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RECOGNITION OF OBSESSIVE-COMPULSIVE DISORDER BY NON-SPECIALIST HEALTH WORKERS IN INDIA: TREATMENT DELAY AS A MODIFIABLE OUTCOME: A NARRATIVE REVIEW

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ABSTRACT

Background: Obsessive-compulsive disorder (OCD) is a treatable mental health condition frequently recognised late. Patients often first present to general health settings, where non-specialist health workers play a crucial role in early identification.

Objective: To synthesise evidence on treatment delay in OCD, examine barriers to recognition in non-specialist settings, and assess the potential role of the general health workforce in reducing delays in the Indian context.

Methods: A narrative review was conducted using PubMed, Scopus, and Google Scholar to identify literature published between 2005 and 2025. Search terms included OCD, duration of untreated illness, help-seeking, recognition, misdiagnosis, mental health literacy, health workers, nurses, and India. Relevant national survey reports were also reviewed. Studies were selected based on relevance rather than systematic eligibility criteria.

Findings: Pooled estimates indicate a mean age at help-seeking of 28.66 years, compared with an onset age of approximately 19.5 years, with a pooled duration of untreated illness of 80.23 months. Prolonged untreated illness is associated with poorer treatment response. Under-recognition, symptom concealment, and professional misdiagnosis contribute to delays. In India, an estimated 84.5% treatment gap for mental disorders and psychiatrist availability of approximately 0.3 per 100,000 population highlight the importance of non-specialist healthcare providers. Mental compulsions, scrupulosity, and intrusive postnatal aggressive thoughts may be particularly difficult to recognise.

Conclusion: Evidence on OCD knowledge among Indian non-specialist health workers remains limited. Integrating symptom recognition, brief screening, and cadre-specific training into general healthcare may improve early identification. Descriptive research is urgently needed to establish baseline knowledge and inform targeted interventions.

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1. INTRODUCTION

Obsessive-compulsive disorder occupies an unusual position in clinical practice. It is common, it is disabling, and it responds to treatment-serotonin reuptake inhibitors at adequate dose and duration, and exposure and response prevention, are both established. Yet it is among the psychiatric conditions identified latest in their course. The interval between symptom onset and the start of adequate treatment is measured in years, and among anxiety disorders it has been reported as the longest [1]. This delay is usually explained in terms of the patient. People with obsessive-compulsive disorder frequently conceal their symptoms out of shame, particularly where the obsessional content is aggressive, sexual or religious. Many do not construe their experience as illness at all; in one clinic series, the most common reason given for delaying a hospital visit was that the person did not consider the symptoms to be those of an illness [2]. These explanations are accurate but incomplete, because they account only for the period before contact with the health system. They do not explain what happens after a person does present. The second half of the delay is a recognition problem, and it belongs to the health system. A person

with contamination obsessions may attend repeatedly for dermatitis of the hands. A woman with intrusive thoughts of harming her infant may be assessed in a postnatal ward. A person with mental compulsions-repetitive mental acts with no observable behaviour at all-may present with nothing visible to observe. Whether obsessive-compulsive disorder is considered at these encounters depends on whether the person conducting them knows what it looks like.

In India this question has particular force. With an overall treatment gap for mental disorders estimated at 84.5%3 and psychiatrist availability of approximately 0.3 per 100,000 population [4], specialist assessment is not the ordinary route into care. The first health worker a person with obsessive-compulsive symptoms encounters-and frequently the only one-is a nurse, an auxiliary nurse midwife, a community health worker or a medical officer in a general setting. Their capacity to recognise the condition is therefore not a peripheral matter of professional education; it is a determinant of whether the condition is identified at all.

This review examines the evidence on treatment delay, the reasons the disorder is missed in non-specialist settings, and what is known-which is very little-about the recognition capacity of the Indian general health workforce.

