

Comorbid Bipolar, Obsessive-Compulsive and Other Anxiety Disorders: A Patient-Report Highlighting Diagnostic and Treatment Issues

Indu Surendran and Subho Chakrabarti*

Department of Psychiatry, Postgraduate Institution of Medical Education and Research (PGIMER), Chandigarh 160012, India

Introduction

Comorbidity is defined as “the presence of more than one specific disorder in a person in a specified period of time” [1]. About half or more of patients with bipolar disorder (BD) have a current comorbid psychiatric condition, with anxiety and substance use disorders being the most common ones [2]. It is estimated that 50%-75% of patients with BD can have at least one comorbid anxiety disorder at some point in their lives [3-5]. Social anxiety disorders, specific phobias and generalized anxiety disorders (GAD) are most frequently associated with BD, while others such as post-traumatic stress disorders, panic disorders and obsessive-compulsive disorders (OCD) are also quite common. Moreover, it is now well established that the presence of comorbid anxiety disorders in BD can worsen the outcome of BD and can compromise its management [3]. The case of a middle-aged man with BD and multiple comorbid anxiety disorders is described to highlight diagnostic and management issues in this combination of comorbid disorders.

Case and Methods Section

Method

The case of a 42 year-old man with BD and several possible comorbid anxiety disorders is described to underline the complexities in diagnosis and treatment of patients with such comorbidities. Written informed consent was obtained from the patient for this report and patient anonymity has been maintained throughout the text.

Case presentation

This 42 year-old engineer working in a government organization attended our psychiatric outpatient clinic with his wife for the first time in March 2014. He had no past or family history of psychiatric illness and was well adjusted pre-morbidly. In October 2008, without any precipitant there was a distinct change in his behaviour, which was quite unlike his previous self, but was clearly apparent to his wife and children. He was more cheerful than he had ever been. He would also become very irritated on minor matters, which was unusual for him. He would sleep only 3-4 hours at night, but appeared fresh in the morning. During the day he appeared more active and energetic than before. He would keep pacing up and down in the house without any apparent purpose and not doing anything useful or productive. He would talk a lot, much more than his usual self. He would start talking with total strangers, something that he had never done before. At times he would speak much faster than usual and in a very loud voice. Others found it very difficult to interrupt him and get a word in. Despite these changes in his behaviour he continued to attend work and did not have any major problems there. He remained in this state for two weeks, after which he gradually became more quiet and withdrawn. He preferred not to interact much with others; he would talk less than usual and spoke only when spoken to. However, he did not express any sadness and carried on with his daily routine. These symptoms slowly got better, but by November 2008 he started having recurrent thoughts that his hands became dirty after touching objects, or touching other people including his children. He regarded these thoughts as his own, knew

them to be excessive and absurd, but could not control them. Anxiety emanating from these thoughts forced him to wash his hands with soap repeatedly, but this provided little relief. Additionally, he would wash his hair daily, would wash his hands for half an hour after passing stools, would bathe for an hour, and spent at least 3-4 hours/day on these activities. He consulted a private psychiatrist, but despite medications (of unknown nature) the repeated hand washing and bathing persisted for about a year. By December 2009, he also began to feel anxious at work; he apparently committed many mistakes and had to go over things repeatedly. He began losing confidence in himself and felt inept. He was treated with fluoxetine 20 mg/day and benzodiazepines during this period, which he took irregularly for about a month. Despite the partial adherence, his repeated hand washing and associated distress began to reduce gradually and was mainly restricted to the office by April 2010. In May 2010, he borrowed some money to build a house. Though the loan was paid back within the stipulated period, he would constantly worry about paying back on time, despite repeated reassurances from his wife. This worry peaked in early 2011 and over the next few months later he started to feel low, lost interest in all activities, became increasingly withdrawn and anxious, and committed more mistakes at work. Somewhat unexpectedly, his excessive hand washing and bathing ceased to be a problem by May 2011. However, he began to remain particularly anxious with sweating and restlessness while travelling on buses, whether empty or crowded ones. He would be scared that something might happen to him and would prefer seats near the door in order to escape quickly, or would avoid travelling on buses altogether. He would also worry excessively about work, his children's welfare and developed palpitations and sweating during these periods. By March 2012 his sadness worsened further; he developed sleep and appetite problems and his self-care declined. He would spend most of the day in bed, became irregular at work and considered premature retirement. Quetiapine and benzodiazepines from his psychiatrist did not provide much relief. There was further worsening of these symptoms in 2013. He stopped going for work. He was convinced that his situation was hopeless, began to blame himself for his troubles, had recurrent thoughts of dying, and once attempted to hang himself. He was treated with different antidepressants and mood-stabilizers by psychiatrists in private practice without much improvement. Following this he attended our hospital in March 2014. Here he was treated on outpatient basis for 3 months and subsequently hospitalized for 6

