Schizophrenia with Co-morbid Obsessive-Compulsive Disorder: A Case Series

Prakash B. Behere1*, Pooja Raikar2, Debolina Chowdhury2, Aniruddh P. Behere3 and Richa Yadav4

1Department of Psychiatry Jawaharlal Nehru Medical College, Director School of Advanced Studies, Datta Meghe Institute of Medical Sciences, Sawangi Wardha-442107, Maharashtra, India.
2Department of Psychiatry, Jawaharlal Nehru Medical College, Datta Meghe Institute of Medical Sciences Wardha –442107, Maharashtra, India.
3Department of Pediatrics and Human Development, Michigan State University College of Human Medicine Grand Rapids MI USA, Adjunct Faculty DMIMS, Wardha-442107, India.
4Department of Psychiatry and Behavioural Sciences, OU College of Medicine ,Oklahoma City, Oklahoma, USA Adjunct Faculty ,DMIMS , Wardha, India.

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This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

ABSTRACT

The frequency of co-morbidities like Obsessive Compulsive Disorder (OCD) is common in schizophrenia. Some studies have reported earlier age of onset, more positive and negative symptoms, more depressive symptoms, and worse prognosis in such patients. The phenomenology and management of OCD in schizophrenia is understudied. Evidence claims that the course of illness of both schizophrenia and bipolar disorders may be affected by obsessive-compulsive disorder whereas in other cases antipsychotic induced obsessive-compulsive symptoms have been observed. A meta-analysis of schizophrenia and its co-morbid psychiatric conditions, found a prevalence of 12.1% for obsessive compulsive disorder, 9.8% for panic disorders, 12.4% for post-traumatic stress disorder and 14.9% for social phobia. SGAs like...
amisulpride and aripiprazole are found to be useful in the treatment of comorbid OCD in schizophrenia due to their negligible serotonergic properties. A combination of selective serotonin reuptake inhibitors (SSRI) with antipsychotics has been recommended by the American Psychiatric Association (APA) for treatment of comorbid OCD in schizophrenia. Escitalopram at a dose of 20 mg/day has been found to be beneficial in such cases while psychosis worsened with the use of fluvoxamine and clomipramine. Below is a series of seven cases of schizophrenia with co-morbid obsessive-compulsive symptoms who are on treatment for their illness from the psychiatric outpatient department of a rural hospital in central India.

Keywords: Schizophrenia; obsessive compulsive disorder; phenomenology.

1. INTRODUCTION

Various psychiatric co-morbidities in patients of schizophrenia have been frequently reported of which obsessive compulsive disorder has been commonly observed. Evidence claims that the course of illness of both schizophrenia and bipolar disorders may be affected by obsessive-compulsive disorder where as in other cases antipsychotic induced obsessive compulsive symptoms have been observed [1]. Early clinicians like Westphal considered OCD to be a prodrome to the psychotic illness [2,3], while Bleuler included the obsessions and compulsions as symptoms of the psychotic illness [3,4]. Consequently, the term “schizo-obssessive disorder” was proposed to address this common phenomenon [1,5].

A meta-analysis of 52 studies of schizophrenia and its co-morbid psychiatric conditions, found a prevalence of 12.1% for obsessive compulsive disorder, 9.8% for panic disorders, 12.4% for post-traumatic stress disorder and 14.9% for social phobia [6]. Such co-morbidities complicate the management of schizophrenia which alone is challenging [1]. Obsessive Compulsive Disorder (OCD) as a co-morbid condition and its phenomenology in schizophrenia has been understudied.

We present below seven cases of schizophrenia with comorbid obsessive-compulsive disorder or symptoms who are regular patients to our Psychiatric outpatient department in rural central India.

2. CASE PRESENTATION

Case 1:

A 40 years old married male, with 10 years of formal schooling, belonging to lower socio-economic strata from a rural background with a premorbid well-adjusted personality and family history of suicide in younger sister was brought to the psychiatry OPD with a total duration of 20 years of illness which was continuous in course with chief complaints of suspiciousness that other people are talking about him and will harm him, suspiciousness towards wife that she is unfaithful towards him which led to aggressive behaviour towards them, hearing of multiple male and female voices talking ill about the patient to which he used to respond which made his appear as if to be talking to himself since 20 years. About 18 months ago he reported repetitive thoughts of sexual content, repetitive thoughts about dirt, blasphemous thoughts leading to compulsive behaviour which included repeatedly chanting God’s name, mental rituals like counting, and repetitive checking behaviour. His general physical examination and systemic examination were unremarkable. Mental status examination revealed decreased tone and volume of speech, increased reaction time, delusions of reference, persecution and infidelity, Obsessions of Contamination, sexual content, blasphemy and compulsions like checking and mental rituals, restricted affect, third person auditory hallucinations, intact higher mental functions with an insight of 1/5. On Yale-Brown Obsessive Compulsive Scale (YBOCS) - patient obtained a moderate severity score of 22. He showed significant improvement on olanzapine (max-20 mg/day) and escitalopram (max-10 mg/day).

