# Case Report

# Obsessive Compulsive Disorder Masquerading as Psychosis

**Dhanya Raveendranathan, Lakshmi Shiva, Eesha Sharma, Ganesan Venkatasubramanian, Mukund G. Rao, Shivarama Varambally, Bangalore N. Gangadhar**

ABSTRACT

Obsessive compulsive disorder (OCD) is commonly regarded as a disorder with good insight. However, it has now been recognized that insight varies in these patients. Pathological beliefs seem to lie on a continuum of insight, with full insight at one end and delusion at the other. This can indeed pose a considerable challenge, especially in a scenario where the phenomenon is difficult to discern. We report a case of OCD, which was initially diagnosed as psychosis.

**Key words:** *Obsessive compulsive disorder, insight, psychosis*

## INTRODUCTION

Patients with Obsessive Compulsive Disorder (OCD) have been traditionally described as having a good insight into their symptoms; they perceive their obsessive-compulsive (OC) symptoms as excessive, unreasonable, and distressing.[1] The DSM IV field trial demonstrated that about a quarter of the patients were uncertain about whether their symptoms were unreasonable or excessive, indicating that a broad range of insight exists among patients with OCD.[2] It is now well-recognized that patients with OCD may present with varying degrees of insight, including poor and complete lack of insight into their OC symptoms.[2-4] Pathological beliefs appear to be placed along an 'insight continuum'.[5] Through their 'symptom component' properties, they determine obsessions at one end, where beliefs are recognized as irrational. Overvalued ideas lie somewhere in the middle, and delusions where the beliefs are considered rational, lie at the other pole.[3] It can be a phenomenological challenge when the thin line of separation between these becomes difficult to discern.

| Access this article online | |
|---|---|
| **Website:** www.ijpm.info | **Quick Response Code** |
| **DOI:** 10.4103/0253-7176.101800 | |

## CASE REPORT

Ms. S, a 35-year-old, married lady presented with a one-year history of marked social withdrawal, muttering to herself, and suspiciousness. On clarification with her husband regarding her 'suspiciousness' it was found that she kept enquiring from him whether their acquaintances had visited her or not, subsequently she would report about her belief that she felt her acquaintances were not visiting her often, and hence, they could possibly be cheating her, but would not elaborate further. She firmly held on to these beliefs in spite of her husband telling her otherwise. For the last two weeks there had been a worsening of illness, characterized by crying spells, along with two suicidal attempts of high intentionality and lethality. After hospitalization, she was found to be tearful and withdrawn, reported of being fearful and expressed death wishes. An initial impression of psychosis, with a phenomenological inference of delusion of persecution, was made as per the longitudinal course of the illness from

Department of Psychiatry, National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, Karnataka, India

**Address for correspondence:** Dr. Dhanya Raveendranathan
Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bangalore – 560 029, Karnataka, India.
E-mail: dhanya.ravi@gmail.com

the available information, and she was started on tablet risperidone 2 mg. She continued to express fearfulness and did not show much improvement with risperidone. During the course of hospitalization, she was noticed to be repeatedly asking others to forgive her for 'a mistake' she had committed. On further clarification, she elaborated that she had been getting repeated thoughts that she had done something wrong, which could be the reason for her feeling that her acquaintances were not visiting her often. This had been interpreted to be 'suspicious behavior'. She would get these repetitive, anxiety provoking thoughts so often that she started wondering whether she had actually done something wrong. The level of conviction regarding this thought was quite high and she did not feel that this thought was in anyway irrational. Hence, she had started feeling 'suspicious' about the reason for others not visiting her. To decrease her anxiety, she would constantly ask reassurance from others, would check with her husband as to why a particular acquaintance had not visited her, and would keep repeatedly muttering to herself about this issue. The thoughts were very repetitive, stereotyped, and distressing, while they remained uncontrollable. As the frequency of these thoughts increased, she started feeling sad throughout the day, along with ideas of hopelessness, guilt, and suicidal ideas. Subsequently, her diagnosis was revised to obsessive compulsive disorder (OCD), with obsessions of intrusive thoughts / images and compulsion of reassurance seeking as denoted in the Yale Brown Obsessive Compulsive Scale (YBOCS) symptom checklist. The YBOCS obsession score was 16 and compulsion score was 10 (YBOCS total score of 26). She was started on fluoxetine 20 mg / day, which was increased to 40 mg per day in a week. The depressive symptoms began to improve initially. The frequency of thoughts began to gradually decrease later. After two months follow-up, she had significant improvement in her symptoms with the YBOCS total score decreasing to 10.

