



ORIGINAL RESEARCH PAPER

Medical Science

EXAMINING THE ATTITUDE OF PATIENTS SUFFERING FROM OCD TOWARDS DRUG ADHERENCE.

KEY WORDS: OCD, patients, non-adherence, gender, age, marital status

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ABSTRACT

Although it is reasonable to speculate that poor treatment adherence in OCD prolongs suffering and increases economic costs, no clear information on the clinical, functional and economic impact of treatment non-adherence is currently available. The main purpose of this study was to assess the level of drug adherence among the patients of Obsessive Compulsive disorder and the role of selected sociodemographic variables as gender, age and marital status. The patients were made to sit comfortably and the Medication Adherence Rating Scale was administered on them. Along with this, reasons for their medication adherence or non-adherence were asked to the participants. Data obtained was noted down and scoring was done on the basis of the manual. Relevant statistics were applied to the data obtained and result tables were formulated. Results showed that female patients, patients from the age group of 46-55 years and patients who were divorced and separated were found to have the maximum percentage of non-adherence to the treatment. It was concluded that psychoeducation for patients and families concerning the treatment of OCD and potential drug side-effects will contribute to increasing adherence to treatment. Limitations and references of the study were stated.

INTRODUCTION

Obsessive-compulsive disorder (OCD) is characterized by recurrent and persistent thoughts, urges or images that are difficult to resist and cause marked anxiety or distress, and/or repetitive behaviors or mental acts that are performed to reduce the anxiety or according to specific rules^[1]. According to a review on the epidemiological studies reporting OCD related data, the 1-month prevalence of OCD ranges from 0.3 to 3.1% of the general population^[2]. Importantly, OCD frequently results in significant costs and reduced quality of life for those affected and their families^[3]. In a recent study, OCD ranked 10th on the Global Burden of Mental, Neurological and Substance- Use Disorders, a position based on the number of future years of healthy life that are lost as a result of the premature deaths or disability occurring in a particular year^[4]. Pathophysiological models of OCD involve a complex interaction between genetic diathesis and environmental factors (e.g., birth complications, traumatic events and infections) leading to neurochemical abnormalities (involving serotonin and dopamine) and increased activity of brain corticostriatal circuits^[5,6]. In OCD, treatment entails administration of serotonin-reuptake inhibitors (SRIs) and/or cognitive-behavioral techniques, including psychoeducation, exposure and response prevention (ERP), and cognitive restructuring^[1].

Although it is reasonable to speculate that poor treatment adherence in OCD prolongs suffering and increases economic costs, no clear information on the clinical, functional and economic impact of treatment non-adherence is currently available^[7]. Identifying the correlates and/or risk factors for treatment non-adherence in patients with OCD would help guide clinicians to develop more effective strategies to maintain patients on an established therapeutic plan. Nevertheless, treatment adherence has only been investigated rarely. Regarding ERP, which is the main psychotherapeutic intervention for OCD, there are only a few studies but they have consistently shown that better adherence to assignments between sessions is associated with better outcome in both the short and long term^[8,9]. Although it is highly intuitive that compliance with pharmacological treatment might have the same effect in regards to outcome, this has not been systematically assessed. As expected, in OCD, predictors of better adherence to psychotherapeutic treatment include better therapeutic alliance and higher treatment readiness^[10]. Hoarding symptoms have been associated with poor adherence to ERP^[10] and to greater chance of refusing ERP^[11]. Poor insight and greater severity have been associated with higher medication refusal^[11]. Regarding the chance of abandonment of pharmacological treatment, comorbid major depression has been described to diminish the chance of abandonment^[12]. While another study has shown that comorbid agoraphobia, social phobia, generalized anxiety disorder and somatization disorder increase the chance of abandonment^[13].

