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Case Study

Integrative Cognitive Behavior Therapy in the Treatment of Paranoid Schizophrenia with Obsessional Ruminations: A Single-Case Clinical Study

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ABSTRACT

Introduction: Those who experience both psychotic symptoms and obsessive-compulsive disorder encounter difficulties that extend well beyond the scope of standard treatment approaches. These individuals might encounter a perplexing blend of distressing thoughts, intense emotions, and actions that do not neatly align with conventional classifications. Consequently, they require therapeutic methods that are specifically designed to tackle not just paranoid anxieties and constant overthinking, but also the foundational patterns of unproductive thought that fuel these challenges. **Objectives:** This case study examines A.S., a 35-year-old research scholar diagnosed with Paranoid Schizophrenia (F20.0, incomplete remission) and Obsessive-Compulsive Disorder (F42.0, characterised by primarily obsessional thoughts and ruminations). The goal is to detail his clinical presentation, clarify the integrated cognitive-behavioral and metacognitive strategies employed to comprehend his challenges, and summarise the hospital-based CBT intervention tailored for him. **Method:** A comprehensive evaluation procedure was conducted, which involved a clinical interview, an in-depth mental status examination, and the use of standardised tools like the Y-BOCS and BPRS. The treatment plan was developed using established psychological models—Freeman's approach for persecutory delusions and Salkovskis' framework for OCD—while also integrating a metacognitive perspective that highlights how individuals can get stuck in cycles of repetitive, negative thinking. A.S. underwent this therapy in a hospital setting while on consistent medication. The intervention involved providing psychoeducation to assist him in understanding his experiences, normalising intrusive thoughts, challenging and reframing unhelpful beliefs, practicing detached mindfulness, and gradually engaging in behavioural experiments to lessen rumination, safety behaviours, and social avoidance. **Findings:** Throughout therapy, A.S. gained greater insight into his thought processes and developed the ability to manage distressing intrusive thoughts with reduced fear and self-judgment. He expressed a sense of reduced threat from paranoid thoughts and an increased ability to manage his emotions, which subsequently improved his connections with others. Post intervention, there was a notable reduction in his obsessive-compulsive symptoms and suspiciousness, shown by a decrease in his Y-BOCS score from 25 to 11, along with BPRS scores reflecting much milder symptoms. The paper emphasises the effectiveness of insight-oriented integrated cognitive behavioural therapy as a valuable addition to medication for

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patients dealing with complex comorbidities in standard hospital environments. **Conclusion:** A customized, integrative CBT strategy based on cognitive and metacognitive models can effectively reduce obsessional ruminations and persecutory ideation while improving functioning in a patient with paranoid schizophrenia and comorbid OCD.

Keywords: *Cognitive Behavior Therapy, Paranoid Schizophrenia, Obsessive-Compulsive Disorder, Insight, Metacognition*

Individuals with comorbid schizophrenia and obsessive-compulsive disorder (OCD) may present with complicated symptom constellations, such as psychotic experiences, intrusive ruminations, and significant affective dysregulation, complicating diagnostic and intervention planning. When persecutory delusions and ego-dystonic obsessions coexist, an integrated strategy is necessary to address both psychotic assessments and maladaptive metacognitive responses to intrusive thoughts. Cognitive models of persecutory delusions emphasize the importance of reasoning biases, threat-focused assessments, and safety actions in the maintenance of psychotic beliefs. Similarly, cognitive-behavioral and metacognitive models of OCD emphasize misinterpretation of intrusive ideas, thought-action fusion, and neutralizing behaviors as important coping mechanisms. Integrative CBT protocols that incorporate cognitive, behavioral, and metacognitive approaches have showed promise as supplementary therapies for psychosis with comorbid obsessive-compulsive symptoms.

This paper presents a case study of A.S., a 35-year-old male research scholar with ICD-10 diagnoses of Paranoid Schizophrenia (F20.0, incomplete remission) and Obsessive-Compulsive Disorder (F42.0, primarily obsessional thoughts or ruminations). The study examines socio-demographics, clinical aspects, cognitive-behavioral and metacognitive formulations, a structured hospital-based CBT intervention, and symptomatic and functional changes during therapy.

