ANZJP

Australian & New Zealand Journal of Psychiatry
2016, Vol. 50(7) 695–698

© The Royal Australian and
New Zealand College of Psychiatrists 2016
Reprints and permissions:
sagepub.co.uk/journalsPermissions.nav
anp.sagepub.com
SAGE

Commentaries

The power of words in psychiatry

Ulrich Hegerl

Department of Psychiatry and Psychotherapy, University of Leipzig, Leipzig, Germany

Corresponding author:
Ulrich Hegerl, Department of Psychiatry and Psychotherapy, University of Leipzig, Semmelweisstr. 10, 04103 Leipzig, Germany.
Email: ulrich.hegerl@medizin.uni-leipzig.de

DOI: 10.1177/0004867416646858

In the letter to the editor by Amad et al. (2016), the authors pointed out that by semantic traditions in clinical practice and medical teaching, psychiatric disorders are often seen as different from somatic disorders. The authors rightly criticise this distinction, because according to natural science concepts, all behaviour and introspective phenomena are based upon processes within the organism and particularly within the brain. Therefore, psychiatric disorders are also somatic disorders. I support the recommendation of the authors that instead of maintaining the dichotomy between psychiatric and somatic disorders, the sole distinction to be made is between psychiatric and non-psychiatric disorders.

How should one respond to patients who ask whether they are suffering from a psychic or somatic illness? In my experience, the metaphor of the two-sided coin has turned out to be helpful.

When observing a patient with a psychiatric disorder, we always have two levels of observation, similar to the two sides of a coin. On the one side, we have the behavioural level, comprising the psychosocial aspects, with all present and past (verbal and non-verbal) environmental experiences. For example, in patients with depression, vulnerability factors (e.g. traumatisation in early life) and triggers of an episode (e.g. life events) may be identified, and psychotherapy can be offered as causal treatment. On the other side of the coin, one can observe what is going on within the organism, the physiological aspects, comprising also the neurobiological processes. Again, we can look for vulnerability factors (e.g. (epi)genetic factors) and triggers (e.g. changes in stress hormones), and antidepressants can be offered as causal therapy.

This metaphor of the two-sided coin supports a disease concept that conceptualises the behavioural and physiological aspects as complementary and not in an either/or relationship. These two sides of the coin are present in all disorders. In diabetes mellitus, for instance, we have the behavioural and psychosocial side that, for example, suggests diet and sport as treatment options and the physiological side that suggests insulin therapy.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

See Letter by Amad et al., 50(1): 100–101.

Reference

Amad A, Fovet T and Geoffroy PA (2016) Keep calm: Psychiatric disorders are organic! The power of words in medicine. *Australian and New Zealand Journal of Psychiatry* 50: 100–101.

Comorbid bipolar disorder and obsessive-compulsive disorder: Which came first?

Matteo Tonna[1], Andrea Amerio[2,3], Anna Odone[4], Brendon Stubbs[5] and S Nassir Ghaemi[3,6]

[1]Department of Mental Health, Local Health Service, Parma, Italy
[2]Department of Clinical and Experimental Medicine, University of Parma, Parma, Italy
[3]Mood Disorders Program, Tufts Medical Center, Boston, MA, USA
[4]Unit of Public Health, Department of Biomedical, Biotechnological and Translational Sciences, University of Parma, Parma, Italy
[5]Institute of Psychiatry, Kings College London, London, UK
[6]Department of Psychiatry and Pharmacology, Tufts University Medical School, Boston, MA, USA

Corresponding author:
Andrea Amerio, Department of Clinical and Experimental Medicine, University of Parma, c/o Ospedale Maggiore, Viale A. Gramsci 14, 43126 Parma, Italy.
Email: andrea.amerio@studenti.unipr.it

DOI: 10.1177/0004867415621395

Downloaded from anp.sagepub.com at TUFTS UNIV on December 12, 2016

More than half of patients with bipolar disorder (BD) also have an additional psychiatric diagnosis, one of the most difficult to manage being obsessive-compulsive disorder (OCD) (Amerio et al., 2014a, 2014b) with higher prevalence rates in youths (23.2%; compared to adults, 13.56%) (Amerio et al., 2015).

In 1970, the famous epidemiologist Alvan R. Feinstein defined comorbidity in relation to a specific index condition, as '*any distinct additional entity that has existed or may occur during the clinical course of a patient who has the index disease under study*' (Maj, 2005). However, the question of which condition should be designated the index and which the comorbid condition is not always self-evident.

In order to address this unanswered question, we updated our recent systematic review (Amerio et al., 2015) to establish the onset of BD and OCD in comorbid patients.

Studies were identified by searching the electronic databases MEDLINE, Embase and PsycINFO. We combined the search strategy of free text terms and exploded MESH headings for the topics of BD, OCD and treatment combined as follows: ((((('Therapeutics' [Mesh]) OR treatment*) OR therap*) OR pharmacotherap*) OR psychotherap*)) AND ((((((((('Bipolar Disorder' [Mesh]) OR Bipolar disorder) OR BD) OR Bipolar) OR Manic depressive disorder) OR Manic depressive) OR Manic)) AND (((('Obsessive-Compulsive Disorder' [Mesh]) OR OCD) OR Obsessive-compulsive) OR Obsessive-compulsive disorder))). Studies published in English through 30 September 2015were included.

