Available online at www.sciencedirect.com
ScienceDirect
Psychiatry Research 159 (2008) 254–258
PSYCHIATRY RESEARCH
www.elsevier.com/locate/psychres

Brief report

Clinical characteristics of schizotypal-related obsessive-compulsive disorder

Michael Poyurovsky [a,b,*], Sarit Faragian [a], Artashez Pashinian [a], Lilah Heidrach [a], Camil Fuchs [c], Ronit Weizman [d,e], Lorrin Koran [f]

[a] Research Unit, Tirat Carmel Mental Health Center, Tirat Carmel, Israel
[b] Rappaport Faculty of Medicine, Israel Institute of Technology - Technion, Haifa, Israel
[c] Department of Statistics and Operations Research, Beverley and Raymond Sackler Faculty of Exact Sciences, Tel-Aviv University, Tel-Aviv, Israel
[d] Tel Aviv Community Mental Health Center, Tel-Aviv, Israel
[e] Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel
[f] Department of Psychiatry and Behavioral Sciences, Stanford University Medical Center, Stanford, CA, USA

Received 7 June 2006; received in revised form 27 September 2006; accepted 15 February 2007

Abstract

In this study we compared 15 patients with DSM-IV obsessive-compulsive disorder (OCD) and schizotypal personality disorder (SPD) and 31 non-SPD OCD patients. OCD-SPD patients had poorer insight, more negative symptoms, lower functioning, more antipsychotic augmentation and more first-degree relatives with schizophrenia-spectrum disorders. A distinct clinical phenotype of OCD associated with SPD should be considered when investigating etiopathogenetic mechanisms.

Keywords: Schizotypal personality disorder; Obsessive-compulsive disorder; Schizophrenia spectrum disorders

1. Introduction

Obsessive-compulsive disorder (OCD) is a heterogeneous condition. Subgroups with early onset, tics and specific types of symptoms have been delineated as potential clinical phenotypes with partially distinct underlying pathophysiology (Miguel et al., 2005).

Growing evidence points toward a complex interaction between OCD and schizophrenia-spectrum disorders. An increased rate of OCD has consistently been found in schizophrenia patients (Poyurovsky et al., 2004). Conversely, schizotypal personality disorder (SPD), which shares common phenomenological and neuro-biological characteristics with schizophrenia (Siever and Davis, 2004) may aggregate in OCD patients at a rate in excess of random epidemiological comorbidity (Eisen and Rasmussen, 1993; Sobin et al., 2000; Poyurovsky and Koran, 2005). Reports are consistent in demonstrating that patients with OCD and associated SPD display a more deteriorative course, greater cognitive impairment, treatment resistance and poorer prognosis than their "pure" OCD counterparts (McDougle et al., 1990, 2000; Baer et al., 1992; Sobin et al., 2000; Spitznagel and Suhr, 2002; Poyurovsky and Koran, 2005). However systematic evaluation is lacking.

* Corresponding author. Tirat Carmel Mental Health Center, 9 Eshkol St., Tirat Carmel 30200, Israel. Tel.: +972 4 8559349; fax: +972 4 8559330.
E-mail address: poyurovs@tx.technion.ac.il (M. Poyurovsky).

0165-1781/$ - see front matter © 2007 Elsevier Ltd. All rights reserved.
doi:10.1016/j.psychres.2007.02.019

As part of an ongoing project aiming to provide a comprehensive phenomenological and neurobiological description of patient subgroups on the putative OCD-schizophrenia axis (Poyurovsky et al., 2004), in the current preliminary investigation we sought to evaluate the distinguishing characteristics of OCD patients with comorbid SPD.

2. Methods

The study group was drawn from referrals to Tirat Carmel Mental Health Center (Tirat Carmel, Israel) who met DSM-IV criteria for both OCD and schizophrenia-spectrum disorders ($N=127$; schizophrenia, schizo-affective disorder, SPD). A comprehensive clinical evaluation, using the Structured Clinical Interview for DSM-IV Axis-I (SCID-I) and Axis-II (SCID-II) disorders (First et al., 1995), identified 15 patients (12 men, 3 women; age 34.1 ± 11.9 years) who met DSM-IV criteria for both OCD and SPD. The comparison group included 31 (of 35 approached) OCD patients without SPD, matched for age (±3 years) (15 men, 16 women; age 32.7 ± 11.4), who were treated in the same center during the same time period.