2. METHODS

This is a narrative review and does not follow PRISMA methodology. PubMed, Scopus and Google Scholar were searched for literature published between January 2005 and August 2025, using combinations of the terms obsessive-compulsive disorder, OCD, duration of untreated illness, help-seeking, delay, recognition, under-detection, misdiagnosis, mental health literacy, knowledge, attitude, health care workers, nurses, primary care and India. National survey documents were retrieved directly from the issuing institutions.

Studies were selected for relevance to the review's themes rather than by predefined inclusion criteria. Preference was given to systematic reviews and meta-analyses where available, and to Indian studies where the question was context-dependent. No quality appraisal instrument was applied and no quantitative synthesis was undertaken; pooled figures reported here are drawn from published meta-analyses. These limitations are addressed in Section [8].

As a review of published literature involving no human participants and no primary data, the work did not require ethics committee approval.

3. BURDEN AND THE INDIAN PREVALENCE QUESTION

International epidemiological work places the lifetime prevalence of obsessive-compulsive disorder at approximately 2.3% and the twelve-month prevalence at 1.2%, with a mean age at onset of about 19.5 years.5 Indian epidemiological data are considerably thinner. A review of Indian research noted that only one epidemiological study had been conducted, reporting a lifetime prevalence of 0.6%-substantially lower than the 2% to 3% reported from European and North American samples, though comparable to a rate reported from Taiwan [6].

This discrepancy should be interpreted with care, and it is directly relevant to the argument of this review. A lower measured prevalence in a setting characterised by high concealment, low mental health literacy and limited case detection is at least as likely to reflect ascertainment as true difference in occurrence. Treating the figure as an established lower burden risks the circularity of using under-detection as evidence that there is less to detect. The honest position is that Indian prevalence is uncertain and that improved case detection would be required to establish it.

The wider context is better documented. The National Mental Health Survey of India, conducted in 2015-16 across twelve states, estimated current prevalence of mental disorders at 10.56% and lifetime prevalence at 13.67%, and placed the overall treatment gap at 84.5%, exceeding 60% for every disorder category apart from epilepsy [3,7]. Regional clinical work on obsessive-compulsive disorder in Karnataka exists-a 2024 cross-sectional study from North Karnataka examined the prevalence and types of mental compulsions among patients with the disorder [8], -but such studies describe patients who have already reached specialist services, which is precisely the population that the delay literature shows to be a minority and a late-arriving one.

4. THE SCALE OF TREATMENT DELAY

A recent meta-analysis of age at help-seeking and duration of untreated illness in obsessive-compulsive disorder reported a pooled mean age at help-seeking of 28.66 years (95% CI 27.34 to 29.98), a pooled mean interval between disorder onset and help-seeking of 6.97 years (95% CI 5.69 to 8.24), and a pooled mean duration of untreated illness of 80.23 months.9 Set against a mean age at onset of approximately 19.5 years, this describes the better part of a decade lived with an untreated but treatable condition, typically through late adolescence and early adulthood-the years in which education is completed, occupation established and relationships formed.

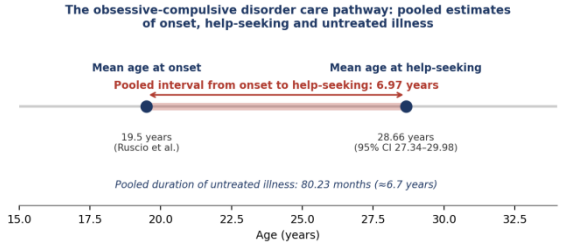


Figure 01: The obsessive-compulsive disorder care pathway, showing pooled estimates of mean age at onset, mean age at help-seeking, and the interval between them.

Estimates of untreated duration vary with setting and definition, as shown in Figure 2. A specialty clinic

cohort in Japan reported a mean of 4.7 years;2 work comparing anxiety disorders found obsessive-compulsive disorder to have the longest untreated duration at approximately 90.6 months;1 and reports from the United States describe an average of around 17 years between symptom onset and treatment, with estimates that between 38% and 89% of affected individuals neither seek nor receive treatment.10 The dispersion reflects genuine differences in how untreated illness is defined-whether the endpoint is first contact, first treatment, or first adequate treatment at appropriate dose and duration-and comparisons across these figures should be made with that in mind.

