International Journal of Science and Research Archive
eISSN: 2582-8185
Cross Ref DOI: 10.30574/ijsra
Journal homepage: https://ijsra.net/

(RESEARCH ARTICLE)

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Obsessive-compulsive disorder and bipolar disorder comorbidity: Diagnostic challenges, clinical implications and therapeutic strategies

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International Journal of Science and Research Archive, 2025, 17(02), 160-165

Publication history: Received on 27 September 2025; revised on 02 November 2025; accepted on 05 November 2025

Article DOI: https://doi.org/10.30574/ijsra.2025.17.2.2986

Abstract

Background: Bipolar disorder frequently presents with psychiatric comorbidities, among which obsessive-compulsive disorder (OCD) poses significant diagnostic and therapeutic challenges. The concurrent presentation of these disorders complicates treatment strategies, particularly given the risk of antidepressant-induced mood destabilization.

Objective: To examine the clinical presentation, diagnostic complexities, and therapeutic management of OCD-bipolar disorder comorbidity through a case report and comprehensive literature review.

Methods: We present a detailed case of a 37-year-old female with OCD-bipolar disorder comorbidity, initially misdiagnosed and subsequently treated with multiple pharmacological interventions. A systematic review of the literature was conducted using PubMed, PsycINFO, and Cochrane databases.

Results: The patient exhibited an 8-year delay in bipolar disorder diagnosis following initial OCD presentation. Multiple SSRI trials without mood stabilization precipitated subsyndromal hypomanic episodes. Eventual treatment with quetiapine 600 mg/day achieved dual symptom control. Literature review reveals OCD-bipolar comorbidity prevalence of 6-16%, with increased suicide risk, treatment resistance, and diagnostic complexity.

Conclusions: OCD-bipolar comorbidity represents a distinct clinical entity requiring early recognition and specialized treatment approaches. Atypical antipsychotics, particularly quetiapine, demonstrate efficacy for dual symptom control. Clinicians should maintain high suspicion for underlying bipolarity in treatment-resistant OCD cases.

Keywords: Obsessive-compulsive disorder; Bipolar-disorder; Comorbidity; Mood stabilizers; Atypical antipsychotics; Treatment resistance

1. Introduction

Bipolar disorder (BD) is characterized by significant psychiatric comorbidity, with anxiety disorders representing the most prevalent comorbid conditions, affecting up to 75% of individuals with BD across their lifetime [1,2]. Among anxiety disorders, obsessive-compulsive disorder (OCD) presents unique diagnostic and therapeutic challenges when comorbid with BD, yet remains relatively understudied compared to other anxiety comorbidities [3].

The co-occurrence of OCD and BD is clinically significant for several reasons. First, the presence of OCD in BD patients is associated with increased illness severity, greater functional impairment, and elevated suicide risk [4,5]. Second, the

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pharmacological management of this comorbidity is complicated by the risk of antidepressant-induced mood destabilization, including hypomanic or manic switches, which can occur in up to 25% of bipolar patients treated with antidepressants without adequate mood stabilization [6]. Third, diagnostic challenges arise as OCD symptoms may be misattributed to depressive rumination or anxiety, leading to delayed recognition of underlying bipolarity [7].

The phenomenology of OCD may differ in the context of BD. Some studies suggest that obsessive symptoms in bipolar patients may exhibit mood-congruent content and demonstrate cyclical patterns corresponding to mood episodes [8]. Additionally, the temporal relationship between OCD onset and bipolar episodes varies, with OCD symptoms potentially preceding, following, or emerging concurrently with mood episodes [9].

This case report and literature review aims to: (1) illustrate the diagnostic complexities and clinical course of OCD-BD comorbidity through a detailed case presentation; (2) synthesize current evidence regarding epidemiology, pathophysiology, and clinical implications; and (3) provide evidence-based recommendations for therapeutic management of this challenging comorbidity.

