

ACUTE ONSET AND REMISSION OF OBSESSIONS AND COMPULSIONS FOLLOWING MEDICAL ILLNESSES AND STRESS

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Obsessive Compulsive Disorder (OCD) is generally chronic. Episodic OCD with complete remission has been rarely reported. Two cases of brief, episodic obsessions and compulsions that appeared for the first time following psychological stress and in the context of medical illness are reported. The possibility of brief episodes of OCD precipitated by stress is illustrated. Exploration of this phenomenon may help us learn more about OCD in general. Depression and Anxiety 12:238–240, 2000. © 2000 Wiley-Liss, Inc.

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INTRODUCTION

Obsessive Compulsive Disorder (OCD) generally begins early in life and has been thought to have an insidious onset [Jenike, 1995]. However, recent works suggest a majority of patients may have a sudden onset, with 50–70% describing onsets preceded by stressful life events [Neziroglu et al., 1992; Khanna et al., 1988]. Once established, OCD is chronic and complete remission is rare. Obsessions and compulsions can occur as symptoms in several other axis I disorders, such as Tourette's syndrome, major depression, and substance abuse, or in the context of physical illnesses, such as multiple sclerosis, Huntington's disease, and Sydenham's chorea [Rasmussen and Eisen, 1994; Tibbo and Warneke, 1999; Cummings and Cunningham, 1992; Swedo and Leonard, 1994]. For a diagnosis of OCD, DSM IV requires that obsessions and compulsions are not restricted in content to concerns arising from another axis I disorder (criterion D) and they are not due to the "direct physiological effects" of a substance or a general medical condition (criterion E). The literature regarding the last criterion (E) is scant and it is unclear how a direct physiological relationship is to be established. The role of life events or major stress in the occurrence of obsessions and compulsions is also not well studied. In this report, we describe two patients who developed OCD abruptly in response to specific stress and in the context of medical illness. Both also experienced abrupt remission in less than a month. The cases raise interesting questions about psychological and biological factors in the onset, course and resolution of obsessions and compulsions.

CASE 1

Mrs. B is a 54-year-old married schoolteacher with no past or family history of mental illness. She developed acute upper respiratory tract symptoms and was diagnosed with allergic rhinitis. She was advised to avoid dust and chemicals and subsequently she became very concerned about cleanliness. This concern grew into an intense preoccupation with dust and constant intrusive thoughts. She developed several cleaning rituals but could not quell her anxiety about dust. Within a week, she was off work and was spending most of her day at home washing, cleaning, and taking showers repeatedly. She even tried to sleep in the bathroom with no clothes to avoid any "germs and toxins." Exasperated, and fearing that she has gone "crazy," she called for an ambulance to take her to the hospital for psychiatric evaluation. She was admitted to a psychiatric unit with a diagnosis of severe and acute OCD. She was found to have anemia and thrombocytopenia, and further evaluation revealed an Acute Myeloid Leukemia. The patient reported that learning of this diagnosis was emotionally devastating, but it abruptly relieved her obsessive thinking and her cleaning and avoidance behaviors disappeared. Three days after this, she was

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evaluated by one of the authors and she did not present with any psychiatric symptoms or signs. She had good insight into the origin and excessiveness of her anxiety, obsessions, and compulsions. Unfortunately, over the next month, she failed repeated cancer chemotherapies and became increasingly withdrawn and depressed as her leukemia advanced, but she never exhibited obsessions or compulsions again. She was discharged home, being gravely ill, with hospice care.

CASE 2

Mrs. E is a 48-year-old married homemaker with no past or family history of mental illness. She was diagnosed with retroperitoneal liposarcoma. She underwent laparotomy and excision of the tumor. She was discharged home with instructions regarding wound care and dressing changes. She quickly became very concerned about the wound and infection risks. Within a week, she developed severe obsessions and cleaning compulsions. Constant preoccupation with the wound, infection risks, and contamination fears led her to spend her day washing repeatedly and changing clothes more than a dozen times a day. She was diagnosed with OCD by a psychiatrist and treated with sertraline 200 mg. Her deterioration continued, however, and she became sleepless and unmanageable at home, engaging in around the clock cleaning activities. She was admitted to a psychiatric unit with diagnoses of OCD and manic episode and was treated with valproic acid and sertraline. Over the next 12 days, she improved and was discharged home with valproic acid, clonazepam, and sertraline. Her "manic" and "OCD" symptoms disappeared over the following 10 days. Three weeks later, she returned to the hospital with post-radiation peritonitis and bowel obstruction and was admitted for gastric tube placement. Owing to the obstruction, she was vomiting and presumably was not absorbing her medications. Her valproic acid level was negligible. It is possible that she had not absorbed medications for the prior 3 weeks, during which time she was vomiting. At this admission, she had no symptoms of OCD or mania. We recommended that the medications be stopped and subsequently she remained symptom free for more than 6 months. The patient gained good insight into her condition and recognized that her cleanliness concern was excessive but remained uncertain as to why this had happened.

