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Complex Presentation of Schizophrenia-Spectrum Psychosis with Obsessive-Compulsive Symptoms: A Psychiatric Case Report from Somaliland

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Case Report

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Abstract

Background

The co-occurrence of schizophrenia-spectrum psychosis and obsessive-compulsive symptoms presents diagnostic and therapeutic challenges. Although often described in the literature as a schizo-obsessive presentation, this term is descriptive and does not represent a formal DSM-5 diagnostic subtype.

Case Presentation:

A 24-year-old Somali male presented with a 6-month history of auditory hallucinations, paranoid delusions, and severe compulsive rituals, including repetitive handwashing, lock-checking, and counting behaviors. There was no family history of psychiatric illness, substance use, neurological illness, or major medical comorbidity. Clinical evaluation, laboratory investigations, and brain CT scan did not suggest an organic cause. Baseline assessment showed severe psychotic and obsessive-compulsive symptoms, with a PANSS score of 92 and a Y-BOCS score of 32/40.

Intervention:

The patient was treated with risperidone, initiated at 2 mg/day and titrated to 6 mg/day over two weeks, together with fluvoxamine, initiated at 50 mg/day and gradually increased to 200 mg/day over four weeks. Psychotherapy included cognitive-behavioral therapy with structured exposure and response prevention targeting contamination fears, checking rituals, and counting behaviors.

Outcomes:

Over 12 weeks of follow-up, the patient showed marked clinical improvement. PANSS decreased from 92 at baseline to 54 by week 8 and 42 by week 12, while Y-BOCS decreased from 32/40 at baseline to 22 by week 6 and 14 by week 12. Improvements were accompanied by reduced hallucinations, fewer compulsive rituals, better daily functioning, good adherence, and no major reported adverse effects.

Discussion

This case highlights the importance of multimodal treatment, including antipsychotic medication, SSRI therapy, ERP-based psychotherapy, psychoeducation, and family involvement in managing complex psychosis with obsessive-compulsive features.

Conclusion

Integrating pharmacological therapy, behavioral interventions, culturally sensitive psychoeducation, and family engagement can achieve meaningful short-term outcomes in schizophrenia-spectrum psychosis with obsessive-compulsive symptoms in low-resource settings.

1. Introduction

Psychiatric disorders frequently exhibit overlapping symptoms, which complicate diagnostic clarity and treatment decisions (1, 2). Among these, the co-occurrence of psychosis and obsessive-compulsive disorder (OCD) has increasingly been recognized as a distinct clinical phenomenon often referred to as the schizo-obsessive spectrum (3, 4). Although the term “schizo-obsessive disorder” is used in the literature, it is not formally recognized as a distinct DSM-5 diagnostic subtype. In this report, the term is used descriptively to refer to a schizophrenia-spectrum presentation with clinically significant obsessive-compulsive symptoms. This distinction is important because obsessive-compulsive symptoms with poor insight may resemble delusional beliefs, while psychotic symptoms may complicate the recognition and treatment of OCD. Psychotic disorders typically present hallucinations, delusions, and disorganized thinking, while OCD is characterized by intrusive thoughts and repetitive, distressing rituals (5–7). Growing evidence suggests shared neurobiological pathways and a higher-than-expected rate of comorbidity, supporting the conceptualization of these conditions along a spectrum rather than as entirely separate entities (8–10). This overlap not only raises challenges for accurate diagnosis but also requires careful consideration when developing integrated therapeutic approaches.

In Somaliland, mental health care faces unique challenges due to limited psychiatric infrastructure, a scarcity of trained professionals, high levels of stigma, and continued reliance on traditional healing practices (11, 12). These systemic barriers increase the likelihood of delayed or missed diagnoses, inappropriate treatments, and poorer patient outcomes. Against this backdrop, this case report describes a young Somali man presenting with concurrent psychotic and obsessive-compulsive symptoms. By outlining diagnostic reasoning, therapeutic interventions, and short-term outcomes, the report aims to contribute to the sparse literature on complex psychiatric comorbidities in low-resource settings and to highlight the potential for culturally adapted, evidence-based care.

