

Obsessive Compulsive Symptoms May Precipitate Manic, Mixed or Hypomanic Episodes in Patients with Bipolar Disorder

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Bulletin of Clinical Psychopharmacology 2013;23(1):6-7

In patients with bipolar disorder (BPD) and obsessive-compulsive disorder (OCD) comorbidity, each disorder may interfere with symptomatological expression and prognosis of the other (1). As serotonin reuptake inhibitors (SRI) are first line treatment for OCD, comorbidity is a difficult therapeutic challenge with the risk of promoting a switch to manic or mixed episodes. Contrary to previous reports presenting manic or mixed episodes produced by antidepressant treatment for OCD, we are presenting four patients with comorbid OCD and BPD, whose manic or hypomanic episodes were precipitated by obsessive-compulsive symptoms.

Two female patients with BPD I had evidence of documented mood episodes in the past. The other two male patients were diagnosed as BPD II due to past hypomanic and depressive episodes. All patients had been treated with mood stabilizers [lithium (1200mg/day); lithium (1500 mg/day) and valproate (1000 mg/day); lithium (900 mg/day) and quetiapine (200 mg/day); and valproate (1000 mg/day) and quetiapine (300 mg/day), respectively]. Before their last episodes, they had been also diagnosed with comorbid OCD. While two of them had been chronically suffering from OCD, their contamination obsessions and cleaning-washing compulsions had been exacerbated within the 3 weeks, before the last episodes (The Y-BOCS scores were 30 and 34). The other two patients' symptoms emerged within 4 weeks before their last hypomanic episodes. Their major complaints were religious and sexual obsessions and avoidant behaviors (The Y-BOCS

scores were 22 and 28, respectively), and they had episodically suffered from same OC complaints in the past. They were not receiving antidepressant treatment before experiencing a mood episode. The patients with BPD I were hospitalized and they were treated with haloperidol 20 mg/day (IM) for 3-7 days. In one patient with a manic episode, lithium (1500mg/day) and quetiapine (600 mg/day) doses were increased. In another patient with a mixed episode, olanzapine (30 mg/day) was added to lithium and valproate, while increasing valproate to 1500 mg/day. Mood symptoms were resolved within the following 4 weeks. In one patient with BPD II, lithium was increased to 1500 mg/day and quetiapine 600 mg/day was added. The other patient was maintained on the same treatment. There was no evidence of a mood episode after 3 weeks in both patients. While three patients' OC symptoms disappeared during their manic or hypomanic episodes, one patient still continued to perform washing and cleaning behaviors without obsessions; these behaviors were evaluated as an increase in goal-directed activity.

Since the nature of theoretical and practical problems emerging from BD and OCD comorbidity has not been recognized in detail (2), this report may clarify some aspects of this complex relationship. Some authors have noted that the episodic nature of OCD problems is due to BPD. On the contrary, OCD symptoms may also precipitate an active episode in a patient with past presence of signs or symptoms consistent with BPD, or a familial load for BPD. OCD symptoms may also precipitate an active episode in a patient with past presence of signs or symptoms consistent with BPD, or a familial load for BPD. Hence, exacerbated OC symptoms might be seen as early signs of a probable mood episode. Unlike other obsessions, religious and sexual obsessions are perceived as more repugnant, upsetting, peculiar, ego-dystonic, embarrassing and absurd. With regard to contamination-washing symptoms, impaired social relationships because of criticism by family members and increased rejection toward the patient may exacerbate a mood episode by increasing the patients' anxiety and dysphoria especially when the

patient cannot perform compulsions. In summary, since particular obsessions contradict important and valued aspects of self because of their repugnant

nature, and particular compulsions interfere with social relationships, they may generate vulnerability to bipolarity by impairing emotion regulation.

References:

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