Case 2:

A 50 years old married female, with 9 years of formal schooling, homemaker, belonging to lower socio-economic strata from a rural background with a premorbid well-adjusted personality and probable family history of dementia with behavioural disturbances in elder brother was brought to the psychiatry OPD with a total duration of 6-7 years of illness which was continuous in course with chief complaints of repetitive thoughts regarding household work,
that a stray dog may come into her house, repetitive thoughts about dirt and contamination, arranging things in symmetry, compulsive behaviour like repeatedly reciting all the work that has to be done, hand washing, increased time spent on washing utensils and clothes, repetitive checking, which leads to incomplete work. Patient also has ritualistic behaviour - she would say she has not made any mistake and everything is fine then would get up from bed and shake her arms in air and pace around the house 3-4 times reportedly to ward off danger. She is suspicious that someone may steal her clothes or someone may harm her and her family members. Her general physical examination and systemic examination were unremarkable. Mental status examination revealed decreased tone and volume of speech, increased reaction time, reciting work to be done, delusions of persecution and theft, obsessions of contamination, symmetry and compulsions like washing, checking and mental rituals, magical thinking, restricted affect, ill-sustained attention, with an insight of 1/5. She was started on fluoxetine (Max - 80mg/day), clomipramine (max-50mg/day), olanzapine (max-20mg/day), trifluperazine (max-15 mg/day).

**Case 3:**

A 25 years old married male, with 10 years of formal schooling, manual labourer, belonging to lower socio-economic strata from a rural background with a premorbid well-adjusted personality and family history of schizophrenia in paternal aunt, was brought to the psychiatry OPD with a total duration of 5 years of illness which was continuous in course with chief complaints of suspiciousness that someone has done black magic on him to make him ill, suspiciousness that people are talking about him, muttering to self, laughing to self, anger and irritability towards family members, repeatedly touching things like wall, table, items on the table, switches, in a particular order, excessive time spent in washing clothes, excessive soap and water usage for bathing, repeated burping, decreased interaction with family members and socio-occupational decline. His general physical examination and systemic examination were unremarkable. Mental status examination revealed decreased tone and volume of speech, increased reaction time, delusions of persecution and reference, obsessions of contamination, obsessional slowness and compulsions like washing, and ritualistic behaviour, irritable affect, intact higher mental functions, with an insight of 1/5. He was treated with olanzapine (max-20mg/day), trifluperazine (max- 10mg/day), fluoxetine (max- 60 mg/day).

**Case 4:**

A 17 years old single male patient, with 10 years of formal schooling, student, belonging to middle socio-economic strata from an urban background with a premorbid well-adjusted personality and family history of psychiatric illness in paternal grandfather and paternal cousin brother, history of seizure disorder in paternal cousin brother, past history of seizure disorder on treatment with sodium valproate (max- 1g/day), lamotrigine (max-200mg/day), was brought to the psychiatry OPD with a total duration of 6 years of illness which was continuous in course with chief complaints of suspiciousness that his teachers and classmates are plotting against him, suspiciousness that something is mixed in his food to harm him, talking to self, laughing to self, irritability towards others since 6 years. He developed decreased sleep, decreased appetite, repetitive splitting behaviour and repetitive hand washing and increased time spent while bathing for 3 months. His general physical examination and systemic examination were unremarkable. Mental status examination revealed decreased tone and volume of speech, increased reaction time, delusions of persecution and reference, obsessions of contamination, obsessional slowness and compulsions like washing, and ritualistic behaviour, blunt affect, impaired abstraction, impaired judgment and Insight of 1/5. He was treated with olanzapine (max-15 mg/day) and amisulpride (max-100 mg/day).

**Case 5:**

A 17 years old single male patient, with 12 years of formal schooling, student, belonging to middle socio-economic strata from an urban background with a premorbid well-adjusted personality and family history of psychotic illness in father and paternal uncle, history of suicide in paternal grandfather, was brought to the psychiatry OPD with a total duration of 7 years of illness which was continuous in course and gradually progressive with chief complaints of repetitive checking behaviour like door locks and gas since 7 years. For 2 years, repetitive thoughts about metaphysical concepts weighing pros and cons, repetitive thoughts of sexual content, repetitive images with nude content, repetitive thoughts of jumping from height or poking someone with sharp objects which causes fearfulness and guilt. In the past 6 months has reported sadness of mood and decreased interaction with others,
Case 6:

