

Psychiatric Morbidity among OCD Patients in Kashmir

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ABSTRACT

Introduction: Obsessive Compulsive Disorder is a chronic and disabling psychiatric disorder characterized by recurrent intrusive thoughts, images and impulses known as obsessions which are usually accompanied by repetitive acts or behaviors known as compulsions. Many of these patients have associated psychiatric disorders. We aimed to study these patients for comorbid disorders presenting to our hospital from different areas of Kashmir.

Material and Methods: Our study was a cross sectional observational study. Obsessive Compulsive Disorder was diagnosed as per DSM IV TR criteria. A total of 156 patients were included in this study. Psychiatric comorbidity was assessed with Mini International Neuropsychiatric Interview. Data analysis was done with the help of SPSS, version 20.

Result: Mean age of patients was 29.58 years with range of 50 (18-68). Comorbidity among patients was 62.82% (98 patients). Depression was the commonest comorbidity with 29.48% (46) patients followed by anxiety disorders in 26.92% (42) patients. Least common psychiatric disorder was substance use disorder in 1.92% (3) patients.

Conclusion: Comorbidity is not an exception in OCD but it is found in majority of these patients. Clinicians need to be aware of associated disorders for better outcome of OCD patients while managing them.

Keywords: Psychiatric Morbidity, OCD Patients

INTRODUCTION

Obsessive-compulsive disorder (OCD) is a neuropsychiatric disorder, characterized by recurrent intrusive ideas, impulses, or urges (obsessions) along with overt or covert behaviours (compulsions) aimed at reducing the distress.¹ Reported as the tenth leading cause of disability in the world by the World Health Organization (WHO) in 1996, OCD causes disrupted development, social withdrawal, family and relationship problems, difficulties with concentration and academic performance.² A majority of patients with OCD are at high risk of having one or more comorbid (co-existing) psychiatric illness. In the Epidemiological Catchment Area (ECA) study, two thirds of those with OCD had a comorbid psychiatric illness.¹ Depression and anxiety disorders are the common comorbid conditions reported in most studies of OCD. Other common psychiatric disorders co existing with OCD include bipolar affective disorders, Schizophrenia and other psychotic illnesses, personality disorders, Substance use disorders etc.^{1,3} Keeping these observations under consideration, we decided to embark on this study so as to study the associated psychiatric disorders in OCD patients as no data is available on the same from Kashmir Valley.

MATERIAL AND METHODS

This study was carried in the Government Psychiatric Diseases Hospital Srinagar which is the lone tertiary psychiatric hospital in Kashmir and caters to whole Kashmir region, along with some adjoining areas of Jammu and Ladakh region, a population of about 12.5 million (census 2011).⁴

Our study was a non-controlled non-interventional cross sectional observational study which was carried amongst patients attending OCD clinic of Government Psychiatric Diseases Hospital Srinagar, an associated hospital of Government Medical College Srinagar over a period of one year and three months, from March 2014 to May 2015. The OCD clinic runs once every week.

Patient Selection

Diagnosis of OCD was made as per DSM IV TR criteria by consultant psychiatrist.⁵ Each Patient was informed about the purpose of the interviewing. All the data of the patient including general description, demographic data was recorded in the semi structured case sheet especially designed for this study. All the new patients registered during the time period of March 2014 to May 2015 were screened and those who fulfilled the following criteria were taken up for the study.

Inclusion criteria

1. OCD as per DSM IV TR criteria
2. Age at least 18 years.
3. Those who gave consent.

Exclusion criteria

1. Those aged less than 18 years.
2. Those who don't give consent.
3. Presence of organic brain/medical disorders.
4. Those with endocrinopathies.
5. Presence of severe medical problems.

As a result, 156 patients were recruited.

