

Essay

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[Jackson Cowherd](#)*

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Essay

Schizotypy and Cluster A Personality Disorders in the DSM: Advocating for a Spectrum-Based Model

Jackson Cowherd

Pacific University, Department of Psychology; f091134s@pacificu.edu or cowherdjackson@gmail.com; Tel: +1-(860)-550-2831

Abstract: This paper critically examines the current classification of schizotypy and Cluster A personality disorders in the Diagnostic and Statistical Manual (DSM). By examining empirical evidence, including genetic, neuropsychological, and symptomological overlaps across these nomologically distinct disorders, this paper argues for their integration into a schizophrenia-schizotypy spectrum. It is believed that a spectrum-based model would enhance diagnostic precision, therapeutic interventions, and our overall understanding of these disorders. While aligning with contemporary research, challenges in operationalizing this framework are acknowledged, thereby necessitating further empirical exploration. Ultimately, this paper advocates for a diagnostic evolution that reflects the continuum of schizotypy and schizophrenia, advancing both clinical practice and research.

Keywords: schizotypy; cluster a personality disorders; schizophrenia spectrum; DSM classification; spectrum-based model; psychodiagnostics; psychopathology; individualized treatment

1. Introduction

Schizophrenia, a psychotic disorder characterized by severe and chronic disturbances in perception, cognition, and thought, is frequently at the forefront of psychiatric and psychological research due to the intense and severe impact it has on those affected by it. Historically, schizophrenia was viewed primarily as a perceptual disorder; however, most contemporary research now suggests that it may actually lie at the intersection of personality, genetic, and neuropsychiatric pathology, which shows that it is a more nuanced disorder than once thought. In contrast, Cluster A personality disorders, as described in the DSM-4/5, are defined by odd and eccentric traits that persist over time [1]. While a clear distinction between Cluster A personality disorders and schizophrenia exists with regard to psychosis, numerous studies highlight salient similarities between them, particularly in neuropsychological, biological, and symptomological overlaps. As a result, some have begun to argue that Cluster A personality disorders, specifically Schizotypal Personality Disorder (STPD) and Paranoid Personality Disorder (PPD), should be categorically reconsidered in the DSM. This paper takes that argument a step further by highlighting the potential benefits of fully integrating Cluster A personality disorders into the schizophrenia spectrum as forms of 'schizotypy,' which represent a range of traits and behaviors associated with a schizophrenia spectrum. While no specific model is suggested here, this paper advocates for a shift in classification and outlines various historical and contemporary models that have explored this integration. Such an approach would better capture the broad spectrum of manifestations associated with these disorders rather than treating them as distinct personality disorders.

2. Historical Context

On a historical basis, schizophrenia has been distinctly described based on the time period and culture in reference, with most accounts prior to the 20th century referring to the disorder as some type of insanity or dementia. In Scotland, schizophrenia was described as a form of 'adolescent insanity' [2]. In contrast, in France and Germany, respectively, psychiatrists Bénédict Morel and Emil Kraepelin noted a type of 'dementia' that would infect the young, thereby highlighting the

dysfunctional and early-onset components of the disorder [3,4]. It wasn't until 1920 that Eugen Bleuler, a Swiss psychiatrist, first published his conceptualization of schizophrenia as a "plural" set of diseases rather than a mere single disease [5]. Bleuler believed that the spectrum of disease included *basic* (as fundamental) and *accessory* (as supplementary) symptoms that comprised the disorder's primary diagnostic profile. Most notable, however, was his theory that schizophrenia was a "broader concept," wherein subgroups and subclinical forms of schizophrenia, including aberrant schizophrenia-like personality traits, were part of the disorder. This pioneering perspective was pivotal in laying the foundation for our modern understanding of schizophrenia and its spectrum-related disorders. However, the formal conceptualization of schizophrenia as a spectrum did not emerge until nearly half a century later.

Rado (1952) [6] and Meehl (1962) [7] were the first to introduce the term "schizotypy." Schizotypy, to Meehl (1962), described a set of personality characteristics that closely resembled schizophrenia but that were found in some who were not pathologically schizophrenic. Meehl proposed a quasi-dimensional model of schizotypy and schizophrenia, wherein a biological predisposition – which he called a "schizo-gene" – would mix with environmental factors to influence one's risk of developing schizophrenia. Claridge (1994) [8] built upon this theory, proposing a fully-dimensional model and viewing schizotypy along a continuum where schizotypal traits exist within the general population, ranging from non-pathological to pathological expressions. Even so, the pathologization of schizotypy predates Claridge's contributions, with "schizotypal personality disorder" (STPD) being formally recognized in the DSM-3 in 1980. Its inclusion coincided with the addition of paranoid personality disorder (PPD), both of which were categorized within the newly defined "Cluster A" personality disorders, a grouping characterized by odd and eccentric behaviors.

