CASE REPORT

Antidepressant-induced mania in obsessive compulsive disorder

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ABSTRACT

Serotonin-reuptake inhibitors have come forth to become the mainstay of treatment in obsessive compulsive disorder (OCD), predominantly as a result of evidence from clinical psychopharmacological response studies. Comorbid psychiatric disorders frequent OCD patients, most often depression. Although selective serotonin reuptake inhibitors are effective in the treatment of both OCD and depressive disorder, all antidepressants are associated with treatment-emergent affective switch. We present a 48-year-old patient with OCD, on antidepressants, initially for OCD and later for depression as well. She switched to mania after 20 years of treatment, which responded to olanzapine and divalproex sodium.

Key words: Major depressive disorder, obsessive compulsive disorder, selective serotonin reuptake inhibitors, treatment-emergent affective switch

INTRODUCTION

Treatments for obsessive compulsive disorder (OCD) have evolved tremendously in the past three decades. A serotoninergic basis for OCD stemmed largely from pharmacological treatment studies in the 1980s. Ananth et al. (1979) treated 20 patients with clomipramine, an antidepressant, and noticed substantial improvement in the severity of obsessions. Later, similar drugs, especially selective serotonin reuptake inhibitors (SSRIs), were found to have remarkable antiobsessional properties.

Many OCD patients present with other psychiatric comorbidities, major depressive disorder (MDD) being the most frequent, affecting treatment outcomes negatively. Here, we describe a patient with OCD who was on treatment for 10 years with clomipramine (25–175 mg/day) before she developed depression, and later mania with fluoxetine (20–60 mg/day). OCD patients need higher doses of drugs that are also antidepressants; this may be a cause of concern in OCD cases with comorbid bipolar depression.

CASE REPORT

Mrs. S is a 48-year-old female with a history of OCD since 1986, with obsessions centered around her fear of contamination (repetitive cleaning and washing rituals), failing which she would feel uneasy and distressed. Early on in the illness, Mrs. S felt contaminated with her husband’s semen subsequent to sexual intercourse, and with futile attempts to curb such thoughts, finally decided to stop engaging in sexual activity altogether. With these symptoms, the patient reported to the psychiatrist in 1991, when she was started on clomipramine, initially 25 mg/day, and gradually escalated to 175 mg/day, which she took irregularly for the next 10 years.

For over a decade since the onset of her illness, Mrs. S was reportedly euthymic; she did not experience sad mood, suicidal thoughts or other such symptoms, although she reported feeling uneasy while she refrained from carrying out her washing and cleaning rituals during times of water scarcity. However, 15 years into her illness, in 2001, while on clomipramine, when Mrs. S was 38-years-old, she was...
noticed by her husband to be dull and withdrawn, with
low mood, frequent crying spells and occasional suicidal
thoughts but with no plans. She was unable to carry out
household work, woke up in the early hours of the morning
and showed signs of fatigue during the day.

She was started on fluoxetine 20 mg/day. As she failed to
improve satisfactorily on follow-up, the dose was increased
to 60 mg/day over the next 6 weeks, and her depressive
symptoms showed slight improvement. During this time,
she continued to harbour obsessions of contamination,
and would be distressed as she was unable to carry out her
cleaning rituals as before. Yet, Mrs. S would spend several
hours washing vessels repeatedly, cleaning her house and
bathing several times a day till she felt clean. In spite of doing
so, Mrs. S had ideas of guilt and worthlessness as she felt she
was unable to carry out the household chores to satisfaction.

She was on regular follow-up for another month. The
depressive symptoms improved, resulting in the patient
discontinuing medication on her own. She, however,
promptly reported in the outpatient department,
accompanied by her husband, when depressive symptoms
returned and would follow-up for a month or two, to again
discontinue treatment once she felt she was better.

Thus, over the next 10 years, Mrs. S was treated for recurrent
depressive episodes at least once or twice in a year. During
this entire time frame, although her obsessive compulsive
symptoms persisted, she refused to be on regular treatment
for the same.

In March 2011, Mrs. S reported to our outpatient clinic.
She was brought by her husband with complaints of
sadness, fatigue, insomnia and suicidal intent. As she used
to respond well to fluoxetine earlier, she was restarted on
the same at 20 mg/day, with dose titrated to 60 mg/day
over the next 8 weeks. The need for medication compliance
was stressed and, on follow-up, she was seen to have
significantly improved mood, with improvement in sleep
and psychomotor retardation. She was followed-up
regularly, and reported feeling better with each visit,
although her cleaning and washing rituals persisted.
Five months into this treatment for depression, Mrs. S’s
husband noticed that she had become extremely talkative
and irritable. She would spend considerable time dressing
herself and in loud prayer. She would not sleep at night
and would engage herself in repetitive washing of utensils
as she felt that they were still dirty. She believed that she
had special powers and made tall claims about having made
large amounts of money to help the poor and needy.
She was seen to be restless and accused her husband of not
obeying her commands, requiring inpatient care for the first
time. In the ward, she was noticed to be agitated, initiating
conversation on her own and talking authoritatively to her
husband and ward-staff. Fluoxetine was tapered and she
was started on divalproex sodium 1 g and olanzapine 10
mg in divided doses. The patient was discharged within 1
week, and was seen to have remarkable improvement on
subsequent follow-up.

DISCUSSION

Medications with proven efficacy for OCD include
cloimipramine and the SSRIIs. Although all antidepressants
are associated with treatment-emergent affective switch,
mood switches are considerably more frequent with tricyclic
antidepressants (TCAs) (11.2%) than with SSRIs (3.7%) or
placebo (4.2%).[5] Wehr and Goodwin studied patients with
bipolar disorder (BPD)-I and II, and found that patients with
BPD-I switched while on TCAs after an average of 21 days,
while it was 35 days for those with BPD-II.[6] Interestingly,
our case is unique as she did not experience a mood
switch although she was on appropriately high doses of
cloimipramine for over 10 years. OCD symptoms are generally
seen to improve or disappear with mania.[7] Yet, our patient
continued to have florid obsessions and compulsions
throughout the manic episode, and was noticed to engage in
prolonged washing rituals during her stay in the ward.

In the Johns Hopkins OCD Family Study (2001), looking
at comorbidity with OCD, although recurrent depression
was frequent, BPD occurred in only one OCD proband.[8]
Distinguishing between BPD and MDD is of critical value
as optimal management of both conditions takes different
directions. Bipolar OCD may be treated with antidepressants,
but cautiously and in combination with a mood-stabilising
agent.[9] However, it is imperative that the treatment of BPD
gains precedence,[10] considering the implications of social
disruption in mania and suicidal intent in depression.

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