Raza and Gracious. *HCA Healthcare Journal of Medicine* (2022) 3:5
https://doi.org/10.36518/2689-0216.1338

Case Report

Sexual Obsessions in a Patient With Schizophrenia

Mohsin Raza, MD, MSc[1]; Barbara L. Gracious, MD[1,2,3]

Author affiliations are listed at the end of this article.

Correspondence to:
Mohsin Raza, MD, MSc
2001 Kingsley Ave
Orange Park, FL 32073
(mohsin.raza@hcahealthcare.com)

Abstract

Description

Obsessive-compulsive symptoms in schizophrenia are often initially unrecognized or missed entirely in the diagnostic process. Sexual obsession is common in patients with schizophrenia. Therefore, identifying sexual obsession early in treatment has significant implications for appropriate multidisciplinary management and prognosis. We report the case of a Hispanic male in his 20s who presented with self-injurious behavior and worsening psychotic symptoms in the context of a recent diagnosis of schizophrenia and without a past diagnosis or historical symptoms of obsessive-compulsive disorder (OCD). This report elucidates the importance of identifying the underlying cause of self-injurious behavior, which in this young man was due to new onset OCD presenting as sexual obsession comorbid with schizophrenia. Olanzapine, paroxetine, and cognitive behavioral therapy (CBT) were administered with good therapeutic response.

Keywords

obsessive-compulsive disorder; schizophrenia; obsessive behavior; comorbidity; diagnosis; medical history taking

Introduction

Diagnostic criteria of obsessive-compulsive disorder (OCD) include obsessions, compulsions, or both, that are time-consuming and cause clinically significant distress or impairment in social, occupational, or other areas of functioning.[1] Obsessions may take the form of fear from contamination, or preoccupation with sexual, religious, or aggressive themes, with or without accompanying compulsions such as cleaning, checking, hoarding, repeating, and arranging, in attempts to decrease anxiety and distress. In 2009 a 10% prevalence of obsessive-compulsive symptoms in patients diagnosed with schizophrenia was found.[2] Sexual obsession is common in schizophrenic patients but has not been adequately studied.[3] The cause of OCD comorbidity in schizophrenic patients is not fully understood, and only distinct explanations have been proposed for the high comorbidity rate.[4] Studies have suggested that OCD comorbid with schizophrenia is associated with poorer clinical outcomes, more severe psychotic symptoms, and worse social impairment.[5,6] Studies have noted varying clinical presentation, greater negative and depressive symptoms, and differences needed in clinical approach, including a need for psychosocial treatments.[4,5] In this case report, we describe the clinical correlates of sexual obsession in a patient with OCD and schizophrenia who presented with self-injurious behavior and psychosis.

Case Description

A Hispanic male in his 20s was brought to a community hospital emergency department by his parents due to self-injurious behavior (scratching and punching his face and forearm) and worsening psychotic symptoms. He had been diagnosed with schizophrenia 4 months earlier but he had no other significant past medical or psychiatric history. He was admitted to the inpatient psychiatric unit for further assessment and management.

During the initial interview, the patient stated emphatically that he did not want to talk to any female physicians or nurses, and he

© 2022 HCA Physician Services, Inc. d/b/a Emerald Medical Education

refused to take any medication. Upon further inquiry, he said he “has a very special woman" in his life, and he didn’t want to “share her with other women." He then refused to provide any additional information. Later, the patient reported anxiety and obsessive sexual thoughts but denied compulsions. He admitted to scratching himself and punching his head and the wall to distract himself and block the intrusive thoughts. He also reported a negative self-image, with the inability to socialize and interact with females, including his mother, due to being unable to control his distressing sexual thoughts. He had recently decided to move into a shelter to be away from his family due to intrusive sexual thoughts toward his mother and sister, and he admitted to being afraid he would act on these thoughts. His psychosocial functioning was significantly affected, as due to the obsessive thoughts and psychosis, he became more isolated from his family. He had also been fired from his job due to poor performance.

The patient was willing to talk about the “special women” on the sixth day of his hospital admission. He reported that he was not able to express his feelings to her due to his “inappropriate sexual thoughts.” He reported a fear of abandonment by her. He mentioned that he had committed several "sexual sins" such as "inappropriate sexual behavior and masturbation." He also admitted to inappropriate sexual thoughts of intending to have sexual affairs with women other than the “special woman,” whom he fantasized to be dressed in shorts. He admitted that talking to a female or the mere appearance of a female would provoke his sexual desire. He acknowledged his thoughts were unnecessary, excessive, and uncontrollable. Therefore, he preferred not to interact with females.

