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Case Report

Psychiatry/Mental Health Section

Elusive Nature of Schizotypal Personality Disorder: A Case Report on Diagnostic and Treatment Challenges

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ABSTRACT

Schizotypal Personality Disorder (SPD) is characterised by pervasive social and interpersonal deficits, cognitive–perceptual distortions, and eccentric behaviour, and is frequently misdiagnosed due to symptom overlap with schizophrenia, anxiety, and obsessive-compulsive symptoms. It occupies a distinct position across diagnostic systems, being placed within schizophrenia spectrum disorders in the International Classification of Diseases, 11th Revision (ICD-11), while the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) classifies it under Cluster A personality disorders. This case describes a 25-year-old male who initially presented with social anxiety and ritualistic behaviours and was diagnosed with social anxiety disorder with obsessive-compulsive features. In subsequent visits, additional diagnoses of depression and psychosis were considered based on the evolving symptom profile. He responded poorly to treatment despite multiple trials of medications and inpatient care. On his fourth admission, a comprehensive evaluation with diagnostic psychometry was undertaken, incorporating birth and developmental history and thorough tracking of the longitudinal course of symptoms, which revealed an enduring pattern of eccentric behaviour, persistent odd beliefs, impaired interpersonal functioning, constricted affect, transient stress-related suspiciousness, and poor treatment adherence, leading to significant occupational and social impairment. The diagnosis was revised to SPD, and he was treated with psychotherapy and pharmacotherapy. The case highlights the importance of a Kraepelinian longitudinal approach to evaluation in psychiatry, which is often neglected in contemporary practice.

Keywords: Obsessive compulsive disorder, Psychosis, Psychotherapy

CASE REPORT

A 25-year-old male graduate presented with difficulty at work since five months. He had recently begun his first job and reported marked discomfort in social situations, interacting with colleagues, and paying attention in meetings. In detailed history, he described being uncomfortable facing people, even close relatives or friends with whom he was in regular contact. In situations where he was required to interact with strangers, he would visualise or rehearse the interaction and felt compelled to perform internal rituals, including a "mental handshake" and mentally narrating his past experiences before initiating conversation. He explained that this helped him feel prepared and organised before interacting. He categorised women he encountered into "good," "bad," or "flirtatious," which influenced how he interacted with them. He reported an urge to touch someone back if he was touched. He described this urge as a repetitive thought that was his own, recurring even when he attempted to distract himself. These repetitive intrusive thoughts caused significant distress. He tended to describe experiences in an elaborate and highly detailed manner. Emotional expression was constricted, with a limited range even during personally significant situations. He was initially diagnosed with social anxiety disorder with possible obsessive-compulsive features.

He remained regular with follow-ups but demonstrated poor adherence to medication. He independently stopped, restarted, increased, or reduced doses based on his own understanding of how medication should work. Despite appearing cooperative during sessions-often spending extended time discussing what he felt was "wrong" with him-he did not follow through with treatment recommendations.

Over the next one and a half years, he underwent multiple trials with medications introduced based on symptoms he presented with on each visit. When he reported anxiety symptoms, he was treated with escitalopram up to 15 mg for six months, both as monotherapy and in combination with risperidone 1 mg for four months when additional psychotic symptoms of referential delusions were reported. Due to poor response, fluoxetine was initiated and titrated up to 40 mg with little improvement. When he continued to report psychotic symptoms, olanzapine was introduced and titrated up to 10 mg along with fluoxetine for approximately three months. Additional short trials included amisulpride 100 mg, modafinil 100 mg, bupropion 150 mg, vortioxetine 15 mg, and mirtazapine 15 mg. Despite these pharmacological interventions, he showed minimal improvement.

On follow-up visits, he started reporting additional symptoms. He began describing a need to imitate film actors and adopt their mannerisms in daily life. Around this time, he resigned from his job and became fixated on the idea of working in the shipping industry. When he experienced occupational and interpersonal stress, he developed suspicious thoughts, including the belief that others were observing him in a sexualised manner or indicating homosexual interest toward him. These experiences were transient and intensified during stress rather than being sustained.