In OCD, as in other medical conditions or psychiatric disorders, working to improve patients' compliance with professionals' advice is, to say the least, challenging. Some work has been carried out to evaluate if motivational interviewing techniques adapted from the drug and alcohol dependence protocols could help to better engage OCD patients with treatment. Simpson et al. were unable to show that adding motivational interviewing to an ERP protocol yielded better adherence or outcome than when the ERP protocol was applied alone^[14]. Several factors may have contributed to these negative results, including the small sample size (n = 30, 15 in each intervention group) and good baseline adherence to ERP assignments in both groups. Consequently, there was not much room for improvement of adherence to start with, this is also called a ceiling effect. On the other hand, previous studies have shown that adding motivational interview to ERP protocols could yield better treatment acceptance among patients who have refused ERP before^[15] and accelerate improvement^[16].

Therefore, motivational interviewing is still a promising intervention to improve adherence in OCD for those who show poor baseline adherence. The efficacy of this intervention should be further investigated in controlled trials. Regarding pharmacological intervention, there is some evidence that reducing the length of intervals between medical appointments (seeing patients every 2 weeks instead of every month) might be helpful to prevent early treatment abandonment^[18]. Likewise, as OCD patients with comorbid generalized anxiety and somatization disorder are more prone to abandon treatment due to medications' side effects, it might be helpful to assign these patients to psychotherapy whenever possible and to carefully choose drugs with better side-effect profiles for each specific patient^[18]. There is also evidence that selective SRIs are associated with better treatment adherence than clomipramine due to the side-effect profile of the later^[17].

REVIEW OF LITERATURE

Studies have shown that OCD frequently follows an inflexible course in a chronic pattern, and that long-term treatment may be necessary to prevent relapse. Preliminary data have shown that patients whose symptoms recur following medication discontinuation respond positively but with relatively lower effectiveness compared to the first treatment when the same drug is resumed^[19]. These observations underline the need to determine markers of treatment dependence in OCD. Although adult-based studies have been performed, ours is the first study to assess medication side-effects and adherence to treatment in a pediatric OCD population. OCD has a tendency to chronification, and the importance of early treatment has been shown in the literature. Recovery can be achieved with monodrug or multidrug medication

and psychotherapy. Psychotherapy is effective, but pharmacotherapy is widely employed as the first and sole form of treatment^[20,21]. In one study of 246 children diagnosed with OCD and with a mean age of 11.9 years, SRIs were general prescribed (55%), and antipsychotics were added, either alone or in combination with another medication, in 22%. The level of receipt of psychotherapy plus at least one medication was 36%^[17]. The rate of antipsychotic use was higher in our study (45%). Only 33 (29%) of the 114 patients in our study were receiving psychotherapy. However, the rates of psychotherapy receipt were very low in and similar between both the augmentation and monotherapy groups.

Although pharmacotherapy represents the current foundation of OCD treatment due to the availability of effective medication, CBT is also reported to be effective in the disease^[18]. Wilson and Roman reported that problems concerning difficulty of access to CBT and inadequate education represented the greatest obstacles to the use of this effective therapeutic method^[19]. We attributed the low psychotherapy and high augmentation rates in our study to difficulties in accessing psychotherapy.

Non-adherence to treatment is common in patients with OCD. Sixty-one percent of patients with OCD receiving drug therapy are reported either to use their medications less frequently and/or at lower doses, or else to discontinue the medication entirely^[20]. This has been attributed to medication side-effects (78%), insufficient therapeutic efficacy (41%), and high levels of concern over drug use (41%)^[21].

Non-adherence to treatment can be reduced either by selecting medication that will cause fewer side-effects, or else by providing information for patients. Patients generally experience concerns over side-effects. It may be useful to provide advice about side-effect management strategies in order to reduce this fear to a minimum; written prescription information can be provided, and follow-up visits at intervals of 1-4 weeks can be performed following the first visit^[22].

OBJECTIVE

The main purpose of this study was to assess the level of drug adherence among the patients of Obsessive Compulsive disorder and the role of selected sociodemographic variables as gender, age and marital status.

HYPOTHESIS

There will be a differential effect of selected sociodemographic variables on the level of drug adherence among the patients of Obsessive Compulsive disorder.

