

# Cluster A Personality Disorders: Challenges in Establishing Diagnostic Clarity and Addressing Treatment Gaps

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**Objective:** This paper aims to highlight the gaps in research related to the diagnosis and treatment of Cluster A Personality Disorders (PDs) and discuss clinical implications of current research for detection, early prevention and symptom management. Additionally, the paper examines how existing research on prodromal psychosis and schizophrenia may support increased diagnosis and treatment efforts for Cluster A PDs.

**Methods:** A review of the existing literature was conducted regarding the clinical presentation of Cluster A PDs, diagnostic overlap with prodromal psychosis and schizophrenia, and the effectiveness, acceptability, and feasibility of psychosocial and pharmacological treatments for Cluster A PDs.

**Results:** There is immense overlap in clinical presentation across Cluster A PDs, prodromal psychosis, and schizophrenia, resulting in increased difficulties with differential diagnoses and possible misdiagnosis. Little research has examined effective and pharmacological and psychotherapy focused interventions for individuals diagnosed with Cluster A PDs. Generally, pharmacological treatments appear to be less effective and specialized to Cluster A PDs. Low rates of feasibility and acceptability and high dropout rates were reported for both pharmacological and psychosocial treatments.

**Conclusion:** Cluster A PDs are the most under researched amongst the three clusters of personality disorders, and it is imperative that future research prioritizes improving the diagnostic differentiation of Cluster A PDs in the future. Additionally, it is paramount that experts work towards specificity in future research to examine how available treatments can be tailored to individuals who are diagnosed with Cluster A PDs in order to create more effective, targeted, and acceptable treatments for this population.

## Introduction

Cluster A PDs are a group of psychological conditions that can significantly impair an individual's abilities and contribute to the deterioration of one's health. Cluster A PDs, one of the three clusters of personality disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), encompasses three disorders: (1) Paranoid Personality Disorder, (2) Schizoid Personality Disorder, and (3) Schizotypal Personality Disorder (American Psychiatric Association, 2013)<sup>1</sup>. Although under the same cluster, these disorders are similar yet distinct, with the main characteristics including social awkwardness, withdrawal, and strange behaviors. The prevalence of Cluster A PDs in the general population is between 1.6 and 4.1% (Coid et al., 2006; Torgerson, Kringlen, & Cramer, 2001)<sup>2,3</sup>, and is even higher in psychiatric patients, with rates between 5.6 – 13.2% (Bornstein et al., 1988; Zimmerman, Rothschild, & Chelminski, 2005)<sup>4,5</sup>. Cluster A PDs are associated with odd and eccentric behaviors and if left untreated may lead to poorer outcomes, high levels of distress, or even functional impairment. Additionally, Individuals diagnosed with Cluster A PDs often experience functional and cognitive impairments. Studies suggest that certain patterns of cognitive impairments associated with Cluster A PDs

resemble the severity and presentation of impairments present in individuals diagnosed with schizophrenia (McClure et al., 2010)<sup>6</sup>.

In addition, individuals diagnosed with Cluster A PDs have been observed to exhibit a poor response to treatment, including unusual sensitivity to the side-effects, impairment such as social, occupational, and reluctance to engage with treatments (Farooq & Ayub, 2022)<sup>7</sup>. Along with poorer treatment prognosis, despite intensive psychiatric treatment; Karterud et al., 2003). Epidemiological data from the United States found diagnosis of a Cluster A PD (i.e., Paranoid Personality Disorder) was associated with disability status. Additionally, individuals with a Cluster A PD diagnosis experienced greater occupational impairment to disability, and even if they do not become disabled, they are unable to work for as many years as other individuals with different personality disorders (Grant et al., 2004)<sup>8</sup>.

Despite substantial evidence of the impairments associated with Cluster A PDs, they remain an extremely under researched area in the field of mental disorders and is often overlooked by many mental health professionals. Most critically, existing evidence on the treatment of Cluster A PDs is scant, with the majority of the research depending highly on existing treatment research for borderline personality disorder (BPD), a cluster

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with very different symptoms, development, and treatment needs (Farooq & Ayub, 2022)<sup>7</sup>. Additionally, although each of the three Cluster A PDs encompass distinct clinical presentations and subsequently may require different pharmacological and psychosocial interventions, little research has examined effective methods to tailor treatments to unique features of the three Cluster A PDs. Paranoid Personality Disorder (PPD) is characterized by a prevalent feeling of distrust and suspiciousness, in addition to distorted thinking and misinterpretations of other's actions. Schizoid Personality Disorder (SPD) has characteristics of pervasive social detachment, limited emotional expression, and isolation. Additionally, SPD may resemble the negative symptoms of schizophrenia. Lastly, Schizotypal Personality Disorder (SZPD) is characterized by discomfort in social settings or interactions, individuals with SZPD often experience cognitive and perceptual distortions, including hallucinations or odd beliefs (American Psychiatric Association, 2013)<sup>1</sup>.

