A 48-year-old Man With a History of Obsessive-compulsive Disorder, Comorbid Bipolar, Panic Disorders

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Editor's Note: This monthly feature is based on a series of talks related to the annual Psychiatric Annals Symposium in New York, NY. Each presentation describes a case of a psychiatric disorder, discusses past treatment attempts, offers options for continuing treatment, and explains the reasons the solution was selected. The third annual Psychiatric Annals Symposium, on treatment-resistant and bipolar depression, will be held April 1-3, 2005, in New York.

This presentation was provided by Eric Hollander, MD, professor of psychiatry and director, Seaver and New York Autism Center of Excellence, director of clinical psychopharmacology, and director, Compulsive, Impulsive and Anxiety Disorders Program, Mount Sinai School of Medicine, New York, NY; and Jennifer Bartz, PhD, postdoctoral fellow, Seaver and New York Autism Center of Excellence, Compulsive, Impulsive and Anxiety Disorders Program, Mount Sinai School of Medicine.

PATIENT HISTORY

Mr. X is a 48-year-old man with a history of treatment-resistant obsessive-compulsive disorder (OCD) with comorbid bipolar spectrum disorder (bipolar II) and panic disorder. Mr. X's obsessions center primarily on the need to do things perfectly and having things "just so." He also tends to obsess about health-related issues, injury, and illness. He realizes his thoughts are irrational but feels incapacitated by them. Mr. X also engages in checking and mental rituals (rethinking, reordering, writing neatly), feeling uneasy if unable to perform these rituals. While he does not evidence sexual or aggressive obsessions, tics, or signs of ADHD, he does exhibit some impulsivity — he becomes bored easily, exercises to extremes, and has had an affair.

Mr. X has had four to five major depressive episodes. Beginning his first year in college, they have recurred intermittently roughly every 5 years. Between episodes, Mr. X is relatively healthy and functional. The episodes are marked by feelings of hopelessness, isolation, lethargy, and suicidal thoughts (but no plan), and notably are accompanied by obsessive thoughts, anxiety, and feelings of panic.

While not characteristic of full blown mania, Mr. X has also exhibited periods of markedly increased physical activity and decreased need for sleep, which have preceded the depressive episodes. During the past 20 years, Mr. X has seen numerous physicians, psychologists, and therapists, and while treatment has provided temporary relief of his OCD, depression and anxiety, the benefits have generally been short-lived.

Mr. X's childhood was relatively
normal. He grew up in a small town, and went to Catholic school. He did well in high school and completed college. His parents were, and still are, married, and he has one older sister. He describes his father as strong, but strict and controlling. He reports having had a great deal of conflict with his father while growing up and still harbors some aggression toward him. Nevertheless, he remains close to his father in adulthood. His father often accompanies him on visits to doctors and, during one particularly severe episode, he temporarily moved in with his parents. He described his mother, on the other hand, as more passive but a perfectionist and compulsive about cleanliness. She has a history of anxiety, panic attacks, and chronic low-level depression, for which she has been prescribed chlordiazepoxide and diazepam.

TREATMENT HISTORY

Mr. X experienced his first episode of depression in college. During this period, he reported feeling overwhelmed by persistent and oppressive thoughts related to perfection (eg, concerns about frayed jeans and scuffs on his shoes). While he completed college, he said it had been very difficult to overcome his obsessive thoughts. Mr. X married shortly after graduation, and within a few years he and his wife built their own house. One year after the house was completed, Mr. X experienced his first major depressive episode (at age 30), which was again accompanied by obsessive thoughts, this time concerning imperfections in the new house. He also reported feeling scared by how out of control his thoughts were, noting that as soon a one thought let up another took its place.

At this point, Mr. X went to see a therapist, who prescribed imipramine. After 4 to 6 months, he began to feel much better. A year and a half later, Mr. X divorced his wife of 9 years. While he and his wife had been getting along well, Mr. X had started an affair with another woman whom he subsequently married.

The next major depressive episode occurred 3 to 4 years later and was instigated by concerns about losing his property. At this point, Mr. X also began to have gastrointestinal problems and was diagnosed with irritable bowel syndrome. He became depressed, anxious, panicky, and obsessed about his intestinal problems. He also lost 10 pounds (he was 5'4" and 124 pounds after his weight loss), had difficulty sleeping, and was suicidal. Unable to overcome his depression and anxiety, Mr. X was briefly hospitalized. He was diagnosed with panic disorder and unipolar depression with obsessive-compulsive features and was prescribed alprazolam (25 mg per day) for anxiety and panic, and imipramine (25 mg three times per day) for depression. He returned home 2 weeks later.

