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A STUDY OF COMORBID PSYCHIATRIC ILLNESSES IN PATIENTS WITH OBSESSIVE COMPULSIVE DISORDER

Psychiatry

Asha mounika D Senior resident in Psychiatry, Department of psychiatry, Apollo Institute of medical sciences, Chittoor.

Omesh kumar Senior resident in Psychiatry, Department of psychiatry ESI medical college, Hyderabad.

ABSTRACT

Aims And Objectives: To study other psychiatric comorbidities and their effect on treatment outcome in patients with OCD.

Methods and materials: Patients diagnosed OCD(ICD-10) at OP setting were included in the study and were followed up for three months under treatment with SSRIs. MINI-PLUS and YBOCS severity scale were administered at the time of entry into the study and after 12 wks of treatment. A 35% reduction in YBOCS score is considered response on basis of which variables were further evaluated.

Results: Of 49 patients 31(63.3%) had a co-morbid diagnosis. Mood disorders(46.9%), anxiety disorders(16.2%), alcohol dependence syndrome(6.1%) , were the common comorbid disorders. 83.6% of non responders and 40% responders had a comorbidity(p = 0.005).

Conclusion: High rate of comorbidity is seen in OCD. Presence of comorbid disorders has significant impact on treatment outcome in patients with OCD.

KEYWORDS

Comorbidities, OCD, Treatment response

INTRODUCTION

Obsessive compulsive disorder(OCD) is a serious and persistent mental health problem. There has been an increasing interest in conceptual understanding of OCD and factors effecting the disease course and treatment outcome. OCD is a disorder that seems to be under-diagnosed and under-treated in all age groups. OCD is the fourth commonest mental disorder worldwide and in India with a lifetime prevalence of 1-2% worldwide. In India it was found to be 0.6% (Y J Reddy et al. (2010)).(10)OCD is characterized by the presence of persistent and recurrent irrational thoughts (obsessions), resulting in marked anxiety and/or repetitive excessive behaviors (compulsions) as a way to try to decrease that anxiety. Major psychiatric disorder comorbidity ranges from 27% - 50% in patients with OCD in several studies. The most common comorbid disorders are depression, other anxiety disorders, eating disorders and substance abuse(Denys D et al (2004), Bhattacharyya S et al (2005), Kalra H et al (2008)).(4, 3, 6) The purpose of this study is to investigate comorbities and their association with the treatment outcome in OCD patients at our clinical setting.

PATIENTS AND METHODS

STUDY DESIGN: This is a prospective study done to study other cormorbid psychiatric illnesses and their effect on disease outcome in patients with OCD. AREA OF STUDY- Institute of mental health , Erragadda, Hyderbad.

SAMPLE SIZE : All patients attending the out patient services at Institute of mental health, diagnosed as having OCD at the hospital, fulfilling inclusion and exclusion criteria are considered.

INCLUSION CRITERIA:

1. Males and Females aged between 18-60yrs.
2. With primary diagnosis of OCD according to ICD 10.

EXCLUSION CRITERIA.

1. Age less than 18 and more than 60 years.
2. Pregnancy or lactation.

PROCEDURE: Patients from OP departments with their main diagnosis as OCD (according to ICD – 10) fulfilling inclusion and exclusion criteria are included in the study. At the time of entry into study, after taking written informed consent, socio-demographic details are taken through an intake proforma. and Mini International Neuropsychiatric Interview plus(MINI-Plus) was administered to diagnose psychiatric comorbities. Y-BOCS(Yale Brown Obsessive Compulsive Scale) severity scale were administered at time of entry into study and after 12 wks of treatment to assess the severity of illness . A 35% reduction in Y-BOCS score on this scale is considered response. On that basis, patients are grouped into responders and non-responders and above variables evaluated. **Statistics :** The findings are tabulated and analysed using Microsoft excel and SSPS (Statistical Package for the Social Sciences) version 22.

RESULTS

A total of 63 patients with OCD were interviewed. 55 patients included in to the study and 8 patients were ruled out as they did not fulfill the inclusion and exclusion criteria. 4 patients were lost to follow up. The final sample consisted of 49 participants. Based on treatment response, patients were divided into two groups. The responded group (>35% treatment response) contained 20(40.7%) patients of total sample. The non responded group (<35% treatment response) had 29(59.3%) patient of total sample.

