Current PSYCHIATRY

Could it be OCD or PTSD?

I do not believe the authors of "Afraid to leave home," (Cases That Test Your Skills, CURRENT PSYCHIATRY, June 2009, p. 60-68) adequately defended their rationale for dismissing a diagnosis of obsessive-compulsive disorder (OCD) and did not consider posttraumatic stress disorder (PTSD) for Mr. B, the patient described in the article. DSM-IV clearly states that the person exhibits either obsessions or compulsions; both are not needed for a diagnosis. The patient was described as having "intense fear of bridges, upper-floor windows, express buses, subways, [and] riding in speeding vehicles," which leads him to have intrusive, ego-dystonic thoughts that are ruminative; and he "avoids these triggers at all costs." Clinically these sound like obsessions, which would qualify for OCD if he met other criteria, which—based on the case—he did. Furthermore, Mr. B was actively avoiding multiple situations when he felt he might harm himself. Avoidance is a common, often overlooked component of OCD that can reduce anxiety.

It would have been more helpful if Drs. Klein and Myers had described why they felt the patient did not have OCD or PTSD. It seems Mr. B would—if willing and not psychotic—have been a good candidate for exposure response prevention therapy. With such an anxious patient, this therapy could have been started as a home-based program. In addition I feel the authors did not consider the PTSD diagnosis stemming from the fear of relapse of his psychosis, which added to the clinical picture.

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Dr. Klein responds

OCD was the primary working diagnosis for quite some time because the thoughts did have the quality of being intrusive, ego-dystonic, and inappropriate. Furthermore, some reports associate clozapine treatment with the emergence or exacerbation of OCD symptoms.[1-3] However, OCD was ruled out after we established a strong therapeutic alliance and discovered that the thoughts did not distress him. Instead, it was the inherent fear of losing control and having no escape. The fear appeared first, and the situations in which he experienced that fear were subconsciously created because they explained the emergence of the feeling.

On a different note, Mr. B's obsessions did not appear if he successfully avoided the situation and—most importantly—he did not find them entirely unreasonable. Mr. B felt his fear was well justified because it protected him from public humiliation or self-harm.

Regarding the PTSD diagnosis, although I would agree that Mr. B had a traumatic recollection of his illness presentation and course, he did not re-experience the events, he did not avoid the situations associated with it, and his hypervigilance could be better explained by residual paranoia of his main disease process, which is schizophrenia, chronic paranoid type.

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References

1. Ke CL, Yen CF, Chen CC, et al. Obsessive-compulsive symptoms associated with clozapine and risperidone treatment: three case reports and review of the literature. Kaohsiung J Med Sci. 2004;20(6):295-301.
2. Bressan RA, Monteiro VB, Dias CC. Panic disorder associated with clozapine. Am J Psychiatry. 2000;157(12):2056.
3. Sagar R, Berry N, Sadhu R, et al. Clozapine-induced cardiomyopathy presenting as panic attacks. J Psychiatr Pract. 2008;14(3):182-185.

Correction

A staff-written summary of a presentation by Marlene P. Freeman, MD, (CURRENT PSYCHIATRY, May 2009, p. 56) paraphrased her as saying "atypical antipsychotics may pose a lower risk of fetal malformations compared with lithium or anticonvulsants." Dr. Freeman did not make this statement and states that available data are insufficient to support this comparison. She wishes to clarify what the scientific evidence supports when treating bipolar disorder in pregnant patients:

"Because relapse rates for bipolar women who discontinue medication during pregnancy are high, it is recommended that patients consider the serious risks of untreated bipolar disorder as well as medication exposure. Valproate appears to be the mood stabilizer associated with the greatest teratogenic potential. Among the anticonvulsants, lamotrigine appears to have the most favorable reproductive safety profile, and lithium appears to have a much lower risk of teratogenicity than was thought years ago, with a very low absolute risk of malformations with first-trimester exposure. More data are needed to inform the use of atypical antipsychotics across pregnancy and breast-feeding."

To comment on articles in this issue or other topics, send letters in care of Erica Vonderheid, CURRENT PSYCHIATRY, 110 Summit Avenue, Montvale, NJ 07645, erica.vonderheid@dowdenhealth.com or visit CurrentPsychiatry.com and click on the "Send Letters" link.