*Corresponding author: Subho Chakrabarti, Department of Psychiatry, Postgraduate Institution of Medical Education and Research (PGIMER), Sector 12, Chandigarh 160012, India, Tel: +91-172-2756808; E-mail: subhochd@yahoo.com

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weeks. During this entire period he received 6 ECTs (for his severe depression, psychotic symptoms and high suicidal risk), lithium carbonate 1050 mg/day (for mood stabilization), bupropion 300mg/day (for treatment of depression) and propranolol (for autonomic anxiety). His depression remitted within 3-4 weeks of hospital-stay; Hamilton Depression Rating Scale (HDRS) scores of 27 at admission fell to 6 within this period. However, he continued to have travel phobia and worry over minor matters. These symptoms eventually responded to psycho education, supportive treatment, relaxation exercises, and exposure and response prevention for the travel phobia. At the time of his discharge from the hospital in August 2014, he was euthymic (HDRS 1) with minimal anxiety symptoms. He has been continued on lithium, bupropion, propranolol and psychosocial treatment for the past one and a-half years. He has come regularly for outpatient visits and has adhered to the treatment regimen. He has had no depressive or manic symptoms. At times he tends to worry about minor matters for a few days, but the intensity and frequency of such worrying is much less than before.

Discussion

A diagnosis of BD could be made in this patient given the initial episode of elevated mood, over-activity and other accessory symptoms followed by the subsequent depressive episode. The initial episode was characterized by a period of abnormally elevated mood, irritability and increased energy associated with decreased need for sleep, being unusually talkative and having pressure of speech, and psychomotor agitation for 2 weeks. The diagnosis of hypomania was made on the basis of these symptoms since there was only mild functional impairment. Therefore, the subtype diagnosis was bipolar II disorder. It was also apparent that he had several comorbid anxiety disorders. The likely possibilities were OCD, GAD and a phobic disorder. The presence of comorbid anxiety disorders was not at all unexpected since a number of clinical and epidemiological studies have found that 50% -75% of patients with BD have a comorbid anxiety disorder [3-5]. Moreover, more than one comorbid anxiety disorder has also been reported in about 11% - 47% of the patients with BD [3,6,7]. However, whether rates of comorbid anxiety disorders are higher in bipolar II disorder is somewhat uncertain, with some studies reporting higher rates in BP I disorder [8], others finding higher rates in BP II disorder, or no difference between the subtypes of BD [9,10]. Finally, the longitudinal course of our patient's illness was illustrative of how the presence of anxiety comorbidity in BD adversely affects the clinical and functional outcome of BD [2-6,11].

Nevertheless, the diagnoses of comorbid anxiety disorders in this patient raised certain issues, which have found mention in existing literature. The high rates of comorbidity among psychiatric disorders in general, and bipolar disorders in particular have led to the concern that much of it may be an artefact of current classificatory systems and diagnostic practices [2,12,13]. Therefore, caution needs to be exercised while diagnosing comorbid conditions and differentiating true from spurious comorbidity, which could reflect co-occurrence of related disorders or different symptomatic aspects of a single disorder. Firstly, true comorbidity presupposes that the comorbid disorders will be independent and distinct disorders, which occur together at rates greater than chance co-occurrence [2,14]. However, certain studies have considered sub-threshold anxiety disorders, or symptoms of anxiety as a part of the overall comorbidity of BD, which often leads to over-diagnosis and inflated rates of comorbidity [2,6,14]. Another way to reduce spurious comorbidity would be to impose diagnostic hierarchies [12,13]. Though not without its problems, this approach is incorporated

