OCD presenting as psychosis: A series of 3 cases

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Abstract---OCD was initially thought to be an illness of good Insight. But it has been seen that the same can vary from Excellent-Delusional leading to a significant diagnostic and therapeutic challenges as the illness may perfectly mimic psychosis. Antipsychotics given for treatment in such cases can worsen the OCD. Hence it is important to be able to differentiate between them and reach a proper diagnosis.

Keywords---OCD, Insight, Antipsychotics, Psychosis.

Introduction

Obsessive compulsive disorder patients were initially thought to be always having a Good Insight. But various studies conducted over the years have found a much broader range of Insight among such patients, varying from Excellent-Good-Poor-Delusional. Contrary to the initial belief that OCD patients were completely aware of the irrational nature of their beliefs, recent studies have found that a subset of such patients are not aware of the same and regard their beliefs to be absolutely true, hold on to the same with conviction. This poses a considerable amount of diagnostic and therapeutic challenge. We present a total of 3 such cases with similar picture.

Case Presentations

1) Mrs. R, a 32 yr old female, housewife, married, having 2 children, belonging to lower middle socioeconomic status presented to us a total h/o 10 months with symptoms having an insidious onset and a progressive course with no antecedent stressor with c/c in the form of suspiciousness, fearfulness, muttering to self, social withdrawal. An elaborative history by her family members also revealed that she would be repetitively folding her hands in a namaskar position and would be asking everyone to forgive her. Alongside, since last 1 week there was a significant decrease in sleep as well as her appetite. Also, she was not maintaining herself hygiene. Upon admission, she was found a have a shabby
appearance with poor grooming and was not maintaining eye contact. She was talking on neutral topics but was guarded regarding psychopathology. An initial provisional diagnosis of psychosis was made, and she was started on a combination of Trifluoperazine (5 mg) and Trihexyphenidyl (2 mg). She was on the same line of treatment for 7 days but there was no significant improvement. On subsequent mses, she gradually became cooperative with the medical team. She revealed that she was having repetitive thoughts that she had caused harm to someone by her act. This was the reason that she would keep asking for forgiveness. She also explained regarding her self-muttering behavior wherein she stated that she would always be taking to herself saying that I should not have done this act. On further questioning, she revealed that she was totally convinced of having done some wrongful act. Gradually as her thoughts had increased in frequency, she would feel depressed for most part of the day and had developed poor biological functioning along with social withdrawal. Further assessment revealed a total Y BOCS score of 20 on obsessions and 16 on compulsions. The obsessive thought was fear of causing harm to someone with the compulsive act in the form of rituals of seeking forgiveness for the same. In view of this, the earlier mentioned medications were discontinued and she was started on Tab Fluvoxamine 50 mg 1bd. By 10 days after starting the new treatment, there was significant improvement in her condition in all aspects, symptomatology as well as biological functioning. After that she was discharged. On follow up in the OPD after 1 month, she reported of 2/3rd improvement in all symptoms.

2) Ms. G, a 25 year old female, unmarried, teacher by occupation belonging to upper middle socioeconomic status, presented to us with chief complaints of Muttering to self, Irritability, Aggressiveness and suspiciousness since 2 years with an insidious onset and a progressive course with no significant antecedent stressful event. On further questioning from the family members, it was revealed that the patient would report that she could hear voices inside her head as if she was talking to her mind. Mental status examination of the patient revealed Anxious Mood. On asking her about the voices, patient stated that she would have regular conversations with herself regarding right and wrong, what she should do and what she should not. On questioning regarding the Aggressiveness and Irritability, she stated that she would usually get frustrated by the fact that her mind was out of her control. This in turn would lead to a sense of irritation. On the point of getting Aggressive, she said that if someone keeps asking her regarding her health she gets really upset because she feels that she is not in control of her own mind. Throughout the whole duration of illness, her sleep and appetite were normal along with intact self-hygiene. Based on this she was diagnosed as a case of Obsessive Compulsive Disorder with Predominant Obsessions. Y-BOCS scale was applied. It had a score of 22 in the obsessions. She was started on Cap Fluoxetine 40 mg 1 OD which was gradually built up to 80. On This poses a considerable amount of diagnostic and therapeutic challenge. On follow up after 2 months, there was significant improvement in the above mentioned symptoms.

3) Mr H, a 23 year old male, unmarried, belonging to lower middle socioeconomic status, presented to us a history of 1 month with the symptoms having an acute onset and a progressive course with chief complaints in the form of suspiciousness, fearfulness, avoidance of family members, decreased sleep and
appetite along with purposeless wandering behavior. On further elaboration of the
history, family members reported of muttering to self-behavior since last 15 days.
In the initial MSE, pt was uncooperative and not talking even on neutral topics.
An initial provisional diagnosis of Acute psychosis was made, and patient was
started on Tab Olanzapine 10 mg 1 hs. During the ward rounds by day 5 post
starting tab olanzapine, it was noticed that the patients symptoms started
worsening. He would arrange and clean his bedsheets repeatedly and would walk
in a strange manner – 4 steps forward, 2 step backwards and so forth. By this
time, patient had gradually become more cooperative in his MSEs. During one of
such interviews, he revealed that he felt as if his mind was working like a motor,
continuously and was completely out of his control. On further probing, he
revealed that he would have regular thoughts that he might cause harm to his
family members. Also, he would have regular sexual images of his sister. Overall,
he was basically terrified by these thoughts and was not able to understand what
had happened to him. As per his own verbata, that was the reason because of
which he would keep away from the family members. Regarding the behavior in
the ward, he stated that if he walks in a particular manner or keep things in a
particular place, something bad would happen to him or his family members.
Based on these findings, his diagnosis was revised to obsessive compulsive
disorder mixed type. Olanzapine was immediately discontinued and the patient
was started on Cap fluoxetine 40 mg 1 od with clonazepam 0.25 mg 1 bd. This
was increased to 60 mg by day 4. By the time of discharge, which was 7 days
after starting fluoxetine, patient reported of significant improvement in his
symptoms. His biological functioning had also improved. On follow up after 2
weeks, he was maintaining well.

Discussion

The cases mentioned above give a different view of OCD. It is totally incongruent
with the common themes of OCD viz. dirt and contamination, symmetry, sexual
obsessions, etc. They also deviated from the typical presentation of OCD in terms
of poor to delusional insight, while patients with OCD usually have a good to fair
insight. This is very important from clinical point of view. Such cases can present
as a diagnostic dilemma because of the conviction of such beliefs. It has also been
commonly seen that cases with chronic OCD also develop a poor to delusional
Insight as they may get used to the symptoms or may accept the symptoms as a
part of normal day to day life. Such cases can be hard to manage as they may
perfectly mimic psychosis which can eventually lead to misdiagnosis and wrong
treatment. The clincher in such cases could be the theme of presenting symptoms
which can give a clue towards Obsessive Compulsive Disorder. Also, a detailed
history from the onset of symptoms keeping the questioning open ended and
exploring all possible avenues might help in establishing the correct diagnosis.
The reason why this is extremely important is because both these illnesses belong
to completely different spheres. Their course and prognosis and the modalities of
treatment are completely different from each other. It should also be mentioned
here that certain atypical antipsychotics- Clozapine, Olanzapine and Risperidone
can worsen OCD, the evidence of which was seen in the third case report
wherein Olanzapine worsened the patient’s illness. Keeping all of this in mind, it
is important that a correct diagnosis is reached so that a proper therapeutic
management is carried out.
Conclusion

The above case series gives a different perspective of OCD. It highlights the importance of proper history taking and correct identification of symptoms for reaching a proper conclusion and thus aid in proper management of the patient.

References