

ATTENTIONAL PROBLEMS AS THE MAKEUP OF OBSESSIVE – COMPULSIVE DISORDER AND ITS DIFFERENTIAL DIAGNOSIS FORM ADHD: A CASE REPORT

Dėmesingumo problemos, maskuojančios obsesinį-kompulsinį sutrikimą, bei jo diferencinė diagnostika nuo aktyvumo ir dėmesio sutrikimo: klinikinio atvejo analizė

Milda SAKALAUSKIENE, Darius LESKAUSKAS

Lithuanian University of Health Sciences, Department of Psychiatry, Kaunas, Lithuania

SUMMARY

Obsessive-compulsive disorder (OCD) is a prevalent neuropsychiatric condition characterized by intrusive thoughts (obsessions) and repetitive behaviours (compulsions), affecting 1–3% of the population. Despite its distinct diagnostic criteria, accurate diagnosis and treatment are often challenging due to its chronic nature, polymorphism, and overlap with other psychiatric disorders like attention-deficit/hyperactivity disorder (ADHD). The possible co-occurrence of ADHD in adult OCD patients further complicates diagnosis and management, with reported prevalence rates varying widely. Differential diagnosis between OCD and ADHD is essential, given their distinct treatment approaches. The case of an 18-year-old female patient illustrates these diagnostic complexities, as she initially presented with symptoms of attention deficit but subsequently revealed manifestations of OCD. Treatment adjustments targeting them led to a significant improvement in her condition, highlighting the importance of comprehensive assessments. The presentation of this case also addresses the limitations of current diagnostic classification systems, such as disparities between the DSM and ICD criteria for ADHD diagnosis.

Keywords: obsessive – compulsive disorder; attention-deficit/hyperactivity disorder; attentional problems

SANTRAUKA

Obsesinis – kompulsinis sutrikimas (OKS) – lėtinis psichikos sutrikimas, kuriuo serga apie 1–3% populiacijos, pasireiškiantis įkyriomis mintimis (obsesijomis) ir pasikartojančiu elgesiu (kompulsijomis). Nepaisant aiškių diagnostinių kriterijų OKS diagnozavimas ir gydymas dažnai kelia iššūkių. Tam įtakos turi lėtinė OKS eiga, simptomų polimorfizmas bei klinikoje dažnai pasitaikantys gretutiniai psichikos sutrikimai, tokie kaip aktyvumo ir dėmesio sutrikimas (ADS). Galimo ADS ir OKS komorbidiškumo dažnis literatūroje itin varijuoja; nepaisant to, tiksli diferencinė diagnostika tarp OKS ir ADS yra būtina dėl kardinaliai skirtingos minėtų sutrikimų gydymo taktikos. Šis klinikinis atvejis aprašo 18 metų pacientę, kurios klinikiniam vaizdą iš pradžių vyravo dėmesio sutrikimai, tačiau palaipsniui išryškėjo OKS simptomatika. Ženklaus būklės pagerėjimas taikant tikslingą, į obsesijas bei kompulsijas orientuotą gydymą, atskleidė tikslios bei išsamios diagnostikos svarbą. Šiame klinikinio atvejo pristatyme taip pat aptariami dabartinių praktikoje naudojamų diagnostikos klasifikacijos sistemų (DSM ir TLK) trūkumai bei galimi netikslumai, susiję su ADS diagnostika.

Raktiniai žodžiai: obsesinis – kompulsinis sutrikimas, aktyvumo ir dėmesio sutrikimas, dėmesingumo problemos

Corresponding author: Milda Sakalauskiene, Lithuanian University of Health Sciences, Medical Academy, A. Mickeviečiaus st. 9, LT-44307 Kaunas, E-mail: sakalauskiene.milda@gmail.com

INTRODUCTION

Obsessive-compulsive disorder (OCD) is a neuropsychiatric condition characterized by unwanted obsessions and/or compulsions. It is a common psychiatric disorder, affecting 1-3% of the general population [1, 2]. Due to its chronic nature, it has become one of the most disabling illnesses which are highly debilitating and resulting in great suffering for patients worldwide [3, 4]. Despite its prevalence, OCD presents challenges in accurate diagnosis and effective treatment, often being misdiagnosed and inadequately addressed [3]. One of the reasons for this is that OCD comprises comorbid symptoms with many other psychiatric disorders, for example, attention-deficit/hyperactivity disorder (ADHD), raising controversies over accurate diagnosis and overlap of their neural underpinnings [5]. The co-occurrence of ADHD in adult OCD patients is reported to range from 5.5% to 52% [6]. However, it is claimed that obsessive anxiety can be causally associated with inattention and executive dysfunction, leading to an inadequate diagnosis of ADHD in OCD subjects [7, 8]. It could contribute to a delay between the mean age of onset and age at diagnosis of OCD which recently has been reported to be 7.1 years (with the mean age of onset of 13.6 years and age at diagnosis of 20.7 years old) [9]. The heterogeneity of OCD together with the findings that 39% of mental health professionals and 50.5% of primary care physicians misdiagnosed OCD when asked to give their diagnostic impressions of individuals presented in clinical vignettes emphasises the great need for a careful examination of the patient and the importance of understanding the complexity and possible diagnostic challenges of OCD [9].

