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CASE REPORT

When Obsessions Meet Psychosis: Recognizing the Schizo-Obsessive Spectrum Through a Case of Autism, Obsessive-Compulsive Disorder, and Schizophrenia

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ABSTRACT

The schizo-obsessive spectrum encompasses a range of phenotypes positioned between obsessive-compulsive disorder (OCD) and schizophrenia (SCZ), characterized by the co-occurrence of obsessive-compulsive symptoms within a psychotic illness. While the high prevalence of obsessive-compulsive symptoms in schizophrenia — affecting up to 64% of patients — has generated substantial interest in whether schizo-obsessive disorder constitutes a distinct diagnostic entity, clinical recognition remains limited and diagnostic criteria continue to be debated. Differentiating obsessions from delusions, and compulsions from stereotypies, presents a formidable clinical challenge, particularly in the context of co-occurring autism spectrum disorder (ASD), where overlapping phenomenology can obscure diagnosis across all three conditions. We present the case of an adolescent male with ASD whose clinical course evolved from social anxiety to OCD to schizophrenia over several years, with symptoms that never fully conformed to any single diagnostic category. His presentation — intrusive thoughts without frank compulsions, positive psychotic symptoms without negative symptoms, and preserved insight despite active hallucinations — exemplifies the diagnostic ambiguity inherent to the schizo-obsessive spectrum. This case underscores the clinical utility of conceptualizing schizo-obsessive presentations as a spectrum that has direct implications for treatment selection, prognosis, and the avoidance of diagnostic errors that may delay effective care.

Introduction

Schizophrenia (SCZ) and obsessive-compulsive disorder (OCD) are two chronic illnesses that can be extremely debilitating. Schizophrenia falls within the diagnostic category of psychotic disorders, while OCD is classified under Obsessive-Compulsive and Related Disorders according to the Diagnostic and Statistical Manual of Mental Disorders 5th Edition[1]. This categorical separation, however, belies the considerable phenomenological overlap between the two conditions, which can pose profound challenges to accurate diagnosis and effective treatment.

Diagnostic criteria for SCZ include both "positive" and "negative" symptoms. Positive symptoms include disorganized speech, disorganized behavior, the presence of hallucinations-untrue sensory perceptions, and delusions-fixed false beliefs. Negative symptoms include social withdrawal, avolition, diminished emotional expression, and decline in functioning and cognition[1]. Additionally, the diagnostic umbrella of schizophrenia includes schizotypal personality disorder, which is characterized by diminished social skills, difficulty forming close relationships, and eccentric behavior leading to some cognitive and perceptual distortions[2], representing a milder but related phenotype that is relevant to the diagnostic complexity discussed in this report.

Obsessive Compulsive Disorder is a separate diagnostic entity and is characterized by obsessions-persistent and intrusive unwanted thoughts or urges, and compulsions-unwanted repetitive behaviors[1]. Compulsions traditionally are physical actions such as tapping or counting to alleviate the anxiety caused by obsessions; however, some compulsions are performed mentally. For example, a patient may think they need to correct their thoughts or to repeat certain phrases internally in a prescribed, compulsive manner. Due to their less objective or observable nature, mental compulsions are often more difficult to identify, and providers may miss these symptoms altogether[3]. Recognition of mental compulsions is particularly important in the context of psychotic-spectrum presentations, where the boundaries between compulsive mental acts and psychotic phenomena may be difficult to draw.

The epidemiological overlap between these two conditions is striking. Twenty-three percent of individuals diagnosed with schizophrenia meet the diagnostic criteria for OCD, and as many as 64% display obsessive-compulsive tendencies that may not achieve a full OCD diagnosis[4]. This significant comorbidity has led to the proposal of the schizo-obsessive spectrum, a dimensional framework that encompasses a range of phenotypes positioned between the two diagnostic poles including OCD, OCD with poor insight, OCD with schizotypal personality disorder, schizophrenia with obsessive-compulsive symptoms, schizophrenia with OCD, and schizophrenia[5]. While the percentage of OCD patients who develop SCZ is relatively low, around 1.7%[6], the prevalence of those with OCD who develop schizotypal personality disorder ranges from 5% to 50% and between 13.8% to 30.7% of OCD patients develop poor insight[7].