3. DSM-5 and Cluster A Personality Disorders

In the DSM-5, Cluster A personality disorders are linked together by their oddity or eccentricity, comprising three specific disorders: schizotypal personality disorder (STPD), paranoid personality disorder (PPD), and schizoid personality disorder (SZPD) [1]. To differentiate these disorders fully, we can look at their classification in the DSM-5. In the DSM-5, STPD is characterized by a diverse range of symptoms, including odd or magical beliefs, eccentric behavior, social anxiety, and unusual perceptual experiences – features that closely resemble schizophrenic symptoms. In contrast, PPD is more phenomenologically uniform and is defined by "a pervasive distrust and suspiciousness of others," marked by unjustified doubts and persistent grudges that negatively impact the individual. SZPD is described as involving "a pervasive pattern of detachment from social relationships and a restricted range of emotional expression in interpersonal settings," intuitively setting it apart symptomatically from PPD and STPD.

While these intuitive differences exist between Cluster A personality disorders, a substantial body of empirical research has highlighted the key distinctions rooted in the balance of positive (additive) and negative (deficit-based) symptoms that would explain these differences. STPD encompasses both positive and negative symptoms, often resembling and sometimes mimicking schizophrenia [9]. In contrast, PPD is primarily characterized by positive symptoms, such as paranoia and delusions, while SZPD consists solely of negative symptoms, such as social anhedonia [9]. Consequently, the close resemblance between schizophrenia and STPD can be logically explained by the presence of both positive and negative symptoms in schizotypal personality disorder; by contrast, the exclusively negative or positive symptoms in SZPD and PPD, respectively, account for a more limited connection to the schizophrenia spectrum. This perspective is essential to consider moving forward, as it suggests that neither schizoid personality disorder nor paranoid personality disorder is inherently less "schizophrenia-like." Instead, each disorder illustrates diverse manifestations of schizophrenia, proving the need to view them as an integrated spectrum from which further assumptions can be made.

4. Empirical Evidence for a Spectrum-Based Approach

Notwithstanding the distinct attributes of each Cluster A personality disorder, there are remarkably similar comorbidities and diagnostic outcomes within each disorder. Hsu and colleagues (2021) [10] found that neurodevelopmental disorders, schizophrenia, and neurocognitive disorders were the most common comorbidities in Cluster A personality disorders. Among these comorbidities, schizophrenia stood out with the highest prevalence, revealing a 39% concurrence. A significant overlap, as such, suggests a foundational link between Cluster A personality disorders and schizophrenia.

Furthermore, this assumption is paralleled by contemporary neuropsychological and genetic findings, as research has indicated that these conditions may be more interrelated than previously assumed. In fact, the genetic underpinnings of these disorders, while similar, could perhaps be indistinguishable from one another, as seen in the work by Baron and colleagues [11,12]. Baron and colleagues, throughout the years, have examined schizophrenia in relation to Cluster A personality disorders, focusing predominantly on paranoid personality disorder and schizotypal personality disorder. In Baron's 1987 study on schizotypal personality disorder and schizophrenia, he concluded that "chronic schizophrenia and schizotypal personality disorder represent different phenotypic manifestations of the same underlying process" [12].

Most modern research upholds this conclusion drawn by Baron et al., which reinforces the idea that schizotypal personality disorder – or, more broadly, schizotypy – and schizophrenia share underlying biological mechanisms.

Additionally, neuropsychological research has further examined the link between schizophrenia and Cluster A disorders. For example, Besteiro-González et al. (2004) conducted extensive neuropsychological assessments across personality disorder clusters (i.e., Clusters A, B, and C) and found that significant deficits in executive functioning were unique to the Cluster A group [13]. This finding is consistent with the well-documented cognitive impairments associated with schizophrenia-spectrum disorders [14]. Likewise, Besteiro-González and colleagues identified notable similarities in personality measures within Cluster A subjects, adding another layer to our understanding of how personality science reveals parallels between schizophrenia and schizotypal behaviors.