in current classifications, which mandate that when an additional disorder is likely, the content of symptoms of the anxiety disorder should be either unrelated to that disorder, or not overlap entirely with that of the additional disorder. Finally, the course of the disorders often proves to be the principal variable, which serves to differentiate true from spurious comorbidity. This is best illustrated by recent meta-analyses and systematic reviews of comorbid OCD in BD [15,16]. These reviews found that the pooled prevalence of OCD in BD was 17%, which was keeping with earlier reports. However, in 50%-75% of these patients comorbid OCD was limited to the mood episodes in BD. OC symptoms in BD appeared more often or exclusively during depressive episodes, frequently remitting during manic or hypomanic episodes. Moreover, both the comorbid OCD and BD followed an episodic course. Thus, these patients appeared to have a form of spurious comorbidity since the comorbid OCD was secondary to BD. In contrast in patients with true comorbidity, OC symptoms were independent of BD, and although these symptoms showed variations in intensity during mood episodes, they were not present exclusively during such episodes. The implication of this finding is that truly comorbid anxiety disorders in BD should be present even when the mood episodes of BD have remitted. Finally, different patterns of correlations between anxiety disorders and BD have been reported in other studies. For example, in one study while OCD and panic disorder were more common among patients with bipolar than unipolar depression, social phobia was more common in unipolar depression and GAD was associated with dysthymia rather than unipolar or bipolar depression [17]. In another study though social phobia and OCD were more likely than panic disorder to present with comorbid mood disorders, social phobia usually preceded mania but resolved with the onset of a manic episode [18].

Given these caveats the only comorbid diagnosis that could be established in this patient was OCD because it consisted of a full syndrome associated with impairment; the content of OC symptoms (contamination obsessions and washing compulsions) was distinct from the symptom-content of mood episodes, and OC symptoms were present even when the BD was in remission. The diagnosis of GAD was less certain because even though it consisted of a full syndrome, there was a great degree of overlap between the content of GAD and depressive symptoms, and it was not entirely clear whether the GAD was present during periods when the BD was in remission. The diagnosis of a specific travel phobia was the least likely of all, because it appeared to occur exclusively during the depressive episodes of BD and disappeared during remission (albeit with behavioural treatment).

The case-history of this patient also highlights the complexity of treatment in BD with comorbid anxiety disorders. The current evidence appears to indicate that mood-stabilization with lithium, anticonvulsants and second-generation antipsychotics should be the primary treatment of patients with such comorbidity [19]. Though SSRIs are first-line treatments for OCD, they are best avoided as adjuncts because of their doubtful efficacy and their tendency to cause mood-instability, especially with prolonged use at high doses [19]. The evidence for efficacy of adjunctive psychosocial interventions is particularly scant. Nevertheless, three main treatment approaches have been followed including an integrated approach, where anxiety-focused strategies are built into a BD-focused interventions; a sequential approach, which consists of specific and separate interventions for the BD and the anxiety disorder; and a modular approach based on a standard cognitive-behavioural treatment (CBT) to treat both disorders [11,20]. In this patient, a CBT-based approach which incorporated psycho education, relaxation, supportive treatment and exposure-response prevention was used, combining all three approaches. The

success achieved with this patient, thus, underscores the efficacy of additional psychosocial interventions in the management of patients with BD and comorbid anxiety disorders. Though more treatment-trials are needed to determine the efficacy of adjunctive psychosocial interventions, CBT-based treatments appear to hold the greatest promise in treating BD comorbid with anxiety disorders.

Conclusions

The presentation of this patient with comorbid BD and anxiety disorders reiterates the common occurrence and adverse consequences of such comorbidity. At the same time, it emphasizes the need for diagnostic caution to differentiate true from spurious anxiety comorbidity in BD. Finally, it underlines the usefulness of adjunctive psychosocial treatment in the management of patients with comorbid BD and anxiety disorders.

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