He began consuming alcohol and smoking, claiming that these were more effective than prescribed medications. He consumed alcohol 1-2 times/week (90-180 mL Indian-Made Foreign Liquor) without withdrawal symptoms or loss of control, suggesting harmful use rather than dependence. He also expressed a belief that deliberately entering and ending a romantic relationship would create emotional pain that would "resolve" his other worries. Within two months, he resigned from offshore employment and continued outpatient follow-up.

Approximately one and a half years after initial contact, he presented with his mother for inpatient admission, as he was unable to continue working. A more detailed developmental history obtained during admission revealed longstanding patterns. Since childhood, he had difficulty forming close relationships and was

described as socially withdrawn and "different" by peers. In school, he often attempted to regain friendships through socially awkward behaviours, such as dressing up as film characters and reenacting movie dialogues while assuming their personas. He also engaged in a relationship with a neighbour, spending prolonged periods alone with her despite parental prohibition, which led to social difficulties for the family.

Further history revealed that he had consulted multiple doctors across different hospitals and had collected medications from various clinicians without consistent adherence. Despite being professionally qualified, he began working in odd jobs such as delivery work and catering. He repeatedly expressed the belief that marriage would resolve his problems.

During inpatient care, psychological assessments were conducted. Rorschach findings indicated impaired perceptual integration, with a low number of popular responses, suggesting limited engagement with shared reality [1]. The protocol showed a predominance of form-based responses, reflecting an overreliance on intellectualised processing with reduced affective involvement. There was limited evidence of integrative or affectively elaborated responses, indicating difficulty in synthesising internal experiences with external reality. Overall, the profile was suggestive of a poorly integrated personality organisation, with disturbances in self-experience and interpersonal relatedness, consistent with schizotypal traits. On the multiphasic personality questionnaire, elevated scores were observed on the schizophrenia-8 (cut-off score of 7) and anxiety-11 (cut-off score of 11) scales [2]. On the Schizotypal Personality Questionnaire (SPQ), he scored 41, indicating a borderline score [3].

Based on these findings, psychoeducation was provided and pharmacotherapy was optimised. Patient was discharged after 12 days of inpatient care. He was irregular for follow-ups and consulted other hospitals in the intervening period before restarting treatment in this institution. He continued multiple odd jobs like catering, events work, delivery work for short duration. Following psychoeducation, diagnostic clarification and treatment modification, the patient demonstrated partial insight into the enduring nature of his symptoms, reduced stress-related suspiciousness and a reduction in obsessive thoughts. At present, he is maintained on sodium valproate 600 mg/day, risperidone 1 mg/day, and fluoxetine 20 mg/day, but continues to take medication irregularly.

DISCUSSION

The SPD occupies a unique nosological position, classified within schizophrenia spectrum disorders in World Health Organisation ICD-11, while American Psychiatric Association DSM-5 retains it under Cluster A personality disorders [4]. SPD is considered part of the schizophrenia spectrum and shares genetic, neurobiological, and phenomenological overlap with schizophrenia, although psychotic symptoms in SPD are typically transient, stress-related, and not sustained [5].

This case illustrates how SPD may initially present with symptoms resembling psychosis, depression, anxiety or obsessive-compulsive disorder, leading to diagnostic uncertainty in early stages. Similar cases in the literature describe prolonged diagnostic ambiguity, where patients are initially labelled with schizophrenia-spectrum or mood disorders before a later revision to SPD following longitudinal assessment [6,7]. SPD is characterised by pervasive social and interpersonal deficits, cognitive-perceptual distortions, and eccentric behaviour beginning by early adulthood and present across contexts [4]. In this patient, early features such as persistent social anxiety, ritualistic internal behaviours, and interpersonal discomfort initially suggested anxiety-spectrum pathology. However, longitudinal observation revealed a broader pattern consistent with schizotypal personality organisation. Such evolution from symptom-based diagnoses to a personality-based formulation has been repeatedly emphasised as a key challenge in SPD recognition [6].

