BRIEF RESEARCH COMMUNICATION

A Naturalistic Study of Obsessive-compulsive Disorder: A Retrospective Chart Review

Anil Kumar Agarwal[1], Shrikant Srivastava[2]

Received on: 11 July 2022; *Accepted on:* 29 July 2022; *Published on:* 31 August 2022

Abstract

The electronic case records were retrieved for patients with a primary diagnosis of obsessive-compulsive disorder (OCD), and who had visited the clinic during a specified period ($n = 125$). The mean and standard deviation (SD) of the age of the patients were 36 ± 13.5 years, the duration of illness was 8.6 ± 7.3 years, and the follow-up period was 45.5 ± 41.9 months. The age of onset of the illness was in the late 20s. Comorbid diagnosis with OCD was seen in 41% cases–bipolar disorder (BD) 28% and schizophrenia = 13%. A family history of a psychiatric illness was present in nearly one-third of the cases. Subjectively, outcome of "Normal" or "Better" was seen in 41% cases of pure OCD, 19% of OCD + BD, and 5% in OCD + schizophrenia. Clinical presentations of cases are also discussed. The patient's behavior in attending the clinic showed that initially the patients visit the clinic more frequently when the illness is severe, but later they come for consultation whenever there were some problems, but they continue taking medicines.

Keywords: Comorbidity, Counseling skills, Developing practice, Improving psychiatric practice, India, In-patients, Obsessive-compulsive disorder.

Indian Journal of Private Psychiatry (2022): 10.5005/jp-journals-10067-0122

Introduction

Obsessive-compulsive disorder is a chronic disorder with variable outcomes. The lifetime prevalence is reported to be 2–3% in Europe and North America,[1–3] whereas the corresponding figure in the Indian population is between 0.6% and 0.76%.[4,5] A probable reason for the lower prevalence rate is the nature of the disease as most OCD patients are very secretive and do not disclose their illness. Clinical picture has been found to be similar[6–10] everywhere. Numerous studies have reported that selective serotonin reuptake inhibitors (SSRIs), cognitive behavior therapy, psychosurgery, and direct stimulation of specific brain areas are effective. Indian Psychiatric Society[11] has provided guidelines for the treatment of OCD. Obsessive-compulsive disorder has comorbidities like attention deficit hyperactivity disorder (ADHD), tic disorder, depression, BD, and anxiety disorder.[12–18] Current classifications have removed OCD from anxiety disorders to a separate category, and this group includes body dysmorphic disorders, trichotillomania, skin picking disorders, and some others as they seem to have similar symptomatology and treatment and share the same brain circuitry abnormalities.[12]

Aims and Objectives

The study aimed at studying the natural course of OCD and its response to treatment in private psychiatric clinic in India.

Materials and Methods

The current study is a retrospective review of clinical records from a private clinic,[19,20] which are maintained from 1996 onwards till date. The clinic records were originally in paper format and were digitalized in 2017. All the records are assigned a unique case ID which has been retained since the beginning of the practice, thus providing a longitudinal perspective for each patient.

[1]Consultant Psychiatrist, B104/2 Nirala Nagar, Lucknow, Uttar Pradesh, India

[2]Department of Geriatric Mental Health, King George's Medical University, Lucknow, Uttar Pradesh, India

Corresponding Author: Anil Kumar Agarwal, Consultant Psychiatrist, B104/2 Nirala Nagar, Lucknow, Uttar Pradesh, India, Phone: +91 9415006128, e-mail: mradulanil@gmail.com

How to cite this article: Agarwal AK, Srivastava S. A Naturalistic Study of Obsessive-compulsive Disorder: A Retrospective Chart Review. Ind J Priv Psychiatry 2022;16(2):87–90.

Source of support: Nil

Conflict of interest: None

Sample Description

All records where the primary diagnosis was OCD, and the patient visited at least once between 1st November, 2017 and 31st October, 2018, were included. The data were compiled in 2021. Therefore, all new patients were followed up for at least 3 years. The last visit was considered as the date of follow-up. Patients who presented predominantly with depression have been described earlier,[21] and these are not included in this sample.

All these patients were personally treated by the first author. Management of the patients was done by pharmacotherapy and psychological means. All of them were prescribed one of the SSRIs (fluoxetine 20–80 mg, fluvoxamine 100–300 mg, escitalopram 20–80 mg, and sertraline 100–300 mg per day). Adjuvant medications used on as required basis were benzodiazepines, and in few cases, atypical antipsychotics in lower dosage. The adjuvant medications were tapered off in most patients, and they were kept only on the anti-obsessional drugs. Combination of two anti-obsessional drug was used sometimes. The higher doses of these drugs were not used as their use was not recommended at that time.