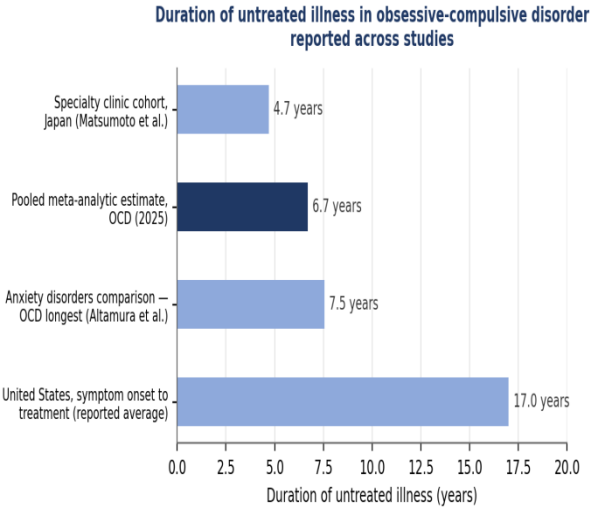


Figure 02: Duration of untreated illness in obsessive-compulsive disorder as reported across studies. Definitions of the endpoint differ between sources; figures are not directly equivalent.

The delay is consequential rather than merely regrettable. Longer untreated illness has been associated with poorer response to serotonin reuptake inhibitor treatment, with one analysis finding that an untreated duration exceeding 24 months predicted poorer response and higher symptom severity scores [11]. This converts delay from an access inequity into a clinical variable: the same treatment works less well the later it is given. It follows that shortening the interval is a therapeutic objective and not only an administrative one.

5. WHY THE DIAGNOSIS IS MISSED

5.1 Concealment and non-recognition by the patient

Shame and embarrassment are consistently described as contributors to delayed help-seeking, particularly where obsessional content concerns harm, sexuality or religion [12]. A second and distinct mechanism is that the person does not construe the experience as illness: in the Japanese clinic series noted above, this was the most common stated reason for delaying a hospital visit. These are different problems requiring different responses-the first calls for a consultation in which disclosure is made safe, the second for public and professional awareness that these experiences constitute a recognised and treatable condition.

5.2 Non-recognition by health professionals

Under-detection by clinicians is documented independently of patient concealment. One study reported that obsessive-compulsive disorder was not recognised in more than 70% of participants,13 and misdiagnosis by health professionals has been cited by patients as a reason for turning to alternative sources of care.14 Reviews of the field have noted that limited familiarity among clinicians with the range of symptom presentations, combined with misdiagnosis, contributes directly to under-recognition, and have identified improving the ability of primary care physicians and mental health professionals to recognise the disorder as a priority for shortening untreated duration.9,11

Two features of the condition make it particularly liable to be missed by those who have not been specifically trained to look for it. The first is that the presenting complaint is frequently somatic or behavioural rather than psychological, so the encounter takes place in a general rather than a psychiatric frame. The second is that a substantial part of the symptomatology may be entirely invisible. Mental compulsions — repetitive mental acts performed internally, with no overt behavioural component — are, as the North Karnataka study observes, performable quickly and anywhere without others perceiving them.8 A clinical approach that looks for handwashing and checking will not detect them.

5.3 Presentations commonly misattributed

Table 01: sets out presentations reported in the literature as liable to misattribution, with the setting in which each is likely to be encountered. The purpose is practical: these are the situations in which a non-specialist worker is positioned to identify the condition and, without prompting, likely not to.

