



Original article

Separation anxiety disorder in adult patients with obsessive-compulsive disorder: Prevalence and clinical correlates



A.P. Franz^{a,1}, L. Rateke^{a,1}, T. Hartmann^{a,1}, N. McLaughlin^{b,2}, A.R. Torres^{c,3}, M.C. do Rosário^{d,4}, E.C.M. Filho^{e,5}, Y.A. Ferrão^{a,*,1}

^a Federal University of Health Sciences of Porto Alegre, Rua Sarmento Leite, 245, sala 109, Porto Alegre, Rio Grande do Sul, 90050-170 Brazil

^b Butler Hospital, Alpert Medical School of Brown University, 45, Prospect Street, Providence, RI, 02912 United States

^c Department of Neurology, Psychology and Psychiatry, Botucatu Medical School, São Paulo State University, Avenue Prof. Montenegro Bairro, Distrito de Rubião Junior, s/n, Botucatu, SP, 18618-970 Brazil

^d Child and Adolescent Psychiatry Unit, Department of Psychiatry, Federal University of São Paulo, Rua Sena Madureira, 1.500, 1° Andar, Vila Clementino, São Paulo, SP, 04021-001 Brazil

^e Institute and Department of Psychiatry, University of São Paulo School of Medicine, R. Dr. Ovídio Pires de Campos, 785, São Paulo, SP, 05403-903 Brazil

ARTICLE INFO

Article history:

Received 22 December 2013

Received in revised form 13 April 2014

Accepted 21 April 2014

Available online 5 June 2014

Keywords:

Obsessive-compulsive disorder

Separation anxiety disorder

Comorbidity

Anxiety

Diagnosis

Epidemiology

ABSTRACT

Objective: Individuals with obsessive-compulsive disorder (OCD) and separation anxiety disorder (SAD) tend to present higher morbidity than do those with OCD alone. However, the relationship between OCD and SAD has yet to be fully explored.

Method: This was a cross-sectional study using multiple logistic regression to identify differences between OCD patients with SAD (OCD + SAD, $n = 260$) and without SAD (OCD, $n = 695$), in terms of clinical and socio-demographic variables. Data were extracted from those collected between 2005 and 2009 via the Brazilian Research Consortium on Obsessive-Compulsive Spectrum Disorders project.

Results: SAD was currently present in only 42 (4.4%) of the patients, although 260 (27.2%) had a lifetime diagnosis of the disorder. In comparison with the OCD group patients, patients with SAD + OCD showed higher chance to present sensory phenomena, to undergo psychotherapy, and to have more psychiatric comorbidities, mainly bulimia.

Conclusion: In patients with primary OCD, comorbid SAD might be related to greater personal dysfunction and a poorer response to treatment, since sensory phenomena may be a confounding aspect on diagnosis and therapeutics. Patients with OCD + SAD might be more prone to developing specific psychiatric comorbidities, especially bulimia. Our results suggest that SAD symptom assessment should be included in the management and prognostic evaluation of OCD, although the psychobiological role that such symptoms play in OCD merits further investigation.

© 2014 Elsevier Masson SAS. All rights reserved.

1. Introduction

Obsessive-compulsive disorder (OCD) is characterised by recurrent obsessions or compulsions [2]. Obsessions are recurrent, intrusive thoughts, images or fears that are usually ego-dystonic and are accompanied by anxiety, distress or feelings of incompleteness [2]. To ignore, suppress or neutralise obsessive thoughts

and associated feelings patients perform compulsions, which are repetitive, purposeful behaviours aimed at reducing anxiety or distress [38,50]. OCD patients frequently report comorbid psychiatric conditions, including affective and anxiety [10,21,34,40,49,53]. Separation anxiety disorder (SAD) is one of the five most common comorbid psychiatric disorders in OCD, the others being major depressive disorder (MDD), generalised anxiety disorder (GAD), social anxiety disorder and simple phobia [10,34]. According to the Diagnostic and Statistical Manual of Mental Disorders-4th edition-Text Revision (DSM-IV-TR), SAD is characterised by developmentally inappropriate and excessive worries about separation from home or attachment figures, the onset typically occurring before 18 years of age [2]. Although SAD is considered a childhood disorder, the symptoms can persist into adulthood, and some authors have argued that adult SAD is more

* Corresponding author. Tel./fax: +55 (51) 3346 1077.

E-mail addresses: ygoraf@ufcspa.edu.br, ygoraf@gmail.com (Y.A. Ferrão).

¹ Tel.: +55 (51) 3303 9000; fax: +55 (51) 3303 8810.

² Tel.: +1 401 863 1000.

³ Tel.: +55 (14) 3811 6000.

⁴ Tel.: +55 (11) 3385 4101.

⁵ Tel.: +55 (11) 2661 6972.

common than suggested in the DSM-IV-TR [41,55]. Adult SAD (ASAD) has been described by Manicavasagar et al. [29,30]. The National Comorbidity Survey-Replication [56] showed a lifetime prevalence of 6.6%, adult onset occurring in only 5.3% of cases, whereas 36.1% started in childhood and persisted into adulthood. The adult SAD clinical characteristics are similar to the ones in childhood [29]. Like children, adults experience intense anxiety about separation from, together with exaggerated fears about harm befalling, close attachment figures, as well as an intense sense of personal threat, reflected in symptoms such as nightmares and anxiety about abandonment.