According to The International Statistical Classification of Diseases and Related Health Problems (ICD), Eleventh Revision (ICD-11), and The Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Edition, Text Revision (DSM-5-TR), essential diagnostic requirements for obsessive-compulsive disorder are the presence of obsessions and/or compulsions [10, 11]. Obsessions are repetitive and persistent thoughts, images, or impulses/urges that are experienced as intrusive and unwanted and are commonly associated with anxiety [11]. The person typically attempts to ignore or suppress obsessions or to neutralize them by performing compulsions, which are repetitive behaviours or rituals that the individual feels driven to perform in response to an obsession (e.g. repetitive washing, checking, and ordering of objects, mentally repeating specific phrases to prevent negative outcomes, reviewing a memory to make sure that one has caused no harm, and mentally counting objects) [10]. Compulsions are either not connected in a realistic way to the feared event or are excessive. Both obsessions and compulsions are time-consuming or result in significant distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning [10, 11]. In the cases when functioning is maintained, it is only due to the significant additional effort of the patient. [10] It is also important to notice that the symptoms or behaviours are not a manifestation of another medical condition and are not present because of the effects of a substance or medication on the central nervous system (e.g., amphetamine), including

withdrawal effects [10, 11].

In addition to ICD-11 and DSM-5-TR definitions, studies in symptomatic OCD also point out some neurocognitive deficits and suggest impairment in executive function, processing speed, sustained attention, and nonverbal memory [4, 12]. Subdomains of executive function that have shown deficits include response inhibition, planning, decision-making, and encoding of nonverbal memory [12]. Despite earlier reports which presumed that OCD patients have elevated intellectual capacity, several studies have shown that individuals diagnosed with OCD have lower full-scale IQ and performance IQ as compared to control groups [13, 14]. Some authors view executive function deficits in OCD as an epiphenomenon caused by the overflow of intrusive thoughts [4, 15]. According to their executive overload model, cognitive deficits in OCD patients result from the attempt to gain control over automatic processes to reduce impulsive behaviour and lapses of attention. This leads to increased consumption of cognitive resources and in return diminished effective control [15].

ADHD is a complex disorder which includes a constellation of clinical manifestations based on attentional difficulties, hyperactivity, and impulsivity [16]. It is a common childhood disorder with only 2–3% prevalence into adulthood [17]. ADHD in adults is characterized by inattentiveness, impulsivity, hyperactivity, restlessness, and difficulties in organizing and planning, as well as making impulsive decisions [17]. It is noted that as many as 80% of adults with ADHD have at least one coexisting psychiatric disorder, including mood and anxiety disorders, substance use disorders, and personality disorders [18]. Studies report that as much as one-third of individuals referred for ADHD diagnostics do not have ADHD but do meet the criteria for affective, anxiety, and personality disorders [19]. Yet it is commonly believed that ADHD may reflect the most extreme version of attentional problems [20].

The two major systems of psychiatric classification, the American Psychiatric Association's DSM and the World Health Organization's ICD, differ in their description of ADHD [21]. ICD, Tenth Revision, Australian Modification (ICD-10-AM), which is currently still used in Lithuania, does not formally acknowledge ADHD but instead includes diagnostic criteria for hyperkinetic disorder (HKD). Diagnosis of HKD requires the presence of symptoms indicating both impaired attention and overactivity including impulsivity; they must also be present before 6 years of age [22]. As with DSM-5-TR, the symptoms must be found in two settings and other conditions that could cause them first have to be ruled out. Three subtypes of ADHD, termed "presentations", are recognized: predominantly inattentive presentation (ADHD-I: symptoms of inattention, but not hyperactivity/impulsivity), predominantly hyperactive/impulsive presentation (ADHD-HI: symptoms of hyperactivity/impulsivity, but not inattention), combined presentation (ADHD-C: symptoms of both inattention and hyperactivity/impulsivity), which are substantially diverse pertaining to their symptom profiles [11, 23]. The symptom compositions for HKD in ICD-10-AR are comparable with the "combined presentation" of

ADHD in DSM-5, but not the “predominantly inattentive” or “predominantly hyperactive-impulsive” presentations [24].