2. Case Presentation

We report the case of a 24-year-old Somali male who presented to a psychiatric outpatient clinic in Hargeisa, Somaliland, with a 6-month history of auditory hallucinations, paranoid delusions, and repetitive compulsive behaviors. He was brought for assessment because of progressive functional decline, social withdrawal, worsening suspiciousness, and time-consuming compulsive rituals that interfered with daily functioning.

Reporting guideline and clinical interview approach: This case report was prepared in accordance with the CARE guidelines. Clinical information was obtained through routine psychiatric history-taking, collateral history from family members, a mental status examination, and a DSM-5-informed clinical

diagnostic interview conducted as part of the patient's clinical care. No study-specific research interview guide or unpublished questionnaire was developed or used, and no previously published standalone interview instrument was administered. Standardized symptom severity was assessed using the Positive and Negative Syndrome Scale (PANSS) and the Yale-Brown Obsessive Compulsive Scale (Y-BOCS).

The hallucinations consisted of voices commenting on his actions and occasionally issuing derogatory remarks. His delusional ideation centered on fears of being followed and harmed by unknown individuals. In addition, the patient engaged in severe compulsive rituals, including repetitive handwashing more than 30 times per day, prolonged lock-checking, and excessive counting routines that occupied more than four hours daily. These behaviors caused significant distress, impaired his daily functioning, and disrupted family life.

The compulsive behaviors were experienced as repetitive, distressing, and difficult to resist. The patient reported temporary relief after performing the rituals, followed by recurrence of anxiety and urge to repeat them. This pattern supported the presence of obsessive-compulsive phenomena rather than purely delusion-driven repetitive behavior, although insight into the irrationality of the rituals was partial.

There was no family history of psychiatric disorders, neurological illness, or substance abuse, and no significant medical comorbidities. Socially, the patient lived with his parents, had completed secondary school, and was unemployed due to worsening symptoms. There was no reported history of previous psychiatric admission, head trauma, seizure disorder, or chronic medical illness. No current alcohol or psychoactive substance use was reported. The patient's symptoms had progressively affected his social functioning, sleep pattern, occupational plans, and participation in family responsibilities.

Mental Status Examination

On mental status examination, the patient appeared anxious and guarded but was cooperative during the interview. His speech was coherent and relevant, with normal volume and rate. His mood was subjectively anxious, and affect was restricted but appropriate to the interview context. Thought content revealed persecutory delusions involving fears of being followed and harmed, as well as contamination-related intrusive thoughts associated with repetitive washing and checking rituals. He reported auditory hallucinations consisting of voices commenting on his actions and occasionally making derogatory remarks. Thought process was generally goal-directed, with no clear formal thought disorder observed during the interview. He was oriented to time, place, and person, and gross cognitive functioning appeared intact. Insight was partial regarding compulsive behaviors but limited regarding persecutory beliefs. Judgment was impaired in relation to symptom-driven avoidance and rituals. No acute suicidal or homicidal intent was reported during assessment.

Physical and neurological examinations were unremarkable. Routine laboratory investigations, including complete blood count, liver and renal function tests, thyroid function, and infectious disease screening, were all within normal limits. A CT scan of the brain was normal, reducing the likelihood of structural or organic causes.

Symptom severity was quantified using standardized tools. The baseline PANSS score was 92, indicating severe psychotic symptomatology, while the Y-BOCS score was 32/40, indicating severe obsessive-compulsive symptoms(13–15). The overall clinical formulation was schizophrenia-spectrum psychosis with prominent obsessive-compulsive symptoms. The term “schizo-obsessive” is used descriptively in this report to reflect the coexistence of psychotic symptoms and clinically significant obsessive-compulsive features, rather than as a formal DSM-5 diagnostic subtype.

