

Changes in Obsessive Compulsive Symptoms during Manic Episodes: A case series

Amir Shabani, MD^{1,2}
Mehrdad Eftekhari MD^{1,2}
Shirin Abedian MD^{1,2}

1 Mental Health Research Centre
2 Department of Psychiatry, Iran
University of Medical Sciences,
Tehran, Iran

Corresponding Author:

Amir Shabani, Assistant
Professor of Psychiatry,
Tehran Psychiatric Institute,
Niayesh St., Sattarkhan Ave.,
Tehran, Iran.
Tel: +98 2166506899
Fax: +98 2166506899
E-mail: amirshabani@tehranpi.org

Objective: Although there are some reports of reduction of obsessive-compulsive symptoms in manic episodes or its exacerbation during depressive episodes, this relationship has not been proved.

Method: Clinical observations of six cases with co-morbidity of bipolar-I-disorder and obsessive-compulsive disorder or symptoms.

Results: The cases presented here show heterogeneity and variety of the relationships between the obsessions and bipolar-I-disorder.

Limitations: Low sample size and non-random sampling.

Conclusions: This variety of clinical presentations may indicate the presence of different clinical groups that their validity should be assessed through more systematized studies.

Key Words: *Bipolar disorder, Classification, Comorbidity, Obsessive-compulsive disorder*

Iran J Psychiatry 2007; 2: 82-85

Obsessive-compulsive disorder (OCD) is an anxiety disorder and its relation to bipolar disorders (BD) has again become the center of researchers' attention in the past two decades. The relationship between these two disorders has been evaluated and reported from several aspects; for example exacerbation of obsessive-compulsive symptoms after prescription of antidepressant drugs to patients with bipolar disorders (1), the emergence of mania or hypomania after drug treatment of OCD (2-5), the episodic course of OCD in bipolar patients (6-7), and the effect of this co-morbidity on the course of OCD (6).

Although the lifetime co-morbidity rate of OCD and BD has been reported to be significant in epidemiologic (8) and clinical studies (9-11), some experts consider OCD manifestations to be rare during manic episodes (12) and there are a few reports that show a remission of OCD symptoms during manic episodes and a relapse of the symptoms after remission of mania or beginning depressive episodes (1, 2, 13, 14). It has been reported in one study that OCD in BD patients is more related to depressive episodes or depressive symptoms than manic episodes (15).

Despite these reports, in a preliminary study there was no significant difference in the severity of OCD in two 30 patients with bipolar-I-disorder (BD); one group in the active phase of mania and one group in the full remission of affective symptoms (16). Moreover, our daily observations in an educational psychiatric hospital in Tehran (Iran) are not concordant with the above reports indicating the reverse relationship between mania and OCD. Therefore, there are some reports of reduction of obsessive-compulsive symptoms in manic episodes or its exacerbation during

depressive episodes on one hand, and a preliminary controlled study with findings in the opposite direction on the other hand. For broadening the view and trying to explain these contradictory findings, the history of six patients with BID and obsessive-compulsive symptoms/disorder that the latter symptoms of whom had been influenced by mood episodes are presented. All the diagnoses have been confirmed by the psychiatrist (the first two authors).

2. Case Reports

Case 1

He was a 39-year-old man who had attempted suicide four days before admission by drug ingestion. His symptoms included irritability, aggressive behaviors, talkativeness, decreased need for sleep, depression, crying, agitation, more desire to go out, no feeling of fatigue, low appetite and worrying about being threatened by others which had started suddenly 10 days before his admission after drug discontinuation. During this episode, compulsive behaviors as repetitive acts for seeking reassurance, exacerbated.

History: The mood episodes and obsessive-compulsive symptoms had begun almost simultaneously since he was 19 years old. His obsessive-compulsive symptoms revolved around seeking reassurance and repetitive acts. Before this episode, he had experienced two episodes of depression and two other episodes of mania with no significant mood symptoms between these episodes. During these years, obsessive-compulsive symptoms had caused significant impairment in academic functioning. He had been under drug therapy occasionally. In both of the manic episodes, the

obsessive-compulsive symptoms exacerbated and there were some reduction of obsession and compulsion parallel with improvement in the manic symptoms.

Treatment: He had been taking clomipramine, trifluoperazine and clonazepam irregularly for several years before the most recent episode of mania. In the recent episode he was treated by valproate and chlorpromazine and the obsessive-compulsive symptoms improved dramatically.

