EDITORIAL

SCHIZO-OBSESSIVE DISORDER; A DIAGNOSTIC MILESTONE IN CLINICAL PSYCHIATRY

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Schizophrenia is classified as a major psychiatric ailment. Its presentation is often quite remarkable, and patients usually present with unique symptoms. Obsessive compulsive disorder is an other mental illness with distinct features and presentation. There are multiple things which differentiate schizophrenia from Obsessive Compulsive Disorder (OCD) including clinical features. Some studies found that Schizo-obsessive patients have higher education and occupational functioning in comparison with schizophrenic patients without obsessive-compulsive features[1].

Yet there are some features which are common to both. These features include both having neurodevelopmental aeteological factors, and patients suffering from these disorders have family history of affective disorders, OCD and schizophrenia. Obsessive-compulsive symptoms are observed to be more prevalent in schizophrenics as compared with the general population[2]. Even the works of early clinicians like Kraepelin and Bleuler reflect the presence of obsessive-compulsive symptoms in their schizophrenic patients[3,4]. This thing has been under the debate for several decades and quite many mental health professionals support the formation of a new entity termed as "Schizo-Obsessive Disorder".

Recently a new entity is introduced in literature termed as schizo-obsessive spectrum disorders which embraces schizo-obsessive disorder, schizophrenia with Obsessive-Compulsive Disorder (OCD), schizophrenia with Obsessive-Compulsive Symptoms, Schizotypal Personality Disorder with OCD, OCD with psychotic features, and OCD with poor insight[5]. It is often difficult to distinguish among these entities. To simplify things, patients who fulfil the criteria for both Schizophrenia and OCD are considered to be suffering from schizo-obsessive disorder. Although the two major psychiatric classification systems (DSM 5 & ICD 11) broadly used worldwide are not able to acknowledge this disorder as a separate entity. It requires further data, exploration and research. Even the current editions of major psychiatric textbooks that are commonly used worldwide by the psychiatrists and trainees have not highlighted schizo-obsessive disorder. Though the latest edition of Oxford Textbook of Psychiatry does mention the term "schizo-obsessive" and accepts it as a disorder that warrants clinical attention[6]. On the brighter side eminent psychiatrist Dr. Michael Poyurovsky authored a book titled "Schizo Obsessive Disorder" which was published by Cambridge University Press in 2013. This book is dedicated solely to this specific disorder and covers all aspects of this unique illness in detail[7].

It is estimated that around 30% of the patients suffering from schizophrenia also experience comorbid obsessive-compulsive symptoms and 12% of these patients also fulfil the criteria of Obsessive-Compulsive Disorder (OCD)[8]. The genetic basis of schizo-obsessive disorder can be explained by the implication of Catechol-O-methyltransferase (COMT) gene polymorphism in patients suffering from schizophrenia with obsessive-compulsive features[9]. The major neurotransmitters attributable to the underlying pathology of this disorder includes dopamine and serotonin[10]. There are specific neuroanatomic pathologies implicated in patients suffering from schizo-obsessive disorder[11]. Fronto-basal ganglia circuits dysfunction carries importance in such patients. Gray matter volume is reduced in patients suffering from schizo-obsessive disorder in specific regions of the brain which includes medial orbitofrontal cortex, medial superior frontal gyrus, anterior cingulate cortex, rectus gyrus, left thalamus and left inferior semi-lunar lobule of the cerebellum. Cortical thickness is also reduced in these patients particularly in right supplementary motor area, right superior temporal gyrus, right middle cingulate cortex, right angular gyrus and right middle occipital gyrus. These changes are specific to patients suffering from schizo-obsessive disorder[12]. MRI of patients with schizo-obsessive disorder reveal that with increasing duration of illness the size of frontal lobe shrinks and this phenomenon is not seen in patients suffering from schizophrenia without obsessive-compulsive symptoms. In another study which revolved around measuring the sizes of anterior horn of lateral ventricle and third ventricle using MRI scans of the brain found that these structures are enlarged in schizo-obsessive patients in comparison with patients with only schizophrenia[13]. On functional MRI (fMRI) lower activation of left dorsolateral prefrontal cortex is linked with the increasing severity of obsessive-compulsive symptoms[14].

