

Cognitive clinical intervention in a patient with schizoid personality disorder: Case report

Julio Cesar Suarez Luna^{a*}  María Alejandra Bazan Marquez^b 

^aUniversidad Autónoma de Ica, Dirección de Investigación y Producción Intelectual, Chincha Alta, Perú; ^bUniversidad de San Martín de Porres, Chiclayo, Perú

ABSTRACT

The present case report describes a 19-year-old male patient whose main symptoms were emotional coldness, absence of close relationships, difficulty experiencing pleasure with other people, and lack of motivation to work or to continue his studies. A schizoid personality disorder was diagnosed as a product of early maladaptive patterns such as inhibition, emotional deprivation, social isolation, and inadequacy. Likewise, a rigid and fragmented family context was evidenced, with an affective absence of parents and a focus on strict behavioral rules. The study aimed to intervene, from a cognitive clinical approach, the early maladaptive patterns and symptoms that maintained the features of schizoid personality disorder in the patient. For this purpose, cognitive behavioral therapy was carried out, with techniques such as debates, images to re-parentalize, assignment of tasks, use of humor, and social skills training, among others. In conclusion, it can be stated that the early maladaptive patterns maintained the schizoid personality symptomatology. Finally, it was demonstrated through clinical and psychometric criteria that cognitive behavioral therapy decreased schizoid personality behaviors in the patient.

KEYWORDS Schizoid personality disorder, Cognitive behavioral therapy, Social isolation, Social skills

INTRODUCTION

A schizoid personality disorder is a maladaptive egosyntonic type of personality, leading to the social isolation of the individual. The preference to be alone, with a lack of interest in interpersonal relationships and emotional coldness, can be pointed out as the most significant features of this personality disorder.

In this regard, Beck and Freeman stated that "the key trait of the schizoid personality is social isolation. These individuals are the embodiment of the autonomous personality. They are willing to sacrifice intimacy in relationships to preserve their detachment and autonomy" [1].

This is how beliefs regarding the conception of others are made from a lack of acceptance by the other, conceiving others as intrusive and annoying. Cognitions of self-worth and the establishment of behavioral strategies of social isolation keep these people apart from others. Regarding emotions, their

emotional inhibition and engagement with the environment make them lack guilt, sadness, joy, or anger [1,2].

Based on these cognitive personality traits and profiles, this disorder is little studied in the clinical setting. For this reason, the present case study was analyzed from a nomothetic description (psychological tests) and a cognitive clinical conceptualization, which Riso [3] manifests as a comprehensive study, approached from three levels:

- Level I descriptive symptomatic: cognitive distortions, irrational beliefs, emotions, and motor response.
- Level II preventive explanatory: nuclear schemas, cognitive biases, and schematic perpetuation strategies.
- Level III explanatory promotional: second-order schemas or social beliefs.

Therefore, the research aimed to intervene in the schemes and symptoms that maintained the traits of schizoid personality disorder in the patient from a cognitive clinical approach. Likewise, the objectives were to describe from a cognitive clinical conceptualization the schemes and symptoms that self-perpetuated the schizoid behavior. The schemes identified in the intervention were inadequacy, failure, emotional inhibition, emotional detachment, and social isolation. Similarly, irrational beliefs or cognitive distortions such as "I have a better time doing my things alone", "I don't need friends to do my things", "people bore me", among others, maintained the

* Corresponding author Jcka85@hotmail.com

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Postal address Av. Abelardo Alva Maurtua N° 489, Chincha Alta, Perú

MAIN MESSAGES

- Schizoid personality disorder comprises a rigid pattern of social isolation and emotional coldness, causing social, occupational, and family deterioration in the patient.
- This study is novel since, in the scientific literature of the last 10 years, there has been only one case report on the subject. This research is essential to provide a better understanding of the etiology and its possible intervention from a cognitive-behavioral model.

schizoid personality schemes and traits in the patient, were also identified.

Among the strengths found in this research are the continuous support of the family throughout the therapy, showing a willingness to collaborate in the treatment, and getting involved in the psychoeducation of assertive behaviors provided to the patient. Another strength was the patient's willingness and responsibility to attend the therapeutic sessions and perform the assigned tasks. Among the limitations, the patient's absence of close social relationships was considered and the patient's lack of interest in initiating a conversation and interacting with others.

