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OCD Presenting As Psychosis: A Series of 3 Case Reports

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Abstract

Obsessive compulsive disorder patients were initially thought to be always having a Good Insight.[1] But various studies conducted over the years have found a much broader range of Insight among such patients, varying from Excellent-Good-Poor-Delusional.[1] 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.[2,3] We present a total of 3 such cases with similar picture.

Case Reports

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 (5mg) 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 furthur 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. Furthur 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 .OnThis 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 furthur 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 bedsheet 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 his mind was working like a motor , continuously and was completely out of his control . On furthur 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 walk 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.[4] 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.[5] 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.[5] Such cases can be hard to manage as they may perfectly mimic psychosis which can eventually lead to misdiagnosis and wrong treatment.[3]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.[2]It should also be mentioned here that certain atypical antipsychotics-Clozapine,Olanzapine and Risperidone can worsen OCD ,[4,5]the evidence of which was seen in the third case report wherein Olanzapine worsened the patients 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. [6]

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 poper management of the patient.

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