Psychological treatment was done using psycho education and modified cognitive behavior therapy.

The patients and their close relatives were informed about the nature of disease. They were informed that this illness occurs due to some changes in brain function and neurochemicals. The illness often has a hereditary link. Most patients and families believed that this illness occurred due to inappropriate practices or due to stress. They were informed that stress or abnormal activities may be precipitating factors but are not the cause of this illness. They were told that patients suffering from this illness start experiencing certain unwanted thoughts, which they know are wrong but cannot control. Some of them start doing some acts repetitively to control these thoughts. They were advised to think the following:

"These thoughts are due to a disease of mind. I should not hold myself guilty for these thoughts. More I resist them or comply with their demand, stronger they become. They were advised to allow the obsessive thoughts to come but resist the subsequent activities they force them to do. They should continue doing their normal activities. They were also explained that they will not succeed from day one, but if they are able to control even once they have taken a step forward. They were also told that this disease is generally not fully cured. Even fifty percent reduction in symptoms will make their lives comfortable."

This advice was repeated at each visit, and the issues encountered by them while practicing it were discussed.

A booklet is prepared for guidance of patients which provides information on OCD and cognitive behavior therapy. Many patients have appreciated this booklet (Available from the author)

Results

Clinical records of 125 patients were included as they had attended the clinic in the specified period (Table 1). The gender distribution was almost equal with slight preponderance of males (55%). The age of onset of the illness was in late 20s; it was lower in males than females (27.1 + 10.7 vs 31.3 + 4.3, years). Fifteen (12%) patients visited only once, and 11 (8%) dropped within 1 year. The mean ± SD of age of the patients was 36 ± 13.5 years, the duration of illness was 8.6 ± 7.3 years, and the follow-up period was 45.5 ± 41.9 months.

A family history of a psychiatric illness was present in nearly one-third of the cases ($n = 36$); the highest proportion was of OCD ($n = 16$) followed by depression and schizophrenia ($n = 3$ each) and suicide ($n = 2$), while in another 12 cases, it was not possible to come to a reasonably accurate diagnosis based on information provided. First degree relatives – father ($n = 5$), mother ($n = 4$), or a sibling ($n = 6$) were affected.

Comorbid Psychiatric Disorders with OCD

A total of 73 patients had OCD, while another 35 had a comorbid diagnosis of BD and 17 had schizophrenia. Among the 35 patients with comorbid BD, 20 patients developed manic episode after receiving SSRI medication, and in 8 of these patients the OCD symptoms disappeared, leaving only manic symptoms which were treated with antipsychotic and/or mood stabilizer. In the rest 12 patients, the OCD and manic symptoms continued to be present at the same time. Importantly the former group had a family history of BD. Fifteen patients had OCD and bipolar symptoms from the beginning.

Seventeen patients had OCD with schizophrenia. Three types of presentations were observed. Some patients were initially diagnosed with OCD, but later developed schizophrenia ($n = 6$). Second group had both illnesses from the beginning ($n = 8$), and they require to be treated for both schizophrenia and OCD. Third group was patients who were initially diagnosed with schizophrenia and later developed OCD ($n = 3$).

Some patients with OCD are wrongly diagnosed with schizophrenia, as they do not complain of obsessive and compulsive symptoms. They do odd activities, may appear to be muttering to themselves and may become abusive.

Table 1: Demographic variables of the sample

	Sex		*Religion*		
Diagnosis	*Males n (%)*	*Females n (%)*	*Hindus n (%)*	*Muslims n (%)*	*Total*
OCD	38 (54%)	35 (46%)	61 (84%)	12 (16%)	73 (59%)
With bipolar disorder	22 (63%)	13 (37%)	17 (49%)	18 (51%)	35 (28%)
With schizophrenia	11 (65%)	6 (35%)	10 (59%)	7 (41%)	17 (13%)
Total	71 (57%)	54 (43%)	88 (70%)	37 (30%)	125

Table 2: Outcome of OCD

Diagnosis	*Normal*	*Better*	*Fluctuating*	*Same or worse*	*Total*
OCD	19 (25%)	26 (35%)	11 (15%)	19 (25%)	75
OCD with bipolar disorder	9 (27%)	10 (33%)	4 (12%)	10 (33%)	33
OCD with schizophrenia	0	5 (29%)	5 (29%)	7 (42%)	17
Total	28 (22%)	41 (33%)	20 (16%)	36 (29%)	125

Case Illustration of OCD Presenting as Schizophrenia

A male around 20 years of age used to stand for prolonged periods and used to mutter. If anybody interfered, he became abusive. On enquiry, it was found that he gets obscene ideas, and to undo their effects, he must remain standing and do some rituals in mind. If somebody interfered in these rituals, he becomes abusive. This patient has been wrongly diagnosed as schizophrenia by two psychiatrists earlier.