There is also a broad overlap in terms of symptoms and experiences between Cluster A PDs and other forms of psychosis and psychotic experiences, including prodromal psychosis and schizophrenia. Examples include shared core clinical features, such as psychotic episodes, delusions, or hallucinations, which may represent shared intervention targets and shared etiological features. However, key differences in the development, overall clinical presentation, duration, and associated impairments signal that these disorders and psychotic experiences are distinct clinical phenomena that warrant individualized and tailored research.

The present paper aims to examine the overlap in the clinical presentation of Cluster A PDs, prodromal psychosis, and schizophrenia and their implications for diagnostic specificity. Additionally, the paper aims to provide a thorough overview of pharmacological and psychosocial treatments available for Cluster A PDs and examine the feasibility and acceptability of those treatments.

## Methods

To gather relevant sources for this literature review, a search was conducted using online academic databases, including Google Scholar, PubMed, and PsycArticles. The search focused on peer-reviewed journal articles and books related to the topic of diagnostic criteria, prevalence, treatment options, and effects on an individual diagnosed with Cluster A personality disorders. In addition, the diagnostic criteria and effects of schizophrenia and prodromal psychosis. Studies were included if they discussed (1) the diagnostic criteria and symptoms of cluster A personality disorders, schizophrenia, and prodromal psychosis, (2) available treatments options and settings for cluster A, and (3) the feasibility and acceptability of these treatments among the population. Articles were published within the last 36 years (1988-2024) and were peer-reviewed or published by reputable

sources. Sources were categorized based on their main themes, including the treatment types and settings, symptoms, feasibility and acceptability, and prevalence across the three disorders, prioritizing cluster A. The findings were then synthesized to identify common trends, gaps in research, and implications for future studies.

## Overlap Between Prodromal Psychosis, Cluster A PDs & Schizophrenia

There are multiple significant overlaps between Cluster A PDs, prodromal psychosis, and schizophrenia, that are important to consider when diagnosing either of these disorders. These key differences are highlighted and expanded upon below and have significant clinical implications for early detections, accurate diagnosis and differentiation between the three, as well as early prevention and treatment of symptoms.

### Prodromal Psychosis

The prodromal psychosis phase is a period of time during which an individual may present with some symptoms for a specific psychotic disorder, but do not exhibit enough symptoms or experiences to meet full criteria for a clinical diagnosis (Yung et al., 1996)<sup>10</sup>. Prodromal psychosis can occur for a disorder before it may fully convert into full psychosis, but full conversion may not always occur. As such, the prodromal phase is a critical time period in which experts may be able to understand the developmental trajectory of certain disorders, allowing for better early detection of emerging symptoms and increasing preventative efforts to manage symptoms. Many researchers have attempted to understand, typically, how the course of prodrome may occur (McGlashan et al., 2001; Phillips et al., 2005; Cornblatt et al., 2003; Schultze-Lutter et al., 2010)<sup>11-14</sup>. It is important to highlight that the course can always differ, depending on the person and disorder. Typically, individuals begin by experiencing negative or nonspecific symptoms, including anxiety, depression, or isolation. Secondly, there are signs of basic symptoms, attenuated positive symptoms (APS). This is followed by more serious APS, the frequency is about once or twice a month, last usually only for a couple minutes and usually less than a day, and intensity is characterized by an unsureness as to the accuracy of hallucinations or delusions. Finally, for the people who do convert into full psychosis, the last stage or the high-risk period, the individual exhibits pre delusional thoughts, pre hallucinations, and more abnormal thoughts (an der Heiden et al., 2000)<sup>15</sup>. In summary, prodromal psychosis is known as a period of change in an individual's behaviors and symptoms that anticipate the onset of "full" psychosis. An important consideration is that there is no guarantee of conversion to full psychosis or another disorder, some individuals may remain at the prodrome level or have symptoms that remit after a certain

