

A Case Report Co-occurrence of Schizophrenia and Obsessive-Compulsive Disorder

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Abstract—Schizophrenia is a chronic and severe mental disorder characterized by distortions in thinking, perception, emotions, language, sense of self, and behaviour. This case report presents a 23-year-old male diagnosed with paranoid schizophrenia and co-morbid obsessive-compulsive disorder (OCD). Initially functioning well, the patient experienced social withdrawal and persecutory delusions following academic failure. Over time, his symptoms progressed to include severe disorganization, poor self-care, and compulsive behaviors. Despite repeated hospitalizations and treatment attempts, adherence remained a significant challenge. A multidisciplinary treatment plan—including risperidone, electroconvulsive therapy, supportive psychotherapy, and art therapy—yielded moderate improvement in delusions and daily functioning. This case highlights the complex clinical interplay between schizophrenia and OCD, underscoring the need for early recognition, integrated treatment, and sustained caregiver support to improve prognosis in such co-morbid presentations.

30% of SCZ patients also had obsessive-compulsive symptoms.⁽²⁾

After controlling for a patient's psychiatric history and a family history of mental illnesses, a previous diagnosis of OCD was linked to increased rates of schizophrenia and schizophrenia spectrum disorders later in life.⁽³⁾ OCD in patients with schizophrenia was 12.3%.⁽⁵⁾ while it was 2–3% in the general population.⁽⁴⁾ OCD and schizophrenia may be connected, as evidenced by the obsessive-compulsive symptoms (OCS) seen in adolescent, adult, and geriatric schizophrenia patients. The emergence of OCS during the use of atypical antipsychotic drugs to treat schizophrenia suggested that comorbid OCD was a drug side effect. However, similar rates of OCS comorbidity were noted in drug-naive patients with first-episode schizophrenia, prodromal stages of schizophrenia, and people at ultrahigh risk for psychosis. As a result, OCS in schizophrenia cannot be caused by a persistent illness or antipsychotic treatment. To investigate the temporal link between two illnesses in a longitudinal approach, more research is required.⁽⁶⁾

I. INTRODUCTION

Schizophrenia is "A severe mental disorder in which there is a gross distortion of reality, disturbances in language and communication, withdrawal from social interaction, and the disorganization and fragmentation of thought, perception, and emotional reaction."⁽¹⁾

Obsessive Compulsive Disorder "A disorder characterized by recurrent obsessions (intrusive thoughts) or compulsions (repetitive behaviors or mental acts), or both, that are severe enough to be time-consuming or cause marked distress or significant impairment."⁽¹⁾

Despite being recognized as distinct and infrequently overlapping diagnostic conditions, obsessive-compulsive disorder (OCD) and schizophrenia (SCZ) appear to have a high degree of comorbidity: Up to

II. CASE REPORT

The patient is a 23-year-old unmarried male diagnosed with schizophrenia in 2020. His psychiatric symptoms began in 2016 after failing to gain college admission. Prior to this, he was functioning well, with normal sleep, diet, hygiene, and social relationships. Following the academic setback, he became socially withdrawn, isolated himself in his room, and developed paranoid delusions, particularly that neighbours intended to harm him. Despite family reassurance, his suspicions intensified, and he resisted medical help.

During this period, he became increasingly aggressive, especially towards family members. His family resorted to secretly administering medication in his food, which led to temporary improvement. However, upon suspecting this, he stopped eating, leading to worsening symptoms. His personal hygiene deteriorated, requiring constant prompting to bathe or brush his teeth.

His first psychiatric admission occurred in 2019 at Hospital due to severe deterioration. He improved with treatment but relapsed shortly after discharge due to medication non-adherence. From 2020 to 2022, he became more paranoid, especially toward his nephew and niece, refused to sleep indoors, and demanded the lights remain off. In 2021, he was readmitted due to increased aggression and suspicion toward strangers. His behavior became increasingly disorganized tearing flashcards, cutting clothes, and throwing objects into washbasins. In 2022, these actions escalated, including hiding torn clothes and refusing to explain his behavior. He stopped maintaining hygiene entirely, going months without bathing or changing clothes, and began urinating and defecating in them. This led to another hospitalization at SJH, where temporary improvement was seen.

Between 2020 and 2023, his paranoia and aggression worsened. Medication refusal led to recurring psychotic episodes. He developed compulsive behaviors related to water, hoarding, and sleep disturbances. Despite repeated hospitalizations, improvement was short-lived due to poor adherence. Self-care remained severely compromised.

Since early 2024, he has consistently refused psychotropic medication, cited mistrust and denied illness. He isolates himself in his room, avoids social interaction, and does not engage in any household activities. His grooming remains poor, requiring repeated reminders. He often accuses neighbour's and family of spying or conspiring against him, with fixed delusions that are not alleviated by reasoning.