Patients with primary affective, organic or substance-use disorders and those with antipsychotic-induced OCD were not included. The results of physical and neurological examinations and routine laboratory tests were normal for all participants. The study was approved by the Institutional Review Board. All participants gave written informed consent for participation in the study after receiving a detailed explanation of the study protocol.

We used SCID-I to screen for additional current and lifetime Axis I psychiatric disorders: major depressive disorder (MDD), substance use disorders, anxiety disorders (panic disorder with and without agoraphobia, social and specific phobias) and OCD-spectrum disorders [body dysmorphic disorder, eating disorders (anorexia nervosa, bulimia nervosa), hypochondriasis, chronic tic disorders and Tourette's syndrome (TS)]. Chronic tic disorders and TS were diagnosed using additional modules based on DSM-IV criteria.

Severity and content of obsessive-compulsive symptoms were evaluated using the Yale–Brown Obsessive-Compulsive Scale (Y-BOCS) and symptom checklist (Goodman et al., 1989). Insight into OCD symptoms was assessed using the Y-BOCS insight item (range from 0, excellent insight to 4, lack of insight). Age at onset of OCD was defined as first occurrence of clinically significant obsessions and/or compulsions.

Severity of positive, negative and disorganized symptoms pertinent to schizophrenia-spectrum disorders was assessed with the Scale for the Assessment of Positive Symptoms (SAPS) (Andreasen, 1984) and Negative Symptoms (SANS) (Andreasen, 1983), and functioning with the Global Assessment of Functioning (GAF) (American Psychiatric Association, 2000).

We also obtained the family history of OCD and schizophrenia-spectrum disorders in first-degree relatives by directly interviewing 54.2% (71/131) relatives, using the specific modules for schizophrenia and OCD of the SCID-I and SPD of the SCID-II, and indirectly obtaining diagnostic information regarding the remaining 45.8% (60/131) relatives with the Family History Research Diagnostic Criteria (FH-RDC) (Andreasen et al., 1977). Indirect family history information was obtained from the best informant(s), primarily first-degree relatives. Since the FH-RDC do not include OCD and SPD modules, we used the SCID-P OCD and the SCID-II SPD modules adapted to a third-person format.

Senior psychiatrists (MP, AP) who have extensive clinical experience in schizophrenia-spectrum disorders and OCD conducted the clinical interviews, and a clinical psychologist (SF) administered the rating scales. All patients were interviewed after stabilization of their mental condition, roughly 3–4 weeks after admission. Inter-rater reliability among the interviewers, who were blind to the patient group assignment, was high for OCD, SPD and comorbid diagnoses (kappa = 0.75–0.90).

To compare between-group differences, analyses of covariance (ANCOVAs) were performed on the continuous variables, and logistic regression on the categorical variables. Since there was a preponderance of men in the OCD-SPD group compared with the "pure" OCD group (12/15 vs. 15/31, respectively; $\chi^2=4.17$, $df=1$, $P=0.04$), gender was entered as a covariate in both models.

3. Results

Results are presented in Table 1. OCD patients with and without SPD had similar age at onset of clinically significant OCD symptoms and similar symptom severity (Y-BOCS). In both groups, contamination, aggressive and symmetry obsessions, and ordering, cleaning/washing and checking compulsions were most prevalent (data not shown). No between-group difference was found in additional Axis I psychiatric disorders: 86.7% (12/15) in the OCD-SPD group and 74.2% (23/31) in the comparison group met DSM-IV criteria for at least 1 lifetime Axis I disorder ($\chi^2=0.92$, $df=1$, $P=0.34$). MDD occurred with the highest frequency in both groups, followed by anxiety and OCD-spectrum disorders.

There were more unmarried and unemployed patients in the OCD-SPD group. They also had poorer insight, higher negative schizophrenia symptom scores (SANS), and