Assessment

For socio economic status of patients, we used Kuppaswamy's socioeconomic status scale which is an important tool in

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hospital and community based research in India. It was proposed in 1976 and revised in 2007. This scale takes account of education, occupation and income of the family to classify study groups in to five social classes: Upper (I), Upper Middle (II), Lower middle (III), Lower lower (IV) and lower (V) socioeconomic statuses.⁶ OCD was diagnosed as per DSM IV-TR criteria. For the diagnosis of psychiatric comorbidity, we used Mini International Neuropsychiatric Interview Schedule Plus (MINI PLUS) which is a comprehensive diagnostic semi-structured interview based on DSM IV possessing good inter-rater reliability.⁷

STATISTICAL ANALYSIS

The data about various parameters was categorized according to age, sex, education, socioeconomic status, psychiatric morbidity etc. The information thus generated was presented in tables and charts. Statistical analysis was carried out with a commercial software package (SPSS, version 16). For the analysis of two categorical variables Chi square test (Fischer test where applicable) was used. Student's t-test was used to compare continuous variables between two groups and to compare categorical dichotomous versus continuous variables. All tests were 2 tailed, and statistical significance was set at $p < 0.05$.

RESULTS

Table 1 shows sociodemographic profile of patients. Majority of patients were Males, in the age group of 18 to 27 years, of rural background, belonging to nuclear families, were married, students by occupation, educated upto high classes (class 10th) and belonging to class III Socioeconomic class. Comorbidity among patients was 62.82% (98 patients) as depicted in table-2

As shown in table 3, Depression was the commonest comorbidity with 29.48% (46) patients followed by anxiety disorders in 26.92% (42) psychotic disorders and somatoform disorders were present in 7.05% (11) patients each. Suicide attempt history was present in 5.76% (9) patients and BPAD in 5.12% (8). About 3.21% (5) patients had dysthymia and substance use was present in 1.92% (3) patients.

DISCUSSION

This is the first study from Kashmir on co morbidity of OCD. A total of 156 patients were included in our study. Sex ratio was tilted slightly towards the male gender with 55.13% (86) males and 44.87% (70) females comprising the whole sample. The majority of the patients belonged to young and the middle age groups. Mean age of patients was 29.58 years and mean age of onset of OCD was 22.6 years. This is in

Variable	Subgroup	Frequency	Percentage	P (Chi Square test)
Sex	Male	86	55.13	0.23 NS
	Female	70	44.87	
Age distribution	18-27	67	42.94	<0.0001
	28-37	68	43.59	
	38-47	22	14.10	
	48 and above	09	5.76	
Dwelling	Rural	81	51.92	0.69 NS
	Urban	75	48.08	
Family Back ground	Nuclear	81	51.92	0.69 NS
	Joint	75	48.08	
Marital status	Unmarried	46	29.48	<0.001
	Married	100	64.10	
	Divorcee/Separated	10	6.41	
Occupation	Student	42	26.92	<0.001
	Unemployed	21	13.46	
	Self employed	39	25.00	
	Govt. Services	18	11.53	
	Housewife	36	23.07	
Education	Illiterate	19	12.17	<0.001
	Primary	06	3.84	
	Middle	19	12.17	
	High school	49	31.41	
	Higher secondary	34	21.70	
	Graduation	13	8.33	
	Post-Graduation and Above	16	10.25	
Socio economic Class	I	09	5.70	0.004
	II	35	22.43	
	III	53	33.97	
	IV	33	21.15	
	V	26	16.66	
Religion	Muslim	156	100	
	Others	0	0	

Table-1: Sociodemographic profile of patients

Comorbidity	Frequency	Percentage
Yes	98	62.82
No	58	37.18
Total	156	100

Table-2: Presence or absence of psychiatric comorbidity

Comorbidity	Number of patients	Percentage
Depression	46	29.48
Anxiety disorders	42	26.92
Psychotic disorders	11	7.05
Somatoform Disorders	11	7.05
Suicide	9	5.76
BPAD	8	5.12
Dysthymia	5	3.21
Substance use (other than Nicotine and Caffeine)	3	1.92