Finally, clinical therapy from the cognitive-behavioral model showed efficient results in modifying and reducing the symptoms that self-perpetuated a deterioration in the patient's social relationships. This could be evidenced within the psychometric criteria (pre- and post-test) and the clinical criteria through cognitive behavioral therapy.

Table 1 explains the procedure and sessions of the case report:

Twenty-one sessions of 1 hour and 30 minutes each were worked with the patient once a week for six months. During the first four weeks, the ideographic and nomothetic diagnosis of schizoid personality disorder was made. Subsequently, the cognitive-behavioral treatment was carried out, showing a decrease in the patient's symptoms through clinical (schemes, beliefs, and symptoms) and psychometric criteria.

CASE REPORT

The patient in this case report was a 19-year-old male from the district of Olmos, Lambayeque region, Peru, a second-cycle management student. He had no significant personal, family, or psychiatric history except for allergies and a lack of interest in socializing from an early age (5 years old). He was an only child and lived with both parents. Among his main symptoms, he exhibited emotional coldness, difficulty in expressing emotions, lack of close relationships, difficulty in experiencing pleasure with other people, and lack of motivation to perform a job or to resume his studies.

In the evolution of the schizoid personality disorder, during the first sessions, the patient presented marked symptoms of social isolation and apathy (first month). From the tenth session (third month), through discussion and social skills techniques, there was a cognitive restructuring of the irrational beliefs regarding the dysfunctionality of interpersonal relationships.

In week 16 (fourth month), by using images to reparentalize, the early maladaptive schemes were cognitively restructured by more adaptive cognitions about his social relationships. He gradually put this into practice in his social environment. Finally, no relapse or significant adverse event occurred during treatment.

Anamnesis

Her mother became pregnant at the age of 25, a pregnancy desired by both parents. The mother received monthly prenatal care following medical recommendations and maintaining an adequate diet. However, the mother faced family conflicts with her mother and her husband, as the latter spent long hours at work. This situation occasionally generated family arguments. The patient was born after nine months of gestation, through vaginal delivery, and with the assistance of the attending physician at the hospital. The baby cried shortly after birth and weighed 2,900 grams.

The patient's mother mentioned that from the start, she looked after her son while also taking care of household responsibilities and her job as a teacher. However, at approximately one year of age, the child's maternal grandmother took over his care because the mother had to increase her work schedule, which made it difficult for her to take care of the child.

In addition, the child's physician check-ups were carried out regularly and in accordance with his age. He did not experience any serious illnesses.

At the age of three and a half years, the patient began his experience in early education, although he did not show enthusiasm for attending, as he preferred to be at home with his toys. His maternal grandmother used to bring him toys, and he remained in the classroom during the first hour of classes for a few weeks. At five years old, he did not participate in group activities, nor did he make many friends during recess. He preferred to focus on individual tasks in his designated area. He always showed obedience to the teacher's instructions and respect for her.

When the patient was seven years old, he started his first grade of elementary school, being diligent with his homework and enjoying working independently. He stood out for his outstanding grades. His parents were proud of his accomplishments, always encouraging him to maintain good academic performance. However, he recalled that his parents spent most of their time working and were not with him. As for his social life, despite having several classmates in the classroom, he did

Table 1. Procedure and sessions of the case report.

Sessions	Category	Indicator
1 to 4 Diagnosis	Cognitive clinical conceptualization: Nomothetic and ideographic criteria	DSM - V Millon's Multiaxial Clinical Inventory Young's Schema Questionnaire Irrational Belief Inventory
5 to 21 Cognitive-conductual treatment	Cognitive techniques Emotional-experiential techniques Behavioral Techniques	Thought records Psychoeducation Debates Rational statements Giving examples and establishing references. Use of humor Images to re-parentalize Rational-emotional images Role reversal Therapeutic alliance Role-playing Social skills training Exercises to attack shame. Use of homework Use of reinforcement
21 Treatment results	Cognitive clinical conceptualization: Family and patient criteria analysis. Psychometric content analysis	Ideographic and experiential experiences Psychometric tests

DSM-V, Diagnostic and Statistical Manual of Psychiatric Diseases, V edition.
Diagnosis and cognitive intervention.
Source: Prepared by the authors.

not have a strong desire to socialize and preferred to be alone, dedicating himself to drawing or painting dinosaurs during recess.