Diagnosis: According to DSM-IV-TR criteria, he was diagnosed as bipolar-I-disorder and obsessive-compulsive disorder. There was a clear and definite relationship between the mood episodes and obsessive-compulsive symptoms.

Case 2

He was a 30-year-old man who was brought to hospital by his family members because of aggression. He showed symptoms of restlessness, hyperactivity, talkativeness, decreased need for sleep and buying sprees during the month before admission. He had psychotic symptoms of grandeur delusion, persecutory delusion and auditory hallucination. He had spent a lot of time for his washing compulsion and exhibited washing and touching compulsion during this one month.

History: He had experienced several manic episodes and three hospitalizations for relapse of mania since he was 23-year-old. The obsessive symptoms had started with beginning of each manic episode and resolved dramatically with improvement in manic symptoms.

He developed temporal lobe epilepsy (TLE) at age 12 and was treated with carbamazepine. He never experienced a seizure after 12, but began to show several motor and vocal tics and significant impairment in several areas of functioning. He had started abusing opium, hashish, heroin, trihexiphenidyl and benzodiazepines. He had a history of a few self-injurious behaviors. One of his uncles was the only person in his family who was diagnosed as bipolar-I-disorder.

Treatment: He had been taking carbamazepine for several years from 12. During the recent episode of mania, the manic and obsessive-compulsive symptoms were controlled by carbamazepine, olanzapine and clonazepam.

Diagnosis: The diagnosis was BID, OCD, Chronic Motor or Vocal Tic Disorder (based on DSM-IV-TR criteria), and TLE. The exacerbation and remission of obsessive symptoms paralleled beginning and ending of mania.

Case 3

She was an 18-year-old girl who was presented because of aggression. She had been irritable for two months before the admission to the extent that she had beaten others and broken dishes. Her symptoms included elevated mood, talkativeness, hyperactivity, decreased need for sleep, increased energy, more desire to go out without any specific reasons and giving the personal

belonging away during this period. Also the severity of obsessive symptoms that were existed before had increased.

History: Because of low IQ she could not continue her education beyond the 3rd grade of primary school. She had had episodes of seizure from childhood and since then she had been irritable (the last seizure was 6 months ago). She had occasionally done self-injurious behavior from 12 and had contamination/washing and doubt/checking symptoms from 14. There was a gradual amelioration of obsessive-compulsive symptoms during the past years. She had been hospitalized because of relapse of depressive episode 6 months before the recent admission in which the obsessive-compulsive symptoms stopped completely. With improvement in depression, the obsession relapsed with less severity. There was no history of a mental disorder in her first degree family.

Treatment: She has been under treatment of several anticonvulsants including phenobarbital, carbamazepine, sodium valproate and again phenobarbital for controlling her seizure from childhood.

Diagnosis: The diagnosis was BID, OCD and mental retardation - based on DSM-IV-TR criteria - and seizure disorder. The obsessive symptoms remitted obviously in the depressive episode and exacerbated with depression improvement.

Case 4

A 40-year-old woman with symptoms of elevated mood, talkativeness, insomnia and increased appetite was hospitalized because of her aggressive behaviors. During this one week she had purchased so many items from supermarkets. She believed that she is in relation with sacred religious figures and heard their voice commanding her to do religious duties. She believed that she was followed so she should pay attention to her environment. During this period the obsessive-compulsive symptoms in the form of contamination obsession and prolonged bathing and frequent washing up had evolved.

History: She had been hospitalized because of relapses of acute mania several times from adolescence. The obsessive-compulsive symptoms emerged only during relapse of mania.

With improvement of mania the obsessions improved without taking any antiobsessional drugs. There was no history of psychiatric disorders in her family.

Treatment: She had never had a good compliance with drugs and had irregularly taken the drugs for a short period. Electroconvulsive therapy (ECT) had been used for controlling manic symptoms in most episodes. The last prescription before this hospitalization was risperidone, clonazepam and lithium. ECT successfully controlled manic symptoms but in spite of previous episodes the obsessive-compulsive symptoms continued.

Diagnosis: According to DSM-IV-TR criteria the diagnosis was BID. The beginning of obsessive

symptoms was always accompanied by manic episodes and improvement in these symptoms occurred with improvement in mania except this last episode.

Case 5

He was a 48-year-old man who was hospitalized because of suicidal ideation. The other symptoms were depressed mood, loss of interest, psychomotor retardation, hopelessness, reduced energy, forgetfulness, low self-esteem and impaired self-care. He got divorce recently and had felt remorse for his behavior with his family and had delusion of guilt. During this depressive episode the contamination/washing obsession that had existed before eliminated.