Table-3: Type of psychiatric comorbidity

agreement with Khanna et al who reported 29.5 years as mean age of assessment.⁸

Majority of patients with OCD are at high risk of having one or more comorbid (co-existing) psychiatric illness. In the Epidemiological Catchment Area (ECA) study, two thirds (66%) of those with OCD had a comorbid psychiatric illness and hence matches our results of about 62.82%.¹ Parmar MC and Shah NP observed 39 (78%) patients having at least one co-morbid DSM-IV-TR psychiatric disorder while as Khandelwal et al report 72% OCD patients having comorbid Axis I disorder.^{3,9} A little lower percentage in our study could be because of the fact that that our study used MINI Plus for the screening of comorbid psychiatric disorders.⁷ MINI Plus does not include disorders like Tic disorders, Trichotillomania, impulse control disorders, Sexual disorders etc. and hence could explain a little lower comorbid percentage in comparison to above mentioned Indian studies as these disorders formed a good number of patients in these studies.

MDD was the most common comorbid disorder in our study with as has been reported in several studies.^{3,10,11} Most studies agree that at least one-third of patients with OCD have concurrent MDD at the time of evaluation which is in accordance with our study finding 46 (29.4%) patients having comorbid MDD at the time of evaluation. Khandelwal et al also reports similar result of 28.78% OCD suffering from MDD at the time of evaluation. Bhattacharya et al report only 16.5% while as Parmar MC and Shah NP¹⁶ report 44% patients suffering from MDD and could be explained by the fact the method of screening used by Bhattacharya et al was electronic OPCRIT system while as sample size in Parmar MC and Shah NP study was small (50 patient only) as compared to sample size in other studies mentioned above.^{3,9} Anxiety disorders were seen in 26.28% (41) patients. 14.74% (23) patients had more than one anxiety disorders. Bhattacharyya et al report 6.9% (15) OCD patients having an any anxiety disorder which is very low as compared to

other studies while as Rahman MH and Kamal AHMKM report 15% and Parmar MC and Shah NP report 30% OCD patients having a comorbid anxiety disorder.^{3,14} All these studies report Anxiety disorders to be second commonest psychiatric comorbidity after depression as found in our study. Our study however contradicts study by Steketee et al who found anxiety disorders to commonest psychiatric comorbidity.¹⁵ Suicidality as characterized in MINI PLUS was found in 22.24%(35) patients, 5.76%(9) patients were past suicide attempters and 88.88%(8) patients had associated depression. Gupta, Avasti et al found 46.1%(60) OCD patients having current Suicidal Ideation and 4.61%(10) patients having history of lifetime suicide attempts. Our results match studies by Gupta, Aavasthi et al from India as well as Mohammadi et al from Iran.^{10,16}

In the Epidemiologic Catchment Area Study, 12.2% of patients with OCD also met criteria for schizophrenia. In our study 7.05% (11) patients also met criteria for schizophrenia.¹ Parmar MC and Shah NP reports 4% OCD patients having psychosis while as Khandelwal et al reports only 1.5% OCD patient having psychotic symptoms.^{1,3} Lower percentage in these Indian studies could be because of the fact that they excluded patients presenting with OC symptoms post development of schizophrenia.

Somatoform disorder included in our study were somatization disorder and Hypochondriasis and formed 7.05% of total OCD patients. Khandelwal et al reports 3% OCD patients suffering from current hypochondriasis while as there was no case of somatization disorder probably because of the small sample size.⁹

Dysthymia was comorbid in 3.21%(5) patients. Bhattacharya et al reports 5.5% patients having dysthymia while as Parmar MC and Shah reports 6% OCD patients having comorbid dysthymia. Thus our results are in accordance most Indian studies.^{3,11} About 5.12% (8) patients had comorbid bipolar disorder. There is paucity of data on Bipolar disorder comorbid with OCD from India and most researchers report isolated case reports thus reflecting less prevalence of this entity as compared to western studies which report much higher percentage. Parmar MC and Shah NP and Khandelwal et al had no case of Bipolar disorder in their study probably because of the fact that they only included patients having primary diagnosis of OCD.^{3,11}

There were 3 patients who were currently using substances other than Nicotine and caffeine. 1.28%(2) patients were using Alcohol and 0.64%(1) was using Cannabis currently. To the best of our knowledge, there is no Indian study on Co morbidity of OCD and substance use disorders. 1% of patients were having co morbid Cannabis use Disorder while as 4% of patients were having co morbid Alcohol use disorder in a study by Mancebo MC et al.¹⁷ Our study is in accordance with the less prevalence of substance use disorders among OCD patients. Less percentage of Alcohol use could be because of the fact because of Kashmir being a Muslim majority state where Alcohol is prohibited.