VARIABLES

- Patients of OCD
- Medication Adherence Rating Scale^[24]
- Sociodemographic factors

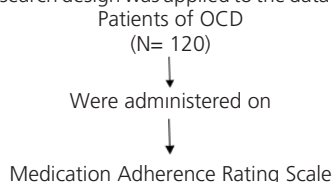
- a) Gender
- b) Age
- c) Marital status

SAMPLE

The sample was selected from the OPD and IPD of Department of Psychiatry, Pacific Institute of Medical Sciences, Ambua Road, Umarda, Udaipur on availability basis. Only those patients who have been taking treatment for more than 6 months were selected for the present study. Age range of the patients was 16-55 years. The sampling procedure followed was of purposive sampling.

RESEARCH DESIGN

Exploratory research design was applied to the data obtained.



PROCEDURE

The patients were made to sit comfortably and the Medication Adherence Rating Scale was administered on them. Along with this, reasons for their medication adherence or non-adherence were asked to the participants. Data obtained was noted down and scoring was done on the basis of the manual. Relevant statistics were applied to the data obtained and result tables were formulated. Interpretations of the results was done and conclusions were drawn. Limitations and references of the study were stated.

STATISTICAL ANALYSIS

Descriptive statistics such as frequency, percentage was calculated in order to get the desired results from the data obtained.

RESULTS AND DISCUSSION

Table 1- Gender-wise distribution of the sample and percentage of patients found non-adherent to the medication.

Gender	N	Non-Adherence	Percentage
Male	53	23	43.3
Female	67	36	55.7
Total	120	59	49.1

Table 2- Age-wise distribution of the sample and percentage of patients found non-adherent to the medication.

Age (in years)	N	Non-Adherence	Percentage
16-25	31	17	54.8
26-35	47	13	27.6
36-45	23	15	65.2
46-55	19	14	73.6
Total	120	59	49.1

Table 3- Marital status-wise distribution of the sample and percentage of patients found non-adherent to the medication.

Marital status	N	Non-Adherence	Percentage
Single	57	21	36.8
Married	34	18	52.9
Separated	14	9	64.2
Divorced	15	11	73.3
Total	120	59	49.1

The main purpose of this study was to assess the level of drug adherence among the patients of Obsessive Compulsive disorder and the role of selected sociodemographic variables as gender, age and marital status.

It may be seen from the table 1 that 55.7% of the female patients suffering from OCD were found to be non-adherent to the medication. The reason behind this could be that women in rural areas have to wait till their husbands take out time to take them to the hospital as they are not allowed to go alone out of the house. 43.% of the males were also found to non-adherent to medications od OCD. In total, 59 patients (49.1%) out of the total sample of 120 were found to drop out from their treatment or take irregular medications.

In table 2 it was found that, maximum non-adherence occurred among the patients between the age group of 46-55 years which was seen to be 73.6%. 65.2% of the patients belonging to the age group of 36-45 years were seen to be non-adherent. Patients taken from the age group of 16-25 were observed to have 54.8% of non-adherence. It was examined that old age people were careless about their medicine intake and same was the case with younger patients. Middle aged patients were comparatively more adherent to their medications.

The assessment of adherence according to the marital status of the patients was analyzed in table 3 where it was seen that divorced and separated patients had the maximum non-adherence rate of 73.3% and 64.2 % respectively. However, 52.8 % of the married couple were also found to be careless about medications. This may be because separated and divorced patients had less people to

care for them and married people do not find time to go for long time regular medications and tend to stop taking them as soon as the symptoms subside.

In summary, some the OCD patients may not respond to treatment as a consequence of poor adherence at least as frequently as other OCD patients. Some factors have been shown to predict higher chance of low adherence, treatment refusal or abandonment. Add-on motivational interviewing and reduced intervals between consultations are the most promising interventions for improving adherence, and decreasing refusal and abandonment.

CONCLUSIONS

Lower adherence to treatment in the OCD population was significantly associated with more drug-related side-effects, gender, age and marital status. Psychoeducation for patients and families concerning the treatment of OCD and potential drug side-effects will contribute to increasing adherence to treatment.

LIMITATIONS

1. Sample size is small, so the data cannot be generalized.
2. Data was only collected from one hospital.
3. Selected sociodemographic variables were analyzed.

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