



A STUDY OF SYMPTOM DIMENSIONS AND THEIR EFFECT ON TREATMENT RESPONSE IN PATIENTS WITH OBSESSIVE COMPULSIVE DISORDER

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 symptom dimensions in OCD and their effect on treatment response in OCD patients.

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. YBOCS symptom checklist and severity scale are administered at the point of entry into study. After 12 wks of treatment, YBOCS severity scale is re-administered.

Results: Of 49 patients most(40) had both obsessions and compulsions. The most common obsession was contamination(30.6%) and compulsion was washing/cleaning(34.6%) . Subtype of obsessions (p = 0.041) and presence of multiple obsessions (p = 0.03) were found to be significantly different between responders and non responders.

Conclusion: Few subtypes of obsessions(sexual/religious) and presence of multiple obsessions were found to be associated with poor treatment response in patients with OCD.

KEYWORDS : OCD, Symptom dimensions, 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 (Kiejna A et al (2002))(6) and in India (Karno et al., (1988))(5) with a lifetime prevalence of 1-2% (Kiejna A et al. (2002))(6) worldwide. In India it was found to be 0.6% (Y J Reddy et al. (2010)).(9) 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. there are several symptom dimensions in OCD few of which are symmetry (symmetry obsessions, repeating, ordering, and counting compulsions), forbidden thoughts (aggression, sexual, religious, and somatic obsessions with checking compulsions), cleaning (contamination fears and washing and cleaning compulsions), and hoarding. The purpose of this study is to study symptom dimensions in OCD and to investigate their association with the treatment outcome in our clinical setting.

PATIENTS AND METHODS

STUDY DESIGN: This is a prospective study.

AREA OF STUDY: Institute of mental health , Erragadda, Hyderabad.

SAMPLE SIZE : All patients attending the out patient services and inpatients 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. 3. Psychiatric comorbidities

PROCEDURE: Patients from OP 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. Y-BOCS checklist and severity scale are administered at the time of entry into the study. Pharmacological treatment is started in drug naive patients and necessary escalation and adjustments made in those on treatment already according to standard guidelines. After 12 wks of treatment, Y-BOCS severity scale is re-administered. A 35% reduction in Y-BOCS score is considered response. On that basis, patients are grouped into

responders and non-responders.

Statistics : The findings are tabulated and analysed using Microsoft excel and SPSS (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.

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

Symptom dimensions :Among Obsessions, Contamination sub type was found in 15(30.6%) patients, aggressive sub type in 9(18.3%), sexual/religious sub type in 13(26.4%), pathological doubt sub type in 4(8.1%), symmetry/exactness sub type in 4(8.1%) and miscellaneous in 4(8.1%) at the time of interview.(only predominant obsession which brought them to hospital considered above) 17(34.6%) of patients had multiple obsessions. 9(18.3%) patients had purely obsessions. Among compulsions, 40(81.7%) of patients had compulsions. 15(30.4%) had multiple compulsions. 17(34.6%) patients have cleaning/washing compulsions, 9(18.3%) patients had checking as compulsion, 3(6.1%) patients had ordering/arranging compulsions, 4(8.1%) had compulsion of repeating rituals and 7(14.2%) had miscellaneous compulsions. (only predominant compulsion which brought them to hospital considered above). Among non responder subjects, 11 (37.9%) were with the sexual/religious , 6(20.7%) with contamination, 4 (13.8%) with symmetry and exactness , 3(10.4%) with the aggressive, 2(6.9%) with pathological doubt and 3(10.4%)miscellaneous obsessions (Diagram 1). 7(24.3%) had cleaning/washing, 5(17.2%) had checking , 3(10.4%) had ordering and arranging, 3(10.4%) had repeating rituals and 6(20.7%)had miscellaneous compulsions(Diagram 2). The responders group included 9(45%) with contamination , 6(30%) with the aggressive, 2(10%) were with the sexual/religious, 2(10%) with pathological doubt and 1(5%) miscellaneous obsessions(Diagram 1). 10 (50%) had cleaning/washing , 4(20%) had checking , 1(5%) had repeating rituals and 1(5%) had miscellaneous compulsions(Diagram 2).