The patient’s mother and stepfather reported that he was placed under a 72-hour psychiatric hold 1 month prior to this admission, for hitting and scratching himself violently in a female therapist’s office. He was fired from his job at a liquor store in 2018 for too many missed days after his involvement in 2 motor vehicle accidents. He lost another job in August 2019 for poor performance. His stepfather stated that in October 2019 the patient began acting out with multiple episodes of anger during which he would hit the wall, hit himself in the face, and scratch himself. He began to isolate himself in his room and began talking to himself in front of the mirror. The stepfather stated the patient feared the air is polluted and is constantly trying to air out his room. His parents reported he has been religiously preoccupied and has disengaged from family members. They denied any known drug or alcohol use, tobacco product use, or legal issues.

The patient was born and raised in Puerto Rico by his mother and grandparents until age 8. He then moved to the United States at age 12 with his stepfather and mother. The patient has never known his biological father because he left the family before the patient was born. There is no history of childhood abuse, neglect, or trauma. He is single with no children. He is religious and goes to church every weekend. He completed some college, dropping out in June 2019 due to financial debt and wanting to focus on work. He had no learning problems growing up. He has no military service history. Additionally, there was no family history of psychiatric or medical illness. The patient was not on any psychotropic drugs. The only medication he tried in the past was risperidone.

The patient’s vital signs were within normal ranges. Physical examination showed multiple self-inflicted superficial scratches on his face and bilateral upper extremities. Neurological examination was unremarkable. Laboratory testing, including a complete blood count, comprehensive metabolic panel, liver and thyroid function tests, blood alcohol level, urinalysis, and urine drug screen were within normal limits.

On the mental status exam, the patient appeared his stated age and was wearing hospital paper scrubs. He was disheveled and poorly groomed. No abnormal movements or tics were noted. He had multiple scratch marks on his hands and face. He exhibited poor eye contact. He described his mood as “concerned and trapped.” His affect was flat and blunt. He appeared unduly suspicious of the interviewer and socially awkward. He was not violent or aggressive at the time of the interview. He showed significant thought blocking, in which long pauses occurred before he answered a question. His concentration was poor and questions had to be repeated multiple times.

His speech was difficult to follow due to the looseness of his associations; the sequence of his thoughts followed a logic that was clear to him but not to the interviewer. He was guarded, internally fixated, and extremely tangential and difficult to redirect. His thought processes were illogical and disorganized. His thought content included passive suicidal ideation, but he refused to talk about homicidal ideation. He also refused to answer questions about hallucinations. The patient expressed a variety of odd beliefs and was delusional about females and his parents, particularly his stepfather. He had poor insight and judgment. His fund of knowledge was poor, but he was oriented to time, place, and person.

Treatment Course

The patient was started on olanzapine 5mg by mouth (PO) twice per day (BID) to target his psychosis and paranoia. Initially, he received intramuscular olanzapine 5mg as needed (PRN) BID, with his mother as his proxy for consent, because he was refusing to take any medication. Paroxetine 20mg PO daily was added to target his sexual obsessions and anxiety. Motivational interviewing techniques were used to encourage and support him in continuing treatment. Olanzapine was titrated up to 10mg PO BID and paroxetine was kept at 20mg. The patient showed significant response with an apparent resolution of his internal preoccupation and self-injurious behavior. His thought processes became more goal-directed, he became more verbal, and his affect also improved. He started participating in group sessions and became less isolated. He was also seen multiple times interacting with nursing staff and therapists, including females. However, he continued to have sexual obsessions but reported they were less frequent and less distressing. He was discharged on olanzapine and paroxetine, and was scheduled for a follow-up appointment with an individual male therapist for cognitive behavioral therapy (CBT) to learn and develop personal coping strategies to better manage his obsessive sexual thoughts.

A telephone follow-up with his mother 1 month after discharge revealed that he has been doing significantly better. He is taking all his medications and is compliant with outpatient psychotherapy treatment. He is now less isolated and interacting well with his parents.

Discussion

We report the case of a young adult male who presented with self-injurious behavior, sexual obsession, and worsening psychotic symptoms in the setting of a recent diagnosis of schizophrenia. Since no 2 patients with schizophrenia have exactly the same symptoms, identifying any underlying comorbidities is key to establishing accurate diagnoses and collaborative work toward the most appropriate treatment approach.

