

Obsessions and Depression

A. Hoffer, M.D., Ph.D. ¹

Leigh, Pare and Marks (1972) wrote that obsessions are "contents of consciousness which are associated with a subjective feeling of compulsion together with a desire to resist. They may tend to be recurrent and pathological in that they may substantially interfere with adequate performance and mental activity, or brief and occasional as may occur in normal subjects. Obsessions may take the form of recurrent ideas or images which cannot easily be voluntarily dispelled."

Obsessive ideas may be pleasant or unpleasant, may last for a brief period or may be present for life. Only unpleasant obsessions present a problem. They make the unfortunate victim unhappy, they are disturbing and annoying, and may lead to behavior which has a major impact upon one's life. Obsessive ideas cause anxiety and depression not only because they are there but because the victim in most cases knows they are irrational and ought not be present, and they force behavior which imposes tremendous problems for the individual. The idea that door knobs are contaminated or dirty leads to excessive hand washing and door passage behavior. A patient with this obsession depended upon having someone open the door for her. If she had to do so herself she would have to cover it with a cloth and then repeatedly wash her hands.

She could not hire a taxi because driver's seldom jump out and open the door for their passengers. Her daughter was the only readily available adult. The extraordinary demands on her created many difficulties for the relationship. This increased the patient's anxiety and depression while her daughter*was irritable, short tempered and resentful.

There is no end to the number and variety of obsessions. In most cases the ensuing behavior is predictable and is what we would ourselves be engaged in with the same obsessions.

Paranoid ideas are often among the symptom complex of schizophrenics. They too take on the qualities of an obsession except that some patients are firmly convinced their ideas are correct, i.e. they are said to have no insight. However, there are many who do have insight and are troubled by the ideas just as much.

It is easy to understand why obsessive ideas lead to anxiety and depression. It takes little wit to understand why a claustrophobic, fearful of leaving home, is depressed. But is this the only logical sequence, obsession to depression? Is it possible that depression will lead to and perpetuate obsessive thinking?

A substantial proportion of depressed patients lose their obsessive symptoms when the depression clears, no matter how they are treated. When I observed this in a number of patients where no attempt had been made to deal directly with the ob-

¹ No. 3A - 2727 Quadra St. Victoria. British Columbia

session, it occurred to me that it might be logically impossible to be both pathologically obsessive and free of depression simultaneously. If this were true, then removing the depression from any patient would remove the obsessions. This should apply even to obsessive patients who do not appear to be depressed. Perhaps they are. I cannot recall seeing cheerful patients with obsessions, especially when under the sway of the obsession.

This idea was examined by Capstick (1977) who wrote, "...it would seem logical that the mode of action in obsessional states should be that of an antidepressant. This would imply that obsessional states were manifestations of a depressive illness or closely related to this condition. This theory has support in so far that depression in childhood does not follow the same pattern as in adult states, and the bizarre ritual could be an abnormal mode of presentation of a childhood depression. When obsessions arise in adult states they are more likely to follow the onset of depressive symptoms."

"Against this theory is the fact that many patients who respond to clomipramine have received other antidepressant therapy before clomipramine without significant improvement. Occasionally patients when recovering from their condition say their obsessions are still present but they seem to be passing into the background thus suggesting that clomipramine has a specific antiobsessional quality."

However, it is common for depressed patients without obsessional symptoms to respond to one antidepressant when they have failed to respond to several others of the same class. This is why it is advantageous to have a choice from many antidepressants.

The hypothesis is that depression is like a motor which keeps the obsessive ideas alive; that the ideas would, in the absence of depression, dampen down or wither away in time. This hypothesis does not try to explain why the obsessive ideas arose in the first place, but it does follow that many people have obsessions now and then which gradually fade away. These people would not become part of any statistics gathered by psychiatrists.

Most of my patients with obsessive ideas are

schizophrenics of whom a small fraction have severe paranoid ideas. In a few patients no treatment has removed these paranoid delusions and their depression, but I had not linked these symptoms together. A man, 36 years old, had been sick and under intensive psychiatric care over twenty four years. This included a four and a half year stay at one of the USA's top psychoanalytic hospitals and a year and a half stint at another. He was started on Orthomolecular therapy about a half year before he came under my care in Saskatoon. According to his father this was the first sustained improvement he had seen since his son had become sick, but the patient continued to voice paranoid ideas about his neighbours. They were spying on him, or making fun of him, or going out of their way to annoy him. Because of these ideas he spent as little time as possible outside his home and was fearful of walking the street. About two years ago I added a tricyclic antidepressant, clomipramine (Anafranil in Canada) to his program. Within a few months there was a striking reduction in his paranoid ideas. Over the past year he has not referred to these ideas. His mood has been normal. I had never asked him about paranoid ideas before or after starting this antidepressant. Since this was the only change in medication it follows that this was the most likely explanation for his striking improvement.

The next case is even more striking.

Mr. J. L, born in 1949, came to see me in October 1976. During that first interview he gave me very little useful information, but his mother, who had looked after him with much care and devotion, provided the necessary background material. John was much more interested in looking at the books in my office library with his back to me. When he did speak it was rambling, inappropriate, and often incomprehensible.

As a child he was uncoordinated, wrote very poorly and learned very slowly. After he did learn to read he became an avid reader. In 1967 he read about the effects of LSD; following this he told his mother he had been hallucinating for as long as he could remember.

