Case Report ISSN 2689-1069

Clinical Reviews & Cases

Case: Schizotypal Personality Disorder→ Confusion, Misdiagnosis & Lessons

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Received: 25 Feb 2023; **Accepted:** 27 Mar 2023; **Published:** 01 Apr 2023

Citation: Gunadeva N, Murchison J, Wozniak N, et al. Case: Schizotypal Personality Disorder→ Confusion, Misdiagnosis & Lessons. Clin Rev Cases. 2023; 5(1): 1-4.

Background

The following is a case of Mr D, a case of a 44 year old male with an eventual diagnosis of Schizotypal Personality Disorder (SPD). We explicate the recent experiences of the authors with this complex case. We first encountered Mr D at our Adult Outpatient Clinic in July 2022. Patient had been followed in this clinic since 2014. During a visit in 2014 patient was state mandated for evaluation (Georgia 1013) to a regional psychiatric hospital for psychosis and paranoia. He was involuntarily hospitalized for 8 days due to displaying the following: decreased need for sleep, paranoia, responding to internal stimuli, and delusional thinking. By the time of discharge Mr D had psychiatrically stabilized and discharged on Haldol 5mg po bid, Haldol dec 50mg IM q4weeks and Benadryl 50mg po bid for extra-pyramidal symptoms.

At the follow-up appointment, he was more organized, sleeping better and compensated. He denied paranoia. He endorsed vague visual hallucinations, however. Due to reported daytime sedation from Haldol, and nosebleeds with Benadryl he was switched to Latuda and Cogentin. He has been maintained on this regimen.

Throughout his time in our outpatient clinic, he held a fixed belief that his mother would not allow him to go to a specific university and would sabotage and even shoot him if he tried to go. Despite going to a university closer to home from which he graduated, he has continued to perseverate on how his mother held him back by not letting him go to the university of his choice when he was 18 years-old. When Mr D did express these concerns during his appointments, his mother would encourage him to pursue a degree at his preferred university. Multiple providers have also offered this as an option the patient could pursue.

From 2014 to present, the patient has been socially isolated. He lives at home with mother and has no close contacts outside of her. He has been unable to maintain employment for a significant period of time. His mother has expressed concern about social anxiety, but the patient denies having such anxiety. He instead reports that he finds it "bizarre (when people) follow me closely or talk too loudly." He does not express interest in wanting to socialize with others, and denied depression or anxiety regarding his isolation. His mother reports that he has always been like this, even as a child. She reports that medications have never changed this.

The patient is a native of Savannah GA. He is an only child. He has been "coddled" and has been reviewed as "strange" by family. He has lived in Savanna and was raised by his mother, godfather, and grandmother. Reports are that he was not developmentally delayed but spoke later and had a pattern of being alone. He did average to well in school and relates that he stayed more to himself, but did engage. He also went to preschool. His mother, it appears, was the manager in later life. He relates that he and she quarreled during his formative years and well beyond. She would protect him and make suggestions to him that he would resent. He graduated from high school, went to a local university and, after a period of time, went to Savannah State, a historically Black college. The patient is Afro-American. He had few jobs: None lasted beyond a few weeks. He has lived with his mother after his godfather and grandmother both died about 15 years ago. His mother worked for the local county for 40 years. He never married, spends his days in his room. Again, he lives with his mother.

Mr D's diagnosis has changed throughout his time at our Outpatient Clinic. He was first diagnosed with schizoaffective disorder and at other times schizophrenia. His social isolation was thought to be one of the negative symptoms of schizoaffective disorder. Patient's extreme interest in this specific university, his wary focus on his mother, and his restrictive and fixated interests suggest avoidance and cognitive distortions in his actions. The patient also struggles to maintain social interactions, and has inappropriate responses, such as laughing to interviewer's questions rather than giving appropriate answers. It is noteworthy that it was only in the most recent months was he diagnosed as SPD. Importantly too, he did

not meet criteria for Autism Spectrum Disorder [1,2].

