

The Treatment of Schizoid Personality Disorder Using Psychodynamic Methods: A Review of the Empirical Literature and Synthesis

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Abstract

The aim of this study was to establish what is known about the treatment of schizoid personality disorder using psychodynamic psychotherapies, by conducting a systematic review of the literature. The limitations of this approach are set out, followed by an account of the development of the use of the term in descriptive psychiatry and the psychodynamic literature. The inclusion criteria used were studies in English and of adults, that had a methodology, had confirmed a diagnosis of schizoid personality disorder in the subject during the study, that used any type of psychodynamic approach, and that measured the outcome. Search terms included “schizoid”, “psychotherapy”, “therapy”, “psychodynamic”, “psychoanalysis”, “trial”, “efficacy”, “effectiveness”, “method”, “methodology”, “qualitative”, “result”, “measure”, and “outcome”. Mesh headings were also used. Databases searched were AMED, the BMI, Embase, Medline, Psychinfo, and CINAHL. Data extraction was performed using critical appraisal tools from the critical appraisal skills programme (Solutions for Public Health). The literature search located two qualitative studies of single psychotherapy cases; one using the Assimilation of Problematic Experiences Scale to analyse data from a therapy using a mix of cognitive behavioural therapy and clarification oriented psychotherapy, and one using the Referential Activity Scale in combination with the Core Conflictual Relationship Theme method. One prospective cohort study using group psychotherapy was also found. All three described positive results in the patient or patient group. These studies were critically reviewed. The literature search found few studies with any methodology at all and an incidental finding was that there were few comprehensive descriptive single case studies in the psychodynamic literature. Potential reasons for the low number of studies are discussed. What needs to be researched to be able to answer the question with any authority is explored, with reference to the validity of the condition, genetics, temperament and attachment. A researchable, evidence based model of the development of the condition is proposed. The future use of qualitative research to uncover testable hypotheses about environmental influences on the development of the condition is recommended. The main finding of the review is that at present the existing literature is inadequate to draw conclusions about the treatability of this condition with psychotherapy.

Introduction

Schizoid personality disorder is one of a number of specified personality disorders in DSM-IV (American Psychiatric Association 1994) and the ICD-10 (World Health Organization 1992); the current criteria for diagnosis have been in existence for over 19 years. According to research criteria the prevalence ranges from between 0.3 and 1.7% in the UK (Coid et al. 2006), and comparable rates (1.4%) have been found in psychiatric outpatients (Zimmerman et al. 2005). A key element of UK department of health policy over recent years has been the development of mental health services to include greater provision for the treatment of personality disordered individuals as a whole (National Institute for Mental Health in England 2003).

Schizoid personality disorder and antisocial personality disorder, as well as psychopaths, can in theory, from an attachment perspective, be subsumed together into the dismissing attachment cluster, of the insecure attachment category. These individuals differ widely in their pathology, and it was felt that this is insufficiently commented on and is not yet fully understood. It was thought that a review of the literature on the treatment of schizoid personality disorder would help establish what is known, and help establish the necessary direction for future research.

This review aims to ascertain what the current evidence is for the treatment of this condition, as it is currently defined by the disease classification manuals ICD-10 or DSM-IV or any derivative scales, using psychodynamic methods; and what research remains to be done to justify providing, or withholding, such treatments in the National Health Service in the United Kingdom.

The question in this form was chosen as it matches the form of many other research questions which seek to establish effective treatments for conditions defined by pre agreed diagnostic criteria, i.e. the DSM or ICD. The diagnostic criteria these manuals specify have face validity. They have been very widely disseminated. They permit comparisons between different studies and the aggregation of results. They are seen to be credible and studies based on them are seen to be credible.

However, the conclusions it is possible to draw, may also be limited, because of weaknesses in the underpinning assumptions that it is necessary to accept in order to feel that this is a meaningful research question.

