Original Articles :

Phenomenology of Obsessive Compulsive Disorder in Eastern India

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ABSTRACT :

Background : The present study focuses on the symptoms and signs of Obsessive Compulsive Disorder as per DSM IV (APA 1994) and ICD 10 (WHO, 1992)[2], were studied by administering Y-BOCS symptom checklist (Goodman, 1989), Kneeding out types of obsessions and compulsions and their sub-types. The presence of depression and suicidal ideas were assessed by administering HAM-D (Hamilton, 1960)[3], Results: The patients diagnosed as OCD are not a single nosological entity. Each patient must be differentially diagnosed.

Keyword: OCD

INTRODUCTION:

Obsessive compulsive disorder is a chronic and potentially disabling condition affecting from 1% to 3%of general population.(James et.al.,2001) The DSM IV (APA, 1994) and ICD-10(WHO, 1992), regard OCD as unitary nosological entity. It may be misleading. The symptoms that define OCD are heterogeneous and it includes various intrusive thoughts and preoccupation, ritual and compulsion. Inevitably, in the beginning, the clinician is struck by the diversity of the clinical presentations of OCD. This initial impression, however, is soon replaced by the realization that the number of types of obsessions and compulsions are remarkably limited and stereotypic. OCD patients rarely have only one or two symptoms- multiple obsessions and compulsions are the rule although an individual's symptoms present at a given time exhibit certain understandable patterns. There are three common clinical presentations: washers, checkers and pure obsessional. Washing and checking alone or in combination constitute more than half the OCD phenomenon cluster. The patients are mostly treated as outpatients'. In-patient treatment are sought when reluctantly by the family members and when the reasons are too compelling .We have tried in this study to delineate types of obsessions and compulsions in the patient attending OPD in a tertiary referral centre of the eastern India and tried to find out disease factors, particularly the psychotic features and severe depression in the OCD patients ,who need inpatient treatment.

MATERIAL & METHODS:

This study was carried in Central Institute of Psychiatry, Kanke ,Ranchi which is a 643 bedded tertiary referral centre and caters the need of larger part of eastern India. The patient registered in the OPD are subjected to detailed work-up and the findings are then discussed with the consultant and the final diagnosis is made as per International Classification of Disease (ICD-10) criteria For this study, the case records of all out patients who were diagnosed as OCD in previous 6 months (from July 2009 to December 2009) and patients admitted or readmitted with diagnosis of OCD in last two years was reviewed. The socio-demographic and clinical details, along with the diagnoses of OCD or other co-morbid psychiatric condition were recorded on a specially designed form. Of the 72 cases,9 cases with primary diagnosis of schizophrenia,3 cases of Bipolar affective disorder and 2 cases of co-morbid recurrent depressive episode were dropped from further evaluation. The diagnoses were independently reviewed by at least two researchers and, only when there was a consensus, a final diagnosis was assigned as per ICD-10.The symptoms of OCD were evaluated with the help of Y-BOCS symptom checklist(Goodman,1989): type of obsession, type of compulsion, subtype; i.e. washer, checker, pure obsessions or primary obsessional slowness. The presence or absence of depression and suicidal ideas were assessed by administering HAM-D (Hamilton,1960).[3]

RESULT: The total number of patients in the sample were 58 (29 male, 29 females), mean age was 30.02±8.73 (SD), and mean duration of symptoms at the time of consultation at the centre was 5 years±4.29 (SD).

Table:1: Phenomenology of obsessions

OBSESSIONS	Total	MALE	FEMALE
Contamination	44(75.9%)	22(37.9%)	22(37.9%)
Pathological doubt	28 (48.3%)	17(29.3%)	11 (19%)
Aggressive	06(10.3%)	03(05.3%)	03(05.3%)
Sexual	08 (13.8%)	05 (09.7%)	03 (5.1%)
Religious	07 (12.5%)	03 (5.1%)	04(06.4%)
Hoarding	01(1.7%)	01(1.7%)	0 (0%)
Need for symmetry	12(20.6%)	09(15.5%)	03(5.1%)
Other	3 (5.3%)	2(3.4%)	1(1.7%)

Table:2: Phenomenology of compulsions

COMPULSIONS	Total	MALE	FEMALE
Cleaning washing	41(70.6%)	18(30.9%)	23(29.6%)
Checking	18 (30.9%)	12(24.6%)	06 (10.3%)
Repeating rituals	03(5.1%)	02(3.4%)	01 (1.7%)
Hoarding collecting	01(1.7%)	01(1.7%)	01(1.7%)
Ordering/arranging	12(20.6%)	08(13.8%)	04(6.4%)

Table:3: Obsession and compulsions in different genders

PREDOMINANT SUBTYPES	Total (N)	Male	Female	Male G(%)VG	FEMALE %F female (%)
Washer	34	12	22	35.29 %	64.71%
Checkers	13	08	05	61.54%	38.46%
Pure Obsessions	13	10	03	76.92%	23.08%
Washer +Checkers	12	08	04	66.67%	33.33%

Table:4: Depression & suicidal ideas in patients with OCD

DEPRESSION	OPD(N=35)	INPATIENT(N=23)	SIGNIGICANCE AT .05%
MILD	2	1	
MODERATE	6	5	
SEVERE	4	7	
SUICIDAL	5	09	* significant

DISCUSSION:

ICD-10 does not actually state how to make the judgment that the obsession/compulsion are not result of, for example, mood disorders or schizophrenia.(Nolfe et.al.,2010) Apart from this ,obsessional symptoms are not uncommon in schizophrenia and a result of treatment with second generation antipsychotic, specially clozapine and olanzapine (Hann et.al.,2002).Obsessive symptoms may be predominant in cases of depressive disorders and depressive phase of Bipolar affective disorders. (Kelly et.al.,2010).We are of the opinion that although they constitute an entity of OCD spectrum disorder, they need to be studied separately.

This study delineates the following findings:

1. Obsessions were multiple .Common obsessions were contamination and dirt (75.9%) and pathological doubts (48.3%)

2. Common compulsions were washing and cleaning(70%),followed by checking(31%) and ordering and arrangement(20.6%)

3. The common subtypes were washer(70.6%), checker(20.6%) and primary obsessional (22.4%). Insel and Arkiskal suggested 4 common presentations of OCD-washers, checkers and pure obsessionals and primary obsessive slowness. We have not found any primary obsessive slowness. Amitabh Saha and Sumeet Gupta studied phenomenology of OCD with a cross-cultural perspective. 40 patients of OCD (as per ICD- 10) were studied using YBOC checklist. The common obsessions noticed were contamination (52%) and aggression (32.5%). Washing (57.5%) and checking (42.5%) rituals were the common compulsions . In our cases,with similar methodology, we have found contamination (75.9%) and pathological doubts (48.3%) were common obsession .Aggressive obsession was found in 10.6% only. Washing and cleaning was found in 70.6 %, followed by checking (31.1%) and orderliness and arrangement. This data is comparable to other studies carried in other parts of India (Girish Chandra et.al,2001 ;Jaisoorya et.al,2003). Depressive symptoms were common accompaniment, and the patients who are admitted were more depressed and had significantly more suicidal ideas.

LIMITATION:

This study suffers from all the deficit of retrospective chart study. Severity of OCD was not assessed which may have important role of inpatient treatment. Assessment for form

and content with Scale for Form and content (SAFC) would have delineated a better phenomenology, but, the chart data were not enough to apply this scale.

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