Case Report

Obsessive Compulsive Disorder with Pervasive Avoidance

Parul Sharma, Ravi C. Sharma, Ramesh Kumar, Dinesh D. Sharma

ABSTRACT

Obsessive compulsive disorder (OCD) is a common disorder, but some of its atypical presentations are uncommon and difficult to diagnose. We report one such case which on initial presentation appeared to be psychotic protocol but after detailed workup was diagnosed as OCD with marked avoidance symptoms.

Key words: Compulsion, obsession, pervasive avoidance

INTRODUCTION

Obsessive compulsive disorder was once thought to be rare, but recent data estimate it to be the fourth most common psychiatric disorder with a lifetime prevalence of 2% to 3%.[1] As per DSM-IV-TR, patients with OCD exhibit varying degrees of insight into the validity of their beliefs, including patients ‘with poor insight’ who for most of the time during the current episode do not recognize that obsession or compulsion is excessive or unreasonable.[2] Occasionally, patients with OCD present with psychopathology more usually thought of as being ‘psychotic.’[3] The present case is also an unusual presentation of OCD and hence reported.

CASE REPORT

A 40-year-old woman presented with complaints of difficulty in walking for 8 to 9 years, being bedridden for 6 years and having decreased interaction for 6 years. The patient neglected personal care, in that, she would not change clothes or take bath for days to weeks. At times she used to pass urine in the bed itself. History of occasional sadness of mood and ideas of hopelessness and helplessness was there for the last 2 to 3 years. There was no history suggestive of substance abuse, psychosis and organicity, including head injury, epilepsy, tics, etc. The past, family and personal histories were noncontributory. The results of physical examination, laboratory tests, MRI brain were within normal limits.

On initial mental state examination, the patient was found to be conscious and cooperative and had untidy hair and fetor oralis. Eye contact was not sustained, rapport was difficult to establish, psychomotor activity was decreased and reaction time was delayed. She walked haltingly with a stooped posture, with the support of her husband. The patient responded in monosyllables; therefore, cognitive functions could not be tested in detail. The patient was indifferent to her state and had impaired insight. On the basis of history and mental status examination, the patient was diagnosed DSM-IV-TR,[2] ‘psychotic disorder not otherwise specified (NOS),’ and was started on flupenthixol 3 mg/day and trihexyphenidyl 2 mg/day.

While observing the patient in the ward, it was noticed that she would keep touching objects like tumblers, combs etc., repeatedly. As the patient started becoming more communicative, she was explored further which revealed that there was a history of repeated hand washing for the last 12 years for the reason that she would feel that her hands were not clean despite
cleaning them time and again. She would feel uneasy and restless if she did not wash her hands repeatedly. Additionally, there was history of repeated checking of door locks, switches and taps etc. She used to wear and take off clothes time and again as she was never sure that she had put on the dress properly. She would say something and repeat the same thing again and again or ask others to repeat what they had said time and again. There was significant distress associated with above symptoms. One prominent and noticeable thing in the patient was her peculiar way of walking. She used to walk a few steps, stop, retrace those few steps and walk those steps again as she doubted whether she had walked those few steps properly or not. Unless the patient walked the steps again, she would feel distressed. With the passage of time, in an attempt to avoid this distress, the patient avoided walking and gradually stopped walking altogether and got confined to bed. Now she would keep lying in the bed almost all the time.

It is pertinent to mention here that, during the initial part of her illness, the patient knew that all these repeated acts were unreasonable and excessive and offered resistance. However, later on she was compelled to perform the repetitive acts to reduce the anxiety, and still later, she started avoiding objects and situations that provoked such repetitive acts/behaviors.

On the basis of new inputs from history, negative physical examination and mental status examination, the first diagnostic possibility that was kept as per DSM-IV-TR criteria was ‘Obsessive compulsive disorder with poor diagnostic possibility that was kept as per DSM-IV-TR examination and mental status examination, the first diagnostic possibility was ‘Psychotic disorder NOS’. The main feature that favoured a diagnosis of OCD instead of psychosis was the clear logical link between thoughts and rituals which was elicited in the patient retrospectively although there was minimal resistance against the compulsive urge and poor insight especially in the later part of the illness. Poor insight and lack of resistance are not unusual features seen in OCD. Khess et al.,[6] in a study conducted at CIP, Ranchi, found that 17 out of 52 patients diagnosed to have OCD, had psychotic features in the form of persecutory delusions, hallucinations and referential thinking. Insel TR et al.,[7] also reviewed the literature on OCD and presented clinical vignettes to illustrate that delusions arise in the course of illness. Using a phenomenological analysis of 23 patients, the authors argued that OCD represents a psychopathological spectrum varying along a continuum of insight. Like our patient, Eisen JL et al.,[8] have also reported that 27 out of 475 probands with DSM III-R OCD, were those whose only psychotic symptoms were lack of insight.

Modified ECT in combination with selective serotonin reuptake inhibitors (SSRIs) has produced marked symptomatic improvement in the index case. SSRI augmentation strategies with a variety of drugs and ECT have shown demonstrable results in individual cases, but no conclusive evidence has been found in placebo controlled trials.[9] Maletzky et al., studied ECT response in 32 patients diagnosed as OCD as per DSMIII-R criteria and found that they showed improvement up to one year after therapy and that the changes in OCD symptoms appeared to be independent of changes in measures of depression.[10]

OCD is an early onset disorder which may present with predominant atypical symptoms like pervasive avoidance developing as a defensive mechanism against distress of yielding compulsions which may masquerade as negative symptoms like alogia, anergia, affective instability and asociality etc., creating diagnostic dilemma between OCD and psychosis. Early
recognition and management of such cases is needed to prevent disability and social dysfunction.

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