Until he was 12 years old, he maintained an outstanding academic performance. He was an introverted and reserved person who preferred to spend most of his time alone, immersed in reading books about various animals and anime comics. In addition, he mentioned that during his high school studies, he had no friends due to his aversion to others approaching him. This resulted in the absence of work groups at school. On the other hand, he always presented a good academic performance, excelling in reading and writing skills, reflected in his early interest in reading comics and mythology books.

The patient showed an inclination toward the field of economics and business administration. However, he abandoned his management studies in the second cycle as he was not interested in having interpersonal relationships with others. His ability to show empathy, listen, and resolve conflicts was limited. He was also under pressure due to the expectations of his parents, who urged him to participate in family gatherings and attend church in order to foster his social life. The patient reported having no friends, as he had other hobbies such as drawing, reading, or playing alone in his room.

As for his sleep and rest patterns, he usually slept about 6 to 7 hours per night, suggesting a normal sleep pattern. However, he occasionally mentioned difficulties in falling asleep due to a tendency to watch mythology videos before sleeping. As for his dietary habits, he followed a balanced diet, with appropriate

consumption of fruits, vegetables, and proteins. Likewise, he stated that he did not engage in regular physical exercise, staying most of the time in his room, watching mythology, reading comics, or playing video games. On the other hand, he said he reserved time for meditation and reflection in the spiritual aspect. In addition, regarding religious beliefs, he stated that he was a Catholic.

The patient maintained a limited and insignificant number of virtual interactions with people through social networks such as Instagram and Facebook. However, he enjoyed and had longer interactions with online gaming peers, being an active member of those virtual communities, with a notorious preference for Minecraft.

Finally, he identified himself as heterosexual but did not experience a relationship with a woman, lacking interest in having one.

Mental state

The patient was accompanied by his father to the consult. He mentioned that nobody understood him and did not like being forced to socialize, presenting a reserved attitude during the first sessions.

On the other hand, he was oriented in space, time, and person. He did not present any type of alteration in his mental spheres. In terms of thinking, he presented a normal course and content. However, he manifested cognitive distortions such as guessing the future: "I am going to be bored with others", and "I have to behave properly". His psychomotor behavior during the first session was stereotyped movements, such as

constantly touching his head with his hands, but this behavior disappeared during the course of the sessions. Regarding memory, he showed the ability to remember past and recent events. His language was clear, and his tone of voice was low. He showed emotional coldness and was depressed when talking about his current conflicts (having to socialize because of his parents' imposition). His judgment was coherent and logical, and he also had insight to solve proposed problems. Finally, he did not present suicidal ideas. His attention was selective, and he was willing to follow the treatment.

Multiaxial diagnosis

According to the American Psychiatric Association diagnostic criteria reference guide [4], the patient meets seven out of the nine criteria for the diagnosis of schizoid personality (F60):

1. Few, if any, activities provide pleasure.
2. Emotional coldness, detachment, or flattened affectivity.
3. Limited capacity to express either warm, tender feelings or anger towards others.
4. Apparent indifference to either praise or criticism.
5. Little interest in having sexual experiences with another person (taking into account age).
6. Almost invariable preference for solitary activities.
7. Lack of close friends or confiding relationships (or having only one) and of desire for such relationships;

These conditions were not attributable to organic facts, drugs, or medication, so a schizoid personality disorder was diagnosed. In addition, there is a differential diagnosis with schizotypal personality disorder regarding the magical thinking, speech, and eccentric dress that are characteristic of this disorder. On the other hand, it differs from avoidant personality disorder since patients with this pathology experience isolation for fear of being embarrassed or rejected. In contrast, a generalized lack of interest and social isolation causes schizoid personality disorder.

PSYCHOMETRIC ANALYSIS

Millon's clinical multi-axial inventory

This instrument assesses personality, emotional difficulties, and personality disorders. It has structural internal validity, demonstrating that the Millon Personality Styles Inventory (MIPS) scales are designed to fully represent a set of theory-matched, multidimensional, and intercorrelated personality types. It has a Cronbach's α coefficient reliability ranging from 0.59 to 0.84 with an average of 0.71 (0.72 for the Spanish sample and 0.77 for the North American sample) [5].

