The Overlooked Mind, Schizo-Obsessive Disorder in Rural Nepal

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ABSTRACT

Schizo-obsessive disorder (SOD) is a diagnostic construct that represents the comorbidity of schizophrenia and obsessive-compulsive symptoms (OCS). It remains underrecognized in clinical practice, particularly in resource-limited and rural settings. We present the case of a 67-year-old male from a remote village in Jumla, Nepal, with a history of early-onset psychotic symptoms followed by obsessive-compulsive manifestations. The clinical course highlights the diagnostic complexity in differentiating between primary obsessive-compulsive symptoms, pseudo-obsessive phenomena, and schizo-obsessive disorder. The case also highlights the importance of timely coordination between dermatologists and psychiatrists, particularly when chronic physical complications arise due to repetitive behaviors.

KEY WORDS

Obsessive-compulsive symptoms, Pseudo-obsessive phenomena, Rural Nepal, Schizo-obsessive disorder, Schizophrenia

INTRODUCTION

Schizo-obsessive disorder (SOD) is a complex and emerging concept in psychiatry, referring to the coexistence of schizophrenia and obsessive-compulsive disorder (OCD). Epidemiological studies indicate that obsessive-compulsive symptoms (OCS) are present in approximately 25% of patients with schizophrenia, with 12% meeting criteria for OCD.[1,2] The presence of OCS in schizophrenia is associated with greater illness severity, cognitive impairment, poor treatment response, and lower quality of life.[3,4]

In certain cases, patients may demonstrate pseudo-obsessive symptoms: ritualistic or compulsive-like behaviors driven primarily by delusional beliefs rather than true ego-dystonic obsessions.[5] Differentiating true OCD, pseudo-obsessive phenomena, and schizo-obsessive disorder has significant diagnostic and therapeutic implications.

This case report documents the clinical course of a 67-year-old male from Jumla, Nepal, who developed psychotic symptoms at age 17, followed by obsessive-compulsive manifestations two years later. His case illustrates the chronicity, psychosocial impact, and diagnostic complexity of schizo-obsessive disorder.

CASE REPORT

A 67-year-old unmarried male from a Hindu nuclear family from a remote village in Jumla, Nepal, unemployed due to illness, presented to the Dermatology outpatient department with chronic eczematous lesions on both hands and feet from repetitive washing rituals. His illness began at the age of 17 with psychotic symptoms, including anger, irritability on trivial issues at home, self-muttering, self-

smiling, delusions of persecution, delusions of reference, and bizarre delusions. He also reported a fixed religious belief that he was a God "son," based on a childhood dream in which Hindu deities Ram and Sita blessed him as he had faced a lot of trouble in his childhood, and he would be saluting everyone he met, despite being stopped by his family members. Disturb sleep and appetite, poor personal hygiene, and functional decline. He often wandered to nearby temples, neglecting family and social responsibilities.

Two years later, the patient developed additional behaviors like repetitive hand washing (initially 20–30 minutes, later increasing to 1–1.5 hours) five to ten times daily and compulsive washing of food plates 10–20 times despite family resistance. He developed a ritual of washing his legs whenever someone touched them, repeating this several times daily. As the illness progressed, he began spending hours at a nearby lake dipping his legs and hands, and would also spend prolonged periods at the government-provided water tap washing his extremities.

Due to chronic, repeated water immersion and repetitive scrubbing, the skin barrier of the hands and feet was altered. As a result, he subsequently developed eczematous lesions, and later these skin changes transformed to ulcerations and cellulitis over both hands and feet, therefore requiring urgent Dermatological and Surgical care. Skin examination revealed a thick, crusty eczematous lesion on the hands and feet with ulceration and prominent progression to cellulitis of the feet. On further exploration of the cause of the eczematous changes, the frequent obsession with hand washing, further psychiatric assessment was taken into consideration, for which the patient was referred to psychiatry for further management. On mental status examination, the patient showed poor grooming and hygiene, restricted mood and affect, disorganized thought processes, persistent religious and referential delusions in thought content, no reported hallucinations in perception, orientation to time/place and person in cognition, and poor insight and judgement.

Diagnostic assessment confirmed Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria for Schizophrenia (symptoms > 6 months duration, including delusions, disorganization, and negative symptoms) with pseudo-OCD features where rituals were ego-syntonic and delusion linked rather than distress driven; primary OCD was ruled out due to lack of ego-dystonia, and bipolar disorder due to absence of mania. Baseline investigations were unremarkable. Therapeutic intervention consisted of risperidone 4 mg/day targeting psychosis and fluoxetine 40 mg/day for residual OCS symptoms, titrated over 2 weeks without adverse effects. At one-month follow-up, rituals were reduced to under 30 minutes daily with milder delusions; ongoing outpatient psychiatric care was recommended, anticipating partial remission.