A 16 years old single male patient, with 10 years of formal schooling, student, belonging to low socio-economic strata from an rural background with a premorbid well-adjusted personality and family history of obsessive compulsive disorder in mother, was brought to the psychiatry OPD with a total duration of 7 years of illness which was continuous in course and gradually progressive with chief complaints of suspiciousness towards his friends and teachers that they are plotting against him and making fun of him, irritability and aggressiveness, hitting behaviour towards family members which he describes as a ‘force from within which is uncontrollable and causes restlessness’, repeatedly checking his phone to look for online trolls against him and repeatedly calling his friends to ask them about past incidents, increased time spent on improving handwriting, decreased interest in studies, sadness of mood and decreased interaction with others. His general physical examination and systemic examination were unremarkable. Mental status examination revealed delusions of reference and persecution, obsessive thoughts, symmetry and checking and aggressive compulsions, depressed affect, intact higher mental functions with an insight of 1/5. On Yale-Brown Obsessive Compulsive Scale (YBOCS) - patient obtained a moderate severity score of 19. He was treated with olanzapine (max -7.5 mg/day), fluoxetine (max- 60mg/day), and clomipramine (max-50 mg/day).

Case 7:

A 21 years old single male patient, with 12 years of formal schooling, student, belonging to middle socio-economic strata from an urban background with a premorbid well-adjusted personality and family history of obsessive compulsive disorder in mother, was brought to the psychiatry OPD with a total duration of 6 years of illness which was continuous in course and gradually progressive with chief complaints of suspiciousness towards his friends and teachers that they are plotting against him and making fun of him, irritability and aggressiveness, hitting behaviour towards family members which he describes as a ‘force from within which is uncontrollable and causes restlessness’, repeatedly checking his phone to look for online trolls against him and repeatedly calling his friends to ask them about past incidents, increased time spent on improving handwriting, decreased interest in studies, sadness of mood and decreased interaction with others. His general physical examination and systemic examination were unremarkable. Mental status examination revealed delusions of reference and persecution, obsessive thoughts, symmetry and checking and aggressive compulsions, depressed affect, intact higher mental functions with an insight of 1/5. On Yale-Brown Obsessive Compulsive Scale (YBOCS) - patient obtained a moderate severity score of 19. He was started on risperidone (max - 4mg/day), trifluperazine (max – 10 mg/day).

3. DISCUSSION

Obsessive-Compulsive (OC) symptoms were identified as a feature of schizophrenia by many modern psychiatry founders like Westphal, Mayer-Gross and Bleuler [7]. OC symptoms can occur in the prodromal phase, during the first episode psychosis, during chronic schizophrenia or even following the treatment with anti-psychotics [8]. OC symptoms are more commonly seen in males, usually with an insidious onset of illness [9]. OCD and schizophrenia have similarities with respect to various characteristics like age of onset, gender distribution and younger age of onset in males [10]. More severe depressive symptoms and impaired social functioning was seen in patients of schizophrenia with comorbid OCD [11].

The phenomenology of OC symptoms in schizophrenia is similar to that in primary OCD but severity is moderate to severe [12]. Many studies have reported a younger age at onset, longer duration of illness, more positive and negative symptoms, more depressive symptoms and suicide attempts, frequent hospitalization,
lower quality of life, resulting in poorer prognosis [13–15].

The first-degree relatives of schizo-obsessive disorder had a higher risk for schizo-obsessive disorder, OCD and obsessive–compulsive personality disorder [16]. In a study done with 200 patients of schizophrenia, it was found that those with comorbid OC symptoms had a significantly greater family history of OCD than those without [17].

Second generation antipsychotics like risperidone, olanzapine and more frequently clozapine, are implicated in both emergence and exacerbation of OC symptoms in schizophrenia [18].

There is limited research on treatment of comorbid OCD in schizophrenia. SGAs like amisulpride and aripiprazole are found to be useful in the treatment of comorbid OCD in schizophrenia due to their negligible serotonergic properties [19]. A combination of selective serotonin reuptake inhibitors (SSRI) with antipsychotics has been recommended by the American Psychiatric Association (APA) for treatment of comorbid OCD in schizophrenia [20]. Escitalopram at a dose of 20mg/day has been found to be beneficial in such cases while psychosis worsened with the use of fluvoxamine and clomipramine [21–23].

4. CONCLUSION

Co-morbidities in schizophrenia like OCD is associated with earlier age of onset, poor quality of life and poorer prognosis. Limited research on treatment of OC symptoms in schizophrenia poses significant challenges in its management. More research is needed to understand the association between these comorbidities and their management.

CONSENT

As per international standard or university standard, patients’ written consent has been collected and preserved by the author(s).

ETHICAL APPROVAL

As per international standard or university standard written ethical approval has been collected and preserved by the author(s).

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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