From the point of view of diagnosis, there are, to begin with, significant difficulties with the concept of personality disorder as a whole, in the way it is defined. DSM-IV and ICD-10 use a categorical approach where a number of imprecisely defined and overlapping symptoms are required to cross an arbitrary threshold to make a diagnosis. These are little more than intuitive clinically informed descriptions of commonly encountered pathology (Jang & Vernon 2001; Huprich & Bornstein 2007). In contrast to this arrangement which is difficult to defend in terms of quality of evidence, a dimensional approach has been suggested for the DSM V which would use a multi-axial system of personality pathology. This is not without its difficulties however. Overlapping diagnoses can be more easily accommodated, but the axes chosen run the risk of being equally arbitrary, and currently there are competing alternatives for what is included. A leading contender model for a dimensional module in the next DSM is the “Big Five” model (McCrae & Costa 2010), but this has the significant weakness that it is originally based on the “lexical hypothesis”- the assumption that words will have developed to accurately describe dimensions of personality, and these dimensions can therefore be elicited by comparing terminology for personality from different cultures and languages. Whether this is a good enough hypothesis appears to be a matter of opinion (Ashton & Lee 2005), and whether an assessment based on this scale has sufficient clinical utility has been questioned (Spitzer et al. 2008).

There are alternative approaches in consideration, including the use of the “interpersonal circumplex”, which has its own “lexical solution” (Pincus 2001); and the “psychobiological model of temperament and character” (Cloninger et al. 1993) both of which lead personality assessment in a more theoretically informed direction, using interpersonal theory, and cognitive and behavioural

theory respectively. Another approach is a dimensional model of traits found in personality disorders, informed primarily by heritability studies (Livesley 2001).

These scales may well resolve into an agreed dimensional diagnostic system, but at present differences between them are in contention and so a universal system is not yet available (Millon et al. 2010; Jang & Vernon 2001); and the assessment of personality disorders is effectively in limbo.

Although categorical diagnostic categories are broadly accepted as workable as research criteria, there is also an implicit assumption in their use, currently widely in effect, that non co- morbid populations are sufficiently representative of the target group as encountered in clinical practice. Co-morbidity may be the presence of two unrelated conditions, the same condition described in a different way, or simply a condition that is difficult to differentiate from other overlapping diagnostic categories. Schizoid personality disorder shares some similarities in criteria with schizotypal personality disorder, avoidant personality disorder, and Asperger's syndrome. In an outpatient setting over 80% have another diagnosable personality disorder (Zimmerman et al. 2005). This is worrying when it comes to interpreting the results of studies that investigate a single diagnosis, since the individuals in question may not be typical, or may not even have the disorder one wishes to study.

Choosing a systematic review as the research method also makes assumptions that can be questioned. The most powerful and influential evidence in psychological treatments is widely perceived to come from randomized controlled trials, which have impact on treatment guidelines and policy. Good controls are difficult to establish particularly in long term psychotherapies. Treatments may need to be manualized in order to establish consistency of treatment but may lose depth and flexibility as a result, despite scoring more highly in systematic reviews. This introduces a bias against psychodynamic approaches, training in which is based on an apprenticeship model and the experience of personal therapy, which is effectively impossible to manualize, as opposed to the scientist- practitioner model of clinical psychology.

Within some of these broad limitations, this topic and method was chosen because on initial perusal of the evidence base there appeared to be a dearth of research, but also because it was felt that schizoid personality, being as it is a condition that by definition demands little attention from society at large, would be likely to get neglected compared to the more urgent cluster B disorders. The testing of psychodynamic methods in this condition seems appropriate. There has been much work on schizoid pathology by psychoanalytic thinkers, as this study will illustrate. However the analytic canon is not a consistent body of thought in its theory or terminology. Beyond narrow questions of efficacy, attempts to rigorously study the treatment of schizoid personality may throw light on our understanding of personality disorder and psychopathology as a whole, and help inform new directions for future work, helping to bring empirical psychiatry and the analytic frontier closer together.

Background

The term prefix “schiz-“ is derived from the Greek “schizein” meaning to cleave (Chambers Publishers 2006).

There have been two main strands of development of the concept of schizoid personality. The first comes from the tradition of descriptive psychiatry, and the second comes from the psychodynamic tradition. These strands will be briefly summarized here.

