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# Obsessive-compulsive disorder in disguise—Case report*

**John E. Berg#†, Jorid Grimeland†**

Faculty of Health Sciences, Oslo and Akershus University College, Oslo, Norway
Email: #john@pong.no

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## ABSTRACT

**Obsessive-compulsive disorder (OCD) may mimic other minor and major psychiatric disorders or symptoms. Psychomotor disturbances may also be seen in OCD. Symptoms and complaints could be misinterpreted. Differential diagnostic assessments would be difficult either if the person has OCD or another diagnostic entity with OCD related symptoms. If clinicians in residential or outpatient settings do not realize this, the patients may suffer from inadvertent pharmacological treatment efforts, to no avail. A representative case of the former is presented. Withdrawal of all psychotropic medications cold turkey did not increase symptom load during the following weeks, indicating little benefit from medications. Because of continued complaints from the patient, psychotropic medications were gradually reintroduced, without any improvement. OCD patients may not be helped by extensive use of psychotropics and doctors responsible for them should employ other methods of reducing OCD symptoms than lumping together diverse psychotropics. There is evidence for the value of intensive cognitive behaviour therapy, but also for addressing the social conditions of the patients.**

**Keywords:** Obsessive-Compulsive Disorder; Medication; Ward Atmosphere

## 1. BACKGROUND

Acute psychiatry departments get in contact with patients suffering from frightening exacerbations of obsessions or compulsions. Patients with such obsessive-compulsive disorders (OCD) are a natural part of the acute treatment of disorders not handled well in ambulatory treatment. A referral to intramural treatment may include the necessity of observing the patient outside the home where the obsessive-compulsive symptoms are aggravated. On the other hand OCD may mimic other psychiatric illnesses often seen in the acute wards. The symptoms may take the form of anxiety, borderline psychotic behaviour, suicidal ideation, physical and mental rigidity and intolerable acts or thoughts for spouse or other family members. Some patients are even admitted with gait disturbances and body discomfort, which may otherwise be seen in acute debut of schizophrenia. Hymas *et al.* observed obsessional slowness in patients with OCD [1]. This was described as subtle neurological abnormalities giving rise to hesitancy in limb movements, speech and gait abnormalities and even cog-wheel rigidity and tics.

Patients with OCD, who were non-responders to medication, benefited from cognitive behaviour therapy (CBT) in a prospective one-year follow-up study by Anand *et al.* [2]. They indicated that after 20 - 25 sessions of CBT there was a reduction in severity of illness in 31 adult patients as measured by Clinical Global Impression (improvement 1 - 2 points) and on the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) severity score.

Patients, when asked, prefer a combination of medication and psychotherapy [3]. The study was based on telephone interview with 89 patients calling an obsessive-compulsive disorder (OCD) centre. Most participants chose combination treatment (43%) or Exposure and Ritual Prevention (EX/RP) (42%) over serotonin reuptake inhibitors (SRI) medication (16%). Participants ranked investigational psychotherapy as their most preferred novel treatment (endorsed by 48% of participants) and deep brain stimulation as their least preferred novel treatment (endorsed by 77% of participants).

Aripiprasol augmentation of serotonin reuptake inhibitor (SSRI) treatment in adolescents with obsessive-compulsive disorder (OCD) who did not respond to two initial trials with SSRI monotherapy was studied by Masi *et al.* [4]. A consecutive series of 39 adolescents with OCD were included. The mean final aripiprazole dosage was 12.2 ± 3.4 mg/d. At the endpoint, 27 patients (59.0%) had a Clinical Global Impression (CGI)-Improvement score 1 or 2 (very much or much improved) and a Clini-

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#Corresponding author.
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cal Global Impression-Severity (CGI-S) score 3 or below and were thus considered responders. The CGI-S improved from 6.0 ± 0.9 at the baseline (severely to extremely severely ill) to 3.5 ± 1.0 (mild to moderately ill) at the end of the follow-up ($P < 0.0001$). Subtypes of OCD comorbidity and absence of insight did not affect clinical response. In these severely impaired adolescents, aripiprazole augmentation of SSRIs was well tolerated and effective in more than half of the patients.

Women with purported postpartum depression may have a postpartum OCD. In a recent review by Speisman *et al.* it is demonstrated that at 6 weeks postpartum 4% of women had developed clinically significant obsessive-compulsive symptoms [5]. These symptoms are also common in women who experience postpartum—onset depression. The combination is followed by higher number of often more aggressive obsessions. Cognitive treatment would be preferred in the case of severe post partum OCD symptoms, whereas a severe post partum depression patient should be offered electroconvulsive treatment [6]. The two diagnostic categories may be difficult to separate.

Thus there seems to be documented some, but not an overall, effect of medications on OCD. SSRI's and the older tricyclic antidepressants, antipsychotics and different calming agents have all been employed with variable efficiency on symptoms. It would be of interest to see what happens in a representative patient after stopping all medication used for OCD.

## 2. METHODS AND CASE DESCRIPTION

The information on the presented case was gathered through the medical records after two resident stays, observation and therapeutic talks with the patient and her spouse. Anamnestic information (altered at points not essential for the evaluation of the therapy change):

The patient is a 58-year-old married woman, with grown up children, said to have suffered from anxiety since childhood. She was a trained Kindergarten teacher (three years of college education in Norway). From 2008 she has been granted a permanent invalidity pension.