Symptoms and Treatment

Cleaning and checking were the highest reported compulsive symptoms, while "feeling that something bad will happen" and blasphemous thoughts were most frequent obsessional symptoms. All the patients were treated with an SSRI – the highest prescriptions were for fluvoxamine ($n = 73$) and escitalopram ($n = 49$). Rescue benzodiazepines were required in 44 patients either as sedative and/or anxiolytic (clonazepam = 39, lorazepam = 8).

Outcome of the Illness and Duration of Treatment

The outcome data is more subjective as no formal assessments were conducted at the first or successive visits. The outcome described in Table 2 is based on the version of the patient and the subjective evaluation of the author. Nearly 25% patients of OCD reported complete normalcy with no symptoms and no functional impairment. The best outcome was in the OCD and OCD + BD groups, where 60% of patients in each group were either free of symptoms or had only few symptoms that were not impairing social

and occupational functioning. Many patients of OCD start feeling normal as soon as the severity of symptoms reduces, but they are still functionally impaired. Most of the patients who continue in treatment are better than before. If we had done a follow-up by telephone or home visit, a better outcome might have been found.

Most patients of OCD are very reluctant to accept cognitive behavior therapy. They try it for short periods and give up as it increases anxiety. These patients require repetitive assurances and support for continuing the therapy. Most patients continue treatment if they feel some relief.

Secondly the families of these patients are in turmoil. The patient blames the family members that they shout on him/her. The family complains that the patient does not make an honest effort. This blame game becomes an excuse for not trying. The family members and the patient must be explained that the disease is such that the patient cannot stop it at will. The family needs to support the patient, even if he fails, as it will encourage him to make more efforts. There are always periods of worsening. Many times, such deterioration in illness leads to hopelessness. They need regular encouragement.

Obsessive-compulsive disorder symptoms fluctuate with circumstances. One of the patients who had severe OCD could control her symptoms and looked after her husband when he developed cancer. Once his symptoms improved, the intensity of obsessive symptoms worsened.

Discussion

The patients in this sample cannot be said to be representative of either the illness in general population or even in private practice. This sample will provide an idea of how patients with OCD present in a private clinic and how they progress and react to treatment. From the total sample of 125 patients, 73 (59%) had only OCD, while 35 (28%) and 17 (13%) had associated BD and schizophrenia, respectively.

Comorbidity with OCD

Most patients of OCD have associated mental illnesses, and identifying them is important for treatment. Population-based studies showed that comorbid OCD in BD (bipolar affective disorder) patients ranges from 11.1 to 21%. Lifetime prevalence of BD in patients of OCD lies between 6 and 58.5%. The pooled prevalence of OCD in BD is 17%, and BD in OCD is 18%.[12,16,17] The present study confirms this association.

The current study also shows that some patient of OCD switch to mania after receiving SSRI medications. In some of these patients, the manic symptoms reduce as SSRIs are reduced, but others convert to typical BD, while others continue to have OCD and BD together. It shows that in some BD patients, OCD can be a presenting feature, which converts to BD, while in others, it may continue as OCD. Switching to mania is a major challenge as the most accepted treatment of OCD are SSRI. One needs to use drugs that have low chances of switch to mania. This author's preference had been fluvoxamine.

The relationship between OCD and schizophrenia is also well studied. The comorbidity of the two disorders[12,16–18] lies between 5 and 64%, and the nature of this relationship is not clearly understood. The present study shows three patterns: (i) OCD is the primary diagnosis, and symptoms of schizophrenia develop after some time, (ii) OCD and schizophrenia develop simultaneously, (iii) Sometimes long-standing patients with schizophrenia develop OCD, usually when clozapine was used.[20,22,23] Correctly diagnosing this association is important for treatment. Different treatment approaches have been recommended.