Among the 49, 32 were males (65.3%) and 17 were females (34.7%). The mean age of subjects being 31.42 years (SD+/-9.46) years and the average age of onset of OCD was 26.24 years. No significant differences between responders and non-responders were observed in terms of gender, age, age of onset , socioeconomic status, educational status, occupation, domicile , marital status and religion(Table 1).

Variable		Non responder N(%)	Responder N(%)	Chi square value λ2	p value
Gender	Male (32)	20(69.0)	12(60)	0.420	0.517
	Female (17)	9(31.0)	8(40)		
Socioeconomic status	Lower (27)	14(48.3)	13(65)	1.338	0.247
	Middle (22)	15(51.7)	7(35)		
Education	Illiterate (5)	2(6.9)	3(15)	8.845	0.115
	Primary (10)	3(10.3)	7(35)		
	SSC (6)	4(13.8)	2(10)		
	Intermediate (5)	3(10.3)	2(10)		
	Graduation (20)	16(55.2)	4(20)		
	Post graduation (3)	1(3.4)	2(10)		
Occupation	Unemployed (12)	11(37.9)	1(5)	3.101	0.683
	Unskilled laborer (2)	1(3.4)	1(5)		
	Skilled laborer (9)	1(3.4)	8(40)		
	House wife (11)	6(20.7)	5(25)		
	Unprofessional (11)	6(20.7)	5(25)		
	Professional (4)	4(13.8)	0(0.00)		
Residence	Rural (23)	12(41.4)	11(55)	0.882	0.348
	Urban (26)	17(58.6)	9(45)		
Marital status	Married (24)	16(55.2)	8(40)	2.084	0.353
	Unmarried (24)	12(41.4)	12(60)		
	Divorced (1)	1(3.4)	0(0.00)		
Religion	Hindu (39)	24(82.8)	15(75)	0.439	0.508
	Muslim (10)	5(17.2)	5(25)		

Table 1: Socio-demographic variables among responders and non-responders

31(63.3%) of patients had a co-morbid diagnosis. Mood disorders were present in 23(46.9%) patients. Anxiety disorder other than other than OCD were present in 8(16.3%) of patients. 3(6.1%) patient had alcohol dependence and one had other diagnosis.(Table 2). 4(8.2%) of patients had more than one co-morbid disorder.

Variable		N(%)
Comorbid disorders	Depression	23(46.9)
	Anxiety disorders	8(16.2)
	Alcohol dependence	3(6.1)
	Others	1(2)
	Nil	18(36.6)

Table 2: Comorbid diagnosis in the group.

23(86.3%) subjects in the non responder group had a comorbid disorder while only 8(40%) of responders had one. This difference with respect to presence or absence of comorbid disorder appears to be significant with Chi-square value being is 7.8. The p value being 0.005*. The non responder subjects had comorbid disorders such as depression 12(41.4%), other anxiety disorders 8(27.6%), alcohol dependence 2(6.9%) and body dysmorphic disorder(BDD) in 1(3.4%). Among responders 7(35%) subjects met the criteria for depression and 1(5%) for alcohol dependence. Significant difference is observed between responders and non-responders in terms of comorbid disorders (p = 0.023*).(Diagram 1, Table 3)

Anxiety disorders when compared individually had shown significant difference among the both groups with p = 0.010*.

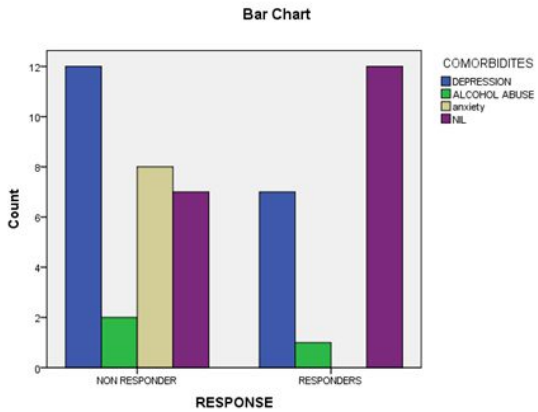


Diagram 1: Comorbidities in responders and non responders

		Non responders N(%)	Responders N(%)	Chisquare value λ2	p value
Comorbid disorders	Depression	12(41.4)	7(35)	11.38	0.023*
	Anxiety disorders	8(27.6)	0(0.0)		
	Alcohol dependence	2(6.9)	1(5)		
	Others	1(3.4)	0(0.0)		
Comorbid disorders	Present	23(79.3)	8(20)	7.87	0.005*