Presentation	Where it is likely to be seen	How it is commonly misread
Contamination obsessions with washing	General outpatients, dermatology, primary care	Recurrent hand dermatitis or eczema treated symptomatically; the frequency of washing not enquired into
Health-related obsessions and reassurance seeking	General practice, general medicine outpatients	Repeated consultation and repeated investigation; the pattern read as anxious temperament rather than as a compulsion, with each reassurance reinforcing it
Religious obsessions and scrupulosity	Community settings; often taken first to religious	Interpreted as devoutness or as a spiritual difficulty; the distress and resistance to the thoughts not

	rather than health sources	enquired into
Intrusive aggressive thoughts, including thoughts of harm to an infant	Postnatal and obstetric care	Misread as psychosis or as intent, with serious consequences for the mother; the ego-dystonic quality that distinguishes obsession from intent not assessed
Sexual obsessions	Rarely disclosed in any setting	Concealed through shame; where disclosed, liable to misinterpretation as deviance rather than as obsessional content
Mental compulsions, symmetry and ordering	Any setting; no observable behaviour	Not detected at all, since nothing is visible; the person may appear slow or preoccupied
Checking	General practice	Presented as forgetfulness or a memory complaint

6. WHAT IS KNOWN ABOUT HEALTH WORKER KNOWLEDGE-AND WHAT IS NOT

The most striking finding of this review is a negative one. Despite a substantial international literature on treatment delay, and clear statements in that literature that clinician recognition is part of the problem, direct evidence on what non-specialist health workers in India actually know about obsessive-compulsive disorder is close to absent. Knowledge, attitude and practice research among Indian health workers exists in volume for other domains-antimicrobial resistance, for instance, has been the subject of a systematic review covering nineteen studies and over four thousand health providers15-but the comparable work for obsessive-compulsive disorder has not been done.

This absence is not a minor bibliographic gap. Every proposal to improve case detection through the general workforce presupposes a baseline: which cadres know what, which presentations are recognised and which are not, and whether the deficits are in factual knowledge, in confidence to enquire, or in attitude. Without that baseline, training content is guesswork and no intervention can demonstrate effect. Establishing it is the first piece of work required, and it is well within the scope of an institutional nursing research programme.

What can be said from the adjacent literature is limited but not nothing. Reviews have noted that even mental health professionals often have restricted awareness of the range of symptom presentations, which suggests that expectations of non-specialist staff should be calibrated accordingly. Mental health literacy in the general Indian population is described as low and is identified as a contributor to the treatment gap;16 health workers are drawn from that population and their pre-professional beliefs are formed within it. And the wider Indian mental health literature consistently identifies stigma and low literacy, rather than treatment unavailability alone, as the operative barriers.

7. IMPLICATIONS FOR PRACTICE

The argument for locating case detection in the general health workforce is structural. Given psychiatrist availability of approximately 0.3 per 100,000 population,4 no plausible expansion of specialist services will place a psychiatrist at the point of first contact for most of the population. The contacts that do exist-general outpatient departments, primary health centres, antenatal and postnatal care, community visits-are staffed largely by nurses, auxiliary nurse midwives and medical officers. If the disorder is to be identified within years rather than decades of onset, it will be identified there.

7.1 Screening

Detection does not require a diagnostic instrument. Two questions, asked where the presentation raises the possibility, will identify most cases warranting referral: whether the person is troubled by thoughts that keep coming back and that they cannot get rid of even though they want to; and whether they feel driven to repeat any action, or any mental act such as counting or repeating words, in order to feel settled. The second question is the more important of the two for the reason given in Section 5.2-without it, mental compulsions are invisible and the case is missed.

Brief validated screening instruments for obsessive-compulsive disorder exist and may be preferable where a structured tool is required. Any such instrument should be selected, and its validation in the relevant language and setting confirmed, before use.

7.2 What each cadre can contribute

Table 02: sets out cadre-specific actions. The list is deliberately modest: the objective is recognition and referral, not management by non-specialists.