Duration of Treatment and Frequency of Visits

The dropout rate in OCD is much less, and only 15 (12%) patients dropped out after 1 visit and another 11 (8%) within 1 year. The dropout rate for total patients in this clinic was very high.[20] The frequency of visits is related to the severity of discomfort, and those with severe pathology tend to continue the treatment and visit regularly. The pattern of the visit shows that as soon as the patient develops some symptom relief, they stop coming regularly but continue taking treatment. They revisit the clinician when they have some fresh problems. Most patients adhere to treatment after one initial stoppage of treatment. They learn that the drugs are essential for keeping them well. This aspect of treatment behavior has not been sufficiently emphasized in Indian literature.

Outcome of the Illness

Many studies have been done to study outcome of OCD in India and in the world.[20–29] Most studies report low rates of remission. One study[20] conducted in India in juvenile onset OCD reported that 62% were fully normal and 21% were still on medications. This sample had very few patients with an age of onset below 15 years, and majority had an age of onset between 16 and 50 years. Twenty-five percent remitted, and another 35% percent of pure OCD improved. Overall improvement was in 60%. Notably, no patient with schizophrenia comorbidity remitted. Patients with BD showed frequent relapses but participated in treatment. Most patients with OCD continue to live a normal life with certain limitations. The continuous contact with a clinician makes this journey easier.

Nearly 30% do not improve or deteriorate. This number can be reduced by improving drug treatment to higher dosages and by more intense cognitive behavior therapy. New treatments like direct stimulation of brain areas with different methods will further improve more patients. Most patients of OCD improve with proper treatment.

Conclusion

Obsessive-compulsive disorder is a common disorder in clinical practice. The diagnosis is sometimes missed as they hide the obsessive symptoms and complain of only depression.

The onset of the disorder is spread over all ages, but more patients developed the disorder between 16 and 50 years of age. History of similar illness and other psychiatric disorders is present in one-third of patients. The patients are often reluctant to take treatment, but if they experience relief, then they continue taking it for prolonged periods. SSRIs are the mainstay of treatment. Psychological help is crucial in making the patients and their families understand the illness and cope with it. Simple cognitive understanding and efforts go long way in treating the illness. Many OCD patients have comorbidities which often complicate the treatment. This illness can be controlled in majority of patients if there is a proper diagnosis and focused drug and psychological treatment.

