



The schizo-obsessive disorder: a case report

Anna Urbańska¹_{A,B,C,D,E,F}, Agnieszka Lis¹_{B,C,D,E,F}, Mateusz Sołowiej²_{C,D,E},
Aneta Perzyńska-Starkiewicz¹_{A,B,C,D}, Diana Szymczuk¹_{B,C,D}, Marcin Olajossy¹_D

¹II Department of Psychiatry and Psychiatric Rehabilitation of the Medical University in Lublin

²Neuropsychiatric Hospital in Lublin

Abstract

Purpose: A case of schizophrenia with coexisting obsessive-compulsive symptoms is reported.

Case: The frequency of obsessive-compulsive disorder (OCD) and obsessive-compulsive symptoms (OCS) occurrence among patients suffering from schizophrenia is considerably higher in comparison to general population. The results of some studies show that schizo-obsessive disorder is characterized by higher intensity of negative and depressive symptoms. Patients with comorbid schizophrenia and obsessive-compulsive disorder show greater level of social dysfunction and they exhibit suicidal behaviours more often than patients diagnosed with schizophrenia. We present a 33-year-old female with obsessive-compulsive symptoms with onset in her early teens with no satisfactory response to treatment, in spite of her good intellect and insight into illness and cooperation.

Comment: There is some evidence suggesting that patients with “schizo-obsessive disorder” have a worse prognosis compared to the group of patients suffering only from schizophrenia, but the effect of OCD on schizophrenia symptom profile is unclear.

Keywords: schizophrenia, obsessive-compulsive disorder, schizo-obsessions, schizo-obsessive disorder, case history

Introduction

The term “schizo-obsessive disorder”, used for the first time in 1994 by Hwang and Opler, refers to the diagnosis of schizophrenia with coexisting obsessive-compulsive disorder (OCD) or obsessive-compulsive symptoms (OCS) [1]. The frequency of OCD and OCS occurrence among patients suffering from schizophrenia is considerably higher (even 5 or 6 times) in comparison to general population. It is estimated that the proportion of schizophrenic patients who developed symptoms of obsessive-compulsive disorder is around 12-15%. However, the incidence rate differs significantly depending on the sources. It remains unclear whether obsessive-compulsive disorder can be recognized as a separate clinical unit, whereas some recent studies do not provide sufficient evidence to back up this thesis. The results of some cross-sectional studies show that schizo-obsessive disorder is characterized by higher intensity of negative and depressive symptoms. What is more, patients with schizophrenia and comorbid obsessive-compulsive disorder show a greater level of social dysfunction and they exhibit suicidal behaviours more often than patients diagnosed with schizophrenia [8-12]. However, in their study from 2014, Frías Á, Palma C, Farriols N, Salvador A, Bonet J, Bernáldez I. demonstrated the lack of above mentioned differences between patients with schizo-obsessive disorder and patients with schizophrenia [5].

Case history

A 33-year-old female patient was directed by a psychiatrist and admitted to the Clinic of Psychiatry due to

the deterioration in her mental state for about a month. There occurred a significant worsening in disruptive episodes of derealization, determined by the patient as ‘attacks’, which disarrayed her daily functioning. During the ‘attacks’ the subject was disorientated, but did not lose touch with reality. The episodes of derealization, varying in intensity and characteristics, lasted from a few minutes to several hours and appeared every day at different times. *The patient complained about periodic agitation, increased mental stress, the presence of obsessive thoughts, delusions of thought broadcasting, anxiety, sadness, nightmares.* Periodically, she had a feeling that ‘something wicker was spinning in her mouth’. She also reported sporadic imperceptible pseudo-oculogyric attacks, which failed to be observed by the personnel during hospitalization. When asked, ‘*What would you like to change in your frame of mind?*’, she answered: ‘*if only there were no attacks*’, ‘*if only my head was ok*’, ‘*I’d like to feel good at home*’.

On admission to the hospital, the patient was in complete auto- and allopsychic adjustment, calm, presented adaptive behaviour, in a logical verbal contact, affectively vivid, in a balanced mood and drive. Increased pace of speech and psychomotor anxiety were noticeable. She negated suicidal thoughts. Based on the MINI scale, the suicidal risk was assessed as low - on account of her suicide attempt in 2004, the patient gained 4 points. After an overdose of 30 Relanium pills, she was hospitalized in the Department of Toxicology.

