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Schizotypal Personality Disorder in the Alternative Model for Personality Disorders

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Schizotypal personality disorder (SPD) first appeared in the American Psychiatric Association diagnostic nosology in 1980, although its roots stretch back more than 100 years under labels such as borderline, ambulatory, and latent schizophrenia. SPD is unique in that it is conceptualized both as stable personality pathology and also as a milder manifestation of schizophrenia-spectrum psychopathology. The categorical operationalization of SPD has remained largely unchanged for the last 40 years, with emphasis on interpersonal deficits, cognitive and perceptual distortions, and odd and eccentric behaviors. The alternative model for personality disorders (AMPD) retained many of the aspects of SPD while offering a hybrid model that includes both disturbances in personality functioning and specific pathological personality traits. The present review examined the empirical literature on the success of the AMPD model in capturing SPD. Although research specifically examining AMPD SPD is limited, there is converging evidence that the six trait facets proposed for the AMPD SPD provide good coverage of SPD and correspond closely to criterion counts from the categorical SPD diagnosis. Furthermore, most studies find that the inclusion of additional facets not proposed for SPD do not account for appreciable variance. However, SPD offers a rather heterogeneous construct, and future studies should consider whether specifying positive, negative, and disorganized traits within the disorder might improve the clarity of the diagnosis.

Keywords: alternative model, personality disorders, schizotypal, schizotypy

Since its initial appearance in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*; American Psychiatric Association, 1980), schizotypal personality disorder (SPD) has occupied an important diagnostic space between psychotic and nonpsychotic psychopathology. SPD is conceptualized both as stable personality pathology and also as a milder manifestation of schizophrenia (Kwapil & Barrantes-Vidal, 2012). SPD is multifaceted with cognitive and perceptual distortions, odd and eccentric behaviors, and interpersonal deficits; thus, it includes aspects of the positive (psychotic-like), negative (deficit), and disorganized dimensions of schizophrenia-spectrum psychopathology and schizotypy. The conceptualization of SPD as a categorical disorder was relatively unchanged from *DSM-III* to *DSM–5* (American Psychiatric Association, 2013), and many of its features were preserved in the alternative model for personality disorders (AMPD) proposed a decade ago in *DSM–5*. The present review examines the empirical evidence regarding the success of the AMPD model in capturing SPD.

SPD's origins stretch back more than 100 years under labels such as borderline and latent schizophrenia (Kwapil & Barrantes-Vidal, 2012). Its roots lie in both the descriptive psychopathology tradition's "borderline" states and in personality conceptualizations of schizotypy. The SPD diagnosis grew out of Spitzer et al.'s (1979) review of borderline states that identified two constructs. The first, typified by Gunderson and Singer (1975) and Kernberg (1967), involved emotional dysregulation, vulnerability, and instability. The second was characterized by phenotypic and genetic relatedness to schizophrenia and drew from Kety et al. (1968). The former evolved into borderline personality disorder and the latter into SPD. *DSM–5* cross-lists SPD in both the Schizophrenia Spectrum and Other Psychotic Disorders and the Personality Disorders sections, reflecting its dual role as a non-psychotic expression of schizophrenic psychopathology and as personality pathology. The diagnosis requires a minimum of five of nine criteria pervasively experienced that result in distress or impairment and do not occur as part of another psychotic or autism spectrum disorder.

AMPD Representation of SPD

The *DSM*'s categorical system for personality disorders has existed for over 40 years, been used worldwide, and served as a stimulus to research. Nevertheless, problems of this approach have been identified (Krueger et al., 2014; Skodol, 2014; Widiger & Trull, 2007) that include the arbitrary number of criteria required for diagnosis, all-or-none nature of personality disorder diagnoses,

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heterogeneity within categorical diagnoses, and blurred boundaries and comorbidity across personality disorder diagnoses. The most comprehensive approach to address these limitations has been the AMPD developed by the Work Group for Personality and Personality Disorders. The Work Group produced a hybrid model of personality disorders that was based on impairment in personality functioning (including domains of self and interpersonal functioning) and pathological traits that included five trait domains and 25 facets (Krueger & Hobbs, 2020). The AMPD retained and reformulated SPD within the personality functioning and pathological trait framework.