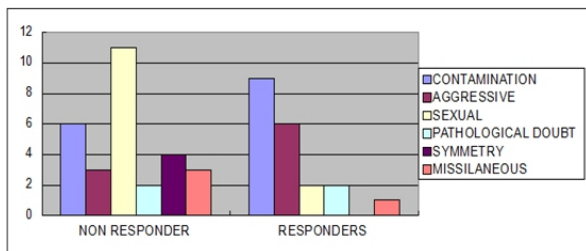


Diagram 1: Sub types of obsessions in responders and non responders

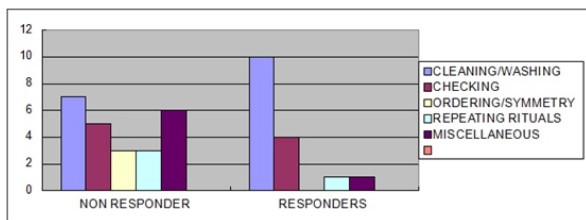


Diagram 2: Sub types of compulsions in responders and non responders

Significant differences were present between responders and non-responders in terms of subtype with respect to obsessions(p value = 0.041*) but not compulsions(p value = 0.142)(Table 2). Presence of multiple obsessions(p = 0.03*), but not compulsions(p= 0.319) was significant.

		Non responders N(%)	Responders N(%)	Chisquare value λ2	p value
Obsessions	Aggressive	3(10.4)	6(30)	11.57	0.041*
	Contamination	6(20.7)	9(45)		
	Sexual/Religious	11(37.9)	2(10)		
	Symmetry-Exactness	4(13.8)	0(0.0)		
	Pathological doubt	2(6.8)	2(10)		
	Miscellaneous	3(10.4)	1(5)		
Compulsions	Cleaning/washing	7(24.3)	10(50)	6.887	0.142
	Checking	5(17.2)	4(20)		
	Ordering/Arranging	3(10.4)	0(0.0)		
	Repeating rituals	3(10.4)	1(5)		
	Miscellaneous	6(20.7)	1(5)		

Table 2: Clinical subtypes in responders and non responders.

DISCUSSION

This study focuses on symptom dimensions and their prognostic value in patients with OCD as a function of treatment response.

When only one predominant obsession which brought the patient to medical attention was considered, Contamination sub type was found to be most common as in study by Jaisoorya T S et al. (2003).(4)Contamination was followed by sexual/religious sub type ,aggressive sub type and pathological doubt, symmetry/exactness, miscellaneous . Only 81.7% of patients had compulsions with 30.4% had multiple compulsions. Cleaning/washing compulsions were most common followed by checking compulsions, miscellaneous compulsions, compulsion of repeating rituals and ordering/arranging in that order. Among non responders , sexual/religious obsessions were the most common followed by contamination, symmetry and exactness, aggressive, pathological doubt sub type of obsessions in that order and miscellaneous obsessions. The most common compulsions were cleaning/washing followed by checking, ordering and arranging, repeating ritual sub type of compulsions in that order and miscellaneous compulsions. In the responder group, contamination was the most common obsession followed by aggressive, sexual/religious, pathological doubt and miscellaneous subtypes of obsessions. Most common contamination in this group was cleaning/washing followed by checking , repeating rituals and miscellaneous compulsions. Hoarding/saving obsessions or compulsions were not represented in our sample. In this study the symmetry/exactness obsession and ordering/arranging compulsion were solely represented among non responder group. However, they failed to show a significant impact on outcome. Obsessions(p value = 0.041) but not compulsions(p value = 0.142) in our study were a predictor of outcome. When assessed individually, sexual/religious obsession were found to be a predictor of non response. This finding runs parallel to that in study done by Alonso P et al (2001)(1), Shetti CN et al (2005)(10) where sexual and religious obsessions were the only factors associated with poorer outcome in the long term follow up of OCD patients treated with behavioral and pharmacological therapy. Also, in a study by Mataix Cols et al (2002)(7), it was reported that after controlling for the severity of illness, sexual/religious obsessions predicted poorer outcome in patients with combined treatment. When studied individually we did not find cleaning or washing rituals to be significantly associated with any group. This is in contrast to studies by Ravizza et al (1995) (8) who reported that washing rituals were more frequent in the non-responder group, Black et al (1998)(2) who reported cleaning rituals and hoarding obsessions and compulsions as the predictor of poor treatment response and Shetti CN et al 2005(10) which reported that washing and miscellaneous compulsions were associated with poor outcome. The results in this study are in contrast to the findings of Denys et al 2003(3), where the findings showed a trend towards