CASE PRESENTATION

A.S., a 35-year-old unmarried Bengali-speaking male residing with his nuclear family in a suburban area of West Bengal. The Ph.D. candidate and research scholar hails from a middle-class Hindu household and sustains himself via his stipend and savings. He was referred for psychological intervention by the Department of Psychiatry, IOP-COE, Kolkata, with primary complaints of: (a) profound guilt accompanied by a propensity to avert his gaze; (b) apprehension regarding a potential serious ocular condition; (c) recurrent intrusive thoughts of using abusive language towards others; (d) escalating social isolation; and (e) paranoia and fearful notions that others were conspiring to harm him. The onset of his disorder was insidious; however, with medication he showed some improvements since the referral.

During lockdown in March 2020, his friends called him by a sexually derogatory name due to his habit of continuously looking down at the screen. This particular event created a massive impact on him, making him feel guilty and ashamed in social interaction, especially with women. He reported obsessing over his eye blinking, which he felt as involuntary. He attributed this to a neurological disorder (ophthalmoplegia), which he mistakenly linked to his past alcohol consumption. Following this, from June 2020, after watching a lot of spiritual content on the internet, he took a resolution to change his previous habits of consuming alcohol, using slang, and engaging in any sexual act. He mentioned that he

wanted to live life as "pure" as possible. Since that time, he started getting repetitive unpleasant thoughts of uttering profanities to others, which reportedly made him feel anxious. He also stopped any masturbatory practice, followed by guilt and shame over morning erections and any sexual urges. His anxiety was frequently triggered upon hearing others use derogatory language or any sexual content in their conversations. As a result, he started to isolate himself from everyone and frequently felt low mood, resulting in crying spells.

In mid-June 2021, his suspiciousness over his phone being hacked started, and he felt that people were able to read his mind through his phone. He believed many social media and TV broadcast contents were directly referring to him. He was afraid of his paternal uncle, whom he thought was a 'tantric' and black magic practitioner who could read his thoughts and harm him. His childhood and teenage years were mostly friendly, but there were financial struggles and arguments between his parents and uncles. The patient recalled facing verbal abuse from cousins and feeling uneasy about his mother's pride in his academic achievements. Before the onset of his condition, he exhibited sociability, cheerfulness, responsibility, commendable academic and leadership skills, and lacked any severe disciplinary or interpersonal issues, indicating a well-adjusted premorbid personality. Alcohol consumption increased following relocation to a hostel during his graduation years; nevertheless, it did not fulfill the criteria for dangerous use or dependence and subsequently resolved completely, with total abstinence since June 2020. Family history shows a maternal uncle with psychosis and an older sister dealing with untreated depression and OCD.

Diagnostic Formulation

Based on ICD-10 and DSM-5 criteria, the final working diagnosis was: Paranoid Schizophrenia, incomplete remission (ICD-10: F20.0; DSM-5: 295.90, first episode currently in partial remission) and Obsessive-Compulsive Disorder, predominantly obsessional thoughts or ruminations, with good/fair insight (ICD-10: F42.0; DSM-5: 300.3).

The diagnosis of schizophrenia was supported by: persistent ideas of persecution and reference; thought broadcasting; marked decline in functioning in occupational and interpersonal domains; duration of continuous signs >6 months; and absence of substance/organic etiology. The OCD diagnosis was supported by recurrent intrusive aggressive/sexual thoughts, associated distress, cognitive compulsions (repetitive mental checking), ego-dystonicity, attempts at resistance, time consumption and functional impairment, and exclusion of other primary disorders. Good prognostic indicators included, higher education (Ph.D. level), good insight, partial remission of symptoms with pharmacotherapy, absence of significant cognitive deficits, adjusted premorbid personality, and good treatment compliance. Adverse prognostic factors comprised comorbid OCD symptoms, family history of psychosis and mood/OCD disorders, earlier heavy alcohol consumption, and critical comments from his mother about his illness.

COGNITIVE-BEHAVIORAL AND METACOGNITIVE FORMULATION

Cognitive Model of Persecutory Delusions

The formulation of persecutory ideation was based on Freeman et al.'s cognitive model of persecutory delusions, which emphasised triggering events, emotional arousal, reasoning biases, and safety behaviours. Triggers for A.S. included self-experienced anomalies (e.g., eye blinking, eyelid drooping), exposure to illness-related social media content, knowledge of dark-net and hacking, and strained relationships with family members considered to