## DISCUSSION

This case demonstrates the importance of eliciting psychopathology in greater detail for specific diagnosis and treatment decisions, especially in the absence of a clear history. The presentation of the case with suspiciousness as the major symptom raised the possibility of psychosis. However, a careful analysis of the phenomenon revealed its exact nature. As there was no morbid illogical reasoning for the belief / thought, delusion was ruled out. Additionally, the repetitive nature of the thought, which was stereotyped, causing severe distress, pointed toward a possibility of obsessions. This was supplemented by the compulsive nature of reassurance seeking, which provided some temporary relief to the anxiety caused by the thought. However, the difficulty here was the lack of insight of the patient into this thought phenomenon. Even though traditionally viewed as a condition with, 'egodystonic thoughts recognized as illogical' by patients, OCD could present with lack of insight. Depressive ruminations were another diagnostic possibility. The patient had a depressive syndrome only during the later part of her illness. Furthermore, depressive ruminations were usually associated with negative emotions regarding some past event, while in this case the event appeared like an intrusive meaningless thought when it originated. Insight in OCD was not a dichotomous construct.[6] Insight in OCD had therapeutic implications such as poorer response to medications[4,7,8] and prognostic implications, wherein, schizophrenic spectrum symptoms could lead to worse prognosis. The continuity model between obsessions, overvalued ideas, and delusions seems to be more satisfactory,[5] although it calls for a careful analysis of the phenomenon in clinical settings, for prudent treatment choices.

## REFERENCES


1. Kozak MJ, Foa EB. Obsessions, overvalued ideas, and delusions in obsessive-compulsive disorder. Behav Res Ther 1994;32:343-53.
2. Foa EB, Kozak MJ, Goodman WK, Hollander E, Jenike MA, Rasmussen SA. DSM IV Field Trial: Obsessive-compulsive disorder. A J Psychiatry 1995;152:90-6.
3. Insel TR, Akiskal HS. Obsessive-compulsive disorder with psychotic features: A phenomenologic analysis. Am J Psychiatry 1986;143:1527-33.
4. Ravi Kishore V, Samar R, Janardhan Reddy YC, Chandrasekhar CR, Thennarasu K. Clinical characteristics and treatment response in poor and good insight obsessive-compulsive disorder. Eur Psychiatry 2004;19:202-8.
5. Markova IS, Jaafari N, Berrios GE. Insight and obsessive-compulsive disorder: A conceptual analysis. Psychopathology 2009;42:277-82.
6. Fontenelle JM, Santana Lda S, Lessa Lda R, Victoria MS, Mendlowicz MV, Fontenelle LF. [The concept of insight in patients with obsessive-compulsive disorder]. Rev Bras Psiquiatr 2010;32:77-82.
7. Catapano F, Sperandeo R, Perris F, Lanzaro M, Maj M. Insight and resistance in patients with obsessive-compulsive disorder. Psychopathology 2001;34:62-8.
8. Erzegovesi S, Cavallini MC, Cavedini P, Diaferia G, Locatelli M, Bellodi L. Clinical predictors of drug response in obsessive-compulsive disorder. J Clin Psychopharmacol 2001;21:488-92.


**How to cite this article:** Raveendranathan D, Shiva L, Sharma E, Venkatasubramanian G, Rao MG, Varambally S, *et al*. Obsessive compulsive disorder masquerading as psychosis. Indian J Psychol Med 2012;34:179-80.

**Source of Support:** Nil, **Conflict of Interest:** None.