According to some studies, OCD could be perceived as a disorder of attention, characterized by dysfunctional hyperfocus on typically ignored sensory and motor stimuli [25]. It was shown that patients with OCD experience the greatest impairments of sustained attention, followed by social phobia and eating disorders (bulimia nervosa and binge eating disorder); remarkably, all these disorders showed significantly greater difficulties with sustained attention than probable ADHD [20]. These findings indicate that impaired attention is non-specific for ADHD, and a markedly larger deficit may be associated with other disorders. It encourages clinicians to pay special attention to possible OCD when attentional complaints are expressed, as OCD symptoms may manifest in this unexpected manner [26]. Here we present the clinical case of such manifestation, illustrated by a young woman with a predominant complaint of long- lasting attentional problems.

CASE REPORT

An 18-year-old female patient was hospitalized at a psychiatric hospital due to complaints of difficulties in concentrating, attentional problems, and having too many thoughts in her mind which resulted in memory and sleep impairment as well as sadness and anxiety. Her initial diagnosis at the time of hospitalisation was a moderate depressive episode. The patient's medical history revealed that she was a second child from the first marriage; she had an older brother, who was deceased because of unnatural causes despite having no prior health issues (see below). There was no reported family history of psychiatric disorders or tic manifestations. Prenatal and perinatal periods were uncomplicated, and early psychomotor development went normally and timely. According to her parents, during the patient's preschool years she was a calm and shy child but, despite that, sought attention and was able to express affection decently. At the age of 4 years, she started to go to preschool in which she had a few friends and no significant difficulties in adapting. From the beginning of primary school (at the age of 6 years) the patient “faced difficulties in learning”: subjectively had problems with concentrating, a weaker memory, and a slower performance than her peers. According to her parents, she was still able to participate in all curricular activities successfully which was explained as a result of some extra support and care from an attentive teacher. From the 5th grade (when the patient was 11 years old) the complaints started to loom: she subjectively had a hard time sitting still during the lessons because of poor concentration and “many thoughts interfering to her mind”. Her academic performance started to decrease ever since (from an average of ~6-7 during the 5th grade to an average of 4 in the 11th grade). In the 7th grade (13 years old) she started to have trouble falling asleep because of many interfering thoughts and experienced an episodic, strong anxiety, led by an increased heart rate; at that time, she did not seek any medical treatment. While studying in the 8th grade (14 years old) the patient had experienced acute psychoemotional stress (homicide of her older brother) after which she started to commit actions of self-harm (cutting her forearms and

thighs with a razor); this behaviour lasted for approximately 6 months. During that period, she also felt increased anxiety while participating in social interactions with other peers, led by stuttering and vegetative reactions (e.g. increased palm sweating) and expressed a lack of motivation to study. Because of these complaints, she was administered to the Department of Adolescent Psychiatry. A psychological evaluation of her emotional status was performed (using the Hospital Anxiety and Depression Scale- HADS), which showed high levels of depression and medium levels of anxiety. A diagnosis of moderate depressive episode was established and the 10-day treatment in an in-patient setting was carried out due to her low mood, suicidal thoughts, and self-harm ideations. After her discharge from the hospital, she was advised to carry on taking Fluoxetine 20 mg/day. However, she refused to continue the treatment in an outpatient setting and stopped taking the medicine soon after the end of hospitalization. The patient recalled a notable improvement in her condition during the 9th grade (at 15 years old), characterized by improved sleep quality and increased motivation to participate in daily activities and studies. However, she was unable to identify any specific reasons for this positive change. In the 11th grade (17 years old) she experienced another deterioration of her mental status: strong, persistent anxiety, difficulties in concentrating due to “the feeling like more than 15 thoughts were jumping in her mind at the same time”, and sleep disturbances, including severe difficulty falling asleep and waking up in the morning. The patient claimed that due to her distorted sleep she missed many lessons and eventually was not motivated to go to school or participate in any activities at all. Her academic performance dropped significantly and, because of her poor attendance and attainment, she was strongly advised to leave her former school after completing the 11th grade. She decided to finish her secondary education (12th grade) at a school of vocational education and training; however, as the same symptoms persisted and her sleep remained distorted she was unable to attend classes again. It forced her to temporarily stop her studies. 4 months before her admission to the psychiatric ward, the patient was consulted by a neurologist regarding her sleep issues. Following a thorough neurological examination, no somatic pathology was identified, and the patient was referred to a psychologist for an evaluation of her emotional status. The psychological assessment revealed markedly high levels of anxiety (HADS anxiety score of 17, with a range of 0 to 7 considered normal and maximum score being 21 [27]) and signs indicative of depression (HADS depression score of 9, with a range of 0 to 7 considered normal and maximum score being 21 [27]). The neurologist recommended further evaluation by a psychiatrist to consider possible diagnoses of ADHD, depression, or anxiety disorder. After the following psychiatrist's consultation, the diagnosis of a moderate depressive episode was made and Bupropion 75 mg/day and Quetiapine 50 mg/day were prescribed. The patient used these medications for ~5 weeks but claimed that no clinically significant improvement was felt, which was the reason for her hospitalization.