In 1968 he was given a series of ECT during

a two month session in hospital, and he continued to receive ECT as an outpatient every two weeks. Apparently he received over 100 treatments. It calmed him but affected his memory. In 1974 he was again in hospital for over four months with no improvement. After that he started on Orthomolecular therapy, but no physician was found who would be willing to supervise it. In 1975 he received a series of allergy tests and was started on a vaccine specifically designed for him; there was no improvement and after each injection there were adverse effects. Somewhat later it was found he became psychotic when tested with synthetic colours. He was placed on the Feingold diet, but in spite of this massive amount of treatment there had been minimal improvement. He still suffered from visual hallucinations, heard voices and his own thoughts, still was irrational, inappropriate, blocked, and suffered from violent mood swings, hyperactivity and agitation. At times he had been aggressive. There was no doubt about his diagnosis as a chronic schizophrenic, and no psychiatrist under whose care he had been had ever doubted it.

I readjusted his nutrient program and added lithium carbonate, but even 150 mg. per day made him excessively drowsy and it had to be discontinued. Six months later I saw no consistent improvement. At times he seemed to be better. His mother continued to find foods to which he was allergic, eg. bread, which he loved, made him ill and it had to be hidden from him. His paranoid ideas remained.

About ten months later there appeared to be some improvement. He had not suffered a severe psychotic outburst in a month. I could talk to him but he spent most of the time complaining about his wasted years and blaming his parents. He was so clearly paranoid it occurred to me I should try Anafranil 75 mg. per day. There were two indications, (1) its antihistaminic properties would be useful to help control his many allergic reactions, (2) to test the idea that it is difficult to be obsessively paranoid when there is no depression. Three weeks later there was a dramatic change. When he and his mother came into my office there was no doubt a major improvement had occurred.

His mother, normally tense, worried and haggard, was smiling, relaxed and cheerful. I have found that the appearance and attitude of family provides a very useful guide for judging improvement. John no longer wandered about my office until asked to sit down. He sat down on his own, was relaxed, at ease. For the first time in fifteen interviews I was able to talk with him. The voices and visions were nearly gone, there was very little thought disorder, he was much more appropriate. For the first time I began to think he might recover.

Since then he has continued to improve. He sees me every three or four months. His complicated nutrient program gradually became less complicated. It now includes niacinamide 3 grams, ascorbic acid 1½ grams, pyridoxine 5 mg., folic acid 5 mg., vitamin B-12 25 ug., vitamin E 200IU, thiamine 100 mg., zinc sulphate 220 mg. and some calcium and magnesium. The drugs include Haldol 2.5 mg. and Anafranil 75 mg. per day.

Now we are faced with the second major phase of treatment; to overcome a lifetime of illness. He had never had a chance to learn the whole complicated psychosocial skills essential for normal social intercourse. He had never had a chance to learn any useful skills, even though he is intelligent and his memory is normal. Perhaps it is too late and at his best he will remain socially impaired; only time will settle this, but it would have been impossible even to hope he could become normal until his dramatic change three weeks after the introduction of Anafranil. He no longer entertains any paranoid ideas and he is relaxed and feels good.

Two cases do not make an impressive series quantitatively. Qualitatively they are significant and do support the hypothesis. In each case the improvement followed the introduction of the antidepressant. Fortunately my practice does not contain many obsessive patients with this severe intractable obsessive ideation. It would take much too long to run a large series or even to conduct a double blind therapeutic trial even if I were inclined to do so.

I have not concluded that Anafranil alone would work in the same way, only that it

OBSESSIONS AND DEPRESSIONS

was effective in these two patients when it was added to a comprehensive Orthomolecular treatment program, or that it will help every schizophrenic. In several patients the Anafranil increased the severity of the psychosis.

The antihistaminic properties of the tricyclic antidepressant may play an important role in alleviating depression. Recent clinical evidence of the relationship of depression and allergies has been gathered by Orthomolecular psychiatrists and clinical ecologists.

Over the past ten years I have been impressed with the high proportion of patients with depression who have a history of severe allergic reactions in their past. These include eczema, rashes, asthma, hayfever, hives, sinus problems and a large variety of other forms. In a high proportion of cases food allergies are involved. It is rare to find patients with multiple food allergies who are free of depression. When allergies are alleviated the depression lifts.

Antihistamine phenothiazines have been used to deal with the somatic expressions of allergies. Tricyclic antidepressants might be as effective. I have several patients with multiple food allergies who were able to eat these foods with no adverse reaction when they began to take the tricyclic antidepressants. Any one of them was effective for some patients; usually smaller dosages, well below the level which causes side effects, are effective. But in some one tricyclic would be effective when others were not, or caused side effects.

It is possible that the presence of somatic allergies in patients who are depressed is an indication for the use of tricyclic antidepressants, but it also suggests that a search should be made for food allergies. Appropriate therapeutic intervention will decrease the amount of antidepressant required, and will decrease the likelihood of further relapses.

REFERENCES

CAPSTICK, N.: Clinical Experience in the Treatment of Obsessional States. *J. Int. Med. Res.*, 5,71 - 80,1977.

LEIGH, D., PARE, C.M.B., and MARKS, J.: *Encyclopedia of Psychiatry*. Hoff man-LaRoche publication, 1972.