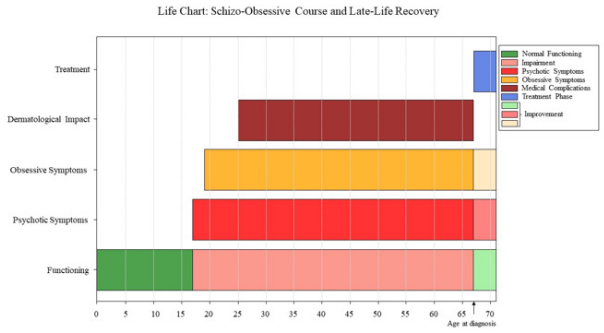

Figure 1. Life Chart: Schizo-Obsessive Course and Late-Life Recovery

Life Chart Interpretation

• Psychotic phase: Began at age 17 — persecutory and religious delusions, disorganized behavior, and decline in functioning.

• Obsessive phase: Started at age 19 — repetitive, prolonged washing rituals (pseudo-obsessive, not ego-dystonic).

• Overlap: Psychotic and obsessive symptoms coexisted chronically (schizo-obsessive course).

• Dermatologic consequence: Chronic water exposure → Eczematous changes, then ulceration and cellulitis.

• Improvement: Noted after initiation of antipsychotic + antidepressant treatment at age 67.

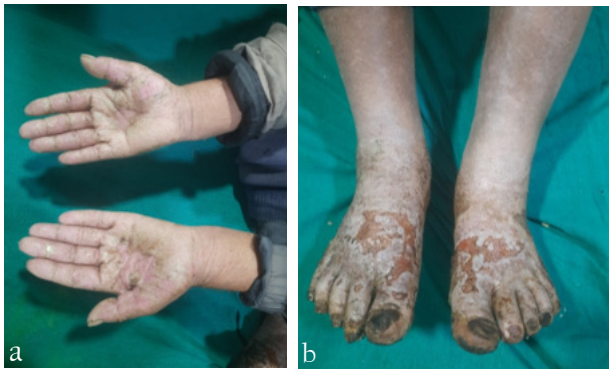

Figure 2a & b. Eczematous lesion with Ulceration and Cellulitis due to chronic hand washing

DISCUSSION

The coexistence of schizophrenia and OCS has been recognized as a distinct clinical entity, schizo-obsessive disorder. Patients often show an earlier onset of psychosis, a more severe clinical course, and greater functional impairment.[1,6] Differentiating between true OCD and pseudo-obsessive phenomena remains a diagnostic challenge. Unlike OCD, pseudo-obsessive symptoms are typically ego-syntonic, lack distress, and are closely tied to delusional beliefs.[5,7]

In this case, the patient's hand- and leg-washing rituals initially resembled OCD but were ultimately extensions of his psychotic framework and delusional conviction. His compulsive behaviors were ego-syntonic, resistant to external discouragement, and resulted in severe physical consequences on the skin (chronic eczema, then cellulitis and ulcerations). These features are consistent with pseudo-obsessive phenomena within schizo-obsessive disorder.

From a treatment perspective, antipsychotics remain the mainstay, though some (e.g., clozapine) may worsen OCS.[2] Selective Serotonin Reuptake Inhibitors (SSRIs) can be considered in true comorbid OCD but may have limited benefit in pseudo-obsessive states.[6] Psychosocial interventions, including psychoeducation and cognitive-behavioral therapy for psychosis, may further aid in reducing symptom burden and improving quality of life.[4,6]

The rural context of this case is also significant. Limited access to psychiatric services in Jumla delayed diagnosis and contributed to chronicity. Initial reliance on rituals and faith healing reflects the cultural framework of mental illness in rural Nepal, where psychiatric care is often sought only after medical complications arise.

This case underscores the importance of recognizing schizo-obsessive disorder and differentiating true OCD from pseudo-obsessive symptoms in psychosis. Chronic, untreated illness not only perpetuates psychiatric disability but may also result in severe physical morbidity, as seen in this patient. Early psychiatric evaluation for the dermatological consultation clinic in rural and resource-limited settings is critical for improving outcomes. Clinicians should maintain a high index of suspicion for schizo-obsessive presentations, and timely coordination between Dermatologist and psychiatrists is crucial for bringing a favorable outcome for the patients.

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