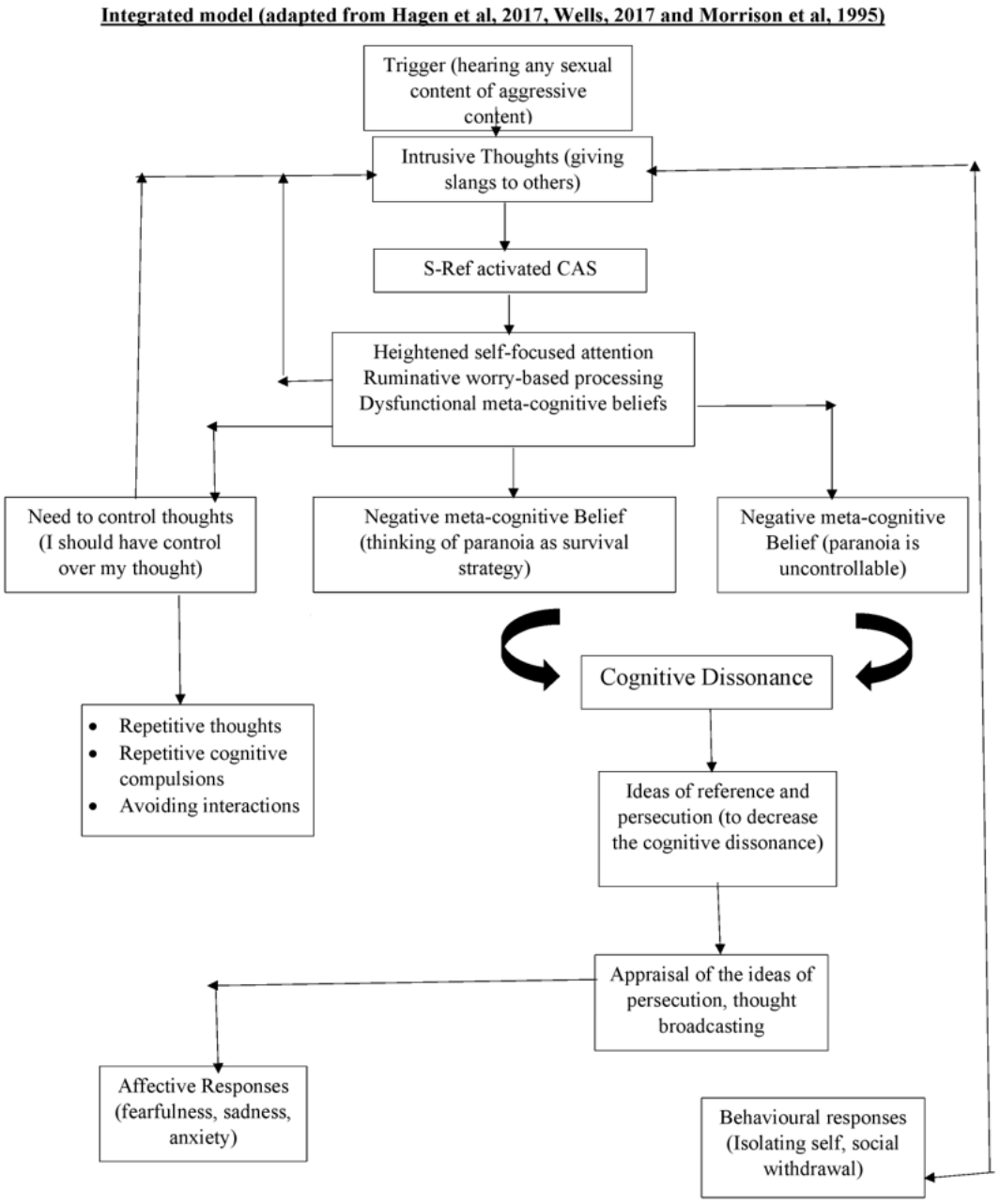
practise tantric rites. These triggers elicited significant levels of arousal, anxiety, and social retreat. Subsequently, all these experiences were followed by a search for meaning marked by threat-focused interpretations: his phone had been hacked, his mind could be read, and others (including relatives and mental health practitioners) may damage or humiliate him. His selective attention to confirmatory cues—such as algorithmically tailored thumbnails reading "Are you mentally ill?"—and safety behaviours like avoiding electronic devices and limiting social interaction maintained his persecutory views while preventing disconfirmation.

