

## Comorbidities in Nepalese psychiatry out-patients with Obsessive Compulsive Disorder

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### Abstract

**Introduction:** Obsessive compulsive disorder (OCD) is among the most prevalent and debilitating mental illnesses. Associated physical and psychiatric comorbidities further complicate its outlook. The present study was conducted to sort out psychiatric and major physical comorbidities among Nepalese OCD patients presenting to a psychiatric out-patient service.

**Material And Method:** We used the 'ICD-10: Classification of Mental and Behavioral Disorders' for diagnosis and the 'Yale Brown Obsessive Compulsive Scale' (YBOC) for rating OCD symptoms. Psychiatric comorbidity diagnoses were made as per the ICD-10 and physical diagnoses according to the departments from or to where subjects were referred.

**Results:** Of total, 45 (60%) were male. The most commonly affected age groups were 20-29 (39%) and 30-39 (32%). More than half subjects presented after more than five years of illness. Thirteen percent subjects had suicidal intents. Nearly two third subjects had presented with the YBOC score of severe range. Forty percent subjects reported past history and 55% family history of significant illness. One fourth revealed substance use and assessment indicated premorbid cluster C traits/ problems among nearly 45%. Nineteen percent had physical and 63% comorbid psychiatric disorders. Mood, mainly depressive and other anxiety disorders were the most common ones.

**Conclusion:** Many of Nepalese OCD patients present late to psychiatric service when they are severely affected and have other comorbidities. Depressive and other anxiety disorders are the most common psychiatric comorbidities.

**Keywords:** Comorbid illness, Obsessive compulsive disorder, Physical disease, Psychiatric disorders

### INTRODUCTION

Obsessive compulsive disorder (OCD) manifests with obsessions and or compulsions resulting into anxiety.<sup>1-4</sup> OCD is reported as one of the common psychiatric<sup>5-10</sup> and one of the most disabling medical disorders.<sup>5,11,12</sup> Its lifetime prevalence is estimated around 2%.<sup>5-8,10-12</sup> OCD is a chronic condition with significant morbidity, distress and dysfunction.<sup>3,4,13</sup> Comorbidities, which are common further complicate its outcome.<sup>3,4,13,15,16</sup> Depression and other anxiety are common as its co-morbid psychiatric disorders.<sup>3,10,13,15,16</sup> There is often delay in seeking help.<sup>3,5,17</sup> The disorder has been associated with high family history of psychiatric

illness and other components of obsessive compulsive spectrum disorders.<sup>4,18</sup>

There is a paucity of information about this distressing and disabling disorder and associated comorbidity in Nepalese context. The objective of the study was to find out prevalence of comorbid psychiatric and major physical illness and to sort out common comorbid psychiatric disorders among Nepalese OCD patients presenting to a psychiatric out-patient service.

**MATERIAL AND METHOD**

This descriptive study was conducted in the department of psychiatry of a health science teaching institute in eastern Nepal during study period of two years (August 2006 - September 2008). All the patients with OC symptoms and diagnosed as OCD coming in the contact of the investigator during the study period were included after their informed consent. The information was kept confidential. Patients who refused to participate in the study and could not provide required data due to clinical conditions or disability like deafness or dumbness 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 judged to be required as per clinical assessment for the management were done (with consideration of other factors like affordability of the clients). The final psychiatric diagnoses were made according to the International Classification of Diseases-10 (ICD-10) criteria.<sup>1</sup> The obsession, compulsion and related psychopathology were rated with the help of the 'Yale- Brown Obsessive Compulsive Scale' (YBOCS).<sup>19,20</sup> 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. The physical diagnosis was as per the department from which or to where the patient was referred.

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

**RESULT**

A total of 75 patients were enrolled in the study, with 45 (60%) male subjects (male to female ratio of 1.5:1). Most patients belonged to the age groups (year): (20- 29) with 29 (38.67%) subjects, (30- 39) 24 (32.00%) and (10- 19) 14 (18.67%). Subjects were mainly from the ethnic groups of: hill ethnic groups (Rai, Limbu, Gurung, Tamang) 22 (29.33%), Brahmins 20 (26.67%),

Newars 12 (16.00%) and native Terai and Indians 11 (14.67%). Only 3 (4%) were illiterate and majority were relatively better educated. (Table 1)

