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Research Article

OCCURRENCE OF OBSESSIVE-COMPULSIVE SYMPTOMS AMONG PATIENTS OF ANXIETY AND DEPRESSION

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A B S T R A C T

Both anxiety disorders (AD) and depressive disorders (DD) are clinically heterogeneous, and substantial differences in clinical presentation and course occur between individual patients. Clinical practice would benefit from specifies that distinguish between mild disorders with favorable course trajectories and severe disorders with unfavorable course trajectories. Co morbidity in both anxiety and depressive disorders is observed in many patients while diagnosing. Many patients were observed to have some of the characteristic symptoms of Obsessive Compulsive Disorder (OCD) present in patients suffering from anxiety and depressive disorders. The current study focuses on studying the co morbidity of OCD among the patients of Anxiety and depression. A total of 70 patients of (35 with anxiety disorder and 35 depressive disorders) were included in this study. HARS, HDRS and YBOCS were applied in all the patients who fulfilled the selection criteria. It was found that, approximately 28.5% of the total sample selected of anxiety disorder had severe OCD symptoms and 14.3% had extreme OCD symptoms. Furthermore, around 17.1% patients of depressive disorder were found to have severe OCD symptoms whereas 8.5% were found to have extreme co morbidity of OCD. Therefore, it was concluded that intervention techniques for OCD should also be combined with the treatment and intervention of AD and DD in order to assist in rapid recovery of the patient.

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(Abramowitz, *et al*., 2009). According to a review on the epidemiological studies reporting OCD related data, the 1-month prevalence of OC Dranges from 0.3 to 3.1% of the general population (Fontenelle *et al*., 2006). Importantly, OCD frequently results in significant costs and reduced quality of life for those affected and their families (DuPont *et al*., 1995). 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(Collins *et al*., 2011).

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Both anxiety and depressive disorders are clinically heterogeneous, and substantial differences in clinical presentation and course occur between individual patients.

Clinical practice would benefit from specifies that distinguish between mild disorders with favorable course trajectories and severe disorders with unfavorable course trajectories. Co morbidity between anxiety and depressive disorders is associated with higher illness severity, impaired functioning, unfavorable course, and poorer treatment outcome (Rush, *et al*., 2005). Likewise, the combination of 2 anxiety disorders in an individual is associated with higher severity and chronicity compared with single anxiety disorders (Hofmeijer- Sevink, *et al*., 2012). Further, in obsessive-compulsive disorder(OCD), co morbidity with anxiety and/or depressive disorders is associated with higher symptom severity, chronicity, and negative consequences in daily life (Bruce, *et al*., 2005). Even co morbid symptoms that by themselves do not reach a threshold to be considered a disorder may have an unfavorable impact on the course of the other disorders that they accompany. The most explicit example is panic attacks.

Based on their negative impact on a variety of disorders, panic attacks are included as a specifier in the fifth edition of the

Diagnostic Manual of Mental Disorders (DSM-5) to alert clinicians to unfavorable outcomes.

METHODOLOGY

Setting and Sample Size

Patients attending outpatient section of Department of Psychiatry, Pacific Institute of Medical Sciences, Udaipur, Rajasthan, India, were screened to include in this cross-sectional study. Those diagnosed to be suffering from anxiety and depressive disorder by ICD-10 DCR, with duration of illness of minimum two years without any exacerbation or hospitalization, and accompanied with a primary care giver were assessed further. All patients with co-morbid medical and psychiatric illness, likely to contribute in disability, were excluded. Informed consent was taken from the primary care giver. The target was to include about 35 consecutive patients for each illness. HARS, HDRS and YBOCS were applied in all the patients who fulfilled the selection criteria. A total of 70 patients of (35 with anxiety disorder and 35 depressive disorders) were included in this study. The consecutive and purposive sampling method was used to select the study subjects.

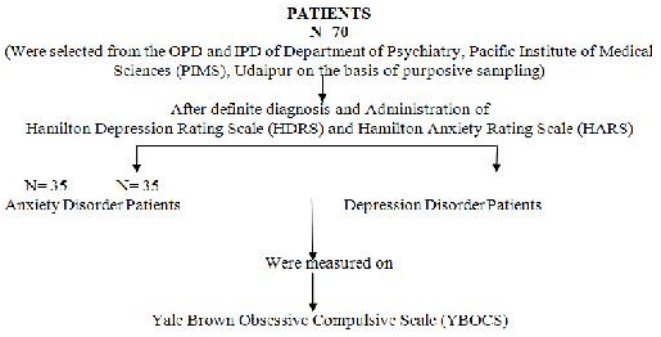
Inclusion and Exclusion Criteria

All the subjects between 18-45 years age group with duration of at least two years illness of OCD (as OCD has bimodal onset with late adolescent and adult onset of illness, the subjects were recruited in the above age group) and DD (as it may be early onset i.e., before 21 years and late onset i.e., after 21 years) period were included in the study. Patients having co-morbid organic brain syndromes, psychosis, bipolar affective disorder, maniac depressive disorder, alcohol and substance dependence, personality, disorder and mental retardation, patients having a concomitant chronic physical illness, past history of psychiatric illness and family history of psychiatric illness were excluded from the study.

