Department of Psychiatry

Obsessive-Compulsive Disorder with Good Insight

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The Case

22 years old unmarried Hindu male, D-Pharmacy graduate, currently working in a mobile repair shop, was brought to the Psychiatry OPD with chief complaints of:

- Repetitive, intrusive thoughts of contamination
- Repetitive handwashing
- Apprehension, palpitations, restlessness when interrupted
- Decreased sleep and appetite

Symptoms have been present for 6 months.

Onset of symptoms is insidious, gradually progressive, and deteriorating

HOPI

- Patient was asymptomatic 6 months back when he started having repetitive, intrusive thoughts of his hands being contaminated.
- The thoughts persisted throughout the day, distressing the patient, creating a sense of apprehension accompanied by palpitations and restlessness.
- To overcome this rising inner distress, he would resort to handwashing for long periods till he felt relief from the anxiety.
- The family would note him spending long hours washing his hands, multiple times a day (8-10 times a day), spending 2 hours daily in the act.
- He was aware that his thoughts were irrational, but he felt compelled to follow his handwashing ritual.
- Interruptions in the ritual would result in severe apprehension and restlessness, requiring the patient to restart the handwashing.
- The time spent in handwashing would affect his daily functioning, making him unable to leave his home for months.

Bio-functions:

Sleep and appetite were reduced.

Bowel and bladder were regular.

Past History:

No H/O similar symptoms in the past.

No H/O any major respiratory, cardiac and movement disorders.

No H/O any recent significant head injury or seizure episode.

K/C/O hypothyroidism since 2023. Currently maintained on medications.

Family History:

No significant history.

Personal History:

No significant history.

General Physical Examination:

A 22-year-old male, thin-built and nourished.

Height – 170cm BP – 118/80mmHgPR

Weight – 58kg PR – 88/min

BMI – 20.1kg/m^2 SpO2 – 100% on room air

Systemic Examination:

All systems were within normal limits.

Mental Status Examination:

A thin-built, well-kempt, and groomed male, appearing anxious and restless. Mood conveyed as anxious with a distressed affect. Thought content revealed obsession of contamination with no perceptual disturbances. Insight was good and judgment was intact.

Higher mental functions were intact.

Provisional Diagnosis:

Obsessive-compulsive disorder with good insight, with Hypothyroidism

Investigations:

All laboratory investigations, including TSH, were within normal limits.

Management:

- Patient started on Tab. Fluoxetine 20mg OD and increased to 60mg OD over subsequent OPD visits.
- Tab. Clonazepam 0.25mg HS for 7 days and stopped.
- Thyroxine replacement continued.
- Patient reported significant improvement in obsessions and compulsions after 2 months of treatment on 60mg Fluoxetine.

Obsessive-Compulsive Disorder with Absent Insight

Dr. Saumya Agarwal
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The Case

A 24-year-old, married, Hindu male, educated till 12th standard, dropped out of B. Architecture 1st year, unemployed, presented to the Psychiatry OPD with complaints of:

- Repetitive acts of placing or arranging things symmetrically
- Repeating words or actions a certain number of times till the patient felt satisfied
- Involving family members in his rituals or repetitive acts
- Felt something bad will happen if things are not done in this manner

Symptoms were present since 3 months, insidious in onset and progressively deteriorating.

HOPI

- Patient was apparently well 3 months ago when he started feeling an excessive need for order and symmetry. He would spend prolonged time arranging household objects in a particular order and would become highly distressed if others changed their placement.
- Within a few months, he developed a pattern of repeating certain actions and words a fixed number of times. He reported that if he did not perform these acts, he would feel extremely anxious and feared that “something bad will happen to his family.”
- Gradually, these behaviors intensified, and he began involving family members in his rituals. He insisted that they walk through a certain route, undo certain actions or maintain certain postures until he felt satisfied.
- Compulsions consumed 4–6 hours daily, severely interfering with his daily routine. He was unable to concentrate on his studies, leading to eventual discontinuation of his college course.
- Instead of considering his thoughts to be unwanted or irrational, he insisted that this was the only way to keep his family safe and “bad things will definitely happen” if the rituals are not performed.

- Concerned with this behaviour, his family brought him to the Psychiatry OPD.

Bio-functions:

- Sleep and appetite were reduced.
- Bowel and bladder were regular.

