

LE Magazine September 2004

ASK THE DOCTOR

Nutrients for Treating Obsessive-Compulsive Disorder

By Eric M. Braverman, MD

Q: My mother was recently diagnosed with obsessive-compulsive disorder (OCD). She checks the stove about a hundred times to make sure it's off before she leaves the house. Her doctor wants to put her on Prozac®. Is there a nutritional protocol for this disorder that we can use instead of an anti-depressant?

A: Like depression, obsessive-compulsive disorder has been primarily associated with a brain chemical imbalance involving serotonin, the neurotransmitter responsible for mood, sleep, and the brain-body connection. Because nutrients supply the raw material needed by brain chemicals, there is certainly a natural protocol we can recommend—provided that obsessive-compulsive disorder is the correct diagnosis and that your mother is not at a critical stage requiring immediate pharmaceutical intervention. First, a brief discussion of these two qualifiers is instructive.



Proper Diagnosis: Confirming OCD

While the “checking” ritual you describe is certainly indicative of OCD, its symptoms can also be the result of a brain injury or encephalitis (infection), anxiety disorders, dysthymia (the “blues”) or major depression, or a traumatic event such as the death of a spouse. Tourette’s syndrome, eating disorders, habit disorders such as hair pulling, and neurological conditions such as epilepsy frequently complicate an OCD diagnosis and must be ruled out as well.

If your mother was diagnosed with depression before her ritualistic behavior began, a diagnosis of OCD might not be indicated. It would also not be indicated if she considers her behavior to be rational and acceptable, which would reveal anxiety or possibly a personality disorder. OCD patients understand that the compulsion is illogical, are ashamed of the behavior, and want to change.

Quantitative tests can be used to confirm OCD. A clinician should use one of the proven interview tools, such as the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), during examination to identify the severity of OCD traits.¹ New neuro-imaging tests show promise for classifying OCD. Positron emission tomography (PET) scans show a definitive metabolic difference in OCD patients compared to norms, and morphometric magnetic resonance imaging (mMRI) shows different amounts of gray vs. white matter in OCD patients.²

While blood tests are not definitive, they can provide information about levels of serotonin and other brain chemicals that would be part of a complete clinical picture. OCD usually involves serotonin imbalances, but in many instances, imbalances of other primary brain chemicals are a more important part of the clinical picture. Some OCD cases are induced by fatigue related to the brain chemical dopamine; others are induced by cognitive impairment related to acetylcholine; and still others are based on anxiety associated with a gamma-aminobutyric acid (GABA) imbalance. All of these will bear on the diagnosis and treatment of OCD, and all can be measured with specific blood tests. Successful treatment—and the avoidance of unnecessary drug complications—depends on accurate diagnosis.

This discussion of proper diagnosis is important for another reason. Research has shown that while patients typically hide their symptoms and avoid treatment for a period of seven years, 80% of OCD cases occur by the age of 35. The average age of occurrence is somewhere between 20 and 25, and fewer than 5% of patients experience onset after the age of 40.^{3,4}

Considering all of the above, it is reasonable to question whether your mother has been properly and completely diagnosed. However, assuming that other conditions and contributing factors have been ruled out, and that OCD has been confirmed at least with a Y-BOCS test, then there is one other issue to address before discussing a natural treatment approach.

Drug Intervention and Behavior Therapy

If your mother's behavior is severely affecting her day-to-day life and ability to take care of herself, then pharmaceutical intervention might be necessary to provide initial symptom relief. Drugs, however, are far from a cure-all.



Because several selective serotonin reuptake inhibitors (SSRIs) have proven to be effective in mitigating OCD symptoms,⁵⁻⁷ doctors typically recommend one over another based on the anticipated side effects. Insomnia and weight loss have been associated with Prozac®, while nausea, weight gain, and sexual dysfunction have been associated with other SSRIs. Be sure to discuss side effects thoroughly before taking anything.

