IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 24, Issue 8 Ser. 1 (August. 2025), PP 28-29
www.iosrjournals.org

Schizotypal Disorder In A Young Adult: A Case Report And Comprehensive Management Approach

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Abstract:
Background of the study:
Schizotypal disorder is characterized by pervasive social and interpersonal deficits, as well as cognitive and perceptual distortions and eccentric behaviors, but the degree of impairments are lower than that seen in patients with Schizophrenia.[1,2] Schizotypal disorder is associated with a high level of disability at an individual level and high societal costs[3]. However, clinical recommendations for the treatment of schizotypal disorder are scarce and based on limited evidence.[4] The case report illustrates the presentation, diagnosis and management of schizotypal disorder in a young male patient with a combination of pharmacotherapy and psychotherapy.
Aim and objectives: *Diagnosis of a schizotypal disorder and its management*
Methods:
A case report was made utilizing the patient's history, and clinical assessment. Diagnosis was established in accordance with ICD 11[5] as well as ICD10[6]. A tailored management strategy was devised to address schizotypal disorder.
Case Description:
A 20-year-old unmarried male presented to the outpatient department with a six-year history of persistent psychological distress, including heightened anger, verbal and physical aggression, intense feelings of guilt, frequent self-harm behaviors, suicidal ideations, disorganized speech, and significant sleep disturbances. Notably, these symptoms had markedly worsened in the preceding year, leading to substantial impairment in his occupational functioning and social interactions.
The onset of symptoms traced back to the 8th grade, when the patient voluntarily isolated himself from his peer group to focus on academics and future high-paying job opportunities. He developed the belief that his friends harbored resentment towards him due to his withdrawal. In his solitary moments, he engaged in elaborate fantasies, imagining scenarios such as himself as a king with omnipotent control over the universe. He also developed some beliefs that others disliked him because of his darker skin tone and shorter stature. These preoccupations fostered frequent interpersonal conflicts, and while in 11th grade, he reacted explosively towards a hostel warden—resulting in both verbal and physical altercations—after perceiving inadequate intervention in cases of bullying and other improper management at the hostel.
The patient frequently punished himself in response to guilt, employing methods such as cutting, burning himself, or forcefully hitting walls. His speech often became disorganized, with tangential or irrelevant references to esoteric topics like the theories of aging and quantum physics. Episodes of sleep disturbance were also reported during these periods of exacerbated symptoms.
No significant history of familial psychiatric illness or substance abuse was obtained. Developmental history revealed an eccentric temperament and odd beliefs since childhood. During the mental status examination, he exhibited a sad affect, with prominent overvalued ideas, magical thinking, pervasive suicidal ideation, obsessive ruminations, and ideas of reference—wherein he misinterpreted neutral events as having particular personal significance.
Results:
The patient exhibited eccentric behavior and unusual thinking and affect that resembled schizophrenia, although they have not shown any clear or characteristic symptoms of schizophrenia at any point[7].
Dr. Reddy's previous study noted that cognitive-perceptual distortions and affective symptoms in Emotionally Unstable Personality Disorder (EUPD) seem to overlap with the disorganized and cognitive-perceptual symptoms of schizotypal disorder. This finding is similar to the situation in this case.[8] This case report illustrates the typical presentation and management of schizotypal disorder
Patients with schizotypal disorder may vary greatly in constellation of symptom as both attenuated psychotic symptoms, self-disorders and comorbid symptoms from other mental disorders. This complexity may lead to a low detection rate, schizotypal disorder being misdiagnosed and leading to complications in treatment planning.[9]

The management plan consisting of combination of pharmacotherapy (antipsychotic-Tab risperidone hydrochloride) and psychotherapy as done in Kirchner SK, Roeh A, Nolden J, et al. study.[10]

Conclusion:

This case report highlights that there is a need for defining and treating schizotypal disorder as a separate diagnosis.

Schizotypal disorder is rarely seen as the primary reason for treatment in a clinical setting and can be misdiagnosed.

A combination of pharmacotherapy (antipsychotic) and psychotherapy are crucial for alleviating symptoms and enhanced quality of life

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Date of Submission: 25-07-2025 Date of Acceptance: 05-08-2025

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