The AMPD was presented to the American Psychiatric Association Board of Trustees, who subsequently decided to retain the largely unchanged *DSM-IV-TR* (American Psychiatric Association, 2000) diagnostic system and include the AMPD in Section III of *DSM–5* for emerging measures and models due to concerns that there was insufficient evidence regarding the validity and clinical applicability of the model (Oldham, 2015; see commentaries in Krueger & Markon, 2014; Miller & Lynam, 2013; Skodol, 2014).

Assessment of AMPD SPD

The *DSM–5* AMPD provides a five-point scale for rating personality functioning in four self and interpersonal areas. Moderate impairment is required in at least two domains for the SPD diagnosis. Both interview (First et al., 2018; Thylstrup et al., 2016) and self-report measures (Morey, 2017; Weekers et al., 2019) have been developed to assesses personality functioning. The AMPD includes definitions of the personality domains and facets, providing the basis for interview (First et al., 2018) and self-report measures. The Personality Inventory for *DSM–5* (PID-5; Krueger et al., 2012) is widely used for assessing AMPD trait domains and facets. However, concerns have been raised that some PID-5 items assessing SPD traits tap overt delusions, including Schneiderian first-rank symptoms (e.g. "Sometimes I feel 'controlled' by thoughts that belong to someone else"), as opposed to tapping magical ideas not held with delusional conviction (Crego & Widiger, 2017). The Section II diagnostic criteria indicate that SPD is distinguished from psychotic disorders by the absence of overt psychotic symptoms.

Empirical Support for the AMPD Criteria for SPD

The AMPD has generated a large empirical literature; however, there are relatively few studies examining the empirical properties of AMPD SPD. Summaries of the AMPD research literature can be found in Krueger and Hobbs (2020), Morey et al. (2015), and Zimmermann et al. (2019). Numerous studies have reported on the reliability of the AMPD Criterion A level of personality functioning and Criterion B pathological personality traits with supportive findings (Few et al., 2013; Garcia et al., 2018; Zimmermann et al., 2014). However, limited studies have examined the reliability of the AMPD SPD diagnosis. Somma et al. (2019) reported good interrater agreement (kappa = .90) for AMPD SPD diagnosis in a relatively small sample using the Structured Clinical Interview for the *DSM–5* Alternative Model of Personality Disorders (First et al., 2018) with trained raters. Furthermore, they reported relatively low co-occurrence of SPD with the other AMPD diagnoses (16%). Concern has been raised about the extent to which the Criterion A level of personality functioning provides incremental validity beyond the Criterion B trait component, although there is limited specific examination of this in SPD. Sleep et al. (2019) reported that SPD criterion A level of functioning and criterion B traits correlated on the order of a large effect (r = .71). However, they found that Criterion A only accounted for a small increment in variance over-and-above Criterion B in the prediction of SPD (sr^2 = .06).

The strongest evidence for AMPD SPD comes from Morey and Skodol (2013), who examined the correspondence between *DSM-IV-TR* and AMPD personality disorders. They reported that the criterion counts for SPD from the two systems correlated .63 in clinician ratings of 337 patients. This association was weaker than for borderline, antisocial, avoidant, and narcissistic, but stronger than for obsessive-compulsive personality disorder. The SPD criterion counts showed good discrimination from the other five personality disorders. Furthermore, the authors found support for the requirement of at least two areas of personality impairment and that correspondence with *DSM-IV-TR* criteria was maximized with the AMPD rule requiring at least four of the six indicated pathological traits. Using the same sample, Morey et al. (2016) reported the correlations of *DSM-IV-TR* criterion counts for SPD with clinician ratings of the traits and facets. All of the traits specified in the AMPD as diagnostic indicators for SPD had higher correlations with *DSM-IV-TR* criterion counts than the remaining traits. Specifically, psychoticism correlated .62, with facet correlations of .67 for unusual beliefs and experiences, .66 for eccentricity, and .61 for cognitive perceptual dysregulation (large effect sizes). Detachment (which contained facets not linked to SPD) correlated .37, with facet correlations of .46 for suspiciousness, .42 for withdrawal, and .37 for restricted affectivity (medium effect sizes). The other traits and facets that were not proposed as part of AMPD SPD had modest associations with SPD criterion counts (correlations from −.04 to .22). Thus, the proposed AMPD pathological traits showed good fidelity with the *DSM-IV-TR* operationalization of SPD. The six proposed traits accounted for 60% of the variance in the *DSM-IV-TR* criterion counts, whereas the remaining facets only accounted for an additional 2% of the variance. Notably, the addition of AMPD Criterion A ratings in the prediction of *DSM-IV-TR* criterion counts did not account for any additional variance over-and-above the six criterion B personality traits—perhaps suggesting that the impairment in SPD is adequately represented within the pathological personality traits. Similarly, Hopwood et al. (2012) in a study of 808 young adults found that the nonproposed AMPD traits provided no incremental information in predicting SPD, beyond the proposed SPD traits.