Therapeutic Interventions

The patient was initially admitted for stabilization and started on risperidone 2 mg/day, which was titrated to 6 mg/day over two weeks. This dose was maintained because it achieved adequate control of positive psychotic symptoms without clinically significant extrapyramidal side effects. In parallel, fluvoxamine was initiated at 50 mg/day and gradually increased to 200 mg/day over four weeks to target obsessive-compulsive symptoms. The patient tolerated this combination well, with no significant adverse effects reported during the treatment period. Safety monitoring included clinical assessment for extrapyramidal symptoms, sedation, gastrointestinal intolerance, sleep disturbance, activation symptoms, weight change, blood pressure, and other tolerability concerns. Where available, basic metabolic monitoring was considered because of the long-term metabolic risks associated with antipsychotic treatment.

After acute stabilization, the patient commenced cognitive-behavioral therapy sessions with a focus on exposure and response prevention. The ERP hierarchy was collaboratively developed, beginning with lower-anxiety triggers, such as reducing handwashing frequency, and gradually addressing more distressing compulsions, including lock-checking and prolonged counting rituals. Each session incorporated psychoeducation, anxiety-management skills, and relapse-prevention strategies. Progress was monitored weekly using Y-BOCS scores.

By the sixth week of combined pharmacological and psychotherapeutic management, the patient demonstrated marked reductions in compulsive rituals and improved insight. Delusional ideation and hallucinations also diminished, reflected in lower PANSS scores. Table 1

Table 1
Weekly Timeline of Integrated Pharmacologic and Psychotherapeutic Intervention in a Schizo-Obsessive Case.

Time point	Clinical focus	Intervention	PANSS	Y-BOCS	Response
Baseline	Admission and diagnostic assessment	Clinical assessment, labs, CT brain, PANSS, Y-BOCS	92	32	Severe psychotic and OCD symptoms
Week 1	Acute stabilization	Risperidone initiated at 2 mg/day	—	—	Partial symptom control
Week 2	Medication titration	Risperidone titrated toward 6 mg/day; fluvoxamine initiated	—	—	Psychotic symptoms began to stabilize
Week 4	OCD-focused treatment	Fluvoxamine titration continued; CBT/ERP established	—	—	Improved engagement and reduced ritual intensity
Week 6	ERP progression	Continued risperidone, fluvoxamine, and ERP	—	22	OCD symptoms reduced from severe to moderate
Week 8	Psychosis monitoring	Continued medication and psychotherapy	54	—	Hallucinations and delusional intensity reduced
Week 12	Maintenance follow-up	Continued relapse prevention, family support, adherence monitoring	42	14	Mild residual symptoms and improved functioning

Discharge and Maintenance Plan

At discharge, the patient was maintained on risperidone 6 mg/day and fluvoxamine 200 mg/day. He continued structured CBT sessions once weekly for three months, with plans to taper to biweekly thereafter. Family members were engaged in psychoeducation sessions to support adherence, reduce stigma, and reinforce ERP practice at home.

The patient was instructed to attend monthly follow-up appointments for monitoring of symptom relapses, medication adherence, and potential side effects (e.g., metabolic syndrome with long-term risperidone use). No adverse events or tolerance issues were reported during the follow-up period described. The family was advised to monitor early warning signs of relapse, including sleep disturbance, increased suspiciousness, return of commentary voices, worsening contamination fears, increased handwashing, repeated lock-checking, and functional withdrawal. A clear follow-up plan was provided to encourage early clinical review if symptoms worsened.

Follow-up and Outcomes

The patient was followed for three months after discharge, with structured clinical reviews at weeks 2, 4, 8, and 12. Symptom severity was monitored using PANSS and Y-BOCS. PANSS decreased from 92 at baseline to 54 by week 8 and 42 by week 12. Y-BOCS decreased from 32/40 at baseline to 22 by week 6 and 14 by week 12. These changes indicated substantial improvement in both psychotic and obsessive-compulsive symptom domains.