Disorders	Cluster A (PPD, SZPD, SPD)	Schizophrenia	Prodromal Phase of Psychosis
Symptoms	<ul style="list-style-type: none"> <li>● Distrust and paranoia of others</li> <li>● Restricted range of expression</li> <li>● Social isolation</li> <li>● Odd beliefs and magical ideals</li> <li>● Unusual perceptions</li> <li>● Odd speech</li> </ul>	<ul style="list-style-type: none"> <li>● Hallucinations</li> <li>● Delusions</li> <li>● Catatonic behavior</li> <li>● Cognitive, behavioral, or emotional dysfunctions</li> <li>● Disorganized speech</li> </ul>	<ul style="list-style-type: none"> <li>● 1 Fully Positive Psychotic Symptom (e.g. hallucinations, disorganized thinking, or delusions)</li> </ul>
Diagnostic Criteria and Potential Risk Factors	<p>Diagnostic Criteria:</p> <ul style="list-style-type: none"> <li>● Period of distrust and suspiciousness of malevolent intent from others.</li> <li>● Pattern of social detachment and a restricted range of emotions</li> <li>● Pervasive pattern of discomfort within relationships and social settings</li> </ul> <p>Risk Factors:</p> <ul style="list-style-type: none"> <li>● Genetic factors may include a higher risk when a biological relative has been diagnosed with Schizophrenia or related psychosis disorders.</li> </ul>	<p>Diagnostic Criteria:</p> <ul style="list-style-type: none"> <li>● Signs of disturbance and at least two symptoms must be present for over a month</li> <li>● Impaired functioning in terms of social or occupational</li> </ul> <p>Risk Factors:</p> <ul style="list-style-type: none"> <li>● Genetic risk factors may include pregnancy or birth complications, in which there is a higher risk for the fetus</li> <li>● Many lifestyle choices or hereditary traits are linked with higher risk: to name a few, malnutrition, maternal diabetes, or stress</li> <li>● Environmental Risk factors may be higher for children living in urban environments or oppressed groups that face discrimination.</li> </ul>	<p>Diagnostic Criteria:</p> <ul style="list-style-type: none"> <li>● 1 fully positive psychotic symptom demonstrated by the patient for over one week</li> <li>● 1 fully positive psychotic symptom several times a week displayed for at least a month</li> <li>● 1 fully positive psychotic symptom for at least one day if the symptom is disorganizing</li> </ul> <p>Risk Factors (specifically UHR/ultra-high risk):</p> <ul style="list-style-type: none"> <li>● Oftentimes, alterations may be shown in neuroanatomy, neurochemistry, and cognitive relations</li> </ul>
Treatment Approaches (discussed in detail in later sections)	<ul style="list-style-type: none"> <li>● Psychosocial or pharmacological treatments</li> <li>● Including psychotherapy in different settings and treatments such as antipsychotics</li> </ul>	<ul style="list-style-type: none"> <li>● Psychosocial treatments: social skills development in controlled environment</li> <li>● Antipsychotic medications</li> </ul>	<p>UHR specific:</p> <ul style="list-style-type: none"> <li>● Therapy in addition to antidepressants or low-dosage antipsychotics</li> </ul>

**Table 1:** Adopted (American Psychiatric Association, 2013<sup>1</sup>; Modinos et al., 2015<sup>9</sup>)

time, however it is not clear why or who will or will not convert. A study conducted by Klosterkötter and colleagues (2001)<sup>16</sup> aimed to identify the initial prodrome before a psychotic episode occurred. The study originally consisted of 695 patients, but only 160 patients were willing and able to participate through the end of the study. According to the DSM-IV criteria, 79 patients had developed schizophrenia, while 81 had not. All patients received antipsychotics and were in an inpatient setting; depending on when prodromal symptoms had first been found. The results were that the transition time occurred 4.3 years after the onset of the initial prodrome in women and 6.7 in men (Klosterkötter et al., 2001)<sup>16</sup>. These outcomes prove that transition typically occurs earlier for women, however there is still variability for when symptoms originally become apparent and the effectiveness of treatment.