Descriptive Psychiatry

The term schizoid was originated in 1908 by Eugen Bleuler, a Swiss psychiatrist who also coined the term “schizophrenia” (a “splitting of the mind”). His description of a “schizoid” tendency, not amounting to full schizophrenia, appears remarkably straightforward, consisting of a tendency to focus on internal rather than external life (which would later be termed introversion) which, when the expression of this tendency is extreme enough, provided the individual has not become psychotic, is termed a “schizoid personality”. He felt that while such people were quiet and dull, they were also sensitive, and their inner thoughts and feelings had a lack of “uniformity” (Bleuler 1976). This description in its essence lasted a number of years, with various revisions and additions, until the advent of the DSM III (American Psychiatric Association 1980; Akhtar 1987).

The term “shut – in personality” was described contemporaneously by Hoch (1910). He believed it was associated with schizophrenia. Elements of what would in present day categorical systems be allocated between schizoid and schizotypal personality disorders were described by him; among these were tendencies to secretiveness, mystical interests, shyness, sensitivity and daydreaming (Akhtar 1987).

Kretschmer's observations of the schizoid type appear to demonstrate what has become an ongoing difficulty that exists to the present day, in easily capturing what he felt he was referring to, from a purely phenomenological level:

“They could be lazy and yet act with passionate energy in certain matters. They were socially withdrawn or eclectically sociable without deep psychic rapport yet could develop deep friendships with a select few.... Most striking were their contradictory emotional states behind an apparently detached facade” (Akhtar 1987 p500)

Further work emphasised their solitary nature and subordinate role in groups, and continued to note the contradictory nature of their pathology, as they appeared to have a lack of empathy combined with extreme personal sensitivity (Akhtar 1987).

Asperger first described “autistic psychopathy” in 1944 and his original description is what has evolved into the modern term “Asperger syndrome”. The features he included again contained contrary elements- “extreme personal sensitivity associated with indifference, even cruelty towards others” as well as abnormalities of gaze, “autistic intelligence”, solitariness, and asexuality.

Asperger linked his description to the pre-existing literature on “introverts” and “schizoids” (Akhtar 1987 p501).

At this point there was little distinction made between schizoid personality disorder, schizotypal disorder, avoidant personality disorder and Asperger syndrome. However this changed with the advent of the DSM III (American Psychiatric Association 1980), when the condition was separated into schizoid personality, avoidant personality and schizotypal personality. The logic behind this was to distinguish those with a deficit in the capacity to form relationships (the schizoid) from those with the ability and desire but for whom this goal was conflicted (avoidant personalities); and from those who whose oddities of thought and behaviour, and genetic linkage to schizophrenia (schizotypal personalities) separated them (Akhtar 1987). Those with an autism like developmental disorder were separated when this category was included in the DSM-IV. These distinctions have

persisted into the current edition of the DSM (American Psychiatric Association 1994), as well as the ICD-10 (World Health Organization 1992).

Akhtar criticised the DSM categories, believing that there was an artificial distinction between the avoidant and schizoid personalities. His preferred description of schizoid personality emphasises the disjunction between what he thought schizoid characters felt covertly (actually an intense need for others), which diverged greatly from what they expressed outwardly (Akhtar 1987).

In summary, in the descriptive literature of psychiatry the term appears to have originally derived from a belief that the condition is related to schizophrenia, albeit that after DSM III this aspect of a previously unified condition was separated off and subsequently referred to as schizotypal disorder. The term “schizoid”, at least within psychiatry, is something of an accident.

Psychodynamic literature

Within the analytic literature the term has been used extensively, but different authors have used it to explore different formulations so what is being “cleaved” is not always consistent. It appears that the treatment of these patients has been influential in the production of general theories of psychopathology.

Fairbairn

Fairbairn was quite clear what he meant by “schizoid”:

“It will not escape notice that the concept of ‘Schizoid’ which emerges from the preceding considerations corresponds remarkably closely, particularly where its denotation is concerned, to the concept of the ‘Introvert’ type as formulated by Jung; and it is significant that...Jung expressed the view that the incidence of schizophrenia... was confined to the introverted type” (Fairbairn 1952 p7).

However he felt, in contrast to Jung, that the condition is the result of problems in psychic development and thus represents pathology rather than a “type”. Fairbairn also linked the schizoid personality to both schizophrenia and “psychopathic personality of a schizoid type”. He stated that his conception of “schizoid personality” is based upon “strictly psychopathological factors” and that the term “schizoid” can be seen as “explanatory in a psychogenetic sense” (Fairbairn 1952 p7). So it appears that although the term may have originally derived from the phenomenology of schizophrenia, Fairbairn used the term in an expedient way to support his theory that the condition derived from splitting processes of the ego.