Mental Status Examination

General appearance: The patient is a well-groomed male with a bald head. Patient has no facial hair.
Behavior: Patient is calm and cooperative. He maintains intense eye contact.
Motor: The patient has no evidence of psychomotor agitation or retardation
Gait & station: normal without signs of unsteady gait
Speech: normal rate, rhythm
Mood: Euthymic; patient reports mood as "fine."
Affect: The patient has blunted affect
Thought process: The patient is mostly logical and coherent, but at times becomes tangential, bringing the conversation back to the University his mother would not let him attend and perseverates on how it is her fault.
Thought content: The patient displays persecutory delusions, regarding his mother. He endorses that she is trying to work against him and would physically attack him if he tried to go to this specific University. He denies suicidal thoughts, violent thoughts, or homicidal thoughts.
Perceptions: no abnormalities. Denies auditory verbal hallucinations; no signs of responding to unseen others; no overt delusions elicited during interview.
Attention & concentration: Patient is alert and attentive.
Orientation: oriented to person, place, time. Patient does not believe he needs psychiatric medication so officially he is not oriented to situation.
Language: normal for age and education level
Fund of Knowledge: average
Recent & Remote Memory: intact
Insight/Judgement: The patient's insight is poor to fair as he believes that he does not require medication. He does, however, continue to take his medication as prescribed, demonstrating fair judgement.

Psychological testing was performed and given below.

Psychological Testing

TESTS
ADL and IADL Questionnaire)
Montreal Cognitive Assessment (MoCA)
RBANS
WAIS-IV (selected scales)
WRAT-IV Reading
DES (Dissociative Emotions Scale)
Trails A and B
MINI (MINI International Neurospsychiatric Interview)
PHQ-9
GAD-7
Epworth Sleep Scale (ESS)
Millon Clinical Multiaxial Inventory-III

Current Cognitive Functioning: He carries the diagnosis of schizophrenia or schizoaffective disorder and has been sheltered most all his life. He lives with his mother. He had psychotropic medication in the past and currently. His ADL and IADL profile shows deficits in IADL tasks largely by disuse (cooking and finances). He has a college education and talks well.

Sensory and Effort: This man had no evident problems with hearing. He processes information slowly but, given time, can do well. He was not in pain at the present. He was not easily distracted.

Overall Intelligence: He shows normal intelligence. WAIS-IV Vocabulary (scale score 10) and Block Design (scale score 9) were average. MoCA was also normal (27/30). His WRAT-IV Reading is also average (2 errors only). His overall RBANS showed that he is slightly below normal (86, 18%). He is having problems in attention and figural memory.

Attention: The patient scored in the below average range on index of attention. RBANS Attention Index includes a task of interrelated speeded written test requiring him to match numbers to symbols. This score indicates that he has considerable difficulty with simple attention tasks. He was able to do 5 digits forward on the RBANS. H could do only 3 digits backward. He was excellent, however, on the Trails A.

Visuospatial Constructional Skills: He scored 100 on the RBANS Index. This man had no difficulty with basic line orientation. He had no problems with complex designs from command. He did well on a complex three dimensional task, Block Design. He was also able to draw a clock from command. He did average on Coding. In sum, this is an area where he appears to be responding at a level that is average.

Language: On the RBANS he scored 88 (Index score) on Language. He had no problems with Picture Naming. He has a Vocabulary score at average and Similarities was average. This is then also an area where there are both strengths and some minor problems.

Memory: He scored in the average range on the RBANS Immediate Memory showing a good learning curve (95). He had problems on the first trial of his tasks. He had no problems with Remote Personal Memory (10/10).

On Delayed Memory he had problems (RBANS Index score = 80). He was able to recall 5/10 words, 11/12 story recall bits, and 0/20 figural recall data points. He did score average on the recognition task (20/20). He was average on the MoCA (5/5). His Figural Memory is a problem, as he misrepresented the figure totally with a drawing of an island. Perhaps this misperception was a hallucination. This scale was repeated 3 weeks later, however, and he scored normally as he was clear about his memory task. It was not rescored from the original.