### Cluster A PDs and Schizophrenia

The prodromal phase can be seen before the transition into any disorder, however both schizophrenia and Cluster A PDs are known to be very similar at that stage. Although the two dis-

orders are under different categories in terms of organization: Cluster A, a personality disorder and schizophrenia, a psychotic disorder, the two may often be mistaken for the other, especially during the prodromal phase. The distinguishing of the developmental phase of Cluster A PDs and the full disorder is extremely reliant on schizophrenia and prodromal psychosis. As such, far less research has examined the developmental trajectory specific to Cluster A PDs, impeding efforts to understand how prodromal psychosis or early psychotic experiences may convert to full Cluster A PDs and identify if an individual is going showing early symptoms of a Cluster A PD. A study done by researchers in North America, who were trying to understand the prodromal phase by collecting data from 300 people, with an average age of 18 years identified these criteria, based on the presence of three separate conditions (Cannon et al., 2008)<sup>17</sup>. First, measurement using the Structured Interview for Prodromal Syndromes (SIPS ; Miller et al., 2002; Miller et al., 2003)<sup>18,19</sup>, and that encompasses positive symptoms. Second, brief, irregular psychotic symptoms, beginning within three months of the assessment. SPD is one of the three disorders in Cluster A PDs and is the one with the most amount of research out of

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the three. Most commonly SPD is associated as the prodromal phase for Schizophrenia, although the two disorders, SPD and the prodromal phase for Schizophrenia, are very similar, there are still minor differences. Acknowledging the similarities, the two disorders may first be evident in adolescence. A proposal for DSM-III-R was to make them identical (Widiger et al. 1988)<sup>20</sup>. This proposal however, was rejected, because there were some small notable differences (the prodromal phase can include a lack of interest or fatigue) and making them equivalent would be inconsistent.

Multiple symptoms overlap in the presentation of Cluster A PDs and schizophrenia, including the presence of disorganized speech, delusions, hallucinations, and social isolation (American Psychiatric Association, 2013)<sup>1</sup>. The symptoms and signs of both Cluster A and Schizophrenia tend to be very similar, commonly resulting in psychotic episodes, delusions, or hallucinations. Due to the similarities, there is often a higher risk of a misdiagnosis of the two disorders. The DSM-5 classifies Schizophrenia symptoms as delusions, hallucinations, disorganized speech, catatonic behavior, and negative symptoms and at least two of these symptoms must be displayed by the patient for at least one month in order for a proper diagnosis of Schizophrenia. After comparing the two disorders, there is a clear overlap between symptoms and the presentations of the two disorders.

There are also some similarities in the treatment types, such as the psychosocial interventions and pharmacological treatment. However, there are many differences and considerations in terms of duration, age dependent diagnosis, and levels of impairment. Schizophrenia can only be diagnosed when an individual has been displaying symptoms over the course of one year, meaning that individuals under the age of eighteen may be diagnosed with Schizophrenia. However, the diagnostic criteria for Cluster A PDs only stipulate that symptoms present in a “pervasive pattern” with an onset of “early adulthood” are especially more difficult to diagnose than schizophrenia. More specifically, for Cluster A PDs, professionals look for a pattern of distrust and certain behaviors in social settings.

## Interventions

### Psychosocial Interventions

Few interventions have been tested to specifically treat Cluster A PDs. However, the main intervention is psychotherapy, where the psychologist or licensed mental health professional works with a patient, either individually or in a group setting. Afterwards, they follow through with a plan, specific to the patient, that will allow the individual to understand their behaviors, emotions, and thoughts. The psychologist then notices the patient, adding any additional changes or new methods to their plan, ultimately helping the patient work through their problems and toward the goal of an improved mental state (American

Psychological Association, 2012)<sup>1</sup>.

An important consideration is the setting in which treatment can occur, such as outpatient, day-hospital, and inpatient hospital settings. A study that evaluated the effectiveness of outpatient individual psychotherapy, outpatient group psychotherapy, and inpatient psychotherapy for individuals with personality disorders concluded that there is solid evidence that proves that psychosocial therapy can reduce symptoms and improve social functioning (Leichsenring & Leibling 2003; Perry et al., 1999)<sup>21,22</sup>. Additionally, treatment that is outpatient individual psychotherapy, mainly centered around cognitive-behavioral and psychodynamic: therapy that focused on thoughts, aspects led to opposite results. This is an efficacious intervention that reduced symptoms and improved social functioning among patients suffering from personality disorders (Leichsenring & Leibling 2003; A1 Perry et al., 1999)<sup>21,22</sup>. It is also true that supportive, based around encouragement or validation, variants of thought-centered psychotherapy result in lower dropout rates (Hellerstein et al., 1998; Piper et al., 1998, 1999; Winston et al., 1991, 1994)<sup>22-25</sup>.