In the pretest application (before the intervention), a score of 119 was obtained, denoting elevated clinical patterns of schizoid personality. In contrast, in the post-test (after the intervention), a score of 70 was obtained, representing a suggestive indicator of schizoid personality (Figure 1). This result denoted a significant change after treatment.

Ellis's irrational beliefs test

This inventory aims to determine the existence of irrational beliefs. Its content validity is given by the Aiken V statistic, resulting in a validity of 0.90 and 1 [6].

We can observe in Figure 2 that, before treatment (pre-test), the patient presented irrational beliefs at a score of 200, indicating somewhat irrational thinking. However, after the treatment (post-test), a score of 259 was obtained, typical of somewhat rational thinking. These psychometric results indicate a modification of irrational beliefs before and after the treatment.

Young's schema questionnaire

This tool evaluates early maladaptive schemes. It is validated by Aiken's V statistic equal to or greater than 0.80, at a statistical significance level of $p < 0.05$ [7]. Reliability was obtained with a coefficient $\Omega > 0.80$ for all schemes [8].

In the pretreatment application, the patient presented five significant maladaptive schemes, which were emotional detachment, failure, emotional inhibition, social isolation, and inadequacy. On the contrary, in the post-test, a normal stability of four schemas was evidenced, which were reduced after the treatment. However, the emotional detachment schema remained significant after treatment, according to psychometric evidence (Figure 3).

DISCUSSION

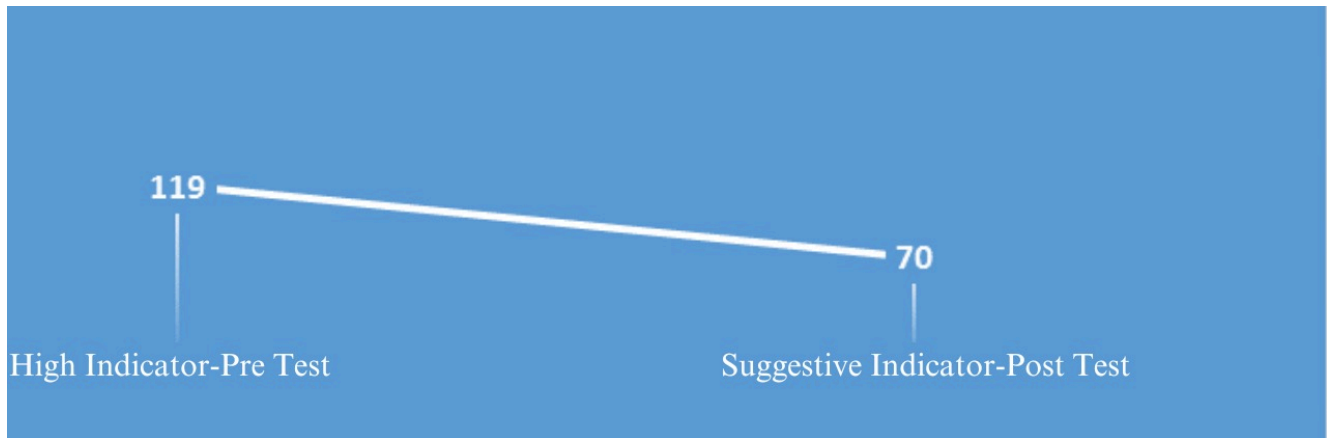
Cognitive clinical analysis

In this area, we describe the case report, the interactions of maladaptive beliefs and schemes that self-perpetuate the schizoid personality disorder in the patient from a cognitive clinical conceptualization, according to Riso's proposal [3]. All this through qualitative techniques such as the clinical interview and the recording of thoughts.

Figure 4 details the descriptive symptomatic level, the cognitive responses of "you should", which the patient has as a self-demand to behave appropriately in front of peers and family members. In this first level, this cognitive response of "I have to go out and behave appropriately", generates cognitive distortions such as future guessing, "I will be bored, and I will feel annoyed", and overgeneralization: "I will always feel annoyed when I am with other people". Both provoked emotional states of disgust and annoyance. Concurrent with these distorted emotions and cognitions, a silent behavior appears, with a lack of proposals of conversation topics that would please him, resulting in his pressure and dislike to stay with close people. Finally, at this symptomatic level, we can observe that people move away as an environmental consequence, where the patient is not interested in establishing any relationship with them.

