

Clinico-demographic Profiles in Obsessive Compulsive Disorders

Shakya DR¹

¹Department of Psychiatry, BP Koirala Institute of Health Sciences, Dharan, Nepal.

ABSTRACT

Introduction: Obsessive compulsive disorder (OCD) is one of the most prevalent and debilitating mental illnesses. The present study was conducted to find out the clinico-demographic profiles of Nepalese OCD patients in the local set up.

Methods: We used the criteria of OCD as per the ICD-10: Classification of Mental and Behavioral Disorders' as a diagnostic and 'Yale Brown Obsessive Compulsive Scale' as a rating tool. Patients diagnosed as OCD were included and related information collected with their consent.

Results: Of 60 cases, 39 (65%) were male. The most common age groups were 20-29 (43%) and 30-39 (28%). Most of the subjects were relatively better educated. About half were married. More than half presented after more than five years of onset of illness. Seventy percent had some precipitating stressors. The most common obsessions were doubt (62%) and ruminations (57%); and compulsions checking (35%) and washing (28%). Somatic (28%) and mood symptoms (22%) were other common presenting complaints. About 7% had high suicidal intents. Nearly two thirds presented when they had YBOC Score of severe ranges, mean YBOC score being in the severe range (24).

Conclusions: Most of the OCD patients present late only when severely affected. This indicates need for public awareness program in our set up.

Key Words: *behavioral disorders, compulsion, mental, obsession, obsessive compulsive disorder*

Correspondence:

Dr. Dhana Ratna Shakya
Department of Psychiatry
BPKIHS, Dharan, Nepal.
Email: drdhanashakya@yahoo.com
Phone: 025-525555

INTRODUCTION

Obsessive compulsive disorder (OCD) is characterized by obsessions and or compulsions resulting into anxiety.¹ ³ OCD is the fourth common psychiatric⁴⁻¹⁰ and one of the most disabling medical disorders.^{5,11,12} Its lifetime prevalence is estimated around 2%.^{5-9,13} OCD is a chronic condition with significant morbidity, distress and dysfunction.³ The most common obsessions are fear of contamination, doubts, somatic obsessions and need for symmetry; and most common compulsions checking, washing, counting, need for asking, confessing, symmetry and precision.^{3,13-16} There is often delay in seeking help.⁵⁻ ⁶ The medications with psychotherapy represent the first line of intervention.^{3-12,17}

There is an immense scarcity of information about this common, distressing and disabling disorder in Nepalese context. The objective of the study was to find out socio-demographic characteristics and clinical profiles of OCD patients and to grade obsession and compulsion at the first psychiatric visit.

METHODS

A descriptive prospective study conducted in department of psychiatry, BPKIHS from August 2006 and January 2008. All the patients diagnosed as OCD during the study period were included after their informed consent. The study was approved by the 'Scientific committee' of the institute. The information was kept confidential. Patients refusing to participate in the study were excluded.

The socio-demographic profile and information about the illness (reason for consultation and psychiatric diagnosis) were recorded. The detailed psychiatric work up, necessary investigative procedures and referrals were done. The final psychiatric diagnoses were made according to the International Classification of Diseases-10 (ICD-10) criteria.¹ The obsession, compulsion and related psychopathology were rated with the help of 'Yale-Brown Obsessive Compulsive Scale' (YBOCS).^{18,19} It is a clinician administered semi-structured interview that includes a symptom checklist and a 10-item severity rating scale. In general, clinician's ratings depend on the report of the patient and reliable informants. This instrument was used to assess the severity of the disorder while the patients came to the clinical attention in the department for the first time.

Data were entered into a computer and analyzed using 'Statistical Package for Social Studies' (SPSS) - software.