Medication must be taken for a minimum of 4-6 weeks before its effect can be evaluated; unfortunately, 40-60% of patients show no improvement after this period of time. A doctor might then recommend switching to another SSRI, as each has a slightly different biochemical mechanism. For the most part, lower dosages are just as effective as larger ones, so conservative dosing is recommended.^{8,9} This "hit or miss" approach is frustrating and potentially futile. Perhaps most worrisome about drug-driven approaches is that when the drugs prove to be effective, they must be taken indefinitely—symptoms usually return when drug use is discontinued.¹⁰ If your mother's condition is not critical, the use of non-drug alternatives is an option.

An interesting study of OCD from 1991 argues against using drug therapies unless absolutely necessary. In that study, one-third of patients with OCD went into spontaneous remission (though after years of illness in some cases) and another 10% exhibited a continuous deteriorating course.¹¹ This is not to suggest that you do nothing to address your mother's condition, but rather that non-drug alternatives may be the best way to treat OCD while nature runs its course. These include behavior therapy, serotonin supplements, a serotonin diet, and lifestyle changes.



Traditional psychotherapy has not been effective in treating OCD.¹² But "exposure and response prevention" behavior therapy, administered to the patient over a period of a few weeks, has been proven over 20 years to have positive results that last for years after it has been administered.¹³ During therapy, the patient is deliberately exposed to the stimulus, such as dirt on the hands or the thought that the stove has been left on, and deliberately prevented from acting, such as by washing the hands or going to check the stove, despite overwhelming urges to do so. When the anticipated dreaded consequences—infection or the house burning down—fail to occur, anxiety and symptomatology improve.

While this approach can be extremely effective, it also has its limitations—30% of patients refuse or fail the treatment, and it has not been effective for patients with depression, those who take drugs affecting the central nervous system, and those who are obsessive ruminators (repeating the same thought) without corresponding compulsions. When positive results are seen immediately after this behavior therapy is completed, however, there is a strong likelihood of lasting benefit. Nevertheless, therapy should be combined with natural serotonin enhancement.

Hormones, Supplements, and Nutrients

Just as there are families of medications such as SSRIs that are specifically formulated to affect a specific brain chemical, substances such as hormones, supplements, and dietary nutrients can likewise affect your mother's serotonin level. Progesterone is the primary serotonin hormone that, when deficient, can exacerbate OCD. A doctor who specializes in hormone therapy should oversee this treatment, but a typical dose is 200 mg per day. Growth hormone and pregnenolone also play a role. Levels of all three hormones should be measured, and imbalances should be corrected with hormone replacement therapy, using bio-identical formulations that duplicate the body's natural hormones, not the synthetic versions that have been at the center of recent controversies.

Tryptophan is the amino-acid precursor to serotonin. L-tryptophan is available in formulations such as my Brain Mood products, and 1-2 grams should be taken daily. Tryptophan is also available in prescription-strength 500-mg capsules. Additional supplements that play a role in support of serotonin, with recommended amounts in parentheses, include: melatonin (300 mcg-1 mg daily); St. John's wort (300 mg 3 times daily); kava kava (60-mg spray, 1-3 times daily); vitamin B6 (50 mg daily); vitamin B3/niacinamide (500 mg 1-2 times daily), fish oil (1-2 grams daily), and magnesium (500 mg 1-2 times daily).¹⁴

Dietary sources of tryptophan are numerous, with turkey being the best known. Serotonin can be supported all day long with menu selections from the following list:

Breakfast: oatmeal, rice bran, lox, wheat germ, eggs, cottage cheese, blueberries, bananas.

Lunch: turkey, roast beef, chicken, whole grains, salmon, Swiss cheese, tofu, beet salad, baked beans, brown rice, broccoli, avocado.

Dinner: turkey, Cornish hen, duck, pheasant, chicken, bluefish, mackerel, salmon, steak, brown rice, broccoli, baked potatoes.

Snacks: hard-boiled eggs, guacamole, Swiss cheese on whole wheat crackers, blueberries, bananas, raw broccoli, mixed nuts, sunflower seeds.

Two additional lifestyle choices could be helpful in treating OCD. Studies suggest that exercise and meditation positively affect anxiety-related conditions, so your mother might wish to incorporate these in a regular routine.

In addition, while psychoanalysis is not effective in treating OCD, family counseling that creates a support system for the patient has been shown to be beneficial in helping patients cope with and overcome OCD.