Past History:

- No h/o similar complains in past.
- No h/o recent head injury, seizures or any febrile illness.
- No h/o recent consumption of any psychoactive substance.
- No h/o any throat infection, cardiac illness or movement disorder was reported in childhood

Family History:

Interpersonal issues with father and paternal grandmother were reported.

General Physical Examination:

- A young adult male, moderately built and well nourished,
- Height : 155 cm B.P. : 120/70 mmHg
- Weight : 64 kg P.R. : 90/min
- BMI : 26.6 kg/m2 SpO2 : 99% on room air

Systemic Examination:

- All systems were within normal limits.

Mental Status Examination

- Patient was found to be restless and fidgety during the interview. He repeatedly adjusted the position of the chair and notepad on the table until “just right.” He was resistant to interviewer’s attempts to interrupt the rituals. He asked the interviewer to sit in a particular position which he felt was “correct”.
- He appeared anxious and irritable when challenged about rituals.
- Thought content revealed obsession of symmetry and order.
- He lacked insight and his judgement was impaired.
- Orientation, memory and intellect were intact.

Provisional Diagnosis:

Obsessive-compulsive disorder with absent insight

Investigations:

- All routine baseline laboratory investigations were sent
- Baseline ECG was obtained

Management

- He was initiated on Cap. Fluoxetine 20 mg OD which was uptitrated to 80 mg.
- As no response was noted on 80 mg of Fluoxetine for 4 weeks, patient was switched to Tab. Fluvoxamine 50 mg OD which was uptitrated to 100 mg.
- Due to minimal improvement, Tab. Clomipramine 50 mg OD was initiated and dosage was increased to 150 mg.
- Low dose antipsychotic Tab. Aripiprazole 5 mg was also augmented to the SSRI and TCA, which was taken up to 10 mg.
- Cognitive Behavioural Therapy sessions were also conducted along with pharmacotherapy.
- Patient eventually reported reduction in the obsessive thoughts, the distress associated with them and the tendency to perform the compulsive acts.
- Patient has been maintaining well since.

Treatment-Resistant Obsessive-Compulsive Disorder

Dr. Reetika Thakur
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The Case

A 29-year-old unmarried Christian female,12th pass, currently not working, resident of Pimpri was brought to Psychiatry OPD with chief complains of-

By self:

- Repetitive uncontrollable thoughts of contamination
- Repeated washing of hands and genitalia for prolonged hours
- Feeling frustrated and hopeless
- Wishing to die

By informant (sister):

- Irritability and crying spells
- Reduced appetite

All these symptoms in the last 3 years increased for 2 months.

HOPI

- The patient was asymptomatic until 3–4 years ago, when she began experiencing repetitive thoughts that her hands were unclean despite frequent washing. She was unable to suppress these thoughts and felt compelled to wash her hands repeatedly a fixed number of times, for relief. If interrupted, she restarted the ritual, often spending up to 2 hours daily on washing. Within 6 months, the duration increased to 4 hours per day. Excessive use of soap, water, and even abrasive materials such as stone led to peeling of the superficial skin.
- Gradually, the washing ritual extended to other body parts, particularly the mouth and genitalia, which she perceived as dirty. She required 4 glasses of water to rinse her mouth before drinking, and eventually restricted fluid intake to 2 glasses daily due to the exhausting routine. The behavior progressed to using nearly 40 buckets of water per day, with up to 12 hours spent in the washroom, during which she also washed taps, pipes, buckets, and mugs.

- Subsequently, she developed concerns about contamination of food, leading her to pick out portions from her plate and progressively reducing intake, resulting in a weight loss of 4 kg over 2 months. These behaviors led to frequent conflicts within the family. She also began stealing water from the neighbors' taps to continue her rituals, which caused repeated altercations between her family and the neighbors.
- She also experienced low mood, diminished interest in hobbies and routine activities, and frequent crying spells. She expressed feelings of being misunderstood, a belief that she could never return to her earlier state, and profound hopelessness. Feeling exhausted and trapped, she expressed a wish to die.
- Patient was admitted thrice in the last 3 years for the above complaints and has been on treatment with multiple SSRIs, SNRIs, TCAs, and antipsychotics in adequate dosage and duration with minimal improvement in symptoms.

Bio-functions:

Sleep and appetite were reduced.

Bowel and bladder were regular.

Past History:

No other chronic medical or surgical comorbidities reported.

No H/O any psychiatric illness.

Family History:

Not significant.

Personal History:

Not significant.