RESULTS

A total of 60 patients were included in the study. Out

of them, 39 (65%) were male, with male to female ratio of 1.86:1. About half of the subjects (31) were married and half (29) unmarried. Patients of age group (20- 29 year) constituted the largest proportion 26 (43.3%), followed by 30-39 year 17 (28.3%) and 10-19 year 10 (16.7%). Ethnicity distribution included mainly 17 (28.3%) Brahmins, 15 (25%) hilly ethnic groups (Rai, Limbu, Gurung, Tamang), 11 (18.3%) native Terai and Indians and 9 (15%) Newars. Occupational distribution mainly showed students, teachers, home makers and service holders (Table 1).

Table 1. Gender, Marital Status, Age, Ethnicity and Occupation Distributions

Gender	Number (%)
Male	39 (65.0)
Female	21 (35.0)
Marital Status	
Married	31 (51.6)
Single	29 (48.4)
Age (in years)	
10- 19	10 (16.7)
20- 29	26 (43.3)
30- 39	17 (28.3)
40- 49	5 (8.4)
50- 59	2 (3.3)
Ethnic groups	
Brahmins	17 (28.3)
Chhetri	6 (10.0)
Newars	9 (15.0)
Hilly ethnic groups	15 (25.0)
Terai natives/ Indian	11 (18.4)
Disadvantaged groups	2 (3.3)
Occupation distribution	
Students	19 (31.7)
Home making	10 (16.7)
Teachers	9 (15.0)
Service	8 (13.3)
Business	4 (6.6)
Farmers	2 (3.3)
Others- self employed, e.g. parlor	2 (3.3)
Retired	1 (1.7)
Unemployed	5 (8.4)

Hindu patients predominated 52 (86%). Buddhists, Muslims, Christians and Kirat were 2 (3.5%) each. 40% came from urban, 38.3% from semi-urban, and 11.7% from rural setting and 10% from India. Only 2 (3%) were illiterate and majority were relatively better educated. Most cases were brought by family members when severely affected (Table 2).

Table 2. Residential settings, Educational status and Source of Referral

Residential settings	Frequency (%)
Urban	24 (40.0)
Semi-urban	23 (38.3)
Rural	7 (11.7)
India/ other countries	6 (10.0)

Educational Status	
Illiterate	2 (3.3)
Primary (literate-4)	1 (1.7)
Lower secondary (5- 8)	2 (3.3)
Secondary (9- SLC)	23 (38.3)
Certificate	20 (33.3)
Graduate	10 (16.8)
Higher	2 (3.3)

Source of referral	Frequency (%)
Eye/ ENT	3 (5.0)
Medical ward	2 (3.3)
Relative/ friend	4 (6.7)
Self	10 (16.8)
Faith healer- Dhami/ Jhankri	1 (1.7)
Family	40 (66.5)

Majority (72%) had insidious onset and same proportion had continuous course of illness. Vast majority of cases present after more than one year of onset (Table 3). Majority 42 (70%) had stressors precipitating the illness. Relational and study related stressors were among the common ones (Table 4).

Table 3. Onset, Total duration and course of illness

Type of onset	No (%)
Abrupt/ acute/ sudden	17 (28.3)
Insidious	43 (71.7)

Total Duration of Illness (in years)	
< 1	6 (10.0)
1-3	15 (25.0)
4-5	7 (11.6)
6-10	16 (26.7)
> 10	16 (26.7)

Course of illness	
Episodic	17 (28.3)
Continuous	43 (71.7)

Table 4. Types of Stressors*

Stressor type	Frequency (%)
Relational problems	9 (15.0)
Relatives away	4 (6.7)
Death of relatives	5 (8.3)
Ill health of relatives	3 (5.0)
Study related	8 (13.2)
Health related	1 (1.7)
Social	4 (6.7)
Political/ legal	2 (3.3)
Non-compliance	1 (1.7)
Bad news/ misinformation	4 (6.7)
Job related	1 (1.7)

The most common obsessions were doubt, ruminations and fear. Checking and washing were the most common compulsions (Table 5).