Eleven studies were selected (Table 1). More than 60% of selected studies reported that BD-OCD patients experienced the onset of OCD prior to the onset of BD. In the minority of cases (25%), the onset of OCD usually was concomitant with the first mood episode, rather than preceding or following it. In contrast, only one study from United States reported an earlier

Table 1. Studies that met inclusion/exclusion criteria for systematic review.

References	Study design	Country	Study population	Diagnosis assessment	Onset (age or mean age)	Quality[a]
Amerio et al. (2014)[b]	Case report	Italy	OCD (n = 1, age = 56)	Y-BOCS; DSM-IV	OCD (20); BD (54)	18/31
Annigeri et al. (2011)[c]	Case report	India	OCD (n = 1, age = 17)	HAM-D, Y-BOCS, YMRS; DSM-IV	OCD (12); BD (17)	18/31
Chen and Dilsaver (1995)[d]	Cross-sectional study	United States	BD (n = 167)	DIS; DSM-III	Similar mean age of onset of OCD and BD	25/31
Cop (2014)[e]	Case report	Turkey	OCD (n = 1, age = 15)	NS; DSM-IV	OCD (12); BD (15)	18/31
Diniz et al. (2004)[f]	Cross-sectional study	Brazil	OCD (n = 161, mean age = 30 ± 10))	SCID; DSM-IV	OCD in comorbid vs non-comorbid (9.5 vs 13.5)	21/31
Fuchs (1994)[g]	Case report	United States	BD (n = 1, age = 9)	NS; DSM-IV	Similar mean age of onset of OCD and BD	18/31
Jana et al. (2012)[h]	Case report	India	OCD (n = 1, age = 4)	NS; DSM-IV	OCD (4); BD (4 ½)	18/31
Joshi et al. (2010)[i]	Case control study	United States	OCD and BD (n = 125, n = 82, respectively; age range = 6–17)	K-SADS-E; DSM-III-R	OCD (14.2); BD (15.6)	19/31
Mahasuar et al. (2011)[j]	Case control study	India	OCD (n = 91, mean age = 29.36 ± 8.31 and 28.39 ± 7.10, in non-comorbid vs comorbid)	SCID; DSM-IV	OCD in comorbid vs non-comorbid (18 vs 19.5)	19/31

(Continued)

Downloaded from anp.sagepub.com at TUFTS UNIV on December 12, 2016

Table 1. (Continued)

References	Study design	Country	Study population	Diagnosis assessment	Onset (age or mean age)	Quality[a]
Masi et al. (2007)[k]	Cross-sectional study	Italy	OCD (n = 120, mean age = 13.7 ± 2.8)	K-SADS-PL, DICA-R, Y-BOCS, CGI, C-GAS; DSM-IV	OCD in comorbid vs non-comorbid (9.4 vs 10.6)	21/31
Tillman et al. (2003)[l]	Case control study	United States	BD (n = 93, mean age = 10.9 ± 2.6)	WASH-U-K-SADS; DSM-IV	Earlier mean age of onset of BD compared to OCD	20/31

BD: bipolar disorder; OCD: obsessive-compulsive disorder; DIS: Diagnostic Interview Schedule; DSM-III: *Diagnostic and Statistical Manual of Mental Disorders–Third Edition*; DSM-IV: *Diagnostic and Statistical Manual of Mental Disorders–Fourth Edition*; SCID: Structured Clinical Interview; DICA-R: Diagnostic Interview for Children and Adolescents–Revised; K-SADS-E: Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children-Epidemiologic Version; K-SADS-PL: Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version. Y-BOCS: Yale–Brown Obsessive-Compulsive Scale; YMRS: Young Mania Rating Scale; CGI: Clinical Global Impression; C-GAS: Children's Global Assessment Scale; HAM-D: The Hamilton Rating Scale for Depression; WASH-U-K-SADS: Washington University in St. Louis Kiddie Schedule for Affective Disorders and Schizophrenia; DAWBA: Development and Well-Being Assessment; NS: Not specified.

[a]Checklist for measuring study quality developed by Downs and Black.

[b]Amerio A, Odone A, Marchesi C, et al. (2014) Do antidepressant-induced manic episodes in obsessive-compulsive disorder patients represent the clinical expression of an underlying bipolarity? *Australian and New Zealand Journal of Psychiatry* 48: 957.

[c]Annigeri B, Raman R and Appaji R (2011) Obsessive-compulsive disorder with bipolar mood disorder: A rare comorbidity in India. *Indian Journal of Psychological Medicine* 33: 83–85.

[d]Chen YW and Dilsaver SC (1995) Comorbidity for obsessive-compulsive disorder in bipolar and unipolar disorders. *Psychiatry Research* 59(1–2): 57–64.