The patient's auditory hallucinations (commentary voices) subsided by week 8, with no recurrence during the follow-up. Compulsive behaviors such as repetitive handwashing and lock-checking were significantly reduced in frequency and distress, with sustained gains during ERP maintenance.

Adherence to risperidone (6 mg/day) and fluvoxamine (200 mg/day) was confirmed by self-report and pill counts; no metabolic, cardiovascular, or extrapyramidal side effects were detected. Engagement with CBT was consistently high, supported by family involvement.

From a functional perspective, the patient demonstrated marked improvements in daily life, including resumption of household responsibilities, improved sleep, and reduced social withdrawal. He reported improved confidence in resisting compulsive urges, particularly with family reinforcement of ERP strategies.

The patient reported that psychoeducation helped him understand his symptoms and reduced his fear of treatment. He described family support as important for maintaining medication adherence and practicing ERP strategies at home.

Patient Perspective

The patient stated that the combined treatment helped him feel safer, sleep better, and regain confidence in resisting compulsive urges. He valued the explanations provided by the clinical team and the involvement of his family, which made it easier for him to continue medication and practice exposure and response prevention exercises at home.

Figure 1. Diagnostic and treatment decision flow for the reported case.

The diagnostic and treatment decision flowchart offers a structured and systematic depiction of the clinical management pathway employed in this case. Beginning with symptom onset, the flowchart emphasizes the importance of a comprehensive clinical assessment, including a mental status examination, a DSM-5-informed clinical diagnostic interview, and exclusion of organic etiologies through neuroimaging and laboratory testing. This stepwise evaluation reflects internationally accepted diagnostic guidelines and underscores the critical role of differential diagnosis in complex psychiatric presentations. The identification of schizophrenia with obsessive-compulsive features as the primary diagnosis demonstrates the need to recognize symptom overlap and the nuances of comorbidity, particularly in young patients presenting with both psychotic and compulsive behaviors.

The subsequent treatment and monitoring phases highlight the value of integrated care. The use of risperidone and fluvoxamine, in tandem with cognitive-behavioral therapy (CBT) focused on exposure and response prevention (ERP), illustrates an evidence-based, multimodal therapeutic strategy. Safety netting procedures, including regular monitoring for side effects, ensure the pharmacological regimen remained safe and tolerable. Finally, the flowchart outlines discharge planning through psychoeducation and relapse prevention, aligning with global standards for continuity of care. Visual representation not only enhances the readability of the clinical course but also serves as a practical model for other mental health practitioners operating in similar low-resource settings like Somaliland. This structured approach bridges clinical theory and real-world practice, advocating for adaptable frameworks that can inform future psychiatric case management in sub-Saharan Africa.

The diagnostic and treatment decision pathway used in this case is summarized in Fig. 1.

3. Discussion

This case underscores the diagnostic complexity of schizophrenia-spectrum psychosis with prominent obsessive-compulsive symptoms. Although obsessive-compulsive disorder is not formally recognized as a DSM-5 subtype within schizophrenia, the term “schizo-obsessive” is widely used descriptively to refer to the co-occurrence of psychotic and obsessive-compulsive symptoms. In the present case, the coexistence of auditory hallucinations, persecutory delusions, intrusive contamination-related fears, and time-consuming compulsive rituals created a diagnostic challenge requiring careful differentiation between obsessions, compulsions, delusions, and poor insight

Differential diagnoses included OCD with poor or absent insight, schizoaffective disorder, mood disorder with psychotic features, substance- or medication-induced psychosis, psychosis due to another medical condition, and brief psychotic disorder. OCD with poor insight alone was considered insufficient to explain the persistent auditory hallucinations and persecutory delusions. Schizoaffective disorder and mood disorder with psychotic features were less likely because there was no clear history of sustained manic or major depressive episodes occurring alongside the psychotic symptoms. Substance-related and organic causes were considered less likely based on the clinical history, normal physical and neurological examinations, unremarkable laboratory investigations, and normal brain CT scan. The 6-month duration, functional decline, hallucinations, and delusions supported a schizophrenia-spectrum formulation with prominent obsessive-compulsive symptoms.