2. Case report

2.1. Patient Information and Clinical History

Ms. A.K., a 37-year-old unmarried female with 12 years of education, initially presented to psychiatric services in 2004 at age 16 with prominent obsessive-compulsive symptoms. Her chief complaints included intrusive thoughts of contamination, excessive washing rituals (approximately 3-4 hours daily), and checking behaviors. She met DSM-IV-TR criteria for OCD with poor insight. There was no documented family history of mood disorders or OCD at initial evaluation.

2.2. Treatment Course (2004-2012)

Over an 8-year period, the patient received sequential trials of multiple selective serotonin reuptake inhibitors (SSRIs) including fluoxetine (60 mg/day), sertraline (200 mg/day), and paroxetine (60 mg/day), each maintained for at least 12 weeks. Despite adequate dosing and duration, obsessive-compulsive symptoms persisted with Yale-Brown Obsessive Compulsive Scale (Y-BOCS) scores consistently above 24 (severe range).

In 2008, concurrent with paroxetine treatment, the patient developed a 2-week episode characterized by decreased need for sleep (4-5 hours with subjective refreshment), increased goal-directed activity, mild irritability, and racing thoughts. This episode was not recognized as hypomanic at the time and was attributed to anxiety-related insomnia. Following this episode, she experienced a 3-month depressive episode with anhedonia, psychomotor retardation, and suicidal ideation without intent, which was interpreted as a complication of chronic, treatment-resistant OCD.

2.3. Diagnostic Clarification and Treatment Modification

In 2012, the patient presented with a frank manic episode lasting 3 weeks, characterized by euphoric mood, grandiose delusions (believing she had special powers to cure others), pressured speech, marked psychomotor agitation, and severe insomnia. Hospitalization was required. Retrospective analysis of her longitudinal course led to a revised diagnosis of Bipolar I Disorder with comorbid OCD.

Antidepressants were discontinued, and she was initiated on sodium valproate, titrated to 1500 mg/day (serum level 75 μg/mL). While manic symptoms resolved within 3 weeks, OCD symptoms remained severe (Y-BOCS score: 28) and were accompanied by significant functional impairment. After 3 months of valproate monotherapy without OCD improvement, the medication was cross-titrated to olanzapine 10 mg/day.

2.4. Clinical Evolution and Current Status

Olanzapine achieved excellent mood stabilization with no mood episodes over 6 months of follow-up. However, OCD symptoms paradoxically worsened (Y-BOCS score increased to 31), with emergence of new contamination fears and expansion of washing rituals to 6 hours daily. Given this clinical deterioration, treatment was modified to quetiapine, gradually titrated to 600 mg/day over 6 weeks. At 6-month follow-up on quetiapine, the patient demonstrated sustained mood stability with no hypomanic or depressive episodes, and significant reduction in OCD symptoms (Y-BOCS score: 16, moderate range), with improved functioning and quality of life. She remains in treatment with monthly follow-up appointments.

3. Discussion

3.1. Epidemiology and Prevalence

The prevalence of OCD in bipolar disorder varies across studies, ranging from 6% to 21%, substantially higher than the 2-3% lifetime prevalence of OCD in the general population [1,2]. A comprehensive French epidemiological study identified OCD-BD comorbidity rates of 11-15%, with a notable predominance of Bipolar II disorder [10]. Gender differences have been observed, with some studies reporting higher comorbidity rates in women and distinct clinical presentations between sexes [1].

The temporal sequence of disorder onset varies considerably. In approximately 60% of cases, OCD precedes the first mood episode, often by several years, as illustrated in our case presentation [7]. This temporal pattern contributes to diagnostic complexity and may result in prolonged delays in recognizing underlying bipolarity, potentially exposing patients to inappropriate antidepressant monotherapy.

3.2. Genetic and Neurobiological Substrates

Emerging evidence supports shared genetic vulnerability between OCD and BD. Family studies demonstrate elevated rates of OCD among first-degree relatives of bipolar probands. Coryell et al. [3] reported OCD prevalence of 2.7% in relatives of Bipolar I patients and 5.3% in relatives of Bipolar II patients, compared to only 0.8% in relatives of unipolar depression probands, suggesting specific genetic linkage to bipolarity.

