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Case Report

Diagnostic Conundrum of Generalized Anxiety Disorder or Obsessive Compulsive Disorder: A Case Study

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ABSTRACT

This case study demonstrates how extreme anxiety caused by a variety of conflicting features of worry and obsessions can make it difficult to diagnose Generalized Anxiety Disorder (GAD) and Obsessive-compulsive disorder (OCD) and how to make the appropriate final diagnosis. GAD is characterized by unrelenting, excessive anxiety over everyday issues, such as how others will see you, your accomplishments, danger, and safety. Obsessions, compulsions, and other intrusive, pointless, and distressing desires are traits of OCD, as are rigorously prescribed activities that must be carried out in order to calm anxiety. However, excessive rumination and worry are features of both illnesses.

KEYWORDS: Anxiety, worry, obsession, compulsion, rumination

INTRODUCTION

Obsessive-Compulsive Disorder (OCD) and Generalized Anxiety Disorder (GAD) overlap due to phenomenology as well as potential neurobiological similarities. While OCD is more specifically characterized by anxiety related to inflated concepts of disgust, contamination, responsibility, damage, symmetry, and hoarding, GAD involves excessive anxiety over everyday life events. Repetitive cognitive intrusions, negative feelings, difficulties ignoring the intrusion, and lack of mental control are examples of common clinical symptoms[1].

GAD typically manifests as bodily worries indicating physiological anxiety that are openly acknowledged, whereas patients with OCD are secretive and do not readily disclose their symptoms. However, GAD and OCD are also fundamentally diverse in their clinical presentation and underlying risk factors. OCD is more typically observed in those with childhood vulnerabilities, such as tics and separation anxiety, whereas GAD is highly contemporaneous with mood symptoms. In a primary care context, it can be difficult to diagnose both diseases since individuals with GAD may receive treatment for somatic issues and those with OCD may conceal their symptoms despite the fact that they are distressing.

GAD - Chronic in nature, the illness often progresses in a waxing and waning manner over time. Patients typically complain of somatic symptoms such headache, muscle soreness, inability to sleep, weariness, and restlessness. Only 20% of GAD patients will initially complain of psychological issues[2].

GAD is frequently accompanied by physical issues that make it more difficult to diagnose it accurately, which eventually worsens the patient's prognosis for the disorder.

Motor tension, autonomic hyperactivity, and hyperarousal disturbances are the three main domains that patients with GAD frequently report experiencing. For instance, individuals may claim to have trouble sleeping, having trouble concentrating, having tense muscles, or feeling "keyed-up" or "on edge" all the time[3]. Patients typically mention pre-existing simple phobias, social phobia, panic disorder, or agoraphobia. Comorbidity with other anxiety disorders is prevalent. Between GAD and other mental conditions, there is considerable overlap. Over 80% of people with GAD and between 60% and 80% of patients with depression also have another anxiety disorder[4]. It is also thought that GAD could be a "gateway" disorder for other conditions such as MDD, dysthymia, and substance abuse. To ensure effective treatment, comorbid problems must be thoroughly evaluated.

GAD has been treated with a variety of drugs, such as benzodiazepines, tricyclic antidepressants, and other antidepressants. Trials using buspirone and selective serotonin reuptake inhibitors (SSRIs) nonetheless offer a lot of possibilities for treating GAD-related anxiety.

OCD - OCD frequently occurs alongside other anxiety and mood disorders, such as generalized anxiety disorder (GAD), panic disorder, social phobia, major depressive disorder (MDD), anorexia nervosa, trichotillomania, and personality disorders such obsessive-compulsive personality disorder, avoidant personality disorder, and dependent personality disorder[5]. It frequently co-occurs, particularly with anxiety disorders and MDD.

Clinical evidence indicates that most people with GAD do not also have OCD, but many people with OCD may also have GAD. In addition, when etiology is taken into account, a family study[6] of OCD discovered that relatives of patients with OCD had higher rates of GAD, a finding that was unrelated to the existence of OCD in relatives. The existence of a shared genetic basis for OCD and GAD was confirmed[7]. Other forms of anxiety did not exhibit similar specificity with OCD[8,9].