General Physical Examination: She is lean built and poorly nourished with a BMI of 17.1kg/m2. her palms were pale, rough, calloused with wrinkles.
All vitals within normal limits.

Systemic Examination: Within normal limits

Mental Status Examination: A young female, lean built, and poorly nourished. Mood was conveyed as sad with a dysphoric affect, tearful & reactive.
Thought content reveal obsession of contamination, ideas of hopelessness and helplessness, Passive death wish.
Fair insight with intact judgement.

Provisional Diagnosis:

Obsessive-compulsive disorder with good insight (treatment resistant)
Single episode depressive disorder, without psychotic symptoms

Management:

- Admitted in Psychiatry ward. All routine investigations and ECG were normal.
- Tab. Fluoxetine 100mg was continued.
- Tab. Clomipramine 25mg was added and increased to 100mg.
- Tab. Escitalopram 5mg added and increased up to 30mg.
- Tab. Risperidone 2mg was added.
- Tab. Memantine 10mg was added.
- CBT sessions were conducted.
- 6 cycles of ECTs were given over 2 weeks with minimal improvement.
- 4 Ketamine sessions were done with no further improvement.

Obsessive-Compulsive Disorder

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Obsessive-Compulsive disorder (OCD)

OBSESSIONS

- Own thoughts/images/urges/impulses
- Repetitive nature
- Intrusive/Unwanted
- Content is odd, irrational, or of a seemingly magical nature
- Time-consuming
- Distressing/produces inner anxiety

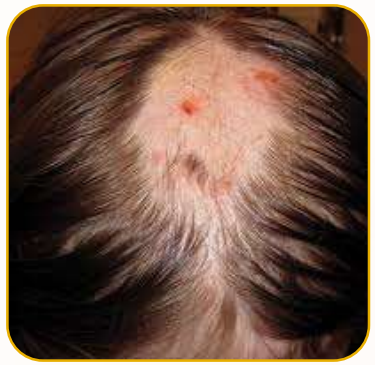
COMPULSIONS

- Repeated behaviors/mental acts done in rigid, rule-bound way
- In response to obsession
- Intrusive/Unwanted
- Observable, covert, or entirely mental
- Time-consuming
- Relieves inner anxiety

Obsessive-Compulsive and Related Disorders

Obsessive Compulsive disorder (OCD)

Body Dysmorphic disorder (BDD)



Trichotillomania (Hair-pulling disorder) (TTM)

Excoriation disorder (Skin picking disorder)

Hoarding disorder (HD)