Childhood SAD is strongly correlated with adult anxiety disorders [25,27], and some studies have attempted to link early-onset separation anxiety with adult social phobia, panic disorder (PD) and agoraphobia [43,66]. Those studies suggested that SAD is a general risk factor to develop a range of anxiety disorders [10,12,57]. For instance, one recent study showed that, among OCD comorbidities, the mean age of onset was earliest for SAD [10]. Among OCD patients presenting SAD as the first comorbid diagnosis, the lifetime frequency of post-traumatic stress disorder (PTSD) is higher, as are scores on the sexual/religious dimension of the Dimensional Yale-Brown Obsessive-Compulsive Scale (DY-BOCS), Beck Anxiety Inventory (BAI) and Beck Depression Inventory (BDI), indicating that SAD is a predictor of anxiety later in life in OCD patients [10]. In the only study examining the differences between OCD patients with and without SAD, which included 470 patients, those with SAD ($n = 80$) were younger, had an earlier obsessive-compulsive symptom (OCS) onset, as well as greater OCS severity and higher prevalence of PD, agoraphobia and social phobia [37].

The objective of the present study was to further explore comorbidity between OCD and SAD in a large patient sample, using highly specific instruments and detailed questionnaires (to better explore OCD dimensions, sensory phenomena, suicidality, insight and psychiatric comorbidities), in order to determine whether adult OCD patients with SAD differ from those without, across a range of socio-demographic and clinical characteristics. The main hypotheses were that, among OCD patients with SAD, age of onset is earlier, symptoms are more severe, the frequency of the DY-BOCS sexual-religious dimension is higher and the incidence of other anxiety disorders, especially PD, agoraphobia and social phobia, is higher.

2. Subjects and methods

2.1. Sample

This was a cross-sectional study involving 955 OCD outpatients who participated in the Brazilian Research Consortium on Obsessive-Compulsive Spectrum Disorders (BRCOCS) project between 2005 and 2009 [34]. The BRCOCS project involves eight university hospitals in six Brazilian cities. All eight hospitals are dedicated to OCD treatment and research. The inclusion criteria were being ≥ 18 years of age and having received a primary diagnosis of OCD (as defined in the DSM-IV-TR). The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) was used in order to confirm the diagnosis [12]. Patients with comorbid schizophrenia, dementia or mental retardation (DSM-IV criteria) were excluded, as were those with any other psychiatric condition that would render the individual incapable of understanding the assessment instruments. Individuals were recruited to the project from primary or secondary health care clinics, private psychiatric services, websites, media announcements, self-help groups, and the Brazilian Association for Tourette syndrome, Tics and Obsessive-Compulsive Disorder. Additional details regarding BRCOCS procedures are available in Miguel et al. [34]. The study

was approved by the institutional review boards of the various BRCOCS centres, and all participating patients gave written informed consent.

2.2. Assessment

The study protocol included collection of socio-demographic data and a review of academic, professional, medical, and psychiatric histories. The instruments of assessment were applied by trained psychiatrists and psychologists. The current severity of obsessive-compulsive symptoms was measured with the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) [16], whereas the DY-BOCS [48] was also used in order to evaluate the occurrence of six dimensions of obsessive-compulsive symptoms: aggressive/violent thoughts and checking rituals; sexual/religious thoughts and related rituals; symmetry/ordering obsessions and compulsions; contamination obsessions and cleaning rituals; hoarding symptoms; and miscellaneous obsessions and compulsions. The OCD symptom dimensions were determined according to the presence of lifetime symptoms. The BDI and BAI [4,5] were used in evaluating the severity of depressive and anxious symptoms, respectively. Insight was assessed with the Brown Assessment of Beliefs Scale (BABS). The University of São Paulo Sensory Phenomena Scale (USP-SPS) [46] is a semi-structured scale designed to investigate the presence and severity of sensory phenomena (uncomfortable, distressing experiences preceding compulsions—also known as premonitory urges, sensory tics, just-right perceptions and sensory experiences). Sensory phenomena were initially described in Tourette syndrome but have also been associated with OCD [11,26,46]. The SCID-I [12,13] was used in order to confirm OCD diagnoses and to assess all other comorbid lifetime psychiatric disorders. Diagnoses of attention deficit hyperactivity disorder (ADHD) and SAD were confirmed by the Kiddie Schedule for Affective Disorders and Schizophrenia [22]. Researchers at each of the BRCOCS centres were trained in the use of all of the instruments. The SCID-I, Y-BOCS, and DY-BOCS presented excellent inter-rater reliability, as described by Miguel et al. [34].

2.3. Statistical analysis

The patients were divided into two groups: OCD with current or past SAD (OCD + SAD); and OCD without SAD (OCD). Categorical variables were initially described as their absolute and relative values, whereas continuous variables were described as mean and standard deviation (SD) or median and minimal/maximal values (when the Kolmogorov-Smirnov test showed no normal distribution). Pearson's, Yates' Chi-square or Fisher exact tests were used in order to compare categorical variables between the two groups. Odds ratios, with 95% confidence intervals, were also calculated. For between-group comparisons of continuous variables, the Student's *t*-test was used for those with normal distributions and the Mann-Whitney test was used for those with skewed distributions. The level of significance was set at $P < 0.05$. Variables with a $P \leq 0.05$ in the univariate analysis, respecting multi-collinearity and clinical-epidemiologic relevance, were included in multiple logistic regression models to determine the factors independently associated with SAD. Due to the great number of psychiatric comorbidities that would enter the model, we conducted two separate forward stepwise logistic regression analyses to adjust the associations for possible confounders: one including socio-demographic variables and clinical variables other than comorbidities (model 1); and one including only comorbidities (model 2). The regression models included all variables that were significant in the univariate analyses, except for those presenting variance inflation factor (VIF) values > 5 , which means

Download English Version:

<https://daneshyari.com/en/article/4184052>

Download Persian Version:

<https://daneshyari.com/article/4184052>

[Daneshyari.com](https://daneshyari.com)