Cadre	Position in the pathway	Practical contribution
Auxiliary nurse midwife / community health worker	Household and community contact; often the only health contact	Notice repeated washing, chapped or dermatitic hands, prolonged bathing or ritual questioning reported by family; ask the two questions; refer under the District Mental Health Programme
Staff nurse, general outpatients and wards	First clinical contact for most presentations	Recognise reassurance-seeking as a possible compulsion and avoid becoming part of the reassurance loop;

		enquire where contamination or checking behaviour is evident; document and refer
Nurse or midwife in obstetric and postnatal care	Contact with women in the highest-risk perinatal window	Distinguish ego-dystonic intrusive thoughts of harm — experienced as unwanted and distressing — from intent or psychosis; this distinction materially changes management and is a specific training requirement
Medical officer, primary health centre	Point at which treatment may be initiated	Consider the diagnosis in recurrent unexplained consultation; initiate treatment at adequate dose and duration or refer, noting that inadequate dosing is itself documented as a contributor to prolonged untreated illness
Nurse educator	Formation of the future workforce	Ensure obsessive-compulsive disorder is taught as a recognition problem with its atypical presentations, not solely as a diagnostic category with a list of criteria

7.3 Education of the workforce

For recognition to become routine it must be taught with the atypical presentations foregrounded. Curricular treatment that presents the disorder through its stereotype-the handwasher, the checker-will not prepare a nurse to identify scrupulosity, mental compulsions or perinatal intrusive thoughts, which are precisely the presentations the literature identifies as missed. In-service education for existing staff should be similarly organised, and the two screening questions are brief enough to be embedded in existing orientation and refresher programmes without additional service time.

7.4 Research priorities

Table 03: sets out the work required, in the order in which it would need to be done.

Priority	What is required
Baseline knowledge among Indian non-specialist health workers is unmeasured	Descriptive studies using a validated instrument, sampling defined cadres separately rather than treating health workers as one population
No validated Indian instrument for this purpose is established	Development and content validation of a knowledge instrument, with translation and back-translation into the regional language
Recognition capacity is untested against clinical material	Vignette-based studies presenting atypical presentations, which measure recognition rather than recall of criteria
No intervention evidence in this workforce	Trials of brief training with case-detection or referral rates as endpoints, rather than knowledge scores alone
Indian prevalence is uncertain and probably underestimated	Community-based epidemiological work using case-finding methods that do not depend on presentation to services

8. LIMITATIONS

This is a narrative and not a systematic review. Studies were selected for relevance rather than by predefined criteria, no quality appraisal was undertaken, and selection bias in the literature included cannot be excluded. Pooled figures are drawn from published meta-analyses rather than generated here.

The underlying evidence carries further constraints. Most delay estimates derive from patients attending specialist clinics, who are by definition those who eventually reached care; people who never present are absent from these samples, and the true untreated duration in the population is therefore likely to be underestimated. Definitions of untreated illness differ across studies. Much of the delay and recognition literature is from high-income settings, and its transferability to India is assumed rather than demonstrated. Most importantly, the central claim of Section 6-that Indian data on health worker knowledge of this disorder are lacking-is an argument from an absence of located evidence, and absence of evidence in a search is not proof that none exists.

9. CONCLUSION

Obsessive-compulsive disorder is treatable, and it is treated late. Pooled estimates place the interval between onset and help-seeking at almost seven years, with untreated duration around eighty months, and longer delay predicts poorer response to treatment. Part of that delay belongs to the patient, in concealment and in not construing the experience as illness. Part of it belongs to the health system, in failure to recognise presentations that do not resemble the stereotype. In India, where the treatment gap for mental disorders approaches 85% and specialist availability is minimal, the second part is decided at contacts staffed by nurses, auxiliary nurse midwives and medical officers rather than by psychiatrists. What those workers know about the condition is therefore a

determinant of whether it is identified — and it is, at present, essentially unmeasured.

This review makes a narrow claim. Establishing what the Indian general health workforce knows about obsessive-compulsive disorder is a prerequisite for any attempt to improve case detection, it has not been done, and it is straightforwardly doable. The presentations to prioritise, a two-question screening approach and cadre-specific actions are set out above as a starting point for that work.

10. CONFLICTS OF INTEREST

None declared.

11. FUNDING

None

12. ETHICAL APPROVAL

Not required; this review involved no human participants and no primary data.

13. DATA AVAILABILITY

Not applicable.

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