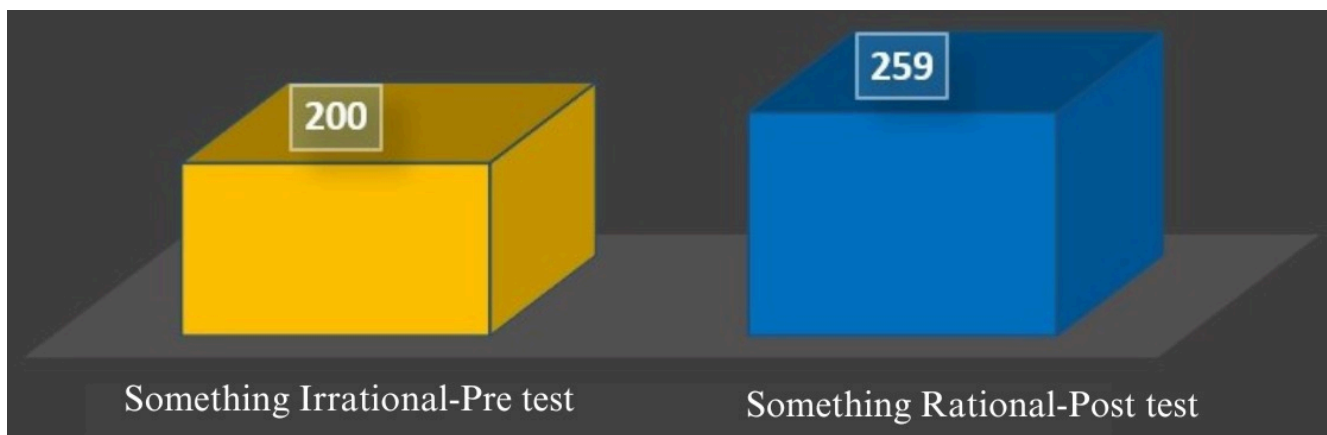
Apathy to socialize is typical of a schizoid personality, according to Sanchez [9], as they feel apart and different from others and the world. Consequently, these people focus on their own subjectivity and fantasies. Regarding this case study, the

Figure 1. Millon's multiaxial clinical inventory.



Results before and after cognitive intervention.
Source: Prepared by the authors.

Figure 2. Inventory of irrational beliefs.



Results before and after the cognitive intervention.
Source: Prepared by the authors.

patient remained in his inner world, having hobbies related to mythological and cultural knowledge and watching or reading anime. All these activities were performed by himself, exacerbating the symptoms that prevented him from establishing relationships or enjoying the presence of others.

The patient manifested a nuclear scheme of social isolation, which self-perpetuated comfort behaviors by being alone in his room. Within the cognitive economy system A, the patient presented memory biases, recalling situations where he moved away from others in his childhood and adolescence to escape from problems. Likewise, within system A, he evidenced an egocentric bias of fixation towards his own world, where he validated his own self above others, with an imaginary audience of feeling different and special, as reflected in Figure 5.

The events that self-perpetuated social isolation behavior as problematic in the patient are described by Beck and Freeman [1] as social detachment that occurs due to cognitive distortions that make the schizoid patient perceive others as intrusive and annoying, denoting self-worth and affirmation by his own

loneliness. This is how the patient, feeling strange or different when he was with others, activated the social isolation schema. This schema was learned from his childhood due to a lack of affective bonds with his parents, who taught him to be alone and to feel different from others.