Thought processes are disorganized, with irrelevant and tangential speech. He often appears internally preoccupied, muttering, gesturing, and laughing to himself—suggesting ongoing perceptual disturbances, though he has not explicitly reported hallucinations. His sleep-wake cycle is reversed, staying awake at night and sleeping during the day, spending excessive time on his phone.

Aggression is mainly verbal, with unprovoked outbursts and foul language directed at family. While no recent physical aggression has occurred, his behavior remains unpredictable. He lacks insight into his condition, refuses treatment, and rejects the need for psychiatric care. Recent minor improvements in grooming and social functioning have been observed, but delusions, aggression, and obsessive behaviors continue to pose significant challenges. He was brought for psychiatric evaluation under caregiver supervision due to functional decline and worsening symptoms.

III. ASSESSMENT

diagnostic assessment revealed several notable findings during the mental status examination. The patient displayed poor eye contact and exhibited guarded behavior, suggesting significant social withdrawal and mistrust. Speech was relevant, although notably reduced in productivity. Subjectively, the patient reported feeling distressed, and their affect appeared blunted, indicating a diminished emotional expression. Thought content was marked by delusions of persecution and reference, reflecting a distorted perception of reality. Additionally, the patient experienced perceptual disturbances in the form of second-person auditory hallucinations. Insight into their condition was severely impaired, classified as Grade 1, indicating no awareness of illness. Based on these observations and in accordance with ICD-10 criteria, the diagnosis is Paranoid Schizophrenia.

IV. TREATMENT AND OUTCOME

Despite severe psychotic symptoms and poor insight, the patient agreed to begin psychiatric treatment under family supervision. A multidisciplinary approach was used, including risperidone, electroconvulsive therapy (ECT), supportive psychotherapy, and art therapy. Risperidone was titrated gradually, and six well-tolerated ECT sessions over three weeks led to a reduction in delusions and hallucinations.

Supportive psychotherapy focused on building rapport and reinforcing adherence, while art therapy facilitated emotional expression and improved communication. Psychoeducation was provided to the patient and family about schizophrenia and treatment adherence.

Over four weeks, the patient showed moderate improvement—better self-care, reduced suspiciousness, and increased engagement. Though insight remained limited, treatment responsiveness improved. He now receives ongoing outpatient care, with continued pharmacotherapy, psychotherapy, and family support, showing partial remission and improved daily functioning.

V. DISCUSSION

This patient presented with paranoid schizophrenia, marked by persecutory delusions and auditory hallucinations, along with co-occurring obsessive-compulsive symptoms such as intrusive thoughts and compulsions. While paranoid schizophrenia is associated with later onset and relatively better prognosis (Tandon et al., 2013), the presence of OCD adds complexity to diagnosis and treatment, highlighting the need for integrated management.

The clinical presentation in this case, withdrawal from social interaction, poor self-care, persecutory delusions, and auditory hallucinations, matches core diagnostic features described in ICD-10 and DSM-5 guidelines (World Health Organization, 1992; American Psychiatric Association, 2013). Importantly, the insidious onset over 1.5 years is consistent with data suggesting that delayed treatment often follows a gradual deterioration, known as the duration of untreated psychosis (DUP). Studies have shown that longer DUP is associated with poorer functional outcomes (Penttilä et al., 2014). This highlights the necessity of early detection and intervention.⁽⁷⁾

Study conducted by Mueser and McGurk (2004), which examined the clinical course of 50 patients with schizophrenia, our patient demonstrated a moderate response to initial antipsychotic therapy (risperidone), echoing findings that second-generation antipsychotics often produce better adherence and fewer extrapyramidal symptoms than typical agents. The use of psychoeducation and family involvement in this case reflects best practices outlined in clinical guidelines for schizophrenia management (NICE, 2014).⁽⁸⁾

Schirmbeck and Zink reported that patients with both schizophrenia and OCD often show greater symptom severity, including increased negative symptoms, cognitive deficits, and poorer insight compared to

those with schizophrenia alone⁽⁹⁾. Similarly, Berman et al. found that comorbid OCD is associated with earlier onset, more chronic illness course, and worse treatment outcomes in schizophrenia patients⁽¹⁰⁾. The current case reflects these findings, as the patient experienced repeated relapses, severe disorganization, and persistent lack of insight despite multiple hospitalizations and a comprehensive treatment approach.

VI. CONCLUSION

This case highlights the complex interplay between schizophrenia and OCD, emphasizing the need for early recognition and integrated treatment. Co-occurring symptoms can worsen functional outcomes and complicate management, making a multidisciplinary approach essential for improving adherence and overall prognosis.

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