Table 3: Comorbidities in responders and non responders

DISCUSSION

This prospective study investigated psychiatric comorbidities and their prognostic value in patients with OCD as a function of treatment response in our study. 'Treatment response' was defined as at least a 35% reduction on the Y-BOCS total score at the end of 12 weeks, similar to previous studies(Rasit Tukel et al (2006)[12], Erzegovesi et al (2001)[5] , Alonso P et al (2001)[1]). On that basis, patients are grouped into responders and non-responders and the above mentioned variables evaluated for their effect on improvement. 63.3% of sample had at least one comordid disorder. This prevalence is much higher than that reported by Denys D et al (2004)- 26%, Bhattacharyya S et al (2005)- 30%.[4,3] This disparity can be attributed to the fact that the patient data was collected from a tertiary psychiatric hospital with high representation of severe cases. Mood disorders(MDD, Dysthymia), Anxiety disorders(GAD, panic disorder,social phobia, specific phobia), BDD and Alcohol dependence were reported as comorbidities in our study. Mood disorders, predominantly MDD was most common comorbidity in our sample followed by other anxiety disorders and this finding is consistent with the literature.[4,3] 79.3% subjects in the non responder group had a comorbid disorder when compared 40% in responders. This difference with respect to presence or absence of comorbid disorder appears to be significant(p- 0.005), meaning that presence of psychiatric comorbidity is a predictor of poorer response. Belotto-Silva et al (2012)[2], , N . Micali et al (2010)[9] reported similar findings. However, in study by Rasit Tukel et al (2006)[12], C H Kim et al (2011)[7] they reported that presence of comorbid disorders in OCD patients was not a significant predictor of treatment outcome. There was also significant difference in the comorbidities represented in responders when compared with those present in nonresponders which was significant (p = 0.023). Mood disorders was most common comorbidity among both responders and nonresponders and was not individually identified as a predictor of outcome. The finding is supported by the findings of the study by C H Kim et al (2011)[7], Rasit Tukel et al (2006)[12], which report that mood disorders (most common being MDD) fail to predict treatment outcome. However, Belotto-Silva et al., (2012)[2], Shetti et al., (2005)[11] and M. J. Maher et al (2010)[8] reported in their studies that presence of depression was a predictor of poorer outcome. Anxiety disorders were only represented in nonresponders and alone were identified as a predictor of nonresponse with (p= 0.01). GAD was found to predict outcome significantly in study by Rasit Tukel et al (2006)[12], Social phobia appeared to be a predictor of poorer outcome in study by Belotto-Silva et al., (2012)[2].

CONCLUSIONS

Strengths of the study: a) The study is a prospective study following the natural course of the disease. **b)** Being a prospective study, there are lesser chances of bias. c) The study enables us to study psychiatric comorbidities in OCD patients in the setting of our hospital. **Weaknesses / limitations of this study: a)**This study was based on follow-up of data obtained from patients who visited only the Institute of Mental Health, Hyderabad. These results may not be generalized to all OCD patients. **b)** The sample size in the study is too small to establish robust results. This study is also limited by its inability to study long-term treatment effects because of its short duration of follow up. **c)** The study is not randomized. **d)** Patients received various types of medications and at different doses. The drug treatment was not supplemented by any psychotherapy as guided by standard guidelines. **e)** In this study, some variables which are known to predict the outcome in the literature such as co-morbid personality disorders, presence of tics , insight etc were not studied.

A study with a larger sample, with longer duration of follow up and more uniform and standardised treatment would yield better results.

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