She had a transient post partum depression with hallucinatory symptoms. Her symptoms were described as frightening visual and bodily sensations. They were treated with anxiolytics. Many years after giving childbirth she abused painkillers (karisoprodol and codeine) for her then bodily sensations of pain. Initially the painkillers were prescribed to her husband after an injury. She insists that her compulsive behaviour started when she stopped using the painkillers.

Somatic investigations and laboratory and X-ray tests were all normal. Psychometric tests revealed the following. On standardized tests of depression and anxiety the patient indicated severe suffering with Beck Depression Inventory total score 56 (normal < 10) and Beck Anxiety Inventory total score 43 (normal < 10). Hopkins Symptom Checklist (SCL-90R) is a combined test of symptom load divided into several subscales. The patient had a mean score of 2.49 with scores above threshold on all subscales except psychotic, paranoid and somatizing (normal < 1.5). On a screening test of OCD, the Zohar-Fineberg Obsessive Compulsive Screen (Z-FOCS) the patient indicated 3 of 5 positive answers (normal < 1). Before entry to the resident acute psychiatric facility she had been treated with SSRI's, antipsychotics in smaller doses, stabilising medication for a purported bipolar disorder and with different anxiolytics and hypnotics. Her condition deteriorated and she was referred to the acute clinic. Medication given at entry to last resident stay in the acute psychiatry department comprised olanzapine 5 mg + 10 mg, lithium 42 mg + 42 mg, mianserin 30 mg, oxazepam 30 mg + 15 mg, hydroxicin 25 mg, buspiron 10mg, zolpidem 20 mg and levothyroxine 50 μg (for hypothyreosis).

The obsessive and compulsive traits became prominent after childbirths, which were experienced as arduous [7]. Her symptoms have included, though changing in expression over time, low self-esteem, no career aspirations after more than 15 years as a Kindergarten teacher, varied relationship with spouse, loss of friends, involvement of family member in symptoms, thinking about suicide, loss of job, abuse of pain killers, fatigue, discrepancy between what she feels she can do and what she is observed to do in the ward. Gait is awkward and cumbersome in the ward with extreme flexion of her back. Walking outside the building is normal according to her physiotherapist. Psychomotor performance is thus not deemed related to an undiagnosed psychotic disorder. Her compulsory thoughts included sexual fantasies when observing trees in motion.

All her medications except levothyroxine were suspended cold turkey. Nurses, the physiotherapist and her treating psychologist observed the following: No change in obsessive-compulsive behaviour. No deterioration of symptoms, neither with psychotic, hallucinatory nor increased depressive symptoms. Sleep was slightly better, and her indoor gait improved. No withdrawal symptoms were observed, and the patient was herself startled with the lack of change after withdrawal of all medication. She received medication for hypothyreosis and this medication was not stopped.

Three weeks after withdrawal of all medications the patient had essentially unchanged behaviour and complaints. But her complaining was met by doctors on duty and nurses in the ward with reinstating medication again for some of her prevailing symptoms.

 

## 3. DISCUSSION

OCD patients are usually treated with a mixture of psychotropic medication because of the burden of suffering. Single symptoms may mimic those seen in other diagnostic entities. The patients may be persuasive and signal lack of satisfaction with the psychotherapeutic or cognitive treatment attempts. In patients with OCD after pregnancy non-pharmacological approaches are recommended [8]. This patient type, among whom the present patient is an example, do manage to persuade therapists to start again on a round of psychotropic medication, despite the observation of no change after withdrawal of all medication in the ward. Suspending all psychotropic medication cold turkey may be viewed as inadvertent negligence. This would be based on a conviction that the medications are needed. Within all aspects of psychiatry a small fraction of patients are non-responsive to medication.

Whether neuropsychological performance is disturbed in OCD patients is still disputed [9]. Neuropsychological deficits were found among symptomatic and remitted patients as well as in unaffected relatives [10]. Contrary to this Krishna *et al.* did not find any difference between medication-naive patients and healthy controls on a large battery of neuropsychological tests [11]. The lack of change in neuropsychological functioning observed in the present patient may thus be connected to the psychotropic medication itself.

Also other patients suffering from inadequate medication may be treated to no avail within a resident stay, as would be the case for benzodiazepine detoxification within an acute psychiatric ward [12]. Wilson's disease may mimic an OCD with contamination obsessions and washing compulsion together with feet tapping [13]. Ward atmosphere may depend too much on the purported effect of medication. Nurses exposed to the vivid suffering of some OCD patients may be tempted to argue for the reinstitution of medications.

## 4. CONCLUSION

Scientific support for the efficacy of medication for OCD is scant, but cognitive treatment strategies fare somewhat better. Observing and meeting the extreme suffering of these patients within the realm of an acute department with good clinical decisions is important. Especially during a resident stay OCD patients may learn to live without unneeded medication. The temptation to counter complaints with medication would be possible to suppress by non-pharmacological efforts, especially by using ward atmosphere and staff in psycho-education.

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