

When re-evaluation redefines diagnosis and treatment: a case of obsessive-compulsive disorder with poor insight mistaken for psychosis

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Article info

Received : 29 Sep 2024
Accepted : 17 Nov 2024
Number of tabs : 00
Number of figs : 00
Number of refs : 08

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Summary

Obsessive-compulsive disorder can be deceptively difficult to identify when insight is limited and compulsions take the form of marked avoidance. This case describes a 32-year-old woman with an 18-month course of worsening daily functioning, including reduced intake, neglected personal care, social isolation, and sleep disruption. Her presentation was dominated by firm fear that routine activities such as eating or washing could invite divine retribution or endanger family members, leading to an initial diagnosis within the psychosis. But, Failure to improve with antipsychotic treatment prompted re-evaluation, which revealed recurrent intrusive thoughts with marked anxiety and avoidance functioning as compulsions, without hallucinations or formal thought disorder. The diagnosis was revised to OCD with poor insight, and targeted treatment led to gradual, steady improvement. This report highlights the diagnostic challenge of poor-insight OCD and emphasizes the value of clinical re-assessment to ensure appropriate management.

Bang J Psychiatry 2024;38(2): 64-66

Introduction

Obsessive-Compulsive Disorder (OCD) is a common, chronic psychiatric condition that often presents with striking internal distress and functional disability. It's defined by the presence of obsessions—recurrent, intrusive thoughts, urges, or images, and/or compulsions—repetitive behaviors or mental acts aimed at reducing distress or preventing feared outcomes.¹ OCD affects nearly 2%–3% of the general population.² Though typically recognized by overt rituals such as handwashing or checking, its clinical presentation can be highly variable and, at times, subtle in a way that's easy to overlook.

The symptom profile of OCD spans a broad range. Common obsessions include fears of contamination, doubts about safety, unwanted aggressive or sexual thoughts etc. In response to these thoughts, compulsions may be physical (e.g., cleaning, checking, arranging) or mental (e.g., silent prayers, counting).³ Another important, yet often underappreciated, form of compulsive behavior is avoidance—the deliberate evasion of people, objects, or situations believed to provoke harm or guilt. Though lacking the visible repetition of typical compulsions, avoidance can be equally ritualistic and impairing, and may dominate the clinical picture in some individuals.⁴

In recent years, the dimensional nature of insight in OCD has received growing attention. The DSM-5 includes an insight specifier, acknowledging that individuals with OCD may recognize

their obsessions and compulsions as excessive (good/fair insight), question them intermittently (poor insight), or hold them with delusional conviction (absent insight).¹ The presence of poor or absent insight complicates diagnosis, often blurring the line between OCD and psychotic disorders.

The prognosis of OCD varies, influenced by factors such as age of onset, symptom severity, comorbidity, and level of insight. While many patients respond to high-dose Selective Serotonin Reuptake Inhibitor (SSRIs) and Cognitive Behavioral Therapy (CBT)—particularly Exposure and Response Prevention (ERP), those with poor insight may exhibit reduced treatment adherence and slower recovery. For such cases, careful reassessment and individualized treatment strategies, including pharmacological augmentation, are often necessary.^{5,6}

This report describes a diagnostically complex case of OCD in a young woman, initially viewed through a psychotic lens due to her food refusal and deteriorating self-care. The case underscores how OCD with poor insight, when compounded by avoidance-based compulsions, can mimic as another disorder entirely—highlighting the importance of clinical curiosity, re-evaluation, and the dimensional understanding of psychiatric diagnoses.

Case summary

A 32-year-old unmarried woman from an urban, middle socioeconomic background of Bangladesh presented with a

1.5-year history of progressive functional decline characterized by food refusal, poor self-care, social withdrawal, and disturbed sleep. She had developed rigid, bizarre beliefs that eating, bathing, or changing clothes would lead to divine punishment or bring harm to her family. These beliefs were expressed with strong conviction leading to the clinical impression of a psychotic disorder.

Antipsychotic treatment was initiated, including risperidone up to 6 mg/day, over several weeks. However, her symptoms showed negligible improvement. The persistence of symptoms despite antipsychotic therapy with moderate dose and adequate duration raised diagnostic uncertainty, prompting a thorough re-evaluation of her psychopathology.

On further exploration, it was revealed that her beliefs were originated from recurrent, intrusive thoughts, which was initially triggered by some disturbing dreams. She described intense anxiety over the possibility that performing ordinary actions such as eating or bathing would result in harm to her loved ones. In the beginning, she attempted to resist these thoughts, but they became increasingly overwhelming. To alleviate the associated distress, she began avoiding these actions altogether. These avoiding behaviors were compulsions, aimed at neutralizing her obsessional fears.