Olfactory Reference Syndrome

Common Obsessions and Compulsions

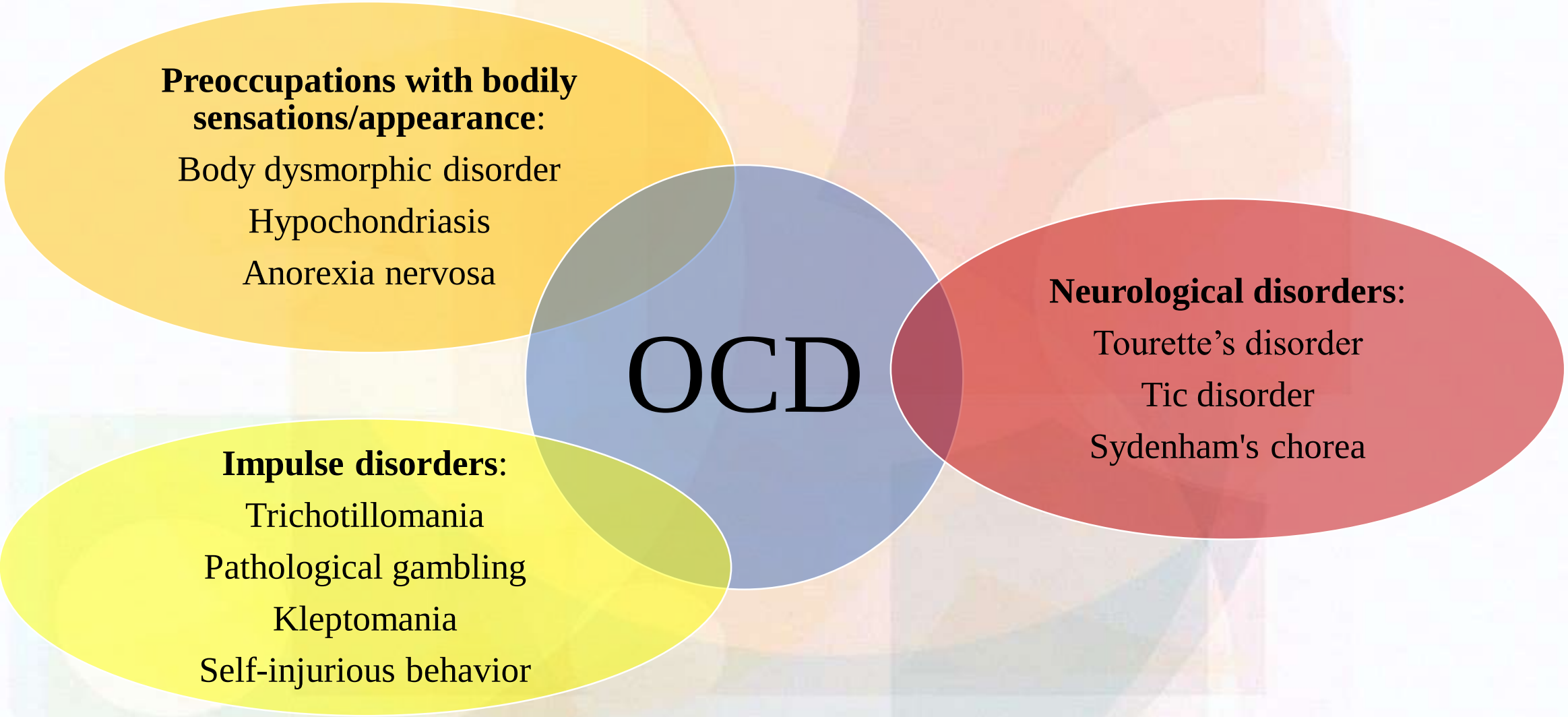
Contamination (Concerns or disgust with bodily waste or secretions, dirt, or environmental toxins)	Excessive or ritualized handwashing, showering, bathing, toothbrushing, grooming, or toilet routine..
Pathological doubt (Checking locks, stove, appliances, etc)	Excessive checking locks, stove, appliances, etc.
Somatic (Concern with illness or disease, excessive concern with body part or aspect of appearance)	Excessive reassurance/visits to medical health professionals.

Symmetry (concerned that another will have an accident unless things are in the right place)	Symmetry and precision, Compulsive ordering
Sexual (Forbidden or perverse sexual thoughts, images, or impulses)	Compulsive/Ritualistic Praying

Epidemiology

- 1-3% of lifetime prevalence.
- No gender differentiation in adults. In adolescents, male predilection is seen.
- Mean age of onset is about 20 years, and 2/3rd are diagnosed by the age of 25 years.
- In older age of onset, rule out neurological causes.

OCD Spectrum Disorders



Medical conditions presenting as OCD

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)

Diagnostic criteria:

1. Presence of OCD, tic disorder, or both.
2. Pediatric onset of symptoms (3 years to puberty)
3. Episodic course of symptom severity
4. Association with Group A β-hemolytic streptococcal infection (Positive throat culture for streptococcus)
5. Association with neurological abnormalities (physical hyperactivity; unusual, involuntary jerky movements)
6. Very abrupt onset/worsening of symptoms

Autoimmune encephalitis

Huntington's disease & Parkinson's disease

Epilepsy

Traumatic brain injury

Insight

- Degree of awareness and understanding that the patient has regarding his/her illness.
- Degree of insight is typically rated on a continuum from absent to full
- Amount of insight is not an indicator of the severity of the illness.

In cases of OCD:

