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Cluster A: SCHIZOTYPAL PERSONALITY DISORDER (StPD)

| Mental Health Issues | Treatment Issues | StPD & Addiction: Dual Diagnosis Treatment Issues |
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| <p>Essential Feature: A pattern of social and interpersonal deficits; acute discomfort in close relationships. Marked by cognitive or perceptual distortions and eccentric behavior (DSM IV™, 1994).</p> <p>Compelling evidence has been found that schizotypal personality disorder and schizophrenia are linked in terms of genetic, biological, outcome, and treatment-response characteristics (Sperry).</p> <p>Self Image: StPDs need to believe that they have extraordinary, supernatural powers in order to feel less empty (Oldham).</p> <p>View of Others: StPDs are distrustful of others and apprehensive in social situations (Sperry).</p> <p>Relationships: StPDs lack close relationships; they experience excessive social anxiety (DSM IV™, 1994).</p> <p>Authority Issues: StPDs are likely to be apprehensive, distrustful, and under stress when around authority figures; symptoms are likely to increase and cognitive slippage will become more apparent.</p> <p>Behavior: StPDs are gauche, with peculiar mannerisms (Millon). StPDs are estranged from people; they appear shy, aloof, and withdrawn (Oldham).</p> | <p>The StPD Coming Into Treatment: Cluster A personality disorders are often forced into therapy by family or the legal system. These individuals are not psychologically resilient and will have severe difficulty in jail.</p> <p>Medication Issues: Psychotropic medication will often be refused or surreptitiously discarded. Non-compliance issues will resemble those of the SMI DD population.</p> <p>Personality disorders are medicated for target symptoms rather than for the personality disorder itself. From a symptomatic approach, StPD can be considered a mild form of schizophrenia; treatment employs similar medications in lower dosages. The atypical antipsychotics are recommended for both positive and negative symptoms. SSRIs can improve both obsessive and depressive symptoms (Joseph).</p> <p>Treatment Provider Guidelines: A sound psychotherapeutic relationship, whether in individual or group treatment modalities, can allow these individuals an opportunity to correct eccentric and bizarre thinking. The treatment approach must be flexible and focused on behavior. Connection to treatment providers may be unusual but quite significant to individuals with StPD.</p> <p>Countertransference Issues: StPDs are inclined to engage treatment providers in circuitous, belabored, odd, and meaningless discourses on subjects like "artistic endeavor and the use of drugs. Treatment providers may become overwhelmed, bored, or frustrated and begin to withdraw.</p> | <p>Incidence of Co-Occurring SA Disorders: Cluster A represents the lowest incidence of co-occurring substance abuse disorders of the three DSM-IV™ personality disorder clusters (Nace, 1990).</p> <p>StPD Drugs of Choice: No single pattern of substance use or abuse can be identified for any of the personality disorders.</p> <p>For StPDs, there is the possibility of an addiction to compulsive fantasy and an inclination to seek drug experiences with the psychedelics that provide imaginative transport such as with marijuana, LSD, and psilocybin. These drug experiences will be ego-syntonic and service provider or family objections to their use will appear to be nothing more than the usual attitudes of the "conforming masses."</p> <p>Walant (1995) notes that LSD give some individuals a false sense of control. The drug allows escape from reality to a drug-induced mental chaos that seems to be in the control the users. Weird perceptual distortions can actually alleviate anxiety about personal strangeness that is not drug induced.</p> <p>Dual Diagnosis Treatment: Pattern of drug use and consequent destabilization may be similar to the seriously mentally ill/dually diagnosed, i.e., destabilization may be triggered by use rather than abuse. Psychoeducation will be vital. Otherwise, the treatment provider may appear to be moralizing and over-reacting to drug use.</p> |

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| <p>Affective Issues: Affect is deficient or disharmonious (Millon). StPDs use "emotional reasoning," i.e., the belief that because there is a negative emotion, there must be a corresponding negative external situation (Sperry).</p> <p>Defensive Structure: StPDs may lead idle, ineffectual lives - rarely accepting enduring responsibilities. They experience depersonalization and dissociation. They are self-absorbed and lost in daydreams (Millon). StPDs are eccentric and susceptible to psychotic episodes, ego boundary confusion, discontinuity of identity, and hypochondriasis (Stone).</p> <p>StPDs engage in four types of odd cognition, these are: suspicious or paranoid ideation, ideas of reference, odd beliefs and magical thinking, and illusions (Beck).</p> | <p>Treatment Techniques: StPDs may fear that treatment will render them "ordinary" (non-special and non-creative). Direct challenging of odd beliefs may trigger withdrawal or an energized and bizarre defense of the individual's perceptions and belief system.</p> <p>Treatment Goals: Treatment goals need to be similar to working with the seriously mentally ill/dually diagnosed, e.g. concrete, focused, measurable, and modulated to meet the capacity of the individual.</p> <p>StPDs experience pain if caught in social isolation. Increasing their social network is an effective therapeutic strategy. Assist StPDs in looking for environmental evidence to evaluate their thoughts rather than simply accepting emotional validation, i.e., if they feel it, it must be true (Beck).</p> | <p>Confrontation usual to substance abuse treatment will be ignored, defended against, or may overwhelm StPDs. Abstinence cannot be a prerequisite to treatment nor should use result in termination from treatment.</p> |
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