Research also suggests that long-term, psychodynamic group psychotherapy is also an effective treatment for all personality disorders. Other findings include that long-term psychodynamic group psychotherapy is considered when patients exhibit personality problems or a mild personality disorder. Additionally, problems are often encountered in this setting, specifically interpersonal problems or ones regarding authority conflict or intimacy. Another important finding is that long-term, psychodynamic group psychotherapy is an efficacious follow-up treatment after day hospital psychotherapy (Verheul, R., & Herbrink, M. 2007)<sup>26</sup>. Furthermore, long-term, psychodynamic, outpatient setting psychotherapy is proven to be one of the most effective follow-up treatments, after day hospital or inpatient psychotherapy (Wilberg et al., 2003)<sup>27</sup>. This is important to note because studies show that patients with personality disorders tend to have high dropout rates, and do not follow through with the treatments given.

A study conducted by Karterud and colleagues (2003), the largest one to date on the treatments of Cluster A PDs, examined the effectiveness of day hospital treatments. Their sample contained 132 patients with a primary Cluster A PD diagnosis and patients with comorbid Clusters B and C PD diagnosis. Their findings showed that patients with a Cluster A PD diagnosis had the highest dropout rate in a day hospital setting (23.9%). Other findings indicated that the treatments were not effective either, patients with paranoid and schizotypal PD showed very few treatment advantages in terms of psychiatric symptoms. Additionally, patients with paranoid PD and comorbidity in borderline PD had substantially worse results at the 1-year follow-up than patients with only borderline PD. As for the group with schizoid PD, the numbers were too small at the 1-year follow-up, which led to the results never being reported (Karterud et

al., 2003)<sup>28</sup>. Additionally, evidence suggests that patients with a Cluster A PD diagnosis receiving treatment in day-hospital programs, may experience a small benefit from short-term, psychodynamic psychotherapy (Karterud et al., 1992; Karterud et al., 2003; Vaglum et al., 1990; Wilberg et al., 1998b)<sup>24,28-30</sup>. The main takeaway from these findings is that multiple studies provide solid evidence that a range of psychotherapeutic treatments are effective, in terms of reducing symptoms in Cluster A PDs and other personality disorders. However, a disadvantage is that in terms of a clinical aspect, motivation, a will to change should already be present in the person, but patients can enroll in a pre-treatment, motivation based, phase (Miller & Rollnick, 1991)<sup>31</sup>.

### Pharmacological Interventions

Pharmacological treatments are often more targeted towards symptom management. Drug treatments are relied on mainly to provide the patient with stabilization, so they will be able to engage in psychosocial treatment (Koch et al., 2016)<sup>32</sup>. With the exception of BPD, there is minimal research available for pharmacological treatments that are effective in treating personality disorders (Farooq & Ayub, 2022)<sup>7</sup>. This raises the concern that there is almost no research available for Cluster A, and existing information may be reliant on current BPD research. Other study limitations include: medication having certain effects on different patients, high drop out rates from studies, and errors or missing information from trial reports.

One study analyzed 15 psychiatric patients who were all diagnosed with PPD, in Denmark. Findings suggest that patients received a variety of medication regimens, with most patients receiving an antipsychotic (most commonly flupentixol) and additional antipsychotic medications (e.g., bromperidol, promazine) as needed. Of the 15 patients, only four patients who received antipsychotic medication therapy showed signs of improvement; however, one patient's condition had worsened at follow-up. In addition, few patients showed improvements and benefit from the antidepressant medications due to a decrease in depressive symptoms (Koch et al., 2016)<sup>32</sup>. These results demonstrate that antipsychotics had variability among this population, and that although most patient's symptoms improved, this is not evidence to prove that this medication is effective for all patients.

A meta-analysis of 35 of the trials had the outcome that the use of anticonvulsants had reduced aggression and antipsychotics reduced cognitive perceptual and mental disturbances (Duggan et al., 2008)<sup>33</sup>. Paranoid thinking fell under the category of a cognitive perceptual domain; however, none of these randomized controlled trials (RCTs) actually included a patient with paranoid personality disorder and paranoid thinking was an outcome secondary to BPD, and not a Cluster A PD diagnosis (Koenigsberg et al., 2003)<sup>34</sup>. A 9-week, randomized, double-