Neurobiological investigations reveal overlapping dysregulation in cortico-striato-thalamo-cortical (CSTC) circuits implicated in both disorders. Functional neuroimaging studies demonstrate hyperactivity in orbitofrontal cortex and anterior cingulate cortex in OCD, regions also implicated in mood regulation [11]. Additionally, both disorders demonstrate alterations in glutamatergic and GABAergic neurotransmission, providing potential mechanistic links.

The observation that OCD symptoms in some patients exhibit cyclical patterns corresponding to mood episodes has led some researchers to propose that certain OCD presentations may represent spectrum manifestations of bipolar disorder rather than true comorbidity [4,8]. However, this hypothesis remains controversial and requires further investigation.

3.3. Clinical Phenomenology and Course

OCD-BD comorbidity is associated with several distinctive clinical features. Perugi et al. [6,7] conducted comprehensive phenomenological studies demonstrating that comorbid patients exhibit:

- Higher rates of sexual and religious obsessions compared to OCD-only patients
- Reduced prominence of checking rituals during mood episodes
- Persistence of OCD symptoms during manic/hypomanic episodes, contrary to earlier assumptions
- Greater frequency of rapid cycling and mixed episodes

Critically, the presence of comorbid OCD confers worse prognosis. Multiple studies document increased suicide risk, with Kruger et al. [5] reporting significantly elevated suicidal ideation and attempts in bipolar patients with comorbid OCD compared to those without. Additionally, comorbid patients demonstrate greater functional impairment, more frequent hospitalizations, and reduced treatment response [2,7].

3.4. Diagnostic Challenges

Several factors contribute to diagnostic complexity in OCD-BD comorbidity:

- ***Phenomenological Overlap:*** Obsessive thoughts may be mistaken for depressive rumination, while compulsive behaviors may be misinterpreted as anxiety-driven avoidance. Conversely, hypomanic racing thoughts may be confused with obsessive intrusions.
- ***Subsyndromal Presentations:*** As demonstrated in our case, initial hypomanic episodes may be subtle and overlooked, particularly when attention is focused on prominent OCD symptoms. This diagnostic overshadowing can delay appropriate treatment for years.
- ***Treatment-Emergent Symptoms:*** Antidepressant-induced mood elevation may be attributed to anxiety improvement rather than recognized as emerging bipolarity, perpetuating diagnostic error.
- ***Sequential Presentation:*** When OCD precedes mood episodes by years, as occurs in the majority of comorbid cases, clinicians may fail to consider bipolar disorder in the differential diagnosis until frank mania emerges.

Therapeutic Management: Evidence and Recommendations

3.5. Pharmacological Strategies

Management of OCD-BD comorbidity requires careful consideration of both mood stabilization and OCD symptom control. Several pharmacological approaches have been investigated:

- ***Antidepressants:*** While SSRIs represent first-line treatment for OCD, their use in bipolar patients carries significant risk of mood destabilization. A meta-analysis by Ghaemi et al. demonstrated manic switch rates of 15-25% with antidepressant monotherapy in BD. If antidepressants are employed, they should be combined with adequate mood stabilization, used at the minimum effective dose, and closely monitored for emergence of hypomanic symptoms. However, many experts recommend avoiding antidepressants entirely in this population when possible.
- ***Mood Stabilizers:*** Traditional mood stabilizers (lithium, valproate) provide essential mood stabilization but demonstrate limited efficacy for OCD symptoms. Some evidence suggests valproate may worsen OCD in certain patients, as potentially observed in our case. Lithium augmentation of SRIs has shown mixed results for OCD, with some studies reporting benefit and others showing no advantage.
- ***Atypical Antipsychotics:*** Second-generation antipsychotics have emerged as particularly promising for OCD-BD comorbidity. Quetiapine has demonstrated the strongest evidence, with multiple case series and small trials showing efficacy for both mood stabilization and OCD symptom reduction at doses of 400-800 mg/day [8]. The mechanism may involve combined serotonergic and dopaminergic modulation.
- Olanzapine combined with fluoxetine has shown efficacy in some studies, though our case illustrates that olanzapine monotherapy may be insufficient for OCD symptoms. The combination of olanzapine with aripiprazole has been reported as beneficial, potentially leveraging complementary mechanisms of action.
- ***Topiramate:*** Some studies report beneficial effects of topiramate for OCD symptoms in bipolar patients, though evidence remains limited. A trial by Berlin et al. found topiramate augmentation reduced OCD symptoms in treatment-resistant cases.

