



Schizophrenia and co-morbid obsessive - compulsive disorder: Clinical characteristics



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ABSTRACT

Background: Psychiatric co-morbidity is a common condition, partly due to the overlap of symptoms in the categorical diagnosis of mental disorders. The co-occurrence of schizophrenia (SZ) and obsessive compulsive disorder (OCD) is a common and challenging co-morbid condition. Also, the relationship between SZ and OCD remains unclear.

Aim: The aim of this study was to describe the co-morbidity of obsessive-compulsive disorder (OCD) among schizophrenia (SZ) patients and compare clinical characteristics of schizophrenia patients with versus without comorbid OCD.

Subjects and Methods: A cohort-study was carried out on 396 patients enrolled between November 2011 to June 2014 at the Department of Psychiatry, Rumeilah Hospital in Qatar. We employed the WHO Composite International Diagnostic Interview (WHO-CIDI), and Structured clinical interview for DSM-5 (SCID-5) for diagnoses, the Yale-Brown Obsessive Compulsive Scale Symptom Checklist for scoring OCD. Patients were grouped in SZ patients with and without comorbid OCD (SZ-OCD vs SZ).

Results: 396 subjects were interviewed. Age of SZ-OCD patients was 42.69 ± 14.33 (years old) whereas SZ patients without OCD ranged 41.59 ± 13.59 years old. There were statistically significant differences in clinical characteristics between SZ with and without OCD : age ($p = 0.010$), BMI (body mass index; $p = 0.011$), education ($p = 0.033$), employment ($p = 0.019$), cigarette smoking ($p = 0.039$), sheesha smoking ($p = 0.008$), and prevalence of consanguinity ($p = 0.043$). In particular, the rate of consanguinity in the current generation was 31.8% [95% CI = 29.1–34.7]. Also, there were statistically significant differences at Hamilton Depression score, General Health Score, Clinical Global Impression- Score, duration of illnesses, and Global Assessment of Functioning ($p < 0.001$). The results show that anxious, mood and psychotic dimensions rated higher among SZ - OCD ones than SZ only patients.

Conclusion: This study confirms that SZ-OCD is a common co-morbidity and prevalence of SZ OCD is higher among patients reporting a degree of consanguinity. Even if this condition is under-recognized in clinical practice, it may significantly change SZ presentation and outcome since psychopathological dimensions report higher scores in the co-morbidity sample.

1. Introduction

Patients with co-morbid obsessive-compulsive disorder (OCD) and schizophrenia (SZ) may represent a special diagnostic category with special treatment requirements (Khan et al., 2004; Chien and Yip,

2013). In fact, diagnosis of OCD among patients with schizophrenia is essentially important in order to select appropriate therapies (Frias et al., 2014). People affected by this complex comorbidity may report common specific clinical characteristics and unmet needs.

Several studies have shown a poorer clinical outcome and prognosis

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among schizophrenia patients with OCD (Chien and Yip, 2013; Aoyama et al., 2000; Berman, 2001; Berman et al., 1999; Bottas et al., 2005; Haan et al., 2006). Poor general functioning, more problems in social behaviours (Lysaker et al., 2004) and higher number of psychiatric hospitalizations are described among SZ-OCD patients. Kayahan et al. (2005) reported that the severity of OCD was associated with positive symptoms but not with negative symptoms of schizophrenia, duration of illness, number of psychiatric hospitalizations, and higher dosage of antipsychotic medications. Prevalence of OCD among SZ subjects may range between 10% and 15% (Bener et al., 2011; Bener and Dafeeah, 2012; Bener et al., 2012a,b). Also, obsessive-compulsive disorder frequently occurs in a substantial proportion of patients with schizophrenia though wide variation in prevalence is reported through the studies. Other evidences report a significant relationship between positive symptoms in schizophrenia and OCD characteristics (Gross-Isseroff et al., 2003; Jaydeokar et al., 1997; Khan et al., 2004; Kumar et al., 2015; Mcgawan and Mctroy, 2005; Mulky et al., 2015; Samiei et al., 2016).

According to these studies the prevalence has been found to range between 1.1% and 4% whereas according to some data from India, the prevalence ranges from 10.57% (Hemrom et al., 2009) to 24% (Devi et al., 2015). Moreover, it has been described that 12% of schizophrenia patients also fulfil the criteria for an obsessive-compulsive disorder (OCD) since 25% of them report obsessive, distressing, and intrusive thoughts with related compulsions (Jaydeokar et al., 1997; Krugr et al., 2000; Bener et al., 2015, 2016a,b).

Since the presence of obsessive-compulsive symptoms (OCS) in schizophrenia is relevant, a new clinical entity has been proposed for those patients who show such co-morbidity: schizo-obsessive disorder (Scotti-Muzzi and Saide, 2017). In fact, there is growing evidence about the clinical relevance of the schizo-obsessive spectrum, although little is known about its neurobiological base.