The obsessions and compulsions encountered in patients suffering from schizophrenia are usually bizarre in nature. The obsessions may be of sexual or religious nature. Schizophrenics usually report obsessive-compulsive symptoms not being egodystonic and patients perceive them as arising from within[15].

Results from recent studies conclude that patients with schizo-obsessive disorder suffer from higher rates of cognitive deficits, depression, suicidal ideation and social dysfunction when compared with patients who suffer from schizophrenia alone. The presence of obsessive-compulsive symptoms in patients with schizophrenia carry poor prognosis. Schizo-obsessive patients carry an increased risk of suicide. There is a strong association between suicide and score on Yale-Brown Obsessive Compulsive Scale (Y-BOCS). Higher scores on Y-BOCS carry an increased risk of suicide[8]. The patients diagnosed with schizo-obsessive disorder demonstrated lower neuro-psychological functioning when assessed using Wisconsin Card Sorting Test in comparison with patients diagnosed with schizophrenia only specifically in areas like cognitive abilities, non-verbal memory, visuospatial skills and executive functions[16].

It is noted that a subset of patients with schizophrenia starts to manifest obsessive-compulsive features after initiation of the treatment with second generation antipsychotics. This phenomenon is more prevalent in patients being treated with Clozapine[8]. First generation typical antipsychotics have negligible effects on the serotonergic pathways in the brain and that makes them not much effective in schizo-obsessive patients. Among second generation antipsychotics, there is a dilemma of paradoxical effect of some antipsychotics worsening the obsessive-compulsive symptoms. Clozapine and risperidone are notorious for worsening obsessive-compulsive symptoms. Quetiapine is also another second-generation atypical antipsychotic which can cause exacerbation of obsessive compulsive features[17]. Olanzapine and aripiprazole have shown good results in patients suffering from schizo-obsessive disorder. Quite often augmentation with an anti-obsessional agent like Clomipramine and Selective Serotonin Reuptake Inhibitors (SSRIs) e.g. Sertraline, Fluoxetine and Fluvoxamine is required. Non-pharmacological interventions including Cognitive-Behavioural Therapy (CBT) can also be used for obsessive-compulsive symptoms[18]. Treatment resistant patients suffering from schizo-obsessive disorder often show good response to electroconvulsive therapy (ECT)[19].

Literature contains ample evidence that supports the reality of schizo-obsessive disorder, yet psychiatrists are quite often reluctant to make this diagnosis. Consultants and supervisors exhibit reservations on this diagnosis, especially for their trainees to avoid the term in examination settings where this particular diagnosis can land a trainee into difficulties. This can partly be explained by the fact that more research is required in this field to clear out the nosological dilemma of placement of this disorder as it is in no man's land . It may be classified either along with schizophrenia or as a variety of OCD. Psychiatrists need to share their experience regarding this entity, its presentation in clinical settings and response to different treatment options on different forums. Patients presenting with features of schizo-obsessive disorders are rising, probably due to increased recognition of this entity among psychiatrists. Supervisors also need to acknowledge this entity and guide their trainees in the early recognition and ample treatment of this disorder. They should be encouraging the psychiatrists of the future to accept and diagnose schizo-obsessive disorder.

The aim of this discussion is to highlight the significance of schizo-obsessive disorder as a separate entity and to warrant special attention of psychiatrists along with specific treatment guidelines for this illness. It is the need of the hour to recognize this disorder and impart the due attention it deserves as the patients with this disorder carry greater morbidity and distress. It requires treatment strategies that are not possible while disregarding the existence of this entity using conventional mindset. We see recognition of schizo-obsessive disorder as the up coming milestone to achieve in the near future.

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