COGNITIVE-BEHAVIORAL CLINICAL INTERVENTION

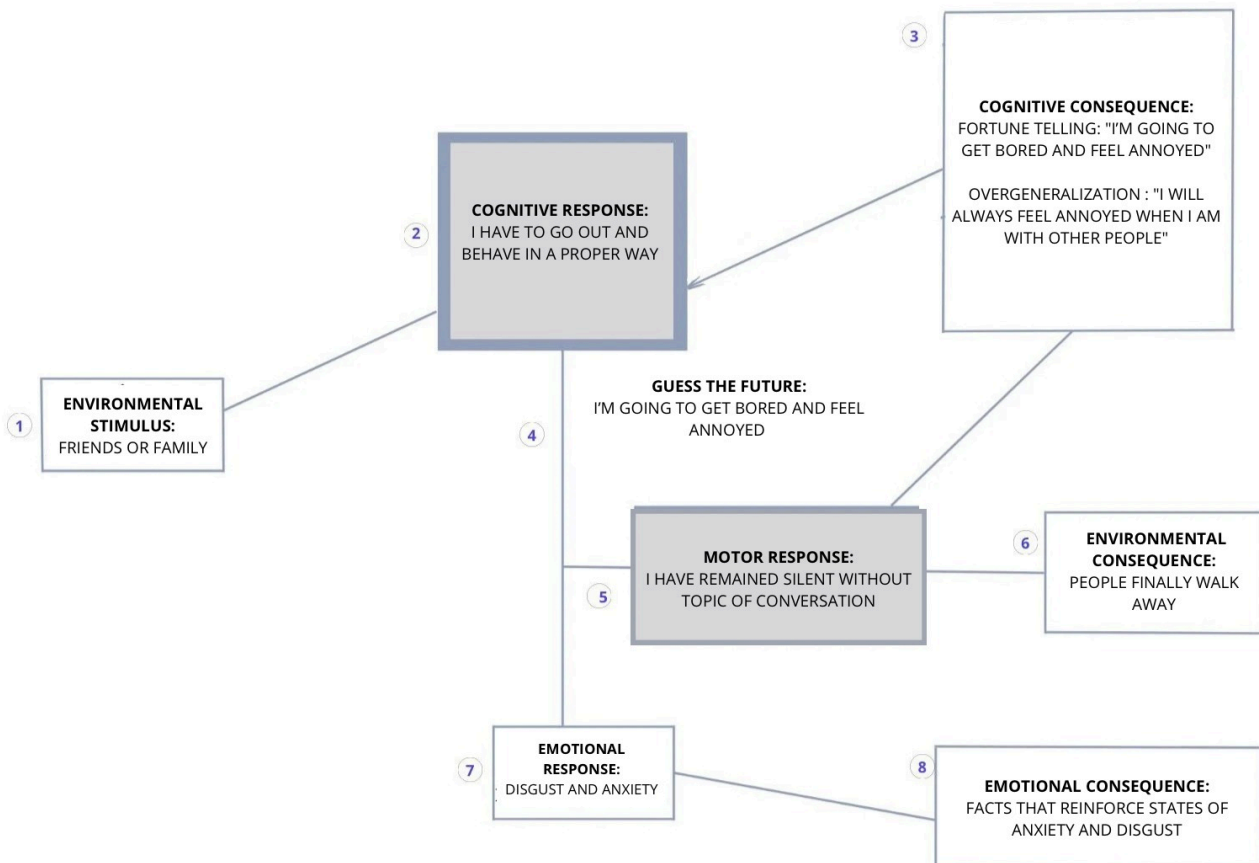
Regarding the intervention, it was based on a cognitive-behavioral model. According to Ellis and MacLaren [10], this psychotherapy starts by modifying the patient's negative and harmful beliefs in an active, directive manner to generate new, healthier, and more adaptive behaviors. Likewise, Gabalda states that cognitive behavioral therapy is an "integration that we can establish between observable behaviors, recognized thoughts and affect, and inferred cognitive processes and affect" [11]. This effective, diverse, and comprehensive therapy can be used for a wide number of psychological problems. In this same line, we can also state that some characteristics of this

Figure 3. Young's schema questionnaire.