Cognitive Model of OCD

Salkovskis' cognitive model of OCD was used to conceptualise repeated intrusive aggressive thoughts of using derogatory language towards others and accompanying compulsions. Critical instances were negative comments from peers about his behaviour during lockdown, as well as his firm resolve to abstain from drink, slang, and sexual behaviours in order to live "purely." Core beliefs and assumptions revolved around exaggerated responsibility, moral rigidity, and thought-action fusion (for example, "if I think something bad, it is as bad as doing it," or "if I think of slangs or lustful thoughts, I am a bad person"). Intrusive ideas were severely misread as proof of moral failure and the possibility of physical injury, resulting in intense anxiety and shame. Neutralising tactics included mentally reviewing previous interactions, avoiding talks (particularly with women), suppressing sexual ideas, and engaging in excessive rumination, which paradoxically enhanced the salience and frequency of intrusions.

Integrated Metacognitive Model

An integrated CBT-metacognitive model (derived from Hagen et al., Wells,2009 and Morrison, 2001) was developed to describe the interaction of obsessions, paranoia, and the cognitive-attentional syndrome (CAS). Hearing sexual or aggressive content, or viewing illness-related material online, triggered intrusive thoughts about slangs and moral purity contamination, resulting in heightened self-focused attention, ruminative worry-based processing, and dysfunctional metacognitive beliefs such as "I must control my thoughts" or "paranoia keeps me safe." The cognitive dissonance between his desire to be "pure" and the persistence of intrusive thoughts led to repetitive rumination, avoidance of engagement, and escalation of ideas of reference and persecution as a method to explain internal distress. Appraisals of mind broadcasting ("people will know what I think") increased terror while maintaining social disengagement and hypervigilance.



Intervention

Given his good insight, psychological sophistication, and identifiable cognitive and metacognitive maintaining processes, Cognitive Behavior Therapy was chosen as the primary modality to address both obsessional ruminations and persecutory ideation. Short-term goals were: (a) therapy engagement; (b) psychoeducation regarding illness and CBT; (c) socialisation to the cognitive-metacognitive model; (d) identification of cognitive distortions and thought-action fusion; and (e) initial challenging of obsessional and delusional appraisals. Long-term goals were: (a) reattribution of beliefs and cognitive schemas; (b) reduction in obsessional distress and persecutory ideation; (c) restoration of social and occupational functioning; and (d) relapse prevention. The baseline assessments included the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) and the Brief Psychiatric Rating Scale (BPRS). The Y-BOCS total score was 25 (obsessions = 12, compulsions = 13),

showing a moderate level of obsessional thoughts and a moderate level of compulsive acts. The BPRS ratings indicated a moderately severe level of suspiciousness, along with a moderate level of anxiety, guilt, and unusual thoughts.

Psychotherapy was implemented in three phases: an initial phase, a middle phase, and a continuation/consolidation phase. The first phase aimed to clarify the history, update the mental status, and review the diagnostic impression together. The therapist provided psychoeducation regarding schizophrenia and OCD, their prevalence, symptom profile, course, prognosis, and the role of medication and psychotherapy, while emphasizing a collaborative stance in CBT and the importance of homework compliance. A preliminary idiosyncratic formulation was constructed using Freeston and Ladouceur's cognitive model (2001) of obsessive thoughts to link triggers, intrusions, appraisals, emotional responses, and neutralizing behaviors. The patient was helped to recognize that intrusive thoughts are common and that the core problem lies in the meanings attached to thoughts and the way they are managed rather than in the thoughts themselves, which provided initial normalisation and reduction of perceived uniqueness.

In the middle phase, symptom fluctuations were reviewed and homework experiences discussed, with the client reporting slight reduction in distress but frequent intrusions and continued efforts to suppress them. Through guided discovery, the therapist explored his strategies for controlling thoughts and highlighted the paradoxical effect of thought suppression using an "ironic process" experiment (instructing him not to think of a pink elephant, which he nonetheless experienced several times). He was then introduced to an integrated model linking triggers (e.g., hearing slangs or sexual content, searching symptoms online, fear of tantra), intrusive thoughts uttering profanities, being lustful), threat appraisals ("if I think it, I will do it; people can read my mind"), and behavioral responses (rumination, isolation, avoidance of devices, safety behaviors), culminating in ideas of reference and persecution. Through Socratic questioning, the therapist socialised him to the concept of thought-action fusion and its role in intensifying anxiety and guilt. Detached mindfulness, based on Wells and Matthews' metacognitive framework, 2011 was introduced as an alternative stance to intrusions, encouraging him to observe thoughts as mental events, allow them to pass without engagement, and refrain from neutralizing or ruminative responses. He was given practice instructions to notice and label intrusive thoughts and then "let them be" without further analysis, while monitoring resulting anxiety and its natural decline.