CASE HISTORY

Mr. M, a 31-year-old Hindu Male from below socioeconomic status, nuclear family, professional driver by occupation, without a history of physical or mental illness, the patient was anxious as a premorbid temperament. He had a six-year history of gradual onset and deteriorating course symptoms that included excessive worrying about his health (as he believed he had multiple somatic complaints), recurring fears (that something would go wrong with him or that he could harm others), difficulty falling asleep, and avoidance of going to certain places. He also had episodes of '*ghabrahat*' associated with palpitations, trembling of hands and legs, felt like he is not able to control his body, unable to concentrate on work, heaviness in head, giddiness. The patient started feeling low mood, lost interest in all enjoyable activities, and ceased going to work six months before reporting to a tertiary level referral hospital in Udaipur due to excessive preoccupation with the aforementioned issues. He would stay inside his house and spend the majority of the day feeling uneasy and restless. This made his family members bring him to the hospital. On applying Hamilton Anxiety Rating Scale (HAM - A), the patient had a significant score of 25 (moderate to severe anxiety). During the mental state evaluation, it was discovered that the patient had persistent, uncontrolled thoughts, including repeated doubts (about locking and unlocking the door knobs). The severity rating on the Yale-Brown Obsessive Compulsive Scale (YBOCS)[10,11] was 38 (severe OCD). Based on the International Classification of Diseases and Related Health Problems (ICD-11), he was identified as having OCD. He was provided with combined pharmaceutical and behavioral treatment while being managed as an inpatient. However he refused for inpatient treatment and was treated on OPD basis. His relevant and routine investigations were within normal limits. He started taking cognitive behavioral therapy, fluoxetine 20 mg/day, and clonazepam 0.5 mg/day. He had distressing, uncontrollable intrusive thoughts about his physical well-being, according to an in-depth review of his conduct. The family first had trouble understanding that M's difficulties were caused by a psychiatric disorder since they thought they were simply a result of his overly critical and sensitive personality. However, the family eventually realized the cause of his sickness, thanks to psychoeducation. He started to show improvement after starting the combined therapy in practically every affected region. With improvements in repetitive thoughts, doubts and frequent checks, anxiety episodes and fear of serious illness, the YBOCS score decreased to 22 (moderate OCD).

DISCUSSION

The above case is being reported for its rather confusing presentation and to highlight the issues involved in diagnosis and management of GAD and OCD cases.

This patient also presented to us with typical complaints of GAD, that is why HAM-A was applied, which proved that patient had moderate to severe anxiety, but on further evaluation, it was observed that the causative factor for the anxiety was finally found to be OCD contents including aggressive, contamination, somatic, miscellaneous obsessions, cleaning/washing, checking, and repeating rituals compulsions as assessed on YBOCS Symptoms Checklist[10]. The patient responded well to the medical line of management along with Cognitive Behavior Therapy and reported significant improvement.

Table 1: Anxiety in OCD vs. GAD

	OCD	GAD
Onset	Childhood (common), Adolescent, later onset	Childhood (common), Adolescent, later onset
Prevalence in India	0.6%[12]	5.8%[13,14,15]
	1:1	2:1
CLINICAL SYMPTOMS		
Obsessions	Intrusive, unwanted, nonsensical ideations, images, or urges[16]	No
Compulsions	Behaviors often associated with rigid rules, often in response to obsessions[16]	No
Anticipatory anxiety	Maybe present, associated with aggressive obsessions[16]	Present, difficult to control[17,18]
Sleep Disturbances	Maybe present, due to obsessive thoughts[16]	Difficulty in initiation and maintenance of sleep[17,18]
Lack of Concentration	Maybe present, due to obsessions[16]	Present, due to worrying thoughts[17,18]
Somatic Symptoms	Somatic Obsessions are possible[16]	Present in form of headache, stomach ache[17,18]
Autonomic Symptoms	No	Present in form of palpitations, sweaty hands[17.18]
Fatigue	No	Present, due to excessive worrying[17,18]
Content of Anxiety	Anxiety due to content of obsessive thoughts and/or compulsions[16]	Anxiety in form of health worries, anticipatory anxiety, performance, competence, etc.[17,18]
COMORBIDITY		
Common Comorbidities	MDD, Social Phobia, Panic Disorder[19]	MDD, Social Phobia, Panic Disorder[20,21,22]
Unique Comorbidities	Tourette's Syndrome, OC-Personality Disorder [10]	-
TREATMENT		
Serotonin	SSRI and Clomipramine[20]	SSRI[20]
Dopamine	Risperidone[20]	-
Cognitive Behavioural Therapy	Yes[20]	Yes[20]

CONFLICT OF INTEREST: None

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