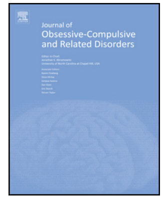
Journal of Obsessive-Compulsive and Related Disorders 5 (2015) 87–92

Contents lists available at ScienceDirect

Journal of Obsessive-Compulsive and Related Disorders

journal homepage: www.elsevier.com/locate/jocrd



Low psychosocial functioning in obsessive–compulsive disorder and its clinical implications

Paraskevi Mavrogiorgou [1], Meltem Akyol [1], Frauke Siebers, Thorsten Kienast [2,1], Georg Juckel *,[1]

Department of Psychiatry, Ruhr University Bochum, LWL University Hospital, Alexandrinenstr. 1, 44791 Bochum, Germany

A R T I C L E I N F O

Article history:
Received 1 November 2014
Received in revised form
1 March 2015
Accepted 13 March 2015
Available online 2 April 2015

Keywords:
PSP
OCD
Social functioning
Psychopathology

A B S T R A C T

Patients with obsessive–compulsive disorder (OCD) seem to be impaired in multiple domains of psychosocial functioning, but this is still insufficiently objectively measured. The Personal and Social Performance Scale (PSP) offers a validated, reliable and operational tool to assess the psychosocial functioning of patients. Using the PSP scale, examination of psychosocial functioning in a larger sample of outpatients with OCD ($n=89$) as well as its relationship to their specific psychopathology was conducted. Patients with severe OCD symptoms had low PSP total scores, especially in the sub-items of socially useful activities, personal and social relationships and disturbing and aggressive behaviors. Significant correlation coefficients were found between the PSP total score and the Y-BOCS as well as the Hamilton-Depression score. However, social parameters such as educational and occupational status were only related to PSP and Y-BOCS and not to HAM-D. Patients with OCD show similarly low psychosocial functioning values on the PSP scale to other patients with severe psychiatric diseases, e.g. schizophrenia, as reported in the literature, which was underestimated up to now. This relationship seems to be mainly mediated by comorbid depression. Psychosocial interventions specifically adapted for OCD patients should now be developed more and applied broadly.

© 2015 Elsevier Inc. All rights reserved.

1. Introduction

Obsessive–compulsive disorder (OCD) is a common psychiatric disorder, which affects 1–3% of the population (Fullana et al., 2010; Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012; Ruscio, Stein, Chiu, & Kessler, 2010). Patients with OCD suffer from recurrent, unwanted thoughts (obsessions) and repetitive, ritualistic behavior (compulsions), often intended to neutralize the anxiety induced by the obsessions. OCD is often a chronic illness (Skoog & Skoog, 1999) that can cause severe occupational and social impairment. In the last two decades, efficacious pharmacological and psychotherapeutic treatments for OCD have been extensively validated and have been well established (Eddy, Dutra, Bradley, & Westen, 2004; Fineberg et al., 2013). Cognitive and behavioral therapy (Otte, 2011; Ougrin, 2011) and several pharmacological agents, especially serotonin reuptake inhibitors (Bandelow et al., 2012; Stein et al., 2012), improve OCD symptoms in about 70% of patients (Stein, 2002). However, there are reports that up to 40% and more of OCD patients do not have a satisfactory response after adequate treatment, either by pharmacotherapy and/or psychotherapy (Pallanti & Quercioli, 2006). This high rate of non-responders and current neurobiological findings suggest that OCD may be a pathogenetic and phenotypic heterogeneous disorder and possibly composed of different subtypes (Hoexter et al., 2009; Mataix-Cols, do Rosário-Campos, & Leckman, 2005). Poorer treatment response has been associated to many other factors such as severity of OCD symptoms, duration of illness, comorbidity and subjective quality of life (QOL) (Moritz et al., 2005; Romanelli, Wu, Gamba, Mojtabai, & Segal, 2014).