Cognitive restructuring was implemented using Socratic questioning to examine the evidence for and against maladaptive beliefs related to intrusive thoughts, guilt, and feared behavioural outcomes (e.g., algorithmic explanations for social media thumbnails, alternative interpretations of others' behaviours). The client used verbal reattribution techniques to identify OCD as the main cause of his intrusive thoughts, rather than seeing them as personal moral failures or character flaws. Common cognitive distortions like mind reading, catastrophising, emotional reasoning, selective abstraction, jumping to conclusions, and attribution bias were identified using examples from the client's own experiences. A dysfunctional thought record (DTR) was introduced to help him recognise the difference between intrusive thoughts and secondary worries, recording triggering situations, intrusive thoughts, emotional reactions, unhelpful interpretations, alternative rational responses, and changes in emotional intensity. The A-B-C model was introduced to counteract his ideas of reference and persecution, emphasising how beliefs, emotions, and behavioural responses influence one another.

The next step focused on generating more flexible and compassionate explanations based on available evidence, which helped lower his anxiety and increase engagement in social interactions. Behavioural experiments were used to check the accuracy of persecutory and referential beliefs, such as gradually facing feared situations—starting with limited use of electronic devices and progressing to brief social interactions or practicing speaking with women while keeping a natural gaze. He was encouraged to ask for clarification to gather real-world evidence that could challenge his negative assumptions.

During the continuation phase, therapeutic gains were reviewed and reinforced. Cognitive restructuring techniques were further applied to address his guilt, social anxiety, and fears related to sexual behaviour. As feedback to previous sessions, he reported enhanced functional improvements, such as better concentration, academic productivity, social connections, and increased autonomy. The client was advised to continue behavioral experiments and monitoring thoughts to generalise therapeutic gains. Relapse prevention strategies were discussed, focusing on recognising maladaptive thoughts early, using cognitive techniques consistently, and developing healthy coping responses.

Outcome

A.S. showed significant improvement in insight, emotional regulation, biological functioning, and coping with intrusive thoughts during therapy. He felt less distress from obsessive thoughts, less guilt about spontaneous sexual ideas, and gained more trust in his ability to allow thoughts to arise without rumination or cognitive checking. Clinically, his suspicion and feelings of being persecuted lessened in intensity and certainty. He was able to consider different explanations for social media content and the behaviour of others, as well as the impact of health concerns on his previous interpretations. He slowly started to engage in social activities and academic duties again, while still feeling some discomfort in certain situations. He showed a notable decrease in obsessive-compulsive symptoms and suspiciousness, as seen in the reassessment scores, supporting integrative CBT as an effective approach for OCD with psychotic features. Follow-up data showed that maintaining gains, adherence to medication, and use of metacognitive and cognitive techniques helped manage stress and intrusive events.

Table 1: Pre- and Post-Treatment Assessment Scores

Assessment Tool	Domain	Pre-Treatment Score	Severity (Pre)	Post-Treatment Score	Severity (Post)
Y-BOCS	Obsessions	12	Moderate	6	Mild
	Compulsions	13	Moderate	5	Mild
	Total Score	25	Moderate	11	Mild
BPRS	Suspiciousness	Moderately Severe	Moderately Severe	Mild	Mild
	Anxiety	Moderate	Moderate	Minimal	Minimal
	Guilt	Moderate	Moderate	Mild	Mild
	Unusual Thought Content	Moderate	Moderate	Minimal	Minimal

DISCUSSION

This case study demonstrates the clinical variability present in the overlap of schizophrenia and obsessive-compulsive disorders. This diagnostic category is considered unique, with more severe illness and higher functional limitations than schizophrenia or OCD alone. There is a need to understand the complicated character of the observed symptoms that goes beyond basic classifications. An obsessive doubt, such as asking "Did I sin?" can strengthen delusional ideas, such as thinking "God is punishing me," creating a cycle of interpretation of cognitive intrusions through a psychotic lens. New transdiagnostic models indicate that OCD and psychosis share underlying metacognitive biases, including the urge to regulate thoughts and the tendency to combine ideas with external stimuli (Tundo et al., 2014; Hagen et al., 2017). This single-case study yielded encouraging outcomes, adding to the growing body of research demonstrating that integrative CBT is both safe and effective for this specific combination of disorders.