Limitations of our study included:

Our study sample was subject to the biases of referral

patterns and selection criteria. Patients were recruited from single treatment centre only and from one specialised clinic, so the degree to which the results can be generalised to other cohorts of patients with obsessive compulsive disorder is uncertain.

CONCLUSION

Psychiatric co morbidity in OCD is fairly common. Depression and anxiety disorders are commonest disorders comorbid with OCD.

REFERENCES

1. Karno M, Golding JM, Sorensen SB, and Burnam MA. The prevalence of obsessive-compulsive disorder in five US communities. *Archives of General Psychiatry*. 1988;45:1094–1099.
2. Murray CJ, Lopez AD. *The Global Burden of Disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020*. Cambridge, MA; Harvard School of Public Health, (Global Burden of Disease and Injury Series). 1996;1.
3. Parmar MC and Shah NP. Phenomenology of Obsessive Compulsive Disorder. *Inter Jour Pharma and Med Res*. 2014;2.
4. Government of India, Ministry of Home Affairs, The Census 2011 online results/paper2/data files/J&K/Population and decadal growth.
5. American Psychiatric Association and American Psychiatric Association Task Force on DSM-IV. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IVTR*. Washington DC, USA: American Psychiatric Association; 2000.
6. Kumar N, Shekhar C, Kumar P and Kundu AS. Kuppuswamy's Socioeconomic Status Scale-Updating for 2007. *Indian J Pediatr*. 2007;74.
7. Sheehan DV, Lecrubier Y, Sheehan KH, Amorim P, Janavas J, Weiller E, Hergueta T, Baker R, Dunbar GC et al. The Mini-International Interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry*. 1998;59:22-33.
8. Khanna S, Rajendra PN, Channabasavanna SM. Sociodemographic variable in obsessive-compulsive neurosis in India. *Int J Soc Psychiatry* 1987;32:47-54.
9. Khandelwal A, Aggarwal A, Garg A, Jiloha RC. Gender Differences in Phenomenology of Patients with Obsessive Compulsive Disorder. *Delhi Psychiatry Journal*. 2009;12.
10. Mohammadi MR, Ghanizadeh A, Moini R. Lifetime comorbidity of obsessive-compulsive disorder with psychiatric disorders in a community sample. *Depression and Anxiety*. 2007;24:602-7.
11. Bhattacharyya S, Reddy YCJ, Khanna S. Depressive and Anxiety Disorder Comorbidity in Obsessive Compulsive Disorder. *Psychopathology*. 2005;38:315–319.
12. Ohara K, Suzuki Y. A variable-number-tandem-repeat of the serotonin transporter gene and anxiety disorders. *Progress in Neuropsychopharmacology and Biological Psychiatry*. 1999;23:55-65.
13. Mancebo MC, Garcia AM, Pinto A, et al. Juvenile-Onset OCD: Clinical Features in Children, Adolescents and Adults. *Acta Psychiatrica Scandinavica*. 2008;118:149-159.
14. Rahman MH, Kamal AHMKM. Obsessive Compulsive disorder: A study on clinical phenomenology. *JAFMC Bangladesh*. 2010; 6:2.
15. Steketee G, Eisen J, Dyck I, Warshaw M, Rasmussen S. Predictors of course in obsessive compulsive disorder. *Psychiatry Research*. 1999;89:229–23.
16. Gupta, Avasthi et al. Factors associated with suicidal ideations and suicidal attempts in patients with obsessive compulsive disorder. *Asian Journal of Psychiatry*. 2014; 12:140–146.
17. Mancebo MC, Grant JE, Pinto A, Eisen JL, Rasmussen SA. Substance Use Disorders in an Obsessive Compulsive Disorder Clinical Sample. *Journal of anxiety disorders*. 2009;23:429-435.

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