The lack of epidemiological data on mental health in the Arab Countries encouraged this study (Bener et al., 2012a,b; Ghuloum et al., 2014; Bener et al., 2015; Bener et al., 2016a,b). Also, in these countries consanguineous relationships are relatively common, defined as those occurring between first degree relatives. In fact, consanguineous marriages, which are known to have significant effects on morbidity and mortality, are a traditional and common practice in Middle Eastern and Arab cultures (Bener et al., 2015; Bener et al., 2016a,b).

Consanguinity has been clearly associated with an increased risk of genetically complex disorders (Bittles, 2013; Bener et al., 2015, 2016a,b).

Authors in this report describe the prevalence of co-morbidity between obsessive-compulsive disorder (OCD) and schizophrenia (SZ) and its clinical characteristics, including the association with the consanguinity rate.

2. Subjects and methods

This is a cohort-study including Qatari patients aged 18–65 years old interviewed from March 2011 to June 2014, Department of Psychiatry, Rumeilah Hospital. All psychiatric diagnoses employed met the ICD-10 (International Classification of Diseases) criteria and were based on the Arabic World Mental Health - Composite International Diagnostic Interview (WMH-CIDI version 3.0; Kessler and Ustun, 2004; Kessler et al., 2004; Ghuloum et al., 2014; Bener et al., 2015; Bener et al., 2016a,b). Paper and Pencil Personal Interview (PAPI) - version 6 has been employed to bridge the data into the BLAISE software and SPSS version 21 was used for statistical analysis (Kessler et al., 2004; Ghuloum et al., 2014; Bener et al., 2015; Bener et al., 2016a,b).

600 Qatari subjects were approached; 396 (73.3%) agreed to be assessed and were interviewed through the Arabic World Mental Health - Composite International Diagnostic Interview (WMH-CIDI version 3.0) validated by the Institute for Development, Research, Advocacy and Applied Care (IDRAAC) centre in Lebanon. 204 subjects did not agree to

be interviewed showing no personal interest in the current study. Additionally, we conducted the rating scale by American Psychiatric Association (2015), structured clinical interview for DSM-5 (SCID-5). The WMH-CIDI instrument in Arabic language was administered by well trained interviewers under supervision of the co-investigators (EED and MTAS).

Socio-demographics, medical and family history were collected through a validated self-administered questionnaire with the help of clinicians and trained nurses. A good inter-rater reliability, test-retest reliability and validity for almost all diagnostic categories have been tested for the CIDI. Cronbach's alpha was 0.89 and 0.90 upon test and retest, respectively, which proved good internal consistency. The mean kappa value was 0.87, indicating a high level of reproducibility.

Authors reported variables routinely collected in the clinical setting and reported in the clinical records.

Institutional Review Board approval was obtained from Weill Cornell Medical College and Hamad Medical Corporation for conducting this research in Qatar.

2.1. Assessment

After the diagnostic assessment, all the patients were rated employing the following instruments:

- 1) Structured Clinical Interview for the DSM-IV (SCID);
- 2) Yale-Brown Obsessive-Compulsive Rating Scale (YBOCS) (Goodman et al., 1989). Yale-Brown Obsessive Compulsive Scale Symptom Checklist was applied to all subjects to assess the presence of obsessions and compulsions;
- 3) Hamilton Depression Rating Scale and (HAM-D) (Hamilton, 1967);
- 4) Young Mania Rating Scale (YMRS) (Young et al., 1978).

2.2. Statistical analysis

Most of data are presented as means and standard deviations. Student-t test was used to compare mean values, confirmed by non-parametric Mann-Whitney test. Chi-square and Fisher's exact test were performed to analyze categorical variables between groups. Findings are considered statistically significant with a two-tailed value less than 0.01, to compensate for multiple comparisons.

3. Results

396 subjects were interviewed. Patients affected by co-morbid OCD-SZ disorder were 102/396 and represented the 25.75% of the whole sample.

SZ with OCD were 42.69 ± 14.33 years old whereas SZ patients without OCD were 41.59 ± 13.59 years old. Socio-demographics of Schizophrenia with OCD subjects vs Schizophrenia without OCD subjects are shown in Table 1.

Statistically significant differences between SZ with OCD patients and SZ without OCD were: age ($p = 0.010$), BMI (body mass index) ($p = 0.011$), educational level ($p = 0.033$), employment ($p = 0.019$), cigarette smoking ($p = 0.039$), sheesha smoking ($p = 0.008$), and prevalence of consanguinity ($p = 0.043$). The rate of consanguinity was 31.8% [95% CI = 29.1–34.7].

Table 2 shows the prevalence and clinical characteristics of SZ with and without OCD. Statistically significant differences were found at Hamilton Depression total score, General Health Score, Clinical Global Impression-BD Score, duration of illnesses, and Global Assessment of Functioning (all shown).

Also, significantly higher proportion of SZ patients with and without OCD had a family history of OCD. The results show that anxiety dimensions (general anxiety, agoraphobia, specific phobia, social phobia, post traumatic stress symptoms, somatisation) mood dimensions (major depression, mania, oppositional defiant behaviour, Bipolarity), ADHD,

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