Broadly, personality psychology has highlighted the overlap between Cluster A personality disorders and schizophrenia, particularly in traits such as low extraversion, high neuroticism, and dysfunctional openness – common to both schizophrenia-spectrum disorders and schizotypal traits [13,15]. Low extraversion, highlighted by Besteiro-González et al. (2004), is a distinctly characteristic trait of Cluster A personality disorders, setting Cluster A disorders apart from other personality disorder clusters; conversely, neuroticism tends to be elevated across all personality disorders, not just within Cluster A disorders [13]. Interestingly, though, 'openness to experience' appears to be 'dysfunctional' in Cluster A subjects compared to both controls and individuals in Clusters B and C, according to research conducted by Piedmont and colleagues [15]. Most importantly, these trait patterns in Cluster A subjects closely mirror those observed in individuals with schizophrenia, particularly in extraversion, neuroticism, openness, and agreeableness [16]. This shared trait profile reinforces the notion of a continuum between these so-called Axis 1 (e.g., psychotic) and Axis 2 (i.e., personality) disorders extending beyond their DSM-defined phenomenology. Consequently, these findings, which demonstrate genetic, neuropsychological, and symptom-based similarities, should invite further inquiry into how and why we differentiate, pathologize, and treat these related conditions.

5. Contemporary Differences in Treatments for Schizophrenia and Cluster A Disorders

Notably, Cluster A personality disorders are not treated with the same rigor as schizophrenia-spectrum disorders. Schizophrenia-spectrum disorders are classified as psychotic disorders and are typically managed with intensive treatment, often involving antipsychotic medications. Cluster A disorders, by contrast, generally do not receive the same medical intervention, with the exception of

paranoid personality disorder, which may lead to “very brief psychotic episodes” and result in acute or chronic pharmacological intervention [17].

6. Contemporary Theoretical Models of Schizotypy

Despite these differences in classification and treatment, it has been suggested that Cluster A personality disorders could serve as a risk factor or even predictor for later-onset schizophrenia, acting as a premorbid or “prodromal” phase of the disorder [9]. Alternatively, it has been theorized that Cluster A personality disorders may not be mere risk factors for schizophrenia but rather may represent a less severe manifestation or placement on the schizophrenia spectrum itself. Historically, both Claridge’s fully-dimensional model (1994) and Meehl’s quasi-dimensional model (1962) of schizotypy stand at the base of this theory, where the spectrum-like nature of schizophrenia is emphasized [7, 8]. Both Meehl’s and Claridge’s models detail a progression from schizotypal traits to full-blown psychosis, yet it is the mechanism of this progression that distinguishes their theories. Meehl’s view – that schizotypy represents a quasi-dimensional or partial and continuous vulnerability to schizophrenia under certain environmental conditions – remains notable in schizotypy theory. Claridge’s fully-dimensional, or fully continuous, theory of schizotypy, where schizotypal traits reflect a range of personality characteristics within the general population, differs from Meehl’s quasi-dimensional approach in its mechanism of progression yet aligns in its overall spectrum-based perspective. In more relevant contexts, as we have gained a deeper understanding of how Cluster A personality disorders may not only predict psychosis but could also be seen as attenuated counterparts, we find increasing validation for these earlier theories by Claridge and Meehl. If this remains true, it would suggest that the various forms of schizotypal disorders may not be orthogonal in nature. Phrased differently, prodromal schizophrenia, with regard to both of these theories, would represent high-intensity schizotypy but lower-intensity schizophrenia on this generalized spectrum. Recent empirical research supports this perspective, suggesting that these historical models of schizotypy put forward by Meehl and Claridge align closely with what we now understand about the spectrum of schizophrenia [18]. Thus, as these theories maintain relevance as foundational perspectives of schizotypy and continue to shape modern interpretations, we should continue to question how our current diagnostic system incorporates – or fails to incorporate – these theories and the impact that might have on the validity of diagnoses.

A notable example of questionable diagnostic validity can be observed in the phenomenological overlap between Cluster A personality disorders and schizophrenia-spectrum disorders. Esterberg and colleagues (2010) highlight instances where the symptoms of a Cluster A personality disorder closely align with those of schizophrenia-spectrum disorders, often resulting in frequent misdiagnoses [9]. This raises a critical question: are these truly “misdiagnoses,” or do they instead reflect an underlying lack of differentiation between Cluster A personality disorders and early-stage schizophrenia or psychosis? If such overlap is systemic, it may indicate that the constructs underlying Cluster A personality disorders are inherently flawed, as they would fail to maintain clear distinctions and orthogonality from other related disorders.