The patient is a childless unmarried woman. She lived with her parents, brother, grandmother, grandfather and uncle until the age of 7. Currently, she lives with her parents and her brother in a detached house, where she occupies one floor. She has a higher education (philosopher). The subject is unemployed and lives off social pension. She has the certificate of a significant degree of disability. She has never been convicted in court. Family history - no mental illnesses, suicides. Grandfather and brother - alcohol dependence syndrome.

In social relations, the patient is a stay-at-home with no need to socialize with people; she has two female friends with whom she meets. She has a partner that she has been dating for a year. They have no plans for the future. They meet at her or his house.

According to the mother, the patient is periodically oversensitive towards her family, overbearing, verbally aggressive when things do not go her way. During the derealization attacks she often screamed 'help', 'why nobody wants to help me', she calmed down after a conversation with the neighbour she trusted.

From medical history: no head injuries, loss of consciousness episodes, comorbid somatic diseases, operations, usage of psychoactive substances, allergies to medicines. Regular menstruation. Her mother had an uncomplicated pregnancy and childbearing. The subject gained the Apgar score of 9. Milestones were reached within a normal period. She started primary school on time, achieved good learning results, received school certificates with distinction. She did not cause any behavioural problems, but had difficulty in making friends.

The beginning of patient's mental health problems falls on the period of childhood. The first symptoms, such as compulsive thoughts and activities, appeared in the third grade of primary school in the form of a compulsion to pray and repeat the prayer from the beginning if you make a mistake. The patient began to have suicidal thoughts at the age of 10. In the seventh grade of primary school, she felt that *'something had messed up in her head'*. She started to have problems with learning in the eighth grade. The patient had difficulty in establishing social contacts; she felt that she did not belong to the group. Outside the school, she maintained contact with two female friends. At that time, she started experiencing something that she called *'paranoia of words'* – she was afraid of words which could possibly refer to her.

The first contact with a psychiatrist took place in 1999, at the end of the first class of secondary school. The patient began to seclude herself from the environment. Delusions of reference, thoughts broadcasting and persecutory delusions appeared. She had the impression of being persecuted by her peers from school and strangers, for example that taxi drivers knew she is on the bus, they

ostentatiously took the newspaper out, they wanted to *'go at her'* and knew her *'problem with words'*. The patient was referred to a psychiatrist, who diagnosed the paranoid personality disorder and prescribed the perazine. A partial improvement in her mental state was obtained, paranoid symptoms diminished, however, a proximal attitude continued.

The patient completed the first class of secondary school in the mode of one-to-one tuition. She achieved average learning results. In 2002, in the final year of secondary school, the aggravation of mental condition in the form of increasing paranoid symptoms, simple auditory hallucinations, sleeplessness, fear and withdrawal from the social life took place. The subject determined the worsening of her mental state as 'attacks of paranoia', 'severe neurosis'. She felt observed by the neighbours, mocked by her attending physician, she did not want to go to school and could not find herself in the group. She functioned quite well at home. She kept in touch with two friends from the outside of school. At that time, the patient was admitted to the Department of Psychiatry for Children and Teenagers at the Clinic of Psychiatry in Lublin, where she stayed for about 4 months. During the last two weeks of hospitalisation, the first attacks of derealization appeared. In the course of the attacks, the patient lied down and covered her head with a pillow, she had the feeling of 'the unreality of surrounding' and was under the impression that her eyeballs rolled up. Episodes of derealization proceeded individually or including pseudo-oculogyric attacks. She was discharged from the hospital with the diagnosis of paranoid syndrome, in the state of incomplete clinical improvement. The remission of paranoid-delusional symptoms was obtained. The patient related: 'They were accusing me of simulating. (...) I was released from the hospital in the state of hypomania, my grandfather died and I was happy, everything pleased me, I thanked God, that I could wipe the table off. It lasted about 2 years.' After an outpatient change of medicines, the woman observed some improvement in her mental state. A year later she passed the secondary school-leaving examination, which she prepared herself for. In the home environment she functioned correctly, cleaned, cooked, went out independently. In April 2005, her mental condition improved - derealization attacks disappeared. According to the patient, it was connected with the death of John Paul II. In 2010, she graduated from the faculty of philosophy at the Catholic University of Lublin (extramural studies). For the first two years of university studies, the patient felt a compulsion to learn; she achieved good learning results and received scholarships. She did not work after graduation. In 2013, she joined the Fuga Mundi Foundation, where she completed several training courses and organised away days independently.