blind, placebo-controlled trial of risperidone in 25 patients with schizotypal personality disorder in 2003. The weekly symptoms were measured by the Positive and Negative Syndrome Scale (PANSS). The symptoms shown decreased during the 9-weeks trial in the treatment group, but there was almost no change in the placebo group. There were many errors and limitations to this study including a high rate of secondary personality disorders, a small control group, an error in the randomization process, and high drop-out rates. In addition, because of the specific doses of the medication, it was unclear whether the improvements were due to an increase in dose of the medicine or an increased length (Koenigsberg et al., 2003)<sup>34</sup>. Another study conducted for schizotypal was an open-label study, with 11 patients with schizotypal personality disorder all receiving olanzapine. The medication showed reduced positive and negative symptoms and depressive symptoms (Keshavan, 2005)<sup>35</sup>; however, the findings of the study were limited given that only 8 of the patients completed the 26-week study no, follow-up visits were conducted to examine the long-term effects of this medication on patient stabilization, many patients were on multiple medications alongside olanzapine to manage their symptoms, and patients in the sample had comorbid personality disorders. As such, it is difficult to extrapolate the findings of this study to better understand effective pharmacological treatment for Cluster A PDs.

There are additional methodological limitations within the existing research on pharmacological treatments for Cluster A PDs. These studies contain different approaches to understanding these disorders, including the number of participants or the durations of the studies. These limitations add variability in terms of an unclear understanding of how effective these treatments may be and the effects they may have on a patient. Additionally, the outcomes of these treatments are unclear as well because there were many methodological limitations while the studies were being conducted and the results depended on the patient. A meta-analysis of 35 of the trials had the outcome that the use of anticonvulsants had reduced aggression and antipsychotics reduced cognitive perceptual and mental disturbances (Duggan et al., 2008)<sup>33</sup>. Paranoid thinking fell under the category of a cognitive perceptual domain; however, none of these randomized controlled trials (RCTs) actually included a patient with paranoid personality disorder and paranoid thinking was an outcome secondary to BPD, and not a Cluster A PD diagnosis (Koenigsberg et al, 2003)<sup>34</sup>. A 9-week, randomized, double-blind, placebo-controlled trial of risperidone in 25 patients with schizotypal personality disorder in 2003. The weekly symptoms were measured by the Positive and Negative Syndrome Scale (PANSS). The symptoms shown decreased during the 9-weeks trial in the treatment group, but there was almost no change in the placebo group. There were many errors and limitations to this study including a high rate of secondary personality disorders, a small control group, an error in the randomization

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These studies highlight specific limitations that significantly impacted the effectiveness of these trials: many patient's follow-up results were not reported, which made the results of the studies ineffective to draw conclusions from. Additionally, there is minimal information explaining the specific statistics of comorbid disorders, including cluster B and C diagnoses as well as drop out rates among the patients that participated in the trials. As such, it is difficult to extrapolate the findings of this study to better understand effective pharmacological treatment for Cluster A PDs. Crucial information from trials are not reported, contributing to further delay in finding efficacious treatment, furthering impairment in individuals with Cluster A and providing minimal awareness about the situation. Additionally, almost no studies that focus on comparing the different treatment settings for patients with Cluster A PDs. It is clear that while there is great variability in pharmacological approaches for Cluster A PDs, and subsequently, it is imperative to tailor the medicine to each person.

## Comparison of Treatment Types

Pharmacological and psychosocial are two treatment approaches that have different purposes as well as benefits. Pharmacological treatments aim to stabilize a patient's symptoms, and allow them to engage in psychosocial treatment by doing symptom management with medication. However, if a patient is stable, drug treatments are not preferred, and rather professionals aim to support the patient through engagement in psychotherapy, where the patient develops techniques and strategies through behavioral therapy or social skills development.

Pharmacological treatments raise a concern in terms of benefit and adherence to the patient. Drug treatments that have been tested give unclear results, not allowing researchers to draw conclusions about the effectiveness of these medications, some patients benefit, while others conditions only deteriorate, emphasizing variability among populations. In addition, many patients refuse these treatments, leaving incomplete trials and also contributing to the lack of conclusions being made about

drug treatments. However, psychosocial treatments prove to have higher engagement and completion, as professionals work towards helping the patient through interactive and targeted methods. These points can conclude that drug treatments are only necessary in situations where the patient needs stabilization, but psychosocial treatments are the preferred method among this population.