Watters et al. (2019) conducted a meta-analysis of 25 independent data sets (16 with SPD) examining associations of AMPD traits and categorical personality disorders. They reported that the weighted mean correlations of the AMPD proposed traits with SPD was .42 and the nonproposed traits was .28. The strongest associations were with psychoticism with correlations of .53 for unusual beliefs and experiences, .50 for cognitive perceptual dysregulation, and .47 for eccentricity (medium to large effect sizes). Moderate associations were found for detachment facets of suspiciousness and withdrawal (.44 and .38, respectively), but a weaker association was found for restricted affectivity (.22). However, the discriminant validity of the AMPD SPD model was questionable in their meta-analysis, as eight of the 19 nonproposed facets had moderate associations with SPD—including four of the negative

affectivity facets and anhedonia. This is not entirely surprising, as negative affect has been historically associated with SPD (e.g., Berenbaum et al., 2006) and with positive and disorganized schizotypy (e.g., Kemp et al., 2018), and anhedonia is a core component of negative schizotypy (Kwapil & Barrantes-Vidal, 2015). The authors also examined the personality trait profile overlap among the six AMPD personality disorders using intraclass correlations. Not surprisingly, given their shared conceptual roots, SPD and borderline personality disorder exhibited moderate agreement, but the overlap with the remaining disorders was minimal, suggesting the AMPD trait profile for SPD was relatively independent from the other disorders.

Boland et al. (2018) examined associations of AMPD traits with measures of interpersonal and intrapersonal impairment in 277 healthy young adults. They reported that the proposed AMPD SPD traits were robustly associated with all of the measures of impairment. Furthermore, regression analyses indicated that AMPD SPD incremented the prediction of impairment over-and-above the traditional categorical diagnosis of SPD. Consistent with the hypothesized disruption in identity as part of impairment in personality functioning, Bogaerts et al. (2021) found that SPD was associated with a marked lack of identity and, to a lesser extent, disturbed identity. The authors conceptually linked this to the confusion regarding personal boundaries and reality testing seen in patients with SPD.

SPD as an Expression of Multidimensional Schizotypy

Current models recognize SPD as part of a larger continuum of clinical and subclinical schizophrenia-spectrum symptoms and impairment referred to as schizotypy (Kwapil & Barrantes-Vidal, 2015; Lenzenweger, 2010). Schizotypy, and by extension schizophrenia-spectrum disorders including SPD, are multidimensional with positive, negative, and disorganized dimensions. Several studies have examined the association of AMPD personality disorder traits and facets with multidimensional schizotypy. Somma, Krueger et al. (2019) examined the associations of multiple measures of schizotypy and schizotypal traits with the PID-5. The authors examined associations of a general (positive) schizotypy factor and an anhedonia factor with the PID-5 perceptual dysregulation, unusual beliefs, eccentricity, restricted affectivity, withdrawal, suspiciousness, anxiousness, and depressivity facets. All eight facets had significant bivariate associations with the general schizotypy factor (medium to large effects), and all of the facets except perceptual dysregulation and unusual beliefs were associated with the anhedonia factor (small to medium effects). Ashton et al. (2012) reported that a dissociation/schizotypy factor had its strongest loading with the PID-5 psychoticism factor and facets. However, the lack of a clear multidimensional assessment of schizotypy in both studies limited the interpretability of the findings.