Executive Function: Executive functions (EF) are higher level cognitive skills that enable him to plan and initiate activity and self-monitor behavior as well as to organize, synthesize,

conceptualize and manipulate information. His performance was generally below average. He could finish Trials B but was slow. He scored adequately on Clock Drawing. On "softer" EF test, he had mild problems; semantic and phonemic fluency. There were minor deficits on the IADL scale (due to underuse), a measure of executive functions. His ADLs are good. In sum, this is an area where he has some skills but is limited.

Emotional Assessment: Emotional self-report scales were evaluated. He was administered the MINI showing no problems with depression or anxiety. He was also normal on current psychosis symptoms. On the PHQ-9, he scored 0, not depressed. On the GAD-7 he was scored as normal [2]. His DES showed no dissociation. He seems to be able to read his emotions accurately but is avoidant.

Pain: His average pain is 0/10.

Sleep: Patient indicates that he has problems sleeping. He has some disrupted sleep and his ESS showed that he is prone to sleep in the day. He does nap but is very inactive. He does not have sleep apnea. He does not exercise to any degree.

Interpersonal Issues: Patient's mother was also interviewed. She has concerns about him being immature, suspicious and unable to be on his own. She reminds him of this frequently. This results in anxiety and irritation in him. He then feels that he is not supported but realizes his need to be supported. This is a powerful contribution to his problems. This dynamic plays out frequently between the two resulting in him being suspicious and isolating.

Personaliy: While there is complexity here, he meets the criteria for a schizotypal personality disorder (MCMI-III and interview). He has interpersonal deficits, with a reduced capacity for close relationships, with cognitive distortions, and eccentricities of behavior. He has odd beliefs, some magical thinking, some ideas of reference, suspiciousness, a lack of close friends, and some minor ideas of reference. Interestingly, he sees himself as not flawed and even as special. Others do not understand him. In some ways, these latter beliefs are a strength, as it seems to motivate him to stay abreast of world events. The MCMI-III was in the clinical area (SPD) and noteworthy eccentric behavior, interpersonal peripheral roles, cognitively autistic patterns (ideas of reference, ruminative, self-absorbed thinking, odd beliefs and obscure suspicions), estranged self-image, chaotic other representations, fragmented organization and distraught and insentient mood.

It is safe to say too that his mother makes a strong contribution to his suspiciousness and irritability. To some degree, he has been protecting himself, isolating, and embellishing his life around fixed ideas regarding his mother. He does not meet current criteria for schizophrenia or a schizoaffective disorder.

For completeness, he shows many features of PDD, NOS, but is absent core features. (This cannot exist along with the schizotypal personality [3].

Summary

This is a 44 y/o male referred for an evaluation for diagnostic status. He has led a sheltered life and has been coddled. He lives with his mother and does little that is productive. He is not clinically depressed or anxious and seems to have little in the way of conflict. He is intrinsically bland and seems to enjoy his status. His cognitive status is largely average and is sufficient for his pursuits. He has deficits in attention and some memory areas, especially figural memory, as well as executive functioning. These deficits are a minor problem but have an influence on him performing independently on his own. It could also be apt that he is functioning as one with a Schizotypal Personality Disorder where he is passively avoidant and seeks refuge in his life largely with mild symptoms, mostly paranoid ideation in the service of avoidance and emotional blunting.

Emotionally he scores on the MINI as uneventful. He experiences his level of social support as being lower than others. He has no close relationships except his mother with whom he has a love/hate interaction. Importantly he reports little stress arising from other areas of his life. His omnibus scales report a largely adequate adjustment. He sees himself as needing to protect his life pattern. He is defensive and fixed in his ideas as well as mildly distortive.

He may benefit from therapy. This would be more of a holding action. At times, this would involve his mother. Now he desires therapy. He is not angry at his life and actually seeks a way to cope. He can be addressed carefully but will need focused goals as well as validation of his life. He needs to feel safe and listened to. He has problems day-to-day in his activities of daily living and he does not fully appreciate this. His EF skills are lower but he can function with support. Attention and EF deficits are minimal.