Kim et al. reported that some patients with schizophrenia present with OCD features prior to their first psychotic episode or concurrently with psychotic symptoms at the onset of the illness, while a considerable number of patients manifest OCD comorbidity years after the onset of schizophrenia.[7] In our case, we were not sure whether the sexual obsessions were present prior to the first episode of psychosis. Patients with schizophrenia who have comorbid OCD often also display pronounced and sometimes treatment-resistant positive and negative symptoms.[8] Furthermore, they also report significant anxiety and depression when compared to patients with schizophrenia without OCD symptoms .[9]

Interestingly, this patient did not show any compulsive rituals to reduce his anxiety caused by his obsessive sexual thoughts, other than masturbation. His self-injurious behavior was the way to punish himself as he was aware that his behavior was not socially or religiously appropriate. Subramaniam et al. reported that approximately 90% of patients with OCD have both obsessions and compulsions, although 30% suffer predominantly from obsessions and 20% primarily from compulsions.[10] The most common comorbid psychiatric diagnoses in patients with OCD are depression, anxiety, and bipolar disorder.[4,10] However, our patient presented with psychosis.

This was an unusual initial presentation of sexual obsession that, combined with concurrent symptoms of schizophrenia initially presenting as paranoia and psychosis, posed a significant challenge in the diagnosis of the patient's condition, which likely would have led to a poor outcome without an accurate detection of OCD. Such patients exhibit specific cognitive defects such as inhibition deficit, which can

affect goal-directed behaviors and increase impulsivity, impacting their cognitive functioning. Patients with co-occurring schizophrenia and OCD suffer from more severe illness and complications, characterized by an earlier age of onset, poorer outcome, lower functioning, greater depressive symptoms, and suicidality. OCD can be considered a severity marker in schizophrenia.[11] It would have been helpful to have utilized the Yale-Brown Obsessive-Compulsive Scale ratings (YBOCS)[12,13] to further evaluate this patient's response to treatment, but the patient repeatedly refused to complete this instrument. On a Brief Psychiatric Rating Scale (BPRS)[14] at the time of admission, his score was 78 out of 126 and, at the time of discharge, it was 29, indicating significant improvement in his psychiatric symptoms and response to treatment. In this case, a comprehensive exploration of the origin of the patient's sexual thoughts was essential to the diagnosis of OCD with sexual obsessions. In our patient, it is possible that his Catholic and Puerto Rican heritage, and being raised by his grandparents as a young child, may have contributed culturally to a sense of guilt and shame over normal psychosexual development. Further questions about scrupulosity in extended family members would be of interest.

The available evidence supporting the use of CBT for OCD in those with schizophrenia is limited to smaller studies; additional controlled clinical trials are required.[12 15] However, a summary of the published reports on 30 comorbid patients who were treated with CBT showed favorable changes in outcome measures, with a significant reduction of OCD severity in 24 patients.[12 15]

Conclusion

This case highlights the importance of taking an accurate history and making a comprehensive clinical evaluation of psychotic patients when their symptoms arise from causes other than their primary psychiatric diagnosis. Behavioral disturbances such as agitation, psychosis, or self-injurious behavior, especially when violent, can lead to a rapid transfer to a psychiatric ward for the safety of the patient and others. Immediate treatment with antipsychotic agents without a comprehensive evaluation of other underlying biopsychosocial and cultural issues may limit outcomes and prognosis. OCD with sexual obsession in a newly-diagnosed schizophrenic patient is not a common presentation. In the present case, identifying OCD symptoms in the midst of a severe psychotic presentation was critical to ensuring accurate diagnosis and appropriate multidisciplinary treatment. Patients presenting with self-injurious behavior and psychosis should undergo a thorough and detailed assessment to identify the cause of the self-injurious behavior, particularly if there are other comorbid psychiatric diagnoses. A comprehensive exploration of the origin of the patient's behavior and symptoms, including collateral information from those who know the patient well, is essential to the diagnosis and multidisciplinary treatment of OCD with sexual obsessions comorbid with schizophrenia. In this case, a combination of a selective serotonin re-uptake inhibitor (paroxetine), an atypical antipsychotic (olanzapine), and CBT was effective in the management of symptoms of OCD with sexual obsessions comorbid with schizophrenia.

Conflicts of Interest

Dr Gracious reports personal fees from Novo Nordisc, outside the submitted work.