Mental status during the first contact was as follows: tidy appearance, good hygiene; communicating with reluctance.

The patient was tensed and showed signs of anxiety, her mood and facial expressions were bland, she rarely engaged in eye contact. Her thinking was rather slow, concrete, with low productivity. No hallucinations, delusional ideas, signs of delirium or suicidal ideation were seen. The patient was correctly oriented in time and environment but talked quite inconsistently and could not give more details about many subjectively significant life events. Notable problems with concentration and sustained attention were evidenced by episodic distraction, lapses in dialogue, and difficulty retaining conversation topics. The patient also noted difficulties in falling asleep and fatigue during the daytime as well as strong anxiety accompanied by lowered mood and declined interest to participate in any activities. Neurological examination revealed no notable abnormalities at the time of assessment.

After a few days of hospitalisation, it was noticed that the patient had certain repeated behaviours (e.g. arranging her slippers in a specific manner beside her bed before sleeping). Upon reluctant confirmation, she revealed having numerous everyday rituals (e.g. compulsive need to adjust levers on household appliances before bedtime). Efforts to ignore or overcome those impulses resulted in difficulty falling asleep due to heightened distress and anxiety. The patient also reported that her frequent lapses in attention were caused by various perceived imperfections in her surroundings, particularly asymmetrical or uneven features on walls or furniture. She also described experiencing heightened perspiration in her palms, leading to obsessions about cleanliness and compulsive handwashing rituals exceeding 15 times a day. Difficulties in discarding her old possessions due to an intense fear of needing them afterwards (or "something bad would happen") were also expressed.

A comprehensive psychological evaluation was planned to distinguish between potential mood or personality disorders, intellectual disability, ADHD, autism spectrum disorder (ASD), and OCD. Evaluation of intellectual abilities (WAIS-III) was as follows: verbal intelligence index was very low (VIQ 75), nonverbal intelligence index was lower than average (NIQ 81), and overall intelligence index was low (IQ 76). Her level of general knowledge was notably low compared to her age, and she displayed difficulties with orientation in social situations and memorization; her language expression was notably poor. According to WAIS-III, while engaging in constructive activities, the patient demonstrated a slow psychomotor pace; however, she exhibited significantly better performance in perceptiveness to details and establishing logical sequences of events, reaching normal values in these domains. Qualities of thinking were as follows: abilities for generalization were not higher than average and mostly based on nonessential features and accentuation of the function of the object. In the process of generalisation, some features of inert thinking were seen. In the adult ADHD Self-Report Scale (ASRS-v 1.1) likely signs of ADHD were noticed (the patient gathered 4 responses at specific severity levels in Part A and 8 responses at specific severity levels in Part B). In the obsessional compulsive inventory (OCI-R) the patient attributed herself significantly more obsessions/ compulsions than the general population (scored 47 points; recommended

cut-off for OCD is 21 (28)), especially obsessive thoughts (10/12 points), compulsive behaviour like excessive washing (9/12 points), ordering and checking (8/12 points) and hoarding (12/12 points). The patient's personality assessment revealed immaturity, heightened sensitivity, low self-assurance, low self-esteem, and indications of particularity. These traits could contribute to difficulty in decision-making, fear of taking risks, and avoidance of unfamiliar situations. The patient exhibited a relatively high level of social discomfort, preferring solitude over social interaction. The Childhood Autism Rating Scale, Second Edition (CARS2-ST), completed based on information from both the patient and her mother, yielded a score of 22.5, indicating the absence of autism-specific features.

Initial treatment was started with a low dose of Paroxetine (20 mg/ day) together with Lorazepam (up to 3 mg/ day) to tackle the patient's low mood and anxiety; augmentation with Quetiapine (75 mg/ day) was also selected. A quick and considerable improvement in anxiety and sleep quality occurred during the first 3 days of treatment and prompted a gradual reduction in Lorazepam to 2 mg/day and Quetiapine to 25 mg/day. A significant deficiency in attention and concentration persisted: though the patient's ability to retain attention remarkably improved, she continued to complain of too many thoughts in her mind which complicated her daily activities. A tricyclic antidepressant Clomipramine (25 mg/ day) was introduced during the 5th day of her hospitalization; following the initiation of the treatment with Clomipramine, the patient reported a reduction in intrusive thoughts, leading to a notable improvement in sustaining attention as well as an improvement in some compulsive behaviours (e.g., reduced frequency of hand washing). On the 9th day of treatment, Clomipramine dosage was increased to 50 mg/day to reach the target dose while the dose of Paroxetine was also raised to 30 mg/day to manage anxiety symptoms and facilitate the tapering of Lorazepam until complete discontinuation. Further titration of Paroxetine and Clomipramine in an in-patient setting was not possible because of the manifestation of gastrointestinal complaints (strong nausea), and the patient's refusal to continue higher doses and wait for the reduction of side effects.