## Feasibility and Acceptability of Treatments

The feasibility and acceptability of treatments is key in understanding whether or not the treatment can be implemented long-term. Feasibility is if a specific treatment is accessible and can easily be carried out to a population. Accessibility is if the population is willing to use the treatment and continue the treatment long-term. Oftentimes barriers for this population can include high dropout rates, a lack of motivation to begin a treatment, and missing information from studies or trials, leading to the minimal information available. Researching can help determine how feasible the treatment can be and if patients are open and accepting of the treatment.

A study that focused on the feasibility of an intervention that targeted suspiciousness in positive schizotypy found that engaging with a mindfulness app, known as Headspace, for at least ten minutes a day had been feasible and accepted by the group. Schizotypy is defined as the characteristics that are similar to schizophrenia and corresponds to the domains of the disorder. The trial was conducted with 342 participants from a previous trial, (McDonald et al., 2024)<sup>36</sup> in addition to 93 new participants. The participants had to take part in the Schizotypal Personality Disorder (SPQ; Raine, 1994)<sup>37</sup> and if they met the feasibility inclusion criteria, which was an online survey, they were able to participate in the trial. At the end of the trial, the results showed that this treatment was both acceptable and feasible. This intervention was incredibly successful with this population, possibly due to the minimal interaction with others. This study reported no dropouts or resistance, and high rates of session completion to the treatment and described the steps taken by the patients, involving no contact with a trained instructor, which reduced the state of paranoia, making this treatment highly effective and engaging.

An important consideration is that many psychiatric patients stop engaging with antipsychotics after a certain point, since they may have multiple negative effects, as proved by many studies. A meta-analysis of multiple studies that included patients with serious psychotic disorders, such as schizophrenia or bipolar disorder came to the conclusion that antipsychotics are effective in treating symptoms, however the medication is only effective when it is ingested. Furthermore, it is imperative that there is continuous adherence to the medication, in order to have positive results in patients with serious mental illnesses (SMI). However, previous use of other substances, alcohol, or antide-

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pressants were predictors that reduced patient's adherence to the antipsychotics given during studies. In addition, discontinuing the medication for as little as one to ten days can have significant impacts. There is a possibility of immediate hospitalization for patients with schizophrenia (Weiden et al., 2004)<sup>38</sup>, along with the possibility of an increased use of emergency psychiatric services, violent or erratic behaviors, arrests, or a higher risk of suicide attempts, and poor functioning (Ascher-Svanum et al., 2006; Novick et al., 2010; Hong et al., 2011)<sup>39-41</sup>. It is also critical that there is not one standard method or "fit" to improving the adherence of medications because they are effective and significantly reduce risks (Velligan et al., 2009)<sup>42</sup>. These engagement challenges often manifested as challenging, and observed that patients experiencing engagement challenges often engaged in behaviors such as belittling, threatening, and being uncooperative with physicians, which could serve as an additional barrier to receiving needed care behavior (Angstman & Rasmussen, 2011)<sup>43</sup>. The vast difference in these findings prove that psychosocial interventions, specifically mindfulness based, have a higher efficacy, but antipsychotics pose serious threats to the patient's health and are proved ineffective unless adhered to, affecting the feasibility and acceptability. There is also much variability to the effectiveness of antipsychotics, mainly dependent on the patient and their symptoms and diagnoses.

## Discussion

The present paper aimed to discuss the overlap between Cluster A PDs and psychosis disorders, specifically schizophrenia, available treatments, and the feasibility and acceptability of these treatments. Findings suggest that there are many overlaps in the clinical presentation of Cluster A and psychosis disorders. The collected studies analyzed various forms of treatments and different settings. If researchers were to prioritize looking into early signs and ways to treat these disorders in advance, this research would be an imperative initial step to understanding more aspects of Cluster A PDs and improving research, studies, and providing patients with the assistance they require.

Additionally, there is almost no information that shows why Cluster A PDs may develop in childhood and adolescence, versus adulthood, or more broadly, why it develops. For example, given the evidence suggesting that traumatic experiences involving neglect and interpersonal violence are associated with a larger risk of psychosis as compared to situations involving exposure to unintentional injury, economic status, or the loss of a parent, it is possible that this research may extrapolate to later diagnoses of Cluster A PDs. Clarifying risk factors would be a crucial first step to identifying effective treatments for this population.