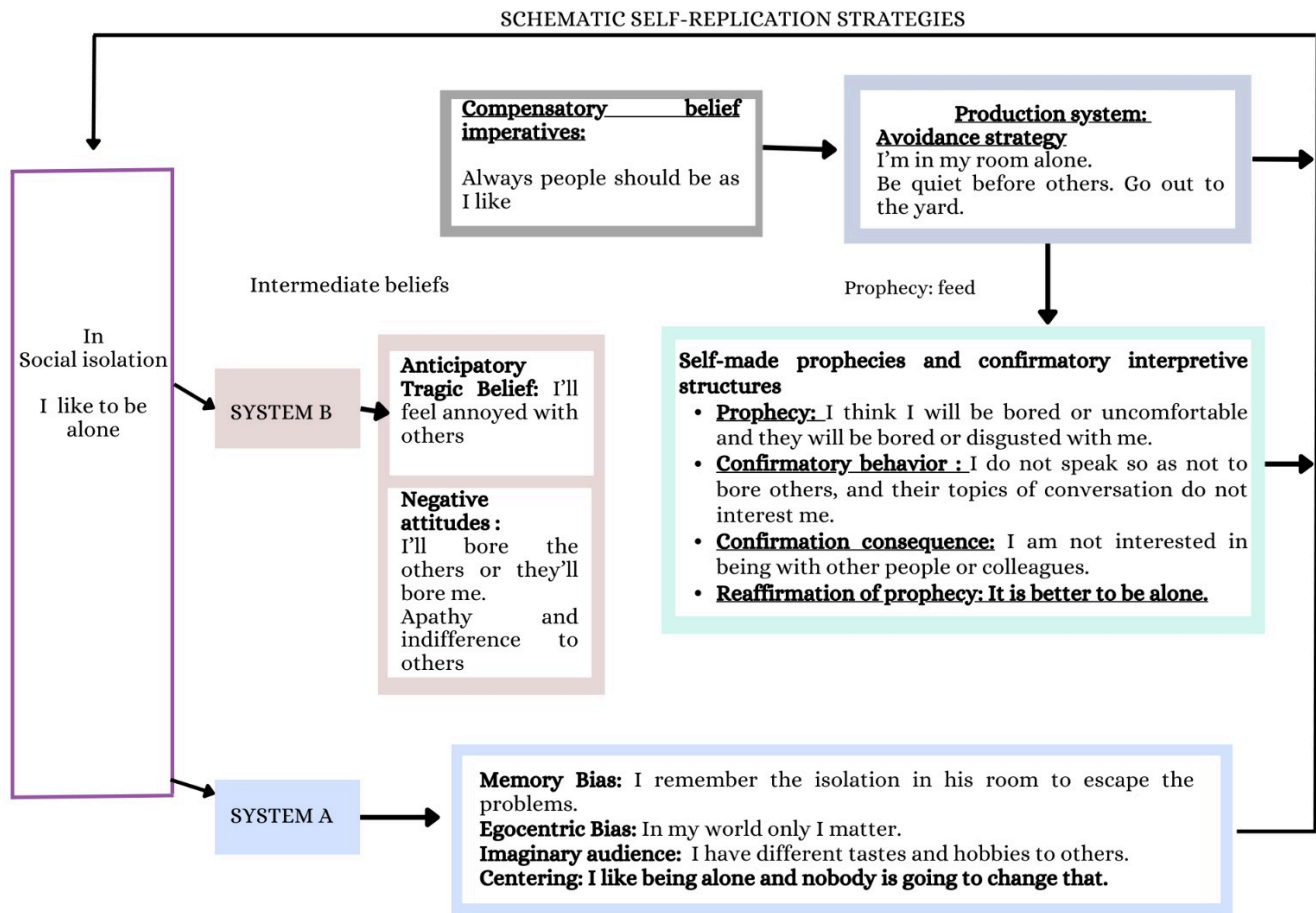
Results before and after cognitive intervention.
Source: Prepared by the authors.

Figure 4. Symptomatic descriptive level.



Source: Prepared by the authors.

Figure 5. Nuclear scheme of social withdrawal.



Source: Prepared by the authors.

therapy make it biographical and historical (early maladaptive schemas, according to Jeffrey Young). In contrast, others focus on creating less dogmatic and rational beliefs in the present (rational emotive behavioral therapy) or changing distorted thoughts about reality, such as Aron Beck's cognitive therapy. From this case report, various orientations and techniques of the authors mentioned above were used in order to have an arsenal of strategies that resulted in the treatment's success. This was because emphasizing only the patient's present beliefs or distortions could cause a lack of collaboration and a tendency toward rationality.

Thus, from this cognitive-behavioral approach, different techniques were used to modify schemes, beliefs, and symptoms that self-perpetuated the schizoid personality disorder. Among the techniques used, we highlight psychoeducation for the patient to incorporate information on cognitive behavioral therapy (irrational beliefs, schema modes, etc.), social skills to increase assertive behaviors, humor, coping styles, belief registers, images to reparentalize, and debates. In addition, it was possible to work for three sessions on assertive behaviors and social skills with the parents, this being fundamental for

learning something new within the family environment and relationships with the patient.