**Table 1: Gender, Age, Ethnicity and Educational status Distributions**

Gender	Number (%)
Male	45 (60.00)
Female	30 (40.00)
<b>Age (in years)</b>	
10-19	14 (18.67)
20-29	29 (38.67)
30-39	24 (32.00)
40-49	6 (8.00)
50-59	2 (2.67)
<b>Ethnic groups</b>	
Brahmins	20 (26.67)
Chhetri	7 (9.33)
Newars	12 (16.00)
Hilly Ethnic Groups	22 (29.33)
Terai natives/Indian	11 (14.67)
Disadvantaged groups	3 (4.00)
<b>Educational Status</b>	
Illiterate	3 (4.00)
Primary (Literate-4)	3 (4.00)
Lower secondary (5- 8)	5 (6.67)
Secondary (9- SLC)	28 (37.33)
Certificate	21 (28.00)
Graduate	13 (17.33)
Higher	2 (2.67)

Most cases were brought by family members long after the onset of illness (average 6.56 years of illness). (Table 2)

**Table 2: Source Of referral and Total Duration**

Source of referral	Frequency (%)
Faith/ alternative healer	2 (2.67)
Eye/ ENT	3 (4.00)
Medicine and family medicine	5 (6.67)
Relative/ friend	6 (8.00)
Self	17 (22.67)
Family	42 (56.00)
<b>Total Duration of Illness (Yrs)</b>	
<1	6 (8.00)
1-3	19 (25.33)
4-5	11 (14.67)
6-10	21 (28.00)
>10	18 (24.00)

The most common obsessions were doubt, ruminations and fear. Checking and washing were the most common compulsions. Mean of YBOC scores was 26 out of 40. Physical/somatic, anxiety and mood symptoms were other presenting complaints. (Table 3)

**Table 3: Table showing the Presenting Complaints Of the subjects**

Complaints	No. of responses (% of total cases)
<b>Obsession-</b> Contamination	10 (13.33)
Doubts	49 (65.33)
Ruminations	47 (62.67)
Images	15 (20.0)
Impulses	4 (5.33)
Sexual/ obscene	11 (14.67)
Religious	3 (4.00)
Fear/ anticipation	28 (37.33)
Diseases/ health	23 (30.67)
<b>Compulsion-</b> Checking	28 (37.33)
Washing	22 (29.33)
Assurances	11 (14.67)
Ask/ confirm	5 (6.67)
Ritualistic	4 (5.33)
Counting	9 (12.00)
Spitting	1 (1.33)
Scratch/ move	2 (2.67)
Grooming	3 (4.00)
Hoarding	2 (2.67)
Behavioral problems	5 (6.67)
Mood	19 (25.33)
Anxiety	22 (29.33)
Speech/ FTD	6 (8.00)
Perceptual/ derealization	5 (6.67)
Unresponsive/ LOC	2 (2.67)
Substance use	4 (5.33)
Self harm/ suicidal tendency	10 (13.33)
Somatic/ physical symptom	24 (32.00)
Tics/ throat clearance	8 (10.67)

In the past, 43% had illness, including 39% with psychiatric illness which also included anxiety and OCD. (Table 4)

**Table 4: Past History of Psychiatric/Physical Illness**

Illness in past	Frequency (%)
Present	32 (42.67)
Absent	43 (57.33)
OCD	7 (9.33)
Other anxiety	5 (6.67)
Panic disorder	4 (5.33)
Neurological	3 (4.00)
Psychiatric (including anxiety/OCD)	29 (38.67)
Depression	16 (21.33)
BPAD	2 (2.67)
Schizophrenia	1 (1.33)
Dissociative	1 (1.33)
Other	1 (1.33)
Other medical diseases	2 (2.67)

More than half subjects revealed close relatives to suffer from some significant illness, including 33% with psychiatric disorders. (Table 5)

**Table 5: Family History Of Illness**

Illness in family	Frequency (%)
Absent	33 (44.00)
OC spectrum	25 (33.33)
OCD	5 (6.67)
Tics	8 (10.67)
Throat clearance	2 (2.67)
OC traits	3 (4.00)
Neurological	2 (2.67)
Psychiatric	25 (33.33)
Substance use disorder	1 (1.33)
Schizophrenia	1 (1.33)
Depression	10 (13.33)
BPAD	2 (2.67)
Anxiety including OCD	9 (12.00)
Dissociative	2 (2.67)
General medical diseases	2 (2.67)

**Table 6: Psychoactive Substance Use**

Substance used	No. of cases (%)
Absent	55 (73.33)
Present	20 (26.67)
Alcohol	10 (13.33)
Nicotine	10 (13.33)
Opioides	1 (1.33)
Cannabiz	3 (4.00)
Benzidiazepines	1 (1.33)

**Table 7: Premorbid Personality/Temperament Problems**

Personality traits	No. of cases (%)
Well adjusted	34 (45.33)
Cluster 'A' traits/ problems	5 (6.67)
Cluster 'B' traits/ problems	1 (1.33)
Cluster 'C' traits/ problems	35 (46.67)
OC traits	17 (22.67)