Table 5. Presenting complaints*

Complaints	No. of responses (% of total cases)
Obsession- Contamination	9 (15.0)
Doubts	37 (61.6)
Ruminations	34 (56.7)
Images	12 (20.0)
Impulses	2 (3.3)
Sexual/ obscene	10 (16.7)
Religious	2 (3.3)
Fear/ anticipation	18 (30.0)
Diseases/ health	15 (25.0)
Compulsion- Checking	21 (35.0)
Washing	17 (28.3)
Assurances	7 (11.7)
Ask/ confirm	4 (6.7)
Ritualistic	4 (6.7)
Counting	8 (13.3)
Spitting	1 (1.7)
Scratch/ move	1 (1.7)
Grooming	3 (5.0)
Hoarding	2 (3.3)
Behavioral problems	1 (1.7)
Mood	13 (21.7)
Anxiety	11 (18.3)
Speech/ FTD	3 (5.0)
Perceptual/ derealization	4 (6.7)
Unresponsive/ LOC	1 (1.7)
Substance use	3 (5.0)
Self harm/ suicidal	7 (11.7)
Somatic/ physical symptom	17 (28.3)
Tics/ throat clearance	6 (10.0)

Mean of OC scores was (23.7) 24 out of 40. Nearly half of the subjects had both obsessions and compulsions. Only one case had predominance of compulsions. Only about one fourth of the cases (26%) had understanding and realization about signs and symptoms. Total 42% lacked and 30% had partial insights (Table 6).

Table 6. Types of OCD

OCD TYPES	No (%)
Predominantly obsession	30 (50.0)
Predominantly compulsion	1 (1.7)
Mixed	29 (48.3)
With full insight (in YBOCS)	16 (26.7)
With partial insight (2)	18 (30.0)
With poor insight (3- 4)	25 (41.7)

Deliberate self harm was seen in 7%. One patient had scratched till he had deep wound. The most common treatments included Fluoxetine, Clonazepam and psychological interventions (Table 7).

Table 7. Management*

Treatment modality	No (%)
Antipsychotic	4 (6.7)
Benzodiazepines- Clonazepam	51 (85)
Fluoxetine	50 (83.3)
Other SSRIs	5 (8.3)
TCAs	2 (3.3)
Fluvoxamine	3 (5.0)
Clomipramine	3 (5.0)
Other symptomatic	3 (5.0)
Thyroid supplementation	3 (5.0)
Sodium valproate	2 (3.3)
Counseling/ psycho-education	50 (83.3)
ECT	1 (1.7)

*Multiple response category - One respondent may have one or more responses.

DISCUSSION

Even though the great magnitude and associated disability are more or less similar worldwide,^{5,17,20} there is a lack of study and data about OCD in Nepal. The present study is expected to open avenues for further larger studies. Though literature supports its similarity regarding prevalence, socio-demographic characteristics and clinical profiles across the countries,^{5,17,20} it merits confirming in Nepalese context.

Obsessions and or compulsions are main manifestations of obsessive compulsive disorder.¹⁻³ Obsessions are repetitive, stereotypical, intrusive, ego-dystonic; patient's own ideas, images, impulses, feelings and sensations.¹⁻

⁶ Compulsions are conscious, standard, stereotyped, repetitive, ego-dystonic ritualistic behaviors; patients usually carry out in an attempt to relieve obsession-associated-anxiety. Though compulsive acts may transiently reduce anxiety; it either comes again, increases or even worsens on resisting carrying out compulsions.¹⁻

⁶ Besides OCD, a wide range of obsessive compulsive

spectrum disorders (OCD; neurological- tics, Tourette; somatoform) and even schizophrenia may have obsessions or compulsions as a part of clinical picture.^{1,4-6}

This hospital based study incorporated 60 OCD patients coming into the contact with the investigator during the study period. It utilized the criteria of the ICD-10 to diagnose¹ and the YBOCS to rate the severity of OCD,^{18,19} both the tools being administered by a clinician and widely validated across the world.

