Thought disorders in obsessive-compulsive disorder

A. L. Palomo Nicolau, O. Alcoverro Fortuny, G. Hurtado Ruiz and A. Guerrero Pedraza

Centros Asistenciales Torribera. Santa Coloma de Gramenet. Barcelona

Trastornos del pensamiento en el trastorno obsesivo-compulsivo

Summary

Obsessions are typical thought disorders in the obsessive-compulsive disorder (OCD), as defined in the DSM-IV and ICD-10. From obsessive ideas, overvalued ideas to delusional ones, there is a seriousness spectrum that is defined by the presence or absence of disease insight. Absence of disease insight can include global or partial functioning of the individual, but only the latter is contemplated in the DSM-IV since the first case is diagnosed as «psychotic disorder not otherwise specified» or «delusional disorder.»

This article reports four cases with OCD diagnosis with the aim to illustrate a possible classification of this disease in relationship to disease insight.

Key words: *Obsessive-compulsive disorder. Obsessions. Delusions.*

Resumen

En el trastorno obsesivo compulsivo se presentan alteraciones del pensamiento características como son las obsesiones, tal y como están definidas en los manuales diagnósticos más utilizados. Desde ideas obsesivas, ideas sobrevaloradas hasta ideas delirantes hay un espectro de gravedad que viene definido por la presencia o ausencia de conciencia de enfermedad. La ausencia de conciencia de enfermedad puede abarcar la globalidad del funcionamiento del individuo o bien afectarlo de forma parcial, solamente este último aspecto está contemplado en el DSM-IV ya que si sucede el primer caso de diagnostica de trastorno psicótico no especificado o trastorno delirante.

El objetivo de la presente comunicación es la descripción de cuatro casos clínicos para ilustrar una posible clasificación de este trastorno en relación a la conciencia de enfermedad.

Palabras clave: *Trastorno obsesivo-compulsivo. Obsesiones. Ideas delirantes.*

INTRODUCTION

The concept of obsession and its characteristics as an unusual, parasitic, repetitive and cutting thought accompanied by an anxiety struggle and atmosphere of doubt is inherited from classical psychopathology[1]. Both the DSM-IV as well as ICD-10 include this fundamental concept. The DSM-IV offers the possibility of adding delusional disorder or not otherwise specified psychotic disorder to the obsessive-compulsive disorder (OCD). It also indicates the possibility of adding loss of insight. The ICD-10 establishes that obsessive symptoms in presence of schizophrenia should be considered as a part of it[2-4]. Going from an obsession to an overvalued idea (erroneous conviction accompanied by a significant affective substrate) and a delusional idea (strongly maintained erroneous belief) could be the manifestation of a psychopathological continuum[5]. The clinical fact is that we observe patients who present psychotic episodes in the context of an OCD[6] and patients who have been listed as OCD with chronic psychotic characteristics due to the lack of disease insight and their non-resistance to the obsessions[7]. Another more categorial and different view of the problem classifies the patients as affected by psychotic disorder even when they have begun with obsessions and psychotic symptoms, schizophrenic disorders with obsessive phenomena, obsessive disorders in which paranoid and reactive reactions appear and obsessive psychosis in patients who have symptoms that border on delusional, but who are not really schizophrenics, appear afterwards[7].

We present four clinical cases to illustrate these aspects: OCD, OCD with partial loss of disease insight, OCD without disease insight.

CASE 1

A 70 year old female patient suffering long evolution OCD whose predominant symptoms and signs consisted in an impulse to look at the men's genitals. Over time, she developed the delusional idea that everyone, first in her neighborhood and after in her city, knew that she was doing this and repudiated her for this reason. Some stopped greeting her, others, when they met her on the

Correspondence:
Antonio L. Palomo Nicolau
Centros Asistenciales Torribera
Prat de la Riba, 171
08921 Santa Coloma de Gramanet. Barcelona (Spain)
E-mail: palomoal@diba.es

street, changed direction or lowered their head. She believed that the shopkeepers avoided serving her in order to not have to speak with her. She presented a secondary depressive syn-drome as well as guilty ideas due to the morbidness of her thoughts. She initiated treatment with sertraline up to 200 mg/day. Her impulses decreased in intensity, appearing less frequently and were controlled by the patient. The ideas that the persons with whom she met knew what was happening and what she had done and that they avoided her persisted for a period of three months with this treatment. Three mg/day of risperidone were added, and at three weeks of having initiated the treatment, her delusional ideas of reference dis-appeared completely, people did not avoid her and she could carry out a normal life in her neighborhood. The delusional conviction that all had been true persisted.

CASE 2

A 51 year old female patient suffering from long evolution OCD that initiated with obsessive ideas in relationship with order, doubts and checking rituals and that partially improved with fluoxetine.

At present, the obsessive idea consists in repeated thoughts that become more and more intense and frequent, are egodistonic and with correct testing of reality that consists in thinking that the money she spends is not hers and that she has to return it. When the intensity of thought increases greatly, the patient thinks that it is true and a secondary depressive syndrome appears.

Treatment with fluoxetine was increased to 60 mg/day, with no result, so that she was changed to clorimipramine 250 mg/day and alprazolam 3 mg/day. The signs and symptoms abated partially, the reality test was correct again, and she remained stable for three weeks.