History: The mood disorder had begun 20 years ago and he had experienced several depressive and fewer manic episodes during these years. The washing/contamination obsessions had begun from few years ago. These symptoms had existed between the episodes, exacerbated during the manic episodes and eliminated during the depressive episodes.

He had used to smoke cannabis but only smoked cigarette during the days around hospitalization. His mother and uncle were affected by BID.

Treatment: He had been hospitalized and received ECT several times. The ECT had always had a dramatic effect on manic symptoms but not on the obsessive-compulsive symptoms. He had not had good drug compliance. From the previous mood episode, depression, he was taking sodium valproate and fluoxetine.

Diagnosis: He was diagnosed as BID and OCD based on DSM-IV-TR criteria. The obsessive symptoms had a direct relationship with manic symptoms and a reverse relationship with depression and also were present independent of mood episodes.

Case 6

She was a 30-year-old divorced woman who had elevated mood, talkativeness, pressured speech, hyperactivity, excessive preoccupation with religious issues, self-talking and aggressive behaviors 10 days before admission. Auditory and visual hallucination and grandeur, religious and persecutory delusion was revealed in mental state examination. The contamination/washing obsession which was severe until 10 days before hospitalization had suddenly stopped with the beginning of the manic symptoms.

History: She had not had any significant affective disturbances but she had obsessive-compulsive symptoms continuously from several years ago which was left untreated. The only history of substance abuse in her life was related to an instance of cannabis smoking a few days before the beginning of mood symptoms. Her mother and one of her sisters suffered from a depressive disorder and OCD respectively.

Treatment: First, she took 12 sessions of ECT to control severe manic symptoms. Then lithium, haloperidol and biperiden were prescribed. The

psychotic symptoms remitted first and it took more than 4 months for normalization of mood. There were no obsessive-compulsive symptoms all through this period.

Diagnosis: The patient's diagnosis was OCD and with appearance of the first episode of mania the diagnosis of BID was added (DSM-IV-TR criteria). The obsessive symptoms were not seen during the manic episode and even in a significant period of remission.

Discussion

All of the aforementioned cases suffered BID and obsessive symptoms that except case 4 co-morbid diagnosis of OCD was present and except case 6 the obsessive symptoms exacerbated with mania and improved with depression. In case 4, the obsessive symptoms only appeared during manic episodes and did not have a separate identity from BID. In case 6 the appearance of mania accompanied improvement in OCD symptoms and these symptoms did not remit even after improvement in mania.

To the best of our knowledge, a case with exacerbation of obsession during manic episodes has not been reported and the reports of opposite relationship improvement in obsession during mania or exacerbation during depression- are scarce (1, 2, 13-15). In a systematized study of relationship between obsession and various phases of BID, the obsession of hospitalized patients in acute phase of mania were compared with the bipolar patients in remission who had visited in outpatient setting with Yale-Brown Obsessive Compulsive Scale (16). The current prevalence of OCD was 13% and 17% respectively that did not show a significant difference. Indeed the study was not on the patients with lifetime co-morbidity of OCD and BID and this may have caused the insignificance of the result.

Therefore according to the present knowledge the various relationships between OCD and BID can be suggested:

1- The obsession as a nonspecific symptom of mania: As it is seen in case 4 the obsessive symptoms may present only in the manic episodes and improves completely with remission of mania without any specific treatment on OCD. This resembles the Kraepelin's consideration of anxiety as a symptom of mania (17).

2- OCD as an independent disorder not influenced by the lifetime co-morbidity with BID: According to several studies the lifetime co-morbidity of these two disorders is higher than what was expected by chance (8-11), but it does not necessarily imply the influence of BID on the obsessive manifestations. We excluded several cases that their obsession had not been affected by BID to find these 6 cases and possibly many cases of co-morbidity are like them.

3- OCD as an independent disorder but influenced by the co-morbidity with BID: In the previous reports (1, 2, 13-15) and case 6 of this article, there is a reverse relationship between mania and obsession (or a direct

relationship between depression and obsession). In cases 1, 2, 3 and 5 a direct relation between mania and obsession (or a reverse relationship between depression and obsession) can be seen. Therefore this type may be more divided to two subtypes.