After 17 days of hospitalization, the patient exhibited reduced anxiety levels, improved mood, sleep, attention, and depletion of intrusive thoughts and compulsive behaviours. Upon discharge, it was recommended to continue Paroxetine at 30 mg/day, Clomipramine at 50 mg/day, Quetiapine at 25 mg/day, and Lorazepam at 2 mg/day (gradually tapering until complete discontinuation). Treatment continuation for at least 12 months post-OCD remission, alongside cognitive-behavioural therapy (CBT), was recommended to prevent relapse and facilitate further improvement.

DISCUSSION

This clinical case is interesting due to many different aspects. The patient's complaint of excessive thoughts and inability to concentrate is not typically associated with OCD, highlighting the diverse symptomatology of the disorder. Clinical manifestation of OCD symptoms could be suspected since the age of 11, which complies with the consideration that

obsessive-compulsive disorder has a bimodal age distribution with a first peak at age 11 and a second peak in early adulthood [15]. The patient's symptoms have been perceived as a part of moderate depressive episode both by in-patient and out-patient psychiatrists; a possible neurological deficit was also suspected and required the examination of a neurologist. We can only hypothesize whether the latest chosen outpatient treatment for the moderate depressive episode, which included Bupropion, was intended to address some of the potential ADHD symptoms as this dopamine and noradrenaline reuptake inhibitor is one of the second-line medications used for the treatment of ADHD [29]. The experienced difficulties and delays in diagnosing OCD could be attributed to the patient's below-average intellectual abilities, potentially worsening her introspection of OCD symptoms. For instance, it is noted that compulsions which occur in mentally disabled patients lack "ego-dystonic" qualities that normally lead to reporting their behaviours as excessive or absurd. It has also been documented that the assessment of observable behaviour has good reliability in diagnosing OCD in such patients [30]. In the presented clinical case, this aspect played a significant role in formulating the diagnosis as well.

During the process of differential diagnostics, the evaluation of whether the patient might have ADHD, OCD, or both posed a challenging task. It was known that even though ADHD and OCD appear to be considerably different in terms of their phenomenology, both can present with symptoms of inattention and distraction. Differentiating between primary attentional symptoms and attentional symptoms secondary to a core anxiety disorder was crucial as the attention/concentration difficulties, typical of these two pathologies, can represent symptomatic epiphenomena of different psychopathological nuclei [31, 32]. Completely different treatment strategies are needed: while stimulant medication is typically recommended as the first-line treatment for ADHD, some studies show that its use in OCD may exacerbate OCD symptoms; conversely, SSRIs, the first-line treatment for OCD, are not considered effective for ADHD [7, 33]. The possibility of both conditions co-occurring was also considered, given the reported prevalence rates of ADHD in adult OCD patients ranging from 3% to 52% [6]. However, the significant disparity in these statistics has led some authors to propose that genuine OCD-ADHD comorbidity might be uncommon, with one disorder potentially mimicking another [19, 31]. In certain studies it was suggested that OCD-ADHD comorbidity likely exists only in the presence of a primary or a history of tic disorder, which was absent in the patient's medical history [8, 19].

According to Abramovich, there are several differential features which can specify primary OCD from ADHD [19]. Firstly, most individuals with OCD often exhibit perfectionistic tendencies and are overly critical of their performance [19]. In the presented case the patient did not openly display perfectionism (possibly due to lower intellectual abilities) but her personality evaluation revealed traits of particularity and a focus on details. Secondly, in most cases OCD compulsive rituals are carefully planned, rigidly executed sequences of mental or behavioural acts that are

governed by specific rules; these characteristics are associated with overloading the executive system, particularly working memory, and would make OCD-compulsive rituals unlikely to be performed by individuals with primary ADHD [8, 19]. Given the individuals report intrusive thoughts instead, it is important to inquire whether these thoughts cause significant emotional distress, as seen in OCD, or not, as seen in ADHD. It is also necessary to assess whether the person is trying to cancel these thoughts by mental or behavioural rituals [19]. In this case, the patient described everyday rituals marked by specific rules and sequences of actions, accompanied by emotional distress due to her intrusive thoughts which were often followed by behaviour rituals to relieve them; in circumstances when she tried to resist these strong urges, intense anxiety emerged. Thirdly, ADHD is associated with behavioural impulsivity, sensation seeking, and risk-taking [32]. In contrast, studies show that OCD is characterized by reduced impulsivity compared to non-psychiatric controls and by significantly lower behavioural impulsivity and risk-taking compared to ADHD [19]. The patient's clinical presentation and psychological examination revealed a fear of taking risks and a tendency to avoid unknown situations. It aligned more closely with OCD as avoidance is a typical method to avert obsessions from triggering [34].