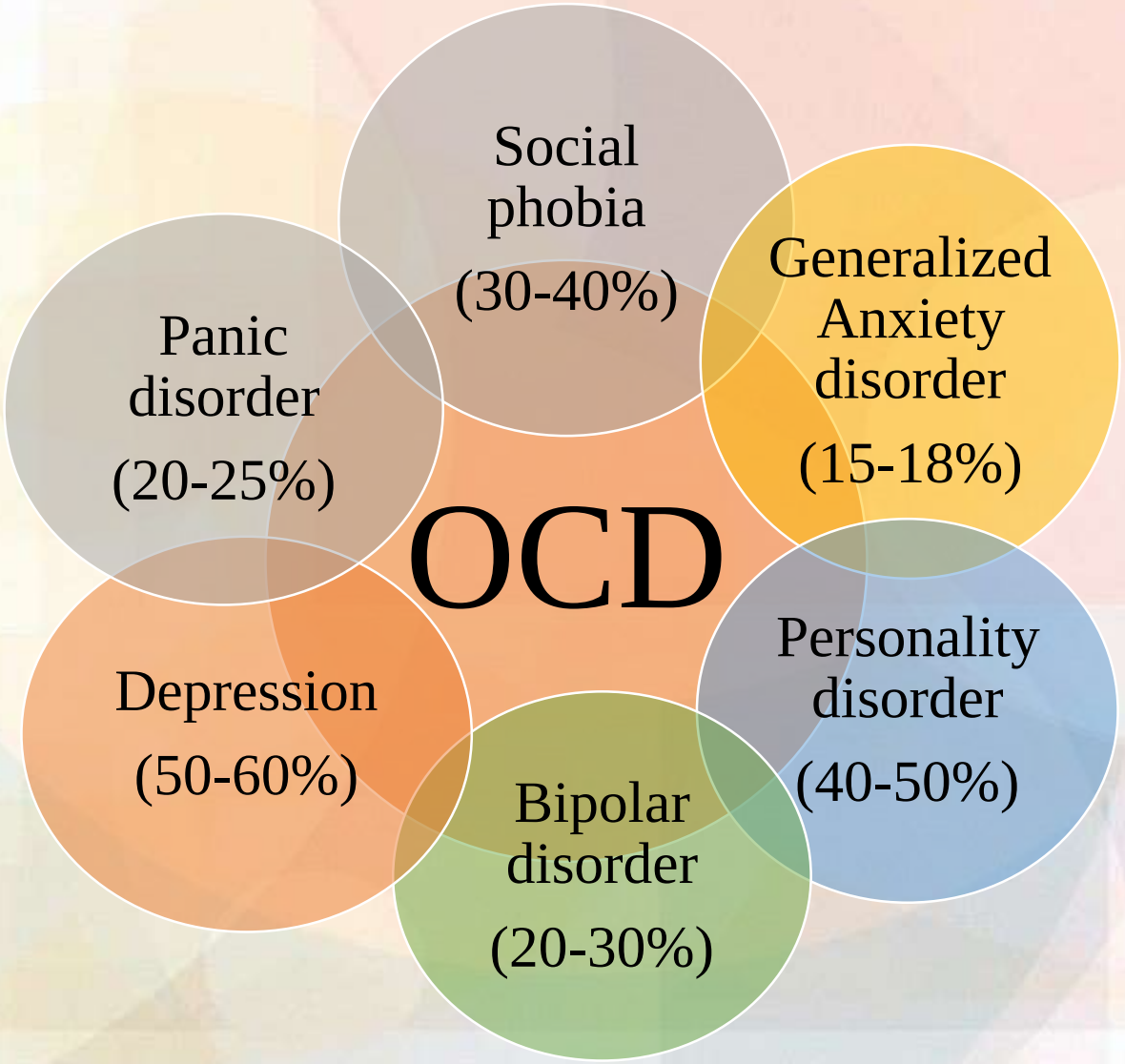
- **With good insight**: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true.
- **With poor insight**: The individual thinks obsessive-compulsive disorder beliefs are probably true.
- **With lack of insight/delusional**: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Insight Spectrum In OCD

Course and Prognosis

- Symptom onset is often gradual.
- Many individuals suffer with obsessions and compulsions for many years before recognizing them as a mental illness.
- More rapid onset may trace their symptoms to a particular stressor/event.
- Most individuals with onset of OCD in childhood or adolescence will have lifetime symptoms. Some individuals will remit by early adulthood.
- 40% individuals (most treated with behavioral therapy, pharmacologic management, or both) achieved remission.
- Without treatment, rates of remission (usually defined as minimal to no symptoms) of OCD in adults are low.
- Remission rates also vary depending on comorbidity, treatment selection, treatment adequacy, and duration of treatment.

Comorbidities in OCD



Pharmacotherapy

- **Selective serotonin reuptake inhibitors (SSRIs) -** Fluoxetine, Fluvoxamine, Paroxetine, Sertraline, Citalopram

Start with the lowest possible dose, titrate slowly over 2-3 weeks.

Higher doses are often necessary for beneficial effects.

The best outcome occurs when combined with behavior therapy.

- **Tricyclic Antidepressants (TCAs) -** Clomipramine

Most effective of all TCAs in the management of OCD.

