Part 7. Comorbidities and Bipolar Disorder

Comorbidity of bipolar affective disorder and obsessive-compulsive disorder

Laura Darby3, Mark Agius1,2 & Rashid Zaman1,2
1 Department of Psychiatry, University of Cambridge, UK
2 South Essex Partnership University NHS Foundation Trust, UK
3 School of Clinical Medicine Cambridge University, UK

Abstract

The comorbidity of bipolar affective disorder and obsessive-compulsive disorder is an important, although relatively unusual in community mental health teams. Patients with comorbid bipolar conditioning affective and obsessive-compulsive disorders appear to require a greater number of outpatient appointments, have a greater number of hospital admissions and also to be more likely to require a care coordinator and to require psychological input than those with OCD alone. They also appear likely to be more difficult to treat and to carry more risk factors than patients with OCD alone.

Key words: obsessive compulsive disorder, OCD, bipolar affective disorder, comorbidity.

There is much recent evidence that there is a frequent comorbidity of OCD with bipolar affective disorder. A review of recent studies has demonstrated that 7-21% of patients with bipolar affective disorder also have an additional diagnosis of OCD (1-5). This link is said to be more prevalent in men. For example, one study showed 69% of those with comorbidity to be male (6). Studies endeavouring to identify bipolar disorder in patients with OCD have found a prevalence of 15-15.7% (1-2,7). It appears that OCD is most commonly associated with bipolar affective disorder II (3,8). The significance of this association lies in the possible effects of comorbidity on the phenotype of each condition and in the implications for treatment.

Research suggests that patients with bipolar affective disorder (BPD) tend to experience a more episodic course of OCD (4). The symptoms of OCD tend to be more severe during the depressive phase of BPD and tend usually to be less severe or absent during the manic/hypomanic phase (6). Patients with comorbid OCD appear to be more likely to have a history of rapid-cycling BPD (4). It has also been noted that there is an increased risk of suicidality and alcohol dependency in patients with this comorbidity (3-4,6,9-10).

Interestingly, olanzapine has been demonstrated to be less effective in treatment of bipolar affective disorder in patients with comorbid OCD (1).

Given the growing evidence of the high rates and complex needs patients with this comorbidity appear to have, we recently undertook a study to establish the additional burden placed on healthcare resources by this comorbidity. We focused on the prevalence of bipolar disorder in outpatients with OCD, and then we explored how the care needs of patients with bipolar-OCD comorbidity differed from those with OCD but without bipolar disorder. This was considered to be particularly important because the OCD-bipolar comorbidity is not frequently described in ordinary UK community psychiatry practice, and the need for increased resources for these patients is not usually taken into account by commissioners, nor is there an adequate provision for these increased resources in the HONOS PBR (payment by results) classification, which in the future is to determine funding for the treatment of mental health patients in the community.

In our study (11), we extracted data from a database of outpatient visits to a community mental health team from 2006-2011. Diagnoses were classified according to ICD-10 criteria. We identified all patients

recorded as having a diagnosis of OCD (N=58). We then assessed the proportion of these patients who were also recorded as having bipolar affective disorder I, bipolar affective disorder II or unspecified bipolar affective disorder (total N=9). We thus found that 16% of the patients with OCD were also diagnosed as having BPD. Of these 67% had bipolar affective disorder II.

In order to study the effect of BPD on patients with OCD, we compared the group of patients with this comorbidity to a control group of patients with OCD, without bipolar disorder who were randomly selected from the database (11). We compared the following measures of healthcare requirements: number of outpatient appointments required; number of home treatment episodes [by the crisis team]/hospital admissions required; whether or not a care coordinator was allocated; the number of risk factors listed, medications prescribed, and use of psychotherapy. We found that the group of patients with this dual diagnosis attended a greater number of outpatient appointments. Furthermore three patients in the dual diagnosis group required hospital/ home treatment admissions while no-one in the pure OCD group did (11). Only patients with more complex needs are assigned a care coordinator. In this sample 78% of patients with comorbid bipolar disorder either currently had or had previously had a care coordinator; in comparison with 55% of patients in the control group. Regarding risk factors, including suicide and self-harm risk, there were more risk factors recorded in the comorbidity group than in the control group. Regarding medication, 44% of the patients with comorbid bipolar disorder were receiving the maximum dose of the antidepressant compared to 22% of those in the control group. However, the drugs used were different from case to case so direct comparison is of limited use. An atypical antipsychotic was prescribed to 78% of those with bipolar and 55% of the controls. Use of mood stabilisers was limited to the comorbid group (55%). Antipsychotics used in the comorbid group included risperidone, quetiapine and aripiprazole. Antidepressants included fluvoxamine, citalopram, paroxetine, sertraline and clomipramine. Anti-manic [mood stabiliser] agents used included lithium carbonate, semisodium valproate and carbamazepine.