According to the Updated European Consensus Statement on diagnosis and treatment of adult ADHD, establishing all comorbidities before initiating treatment is crucial to determine the best treatment order, with priority given to the most severe disorder [33]. Pharmacological treatments should be introduced one at a time to monitor treatment response and side effects [31]. The initial psychopharmacological treatment has been oriented to the patient's visible anxiety and sleep disturbances, which caused significant distress and were considered to take its toll on her attentional deficiencies. A low dosage (20 mg/day) of Paroxetine, a selective-serotonin reuptake inhibitor (SSRI) which shows a marked anxiolytic effect and reduction in avoidance related to phobic symptoms, was initiated together with benzodiazepine Lorazepam (3 mg/day) and atypical antipsychotic Quetiapine (75 mg/day) for augmentation, anxiety reduction, and sleep induction. Subsequently, upon the disclosure of obsessive-compulsive symptoms, the treatment plan was adjusted. As SSRIs are the first-line pharmacological treatment of OCD and no superiority of one SSRI over the other could be seen in various meta-analyses, it was decided to continue Paroxetine [1, 2, 35, 36]. Quetiapine and Lorazepam were also kept: the addition of antipsychotics to standard serotonin enhancers is one of the most documented strategies for augmentation while benzodiazepines are common adjuvants to the reduction of anxiety [1, 35, 36]. It is generally recommended that OCD would be treated with a higher dose of SSRI than the one used in, e.g., depression as it is associated with better clinical response [1, 2, 34]. Nevertheless, the patient did not tolerate a higher than 30 mg dose of Paroxetine due to the complaints of gastrointestinal symptoms and her personal beliefs. Even though a significant reduction of anxiety was achieved, the disturbances in attention and concentration as well as obsessive thoughts and compulsive behaviours persisted so

a new psychopharmacological approach was needed. As the Cognitive Behavioural Therapy/ Exposure and Response Prevention (which is another first-line treatment option for OCD) [1, 36] was not available, a serotonergic tricyclic antidepressant Clomipramine was added, starting from 25 mg/ day. The efficacy of this medication in OCD treatment, according to some studies, appeared to be equivalent to or slightly better than that of SSRIs, although its side effect profile is less favourable [37, 38]. Some studies suggested that the combined treatment with Clomipramine and an SSRI is effective and well tolerated. [36, 39] The dosage was increased to 50 mg/day, with no significant side effects reported; the patient subjectively experienced fewer intrusive thoughts and improved concentration. OCD treatment guidelines indicate that 8–12 weeks is the optimal duration of an SSRI or Clomipramine trial to determine efficacy, but a few meta-analyses noted a significant improvement of OCD symptoms within the first 2 weeks and the greatest incremental gains occurring early in the course of treatment [34, 40, 41]. A similar pattern of improvement in the patient's condition was seen and a significant reduction of symptoms was reached during 17 days of hospitalization.

Likely signs of ADHD were seen in the adult ADHD Self-Report Scale (ASRS-v 1.1) but the positive response to treatment and clinical observation led to the conclusion that inattention symptoms might be a consequence of obsessional thinking rather than indicative of comorbid ADHD. This interpretation was supported by research indicating that the exhaustion of the executive system caused by obsessional thinking results in behaviours that are phenomenologically similar to symptoms of ADHD (e.g., distractibility, forgetfulness), but instead are

related to OCD. [8] The diagnostic decision may have been influenced by the limitations imposed by the current use of ICD-10-AM in Lithuania because under this classification system the patient may not meet the specific criteria for additional HKD but might suffice for the “predominantly inattentive” type of ADHD in DSM-5-TR. It emphasizes the misalignment between DSM-5-TR and ICD-10-AM regarding ADHD diagnosis, highlighting inconsistencies and challenges in diagnostic practices, particularly in regions where the ICD is the primary diagnostic manual [42]. This phenomenon could potentially explain the significant discrepancies observed in the reported prevalence rates of ADHD across various studies. As the ICD-11 revision of ADHD aligns more closely with DSM-5-TR, integrating subtypes of ADHD from DSM-5-TR and introducing additional subtypes, its future implementation might reduce discrepancies and promote uniformity in clinical practice.

In conclusion, this case report highlights the polymorphic nature of OCD and attentional problems which could disguise many of its typical symptoms. Additional research into OCD, its potential presentations, and its co-occurrence with ADHD is needed. Comprehensive studies that address the discrepancies between systems of psychiatric classification are required to gather reliable data on the prevalence of concurrent OCD and ADHD in adults. It would enable a precise assessment of their influence on clinical outcomes, prognosis, and the formulation of effective treatment approaches.

Patient consent for the case report was obtained.