7. Critique of the DSM Framework

This ongoing challenge of distinguishing between disorders reflects a broader and persistent issue in psychopathological research: the problems of discriminant and construct validity. Several researchers argue that the system for diagnosing personality disorders may be fundamentally flawed, supported by extensive empirical evidence showing that many personality disorders in the DSM lack adequate construct and/or discriminant validity [19,20]. Hopwood et al. (2018) argue that the DSM’s categorical model for personality disorders is “empirically problematic and of limited clinical utility,” by which they cite issues such as low reliability, diagnostic comorbidity, and within-disorder heterogeneity [19]. Hopwood and colleagues stress the need to shift toward a dimensional approach as a solution to these issues, thereby improving the scientific validity and applicability of personality disorder diagnoses. This issue is also effectively echoed by Michael First, a research psychiatrist specializing in diagnostic criteria for personality disorders. In his 2011 article, *The Problematic DSM-5*

Personality Disorders Proposal: Options for Plan B, First highlights the complexities of personality and the challenges involved in its pathologization [21]. First proposes in his article a novel approach to diagnosing personality disorders that incorporates a personality continuum and a dimensional profile system. While neither Michael First nor Hopwood and colleagues specifically address Cluster A personality disorders or schizotypy, they acknowledge that the current system of personality pathologization in the DSM-5 may not fully encompass the spectrum of personality psychopathology observed in humans through their distinct methods of empirical deduction.

Furthermore, while personality researchers, including trailblazers like Michael First and Hopwood et al., align with the critique of the DSM's categorical framework, some, like William Todd Schultz, specifically apply this idea to schizotypy. Schultz, a personality psychologist and psychobiographer, has extensively studied personality disorders and, consistent with his work, would likely argue that personality psychology – especially personality psychopathology – is even more complex than what First and Hopwood and colleagues suggest. In fact, many researchers like Schultz challenge the foundational assumptions made by the DSM regarding personality disorders. In Schultz's book *The Mind of the Artist* (2021), he discusses many of the issues with diagnosing schizophrenia and its pathologized form, schizotypal personality disorder [22]. Schultz suggests that schizotypy may simply reflect dysfunctional openness – a non-pathological aspect of human personality that the DSM misinterprets. He discusses cognitive disinhibition, a symptom of schizotypy, which involves a reduced filtering between sensations (internal and external stimuli) and perceptions in one's cognitive awareness. Schultz notes that while cognitive disinhibition is associated with schizotypy, it is also a core aspect of openness. Therefore, he posits that if schizotypy correlates with cognitive disinhibition, and cognitive disinhibition is a component of openness, then schizotypy should correlate with openness within its respective facets. Theoretically, dysfunctional or uncontrolled openness, particularly within the facet of fantasy and imagination – which Schultz's theory identifies as a basis for cognitive disinhibition – could plausibly mimic or align with schizotypal behavior. Empirical evidence, as previously detailed, also supports this theoretical perspective through studies that focus on the relationship between these variables.

Moreover, given that there are consistent findings indicating personality traits such as dysfunctional openness, extraversion, and neuroticism overlap with schizophrenia [15,16], we see further support for the need to redefine and reclassify schizotypal disorders. Such a perspective aligns with critiques of the DSM's categorical framework by scholars like Hopwood and First, while Schultz's specific focus on schizotypy provides an alternative lens through which to view this issue. Consequently, simply recognizing that a dimensional framework may offer the most effective technique for capturing the relationship between personality and psychopathology seems not only logical but necessary if we are to advance diagnostic practices. That said, it could be argued that applying such a framework to Cluster A personality disorders could be one of the first steps toward a broader, more precise, and clinically influential revision of the DSM's classification system.

8. Proposal for a Spectrum-Based Approach

One such approach to redefining and reclassifying schizotypy would be to integrate a contemporary dimensional model of schizotypy, such as the one put forward by Kwapil and Barrantes-Vidal (2014) [18]. In their paper titled *Schizotypy: Looking Back and Moving Forward*, Kwapil and Barrantes-Vidal review a wide range of empirical and historical research surrounding the constructs and phenomenology of schizotypy. Through a reasonable deduction of evidence, the researchers conclude that “a clear and comprehensive operationalization of schizotypy” must be developed, as it offers a “promising, useful, and integrative construct for capturing pathological and subclinical variation across this continuum.” In other words, they recognize schizotypy as a core component of the schizophrenia spectrum, which accounts for the diverse manifestations of the disorder(s). However, Kwapil and Barrantes-Vidal also point out limitations in their study. While their model looks at the big picture, they emphasize the need for a more comprehensive framework to advance their construct. They propose that future models should clearly articulate the theoretical framework of schizotypy, provide more precise definitions of its multidimensional structure, develop

improved measures that align with current conceptual models, incorporate modern measurement techniques, and resolve the ongoing dimensional versus taxonomic debate.