Fairbairn elaborated extensively on how he thought this splitting came about, and the splitting mechanisms of the ego and the object that are associated with this. Fairbairn stated clearly that the schizoid individual’s omnipotence, detachment and preoccupation with their inner reality, is a result of their having come to regard their libidinal need for others as destructive; therefore this is vigorously defended against. He hypothesised that this originated in a traumatic experience where the child feels it is not really loved for him or herself. As a result of this there is withdrawal into a kind of internal space which is organised at the oral stage, resulting in:

“a narcissistic inflation of the ego arising out of *secret* possession of, and considerable identification with, internalized libidinal objects (e.g. the maternal breast and the paternal penis). Here it would be difficult to exaggerate the importance of the element of *secrecy*” (Fairbairn 1952 p22).

The oral stage, populated by part objects, was previously satisfying, and Fairbairn sees the schizoid as regressing back into it, and using others as objects therefore, rather than as whole people. Oral anxiety (a conviction about having drained the maternal “goodness” by being so greedy) links with worries about being unloved to create the impression the child’s love for its object is destructive and bad. Being loved or loving is dangerous.

While the child is in the oral mode of incorporation in Fairbairn’s scheme, bad objects are internalized and repressed.

“It is impossible for anyone to pass through childhood without having bad objects that are internalized and repressed” (Fairbairn 1952 p64).

The bad object is created from the splitting of the experience of the frustrating libidinal object into good and bad aspects. The internalization is motivated by a wish to control the bad aspect. The bad object is then subdivided into exciting and rejecting aspects. Repression is driven by aggression.

“The child seeks to circumvent the dangers of expressing both libidinal and aggressive affect towards his object by *using a maximum of his aggression to subdue a maximum of his libidinal need*. In this way he reduces the volume of affect, both libidinal and aggressive, demanding outward expression” (Fairbairn 1944 p84).

What results then is the constricted affect of the schizoid state; the schizoid individual has internalized the burden of badness using up the force of their aggression in the process.

Fairbairn's theory has been both praised and criticised; his approach has been described as humane, but there are hidden paradoxes in the metapsychology; any mental structure at all to him represents psychic damage, which is therefore universal; and if the child starts without structure in a state of primary identification with its mother, how can it be object seeking in a way that is defined by its awareness of separateness? Nevertheless he is given credit for setting out the first full object relations theory of the personality (Gomez 1997).

Melanie Klein was impressed by some of what Fairbairn thought he had discovered, and borrowed both the idea of early splitting, the term which she incorporated into the “paranoid schizoid position” (Klein 1946). However her account of what happens is a quite different configuration of the splitting of ego and objects, with withdrawn avoidance of social interaction just one possible end result.

Klein's writing on the paranoid-schizoid position emphasises that paranoid thinking is not in and of itself pathological. The paranoid schizoid position is a fundamental template for organising experience that persists in a universal way (Gabbard 2005). She disagrees that the earliest splitting is motivated by the experience of rejection, as she regards innate aggression and anxiety to be the main motivating forces in the psyche of the infant from the beginning. In her theory the splitting is necessary in the earliest months of life because of the extent of early anxiety; splitting of its experience into good and bad allows it to form a trusting relationship with the good object. What remains in the bad sector is persecutory anxiety. This can be partly based in bad experience, and exacerbated by maltreatment, but acquires its greatest force from the return of the projected death instinct, which has to be projected to stop it killing off the child from within. Klein describes withdrawn, unemotional schizoid patients specifically and did appear to use the term conventionally; however in the Kleinian model, splitting and projection can result in either: a "shrinking from people" to prevent a destructive intrusion into them and subsequent retaliation, or a compulsion to control others. Klein agrees with Fairbairn that schizoid patients can be observed repressing frightening split off object relations, but it is persecutory anxiety which triggers this process, and this is rooted in the congenital quantity of death instinct (Klein 1946).

These differences with Fairbairn are major in terms of how they are likely to impact upon an analytic formulation of a schizoid patient and what interpretations are likely to be helpful. Interpretations concerning the hidden aggression of the patient, for a therapist thinking in Fairbairn's terms, will simply reinforce the rejecting object in its relationship to the split and repressed antilibidinal ego. This may help reinforce the defences of the personality but will not achieve a cure.