QOL has scarcely been investigated, which is summarized in some current review articles (Subramaniam, Soh, Vaingankar, Picco, & Chong, 2013; Macy et al., 2013). These studies suggest that patients with OCD report significantly lower QOL than the general population, some studies show even lower QOL scores compared to patients with schizophrenia (Bystritsky et al., 2001; Koran, 2000; Moritz, 2008; Stengler-Wenzke, Kroll, Matschinger, & Angermeyer, 2006). Furthermore, several studies have assessed the relationship between QOL and different OCD symptom dimensions. Thus, in the study by Moritz et al. (2005), a strong correlation was found between the severity of obsessions and the scores of mental health, social and emotional functioning. This study used the Medical Outcome Study 36-item Short-Form health

* Corresponding author. Tel.: +49 234 5077 1100; fax: +49 234 5077 1119.
E-mail address: georg.juckel@rub.de (G. Juckel).

[1] These authors contributed equally to this work.

[2] Department of Psychiatry and Psychotherapy, Charité Campus Mitte, Universitätsmedizin Berlin, Charitéplatz 1, 10117 Berlin, Germany.

http://dx.doi.org/10.1016/j.jocrd.2015.03.004
2211-3649/© 2015 Elsevier Inc. All rights reserved.

survey questionnaire (SF-36; Ware & Sherbourne, 1992), which is one of the most commonly used measures to evaluate different domains of quality of life. In the study by Stengler-Wenzke, Kroll, Riedel-Heller, Matschinger, and Angermeyer (2007), compulsions were associated with lower scores in the domains of "psychological well-being", "physical well-being" and "environment" in the World Health Organization Quality of Life-Brief Version questionnaire (WHOQOL-BREF). In this study, obsessions had no significant influence on quality of life, whereas depressive symptoms were found to be an important determinant factor of QOL in patients with OCD. Similarly, Fontenelle et al. (2010) suggest that the severity of symptoms of depression and anxiety were powerful predictors of QOL. In this study, patients with OCD displayed significantly lower levels of QOL in all domains measured by the SF-36 compared to healthy controls. While QOL usually improves after treatment of OCD in general, changes in QOL are not strongly correlated with reduction in OCD symptoms. Substantial QOL impairment appears to persist in OCD patients even after successful remission of symptoms with treatment (Bystritsky et al., 2001; Mancebo et al., 2008). These results strengthen the claim that patient-relevant outcome parameters such as psychosocial functioning and quality of life should be equally assessed independent of psychopathology as relevant indicators for treatment outcome (Schmidt, Neuner, Cording, & Spiessl, 2006).

However, most studies have addressed overall QOL without specifically evaluating psychosocial functioning of OCD. Only a small number of studies have investigated correlates of OCD with different domains of psychosocial functioning (Eisen et al., 2006; Mancebo et al., 2008; Rosa et al., 2012; Steketee & Van Noppen, 2003). In an initial study with a large sample of 238 OCD patients, social and occupational functioning was assessed using multiple scales such the Social and Occupational Functioning Assessment Scale (SOFAS; American Psychiatric Association, 2000), the Global Assessment of Functioning (GAF; Goldman, Skodol, & Lave, 1992), and the Social Adjustment Scale Self-Report (SAS-SR; Weissman & Bothwell, 1976). In this comprehensive study, Mancebo et al. (2008) have found that OCD severity was the most powerful predictor of occupational disability, followed by depression severity and substance use disorders. A current cross-sectional study involving 815 patients with OCD, using only the SF-36 and the SAS-SR, found that OCD patients have poor social functioning in domains related to personal relationships and professional performance (Rosa et al., 2012). Nevertheless, in clinical practice the SF-36 and the SAS-SR are too broad and unspecific for adequately assessing the distinct dimensions of psychosocial functioning in order to draw sufficient conclusions.

Furthermore, for the evaluation of psychosocial functioning in general, the Global Assessment of Functioning (GAF) scale is a simple, short and non-precise instrument. The disadvantage of this scale lies in its incorporation of psychopathological aspects which mix up with the psychosocial factors. On account of this criticism, the Social and Occupational Functioning Assessment Scale (SOFAS) was developed. However, lacking precise operational instructions, this questionnaire does not allow a sufficient rating of severity of disability (Juckel & Morosini, 2008). As a consequence, Morosini, Magliano, Brambilla, Ugolini, and Pioli (2000) developed the Personal and Social Performance (PSP) scale. This scale aims to separate psychopathological from psychosocial aspects, and therefore allows a more exact and specific operationalisation of the occupational, social and personal functioning domains. In addition, the rater can assess a global score as well as four subscores of the main areas: socially useful activities including work and study, personal and social relationships, self-care and disturbing and aggressive behaviors. The distribution in the four subscales creates a higher specific expressiveness in the PSP scale in comparison to the GAF scale and SOFAS. Furthermore, its quick practicability should be mentioned. A plethora of studies in a broad spectrum of neuropsychiatric disorders, foremost schizophrenia, reported high reliability and validity for the PSP scale (Morosini et al., 2000; Juckel et al., 2008; Schaub et al., 2011; Nafees et al., 2012; Jelastopulu et al., 2014).