References

1. Degonda M, Wyss M, Angst J. The Zurich Study – XVIII. Obsessive-compulsive disorders and syndromes in the general population. Eur Arch Psychiatry Clin Neurosci 1993;243(1):16–22. DOI: 10.1007/BF02191519.
2. Karno M, Golding JM, Sorenson SB, et al. The epidemiology of obsessive-compulsive disorder in five US communities. Arch Gen Psychiatry 1988;45(12):1094–1099. DOI: 10.1001/archpsyc.1988.01800360042006.
3. Bebbington PE. Epidemiology of obsessive-compulsive disorder. Br J Psychiatry Suppl 1998;(35):2–6. PMID: 9829020.
4. Ray SD. Obsessional states observed in New Delhi. Br J Psychiatry 1964;110:181–182. DOI: 10.1192/bjp.110.465.181.
5. Gururaj G, Varghese M, Benegal V, et al. National Mental Health Survey of India: Prevalence, Pattern and Outcomes. ISSN: 01615505.
6. Janardhan Reddy YC, Rao NP, Khanna S. An overview of Indian research in obsessive compulsive disorder. Indian J Psychiatry 2010;52(Suppl 1):S200–S209. DOI: 10.4103/0019-5545.69233.
7. Akhtar S, Wig NN, Varma VK, et al. A phenomenological analysis of symptoms in obsessive compulsive neurosis. Br J Psychiatry 1975;127:342–348. DOI: 10.1192/bjp.127.4.342.
8. Akhtar S, Varma VK, Pershad D, et al. Socio-cultural and clinical determinants of symptomatology in obsessional neurosis. Int J Soc Psychiatry 1978;24(3):157–162. DOI: 10.1177/002076407802400301.
9. Akhtar S. Obsessional neurosis, marriage, sex and fertility: some transcultural comparisons. Int J Soc Psychiatry 1978;24(3):164–166. DOI: 10.1177/002076407802400303.
10. Chakraborty A, Gouranga B. Ritual, a culture specific neurosis, and obsessional states in Bengali culture. Indian J Psychiatry 1975;17(4):211–216.
11. Janardhan Reddy YC, Shyam Sundar A, Narayanaswamy JC, et al. Clinical practice guidelines for obsessive-compulsive disorder. Indian J Psychiatry 2017;59(Suppl 1):S74–S90. DOI: 10.4103/0019-5545.196976.
12. Sharma LP, Janardhan Reddy YC. Obsessive-compulsive disorder comorbid with schizophrenia and bipolar disorder. Indian J Psychiatry 2019;61(Suppl 1):S140–S148. DOI: 10.4103/psychiatry.IndianJPsychiatry_527_18.
13. Kokurcan A, Nazlı ŞB. Clinical correlates of obsessive-compulsive disorder comorbidity in patients with schizophrenia. Indian J Psychiatry 2020;62(1):51–58. DOI: 10.4103/psychiatry.IndianJPsychiatry_268_19.
14. Fernandez-Egea E, Worbe Y, Bernardo M, et al. Distinct risk factors for obsessive and compulsive symptoms in chronic schizophrenia. Psychol Med 2018;48(16):2668–2675. DOI: 10.1017/S003329171800017X.
15. Zhou TH, Baytunca B, Yu X, et al. Schizo-obsessive disorder: the epidemiology, diagnosis, and treatment of comorbid schizophrenia and OCD. Curr Treat Options Psychiatry 2016;3(3): 235–245. DOI: 10.1007/s40501-016-0085-6.
16. Amerio A, Stubbs B, Odone A, et al. The prevalence and predictors of comorbid bipolar disorder and obsessive-compulsive disorder: a systematic review and meta-analysis. J Affect Disord 2015;186:99–109. DOI: 10.1016/j.jad.2015.06.005.
17. Amerio A, Stubbs B, Odone A, et al. Bipolar I and II disorders: a systematic review and meta-analysis on differences in comorbid obsessive-compulsive disorder. Iran J Psychiatry Behav Sci 2016;10(3):e3604. DOI: 10.17795/ijpbs-3604
18. Mahendran R, Liew E, Subramaniam M. De novo emergence of obsessive-compulsive symptoms with atypical antipsychotics in Asian patients with schizophrenia or schizoaffective disorder: a retrospective, cross-sectional study. J Clin Psychiatry 2007;68(4):542–545. DOI: 10.4088/jcp.v68n0408.
19. Agarwal AK. Private practice in psychiatry in India–Development and seasonal variations. Indian J Priv Psychiatry 2018;12(1):15–19. DOI: 10.5005/jp-journals-10067-0012.
20. Agarwal AK. Analysis of patients attending a private psychiatric clinic. Indian J Psychiatry 2012;54(4):356–358. DOI: 10.4103/0019-5545.104824.
21. Agarwal AK. Depression in clinical practice: a retrospective case record analysis. Indian J Priv Psychiatry 2020;14(1):1–5. DOI: 10.5005/jp-journals-10067-0049.
22. Skoog G, Skoog I. A 40-year follow-up of patients with obsessive-compulsive disorder. Arch Gen Psychiatry 1999;56(2):121–127. DOI: 10.1001/archpsyc.56.2.121.
23. Srivastava S, Agarwal AK, Sharma M. A three-year naturalistic follow-up of patients receiving clozapine: report from India. Int J Psychiatry Clin Pract 2002;6(3):167–171. DOI: 10.1080/136515002760276108.
24. Janardhan Reddy YC, Srinath S, Prakash HM, et al. A follow-up study of juvenile obsessive-compulsive disorder from India. Acta Psychiatr Scand 2003;107(6):457–464. DOI: 10.1034/j.1600-0447.2003.00082.x.
25. Leonard HL, Swedo SE, Lenane MC, et al. A 2- to 7-year follow-up study of 54 obsessive-compulsive children and adolescents. Arch Gen Psychiatry 1993;50(6):429–439. DOI: 10.1001/archpsyc.1993.01820180023003.
26. Kishore VR, Samar R, Janardhan Reddy YC, et al. Clinical characteristics and treatment response in poor and good insight obsessive-compulsive disorder. Eur Psychiatry 2004;19(4):202–208. DOI: 10.1016/j.eurpsy.2003.12.005.
27. Kamath P, Janardhan Reddy YC, Kandavel T. Suicidal behavior in obsessive-compulsive disorder. J Clin Psychiatry 2007;68(11):1741–1750. DOI: 10.4088/jcp.v68n1114.
28. Janardhan Reddy YC, D'Souza SM, Shetti C, et al. An 11- to 13-year follow-up of 75 subjects with obsessive-compulsive disorder. J Clin Psychiatry 2005;66(6):744–749. DOI: 10.4088/jcp.v66n0611.
29. Math SB, Thoduguli J, Janardhan Reddy YC, et al. A 5-year course of predominantly obsessive vs. mixed subtypes of obsessive-compulsive disorder. Indian J Psychiatry 2007;49(4):250–255. PMID: 20680136.