Dosing must be uptitred upwards 2-3 weeks to avoid adverse effects.

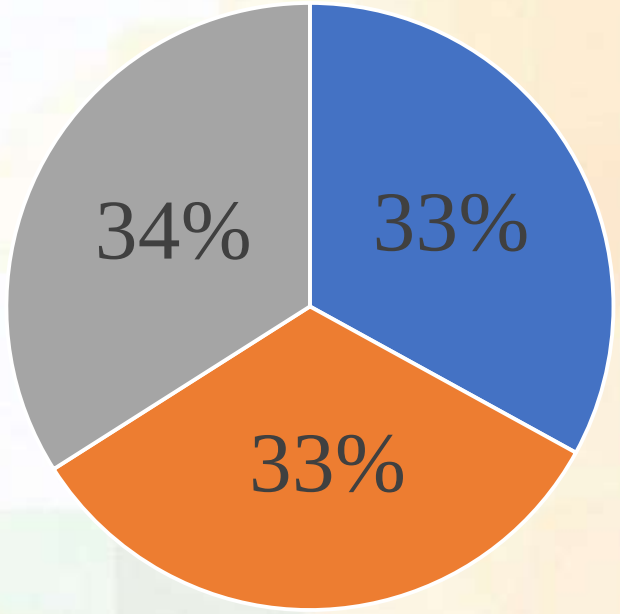
Best outcome when combined with other drugs and behavior therapy.

Behavior Therapy (BT)

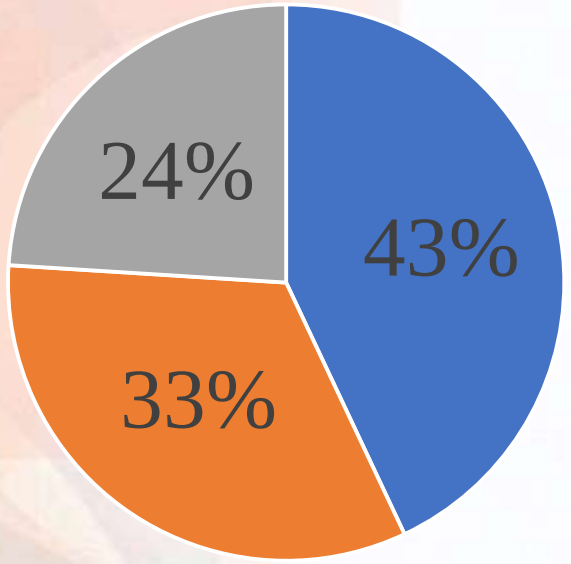
- Conducted in both inpatient and outpatient settings.
- Often combined with Cognitive Behavior Therapy (CBT).
- Principal behavior therapy: Exposure and response prevention
- Other therapies: Desensitization
  Thought stopping
  Flooding
  Implosion therapy
  Aversion therapy

Course and Outcome in OCD Patients

Recovery over 5 years



Recovery over 11 years



Treatment-Resistant OCD

Failure of response to adequate trial of 2 SSRIs + adequate Clomipramine + adequate CBT sessions (min. 16-24 sessions for 2-3 months).

- **Augmentation** – Low-dose antipsychotics, memantine (10-20mg), N-acetylcysteine, Lamotrigine, Topiramate.
- **Switching therapy** – SSRI to another SSRI
  SSRI to Clomipramine
  SSRI to SNRI (Venlafaxine)
  SSRI to NaSSA (Mirtazapine).
- **Combination therapy** – High dose SSRI + low dose Clomipramine (50-100mg), Low dose SSRI + high dose Clomipramine (150-225mg).
- **Mega dose approach** – High dose of SSRIs (Sertraline/Escitalopram)

- **Novel approaches** – Brain stimulation therapies (non-invasive/invasive)

1. Non-invasives – ECTs, rTMS.
2. Invasive – Psychosurgery (Stereotactic surgery/Gamma Knife), Deep Brain Stimulation.

Psychosurgery indicated for OCD: Cingulotomy

Capsulotomy

Limbic leucotomy

Subcaudate tractotomy

Take Home Message

- OCD is a chronic neuropsychiatric illness.
- Hidden epidemic with a 1-3% lifetime prevalence.
- Often associated with comorbidities.
- Easy to identify, difficult to treat.
- Spectrum of insight.
- Varied outcomes from management.

THANK YOU