suspicions and false beliefs in the mind of the child. This develops automatic generation of suspicions in the mind of the child so that guilt reactions become dissociated from actions. The child suffers from constant fear of attack and humiliation because of the “belief” that the parent is somehow “inside” their head.
- Parental responsibilities as a child. The child was given parental / adult responsibilities and threatened if those responsibilities were not done. This exercise may have been for the purpose of controlling the time of the child while the parent was not present. It also cuts the child off from social communication and interaction.
- This personality disorder may be the diminution of either a *SCHIZOID PERSONALITY TYPE* or an *AVOIDANT PERSONALITY TYPE*.
- The parental behavior that formulates this personality disorder must be considered as a very strong form of emotional and psychological abuse.
- Family behavior patterns to investigate at the disorder level include severe abuse (especially “mind games”, but also potentially physical or sexual);⁵ punishment for allegedly inappropriate autonomy; parental “secret knowledge” that the child had done something inappropriate; punishment of the child for performing the same behaviors exhibited by the adult (“do as I say, not as I do”); circumstantial events tied to the child’s behavior (“If you won’t have stayed after school, your mother wouldn’t have gotten in a car accident”); victimization of the child; and, strong injunctions against leaving the home.⁶

[The above list does not contain biochemical considerations associated with the etiology of the *SCHIZOTYPAL 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.]

⁵ In cases of severe abuse, the therapist may find that the client resorts to paranoid withdrawal.

⁶ 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.

DISORDER TRIGGERS

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

Close Interpersonal Relationships. Since the *SCHIZOTYPAL PERSONALITY TYPE* exhibits acute discomfort with and reduced capacity for close 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.

TREATMENT COURSE FOR SCHIZOTYPAL PERSONALITY ISSUES

The following is a summary of treatment objectives when a therapist is dealing with a *SCHIZOTYPAL 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 six major defense mechanisms that are commonly used by individuals with the *SCHIZOTYPAL PERSONALITY TYPE*. Five 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 thoughts onto another person without justification. This is usually a guilt-based reaction to their own perceived negative aspects. [Level #4 – Disavowal Level]

Delusional Projection. The client uses *projection* with the added component of reality distortion. *Projection* places a person's own negative behaviors on another person. With

Delusional Projection, the individual actually believes what they have *projected* onto another person because they believe they have evidence. [Level #7 – Level of Defensive Deregulation]

Psychotic Denial. The client uses *Denial* with the added component of reality distortion. *Denial* is an internal inability to admit that an event has occurred. *Psychotic Denial* build a defense that “proves” to the client that the event has or has not not occurred. [Level #7 – Level of Defensive Deregulation]

Psychotic Distortion. The client experiences internal hallucinations (visual and/or auditory) and other delusions. These elements reshape the client’s view of external reality and create a “new reality” for the client that opposes objective reality. [Level #7 – Level of Defensive Deregulation]

THE TREATMENT PROCESS

Prior to Therapeutic Intervention

The first course in treatment for the *SCHIZOTYPAL 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.⁷ 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.

⁷ 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.

- The therapist should understand that treatment of lower functioning schizotypal individuals in an outpatient setting is potentially non-productive. The likelihood is that these individuals will need psychiatric control, significant medication, and inpatient treatment. This will be indicated rather quickly to the therapist when an individual is unable to focus in therapy or is unable to separate reality and fantasy.
- Some higher functioning schizotypal individuals do respond well to outpatient therapy. This will depend, to some degree on the motivation of the client and their ability to begin working through their fears and paranoias. In order to facilitate this environment, the therapist must adopt a permissive and accepting attitude toward the client. The therapist must understand that this individual may believe that everyone is plotting against them. The therapist must develop a relationship that disproves that fact to the client in order to develop a working relationship.
- Clients with some depressive symptoms fair better in therapy because of the motivation to get past the negative and troubling emotion. Clients with higher level ego functioning are also better prospects.
- The therapist should expect that the client will routinely use *Projective Identification* as a defense mechanism in and out of the therapy office. The therapist must deal with this issue without being overly corrective initially.
- The therapist must also understand that extreme states of agitation and anxiety are often present, especially when the individual perceives that they are going to be placed in a situation that threatens them. The therapist must help the client manage and modify their hypersensitivity, hypervigilance and anxiety.
- Early in the treatment process, the therapist and the client together should produce both a problem list and a goal list. It is essential that the client is involved in this effort for two reasons: 1) the therapist will be able to see the issues that are most important to the client; and, 2) the client will be less likely to believe that the therapist is conspiring against them.
- The client has significant irrational beliefs about others. Most of those irrational beliefs are based in some type of fear related to how others perceive them. Therefore, the therapist must ensure that the client doesn't develop an aversion toward the therapist. If this occurs, the therapeutic relationship may be over and the client is probably best referred to another therapist.
- The goal of the therapist is to help the client develop a correct emotional response to life's experiences. The client needs a new cognitive structure for internalization of thoughts and feelings (and not just behavioral modification or restructuring). The client is basically nonrelational in their mode of functioning.
- Thus, the goal of treatment is to improve adaptive functioning through restructure of automatic thoughts.⁸ The cognitive structure of the individual must be carefully questioned, including all of the maladaptive automatic thoughts that a person has

⁸ "Automatic thoughts" are any thoughts that pre-exist facts. Thus, the client will believe (i.e. think) that someone is "out to get them" or someone is "talking about them behind their backs" even though there is no justification for the thought. These are automatic thoughts and they form the basis for the cognitive functioning of the schizotypal individual. This is little prospect of aiding these individuals if automatic thoughts and beliefs are not curtailed.