A therapeutic alliance was established, which consisted of not violating the patient's way of thinking or behaving. This was an agreement between his subjective way of observing the world and understanding his annoyance at his parents' pressure to interact with his peers. Sanchez [9] states that, in order to achieve adherence to treatment in schizoid personalities, it is necessary not to determine how their egosyntonic behaviors are problematic areas but to understand and empathize with them, accepting them in order to teach them another way of living with the world.

On the other hand, the cognitive responses at the symptomatic level, "I have to go out and behave appropriately", "I will get bored and feel annoyed", and "I will always feel annoyed when I am with other people", were replaced in therapy by rational and pragmatic discussions. In these, the patient was prompted to learn about his or her irrational beliefs of "you should" and unconditional self-acceptance. This is because, as Ellis [10] states, it brings a profound change of perspective on the emotions that may make the patient uncomfortable. Once their cognitive responses and distortions were identi-

fied through thought records, unconditional self-acceptance of others and life was also addressed.

Several techniques were used to modify early maladaptive schemes, such as debates, social skills, and reparentalizing images. Through this last technique, psychoeducation (identification of child-parent modes) was performed, and a conscious regression of the patient in his child mode was created to learn and modify his affections, cognitions, and behaviors of the past that self-perpetuated many of the early maladaptive schemes. Young [12] states that when new behaviors are created in the imagination, these are incorporated in our motor cortex since imagining doing something also activates the pre-motor neurons of our brain system. Thus, having worked with schema-focused therapy techniques was also significant in helping to shape new behavioral and affective responses toward the patient's relationships with others and his family.

On the other hand, the therapy also included work with the patient's parents so that the affective expression would progressively occur and encourage his social interaction behaviors. The work and collaboration of the parents in developing affection and empathy were very important in changing the patient's social interaction patterns.

Finally, after treatment, the patient stated that he had different expectations about interpersonal relationships, being more inclined to have friends or people close to him in order to carry out activities. He also reported being more interested in sharing personal experiences with his family. In the patient's words, "I have come to feel better in everything; I can have friends, I talk more with my family, and I even want to continue with my studies", he said.

CONCLUSIONS

From a cognitive-behavioral approach, it was possible to intervene in the clinical schizoid traits affecting the patient in the deterioration of his socio-affective and behavioral environment. The use of cognitive, behavioral, and emotional-experiential techniques reduced early maladaptive schemes of inadequacy, failure, emotional inhibition, and social isolation. Irrational beliefs related to "I have a better time doing my own things", "I don't need friends to be able to do my own things," and "people bore me", which self-perpetuated behaviors of a schizoid personality pattern, were also reduced.

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Intervención clínica cognitiva en paciente con trastorno esquizoide de personalidad: reporte de caso

RESUMEN

El presente reporte de caso describe a un paciente varón de 19 años, que presentaba como principales síntomas frialdad emocional, ausencia de relaciones cercanas, problemas para experimentar placer con otras personas y carencia de motivación para trabajar o retomar sus estudios. Se diagnosticó un trastorno de personalidad esquizoide, producto de esquemas maladaptativos tempranos como inhibición, privación emocional, aislamiento social e inadecuación. Asimismo, se evidenció un contexto familiar rígido y fragmentado, con ausencia afectiva de padres y direccionado hacia normas estrictas en la conducta. El objetivo del estudio fue intervenir desde un enfoque clínico cognitivo los esquemas maladaptativos tempranos y síntomas que mantenían los rasgos de trastorno esquizoide de la personalidad en el paciente. Para esto se realizó una terapia cognitiva conductual, con técnicas como debates, imágenes para reparentalizar, asignación de tareas, uso del humor, entrenamiento de habilidades sociales, entre otros. Como conclusión se puede manifestar que los esquemas maladaptativos tempranos mantenían la sintomatología de personalidad esquizoide. Por último, se demostró a través de un criterio clínico y psicométrico que la terapia cognitiva conductual disminuyó las conductas de personalidad esquizoide en el paciente.



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