When compared with the available literature, the case aligns with reports showing that comorbid OCD in schizophrenia is associated with greater severity of psychotic symptoms and poorer psychosocial functioning (16, 17). Large cohort studies confirm that obsessive-compulsive symptoms in schizophrenia correlate with impaired activities of daily living, difficulties in social relationships, and reduced overall functioning (18, 19). Published case reports describe similar clinical courses and support the use of integrated pharmacological and behavioral approaches (20, 21). Although rare, the

existing evidence base is steadily growing, and this case contributes to the global understanding of schizo-obsessive disorder, especially from a low-resource setting.

The addition of fluvoxamine was clinically justified by the severity of obsessive-compulsive symptoms but required gradual titration and monitoring because serotonergic treatment may influence anxiety, sleep, activation symptoms, and overall symptom burden (22, 23). The patient's improvement likely reflected the combined effect of antipsychotic stabilization, SSRI treatment, ERP, psychoeducation, and family support rather than the effect of a single intervention. Risperidone is generally regarded as a first-line atypical antipsychotic, and fluvoxamine has proven efficacy in obsessive-compulsive symptom reduction. In addition, cognitive-behavioral therapy with exposure and response prevention targeted compulsive rituals such as repetitive handwashing, lock-checking, and counting behaviors (24). The patient's positive response illustrates the feasibility of multimodal treatment even in resource-constrained environments when family support and structured follow-up are incorporated.

In the Somaliland context, family engagement is particularly important because families often provide daily supervision, medication support, financial assistance, and help-seeking decisions. Involving the family in psychoeducation may therefore reduce stigma, improve adherence, and support behavioral interventions such as ERP outside the clinic.

This report has several limitations. First, as a single case report, the findings cannot be generalized to all patients with psychosis and obsessive-compulsive symptoms. Second, the follow-up period was limited to three months and therefore does not establish long-term stability, relapse risk, or medication tolerability. Third, because pharmacological treatment, ERP, psychoeducation, and family support were introduced together, the relative contribution of each intervention cannot be determined. Fourth, some follow-up information, including adherence and functional improvement, relied partly on patient and family report. Finally, cultural interpretations of psychiatric symptoms may influence symptom disclosure and help-seeking behavior, and this should be considered when interpreting the case.

In conclusion, this case illustrates the diagnostic and therapeutic complexity of schizophrenia-spectrum psychosis with prominent obsessive-compulsive symptoms. It highlights the value of careful diagnostic assessment, exclusion of organic and substance-related causes, standardized symptom monitoring, pharmacological treatment, ERP-based psychotherapy, psychoeducation, and family engagement. The favorable short-term outcome suggests that integrated and culturally sensitive psychiatric care may be feasible in low-resource settings, although longer follow-up and larger studies are needed.

Declarations

Ethics approval and consent to participate

The case report was reviewed and determined exempt from full review by the Hargeisa Group Hospital Health Research Ethics Committee, Hargeisa, Somaliland (Approval/Exemption Ref: HGH/RD/0242, Date: 03/02/2025). The study was conducted in accordance with the ethical principles of the Declaration

of Helsinki. The patient received a full explanation of the purpose of publication and provided written informed consent to share anonymized clinical details. Potentially identifying details were removed or generalized to protect confidentiality while preserving the clinical meaning of the case.

Consent for publication:

Written informed consent for publication of the anonymized case details was obtained from the patient. Identifying information has been removed or generalized to protect confidentiality.

Competing interests:

The authors declare that they have no competing interests.