In April 2015, the symptoms returned, but the attacks of derealization occurred only in the afternoons. In October 2015, the patient was directed to the wholesale company for a work placement, however, due to the intensification of attacks, which began to appear within the entire day, she could not continue working and after 3 months the contract was terminated. The subject started to experience obsessive masochistic thoughts ('to bring herself down', 'cosmic problems'), compulsions in the form of persistent swallowing the saliva, frequent washing of hands, going to the toilet up to a dozen times a day, which did not take the form of complex rituals. The symptoms were accompanied by a sense of guilt.

According to the patient, she was treated with multiple different medications in the past, including valproic acid, carbamazepine, levetiracetam, sertraline – with no therapeutic effect (the lack of full medical history). Recently she was taking olanzapine, clozapine, quetiapine. A month before hospitalization the patient started taking clomipramine and – due to the suspicion of epilepsy – gabapentin, which was prescribed by a neurologist.

The course of hospitalization:

On the first day of hospitalization the patient claimed that she could not look at the faces in the newspaper and on television, she complained of difficulty in concentrating. She felt chaos and racing thoughts. She usually defined her mood as good. She had a normal sleep and appetite. During the over-three-month hospitalization the patient exhibited adaptive behaviour, clear consciousness, experienced intense emotions (vivid affect), was periodically in a dysphoric mood, felt tension and psychomotor anxiety in relation to her troublesome attacks of derealization and fear, mainly of an anticipatory nature. She complained about having nightmares and feeling 'chaos in her head'. In the initial period of hospitalization the patient was loquacious, with an accelerated pace of speaking. She repeatedly experienced episodes of derealization, during which she was anxious, agitated, had compulsive-obsessive thoughts. The subject had the impression that 'people were against her', 'she could see dots and commas', and her eyeballs were rolling upwards. The attacks occurred during hospitalization as well as in the course of independent walks and passes from the hospital. During the morning visits, the patient often complained about malaise, the cause of which she could not identify. An evident histrionic personality disorder (histrionic component) could be recognized. The subject's reactions to temporarily given medicines: hydroxyzine, levomepromazine, chlorprothixene, lorazepam, were variable, mostly unsatisfactory. Many conversations were carried out to support the patient, with different effect.

The EEG examination registered no abnormalities of paroxysmal nature and provided a generalised descrip-

tion of changes in the basic brain activity, which was bilaterally mildly slowed (theta-alfa), and slightly marked changes above the temporal region, mainly in the right part, in the form of very rare groups of theta waves and a voltage, which was slightly higher than the background. No pathological changes were described on the basis of the head computed tomography with radio contrast, which was performed on outpatient basis.

During the hospital stay, psychological tests were performed: the Wechsler Adult Intelligence Scale - WAIS-R (PL) the test-taker obtained the following IQ scores II verbal 124 II non-verbal 105 II overall 116. A test scores interpretation: 'the test-determined intellectual efficiency of the test-taker corresponds to high intelligence in the verbal scale, whereas in performance and general scales it corresponds to average intelligence. There is a difference between verbal and non-verbal abilities, in favour of the former. The resource of general information, understanding of concepts and social situations and the ability to distinguish relevant things from the irrelevant ones are developed at the highest level. Abstract and logical thinking, the range of direct auditory memory and the ability to manipulate numbers are well-developed. The patient shows slightly worse abilities of planning and forecasting, as well as the analytical-synthetic capabilities. In The Graham-Kendall Memory-For-Designs Test, The Benton Visual Retention Test and The Bender Visual Motor Gestalt Test, the subject achieved results within the limits. The results of neuropsychological tests mentioned above do not signalize the existence of organic changes in CUN. In the MMPI-2 test, an interpretable profile was obtained (VRI, TRIN, L, S). There is a strong defence tendency (F, K). The examined demonstrates a strong need for attention and affection from others. She denies hostile and aggressive impulses (HY5). She is cautious, conventional, introverted, presenting somatic complaints (R). Remaining scales are in the area of low results called the area of interpretative silence'. (tab.1)