Ethical Clearance

The study was approved by the Ethical Committee of the medical institution. Informed consent was obtained after explaining the study details to the subjects. This part of the study presented the comparison of mental disability in AD, DD and OCD.

Study Design



Tools

- Diagnostic and Statistical Manual for mental disorders (DSM V-TR) criteria for OCD, AD and DD (APA, 2013)
- Yale Brown Obsessive Compulsive Scale (Y-BOCS) (Woody *et al*., 1995)
- Hamilton Depression Rating Scale (HAM-D) (Hamilton, 1960)
- Hamilton Anxiety Rating Scale (HARS) (Hamilton, 1959)

RESULTS

Table 1 Showing sample distribution of patients suffering from depression (DD) and anxiety disorders (AD).

S.NO.	Category	Disorder				Total
		AD (N=35)		DD (N=35)		
		FREQ	%	FREQ	%	
1.	Age (20-30 yrs)	20	28.5%	20	28.5%	40
2.	Age (30-40 yrs)	15	21.4%	15	21.4%	30
3.	DOI (1-2yr)	10	14.2%	10	14.2%	20
4.	DOI (2-3yr)	25	35.7%	25	35.7%	50

Table 2 Indicating percentage of depressive and anxiety patients suffering from high, medium and low level co morbidity of Obsessive Compulsive Symptoms (OCS).

CLASS	YBOCS		
	Category	Frequency	Percentage
Anxiety Disorder (N=35)	Extreme	5	14.3%
	Severe	10	28.5%
	Moderate	13	35%
	Mild	7	20%
	Sub Clinical	0	0%
	Category	Frequency	Percentage
Depressive Disorder (N=35)	Extreme	3	8.5%
	Severe	6	17.1%
	Moderate	17	48.5%
	Mild	9	25.7%
	Sub Clinical	0	0%

DISCUSSION

After the administration of the tests in the present research work the result tables were formulated by the scores obtained which indicated the Indicating percentage of depressive and anxiety patients suffering from high, medium and low level co morbidity of Obsessive Compulsive Symptoms (OCS) in table 2. It may be clearly seen from table 2 that 35% of the total patients suffering from anxiety disorder depicted co morbidity of OCS, 28.5% has severs OCS and 14.3 were found to have extreme Obsessive Compulsive Symptoms (OCS). When the assessment of co morbidity of Obsessive Compulsive Symptoms was done among the patients suffering from depressive disorder, it was found that 48.5 % of the patients seemed to have moderate OCS, 17.1% of the total sample showed severe symptoms of obsession and compulsion and 8.5% of depressive disorder patients had extreme OCS.

No prior research has systematically examined the impact of co morbid OCS (Obsessive Compulsive Symptoms) on clinical outcomes in anxiety disorders, and OCS impact has been studied in only one study in depressive disorders. Generally, our findings are in line with previous research indicating that co morbidity in anxiety and depressive disorders in general is associated with severity and chronicity of OCD (Denys *et al*., 2004) and, more specifically, in depressive disorders, indicating that co morbid OCS is associated with poorer outcome (Baer *et al*., 2015). Our findings implicate that OCS co morbidity may be a valuable specifier of outcome in both

anxiety and depressive disorders, in line with findings of co morbid anxiety symptoms in depression and panic attacks across the full range of psychopathology that predict worse outcome (Batelaan *et al*., 2010).For example, it was found that relapse occurred in one-fifth of our sample. Given this high rate, which is consistent with relapse rates found in previous research on anxiety and depression co morbidities (Hardeveld, 2010) identifying patients at high risk for relapse is of utmost importance. Especially in anxiety disorders, predictors of relapse have been scarcely identified (Scholten, 2013).

CONCLUSION

Therefore, it may be concluded that approximately 28.5% of the total sample selected of anxiety disorder had severe OCD symptoms and 14.3% had extreme OCD symptoms. Furthermore, around 17.1% patients of depressive disorder were found to have severe OCD symptoms whereas 8.5% were found to have extreme co morbidity of OCD. Hence, intervention techniques for OCD should also be combined with the treatment and intervention of AD and DD in order to assist in rapid recovery of the patient. Our finding also summarize that OCS predicted relapse in anxiety and depression disordered patients means that standard screening for these patients with obsessive-compulsive symptom atology might be helpful to identify those at a higher risk for relapse.

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