(e.g. “people are following me,” “people are watching me,” or “people are plotting against me”).

- The therapist should understand that sometimes silence is a means by which the client responds in some cases. The therapist must be careful not to push the client past silence since it may be too threatening for the client to speak. The therapist should not act on silence. The fact that the therapist will not push the client past silence reinforces to the client that the therapist is on their side.
- The therapist should carefully review the psychosocial etiology of the *SCHIZOTYPAL PERSONALITY TYPE*. It appears that the *SCHIZOTYPAL PERSONALITY TYPE* originates from some extremely traumatic situation or event in the client’s childhood experience.⁹ This may include very severe cases of abuse and neglect (although those are not the only psychosocial elements in the etiology of this Type). The traumatic events of childhood have instilled an archetype of paranoid mistrust of others within the client’s cognitive thought processes as a means of preventing even more trauma.
- With this in mind, it will serve the therapist best to develop some overall concept of where the paranoia originated. It is unlikely that the paranoia developed anywhere outside of the home of origin, but at the same time, there are a number of different reasons that could have generated the paranoia. This case-building exercise on the part of the therapist should be done over a number of sessions without the explicit knowledge of the client. This will greatly aid the therapist in pinpointing treatment methodologies.
- The core of treatment for the schizotypal individual in crisis involves helping them to develop new and more realistic cognitive conceptions of their social and interpersonal environment. The therapist should understand that this process will be slow, especially in the beginning due to both anxiety and paranoia.
- The therapist must aid the client in exploring their automatic thoughts and beliefs about their environment. The therapist must help the client “test” those automatic thoughts. As therapy progresses, the therapist must help the client examine the evidence concerning the reality of the automatic thoughts. It is very important that the therapist uses questions as a primary method of helping the client rethink their automatic thoughts. If this is not done, the client may think that the therapist is acting against their best interest.
- The goal of the therapist is to draw out these automatic thoughts and help the client determine if the thoughts are true or not. If they are not, the therapist needs to help the client develop abilities that will subvert and stop the automatic thoughts.
- After this process has begun, the therapist must help the client learn more appropriate emotions related to their thinking. This is a two-step process: 1) stop the automatic and illogical thinking process; and, 2) restructure the emotional content associated with thinking processes.
- After the client is assured that the therapist is not “out to get them,” the therapist must work to increase the social support network of the client. This is done partly

⁹ While some non-typical occurrences of *SCHIZOTYPAL PERSONALITY DISORDER* may find their primary etiology in biochemical abnormalities, the therapist will likely determine that biochemical etiology as a primary mechanism for the development of this personality type is very rare.

through increase of the client's socially appropriate behaviors and partly through the establishment of more appropriate thinking patterns.

- Modifying the paranoid ideations of a client is sometimes very difficult. The client may ascribe very positive benefits to these automatic thoughts and beliefs. They may provide a safe environment that prevents harm to them. An example will best illustrate this fact.

Therapist: Has anyone ever done anything to hurt you?

Client: No. Not really.

Therapist: But you seem to stay away from other people because you think that they will hurt you.

Client: Well, better safe than sorry... (an automatic thought)

- Thus, even though the client has never been hurt significantly in some adult social situation, they use the aversion to social situations as a positive quality that prevents what they fear. This is only reinforced further if the client has managed to actually be hurt in a social situation. This is not uncommon at all due to the social ineptness of the individual.
- Role-playing may be a significant element in the development of cognitive and social skills as therapy progresses. This should only be done when the therapist believes that it will not overwhelm the client.

Dangers of the Therapeutic Process

There are significant obstacles and potential dangers associated with the therapeutic process for the *SCHIZOTYPAL PERSONALITY TYPE*. These include the following:

- Inability to trust the therapist due to paranoid ideations of harm being done by everyone that they are associated with. This issue can only be resolved by referral once it occurs.
- Major psychotic episode. The type and extent of the psychotic episode cannot be predicted. This will likely occur when the client begins to explore the world without the "aid" of their automatic thoughts. The world may be too scary of a place to encounter without preconceived and automatic beliefs.
- Self-harm or harm to others. This is a possibility especially in the presence of a psychotic episode. The individual may engage in a self-destructive act or an act that harms another person without even understanding what they are doing.

Successful Completion of Treatment

Termination of treatment for the *SCHIZOTYPAL 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:

- Resolution of the abandonment fear that the client will have regarding all or nearly all interpersonal relationships that they engage in.
- Resolution of the belief that the client is alienated from others and that others cannot understand them or meet their needs. This can be done to a significant degree by helping the client repattern their cognitive abilities by preventing automatic thoughts.
- The belief that the client is always vulnerable to harm must be addressed. The client is unusually susceptible to paranoid ideations. These must be addressed and diminished in order for the therapist to deal with the client's fear of imminent catastrophe.
- The client must be taught that they can competently deal with everyday responsibilities without considerable help from others. This is a learned process that goes along with the cessation of automatic thoughts.

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