CASE REPORT

Dilemma of Diagnosing OCD: A Case Report

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Abstract

Obsessive Compulsive Disorder (OCD) may present in the prodromal phase of schizophrenia. However at times it is difficult to distinguish between the pure obsession and psychotic obsessions that exist in patients. We present a case of a patient initially diagnosed as Schizophrenia due to the disorganized aspect of her behaviour, only to discover an extreme form of obsessions that explained her demeanor throughout.

Keywords: Obsessive Compulsive Disorder, Schizophrenia, Relationship

Introduction

Obsessive Compulsive Disorder (OCD) is fairly common in schizophrenia. OCS/OCD should be diagnosed in a more uniform way to improve the identification and evaluation of treatment of this type of co-morbidity [1].

Case Report

48 years old Malay lady, married housewife, who was brought in by social services and subsequently admitted to our psychiatric ward with the chief complaint of not allowing her children to go to school for the past 3 months prior to admission. This was also associated with poor hygiene and self-care, poor sleep and neglect of house chores. Further history revealed that her behavior was due to obsessions regarding her daily schedule which entailed that everything had to follow a rigid order. Any deviation from that proposed order caused severe stress and anxiety which led to what seemed ‘disorganized’ and ‘abnormal’ behavior.

She further explained that the process of sending her children to go to school had to follow a specific routine and order. They could only leave the house after the neighbor’s car had crossed in front of their house. Her children had to take a specific route to school, through the jungle and then via boat to reach the other side of town. This was forced upon them despite having main roads accessible by cars. She felt that by driving through the road, she could not control the order of cars that passed by hence imposed such rules on her children. She also did not allow her children to enter the household compound until that neighbor’s car had returned from work. Her children would spend almost an hour waiting at the gate until about 5pm when the neighbor would return. Only then would she unlock the gate for her children to come in.
With regard to her poor hygiene and self-care, she would only bathe and clean herself when her husband returned home. She could not deviate herself from this orderly routine. Due to some work issues, her husband who is a lorry driver had to spend a number of weeks travelling. Hence she refused to bathe during that period of time until her admission to the ward.

Although her family noted that she had poor sleep, the patient claimed that it was merely another set in her routine that she would call her brother in the early hours of the morning to check that his phone was working just in case she had an emergency.

Her symptoms had been going on for almost 7 years where she would be noted to bathe for hours, spending a lot of time arranging and rearranging clothes, and refusing to go out of the house for fear of not being able to control the order of things.

She developed pseudo-hallucinations during admission, hearing the voices of her children begging her to send them to school, though consciously aware that it was not true.

She had a strong paranormal belief that she was under the influence of witchcraft, sent by her husband’s ex girlfriend, hence had almost no insight to her pathological obsessions.

**Discussion**

In general, there is an increased prevalence of OCD/OCS in patients diagnosed with schizophrenia [2]. There is a fine line between the disorganized behavior exhibited in schizophrenia compared to the rigidity of the obsession that can mimic disorganized behavior.

The diagnosis of OCD is strongly linked to higher rates of schizophrenia and its spectrum of disorders. This suggests that OCD, schizophrenia, and schizophrenia spectrum disorders share a significantly common aetiological pathway [3].

There is a contrasting difference of spatial distribution of motor activity between OCD and schizo-OCD patients, the former being typically stationary and the latter drifting over a large space. These reflect the variability between OCD and schizophrenia in areas relating to cognition, attention and brain function. The difference in spatial behaviour is an accurate reflection of the mental differences between OCD and schizophrenia. Whilst OCD patients tend to focus on specific thoughts, schizophrenia patients wandering thoughts are reflected in the activity of wandering from one place to another [4].

The concept of ‘paranormal beliefs’ usually related in a cultural context, is significantly higher in delusional schizophrenia patients compared to OCD, though there are presence of psychotic like experiences in OCD patients, associated with high emotional distress [5].

OCD patients have little or no control over their thoughts and intrusions. 40% of OCD patients acknowledged that the intrusions had a perceptual quality, but was not significant enough for them to characterize them as voices [6].

Clinical observations show that OCD patients do not regard their symptoms as unreasonable, overvalued or delusional. Hence, obsessive-compulsive beliefs cannot be dichotomized according to the patient’s insight, rather be more appropriately regarded as a continuum of strength of beliefs [7].
There is a qualitative difference when comparing the formal content related criterion in obsessions compared to the criterion of absurdity in delusions. However, the transition from OCD to psychosis shows that these differences have not been scrutinized in sufficient detail. Hence, taking into account compulsive acts, and exploring retrospectively in the cases of delusional ideas may lead to false positive results for obsession in the strict sense [8].

Symmetry Ordering Arranging (SOA) is an extreme form of preference of order and symmetry. Similar to OC symptoms, it exhibits a complex biopsychosocial aetiology. Other factors such as genetics, environment, dysfunctional beliefs, and sensory perfectionism all play a role. SOA responds to first-line treatment of OCD in general, with no evidence suggesting that it is more difficult to treat compared to OCD. However not all patients in OCD and SOA benefit from these treatments and residual symptoms are often present at the end of treatments [9]. Advances in treating SOA and other OC symptoms will likely require a better understanding of the causes of these phenomena.

Schizophrenia and OCD may exist in the same spectrum of disorder. It is common to see schizophrenia patients with OCD symptoms, or OCD patients with poor insight that exhibit psychotic like symptoms. There is evidence to show that the neuropsychological performance of schizophrenia patients with OCD did not differ from that of non-OCD schizophrenic patients, and that OCD patients with poor insight were more likely to share similar cognitive characteristics with the schizophrenia groups. This supports the hypothesis that OCD and schizophrenia may be a spectrum disorders [10].

There is a shared and distinct patterns of deviance of oculomotor movement between schizophrenia and OCD. OCD and schizophrenia both share deficits that point to a dysfunction of a system of cognitive control involving the dorsolateral prefrontal cortex, parietal cortex and the anterior cingulate [11].

Patients with schizophrenia exhibit a narrow range of obsessive content compared OCD, whilst OC and delusional themes are most often related in schizophrenia as a unique symptomatic phenomenon. There is a higher rate of aggressive, sexual and somatisation in OCD patients compared to those with schizophrenia. There is also a positive relationship between washing compulsions and delusions and between hoarding obsessions and delusions [12].

Methodological issues that complicate our understanding of OCD are considered, and theories of delusions are examined in relation to their development in OCD. Consideration of the structure of obsessive phenomena in the strict sense constitutes a feasible way towards an adequate diagnostic evaluation of compulsive acts, obsessive thoughts, and delusional ideas.

References


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