Lee and Cougle (2005) hypothesised that reduced thought-action fusion (TAF) was most likely a contributing factor to the observed changes. Research identifies two types of TAF: "likelihood TAF," in which believing in an idea enhances the possibility of it occurring, and "moral TAF," in which having a belief is considered morally wrong, contributing to rigidity. TAF is strongly associated with schizotypal characteristics. This intervention addressed both evaluations consecutively, impairing the patient's "magical thinking" and preventing erroneous beliefs from forming due to his intrusive thoughts.

Furthermore, Metacognitive Therapy (MCT) with the effective tool of detached mindfulness helped to create doubt about the usefulness of intrusive thoughts. This allowed the patient to take a step back from their obsessions' content, rather than trying to neutralise them through rituals (Miegel et al., 2020). Considering the importance of religious and moral elements in this case, a culturally sensitive examination is necessary. In psychosis, scrupulosity often produces a "double bind" when trying to normalise intrusive ideas in therapy conflicts with the patient's strict moral or spiritual beliefs (Huppert et al., 2010). The positive result implies that separating religious beliefs from psychological issues—helping the client see the intrusive thoughts not as a spiritual failing but as a "disruption" in their mental processes—is a crucial change in therapy.

An important discussion on familial interactions was also yielded from this case study. Expressed Emotion (EE) is an established contributing factor in developing multiple disorders, namely schizophrenia and depression. Previous research indicated individuals diagnosed with both schizophrenia and OCD often receive critical comments from their caregivers, placing them in emotionally overwhelmed households (Balachandran & Bhuvaneswari, 2024). The critical remarks within the family system likely operate as environmental stressors, worsening the patient's internalised "critical voice." Thus, incorporating family psychoeducation has benefits in mitigating high expressed emotion (EE) encounters, which can trigger relapse.

According to research, a positive response to CBT in schizophrenia is frequently associated with intact cognitive capacities and improved functioning prior to the illness's onset. Individuals with schizophrenia who exhibit chronic obsessive-compulsive symptoms (OCS) have lower long-term social and functional outcomes. This distinction implies that while CBT can effectively treat symptoms of the obsessive-compulsive spectrum, the underlying vulnerability requires ongoing care. Booster sessions are not only beneficial but necessary to

prevent the "re-fusion" of thoughts and reality during high-stress situations (Hagen et al., 2017).

This instance also highlights the relationship between schizo-obsessive disorder symptoms and digital technology use. Recent research on "AI psychosis" and "technology delusions" suggests that algorithm-driven content can exacerbate paranoid thoughts and compulsive conduct, creating a feedback loop (Burns et al., 2025; Hudon & Stip, 2025). Vulnerable people may project their sense of control onto digital entities or interpret algorithmic personalisation as "special messages," a condition known as "digital folie à deux." Future treatments could include "digital hygiene" techniques and cognitive restructuring of online interactions to address the relationship between cyber-paranoia and existing conceptions of persecution and fixation (Yoo et al., 2024).

Limitations

While this case study provides valuable clinical insights, it faces significant limitations in determining what truly contributed to change. Without a control condition or comparison group, it is impossible to say conclusively whether the gains were due to integrated CBT, medication, or the non-specific therapeutic relationship. The lack of personality evaluation measures, particularly projective assessments, creates a gap in understanding the underlying psychological framework that influences both symptoms and treatment response. Symptom improvement was tracked only through routine clinical ratings; repeated standardised measures over extended follow-up periods were missing, limiting the possibility of tracking durability and stability of gains over time. The client was highly educated with good premorbid adjustment and intact insight, representing a more favourable presentation than many individuals with this comorbidity experience, limiting generalisability. Throughout the therapy process, cultural, spiritual, and digital-context variables such as the client's beliefs about purity, tantra, and cyber-hacking were thoughtfully addressed clinically rather than systematically measured, leaving uncertainty about which specific cultural adaptations produced therapeutic benefit. These constraints restrict causal inferences about the processes of transformation but do not lessen the therapeutic value of the case study.

CONCLUSION

This single-case clinical investigation suggests that an individualised, formulation-driven integrative CBT strategy could be an effective and potentially successful adjunct to pharmacotherapy for a patient with paranoid schizophrenia and associated obsessional ruminations. The intervention targeted cognitive distortions, metacognitive beliefs, and safety behaviours linked to both psychosis and OCD, resulting in decreased obsessional discomfort, decreased persecutory ideation, and improved emotion regulation and social functioning. Although these findings are promising, larger controlled studies with thorough follow-up are required to reach firm conclusions about efficacy and broader applicability.

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Conflict of Interest

The author(s) declared no conflict of interest.

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