Most importantly, there were no hallucinations, no formal thought disorder, and her thought content was obsessive rather than truly delusional, though insight was markedly poor. The clinical picture was thus revised to obsessive-compulsive disorder with poor insight.

Treatment was accordingly adjusted. Risperidone was tapered, and high-dose fluoxetine (60 mg/day) along with clomipramine (50 mg/day) was initiated. Over the next few days, the patient began to show gradual but steady improvements that strengthened the latter diagnosis.

Discussion

This case raises important questions about the diagnostic boundaries and clinical presentation of OCD when insight is poor and compulsions are not readily visible.

Our patient initially presented with rigid beliefs accompanied by food refusal and poor self-care, which were interpreted as delusional. She was started on risperidone, but minimal clinical improvement prompted a diagnostic re-evaluation. Upon further evaluation, it was evident that the patient experienced repetitive intrusive thoughts—obsessions—which caused significant anxiety, and avoidance behavior. This behavioral avoidance was indeed compulsion in her case as it aimed at reducing the distress caused by these thoughts. The compulsive behaviors were not ritualistic in a classic sense but were consistent with avoidance

patterns often seen in OCD. Over time, the patient's capacity to resist these thoughts diminished, and insight became significantly impaired, although not completely absent.

Such presentations are often misinterpreted as psychotic disorders or severe depressive illnesses with psychotic features, especially when insight is poor and compulsions are covert. However, the absence of hallucinations, formal thought disorder, and disorganized behavior supports the diagnosis of OCD with poor insight. While OCD has traditionally been associated with good insight, it is now well established that insight exists on a spectrum. Reflecting this, the DSM-5 introduced an insight specifier, and studies suggest that poor or absent insight occurs in approximately 15–36% of OCD cases.⁷

Avoidance behavior is increasingly recognized as a form of compulsion seen in people with OCD, as they try to stay away from situations or things that trigger their obsessions. For example, someone with contamination fears might avoid using public restrooms to prevent distress and the urge to perform long washing rituals. This kind of avoidance can act like a compulsion itself, since it also helps reduce anxiety and is done to stop a feared outcome from happening. Studies suggest that around 59.7% of individuals with OCD show these avoidance patterns. Avoidance can make therapy more difficult, especially Exposure and Response Prevention (ERP), as it may prevent patients from fully taking part in exposures or completing tasks between sessions.^{4,5}

In our case, the turning point occurred with a diagnostic re-evaluation. The patient was transitioned from antipsychotic monotherapy to high-dose fluoxetine and low-dose clomipramine. Marked improvement in eating behavior, hygiene, mood, and social interaction was observed within weeks, highlighting the importance of serotonergic pharmacotherapy in OCD. Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine, sertraline, and fluvoxamine are considered first-line treatments for OCD. Clomipramine, a tricyclic antidepressant with strong serotonergic action, is also effective but often reserved for treatment-resistant cases due to its side effect profile.⁶

Although CBT—especially exposure and response prevention (ERP)—remains the gold-standard psychotherapy for OCD,⁶ its success in poor-insight presentations often depends on gradual engagement, insight-building, and initial stabilization via medication. However, Recent evidence indicates that the Inference-Based Approach (IBA) is more effective than CBT in reducing symptoms among OCD patients with poor insight.⁸

Prognosis in OCD with poor insight tends to be less favorable. Insight levels are inversely correlated with treatment responsiveness and quality of life. In longitudinal studies, poor insight in OCD has been linked to more severe symptoms, higher

rates of psychiatric comorbidity, longer illness duration, and lower quality of life. It is also more commonly associated with a chronic course rather than episodic patterns. Moreover, evidence suggests that individuals with poor insight tend to have a reduced response to pharmacotherapy, Cognitive Behavioral Therapy (CBT), and even advanced interventions like deep brain stimulation.⁷

For this patient, the plan moving forward involves continuation of pharmacotherapy with monitoring, followed by gradual integration of CBT targeting her avoidance behaviors. Psychoeducation and involvement of family will also be key to sustaining gains and preventing relapse, particularly given the role of family dynamics in reinforcing avoidance. As insight improves, CBT strategies such as cognitive restructuring and ERP can be introduced more intensively.

Conclusion

This case highlights how OCD with poor insight can closely mimic psychosis, especially when compulsions manifest as avoidance. Recognition of these patterns, timely re-evaluation, and individualized treatment planning are essential for achieving positive outcomes. The effectiveness of serotonergic agents, even in cases of delusional intensity, further reinforces their first-line role in such presentations.

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