REFERENCES

- Janardhan Reddy, Y. C., Sundar, A. S., Narayanaswamy, J. C., Math, S. B. Clinical practice guidelines for Obsessive-Compulsive Disorder. *Indian journal of psychiatry*. 2017; 59: S74-S90.
- Del Casale, A., Sorice, S., Padovano, A., Simmaco, M., Ferracuti, S., Lamis, D. A., et al. Psychopharmacological Treatment of Obsessive-Compulsive Disorder (OCD). *Current neuropsychopharmacology*. 2019; 17(8): 710-736.
- Singh A, Anjankar VP, Sapkal B. Obsessive-Compulsive Disorder (OCD): A Comprehensive Review of Diagnosis, Comorbidities, and Treatment Approaches. *Cureus*. 2023;(Nov 17);15(11):e48960.
- Jalal B., Chamberlain S. R., Sahakian B. J. Obsessive-compulsive disorder: Etiology, neuropathology, and cognitive dysfunction. *Brain and behavior*, 13(6), e3000. 2023.
- Zhan Y., Wei J., M.S., Liang J., Xu X., He R., T Robbins T. W., Wang Z. Diagnostic Classification for Human Autism and Obsessive-Compulsive Disorder Based on Machine Learning From a Primate Genetic Model. *The American Journal of Psychiatry*. 2021; 178(1): 65-71.
- Miyauchi M., Matsuura N., Mukai K., Hashimoto T., Ogino S., Yamanishi K., et al. A prospective investigation of impacts of comorbid attention deficit hyperactivity disorder (ADHD) on clinical features and long-term treatment response in adult patients with obsessive-compulsive disorder (OCD). *Comprehensive Psychiatry*. 2023; 125.
- Dogan-Sander E., Strauß M. Case Report: Treatment of a Comorbid Attention Deficit Hyperactivity Disorder and Obsessive-Compulsive Disorder With Psychostimulants. *Frontiers in psychiatry*. 2021; 12.
- Guzick A. The link between ADHD-like inattention and obsessions and compulsions during the treatment of youth with OCD. *Journal of Obsessive-Compulsive and Related Disorders*. 2017;(12): 1-8.
- Hezel D. M., Rose S. V., Simpson H. B. Delay to diagnosis in OCD. *Journal of Obsessive-Compulsive and Related Disorders*. 2022; 32.
- WHO. International Classification of Diseases 11th Revision.
- Publishing APA. Diagnostic And Statistical Manual Of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR).
- Suhas S., Rao N. P. Neurocognitive deficits in obsessive-compulsive disorder: A selective review. *Indian journal of psychiatry*. 2019; 61: 30-36.
- Abramovitch A., Anholt G., Raveh-Gottfried S., Hamo N., Abramowitz J. S. Meta-Analysis of Intelligence Quotient (IQ) in Obsessive-Compulsive Disorder. *Neuropsychology Review*. 2018; 28: 111-120.
- Hu L., Hao Y., Liu S., Kang H., Qin L., Zeng Z., Abdelrahim M. E. A., Tan Y. Intelligence quotient level and treatment of obsessive-compulsive disorders: Meta-analyses. *Medical Hypotheses*. 2020; 140.
- Brem S., Grünblatt E., Drechsler R., Riederer P., Walitza S. The neurobiological link between OCD and ADHD. *Attention deficit and hyperactivity disorders*. 2014; 6(3): 175-202.
- Magnus W., Nazir S., Anilkumar A. C., Shaban K. Attention Deficit Hyperactivity Disorder. *StatPearls*. 2023.
- Williams O. C., Prasad S., McCrary A., Jordan E., Sachdeva V., Deva S., et al. Adult attention deficit hyperactivity disorder: a comprehensive review. *Annals of medicine and surgery*. 2023; 85(5): 1802-1810.
- Katzman M. A., Bilkey T. S., Chokka P. R., Fallu A., Klassen L. J. Adult ADHD and comorbid disorders: clinical implications of a dimensional approach. *BMC psychiatry*. 2017; 17(1).
- Abramovitch A. Misdiagnosis of ADHD in individuals diagnosed with obsessive-compulsive disorder: guidelines for practitioners. *Current Treatment Options in Psychiatry*. 2016; 10.
- Grant J. E., Chamberlain S.R. Attentional problems occur across multiple psychiatric disorders and are not specific for ADHD. *CNS Spectrums*. 2023; 28(3): 357-360.
- Arnold L. E., Roy A., Taylor E., Hechtman L., Sibley M., Swanson J. M., et al. Predictive utility of childhood diagnosis of ICD-10 hyperkinetic disorder: adult outcomes in the MTA and effect of comorbidity. *European Children and Adolescent Psychiatry*. 2019; 28: 557-570.
- WHO. 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Honkasilta J., Koutsoklenis A. The (Un)real Existence of ADHD-Criteria, Functions, and Forms of the Diagnostic Entity. *Frontiers in sociology*. 2022; 7(814763).
- Gomez R., Chen W., Houghton S. Differences between DSM-5-TR and ICD-11 revisions of attention deficit/hyperactivity disorder: A commentary on implications and opportunities. *World journal of psychiatry*. 2023; 13(5): 138-143.
- Levy N. Obsessive-compulsive disorder as a disorder of attention. *Mind & Language*. 2018;

