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Schizoidia in schizophrenia spectrum and personality disorders: Role of dissociation

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Abstract

Dissociation was one of the roots of the nosopoetic construct "schizophrenia", and a link seems to exist between psychotic and dissociative phenomena. We explored the relationship between dissociation and schizoidia as defined by the Dissociative Experiences Scale (DES) total score and the schizoidia subscale of the Munich Personality Test (MPT), respectively. The study comprised 43 outpatients diagnosed with schizophrenia spectrum disorders in remission, 47 outpatients with personality disorders and 42 non-patients. Besides the DES and the MPT, all participants also completed parts of the Symptom Checklist (SCL-90-R) and theTrauma Questionnaire (TQ). In the final multivariable logistic model, a set of five variables was identified as the strongest contributors to the occurrence of schizoida. The model included TQ broken home, MPT neuroticism, schizophrenia spectrum and personality disorder diagnoses, and SCL aggressivity; it did not include any dissociation variable. The purported relationship between dissociation and schizoidia could not be confirmed; the existence of schizophrenia-inherent dissociation appears questionable.
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1. Introduction

In spite of the recent revival of interest in dissociation, it does not play a prominent role with regard to the concepts of schizophrenia at present. Historically, however, dissociation was one of the roots of the nosopoetic construct "schizophrenia" and schizophrenic ego fragmentation can be viewed as the most pronounced form of dissociation (Scharfetter, 1998). Indeed, there seems to be a link between psychotic and dissociative phenomena: it was claimed that patients with multiple personality disorder frequently presented positive symptoms of schizophrenia such as Schneiderian first-rank symptoms (Kluft, 1987; Ellason and Ross, 1995). In contrast, unrecognized dissociative disorders were identified in a considerable proportion of schizophrenic patients (Haugen and Castillo, 1999), who also reported more dissociative phenomena than non-clinical controls (Spitzer et al., 1997). However, the diagnostic entity of multiple personality disorder has been questioned (Aldridge-Morris, 1989) and the relationship of dissociation to schizophrenia remains unclear.

There exist two diagnostic categories to classify phenomena loosely associated with schizophrenic disorders. These phenomena comprise (1) personality traits similar to fundamental symptoms of schizophrenia and often seen in patients premorbidly (Bleuler, 1972; Angst et al., 1985) and (2) personality peculiarities often seen in

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non-psychotic relatives of schizophrenic patients; the corresponding categories are schizoidia and schizotypy. Kretschmer (1967) postulated as a continuum between schizothymia as a personality variant, schizoid personality disorder and schizophrenia; he defined schizoidia or "schizoid temperament" a personality type of schizophrenia spectrum disorders, a non-psychotic, transitional condition between illness and health, and he equated it with Bleuler's autism. He characterized schizoidia as a mixture of hypersensitiveness and coldness and aloofness. Bleuler (1932) called schizoid disposition a non-progressive anomaly, and according to his son (Bleuler, 1941), schizoid personality disorder ("schizoid psychopathy") is the most frequent personality disorder seen premorbidly in patients with schizophrenia. The conception of schizoidia has been used in Europe for a long time, whereas it was not included in the Diagnostic and Statistical Manual of Mental Disorder until 1980. It was introduced as a new diagnostic category in DSM-III (American Psychiatric Association, 1980) along with the conception of schizotypy; the latter was designated to identify borderline cases (cases on "the border between neurosis and psychosis") belonging to the schizophrenic spectrum (Spitzer et al., 1979). Whereas there is an overlap in the description of schizotypy and schizoidia–both share common features of emotional disturbance and lack of social relationships–schizotypy is also characterized by subtle cognitive-perceptual aberrations that are absent in schizoidia (American Psychiatric Association, 1994). Empirical findings suggest a good discriminant validity for both criteria sets (Bailey et al., 1993). Schizotypy has been claimed to present a higher degree of schizophrenia-relatedness than schizoidia; and a dimensional model of a spectrum of schizoidia–schizotypy–schizophrenia has been advocated (Saβ and Jünemann, 2001).

If there is a relationship between dissociation and schizophrenia, then a relationship between dissociation and schizotypy and schizoidia would also be expected. A high correlation between schizotypal traits and dissociative experiences has indeed been found (Startup, 1999; Watson, 2001); especially, detachment/depersonalization items are not clearly distinguishable from schizotypy (Watson, 2001). Much less is known about the relationship between schizoidia and dissociation. In our study on dissociation, a modest, but significant correlation ($r=0.23$, $P<0.001$) between dissociation and schizoidia was found (Modestin et al., 2002).

The present study approached the larger issue of the relationship between dissociation and schizophrenia indirectly, focussing on the relationship between dissociation and schizoidia. We expected that there would be a relationship between schizoidia and dissociation, but we were not sure how pronounced and how independent it would be in comparison to other variables such as personality traits, psychopathology dimensions and environmental factors. Three different groups of participants were included in the study (patients with schizophrenic disorder in remission, patients with personality disorder, and non-patients); we expected the groups to differ with regard to the degree of schizoidia.

2. Methods

2.1. Probands

A total of 132 probands participated in the study. The sample consisted of two patient subgroups, all patients having been diagnosed according to ICD-10 Diagnostic Criteria for Research (World Health Organization, 1993), and one non-patient subgroup. Included were (1) 43 outpatients diagnosed with schizophrenia spectrum disorders in remission (the patients presented no positive and no prominent negative symptoms): 19 patients were diagnosed with paranoid schizophrenia, 12 with schizoaffective disorder, 8 with delusional disorder, 3 with schizotypal disorder and 1 with acute polymorphic psychotic disorder (corresponding to a brief psychotic disorder with volatile, rapidly shifting symptomatology); (2) 47 outpatients diagnosed with personality disorder (PD), excluding patients with comorbid organic and/or substance-related disorders: 18 patients were diagnosed with emotionally unstable/borderline PD, 12 with narcissistic PD, 7 with schizoid PD, 5 with histrionic PD, 3 with obsessive–compulsive PD and 2 with dependent PD; (3) 42 healthy subjects, all of them professionally affiliated with a mental health facility. According to their own declaration, none of them had ever been in psychiatric inpatient and/or outpatient treatment.

Basic socio-demographic data were collected from all participants (see in Table 1). The determination of social class and social mobility was based on the occupational level of the participants; the classification by Moore and Kleining (1960) was used in its later modification by Dilling and Weyerer (1978).

2.2. Instruments

2.2.1. Munich Personality Test (MPT)

The MPT (von Zerssen et al., 1988) is a brief questionnaire that includes 51 statements, all rated on a 4-point Likert scale from completely true to not true. It consists of six personality scales measuring the personality dimensions of "extraversion", "neuroticism",

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