Table 1. Accounted results of the scales: WAIS-R and neuropsychological tests

| WAIS-R Scale | II verbal 124 | II wordless 105 | II general 116 |
|----------------|------------------|--------------------|-------------------|
| Graham-Kendall | 4 points | - | - |
| Benton | +1, -1 | - | - |
| Bender | 42 points | - | - |

During her stay at the clinic between 15.01 and 20.01.2016, the patient was treated with: olanzapine up to 20 mg/d, clozapine up to 250 mg/d, quetiapine up to 300 mg/d, clomipramine up to 112.5 mg/d, gabapentin up to 800 mg/d, ziprasidone up to 160 mg/d, zuclopenthixol up to 20 mg/d, pregabalin up to 300 mg/d, buspirone 30 mg/d, hydroxyzine 40 mg/d and clorazepate 5 mg/d. (tab.2)

Table 2. Daily dosages of neuroleptics

| Name of drug | Daily dosage |
|----------------|----------------|
| Olanzapine | Up to 20 mg |
| Klozapine | Up to 250 mg |
| Quetiapine | Up to 300 mg |
| Klomipramine | Up to 112,5 mg |
| Gabapentin | Up to 800 mg |
| Ziprasidon | Up to 160 mg |
| Zuklopentiksol | Up to 20 mg |
| Pregabalin | Up to 300mg |
| Buspiron | Up to 30 mg |
| Hydroksizine | Up to 40 mg |
| Klorazepam | Up to 5 mg |

Despite reports on the beneficial effects of clomipramine in combination with antipsychotic treatment [13], there was no significant clinical improvement, regardless of the dose.

Considering the interview and the prior medical history of the patient, the development of obsessive-compulsive disorder as a result of a treatment with olanzapine and clozapine, regardless of the dose, would most likely be excluded [14-18].

At the attempt to include ziprasidone into the treatment, a considerable deterioration in the patient's mental condition was observed. Hence, the medicine was dechallenged after 14 days. A similar situation was presented in the survey by A. Juven-Wetzler, L. Fostick, S. Cwikel-Hamza, E. Balaban, J. Zohar, which showed a variable response to the treatment with ziprasidone in patients with schizophrenia comorbid with OCD: from the significant reduction of clinical symptoms to the deterioration in almost half of the respondents [19].

Due to the lack of noticeable clinical improvement and intensified, seriously disadvantaging the functioning handshaking, the treatment with zuclopenthixol was discontinued.

The applied treatment failed to achieve a satisfactory clinical improvement. The patient was discharged from the hospital with the recommendation of outpatient treatment, psychotherapy and systematic medication treatment: clozapine 200 mg/d, pregabalin 300 mg/d, clomipramine 112.5 mg/d, hydroxyzine syrup on an ad hoc basis.

Conclusions

Based on the conducted examinations and observation of the mental state, according to the ruling ICD-10 classification, the patient was diagnosed with paranoid schizophrenia F20.0 with comorbid obsessive-compulsive disorder F42.0.

Depending on the source, the prognosis for patients with schizophrenia comorbid with OCD is worse [8-12] or the same compared to the group of patients suffering

only from schizophrenia [5], although some earlier studies have reported a better general functioning of the 'schizo-obsessive' patients [20,21].

In the case described above, in spite of her good intellect, insight into illness and cooperation in the treatment, the patient's functioning in everyday life is not satisfactory. However, one should take into consideration the influence of the subject's coexisting personality traits on the effectiveness of treatment, including a clear *histrionic component*.

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Corresponding author:

Correspondence address

Anna Urbańska
 II Department of Psychiatry and Psychiatric Rehabilitation of the
 Medical University in Lublin
 Gluska street 1st,
 e-mail: anna833@poczta.onet.pl
 mobile phone 512-089-765

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