Its onset is generally in late adolescence or young adulthood in western literature.^{5,17} Like other studies,^{5,14,17} this study also found the people of productive ages to be the most affected. Even though studies showed similar sex distribution,^{1,5,14,20} the male preponderance in the present study may be because of better awareness and status of males. Single persons are more affected than married persons, probably reflecting the difficulty maintaining relationship of OCD persons.⁵ Contrary to it, there was almost equal number of single and married subjects in this subject. It might indicate that because of a great severity of illness, those with the family support had come into a clinical attention. Though it needs further confirmation, it might also point towards a greater tolerance on part of the couples in Nepal. The relatively better education of the subjects is consistent with the findings in other parts of the world.⁵

The ethnicity distribution of this study reflects more or less the population distribution of this region of Nepal. The meager figure of the disadvantaged groups- Dalits of utilizing the service is probably because of their backwardness, poverty and ignorance. Under-diagnosis and under-treatment is frequent worldwide.^{3,12,17} Cost per OCD patient for ineffective treatments because of misdiagnosis is significantly higher than that for appropriate treatment.^{12,17} So, timely identification and treatment is important. Unfortunately as in other parts of the world, most of the cases were brought by family members or they came on their own to clinical attention only when the symptoms were severe. The mean YBOC Score at the time of first visit to a psychiatrist was 23.7, in the range of severe grade. They presented late to medical services as elsewhere.^{5,6,17} More had insidious onset of illness in comparison to western data showing relatively more sudden onset.⁶ Majority had continuous course and as in others, had precipitating stressors.⁶

Similar as in other studies, the most common obsessions of the Nepalese OCD patients were doubts, ruminations and fear. Checking and washing were the most common compulsions.^{3,13-16} Most OCD patients acknowledge their behavior to be excessive but some are convinced that obsessions and compulsions are reasonable.²¹ DSM-IV has a separate specifier for this- 'With poor insight'.^{2,4}

Three fourths had impaired insight at the time of presentation (Insight grading: 2- 4 in YBOCS) in this study which is more than in field trial study (one third with poor insight).²¹ It may be because the present study was hospital based and was carried out in clinical subjects requiring help and coming into the contact of psychiatric service when symptoms were severe.

The majority usually have multiple obsessions and compulsions during the course of illness, with a particular fear or concern dominating clinical picture at any one time. The 'International Classification of Disease and Infirmary', tenth edition (ICD-10) categorizes it into five categories- predominantly obsessional thoughts/ruminations, predominantly compulsive acts, mixed obsessional thoughts and acts, other obsessive compulsive disorders and obsessive compulsive disorder, unspecified.¹ Up to 75% of OCD patients have both obsessions and compulsions.⁴ In this study too, many subjects had both obsessions and compulsions.

Suicide phenomena were relatively more in OCD patients in this study.⁶ The high rate may be because of the high co-morbidity and severe grading of YBOCS at the time of presentation. The suicide problem in this region needs validation with further community based studies. Discovery of effective drugs (in 80s) revolutionized treatment outlook. OCD responds selectively to SSRIs and Clomipramine. The medications with psychotherapy,

mainly 'Cognitive behavioral therapy' (CBT) and 'exposure and response prevention' represent the first line of intervention.^{3-12,17}

As in other parts of the world, the Nepalese clinicians rely more on Fluoxetine at first, then change to Clomipramine or fluvoxamine or other SSRIs in need, and augment with atypical anti-psychotics. Some forms of psychological interventions are complimentary to drug therapy.³

CONCLUSIONS

People of productive ages were the most affected by obsessive compulsive disorder. The most common obsessions were doubts, ruminations and fear. Checking and washing were the most common compulsions. These patients approach psychiatric service late only when they are severely affected. A well designed public health awareness program is must.

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