Despite this phenotypic variability, certain clinical distinctions between OCD and schizophrenia are classically considered diagnostically decisive. Chief among these is insight: patients with OCD typically retain awareness of the irrational and ego-dystonic nature of their intrusive thoughts, recognizing them as products of their own mind rather than external realities. When this insight erodes, however, the phenomenological boundary between an obsession and a delusion — or between a compulsive mental act and a hallucination — becomes increasingly difficult to define[8]. The question of whether obsessions with absent insight are categorically distinct from delusions, or simply represent a point along a continuum, remains one of the central unresolved questions in this field.

This diagnostic complexity is compounded further when SCZ and OCD co-occur in the setting of

autism spectrum disorder (ASD). Autism spectrum disorder is itself characterized by features that may superficially mimic both obsessive-compulsive and psychotic symptomatology: concrete and idiosyncratic belief systems that may resemble obsessions or delusions, cognitive rigidity that may be mistaken for compulsive thinking, repetitive motor behaviors (stereotypies) that may be confused with compulsions, and deficits in social-emotional reciprocity that may be misread as the negative symptoms of schizophrenia[1,9]. When all three conditions are present — or when a patient's presentation lies at their intersection without fully satisfying criteria for any one of them — the clinician faces a formidable diagnostic challenge. It is precisely these patients, whose symptoms cannot be fully captured by any single diagnostic category, who may best be understood through the lens of the schizo-obsessive spectrum.

Case Presentation

A 15-year-old white male with a previous diagnosis of social anxiety, ASD, and major depressive disorder was hospitalized for homicidal and suicidal ideation. He reported a gradual development over the past 2 years of weekly intrusive thoughts of killing animals that progressed to near constant visual hallucinations of killing humans. He maintained insight and recognized his thoughts as distressing and ego-dystonic. These symptoms had initially been diagnosed as ASD related social anxiety, but during the hospitalization, were categorized as mental obsessions, and he was diagnosed with OCD.

Over the following year, the patient was rehospitalized several times due to the recurrence of these thoughts. He described additional mild, intermittent behaviors, such as preferring to count things in odd numbers, which were considered to be compulsions. However, these behaviors did not alleviate his anxious, intrusive thoughts and were easily redirectable. Additionally, the anxiety did not increase when he was prevented from performing these behaviors, which would have been expected in OCD. A diagnosis of schizophrenia was considered but not confirmed, and risperidone was initiated with partial effect. He also engaged in CBT (i.e. Cognitive Behavioral Therapy), which led to moderate improvement, but he struggled with group therapy settings.

Over the next year, his symptoms became more reminiscent of schizophrenia. He reported a delusion that he was being broadcast to an imaginary audience (akin to living in a reality TV show), developed auditory hallucinations of the TV directors speaking to him, and believed that his family members were impostors. In contrast to his prior homicidal thoughts, he displayed no major distress over these delusions, no associated compulsive behaviors, and displayed poor insight into the veracity of these thoughts, more akin to the positive symptoms of schizophrenia than OCD. However, he never displayed a downward functional drift nor any negative symptoms of schizophrenia.

His positive symptomatology, alongside his anxiety-driven social reclusivity, inhibited him from functioning well academically and socially in school. As a result, fluoxetine was prescribed in addition to risperidone, with significant success, enabling him to succeed academically, develop friendships, socialize better, and maintain a part-time job. Additionally, his positive symptoms-hallucinations and delusions -responded to the combination of risperidone and fluoxetine, supporting an anxiety-based etiology rather than psychosis alone. His improved socialization also allowed him to attend and benefit from group therapy, which further promoted his progress.

However, in the following months, he developed auditory-visual hallucinations of dark and demonic figures whispering mean comments, typically during social interactions, which exacerbated social anxiety. This was initially felt to be related to his ASD, though he did not display any stimming behaviors nor fixated interests. Therefore, risperidone was cross-tapered to lurasidone to address the recurrence of these positive symptoms while reducing weight gain and brain fog, which he had experienced as side effects of risperidone. Over the past year, on

the combination of lurasidone and fluoxetine, he has experienced almost complete remission of symptoms and no emergence of negative symptoms. He has improved in his social skills, energy, and cognition. He graduated from high school, attends college, maintains friendships, and manages part-time employment.

Discussion

This case illuminates the nuances of the schizo-obsessive spectrum and the diagnostic considerations of which clinicians should be aware. This patient's presentation is notable for what was initially felt to be social anxiety consistent with ASD, then intrusive thoughts felt to be consistent with OCD, followed by positive symptoms of SCZ, including auditory and visual hallucinations. Often, there was overlap between these entities, with symptoms at the intersection of ASD/OCD/SCZ, though his presentation was never squarely consistent with any one of the above. He had the social-interactive challenges of ASD without the sensory processing deficits or restricted interests/stimming behaviors, the intrusive thoughts of OCD but without frank compulsions, and the positive symptoms of psychosis but without negative symptoms. A lack of awareness of one's illness is also recognized as a prime feature of schizophrenia, with most patients denying the need for treatment[10]; however, this patient retained insight into most of his symptoms and consistently sought treatment. His unique clinical presentation supports an intermediate phenotype with components of both schizophrenia and OCD, along the schizo-obsessive spectrum.

