



Letter to the editor

Obsessively thinking through the schizophrenia spectrum: Disentangling pseudo-obsessive schizophrenia from OCD



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Cheng et al. (2019) performed a nationwide population-based longitudinal cohort study on the relationship between Obsessive Compulsive Disorder (OCD) and Schizophrenia Spectrum Disorder (SSD). They found that OCD diagnosis, male gender, age of OCD onset before 20 years, comorbidity of autistic disorder and antipsychotic use were associated with higher risk of SSD. The association between OCD and SSD confirmed previous findings of large cohort studies (Cederlöf et al., 2015; Meier et al., 2014), is supported by partial polygenic overlap (Zilhão et al., 2018) and suggests that emerging OCD in developmental years (especially if concomitant with other severity proxies such as ASD comorbidity and AP prescription) could be an early warning flag for increased lifetime risk of schizophrenia.

This is clearly a crucial clinical problem since early differential diagnosis of OCD from OCD-like epiphenomena in SSD has been a challenge since the inception of the concept of schizophrenia. Indeed, the presence of OCD-like phenomena in SSD has been widely reported since the beginning of the previous century (see Bürgy, 2007 for an in-depth overview), leading clinicians of the past to elaborate constructs such as “schizo-obsessive disorder” or, more subtly, “pseudo-obsessive schizophrenia”. Precisely to facilitate the differential diagnosis, two major concepts were historically coined: *true obsession* (intact insight and resistance against intrusive thoughts felt as irrational) and *pseudo-obsession* (obsessive rumination without inner resistance, often associated with dysmorphophobic, sexual or aggressive contents), with the first phenomenon associated with OCD and the latter associated with SSD. These concepts encountered a progressive fading in subsequent editions of diagnostic manuals, in which broader characterizations of obsessions and compulsion were advanced and accepted. This loss of phenomenological knowledge and the subsequent unintended diagnostic puzzle is exemplified for OCD by the introduction, since DSM IV, of the possibility to specify the presence of *poor insight*, when the patient does not recognize that obsessions and compulsions are excessive or unreasonable. Current diagnostic criteria could therefore allow the overinclusion of SSD with pseudo-obsessions in OCD with poor insight, ultimately leading

to misdiagnosis in cases of. This far from hypothetical scenario (as well as its clinical magnitude) is illustrated by findings of a recent empirical study that assessed lifetime SSD features in a clinical sample of 42 OCD patients recruited in a dedicated outpatient clinic for OCD and anxiety disorders in Copenhagen, Denmark (Rasmussen et al., 2019). Briefly, 26 out of 42 OCD patients (62%) received a DSM-5 based lifetime diagnosis of SSD (schizophrenia $n = 6$; other non-affective psychosis $n = 6$; schizotypal personality disorders $n = 14$). Notably, this subgroup (i.e. SSD with OCD-like presentation aka “pseudo-obsessive schizophrenia”), revealed high degrees of anomalous subjective experiences (i.e. Self-disorders) as compared with the true OCD subgroup. Self-disorders are trait-like, non-psychotic anomalies of subjective experience that have been recursively corroborated as schizophrenia spectrum vulnerability phenotypes in clinical as well as in genetically high risk samples (Parnas and Henriksen, 2014; Raballo and Parnas, 2011), therefore their detection in putative OCD help-seekers could be a relevant clinical landmark for differential diagnosis.

Cheng et al.'s (2019) findings also indicate that age of OCD onset before 20 years are longitudinally associated with increasing risk of SSD, which gradually decreases over time; that is: before 20 years of age, after the onset of obsessive and compulsive manifestations, there is a short-term peak of psychotic risk. This coheres with established psychopathological transition sequences (Ebel et al., 1989) that lead to end-stage psychotic symptoms from more elementary transformations of the experiential field and, particularly, of the subjective experience of the stream of thought (e.g. thought block, thought intrusions, thought interferences, ruminations). For example, such transitions have been described in the progression from non-psychotic experiential precursors to Auditory Verbal Hallucinations through a series of experiential changes of increasing severity. These include basic disturbances of the thought stream (e.g. thought interference, thought block, pressure of thought, obsessive-like perseverations), progressive depersonalization with intensified experience of thought spatialization, alienation, and/or autonomization of the interior dialogue (e.g. repeated inner “self-instructions,” “self-comments,” and/or “self-conversations” become progressively sonorized, automatized, and interfering), loss of the ego-boundaries eventually culminating in “omnipotent and omniscient” alien voices and/or transitive experiences (Raballo, 2017). Therefore, clinicians should be aware of the possibility that, along the psychopathological construction of psychotic states from early prodromal/clinically high risk states, patients could feel and acknowledge the presence of disturbances in their stream of thought that might resemble OCD manifestations. This is even more important when potential compatibility with OCD diagnosis is contextual with early-onset of symptoms and pre-morbid manifestations of putative neurobiological vulnerability (Poletti et al., 2019). Should this be the case, a cautionary exploration of potential SSD features is necessary for timely differential diagnosis. Besides differentiating obsessions from pseudo-

obsessions, such assessment should check the presence of attenuated psychotic symptoms, schizotypal traits and of trait-like, non-psychotic anomalies of subjective experience (e.g. Self-Disorders).

Contributors

MP wrote the first draft.
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Declaration of competing interest

None

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