Treatment of obsessive–compulsive neurosis with haloperidol

J. B. O'REGAN, M.D., C.R.C.P.[C], *Saskatoon, Sask.*

The chronic obsessive-compulsive syndrome is considered by most authorities to be the psychoneurosis least likely to respond to any form of treatment. The prognosis is particularly poor when compulsive, ritualistic acts are the most prominent features. Behaviour therapy may offer a solution, and a case successfully treated by aversion therapy has been reported recently.[1] Except for this promising lead, treatment has been so ineffective, the symptoms are so distressing and the patient's ability to function is so limited that it is perhaps one condition for which psychosurgery may be indicated.

Gilles de la Tourette syndrome is a rare condition, of obscure etiology, characterized by tics and coprolalia. The compulsive pattern of the coprolalia resembles the compulsive ritualistic acts of the severe obsessive-compulsive neurosis, and Singer[2] believes that the condition may be a severe form of compulsive neurosis. In Tourette's disease also, until recent years, there was no means of alleviating the symptoms. However, successful treatment of this syndrome with haloperidol has been reported, and Chapel[3] states that this agent is the only known treatment which has proved consistently effective in the control of the disorder.

This success suggested the use of haloperidol in a patient suffering with obsessive-compulsive neurosis, as a last resort before recommending frontal lobectomy. Considerable improvement in his disabling symptoms was noted. Since this appears to be the only drug which has a specific effect on compulsive behaviour, the case is presented here and another similar case is briefly mentioned.

Reprint requests to: Dr. J. B. O'Regan, 113 Palisades, Saskatoon, Saskatchewan.

Case history

D.S.F., a 57-year-old retired farmer, was first examined on March 11, 1969. He was a small, agitated and depressed-looking man who complained of constantly worrying about minor problems and of compulsive habits. The latter prevented him from carrying on his normal activities and made him, he believed, the laughing-stock of the small town in which he lived. His chief concern was the compulsion to repeatedly check on himself. He could not leave a place without returning several times to make sure he had left nothing behind. He could not leave his car without repeatedly returning to be sure that he had turned the headlights off, locked the doors, etc. This behaviour was apparent to his family, friends and neighbours and they had commented on it. Many other areas of his life were affected, so that he took literally hours to get dressed in the morning, to wash himself, to prepare himself for meals and for bed. He also mentioned compulsive repetitive hand-washing.

He complained of being melancholy and appeared depressed. He blamed this on his inability to overcome his compulsive behaviour and the hopelessness that he felt as a result of failure to obtain relief from any treatment. He was worried because his symptoms had led to his inability to continue farming, and as a result he had had to sell some of his land in 1966. He had had to give up alternative work because his compulsions filled his waking hours. From his history it was apparent that he had a perfectionist, rigid, obsessive-compulsive, premorbid personality. Typically the patient produced sheets of paper on which were noted the details of his history and symptoms. The actual psychoneurotic symptom of ritualistic compulsiye acts began to appear, associated with a depressive mood, in 1959 at the age of 47. He was admitted to a psychiatric ward in 1959 and received electroconvulsive therapy which relieved him to some extent although the compulsive behaviour did not completely disappear. Within a few months, however, both the ritualistic behaviour and depressive mood gradually became more marked, until in 1965 he was unable to farm his land or do any other work. He was readmitted to a psychiatric ward in April 1966 and received another course of electroconvulsive therapy which apparently afforded no relief. He was readmitted once more in 1968 and received yet a further course, again without benefit. He was then treated (as an outpatient) with chlorpromazine, 25 mg. q.i.d.; although it reduced his anxiety, this did not change the frequency or the nature of the ritualistic behaviour.

After my initial examination, I believed there was a possibility that involutional depression might be the primary problem, with the compulsive behaviour as a secondary symptom. In any case, the likelihood of relieving a depressive illness seemed much greater than that of alleviating an obsessive-compulsive neurosis. The patient was given tranylcypromine, 10 mg. t.i.d., and oxazepam, 30 mg. t.i.d., for eight weeks. No improvement was noted as a result of this regimen or after a further course of electroconvulsive therapy. Referral for frontal lobectomy was seriously considered, and another psychiatrist saw him, in consultation, with this in mind. It was agreed that, considering the severity of the symptoms and the lack of response to treatment over

many years, psychosurgery was indicated.

Before this resort was reached, haloperidol, 5 mg. t.i.d., was prescribed, in view of the success reported with this drug in Gilles de la Tourette's disease. Within a week marked improvement was evident. Although the patient still had the compulsion to carry out his ritualistic acts, he was for the most part able to prevent himself from doing so with little discomfort. He was able to control the handwashing completely. On leaving a room he was still unable to prevent himself from looking back over his shoulder to check whether he had left anything behind, but he was able to stop himself from returning to the room several times. Before discharge from the hospital he did develop extrapyramidal symptoms which did not disappear with a reduction of the dose of haloperidol to 5 mg. daily. These symptoms were controlled with benztropine mesylate N.F., but this drug led to a confusional state, so ethopropazine HCl was substituted and found to be equally effective and without undesirable side effects.

Haloperidol 5 mg. daily and ethopropazine HCl 50 mg. t.i.d. have continued to be prescribed since he was discharged from hospital on June 14, 1969. His condition has remained stable during the past six months. He is able to prevent himself from carrying out his compulsive rituals for the most part. He still has obsessive thoughts. He feels comfortable in social gatherings now he has no fear that he will be unable to control his ritualistic behaviour. His wife and family have noted the marked improvement. His depressive mood continues, unrelieved by electroconvulsive therapy and various antidepressants, including imipramine and amitriptyline. He has not returned to work and is not functioning as he was before the development of his illness some 10 years ago.

Discussion

There seems to be no doubt that haloperidol enabled this patient to suppress his ritualistic acts. The results obtained and the speed of relief are very similar to those described by Chapel[3] in Gilles de la Tourette's disease.

Since the above case was treated, I have had the opportunity of managing with haloperidol another patient, a 45-year-old man who also had compulsive ritualistic acts that interfered with his ability to function. His history also extended back over some 10 years. A greater degree of improvement was obtained in this patient, who not only stopped his ritualistic behaviour but claimed to have no mental compulsion to continue his actions. He was able to return to work. The follow-up in this case was for only two months.

It would appear that haloperidol has a specific effect on compulsive behaviour. Although other tranquillizing drugs, such as phenothiazines and the benzodiazepines, confer some relief by their anxiolytic action in obsessive-compulsive neurosis, none have the marked effect of haloperidol on the compulsive rituals. Chlorpromazine and oxazepam had little or no effect on our patient. It would appear, therefore, that it is not solely the tranquillizing effect of the haloperidol that accounts for the improvement in the compulsive symptoms. Obsessive-compulsive neurosis appears to be closely related to obsessive-compulsive personality disorders, and although there are many hypotheses regarding the development of the personality patterns and the neurosis, there is no certainty about the etiology of obsessive-compulsive neurosis. Perhaps when more is known of the action of haloperidol some light will be shed on the physiological basis for compulsive behaviour. In the meantime, it appears that haloperidol is the most valuable if not the only drug available to relieve the suffering of those unfortunate enough to have developed a neurosis which has a poorer prognosis and is more handicapping than most psychoses.

References

1. SOLYOM, L.: *Canad. Psychiat. Ass. J.*, 14: 623, 1969.
2. SINGER, K.: *Amer. J. Psychiat.*, 120: 80, 1963.
3. CHAPEL, J. L.: *Canad. Psychiat. Ass. J.*, 11: 324, 1966.