For Klein the goal is of integration of the split ego, including its aggressive aspects, which of course requires interpretation of biologically rooted aggressive urges. This contradiction between these two theorists is a fundamental controversy. Fairbairn thought he could achieve the "release" of the bad object and repair the repressed and re-enacted bad self-object aspect of the personality,

returning to an earlier more innocent state. For Klein there was basically no such thing as “cure” at least not in Fairbairn’s sense.

Winnicott’s contribution to the understanding of the disorder was that it was a variety of “false self” organisation. The “false self” is called into being by an environment (mother) that fails to be “good enough”, resulting in frightening experiences of unintegration that need managing and attention. This troubled inner state is covered with a façade of coping and compliance, and emotional withdrawal. If this fails, psychosis is the result. Therapy for Winnicott meant reworking some of the early experiences leading to this state; through regressing to an unintegrated state in therapy, and through the provision of sensitive responsive care by the therapist, rather than understanding per se (Winnicott 1990).

Other contributions from the British school have included Guntrip, who popularised Fairbairn’s description of the schizoid position, and elaborated its distinctive features. Guntrip’s theory was also that rejection from early caregivers was a factor in withdrawal, arousing devouring impulses, as was early trauma. He emphasised the conflicted relationships of the schizoid that oscillated between closeness and distance (Akhtar 1987).

Balint described the “basic fault”, another variation on the theme of poorly managed primary narcissism by the caregiver. Balint’s phobic type (object- avoiding) develops to defend against the claustrophobia of untrustworthy objects (Balint 1992).

Khan was also interested in schizoid personalities and felt a particular parenting style predominated in the condition- that of a failure to protect against environmental impingements, together with a collusive relationship he called “symbiotic omnipotence”, leading to a combination of withdrawal and grandiosity (Rayner 1991).

Outside the British school, the condition was delineated from within other frameworks. Kernberg's description of schizoid personality placed it within borderline personality organisation, and at this developmental level weak ego functioning, poor superego integration and splitting as a defence mechanism predominate. Due to the splitting and inability to tolerate ambivalence, their view of others and themselves were split into idealised and horrible aspects (Akhtar 1987).

Kohut felt the schizoid personality was a separate condition from narcissistic personality disorder but pathology arose from the same processes; i.e. failure of the optimal development of healthy narcissism; leading to the internalisation of libidinal energy that subsequently became redirected out of the world of relationships, into an interest in things and concepts (Akhtar 1987).

Schizoid personality organisation was also described by Rey, who emphasised the identity disturbance in the condition, and Burland, who linked the condition to autism and implicated poor maternal care as a cause resulting in a failure to succeed the "autistic phase", in Margaret Mahler's terminology. The child is unable to establish a libidinal object, and this leads to difficulty with all the remaining development phases, resulting in a variety of difficulties with unrelatedness and narcissism (Akhtar 1987).

Akhtar, reviewing the literature in 1987, noted that features of withdrawal, sensitivity and asexuality were the distinguishing clinical features of schizoid personality. His concept of the condition was that the "split" is between the "outer persona and the inner world" (p511), and that inner and outer phenomena should be noted separately because the overt and covert manifestations of the condition differed so widely. For example, supposedly asexual individuals might eventually reveal compulsive use of pornography or perversions, and outwardly unassertive and uncompetitive individuals frequently could be found to be inwardly grandiose.

The majority of authors who have written on this subject have described the schizoid state as originating in an early stage of development. There have been a number of essentially synonymous theories that refer to trauma in an early symbiotic phase, with the work of Melanie Klein standing out most clearly as a distinct logical framework that gives primacy to the role of inherited factors. What is notable is that making sense of the schizoid state has long been considered an important issue in psychodynamic theory.

Method

The aim of this study is to find out what is known about the treatment of schizoid personality disorder by psychodynamic methods, by conducting a systematic review of the empirical research available.

Inclusion criteria

It was noted during the preliminary literature review that there did not appear to be any controlled studies and the available evidence was likely to be from lower down the evidence hierarchy.

Therefore the inclusion criteria were set wide to capture any available literature.