3.6. Proposed Treatment Algorithm

Based on current evidence and clinical experience, we propose the following approach:

- **First-line:** Quetiapine monotherapy (400-800 mg/day), titrated gradually for tolerability, or combination of lithium/valproate with quetiapine augmentation.
- **Second-line:** If partial response, consider addition of clonazepam (0.5-2 mg/day) or topiramate (100-300 mg/day) augmentation.
- **Third-line:** In cases requiring SSRI augmentation, add low-dose SSRI (e.g., fluoxetine 20-40 mg) only after achieving mood stability, with close monitoring for mood destabilization.
- **Refractory cases:** Consider referral for intensive cognitive-behavioral therapy for OCD, electroconvulsive therapy for severe mood symptoms, or emerging neuromodulation approaches.

3.7. Psychotherapeutic Interventions

Cognitive-behavioral therapy with exposure and response prevention (ERP) remains an essential component of OCD treatment. In comorbid cases, psychotherapy should be adapted to account for mood fluctuations, with therapy intensity adjusted during mood episodes. Psychoeducation regarding both disorders is crucial for treatment adherence and early recognition of mood episode warning signs.

3.8. Clinical Implications and Screening Recommendations

Our case and literature review underscore the critical importance of screening for bipolar disorder in patients presenting with OCD. Clinicians should maintain heightened suspicion for underlying bipolarity in the following scenarios:

- Treatment-resistant OCD despite adequate SSRI trials
- History of antidepressant-induced activation or agitation
- Family history of bipolar disorder
- Cyclical pattern of OCD symptom severity
- Presence of atypical features (hypersomnia, hyperphagia, mood reactivity)
- Early age of onset with severe, chronic course

Systematic use of screening instruments such as the Mood Disorder Questionnaire (MDQ) or Hypomania Checklist-32 (HCL-32) in OCD populations may facilitate earlier detection of bipolarity.

Study Limitations

This case report has several limitations. As a single case, generalizability is limited. Retrospective identification of the 2008 hypomanic episode relies on historical reconstruction and may be subject to recall bias. Standardized symptom severity measures were not consistently applied throughout the patient's treatment course. Additionally, the literature review, while comprehensive, was not conducted as a formal systematic review with meta-analysis.

4. Conclusions

OCD-bipolar disorder comorbidity represents a clinically significant and therapeutically challenging condition associated with increased morbidity, suicide risk, and treatment complexity. This case report illustrates common diagnostic pitfalls, including delayed recognition of bipolarity, subsyndromal mood episodes, and treatment-resistant OCD as a potential indicator of underlying mood disorder.

Key clinical recommendations include:

- Systematic screening for bipolar disorder in patients presenting with OCD, particularly those with treatment resistance;
- Cautious use of antidepressants in suspected or confirmed bipolar patients, with adequate mood stabilization;
- Consideration of atypical antipsychotics, particularly quetiapine, as first-line treatment for comorbid cases; and
- Integration of psychosocial interventions with pharmacotherapy.

Future research directions should include: large-scale prospective studies examining long-term outcomes; randomized controlled trials of pharmacological interventions specifically in comorbid populations; investigation of biomarkers to facilitate earlier diagnosis; and exploration of novel treatment approaches including neuromodulation techniques.

Enhanced awareness of OCD-BD comorbidity, systematic screening practices, and evidence-based treatment algorithms have the potential to significantly improve outcomes for this underrecognized and undertreated patient population.

Compliance with ethical standards

Acknowledgments

The authors wish to thank the patient for her consent to publish this case report and her valuable insights into the lived experience of OCD-bipolar comorbidity.

Disclosure of conflict of interest

The authors declare no conflicts of interest.

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