We found that the proportion of patients that had received psychotherapy was greater in the group with the comorbidity (67% vs 44%).

It is important to note that when the study was performed, we only compared groups consisting of nine patients in each group. However the results were useful as a demonstration of the fact that this bipolar/OCD comorbid group had greater special needs compared to patients with OCD alone. Our finding that a substantial proportion of OCD patients seen by the team also had BPD is consistent with the literature. A new study of 605 patients with OCD (12), has reported that there are very high rates of comorbidity in OCD with both depressive disorders (50%) and bipolar disorder (10%). They further reported that there was a graded severity pattern among their patients, with the bipolar group being the most severe, followed by the depressive disorder group and finally the group which had OCD with no other comorbid disorder. As with our study, severity was reflected by the total number of Axis I disorders ($P<.01$), the number of psychiatric hospitalizations ($P<.001$), impairment measures ($P<.05$), and OCD symptoms ($P<.01$).

In another recent study (13), bipolar disorder was reported as often comorbid with obsessive-compulsive disorder. OCD with BPD was characterized by: (i) an episodic course; (ii) a higher number of depressive episodes, greater suicidality and a higher rate of hospitalization; (iii) fewer pathological doubts and more miscellaneous compulsions; and (iv) poorer insight into obsessive-compulsive symptoms. An episodic course appears to be typical of OCD with BPD. The authors suggested that bipolarity has a pathoplastic effect on OCD and that it is possible that some forms of OCD and bipolar disorder are pathophysiologically related. BPD with OCD was said to have a greater morbidity. Long-term prospective follow-up studies and studies addressing the pathophysiology and genetic basis are needed to understand the complexity of such comorbidity.

Since our study was conducted, we have become more alert to the possibility of the existence of this comorbidity, and hence we have continued to identify more patients with this combination of disorders. The total number of patients on our database is now 1172. Of these there are 23 patients with the bipolar-OCD comorbidity. Of these, 10 are bipolar I and 13 are bipolar II. What has been

important is that all of these patients have presented a challenge to treat, and the knowledge that they have the comorbidity has provided an important explanation of the treatment difficulties we have been experiencing. We have found that the patients with comorbid OCD and BPD have more complex needs and draw on more mental health care resources. This remains an important point to consider when planning resource allocation.

Treatment of comorbid patients presents an interesting challenge. One of the first line treatments for OCD is use of SSRIs (selective serotonin re-uptake inhibitors). These medications present a significant risk of inducing mania or rapid cycling in patients with BPD (9,14). Prescription of medications for relief of the symptoms of OCD must therefore be carefully balanced against their potential interaction with the treatment of BPD. Some suggest that one solution would be the preferential use of non-pharmacological treatments for OCD such as CBT. However, if drug therapy for the OCD is necessary, SSRIs are thought to be preferable to tricyclic antidepressants and cover with a mood stabiliser will be important (15). Another area to consider is the general rule in the treatment of bipolar disorder that one should only prescribe anti-depressants in the depressive/euthymic phase of bipolar if the OCD is asymptomatic in the hypomania/mania phase. Since bipolar affective disorder may not be overt at the time of diagnosis of OCD it is important to monitor all patients with OCD carefully for signs of development of mania/hypomania. This is vital if the patient is to be started on antidepressant medication. Further identification and understanding of the pattern of OCD in patients with BPD will allow more effective therapy. Potential warning signs that have been suggested include young age at presentation and the hoarding type of OCD (7,10). Given the evidence for increased morbidity in comorbid patients it is important to find methods for early identification in order to provide appropriate care and support.

In conclusion, comorbid OCD and bipolar disorder is a little recognised but important condition within community mental health teams, which requires identification because of the important treatment and risk issues. We suggest that long-term prospective follow-up studies as well as studies addressing the pathophysiology and genetic basis should be carried out to increase our understanding of this complex comorbidity.

GP Comment

What have I learned from this paper?

This articles increases awareness that obsessive compulsive disorder can be comorbid with bipolar disorder and that the presentation of both conditions can be different when they exist together. It is also clear that patients with both conditions draw on more mental health care resources and are more of a challenge to treat, requiring preferential use of non-pharmacological OCD treatments or an SSRI with a mood stabiliser if pharmacological OCD treatment is needed.

Dr Jenny Hopwood, GP Trainee.

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