Although Mr. X improved somewhat, his symptoms continued to fluctuate — in particular, his anxiety and feelings of panic. He was taken off alprazolam and started on clonazepam (1.0 mg per day), an anti-anxiety agent often used to treat panic disorder. Also, the imipramine was titrated up to 125 mg per day. His symptoms began to improve, and he returned to work. Mr. X's wife then became pregnant with their first child (she had two children from a previous marriage). Although Mr. X felt overwhelmed by the responsibility of caring for a child, his condition continued to improve.

His next major episode occurred roughly 4 years later and was precipitated by stress due to a lawsuit filed against him by a customer (he was a landscaper). To make matters worse, he pulled a muscle in his back, which precluded exercising, something he did regularly and excessively but that relieved his obsessions and dysthymia. He became obsessed about his back and had to quit working. The feelings of hopelessness and sadness returned, as did the suicidal thoughts.

This time, he was prescribed fluoxetine (40 mg per day), which gradually improved his condition. He left his landscaping job and went to work at his father's health food store. Although he felt better and was able to work, the depression was not completely alleviated, and he continued to obsess about his back. He was again prescribed clonazepam (0.5 mg per day), which decreased the intensity of the OCD. He also went to see a behavioral therapist who used flooding techniques; this also led to a slight improvement of his OCD symptoms. Unfortunately, however, the recovery was not long-lasting.

PATIENT STATUS

Six months ago, a few years after the previous major depressive episode, Mr. X experienced his
fourth major depression in which he left his wife and three children and went to live with his parents. He cried frequently and felt sad, hopeless, and fearful. He had no motivation and complained of feeling lethargic and tired. He also isolated himself and avoided social situations. His obsession returned, this time focusing on fears that he might try to hurt himself and feeling out of control. He was prescribed sertraline (200 mg titrated up to 300 mg) and continued to see a behavioral therapist.

TREATMENT OPTIONS

The following options were considered to treat Mr. X’s treatment-resistant OCD:
1. Switch from sertraline to a different selective serotonin reuptake inhibitor (SSRI) antidepressant.
2. Prescribe lithium.
3. Switch from the SSRI to a serotonin norepinephrine reuptake inhibitor (SNRI).
4. Both options 2 and 3.

TREATMENT CHOICE

In this case, option 4 was selected. The most discouraging part about Mr. X’s case is that while his condition improved following antidepressant treatment, the benefits would be temporary — the obsessions, depression, anxiety, and panic inevitably returned. While lithium is not generally known to be beneficial as an augmentation strategy for OCD, when OCD is associated with comorbid mood instability, it is first necessary to stabilize the patient’s mood. If the mood is not stabilized first, the antidepressant response will inevitably be short-lived. Moreover, lithium, either alone or when added to antidepressant treatment, can be successful in augmenting treatment in individuals who do not respond to tricyclic antidepressants. Mr. X was thus prescribed lithium (600 mg titrated up to 900 mg) to stabilize his mood.

Mr. X’s impulsivity may also have been an important factor undermining the long-term effects of antidepressant treatment. His depressive episodes often were preceded by periods of hypomanic activity — that is, increased energy and decreased need for sleep. He also showed occasional impulsivity (eg, spending money, risk-taking behavior, thinking about affairs) and some attention problems (becoming bored easily).

SNRIs have been found to be effective in treating patients who are resistant to SSRI treatment and are also useful when impulsivity is a factor. Mr. X was started on 75 mg of venlafaxine, titrated up to 300 mg a day, for depression and anxiety, and he was tapered him off the sertraline. He was also prescribed clonazepam for anxiety and panic. Initially, Mr. X became worse, feeling depressed, “fuzzy,” and unmotivated. Most likely this was due to the lithium, so it was tapered down to 600 mg a day.

At the next meeting Mr. X was very much improved; however, he exhibited some symptoms of hypomania and restless sleep. He was prescribed trazodone (25 mg titrated up to 100 mg per day) for the insomnia but the other medications were not changed. At the following meeting, Mr. X reported feeling 100% better. He was functioning well at work, had a sense of humor, and said he was “having fun.” Over time, the lithium and venlafaxine were lowered to maintenance dosages.

In the 4 years since, with the exception of a few ups and downs, Mr. X’s condition is much improved, and he has not experienced any major depressive episodes. Mr. X continues to take venlafaxine and clonazepam. The lithium was replaced with lamotrigine, a mood stabilizer with mood-elevating properties.

SUMMARY

When treating patients with OCD and comorbid bipolar spectrum disorder, it is important to evaluate carefully for a history of mood cycling, and to aggressively stabilize mood first. Failure to stabilize mood will inevitably undermine the long-term effects of antidepressant treatment. Second, if the patient remains treatment resistant, one option might be to switch to SNRIs, which can be helpful in addressing problems associated with impulsivity, especially if it is accompanied by attentional problems or ADD.