**Table 8: Physical Diseases**

ICD code	Physical diseases	No. (%)
	Present	14 (18.67)
	Absent	61 (81.33)
E00-E90	Endocrine, nutritional & Metabolic (thyroid/DM)	3 (4.00)
G00-G99	CNS- Neurological / primary headaches	3 (4.00)
H00-H59	Eye	1 (1.33)
H60-95	ENT	1 (1.33)
I00-I99	Circulatory/ Cardio-vascular	1 (1.33)
K00-K93	Digestive/ Gastro-intestinal	2 (2.67)
L00-L99	Skin diseases	1 (1.33)
X60- X84	Intentional/ Deliberate self harm, suicide attempts	10 (13.33)
	Surgical	1 (1.33)

**Table 9: Psychiatric Comorbidity Diagnosis**

ICD code	Psychiatric comorbid diagnosis	No. (%)
	Present	47 (62.67)
	Absent	28 (37.33)
F 0- 09	Organic, including symptomatic	1 (1.33)
F 10- 19	Psychoactive substance use	2 (2.67)
F 20- 29	Schizophrenia, schizotypal & delusional	4 (5.33)
F 30- 39	Mood (affective)	23 (30.67)
F 30- 34 F 38, 39	Manic episode, Bipolar affective	1 (1.33)
	Depressive illness	21 (28.00)
	Others	1 (1.33)
F 40- 45	Phobic, other anxiety (besides OCD)	7 (9.33)
	Stress related/ adjustment	6 (8.00)
	Dissociative (conversion)	1 (1.33)
	Somatoform/ hypochondriasis	4 (5.33)
F 50- 59	Physiological/ physical factors/ Dhat syndrome	2 (2.67)
F 90- 98	Childhood and adolescence onset/ conduct	2 (2.67)
X 60- X 84	Deliberate self harm/ suicide attempts	10 (13.33)

One fourth of total patients were found to ab/use substances, mainly alcohol and nicotine. (Table 6)

Cluster C traits/problems, including anancastic or obsessive compulsive traits/personality disorders were found the most common in clinical assessment. (Table 7)

Nearly one fifth had some significant diagnosable physical illness. (Table 8)

Sixty three percent had psychiatric comorbidity, the most common diagnoses being: mood mainly depression and stress, anxiety and other neurotic disorders. (Table 9)

**DISCUSSION:**

There is a dearth of data about OCD from Nepal.<sup>21</sup> This study anticipates to pave way to further studies. Literature reveals a high psychiatric comorbidity among OCD patients across the countries.<sup>10,15,16</sup> This disorder has been reported in some psychiatry morbidity profile studies in different set-ups from BPKIHS<sup>22-25</sup> but to our knowledge, there is no report about psychiatric comorbidity in OCD patients from Nepalese context.

The current study was carried out in psychiatry out-patient department of the teaching hospital in eastern Nepal and incorporated 75 OCD patients coming into the contact of the investigator during the study period. The criteria of the ICD-10 was used to diagnose<sup>1</sup> and the YBOCS to rate the severity of OCD symptoms<sup>19,20</sup>, both the tools being administered by a clinician and widely validated across the world.

More studies reveal female preponderance of OCD in community<sup>7,10,13</sup> and some similar gender distribution.<sup>5,17</sup> Male preponderance of this hospital based study indicates some of the possibilities: either many female patients are not seeking help from psychiatric service for various reasons or it is more prevalent among Nepalese males. It needs community based study to confirm. The caste/ ethnicity distribution of current study is more or less reflective of the population distribution in this region of Nepal. The small number of the subjects from disadvantaged groups/ Dalits utilizing the

service indicates the likelihood of their backwardness, poverty and ignorance which is also observed in other studies from same institute.<sup>21-24</sup> Education plays a great role in help seeking and service centre based studies show higher education among OCD patients. The relatively better education of the subjects is consistent with the findings in other parts of the world.<sup>5</sup> The community based studies reveal different finding.<sup>7,10</sup>

Consistent with the age of onset in late adolescence or young adulthood<sup>5,7</sup> and late presentation to medical services in western literature<sup>5,26</sup>, the subjects of productive ages were predominating in this study. The average period of treatment delay after the onset of illness was 6.56 years here. Some of the patients presented immediately after the initiation of symptoms since the service was available nearby and they came to know about the problem and the service through different means. Many patients presented late; with the maximum delay of 18 years. Timely and appropriate management reduces the economical burden per OCD patient.<sup>26,27</sup> But like in other countries, most of the cases were brought by their family members or they came on their own to clinical attention late only when the symptoms were severe and they had other comorbid conditions such as depression. The mean YBOC score at the time of first visit to a psychiatrist was 26, in the range of severe grade. This is possibly because it was a hospital-based study carried out in clinical subjects requiring help and coming into the contact of psychiatric service. Similar presentations and severity of OCD were seen in other parts as well.<sup>13,16</sup>