Dr Raza reports no conflicts of interest.

Drs Gracious and Raza are employees of HCA Florida Orange Park Hospital, a hospital affiliated with the journal's publisher.

This research was supported (in whole or in part) by HCA Healthcare and/or an HCA Healthcare affiliated entity. The views expressed in this publication represent those of the author(s) and do not necessarily represent the official views of HCA Healthcare or any of its affiliated entities.

Author Affiliations

1. HCA Florida Orange Park Hospital, Orange Park, FL
2. Edward Via College of Osteopathic Medicine, Blacksburg, VA
3. The Ohio State University, Columbus, OH

References

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. American Psychiatric Association; 2013.

2. Hemrom S, Pushpa, Prasad D, Jahan M, Singh AR, Kenswar DK. Prevalence of obsessive compulsive symptoms among patients with schizophrenia. *Ind Psychiatry J*. 2009;18(2):77-80. doi:10.4103/0972-6748.62263
3. Poyurovsky M, Faragian S, Kleinman-Balush V, Pashinian A, Kurs R, Fuchs C. Awareness of illness and insight into obsessive-compulsive symptoms in schizophrenia patients with obsessive-compulsive disorder. *J Nerv Ment Dis*. 2007;195(9):765-768. doi:10.1097/NMD.0b013e318142ce67
4. Kokurcan A, Nazlı ŞB. Clinical correlates of obsessive-compulsive disorder comorbidity in patients with schizophrenia. *Indian J Psychiatry*. 2020;62(1):51-58. doi:10.4103/psychiatry.IndianJPsychiatry_268_19
5. Baytunca B, Kalyoncu T, Ozel I, Erermiş S, Kayahan B, Öngur D. Early onset schizophrenia associated with obsessive-compulsive disorder: clinical features and correlates. *Clin Neuropharmacol*. 2017;40(6):243-245. doi:10.1097/WNF.0000000000000248
6. Kayahan B, Ozturk O, Veznedaroglu B, Eraslan D. Obsessive-compulsive symptoms in schizophrenia: prevalance and clinical correlates. *Psychiatry Clin Neurosci*. 2005;59(3):291-295. doi:10.1111/j.1440-1819.2005.01373.x
7. Kim JH, Ryu S, Nam HJ, et al. Symptom structure of antipsychotic-induced obsessive compulsive symptoms in schizophrenia patients. *Prog Neuropsychopharmacol Biol Psychiatry*. 2012;39(1):75-79. doi:10.1016/j.pnpbp.2012.05.011
8. Cunill R, Castells X, Simeon D. Relationships between obsessive-compulsive symptomatology and severity of psychosis in schizophrenia: a systematic review and meta-analysis. *J Clin Psychiatry*. 2009;70(1):70-82. doi:10.4088/jcp.07r03618
9. Lysaker PH, Whitney KA. Obsessive-compulsive symptoms in schizophrenia: prevalence, correlates and treatment. *Expert Rev Neurother*. 2009;9(1):99-107. doi:10.1586/14737175.9.1.99
10. Subramaniam M, Soh P, Ong C, et al. Patient-reported outcomes in obsessive-compulsive disorder. *Dialogues Clin Neurosci*. 2014;16(2):239-254. doi:10.31887/DCNS.2014.16.2/msubramaniam
11. Tezenas du Montcel C, Pelissolo A, Schürhoff F, Pignon B. Obsessive-compulsive symptoms in schizophrenia: an up-to-date review of literature. *Curr Psychiatry Rep*. 2019;21(8):64. doi:10.1007/s11920-019-1051-y
12. Goodman WK, Price LH, Rasmussen SA, et al. The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. *Arch Gen Psychiatry*. 1989;46(11):1006-1011. doi:10.1001/archpsyc.1989.01810110048007
13. Goodman WK, Price LH, Rasmussen SA, et al. The Yale-Brown Obsessive Compulsive Scale. II. Validity. *Arch Gen Psychiatry*. 1989;46(11):1012-1016. doi:10.1001/archpsyc.1989.01810110054008
14. Overall JE, Gorham DR. The brief psychiatric rating scale. *Psychol Rep*. 1962;10(3):799-812. doi:10.2466/pr0.1962.10.3.799
15. Schirmbeck F, Zink M. Comorbid obsessive-compulsive symptoms in schizophrenia: contributions of pharmacological and genetic factors. *Front Pharmacol*. 2013;4:99. doi:10.3389/fphar.2013.00099