In sum, he is a perplexing person who has sufficient skills for minimal tasks in life. His personality is best construed as schizotypal. Barriers are his suspiciousness and his fixed ideas and himself and his mother. Short-term goals will need to highlight his strengths, have him attend sessions on his own, target behaviors that he feels successful in and have him deal with his mother better. She will also be involved periodically

SPD Therapeutic Techniques Attempted and Desired

The authors on this paper have all attempted psychotherapy with Mr D and failed. As the DSM-5 notes key features of PDs are lack of agency, goal-directedness, autonomy, low capacity for intimacy, and negative or unstable self-esteem. The capacity for pleasure is also low. As a rule, it is necessary for the therapist to repeat the same problem and tackle the same deficits until new aspects of the cognitive-affective personality system become functional. New behaviors become fluid only with many attempts. Over-controlled PDs, especially the SPD, also involve a rigid inhibition, interpersonal problems (distant/aloof/cautious), often paranoid and clearly an avoidant stance, as well as a strong desire to control one's environment, restrain emotions, limit social interactions, and show cognitive and behavioral rigidity. PDs are a problem unto themselves.

The problem with the SPD is structural: a poorly differentiated self-identity, a concrete quality about feelings and wants, neglected integration (little recall of experiences across time), little capacity for genuine intimacy, and an impaired prosocial behavior outlook. The socially avoidant pattern of the SPD is defined by low affiliation, restricted emotional expression, avoidant attachment, excessive self-containment, inhibited sexuality and an unfulfilled attachment need. The SPD is over-controlled with emotional constriction, poor self-reflection, decreased ability to understand mental states, and little effortful control. The pathology (of the SPD) suggests against the easy path of psychoeducation about the adaptive value of emotions, emotional recognition and tolerance in the context of a supportive relationship. The effort to increase emotion tolerance is seen as less relevant.

Treatment should always be selected on the basis of what works. As just noted, treatment for any PD has an altered focus: It targets the **general features** of chronic interpersonal problems and self-identify problems, as well as **specific features** for each PD. Self-pathology is core as it is both cognitive (differentiation and integration of knowledge of self) and motivational (sense of autonomy and agency). After a focus on the general PD features, then severity is addressed as this best predicts problems. Over time there are phases of change from safety, to containment, regulation and modulation, exploration, and integration and synthesis [4].

The establishment of modest engagement and rapport should promote an opportunity for social engineering and rehabilitation management strategy. It did not. Mr D does not have a great need for people or even to become more comfortable with this fact. The goal is to establish a lifestyle that is compatible with these facts. He does not want to be sociable. He seeks help because others believe this is helpful or required. Acceptance of his personality traits and finding a niche that supports this is all that is necessary for him. More appropriate for Mr D are the goals of acceptance that he does not have to alter his life style and can feel accepted at his level.

Multiple therapeutic techniques have been tried with this patient, such as cognitive behavioral therapy and Interpersonal process therapy. Family therapy was attempted to set rules and clarify roles. This too produced little success. Among the many frustrating problems Mr D continues to perseverate on is being unable to attend the university of his choice when he was 18 years-old. Neuroregulatory models suggest that sensory-perceptual regulation must be assessed as safe, response tendencies must be activated by friendly top-down interventions, and self-control tendencies must be relaxed. How this is done is both long in the making and needs to be carefully activated. In a sense this fixed idea needs to be accepted as is; other aspects of his life may be softly challenged in time. This was not done well with Mr D.

The specific treatment of the SPD is of course more tailored. It is for the therapist to decode confusing communication, accept slow progress, and be attentive to boundary issues. Goals need to be simple and agreed to, as well as monitored. The quixotic notion of big changes needs to be put aside in favor of therapy-compliant behavior (attendance and simple goals), as well as simple features, like behavioral activation. Agreement and buy-in are critical. Bigger goals like living on his own or a job are less realistic. As a general rule the SPD treatment should start not from a narrowly focused, disorder-specific manual but from a deconstruction of the patient's psychopathology into domains of dysfunction. This is being done and some success is already in view.

References

1. https://www.sciencedirect.com/science/article/abs/pii/S0165178112000467
2. https://pubmed.ncbi.nlm.nih.gov/25956249/
3. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition. Arlington, VA, American Psychiatric Association. 2013.
4. Livesley J, Dimaggio G, Clarkin, J. Integrated Treatment for Personality Disorder, A Modular Approach, New York, NY, Gildford Press. 2016.