Studies were included for review if:

1. The study had a methodology
2. The study concerned treatment using psychodynamic psychotherapy or psychoanalysis, in any modality
3. The study was in English
4. The study was published
5. The study concerned adults
6. The study determined the diagnosis of schizoid personality disorder using the ICD, DSM or a derivative instrument
7. The study included a measure of outcome

Literature Search

A systematic literature search was undertaken to find the available evidence, following the method suggested by Greenhalgh (2000).

Initially a search was performed using the NHS evidence health information resources, searching through AMED, the BMI, Embase, Medline, Psychinfo, and CINAHL. Search terms included “Schizoid” “psychotherap*”, “therap*”, “psychodynamic*”, “psychoanal*”, “trial*”, “efficacy”, “effectiveness”, “method*”, “methodology”, “qualitative”, “result*”, “measur*”, and “outcome*”. Databases of reviews of evidence and clinical guidelines were also searched.

Comment/ opinion or articles with no methodology, for example single case descriptions or reports, were eliminated.

Dissertation abstracts referring to unpublished dissertations were excluded. This amounted to 5 dissertations, of which the majority (4) were single case studies, and one qualitative analysis of the countertransference experienced by therapists with difficult patients, including schizoid patients.

There were 2 relevant papers which were not available in English (1 in Russian and one in German). There was one Russian controlled study, but this was of a mixed population and did not appear to be psychodynamic in its treatment model (Burno 1989). There was a German retrospective cohort study (Rüger 1981). These were excluded from the search due to the expense and technical difficulties involved in translation.

Articles that did not address treatment, schizoid personality, or psychodynamic methods were excluded from the study. Duplicates were eliminated. This initial search yielded 3 studies in English out of 577 initial results from the literature search.

Search process:

(psychotherapy AND schizoid).ti.ab 228

and

(schizoid).ti AND ((trial OR therap* OR psychotherap* OR psychodynamic* Or psychoanal* OR treatment OR efficacy OR effectiveness OR method OR methology OR qualitative OR result* OR measure OR outcome)) 393

Combined sets: 577

The strategy was subsequently checked by a librarian with a special interest in psychotherapeutic literature, who commented that the first search strategy was imperfect but likely to have picked up most of the available information. He repeated the search, searching all databases individually including using MESH and other database headings, and no further material was discovered.

MESH Terms used in the second search were: schizoid personality disorder, psychodynamic psychotherapy/ or psychodynamics, psychotherapeutic processes, psychoanalysis, psychotherapy, psychoanalytic theory and schizoidism.

An expert in the field was contacted (Dr Steve Pearce) who confirmed that there were no controlled trials that he was aware of. Dr Salman Akhtar was also contacted in the USA who confirmed that he was unaware of any clinical trials.

A database was kept and regularly updated.

Procedure and Measure

The data extraction forms that were chosen for the research were downloaded from the CASP website (Public Health Resource Unit 2006). These forms were chosen because of their endorsement for use in NHS settings, and because there are measures for use with all types of study design.

It was also planned that an additional score would be added to each category of analysis of each individual CASP tool, so each category was given a rating of 0-5, so that similar studies could be easily compared at a glance. While the scale chosen is essentially arbitrary, it was felt this would aid the comprehensibility of the paper, without concealing any of the underlying appraisal process.

Results

The first search found **577** papers.

Out of these **3** papers met the inclusion criteria.

(TABLE 1)

Reason for Categorisation	Number of Papers
Met inclusion criteria- included in study	3
Duplicates	371
Opinion/ Theory/ mixed papers	76
Review articles	8
Single case study with no methodology	13
Not English (German, Russian, Japanese, French, Turkish and Portuguese)	54
Diagnosis	8
Aetiology	12
Prognosis	1
Not psychodynamic (hypnotherapy)	1

Book reviews	4
Dissertation abstracts, unpublished elsewhere	8
Not Schizoid Personality Disorder	15

Out of the three papers that met the inclusion criteria, there were 2 qualitative studies and 1 cohort study. The cohort study did not specifically address the treatment of schizoid personality disorder, being a study to test one aspect of the validity of the MCMI-II as a tool in rating change in personality disorder; however this contained information on change in the schizoid dimension of the MCMI II and with so few relevant papers this was included. As there was only one cohort study no attempt was made to score this as there is nothing currently to compare it with.