DISCUSSION

In both of these cases, the patients developed obsessions and compulsions in an acute manner, following physiological and psychological stress. Symptoms progressed rapidly in severity and remitted in a short period of time. Though it is believed that OCD is a chronic disease, the brief illness courses in these cases do not preclude a diagnosis of OCD, since DSM IV does not specify a time limitation. Development that

follows medical illness also does not preclude the OCD diagnosis, since a direct physiological relationship cannot be established. Though it is conceivable that some unidentified biochemical or anatomical compromise of the brain, related to their systemic illness, could have caused these patients' OCD symptoms, in neither case could a direct physiological relationship be reasonably established. Both patients had serious systemic illnesses but did not have any neurological deficits that indicated brain involvement. Neither presented histories of rheumatic fever, which might raise concerns about autoimmune origins [Svedo et al., 1997]. Additionally, in neither case were the obsessions and compulsions focused on symptoms related to other Axis I disorders. Neither patient had hypochondriacal features or a somatoform disorder. Neither had obsessive compulsive personality traits. Reading the DSM criteria legalistically, these patients would qualify for the diagnosis of OCD. However, it remains unclear whether these patients should be considered as having clinical OCD in a classic sense. This raises several interesting phenomenological questions about the precision and adequacy of the existing criteria. Can OCD be a brief reactive disorder? How can rapid resolution be explained? Can a systemic illness "cause" OCD? Can a psychological stress cause OCD? What are the possible mechanisms involved in the production and resolution of the symptoms? Scientific answers to these questions would improve our understanding of the disorder and could foster refinements that would make the diagnostic criteria more precise. At a minimum, we need a clearer understanding of what constitutes "direct physiological effects" when OCD symptoms develop in the context of medical illness.

Similar acute courses may be seen in other psychiatric disorders, such as single episode depression and brief reactive psychosis (DSM III-R). Brief reactive psychosis (Brief Psychotic Disorder, with marked stressors in DSM-IV) is an acute psychosis, immediately following major psychosocial stress, that lasts at least 1 day but less than 1 month. Major depressive episodes must last at least 2 weeks, but an episode of a few weeks duration, precipitated by a major stressor and never recurring, would meet criteria for Major Depressive Disorder, Single Episode. The role of life events in precipitating episodes of psychiatric illness has been reported and the possibility of brief episodes of psychosis or depression in response to life events seems widely recognized and accepted [Kendler, 1999]. However, there is little research on these phenomena, and we are not aware of literature on similar versions of obsessive-compulsive disorder. We are curious as to whether there are other examples of this phenomenon in OCD and whether they might have something to teach us about this disorder. We present these cases to stimulate discussion of this possibility in the literature.

One life event that is known to trigger psychotic and depressive episodes is parturition [Kendell et al., 1987]. Psychosis and depression in the post-partum

period can be brief and non-recurrent. Puerperal onset of OCD has been reported [Sichel et al., 1993], but we are not aware of studies to determine whether brief, non-recurrent "episodes" of OCD can occur post-partum or whether most obsessive-compulsive symptoms that develop at this time also follow the chronic course that is thought typical of OCD in general. The post-partum period has an important parallel with the systemic illnesses that seemed to have triggered OCD in our cases, in that it poses simultaneous physiological and psychological challenges. Separating the contributions of these two components, and exploring their mechanisms, will be difficult but potentially illuminating. The possibility of a brief, reactive form of OCD, raised in this case report, might helpfully inform future examinations of obsessive-compulsive symptoms arising in the post-partum period.

In both of the cases presented here there was a clear rationale for the initial concerns about contamination and cleanliness. The symptoms and behavior had some logic, though they became excessive and impairing. There is a similar psychological "sense" to obsessive-compulsive symptoms that may develop in post-partum women who may be concerned about the cleanliness of the newborn. These examples suggest there may be certain psychological contexts in which the initiation of at least some kinds of obsessions and compulsions are more likely. Contexts in which there is adaptive advantage to some degree of focus on contamination and cleanliness may be the most obvious such contexts to examine.

The rapid resolution of symptoms in our cases raises the possibility that OCD developing acutely following an understandable trigger may follow a different, less chronic course than traditional OCD, even when symptoms are severe. It may be a different type of disorder; but we believe that a search for more such cases and efforts to identify similarities and differences to chronic OCD may be illuminating. If life events can cause or precipitate *de novo* development of OCD in patients without prior evidence of susceptibility, then the role of such factors in the onset, exacerbation, and general long-term course of established patients with OCD would merit more detailed examination.

A wide range of follow-up research is suggested by the issues raised here. Better understanding of the precise brain mechanisms that mediate OC symptoms is needed before we can accurately define if and when these symptoms are attributable to the "direct physiological effects" of a drug, medication, or general medical condition. Advances from current neurobiological work will therefore facilitate more precision in this diagnostic criterion. Epidemiological studies of OC symptoms and their course in normal populations would provide useful information on the natural history of sub-clinical obsessions and compulsions. Do they fluctuate over time? Are they tied to environmental

events? Is there a clear demarcation between sub-clinical symptoms and "cases" as defined by current criteria? Prospective studies of post-partum psychiatric symptoms might provide an "enriched sample" in which to find cases of "episodic OCD" and explore factors that influence or predict long-term course. Prospective studies of other post-hospitalization patients would allow comparison of patients with rational "reasons" for heightened sensitivity to contamination and cleanliness concerns (e.g., those leaving the hospital with babies or wounds requiring fastidious care) to similar patients not exposed to such factors. This would enable a direct test of the hypothesis that OC symptom development is influenced by environmental factors that give adaptive value to the symptoms. Prospective studies would also allow examination of vulnerability factors, since only a small portion of people exposed to relevant environmental factors actually develop OC symptoms and predictors could be examined. Much psychiatric disorder seems to involve complex interplay between pre-existing vulnerability, acute neurobiologic perturbations, and psychological challenges, life events, or stressors. Brief, reactive versions of psychiatric disorders, including OCD, may offer a useful context for the study of these interactions.

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