While Kwapil and Barrantes-Vidal strongly advocate for a spectrum-based approach to schizotypy, some researchers push back, favoring classification systems that remain closer to the current framework for personality disorders – particularly for Cluster A disorders. For instance, Zimmerman and colleagues (2011) argue that maintaining familiar diagnostic categories has practical clinical advantages and that the real issue lies in current clinician training on the DSM [23]. However, as previously discussed, this perspective may overlook the deeper flaws inherent in these constructs, which would potentially reinforce a system that fails to fully capture nuanced disorders like those attributed to schizotypy. Hence, by critically reevaluating how schizotypy is conceptualized within the DSM and expanding on theories like those of Kwapil and Barrantes-Vidal, we can draw to the broader challenges in diagnosing personality disorders and work toward a more effective diagnostic system as a whole.

9. Implications for Treatment in Clinical Practice

Despite ongoing resistance to revising the DSM's framework for personality disorders, there is an undeniable shift toward dimensional models of psychopathology. In the coming years, it is plausible that new criteria for Cluster A personality disorders will be integrated into the existing framework rather than abandoning the cluster altogether. However, as the DSM inevitably evolves, it is crucial to emphasize why reclassifying or, at minimum, redefining schizotypy and schizophrenia within the DSM is so important in clinical contexts. Empirical estimates place the prevalence of Cluster A personality disorders at 3.6%, while schizophrenia-spectrum disorders affect less than 1% of the population [24,25]. As previously noted, a difference in diagnosis, even when symptomatological differences are minimal, can lead to entirely different treatment plans. In many cases, this difference could mean whether or not medication is used as part of the treatment. A spectrum-based approach in the DSM could, therefore, significantly improve individualized care by encouraging clinicians to develop a deeper understanding of their clients and provide them with more appropriate treatment options. A notable limitation here is the lack of research on differences in prognosis and patient outcomes between high-functioning schizotypy – possibly in the form of schizotypal personality disorder – and low-functioning schizotypy, such as full-blown psychosis or schizophrenia. However, some studies suggest that early psychosocial intervention and therapy can significantly improve recovery rates, helping individuals regain a more functional state [26]. In this context, early intervention refers to support for those with high-functioning schizotypy, where the illness's progression remains uncertain. Thus, if we were to redefine and classify schizotypal personality disorders within the schizophrenia spectrum, treating it as an early-onset, potentially manageable psychotic disorder, the treatment one receives might prove to be more effective.

Another similar but distinct benefit to redefining schizotypy as a spectrum would be the widespread recognition of symptom-presentation. For instance, classifying schizotypy as being “negatively presenting,” “positively presenting,” or a mix of both would allow clinicians to focus on symptom presentation rather than fixed diagnostic categories. Negative-presenting schizotypy, akin to schizophrenia with negative symptoms, would be characterized by behaviors like social withdrawal (i.e., asociality), blunted affect, and cognitive impairment. Distinguishing negative-presenting schizotypy from other forms of schizotypy would likely increase and enhance the use of specific psychotherapeutic and pharmacological interventions. For instance, psychotherapeutic treatments for negative-presenting schizotypy, like cognitive remediation, focus on enhancing daily functioning [27], while pharmacological treatments may involve drugs used as adjuncts for cognitive enhancement in negative-symptom schizophrenia, such as acetylcholinesterase inhibitors, glutamatergic agents, and certain antidepressants [28]. Conversely, positive-presenting schizotypy – with traits and behaviors that mimic perceptual distortions, delusions, hallucinations, and eccentric thinking – might respond better to cognitive behavioral therapy [29] or low-dose antipsychotics. Therefore, fundamentally redefining these conditions as spectrums of schizotypy or schizophrenia could allow clinicians to deliver more symptom-specific interventions that recognize the complex

variability within each person's psychology. Arguably, a shift like this could better accommodate each person's unique profile and move beyond restrictive diagnostic boundaries to enhance tailored treatment options.