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Author Contribution

Y.H.M. conceived the report, coordinated clinical data acquisition, and drafted the initial manuscript. B.M. contributed to diagnostic formulation, literature review on psychosis–OCD comorbidity, and critical revision of the clinical discussion. A.H.M. assisted with chart extraction, verification of timelines, and drafting of the case presentation. M.A.H. contributed to differential diagnosis, management rationale, and revisions to the methods and implications sections. S.N. provided senior academic oversight, refined the analytical framing, and performed critical revisions for intellectual content. All authors approved the final manuscript and agreed to be accountable for all aspects of the work.

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Data Availability

The data supporting the findings of this case report are contained within the article in anonymized form. Additional underlying clinical records are not publicly available because they contain sensitive and potentially identifiable patient information

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Figures

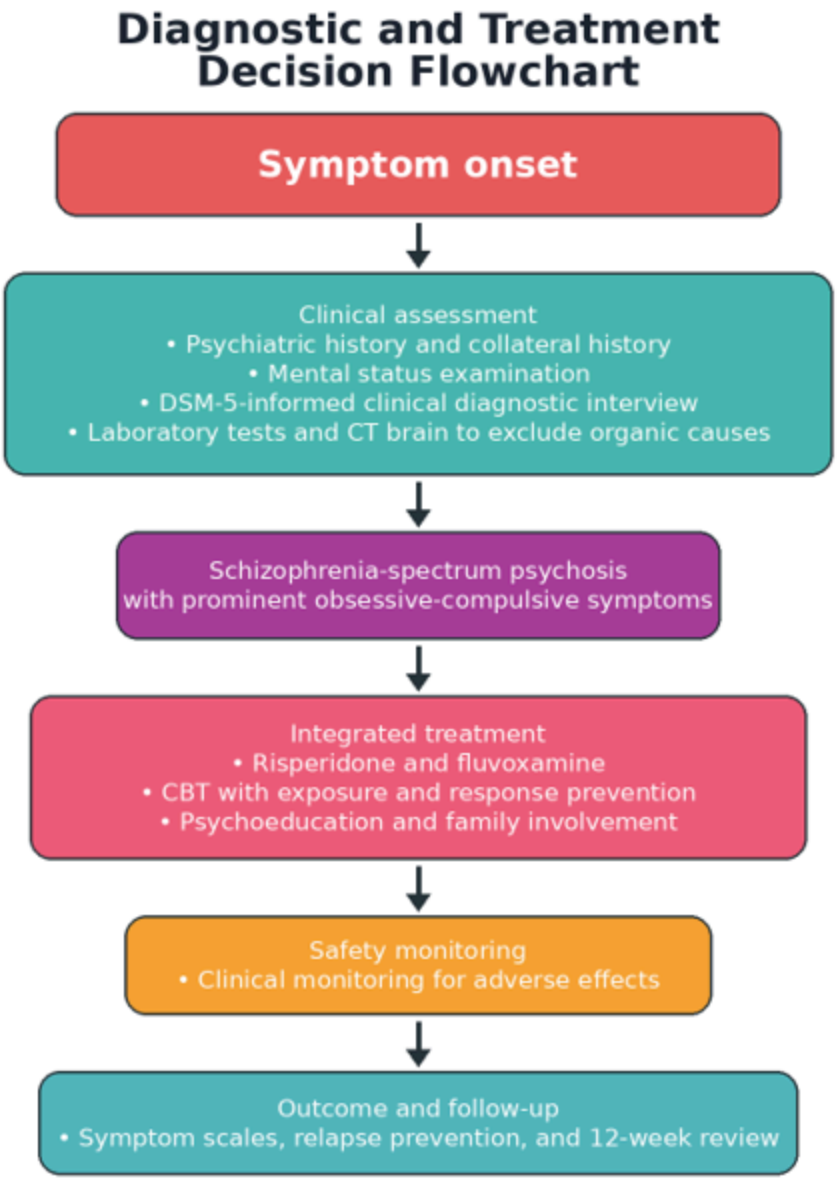


Figure 1

Diagnostic and treatment decision flow for the reported case.