Accordingly, the aim of this study was to examine psychosocial function in OCD patients using the PSP, which is arguably among the best rating instruments available for this purpose. Specifically, we expected a more exact and detailed assessment of psychosocial functioning and its subdimensions compared to previous studies in a larger sample of patients with OCD. Furthermore, we aimed to explore the relationship between specific OCD signs and symptoms patients' psychosocial functioning. We predicted that patients with OCD show comparably poor psychosocial functioning to patients with other severe neuropsychiatric disorders. Finally, we focused on the relationship of psychosocial functioning in OCD with patients' depressive symptomatology as well as socioeconomic parameters

2. Methods

2.1. Subjects

89 patients (49 females, 40 males) with an unequivocal diagnosis of obsessive–compulsive disorder were recruited from the highly specialized outpatient clinic for OCD at the Department of Psychiatry, Ruhr University Bochum. Diagnosis was based on the diagnostic criteria of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV) and *International Classification of Diseases* (ICD-10), and confirmed using a structured diagnostic interview (SCID I and II). Furthermore, disease-specific scales were also carefully rated by long-experienced psychiatrists from the outpatient clinic.

Exclusion criteria were organic psychiatric disorders or recent concomitant neurological or other medical disorders and the presence of severe alcohol or substance abuse. No patient met the criteria for Tourette syndrome. Comorbid major depression and anxiety disorders were not considered as exclusion criteria. Table 1 shows the demographic and clinical data of the 89 patients being included in the study. Most patients received cognitive behavioral therapy and a variety of constant medications including an antidepressant and/or an adjunct antipsychotic agent (Table 2).

All patients underwent a semistructured standardized interview for recording their individual sociodemographic and clinical profile after giving written informed consent for participation. The study was conducted in accordance with the Declaration of Helsinki and approved by the ethical committee of Ruhr University Bochum.

2.2. Instruments

Severity of obsessive–compulsive symptoms was assessed by the Yale-Brown Obsessive–Compulsive Scale (Y-BOCS; Goodman et al., 1989a, 1989b) and the self-rating Maudsley Obsessive–Compulsive Inventory (MOCI; Hodgson & Rachman, 1977). To validate the presence of OCD subsymptoms we used the Yale-Brown Obsessive–Compulsive symptom checklist.

Severity of depressive symptoms was assessed using the Hamilton Depression Rating Scale (HAM-D; Hamilton, 1967) and self-ratings with Beck's Depression Inventory (BDI; Beck, Ward, & Mendelson, 1967). To assess OCD symptoms and depressive symptoms from the professional as well as from the patient's perspective, we used two different versions of the PSP, the findings of which may differ, but also complement each other

Anxiety symptoms were measured using the State-Trait Anxiety Inventory (STAI I and II; Spielberger, Gorsuch, & Lushene, 1970).

The overall severity of the psychiatric disorder was quantified using the Clinical Global Impression score (CGI; National Institute of Mental Health, 1970).

Psychosocial functioning was measured by the Personal and Social Performance scale (PSP) in the German version (Juckel et al., 2008; Schaub et al., 2011). This operationalized 100-point scale consists of four main areas:

a) "socially useful activities, including work and study";
b) "personal and social relationships";
c) "self-care";
d) "disturbing and aggressive behaviors".

Each of the four domains is rated in six degrees of severity with higher numbers for "absent" and "mild" and low numbers for "severe" and "very severe":

Download English Version:

https://daneshyari.com/en/article/912290

Download Persian Version:

https://daneshyari.com/article/912290

Daneshyari.com