Treatment options for Cluster A PDs are limited because of the minimal research available and an insufficient amount

of studies, tests, and data to prove the effectiveness of any treatment, pharmacological or other. Multiple factors make it difficult to come to solid conclusions about the effectiveness of psychosocial treatments for not only Cluster A PD, but all personality disorders. This emphasizes the importance of understanding the difference in personality disorders within each cluster and is distinguished by clear differences in symptoms and clinical presentation. Therefore, there is a great need for tailored research for Cluster A PDs to identify whether unique treatment considerations are warranted.

Additionally, it is possible that clinical characteristics of Cluster A PDs, such as paranoia and distrust of others, leading to possible uncooperating, may serve as an additional barrier to ongoing research and engagement with pharmacological and psychosocial treatments. These characteristics can lead to increased stigma around patients with Cluster A PDs as "more difficult," which could serve as a barrier to high quality care for this population. Low prevalence rates of Cluster A PDs (i.e., schizoid personality disorder) may also serve as a barrier to patient recruitment for future research studies, as is reflected by the low number of studies being conducted on pharmacological treatments for SPD and the scarcity of information related to the treatment, diagnostic considerations, and developmental trajectory in childhood.

Lastly, similarities between Schizophrenia and Cluster A PDs, result in research that is often shared from other psychosis or personality disorders. Furthering research of Cluster A PDs, while simultaneously comparing schizophrenia and Cluster A PDs is a way to find similar predictors across the disorders, maybe even among other similar groups and that way researchers would be able to draw conclusions as to whether they are more similar to each in the aspect of both development and clinically, as a whole.

## Conclusion

Continuing and strengthening research for Cluster A PD is paramount and can help with more accurate diagnosis, improvement of efficacious medications, and many other benefits for patients diagnosed with Cluster A PDs. This research can also contribute to diagnosis and treatment of other, similar, disorders. In addition, showing how real this disorder is and what exactly the risks one may experience with Cluster A, can prove to clinical experts, individuals in the mental health field, and many others that Cluster A is a disorder that is prevalent and must be researched. Prioritizing working with youth can help researchers understand what symptoms may appear earlier than others, how certain symptoms develop over time, and how individuals with an earlier onset respond compared to those with later onset, this is imperative in understanding how to develop more effective treatments to help youth, specifically, and help prevent worsening over time. One future line of research that supports this

could be prioritizing identifying unique predictors that may aid in a clearer differentiation of disorders. While a plethora of research exists for identifying risk factors for schizophrenia, such as early traumatic events, little is known about how Cluster A PDs may develop and what risk factors may increase the likelihood of developing a Cluster A PD. Potential study designs for such tests or studies may include populations below the age of adolescence, observing behaviors that may exhibit possible Cluster A PD symptoms. Additionally, once the individual reaches adolescence, noticing abnormal behavioral patterns that may have carried through, or a stronger resemblance to Cluster A. Professionals may begin by noticing behaviors in situations that may cause frustration or behaviors during social interactions, paying close attention to the individual's response. The professional may then evaluate and compare with other individuals in the study as well as other clinical presentations of the disorders. Comparing an individual from a younger age to adolescence will allow psychiatrists to evaluate if there may be a transition from the prodromal phase to full psychosis. Having this information is significant to understanding how the disorder may develop, allowing for the chance to prevent it from happening. An important consideration is that these studies should examine individuals with only Cluster A PDs, not patients diagnosed with a comorbidity of disorders, as that changes the results of the trials. It is also important to make sure the test groups are all the same or similar based on what is being tested, the information that is crucial includes outcomes, course of illnesses, exact diagnosis, or the duration they have been experiencing symptoms. Furthermore, there is a lot of variability in individuals who have psychotic experiences, so being able to specialize treatments towards specific types of presentations, or in other words, for individuals who share similar symptoms or experiences will allow for more specific and effective treatments, both pharmacological and psychosocial. An increase of effectiveness studies on treatments can help redirect the approach to creating medications or psychosocial treatments, acknowledging the gaps or accomplishments faced by previous researchers' and study outcomes will significantly change perspective of future interventions, especially working towards increased succession. Another key factor is understanding the feasibility and acceptability of treatments and being able to tailor both new and older treatments with the intention of making them more feasible and acceptable among populations. Noticing how people function in different environments and social settings is an effective way to help identify better treatment targets for each setting, and focusing on a specific symptom for each disorder. The treatments, more specifically, will target concerns related to the different Cluster A PDs. Working towards goals to improve future directions of treating and diagnosing Cluster A PDs is essential to further research and help reduce symptoms experienced by populations diagnosed with this disorder and bring awareness to it.

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