- 33(9688): 1-14.
26. Mullin AB. Obsessive-Compulsive Disorder and Identity: The Role of Ego-Dystonicity. Honors Undergraduate Theses. 2023; 1392.
27. Zigmund A. S., Snaith R. P. The Hospital Anxiety and Depression Scale. Acta Psychiatrica Scandinavica. 1983; 67(6): 361-370.
28. Foa E. B., Huppert J. D., Leiberg S., Langner R., Kichic R., Hajcak G., et al. The Obsessive-Compulsive Inventory: Development and Validation of a Short Version. Psychological Assessment. 2002; 14(4): 485-496.
29. ADHD in adults: good practice guidelines. Royal College of Psychiatrists in Scotland. 2017.
30. Bhatia M. Obsessive Compulsive Disorder with Intellectual Disability: A Diagnostic and Therapeutic Challenge. Journal of Clinical and Diagnostic Research. 2015; 9.
31. Cabarkapa S., King J. A., Dowling N., Ng C. H. Co-Morbid Obsessive-Compulsive Disorder and Attention Deficit Hyperactivity Disorder: Neurobiological Commonalities and Treatment Implications. Frontiers in psychiatry. 2019; 10(557).
32. Mersin Kilic S., Dondu A., Memis C. O., Ozdemiroglu, F., Sevincok L. The Clinical Characteristics of ADHD and Obsessive-Compulsive Disorder Comorbidity. Journal of Attention Disorders. 2016.
33. Kooij J. J. S., Bijlenga D., Salerno L., Jaeschke R., Bitter I., Balázs J., et al. Updated European Consensus Statement on diagnosis and treatment of adult ADHD. European psychiatry : the journal of the Association of European Psychiatrists. 2019; 56: 14- 34.
34. Stein D. J., Costa D. L. C., Lochner C., Miguel E. C., Reddy Y. C. J., Shavitt R. G., et al. Obsessive-compulsive disorder. Nature reviews. Disease primers. 2019; 5(1).
35. Albert, U., Marazziti, D., Di Salvo, G., Solia, F., Rosso, G., Maina, G. A Systematic Review of Evidence-based Treatment Strategies for Obsessive- compulsive Disorder Resistant to first-line Pharmacotherapy. Current medicinal chemistry. 2018; 25(41): 5647-5661.
36. de Oliveira, M. V. S., de Barros, P. M. F., de Mathis, M. A., Boavista, R., Chacon, P., Echevarria, M. A. N., et al. Brazilian Research Consortium on Obsessive-Compulsive Spectrum Disorders guidelines for the treatment of adult obsessive-compulsive disorder. Part I: pharmacological treatment. Revista brasileira de psiquiatria (Sao Paulo, Brazil). 2023; 45(2): 146-161.
37. Wilson M, Tripp J. Clomipramine. StatPearls. 2022.
38. Cohen S. E., Zantvoord J. B., Storosum B. W. C., Mattila T. K., Daams J., Wezenberg B., et al. Influence of study characteristics, methodological rigour and publication bias on efficacy of pharmacotherapy in obsessive-compulsive disorder: a systematic review and meta-analysis of randomised, placebo-controlled trials. BMJ mental health. 2024; 27(1).
39. Feng, L., Feng, B., Luo, L. Y. Combination therapy for rapid treatment of severe obsessive-compulsive disorder: a case report. The Journal of international medical research. 2019; 47(10).
40. Varigonda A. L., Jakubovski E., Bloch M. H. Systematic Review and Meta-Analysis: Early Treatment Responses of Selective Serotonin Reuptake Inhibitors and Clomipramine in Pediatric Obsessive-Compulsive Disorder. Journal of the American Academy of Child and Adolescent Psychiatry. 2016; 55(10): 851-859.
41. Issari Y, Jakubovski E, Bartley CA, Pittenger C, Bloch MH. Early onset of response with selective serotonin reuptake inhibitors in obsessive-compulsive disorder: a meta-analysis. The Journal of clinical psychiatry. 2016; 77(5): e605-e611.
42. Kuzmickaitė J., Leskauskas D., Gyltė O. ADHD-Related Mental Health Issues of Young Adult Male Prisoners in Praveniškių Correction House-Open Colony (Lithuania). American journal of men's health. 2019; 13(4).

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