While this patient's social struggles could raise concern for the negative symptomatology of schizophrenia, his particular presentation was deemed more consistent with social anxiety and the symptomatology of his ASD. Key hallmarks of ASD that distinguish it diagnostically include the fact that the observed deficits in social reciprocity and understanding of nonverbal cues are stable over time or even improve with therapy, in contrast to SCZ, which usually worsens over time[11]. This patient's social skills significantly improved over time, especially with therapy, and once started on fluoxetine. This is a vital part of his presentation, as despite experiencing positive symptoms such as hallucinations, delusions, and obsessions, he failed to display any negative symptoms such as downward cognitive drift, disorganized speech, or any catatonic behaviors, which are often key features of schizophrenia. The lack of a full presentation of schizophrenia highlights diagnostic boundaries.

This case also highlights the complexity of distinguishing positive symptomatology in those who lie on the schizo-obsessive spectrum. Though our classical understanding of OCD and schizophrenia relies on clear delineations between delusions, hallucinations, and obsessions, variable levels of a patient's insight into their symptoms can blur diagnostic lines and make these delineations unclear[8,12]. Literature suggests that once insight into intrusive thoughts is lost, they may turn into delusions or become diagnostically indistinguishable from hallucinations[13]. This case also questions the boundaries between OCD and schizophrenia, as severe presentations of OCD can be mistaken for schizophrenia[14]. A subtype or spectrum may better capture patients who exhibit features of both disorders.

Some assert that the primary factor that distinguishes patients with OCD from those with psychosis is the plausibility of their obsessions[15]. Others argue that the ego-dystonic nature of thoughts and the patient's insight into them might differentiate obsessions from delusions[13]. However, none of these characteristics are necessary for OCD diagnosis, and patients diagnosed with OCD without insight also challenge this definition. Recent findings indicate that OCD with a lack of insight might be due to a malfunction in dopamine within the brain in addition to serotonin, which aligns more with the neurobiology of schizophrenia than with traditional presentations of OCD[16]. This may explain why some OCD patients who lack insight or are more treatment resistant respond well to antipsychotics[17], highlighting again

the similarities between the two disorders[18]. Some patients, such as ours, significantly benefit from a combination of SSRIs and antipsychotics.

Treatment of schizo-obsessive spectrum disorders remains complex, as there are suggestions that second-generation antipsychotics (SGA) can increase obsessive-compulsive symptoms through their inhibitory effects on serotonin[19], while others have shown improvement with SGAs such as low-dose risperidone[20]. The APA recommends combined treatment with antipsychotics and SSRIs, and (CBT) in more treatment-resistant cases[21].

Developing recognition and treatment plans for these patients is essential as the presence of obsessive-compulsive symptoms in schizophrenic patients is correlated with higher severity of symptoms overall, especially more negative symptoms, cognitive deficits[21], and catatonia[22]. While OCD and schizophrenia display similar abnormalities in brain structure and function[23], such as reduced activity in the bilateral dorsolateral prefrontal cortex and the frontopolar cortex[24], schizo-obsessive disorder has distinct clinical, neurobiological, and neurocognitive features that differ from OCD and schizophrenia alone[7]. The increased prevalence in these cases and distinction from these two disorders further suggest the existence of a schizo-obsessive disorder[25,26], and the large range of mixed and different presentations supports the need for a spectrum[27]. The schizo-obsessive spectrum allows for fluidity between these two disorders and may enhance diagnostic and treatment clarity[24].

Conclusion

The proposed existence of a schizo-obsessive spectrum has sparked debate regarding whether patients displaying both OCD and schizophrenic symptoms have comorbid disorders or if they represent a distinct diagnostic entity. As shown, symptoms often cross diagnostic entities, and treatment targeted toward a single disorder may not be adequate, supporting an understanding of these disorders along an inter-diagnostic spectrum. The complexity of obsessional presentations calls into question how we define psychosis that lies at the intersection of schizophrenia and extreme cases of OCD, and begs us to reflect on a more holistic understanding of these disorders.

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