To summarize: be certain that your mother's diagnosis is accurate and complete. If her condition is not critical, then a combination of non-drug treatment alternatives—including behavior therapy, serotonin hormones and supplements, and a tryptophan-rich diet—can be implemented. A comprehensive plan can be rounded out with an exercise program and possibly meditation, and family counseling also should be considered.



A physician who is an expert in complementary medicine, which combines conventional protocols with holistic and alternative ones, can offer you and your mother a second opinion about OCD diagnosis and treatment, as well as significant hope for a cure.

Dr. Braverman is the pioneering medical director of a comprehensive anti-aging medical practice located at PATH Medical in New York City. He can be reached at 212-213-6155 or by visiting PATH Medical's website (www.pathmed.com).

Reference

1. Goodman WK, Price LH, Rasmussen SA, et al. The Yale-Brown Obsessive-Compulsive Scale. I. Development, use, and reliability. *Arch Gen Psych*. 1989 Nov;46(11):1006-11.
2. Baxter LR, Schwartz JM, Mazziotta JC, et al. Cerebral glucose metabolic rates in non depressed patients with obsessive-compulsive disorder. *Am J Psych*. 1988 Dec;145(12):1560-63.
3. Minichiello WE, Baer L, Jenike MA, Holland A. Age of onset of major subtypes of obsessive-compulsive disorder. *J Anx Disord*. 1990;4:147.
4. Rasmussen SA, Tsuang MT. Clinical characteristics and family history in DSM-III obsessive-compulsive disorder. *Am J Psych*. 1986 Mar;143(3):317-22.
5. de Vaugh Geiss J, Landau P, Katz R. Treatment of obsessive-compulsive disorder with clomipramine. *Psych Ann*. 1989;19:97-101.
6. Insel TR, Murphy DL, Cohen RM, Alterman I, Kilts C, Linnoila M. Obsessive-compulsive disorder. A double-blind trial of clomipramine and clorgyline. *Arch Gen Psych*. 1983 Jun;40(6):605-12.
7. Ananth J, Pecknold JC, Van Den Steen N, Engelsmann F. Double-blind comparative study of clomipramine and amitriptyline in obsessive neurosis. *Biol Psych*. 1981;5(3):257-62.
8. Jenike MA. Obsessive-compulsive disorder. In: Kaplan HI, Sadock BJ, eds. *Comprehensive Textbook of Psychiatry*, 6th ed., vol. 1. Baltimore, MD: Williams & Wilkins; 1995:1225
9. Robertson MM, Yakely J. Gilles de la Tourette syndrome and obsessive-compulsive disorder. In: Fogel BS, Schiffer RB, eds. *Neuropsychiatry*. Baltimore, MD: Williams & Wilkins; 1996:847-53.
10. Pato MT, Zohar KR, Zohar J, Murphy DL. Return of symptoms after discontinuation of clomipramine in patients with

obsessive- compulsive disorder. Am J Psych. 1988 dec;145(12):1521-5.

11. Karno M, Golding JM. Obsessive-compulsive disorder. In: Robins LN, Reiger DA, eds. Psychiatric Disorders In America. New York, NY: Free Press; 1991.

12. Greist JH. Treatment of obsessive-compulsive disorder psychotherapies, drugs, and other somatic treatment. J Clin Psychiatry. 1990 Aug;51S:44-50.

13. Foa E, Steketee G, Grayson JB, et al. Deliberate exposure and blocking of obsessive-compulsive rituals: immediate and long-term effects. Beh Ther. 1984;15:450-472.

14. Segala M, ed. Disease Prevention and Treatment. 3rd ed. Hollywood, FL: Life Extension Media; 2000.

All Contents Copyright © 1995-2009 Life Extension Foundation All rights reserved.

LifeExtension[®]

These statements have not been evaluated by the FDA. These products are not intended to diagnose, treat, cure or prevent any disease. The information provided on this site is for informational purposes only and is not intended as a substitute for advice from your physician or other health care professional or any information contained on or in any product label or packaging. You should not use the information on this site for diagnosis or treatment of any health problem or for prescription of any medication or other treatment. You should consult with a healthcare professional before starting any diet, exercise or supplementation program, before taking any medication, or if you have or suspect you might have a health problem. You should not stop taking any medication without first consulting your physician.