worse outcome in the presence of contamination and better outcome in presence of aggressive and sexual/religious obsessions. Presence of multiple obsessions ($p = 0.03$), but not compulsions ($p = 0.319$) also found to be a predictor of non-response in this study.

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 symptom dimension 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 and other comorbidities 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.

REFERENCES

1. Alonso, P., Menchon, J. M., Pifarre, J., Mataix-Cols, D., Torres, L., Salgado, P., & Vallejo, J. (2001). Long-term follow-up and predictors of clinical outcome in obsessive-compulsive patients treated with serotonin reuptake inhibitors and behavioral therapy. *The Journal of clinical psychiatry*.
2. Black, D.W., Monahan, P., Gable, J., Blum, N., Clancy, G., & Baker, P. (1998). Hoarding and treatment response in 38 nondepressed subjects with obsessive-compulsive disorder. *The Journal of clinical psychiatry*, 59(8), 420-425.
3. Denys, D., Burger, H., van Megen, H., de Geus, F., & Westenberg, H. (2003). A score for predicting response to pharmacotherapy in obsessive-compulsive disorder. *International clinical psychopharmacology*, 18(6), 315-322.
4. Jaisoorya, T. S., Reddy, Y. J., & Srinath, S. (2003). The relationship of obsessive-compulsive disorder to putative spectrum disorders: results from an Indian study. *Comprehensive Psychiatry*, 44(4), 317-323.
5. Karno, M., Golding, J. M., Sorenson, S. B., & Burnam, M. A. (1988). The epidemiology of obsessive-compulsive disorder in five US communities. *Archives of general psychiatry*, 45(12), 1094-1099.
6. Kiejna A, Rymaszewska J, Kantorska-Janiec M, Tokarski W. (2002) . Epidemiology of obsessive-compulsive disorder. *Psychiatry Pol* 36: 539-548.
7. Mataix-Cols, D., Marks, I. M., Greist, J. H., Kobak, K. A., & Baer, L. (2002). Obsessive-compulsive symptom dimensions as predictors of compliance with and response to behaviour therapy: results from a controlled trial. *Psychotherapy and psychosomatics*, 71(5), 255-262.
8. Ravizza, L., Barzega, G., Bellino, S., Bogetto, F., & Maina, G. (1995). Predictors of drug treatment response in obsessive-compulsive disorder. *The Journal of clinical psychiatry*.
9. Reddy, Y. J., Rao, N. P., & Khanna, S. (2010). An overview of Indian research in obsessive compulsive disorder. *Indian journal of psychiatry*, 52(Suppl1), S200.
10. Shetti, C. N., Reddy, Y. C., Kandavel, T., Kashyap, K., Singiseti, S., Hiremath, A. S., ... & Raghunandan, S. (2005). Clinical predictors of drug nonresponse in obsessive-compulsive disorder. *The Journal of clinical psychiatry*, 66(12), 1517-1523.