



Letter to the Editor

Schizo-obsessive disorder: A clinical quagmire!

The overlap between OCD and schizophrenia spectra is quite clinically challenging yet ubiquitous (Table 1) (Poyurovsky et al., 2012). Phenomenologically, obsessions can be readily mistaken for delusions. Conversely, schizophrenic motor symptom domain can be misconstrued as compulsions.

Some helpful tips to distinguish obsessions from delusions include the content (e.g. contamination obsessions vs. persecutory delusions), insight (present in OCD vs. absent in schizophrenia), affect (obsession-related anxiety vs. delusion-associated paranoid affect), perception (intact vs. delusional), and behavioural concomitants (rituals vs. acting-out of delusions). Similarly, compulsions might be distinguished from schizophrenic movement disorder by typical motor expression (e.g. checking vs. stereotypy), driven agency (obsession vs. autonomy), function (anxiolysis vs. purposeless), and insight (present vs. absent) (Tonna et al., 2016; Bener et al., 2018).

Working differential in these cases should entail- (Hwang et al., 2006; Andrade et al., 2019)

- 1) OCD as psychotic prodroma: Both typical and atypical OCD is prevalent in those at high-risk for developing psychosis (14%) and even more so when considering subthreshold OCD (20%). This is well correlated with higher severity and suicidality.
- 2) OCS in schizophrenia (5–45%)- Schizo-obsessive disorder. Although obsessive-compulsive symptoms are not considered primary features, they are prevalent, independent of psychosis, and substantially modify clinical characteristics, course, treatment and prognosis of schizophrenia. Typically, this portends poor prognostication across life-span and generally poor response to ECT.
- 3) OCD in schizotypal PD- characteristically; early-onset; male preponderance; poor insight; commonly hoarding themes; familial aggregation of schizophrenia spectrum disorders; poor prognosis; CBT less efficacious; and APP augmentation is typically warranted (Naguy, 2017)
- 4) OCD in high-functioning autism (HFA)/ Asperger's syndrome or

- Multi-dimensionally impaired (MDI) disorder in younger children.
- 5) Antipsychotic-induced OCD- characteristically; male preponderance, preexisting OCS in schizophrenia as a primary diagnosis, chiefly compulsions, during the 1st week of treatment, and typically with higher doses. (Naguy, 2017)
- 6) OCD with poor insight- DSM-5 includes a new specifier, namely, absent insight/delusional beliefs

Proposed stepwise treatment of schizo-obsessive disorder comprises (Scotti-Muzzi and Saide, 2017)

- 1) Atypical antipsychotics (AAP) monotherapy (evidence in favour of aripiprazole, amisulpiride, ziprasidone)
- 2) Atypical antipsychotics + selective serotonin reuptake inhibitors (SSRIs)
- 3) Either: another AAP + SSRI. Or: AAP + another SSRI/CMI
- 4) Conventional antipsychotic + SSRI/ clomipramine (CMI)
- 5) Add-on lamotrigine (LAM)
- 6) Add-on cognitive-behavioural therapy (CBT)(graded exposure with response prevention E/RP)
- 7) Low-dose clozapine (CLOZ) (75–300 mg/d)
- 8) Low-dose CLOZ + SSRI (evidence in favour of sertraline and citalopram)
- 9) Electro-convulsive therapy (ECT)

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Table 1
Schematic comparative characteristics of schizophrenia and OCD.

	Schizophrenia	OCD
Prevalence	1 % Broadly defined 2-3 %	2-3 %
Gender (M:F)	1:1	1:1
Onset	2nd-3rd decade M earlier than F	1st- 2nd decade M earlier than F
Course	Chronic Multi-episode	Chronic Wax and wane
Brain regions	Cortex: DLPFC, temporal, ACC; Thalamus, hippocampus, striatum	Cortex: OFC, ACC; Thalamus, striatum
Neurotransmitters	DA, 5-HT, Glut	5-HT, DA, Glut
Treatment	Antipsychotics (add-on SSRIs)	SSRIs (add-on antipsychotics)

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