

Personality Disorders- Schizoid

DSM-IV-TR Diagnostic Code: 301.20 Schizoid Personality Disorder

Diagnostic Guidelines:

1. Establish Diagnostic accuracy as defined in DSM-IV-TR/ICD-9.
2. Identify differential diagnoses and co-morbid problems: Rule out delusional disorders, schizophrenia, mood disorders with psychotic features, Autism, Aspergers, Expressive and Mixed Receptive-Expressive Language disorders, communications disorders, substance related disorders, and other personality disorders. Rarely, one might Use psychological testing to assist with rule outs when treatment based on standard clinical evaluation and treatment approaches is ineffective or fails to improve the client's mental status and related life experiences.
3. Obtain external corroboration of diagnosis when possible through review of past treatment history, legal history, family or third party observations, etc.
4. Review previous treatment episodes to determine efficacy of treatment interventions and therapeutic gains.
5. Assess type and degree of functional impairment, and adaptive and maladaptive coping styles, as these may be targets of treatment.

Treatment Guidelines

1. Individuals with this disorder are unlikely to seek treatment unless they are under increased stress or pressure in their life, or at the insistence of another party who is troubled by their behavior. Treatment will usually be short-term in nature to help the individual solve the immediate crisis or problem. Goals of treatment most often are solution-focused using brief therapy approaches. Long-term treatment generally has limited success and a poor cost-benefit profile.
2. Building rapport will likely be a slow, gradual process that may not ever fully develop compared with other disorders. Because people who suffer from this disorder often maintain a social distance with people, even those close to them, and distrust the expression of emotion, the clinician should respect the need for privacy and avoid aggressive intrusion into the client's daily life and social milieu. Acknowledging client boundaries is important, and the clinician should not look to confront the client on these types of issues, but should be alert for any pain, distress, or motivation to change that could be focused on. Of particular concern are any violent, damaging or antisocial behaviors. The provider should avoid having more ambitious goals for treatment than the client has for himself.
3. Treatment may need to include psycho-educational efforts to address the distress of other people who are upset by the client's detachment.
4. Cognitive-restructuring exercises may be appropriate for certain types of clear, irrational thoughts which negatively influence the client's behaviors. The

therapeutic framework should be clearly defined at the onset. Stability and support are the keys to good treatment. Therapy may also focus on building resiliency to cope with everyday stressors and crises.

5. A person who suffers from this disorder is generally uninterested in social connections and feels self-sufficient, limiting the effectiveness of group therapy, particularly if one is assigned to group therapy too early in therapy. Group therapy may be appropriate if the person has enough minimal social skills and abilities to tolerate group or needs the reduced personal intensity of a group instead of individual contact. Long periods of silence and non-participation are to be expected, and the individual may only gradually participate more on their own terms. Group leaders must be careful to help protect the individual from criticism from other group members for their lack of participation. Self-help and support groups may be considered for developing some level of trust and social interaction.
6. The client may eventually reveal fantasies, imaginary friends, and fears of dependency. Oscillation between fear of clinging to the clinician may be followed by fleeing through fantasy and withdrawal. These types of feelings must be normalized by the clinician and balanced in the therapeutic relationship.
7. Medication is usually not useful for someone who suffers from this disorder, unless they also have an additional Axis I disorder. Medication should be prescribed only for acute symptom relief. However, as schizoid traits are, in some ways, similar to the negative symptoms of schizophrenia, a low-dose antipsychotic medication may have beneficial effects.

BIBLIOGRAPHY:

Grotstein, J. S. & Hedges, L. E. (1994). *Working the organizing experience: Transforming psychotic, schizoid, and autistic states.*

Manfield, P. M.D. (1992, July). *Split self/split object: Understanding and treating borderline, narcissistic, and schizoid disorders.*

Seinfeld, J. (October 1991). *The empty core: An object relations approach to psychotherapy of the schizoid personality.*

Wolff, S. (1995). *Loners: The life path of unusual children.*