Hantouche et al. (6) have considered a subtype of OCD with some features of bipolar spectrum disorders and named it "cyclothymic OCD". This encompasses obsessive-compulsive symptoms that have some significant difference with other classical OCD: greater number of psychiatric admission and earlier age at first admission, more severe obsessional syndrome, episodic course, greater number and intensity of concurrent mania and hypomania and major depressive episodes, elevated risk of suicide, less favorable response to antidepressant therapy associated with higher rate of switching and aggressive behavior. Since cyclothymic OCD does not include only BID and also has some overlap with our classification, it is not considered as a separate class.

Therefore the cases of BID and OCD co-morbidities are a heterogeneous group of patients with various clinical presentations. With regard to wide variety (and sometimes unexpected forms) of therapeutic responses of these patients, implementing the clinical trials on this heterogeneous group is unreasonable. Before doing this, it seems necessary to design and carry out the projects for defining the validity of classifications like the one that is mentioned to access more homogeneous group suitable for clinical trials.

The main limitation of the present study is low sample size and non-random sampling. It may be appropriate to study the validity of the above groups in the patients with dual diagnosis of BID and OCD in a larger clinical sample and even community.

References

1. Raja M, Azzoni A. Case Report Clinical management of obsessive-compulsive-bipolar comorbidity: a case series. *Bipolar Disord* 2004; 6: 264.
2. Baer L, Minichiello WE, Jenike MA. Behavioral treatment in two cases of obsessive-compulsive disorder with concomitant bipolar affective disorder. *Am J Psychiatry* 1985; 142: 358-360.
3. White K, Keck Jr PE, Lipinski J. Serotonin-uptake inhibitors in obsessive-compulsive disorder: a case report. *Compr Psychiatry* 1986; 27: 211-214.
4. Steiner W. Fluoxetine-induced mania in a patient with obsessive-compulsive disorder. *Am J Psychiatry* 1991; 148: 1403-1404.
5. Berk M, Koopowitz LF, Szabo CP. Antidepressant induced mania in obsessive compulsive disorder. *European Neuropsychopharmacology* 1996; 6: 9-11.
6. Hantouche EG, Angst J, Demonfaucon C, Perugi G, Lancrenon S, Akiskal HS. Cyclothymic OCD: a distinct form? *J Affect Disord* 2003; 75: 1-10.
7. Swartz CM, Shen WW. Is episodic obsessive compulsive disorder bipolar? a report of four cases. *J Affect Disord* 1999; 56: 61-66.
8. Chen YW, Dilsaver SC. Comorbidity for obsessive-compulsive disorder in bipolar and unipolar disorders. *Psychiatry Res* 1995; 59: 57-64.
9. Strakowski SM, Tohen M, Stoll AL, Faedda GL, Goodwin DC. Comorbidity in mania at first hospitalization. *Am J Psychiatry* 1992; 149: 554-556.
10. Krüger S, Cooke RG, Hasey GM, Jorna T, Persad E. Comorbidity of obsessive compulsive disorder in bipolar disorder. *J Affect Disord* 1995; 34: 117-120.
11. Pini S, Cassano GB, Simonini E, Savino M, Russo A, Montgomery SA. Prevalence of anxiety disorders comorbidity in bipolar depression, unipolar depression and dysthymia. *J Affect Disord* 1997; 42: 145-153.
12. Karno M, Golding JM, Sorenson SB, Burnam MA. The epidemiology of obsessive-compulsive disorder in five US communities. *Arch Gen Psychiatry* 1988; 45: 1094-1099.
13. Gordon A, Rasmussen SA. Mood-related obsessive-compulsive symptoms in a patient with bipolar affective disorder. *J Clin Psychiatry* 1988; 49: 27-28.
14. Keck Jr PE, Lipinski Jr JF, White K. An inverse relationship between mania and obsessive-compulsive disorder: a case report. *J Clin Psychopharmacol* 1986; 6: 123-124.
15. McElroy SL, Strakowski SM, Keck PE, Tugrul KL, West SA, Lonczak HS. Differences and similarities in mixed and pure mania. *Compr Psychiatry* 1995; 36: 187-194.
16. Shabani A AM, Panaghi L. [Comorbidity of obsessive-compulsive disorder in manic and remission phases of bipolar patients]. *Tehran University Medical Journal* 2005; 63: 386-391.
17. Kraepelin E. *Dementia praecox and paraphrenia together with manic-depressive insanity and paranoia* (RM Barclay, Trans., and GM Robertson, Ed.). Birmingham, AL: Classics of Medicine Library.(Original work published 1919) 1989.