The most common obsessions of the Nepalese OCD patients were doubts, ruminations and fear. Checking and washing were the most common compulsions. This was similar in the preliminary profile study of OCD from the same institute<sup>21</sup> and findings of other parts.<sup>4,17</sup> At psychiatric consultations, physical or somatic complaints such as disturbances of sleep, appetite, aches; anxiety and mood symptoms were other common presenting complaints. As elaborately discussed by Roberts AR et al (2003)<sup>16</sup>, our observations were nearly similar regarding varied presentations of OCD patients mainly showing depression, anxiety and

substance ab/use. Though substance use was not among common presenting complaints and current psychiatric diagnoses, it was revealed upon the assessment in slightly more than one fourth of the total subjects to affect the clinical course of these patients. Alcohol and nicotine are common substances here<sup>23</sup>, with some patients using benzodiazepines in this observation. Benzodiazepines were used to alleviate distress of anxiety upon other's advice. The lifetime prevalence of other psychiatric illness among OCD patients are reported high in community<sup>7,12,13</sup> and higher in clinical settings. So, many OCD patients reveal mental illness. In current study, 43% had significant illness in the past, including 39% with psychiatric illness which included anxiety and OCD too. Since in psychiatric comorbidity, we included current comorbid diagnoses only, the lifetime prevalence will be higher than the current psychiatric comorbidity rate. In the past too, depression was reported the most.

OCD is associated with high genetic contribution in many respects.<sup>5,17,18</sup> More than half subjects revealed close relatives to suffer from some significant illness, including 33% with psychiatric disorders. About one thirds of the subjects reveal OC spectrum traits/problems (OC symptoms, traits, tics, throat clearing) in their family, including 7% with frank OCD. This finding supports the high familial association of psychiatric morbidity, including OC spectrum problems.<sup>18</sup>

Till now, no conclusive remark can be made about the relationship between particular personality aspects (traits/disorders/temperaments) and OCD though some findings indicate some associations.<sup>15,18</sup> The over all rate ranging between 36 and 75% of comorbid Axis II disorders was true for this study with 55%.<sup>15</sup> The high proportion of OCD patients with cluster C, mainly anancastic, anxious and avoidant traits/ personality disorders severe enough to affect the clinical course in this study is indicative of possible relationship between personality and OCD.<sup>15,18</sup>

Nearly one fifth of the OCD out-patients had some significant diagnosable physical illness/problems in this study. The diagnoses were recorded as per the diagnoses of other consulted departments. OC symptoms have been reported

with particular neurological and general medical conditions. We had neurological diagnoses, thyroid abnormalities and the physical effects of deliberate self harm attempts as the main physical comorbidities. Suicide phenomena were relatively more (13%) in OCD patients in this study.<sup>5</sup> The higher rate is possibly because of high co-morbidity and severe grading of YBOCS at the psychiatry consultation.

Psychiatric diagnoses besides OCD at the time of assessment/enrollment were analysed as current psychiatric comorbidity. Psychiatric diagnoses that could be established upon assessment in the past, that were currently remitted and that had no relation with current diagnostic entity were included in the past illness. In this way, 63% of the OCD patients seeking psychiatric OPD service had current psychiatric comorbidity, the finding is keeping with most of the studies.<sup>7,10,13,15</sup> Since this study was carried out in a clinical setting, it is likely to reveal even higher lifetime prevalence. Among the most common current comorbid psychiatric diagnoses were: mood (in 30.67%) mainly depression (28%) and stress, anxiety and other neurotic disorders mainly other anxiety and stress related disorders. This diagnostic profile with preponderance of depression and anxiety/neurotic disorders were seen in most of studies looking into comorbidity of OCD.<sup>7,10,13,15</sup> This finding highlights the great need of clinical alertness regarding psychiatric comorbidity among OCD patients for recognition and management with holistic approach.<sup>4,13,16</sup>

Current study is based on single study site of clinical setting and our diagnoses were based on clinical information and hence its findings should be viewed with these considerations. We recommend further in-depth, community based and multicenter studies.

#### CONCLUSION:

The most common obsessions among Nepalese OCD patients 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 and develop other psychiatric comorbidities. About 3 out of 5 OCD patients had other psychiatric illness when present to psychiatric service. The most common

psychiatric comorbidities were depression and anxiety. Hence, clinical suspicion for comorbidity should be high while managing a case of OCD.

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