During this initial improvement, there was an increase in the intensity of the obsessive signs and symptoms until total loss of insight. Treatment was initiated with risperidone 3 mg/day with remission of the symptoms. She remained stable for several months and presently has periods of total loss of insight in spite of the treatment.

CASE 3

A 38 year old patient who was admitted to the Psychiatry Service due to a depressive syndrome with severe anxiety due to intensified jealousy ideas.

Family background of father diagnosed of schizophrenia, two siblings suffering multiple sclerosis, six siblings who suffered depressive episodes. Personal background of near sightedness and 25 diopter in both eyes. Background of psychological problems due to a jealousy problem.

His present condition began ten years ago with a problem of jealousy in relationship with a woman that has continued up to now, causing depressive feelings and increased anxiety. In the examination, a depressive mood state with psychomotor slowness and little structured suicide ideas stands out. He has always been concerned about order, with egodistonic idea of being dirty or contaminated, without resistance, experienced unquestionably and with correct reality test. They began in childhood. They are accompanied by cleaning rituals as well as doubts and checking to reduce anxiety. He also presents repeated thoughts of smelling bad. As disadaptive personality traits, he presents serious social anxiety due to inferiority and uselessness feelings and avoidance of situations in which he has to relate. This is the only problem for the patient and the reason for his hospital admission. He presents delusional jealousy. He does not present sensoperception disorders. Treatment was initiated with fluoxetine up to 80 mg/day, diazepam up to 20 mg/day and olanzapine up to 7.5 mg/day. The obsessive thoughts and rituals did not improve, so that treatment was changed to clorimipramine up to 150 mg/day, and the obsessive symptoms began to improve. The jealousy ideas disappeared without the patient questioning them. Anxious symptoms and incapacity to maintain correct functioning did not improve.

CASE 4

A 32 year old patient, admitted due to presenting significant deterioration in his physical condition with extreme thinness and paleness as well as lack of care in personal cleanliness. Background of four previous admissions produced under the same circumstances.

In recent months, he does not go out, washed or cut his hair or beard, does not change clothes, goes around the home dressed in the same shirt and only sits in a chair that his mother bought exclusively for him. He is getting thinner continuously since he only eats canned or sealed foods due to fear that they can be contaminated by his mother's hands. The patient does not want to use the same bathtub that his parents use, so that he does not shower. He does not want to wash his clothes in the same washing machine as they do, so that he does not change clothes and has even refused to sleep in his bed since his mother changed the sheets, sleeping since then in his chair. He does not leave home to prevent his parents from entering his room and «contaminating» it.

He reports object and hand cleaning rituals. He avoids those utensils that are frequently touched, for example, door knobs, faucets, telephone receiver. Although he does not know how to explain why he is acting in this way, he recognizes that when he tries to resist the ritual on some occasion, he ends up renouncing it due to anxiety and if he does so, he feels disgust and repugnance the rest of the day. The patient recognizes these ideas as his own and not imposed. He insists that if his parents would adapt to his rules, he would not have any problems. He does not understand the need for admission. He does not observe delusional ideation or sensoperceptive disorders.

Treatment was initiated with intravenous clomipramine in an increasing regime and was then changed to an

i.m. and oral regime until 450 mg/day was reached. Even though he followed antidepressive treatment correctly, partial improvement of the symptoms was observed and clorimipramine was decreased to 150 mg, adding pimozide until 4 mg/day and biperiden until 4 mg/day. After, the patient presented extrapyramidal symptoms so that treatment with pimozide was substituted for risperidone, with a dose of 1.5 mg/day, and gradual withdrawal of the treatment with biperiden, and no new extrapyramidal effects occurred. With treatment, his hygienic habits became normal and his nourishment reached an acceptable level. He continues to have little awareness of his disease, including his obsessions and rituals in his usual traits of thought and behavior.

DISCUSSION

In the clinical observations described as well as the bibliography consulted, we found thought disorders that do not adhere to the classical definition of obsessions[5,6,8,9]. When insight (recognition of thoughts as exaggerated or senseless) and resistance are lost, these patients come closer to suffering psychosis. It is described that as intrusive thoughts become more frequent, their interpretations become more irrational[10], as in case two.

We believe that a useful classification would be OCD, OCD with partial loss of disease insight and OCD without disease insight. The second type would present similar characteristics to the classical OCD, but with delusional ideas, either by transformation of the obsessive ideal into delusional idea or due to the reactive appearance of a delusional idea, responding to treatment with neuroleptics. In the third type, onset in childhood, obsessions are not experienced as rare and the disease insight is either never reached or is lost early; in these patients, delusional ideas with no relation with obsessive idea also appear and, although the neuroleptic treatment normally makes the delusional idea disappear, individual functioning is altered by lack of insight, the thoughts being experienced without any resistance or control.

The first two cases would correspond to OCD and partial loss of disease insight, without involving other areas of functioning, In case three and four, the fundamental feature is lack of disease insight, little recognition of the pathological disorders of thought and behavior and global involvement of the subject's personality. These are treatment resistant OCD in which appearance of psychosis, or as in case four, increase of intensity of the obsessions and compulsions, improve with antipsychotic treatment.

The distinction of this type of patient can have therapeutic implications that are being investigated at present. There are studies that advise the use of neuroleptics associated to treatment with antidepressives with favorable response[12,13].

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