[e]Cop E (2014) An adolescent with obsessive-compulsive disorder and bipolar disorder: A case report. *Bulletin of Clinical Psychopharmacology* 24: S46.

[f]Diniz JB, Rosario-Campos MC, Shavitt RG, et al. (2004) Impact of age at onset and duration of illness on the expression of comorbidities in obsessive-compulsive disorder. *The Journal of Clinical Psychiatry* 65(1): 22–27.

[g]Fuchs DC. (1994) Clozapine treatment of bipolar disorder in a young adolescent. *Journal of the American Academy of Child & Adolescent Psychiatry* 33: 1299–302.

[h]Jana AK, Praharaj SK and Sinha VK (2012) Comorbid bipolar affective disorder and obsessive-compulsive disorder in childhood: A case study and brief review. *Indian Journal of Psychological Medicine* 34: 279–282.

[i]Joshi G, Mick E, Wozniak J, et al. (2010) Impact of obsessive-compulsive disorder on the antimanic response to olanzapine therapy in youth with bipolar disorder. *Bipolar Disorders* 12: 196–204.

[j]Mahasuar R, Janardhan Reddy YC and Math SB (2011) Obsessive-compulsive disorder with and without bipolar disorder. *Psychiatry and Clinical Neurosciences* 65(5): 423–33.

[k]Masi G, Perugi G, Millepiedi S, et al. (2007) Bipolar comorbidity in pediatric obsessive-compulsive disorder: clinical and treatment implications. *Journal of Child and Adolescent Psychopharmacology* 17: 475–86.

[l]Tillman R, Geller B, Bolhofner K, et al. (2003) Ages of onset and rates of syndromal and subsyndromal comorbid DSM-IV diagnoses in a prepubertal and early adolescent bipolar disorder phenotype. *Journal of the American Academy of Child & Adolescent Psychiatry* 42(12): 1486–93.

mean age of onset of BD compared to OCD in comorbid patients. Some investigators also reported an earlier onset of obsessive-compulsive (OC) symptoms in comorbid patients compared to non-comorbid patients.

Taken together, the evidence so far on BD-OCD nosology supports the view that the majority of comorbid OCD cases appeared to be related to mood episodes (Tonna et al., 2015). As confirmed by this review, OC symptoms may be expression of vulnerability to BD increasing the risk of a later BD diagnosis. OC symptoms would initially coexist with BD symptoms even cycling together and they would gradually tend to decrease in the adulthood.

Acknowledgements

M.T. and A.A. have contributed equally to this work. Authors M.T., A.A., A.O., and B.S. designed the study and wrote the protocol. Studies were identified and independently reviewed for eligibility by two authors (A.A., A.O.) in a two-step based process. Data were extracted by one author (A.A.) and supervised by a second author (S.N.G.) using an ad hoc developed data extraction spreadsheet. The same authors who performed data extraction (A.A., S.N.G.) independently assessed the quality of selected studies using the checklist developed by Downs and Black both for randomized and non-randomized studies. M.T., A.A., A.O., and B.S. have been involved in drafting the manuscript and S.N.G. revised it critically. S.N.G. has given final approval of the version to be published. All authors read and approved the final manuscript.

Declaration of Conflicting Interests

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: Dr Tonna, Dr Amerio, Dr Odone and Dr Stubbs report no conflicts of interest. Dr Ghaemi has provided research consulting to Sunovion and Pfizer, and has obtained a research grant from Takeda Pharmaceuticals. Neither he nor

Downloaded from anp.sagepub.com at TUFTS UNIV on December 12, 2016

his family hold equity positions in pharmaceutical corporations.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

See Letter by Amerio et al., 48(10): 957; See also Letter by Tonna et al., 49(6): 578–579.

References

Amerio A, Odone A, Marchesi C, et al. (2014a) Do antidepressant-induced manic episodes in obsessive-compulsive disorder patients represent the clinical expression of an underlying bipolarity? *Australian and New Zealand Journal of Psychiatry* 48: 957.

Amerio A, Odone A, Marchesi C, et al. (2014b) Treatment of comorbid bipolar disorder and obsessive-compulsive disorder: A systematic review. *Journal of Affective Disorders* 166: 258–263.

Amerio A, Stubbs B, Odone A, et al. (2015) The prevalence and predictors of comorbid bipolar disorder and obsessive-compulsive disorder: A systematic review and meta-analysis. *Journal of Affective Disorders* 186: 99–109.

Maj M (2005) 'Psychiatric comorbidity': An artefact of current diagnostic systems? *The British Journal of Psychiatry* 186: 182–184.

Tonna M, Amerio A, Ottoni R, et al. (2015) The clinical meaning of obsessive-compulsive symptoms in bipolar disorder and schizophrenia. *Australian and New Zealand Journal of Psychiatry* 49: 578–579.

Downloaded from anp.sagepub.com at TUFTS UNIV on December 12, 2016