Finally, people diagnosed with schizophrenia often experience social isolation, workplace discrimination, and a sense of self-stigmatization that aggravates their symptoms and hinders recovery [30]. Much of this stigma originates from a lack of knowledge among the general population about schizophrenia, where individuals associate schizophrenia with danger, unpredictability, or incompetence. Accordingly, reclassifying schizotypy as part of a dimensional framework could reduce some of this stigma by inherently embedding variability and commonality into the diagnosis as opposed to rigid and foreboding labels.

A comparison might be drawn with autism spectrum disorder (ASD), where viewing the condition in a dimensional way seems to have contributed to greater awareness of the disorder. Reconceptualizing autism as a spectrum (i.e., "ASD") rather than a binary disorder (i.e., "autistic disorder") appears to have influenced the discourse around neurodiversity in ways that could be seen as less stigmatizing and potentially more accepting, as some cross-cultural research suggests [31]. While the stigma around autism spectrum disorder persists, there are indications that awareness may have improved. Similarly, redefining schizotypy as a spectrum might encourage a focus on the diverse range of symptom expressions and experiences rather than on these rigid labels. Consequently, this dimensional perspective could hypothetically reduce the stigma associated with the more benign features of schizotypy and promote more compassionate attitudes among clinicians and the public through a deeper understanding of the condition's complexities.

10. Discussion

Despite our decades of progress in understanding this generalized spectrum of schizotypy, a notable gap persists between our knowledge of schizotypy and how that knowledge is applied in clinical practice. Hence, it becomes particularly necessary to emphasize the need for researchers to apply this contemporary understanding of schizotypy to the DSM and/or other medical standard books, as it would encourage healthcare professionals to adapt their approaches accordingly. Since much of our knowledge of schizotypy is grounded in spectrum-based conceptual models, these suggestions for redefining or reclassifying schizotypy follow suit with this understanding and allow us to apply what we already know to clinical practice.

While this paper highlights the fact that the current classification of these disorders is, to some, fundamentally flawed and imprecise, the aforementioned approaches to redefining schizotypy and schizophrenia are somewhat surface-level. Thus, while it has been noted that adjustments to the DSM may be necessary as per their wide-ranging implications, a detailed model was not thoroughly highlighted in this paper. In some senses, this lack of a universally agreed-upon framework for implementing a spectrum-based classification highlights the practical challenges of developing criteria that are both precise enough to guide diagnosis and flexible enough to capture the spectrum's variability.

Operationally, a spectrum-based approach would likely lead to more effective treatment strategies and better outcomes, such as more targeted therapies and a greater emphasis on early intervention. Beyond mere operationalism, however, we are shown a lack of existing longitudinal research on the progression of schizotypal traits into full-spectrum schizophrenia and the differences in treatment outcomes. This leaves us with unanswered questions about the predictive validity and treatment efficacy of a new diagnostic system.

Furthermore, the adoption of such a model would require a substantial overhaul of existing diagnostic systems, which may encounter resistance from clinicians and researchers who are accustomed to the current categorical framework. Without sufficient training and resources, clinicians might struggle to transition from diagnostic labels of schizophrenia to a fluid spectrum, which may lead to inconsistencies in clinical practice and disparities in patient care.

11. Conclusions

It is clear that integrating Cluster A personality disorders into the schizophrenia spectrum has the potential to significantly enhance diagnostic and therapeutic practices. This discussion has demonstrated that a shift in classification aligns with contemporary research while providing a foundation for a more nuanced and effective approach to understanding and treating these disorders. Adopting a spectrum-based model of schizotypy would offer a more accurate representation of the overlapping symptoms and shared etiologies – be they genetic, environmental, or otherwise – which would ultimately pave the way for improved clinical outcomes.

Updating our diagnostic framework would allow us to re-conceptualize these conditions as existing interconnectedly, thereby supporting the development of more targeted and individualized treatment strategies. Furthermore, a shift as such could facilitate earlier intervention, which would enable clinicians to address subclinical manifestations before they progress into more severe forms. In this sense, a spectrum-based approach could reduce the rate of “misdiagnoses” and expand the range of therapeutic options available.

Finally, as this paper has repeatedly highlighted, advancing our understanding of schizotypy and its pathologized forms necessitates a concurrent evolution in our classification systems. Only by embracing these advancements can we ensure that our approaches remain both scientifically grounded and practically beneficial for those affected by these disorders.

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Abbreviations

The following abbreviations are used in this manuscript:

STPD	Schizotypal Personality Disorder
PPD	Paranoid Personality Disorder
SZPD	Schizoid Personality Disorder
ASD	Autism Spectrum Disorder

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