A defining feature in this case was social anxiety that did not diminish with familiarity. In SPD, social anxiety is often linked to paranoid fears and interpersonal mistrust rather than fear of embarrassment alone [8]. His "mental handshake" rituals and preparatory internal narration differed phenomenologically from typical obsessions, as they were not intrusive or ego-dystonic but were experienced as necessary for interpersonal functioning. Similarly, his rigid categorisation of women, belief that heartbreak would resolve his distress and conviction that marriage would eliminate his difficulties reflected odd beliefs and magical thinking rather than classic obsessive doubt.

Over time, additional schizotypal features emerged, including eccentric behaviour (adopting film personas) and transient, stress-related suspiciousness. Brief paranoid ideation under stress, without sustained psychosis or progressive deterioration, is consistent with the schizophrenia spectrum conceptualisation of SPD [5]. SPD shares genetic and neurobiological overlap with schizophrenia but typically manifests with attenuated, transient psychotic experiences rather than persistent delusions or hallucinations [5]. Comparable reports have noted that such transient suspiciousness and fixed idiosyncratic beliefs are often misinterpreted as primary psychotic disorders, particularly in the absence of longitudinal evaluation [6,7].

The discrepancy between his apparent engagement in sessions and persistent non-adherence to medication further highlighted enduring personality structure rather than episodic illness. Individuals with SPD may demonstrate intellectual insight yet struggle with sustained behavioural change, particularly when idiosyncratic beliefs influence treatment decisions [9].

Developmental history provided additional support for diagnosis. Early social withdrawal, eccentricity, and difficulty forming close relationships are common antecedents of SPD [10]. Reports of younger patients similarly describe early onset of magical thinking, interpersonal detachment, and odd beliefs preceding functional decline, reinforcing the developmental trajectory of the disorder [11]. These early socially inappropriate behaviours may reflect impaired processing of social cues and abnormal assignment of significance to interpersonal experiences, potentially arising from abnormalities in salience attribution and learning processes described in individuals with schizotypal traits [12]. Epidemiological studies estimate a lifetime prevalence of approximately <1%-4% in the general population, with higher rates in clinical settings [13,14]. Misdiagnosis is common, particularly when early presentations emphasise anxiety or obsessive symptoms without full assessment of cognitive-perceptual distortions and interpersonal patterns [10,15]. The heterogeneity of presentation, with overlapping affective, behavioural, and attenuated psychotic features, further contributes to low detection rates in routine clinical practice [11].

Psychological assessment findings in this case, including impaired perceptual integration and elevated schizotypal traits, are consistent with research demonstrating cognitive-perceptual abnormalities and personality pathology in SPD [16].

This case underscores the importance of longitudinal assessment in differentiating SPD from primary anxiety or obsessive–compulsive disorders. Psychodynamic understanding was incorporated to better contextualise the patient's experience and guide management. As described by Akhtar, such personalities may appear outwardly intact yet remain structurally fragile, with stress revealing underlying vulnerabilities. This is reflected in disturbances in self-experience and interpersonal relatedness, and can be further understood through dimensional models of schizotypy spanning cognitive–perceptual, interpersonal, and disorganised domains. When anxiety symptoms coexist with enduring eccentric beliefs, interpersonal detachment, and stress-related suspiciousness, an underlying schizotypal organisation should be considered rather than discrete psychotic, depressive, anxiety or obsessive pathology [17].

CONCLUSION(S)

The SPD is often under-recognised in routine clinical practice and relatively under-discussed in academic settings and case-based formulations. This case highlights the challenges in its identification, particularly in cross-sectional assessments where symptoms may resemble depression, anxiety, or obsessive-compulsive phenomena. Longitudinal evaluation revealed a persistent pattern of interpersonal deficits, odd beliefs, eccentric behaviour, and stress-related suspiciousness that was not adequately explained by primary anxiety or mood disorders.

It underscores the importance of systematic follow-up and detailed developmental history in such presentations, especially when treatment response is inconsistent and functional impairment persists despite multiple pharmacological trials. It is therefore important for both students and clinicians to recognise its varied presentations, as it can masquerade as more common conditions and remain hidden in plain sight. Early recognition of schizotypal features can facilitate more coherent and structured management.

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