Crego and Widiger (2017) examined associations of the PID-5 with the Five-Factor Schizotypal Inventory (FFSI; Edmundson et al., 2011) and Wisconsin Schizotypy Scales (e.g., Chapman et al., 1978). The authors did not report all of the correlations, but indicated that positive schizotypy correlated with PID-5 psychoticism facets on the order of large effects. FFSI aberrant perceptions, odd and eccentric, and aberrant ideas overlapped with the PID-5 cognitive and perceptual dysregulation, eccentricity, and unusual beliefs & experiences, respectively. Kemp et al. (2021) examined associations of positive, negative, and disorganized schizotypy with PID-5 traits and facets in 1,300 young adults. As predicted, positive schizotypy had its strongest associations with the psychoticism trait and facets (large effects), negative schizotypy was associated with detachment trait and facets (large effects), and disorganized schizotypy was associated with facets of disinhibition (large effects) and negative affectivity (medium effects). Their findings suggest that the multidimensional schizotypy model offers a promising approach for disentangling the heterogeneity that characterizes SPD and schizophrenia-spectrum disorders.

Moving Forward

With the looming release of *DSM–5*, Widiger (2011) warned of a "shaky future for personality disorders." The decision by the American Psychiatric Association to relegate the AMPD to Section III of *DSM–5* highlighted concerns about the development, clinical utility, and validity of the AMPD. Nevertheless, the AMPD offers advantages relative to the traditional categorical approach. SPD is the only schizophrenia-spectrum personality disorder to be retained in the AMPD. Content-wise, the AMPD SPD retains many of its features, including positive (e.g., suspiciousness, odd beliefs and perceptual experiences), negative (restricted affectivity and withdrawal), and disorganized (e.g., eccentricity) traits. The limited research on AMPD SPD supports the fidelity of the diagnosis with the traditional categorical diagnosis and the inclusion of the six specified trait facets. Furthermore, there is evidence that the hybrid AMPD approach provides incremental validity relative to the traditional categorical diagnosis. Future research should consider the association of negative affectivity facets with SPD.

Researchers have charted an agenda for the AMPD (e.g., Krueger & Hobbs, 2020; Morey et al., 2015) that emphasizes the need to evaluate and refine AMPD measures, assess the extent to which the AMPD is superior to traditional DSM personality diagnoses, and translate AMPD-based assessment and classification to treatment initiatives. However, further research should also consider whether a multidimensional approach that incorporates positive, negative, and disorganized trait features of schizotypal, schizoid, and paranoid personality disorders might be superior to simply retaining the heterogeneous SPD diagnosis (and demoting the other two diagnoses). For example, might a trait-specified personality disorder that denotes presence of positive, negative, and disorganized schizotypic traits better capture this rich and heterogeneous aspect of personality pathology?

As noted by Hopwood (2018), the AMPD offers a promising framework for multidimensional case conceptualization, intervention, and treatment monitoring. For example, Bach et al. (2015) presented the assessment and treatment of six cases using the AMPD framework. They highlighted the advantages of this approach and several areas for enhancement. Likewise, Cheli (2020) described a novel assessment and treatment plan for patients with SPD based on the AMPD. Furthermore, Krueger and Hobbs (2020), following Huprich (2018), highlighted the opportunities of using the AMPD to develop integrated multidimensional case conceptualization and intervention.

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Correction to O'Connor and Murphy (2021)

In the article "Effects of Diagnostic Disclosure and Varying Diagnostic Terminology on Social Attitudes to Personality Disorder: An Experimental Vignette Study," by Cliodhna O'Connor and Lisa Murphy (*Personality Disorders: Theory, Research, and Treatment*, 2021, Vol. 12, No. 3, pp. 241–248, https://doi.org/10.1037/per0000447), the online publication date was listed incorrectly. The correct online publication date is July 16, 2020. The online version of this article has been corrected.

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