



by Professor Gordon Parker

mind over matter

Hidden obsessions

Deeper investigation uncovers the complex cause of a woman's chronic depression.

GLENDa, a 32-year-old teacher, described 15 years of chronic depression, with only occasional and partial lifts in mood.

Symptom review identified several features of melancholic depression (e.g. anhedonia, non-reactive mood) but no suggestion of bipolar disorder – and as onset of melancholic depression rarely has onset in adolescence, unless there is bipolarity, a diagnosis of 'melancholia' was unlikely.

She had tried most antidepressants without benefit, and had been advised to have a course of electroconvulsive therapy (ECT). She also described debilitating fatigue, with physical investigations failing to identify any cause.

EXTENDED HISTORY

Glenda had a number of traumatic experiences in her early years.

Her father was quite brutal at times, engendering insecurity, anxiety and foreboding for much of her childhood, and she perceived her mother as indifferent to this impact on her.

Computer screening for current anxiety disorders established that she met criteria for generalised anxiety, had experienced occasional panic attacks but had no distinct symptoms of social phobia or obsessive compulsive disorder (OCD).

When OCD symptoms were reviewed during an interview, she initially denied any, but then quietly observed that she would need to tap three times whenever her boyfriend mentioned particular numbers.

Systematic review identi-

fied longstanding preoccupations about contamination, and compulsions to clean and wash, with much of her day spent pursuing such activities (even cleaning her dog's teeth three times a day), and being unable to settle unless such ritualistic behaviours were taken up.

DIAGNOSIS

The primary diagnosis was OCD, a condition with a lifetime prevalence of 1-2 per cent.

The obsessions usually involve an 'ego alien' idea (i.e. an intrusive idea that is very offensive, and with individual relevance, such as killing a parent or partner, dropping a baby, or sexually molesting a child).

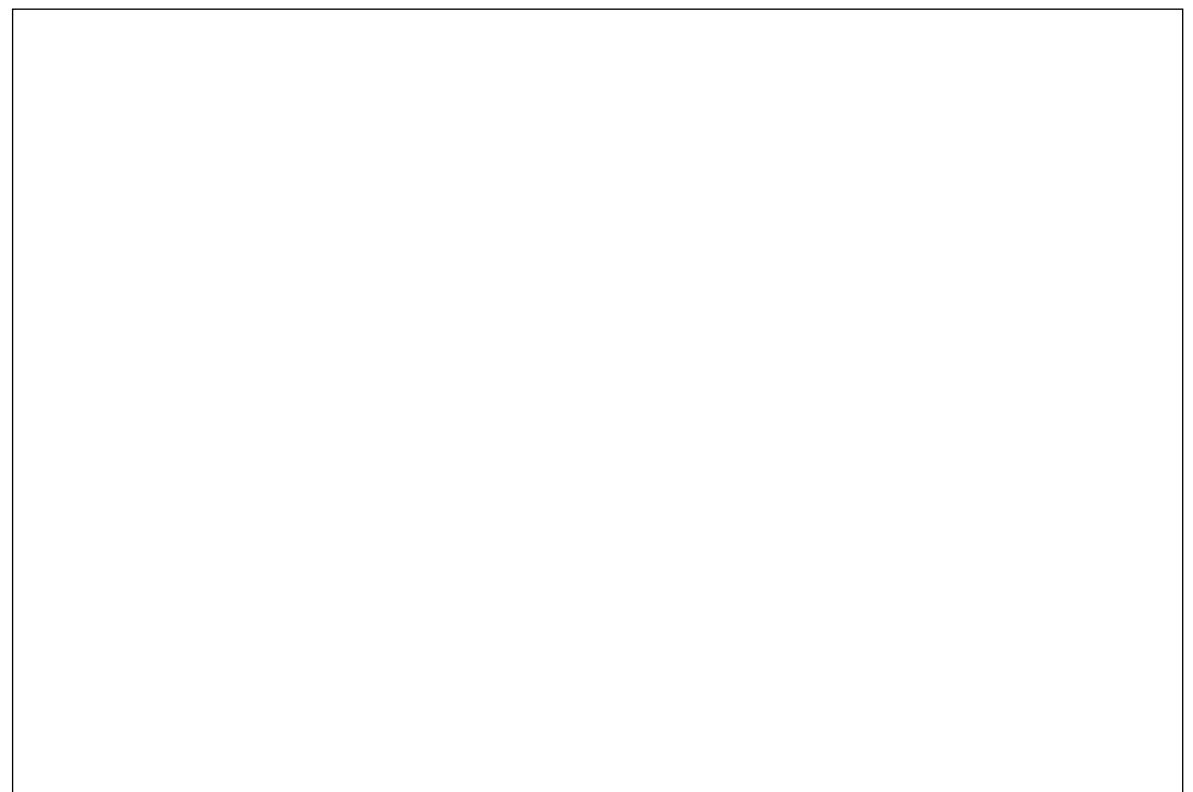
Other obsessions may be less distasteful and more reflect anxiety-based preoccupations (e.g. cleanliness). To ward off such obsessions, compulsive behaviours (e.g. checking, counting, procrastinating) are adopted.

Individuals rarely volunteer (and often deny) their symptoms

To the observer, a very mechanistic process is evident. When an individual receives a certain stimulus (e.g. some piece of clothing is 'contaminated'), they need to initiate a 'behaviour completion circuit', feeling unsettled until they can act out the compulsion.

The compulsion may extinguish the obsession momentarily or transiently but, before long, the behaviour-completing circuit is reactivated.

The many wasted hours, and the never settling mental preoccupation drives a profound sense of fatigue (often a useful indirect signal to diagnosis) and, commonly, secondary depression.



Untreated, many individuals experience lives of quiet desperation, with family members also caught up in the process. A husband may be required, on arriving home, to remove all his clothes at the front door before entering – as if entering a decontamination zone – with many individuals with OCD being confined to their homes.

CLINICAL RELEVANCE

OCD is a severe condition and not easy to manage.

Individuals rarely volunteer (and often deny) their symptoms, as they are ashamed of the 'ego alien' thoughts and more motivated to repeat their compulsive behaviours rather than modify them.

They are usually resistant to the diagnosis, also making management more difficult.

Secondary depression is common and, because it normally presents with a mixture of melancholic and non-melan-

cholic symptoms, many individuals are diagnosed as having a 'treatment resistant depression', receiving a relentless and ineffective array of drugs and ECT.

While uncommon, OCD is a key diagnosis to exclude in those with persistent and treatment-resistant depression.

THERAPEUTIC APPROACH

Combination medication and behavioural therapy are generally the most useful.

Some antidepressants (particularly the tricyclic, clomipramine) can modulate the obsessional thinking. Behavioural therapy can then work on aborting the behavioural completing mechanisms (or compulsions), but requires an experienced therapist.

Self-help books (such as *...nine, ten, do it again* by Kathryn L'Anson, from the Obsessive Compulsive & Anxiety Disorders Foundation of Victoria) can significantly

reduce the sense of alienation experienced by sufferers, as can support groups for those with more intractable conditions.

Prognosis is guarded due to low motivation and self-reinforcing behaviours, but those who adopt a therapeutic program, read self-help material and who include family members tend to improve the most.

KEY MESSAGE

Few patients volunteer their OCD, presenting instead with long-standing depression and, commonly, fatigue.

The assessor's task is to identify the depression as secondary to OCD, and focus (as argued in our sub-typing model for depression management) again on the primary condition or causal factor for the 'depression'. **MO**

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