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# A Study of Duration of Illness And Degree of Insight As Predictors of Treatment Response in Patients with Obsessive Compulsive Disorder

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***Abstract***
***Aims and Objectives:*** *To study the effect of duration of illness and degree of insight as predictors of treatment outcome in patients with obsessive compulsive disorder.*
***Methods and materials****: Patients diagnosed with OCD (ICD-10) at OP setting were included in the study and followed up for three months under treatment with SSRIs. Duration of illness was noted. YBOCS severity scale and BABS were administered at the time of entry into study and after three months of treatment. A 35% reduction in YBOCS score was considered treatment response.*
***Results:*** *Of 49 patients in study, 20 responded to treatment. Non responders had significantly longer duration of illness( p = 0.004 ) and poorer insight(p = 0.046) than responders.*
***Conclusion:*** *Total duration of illness and degree of insight were found to be significant predictors of treatment response in patients with OCD.*
***Key words: Insight, OCD, Treatment response.***

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## I. Introduction

Obsessive compulsive disorder(OCD) is a serious and persistent mental health problem. There has been an increasing interest in conceptual understanding of OCD and factors effecting the disease course and treatment outcome. OCD is a disorder that seems to be under-diagnosed and under-treated in all age groups. OCD is the fourth commonest mental disorder worldwide (Kiejna A et al (2002))[(1)] and in India (Karno et al., (1988))[(2)] with a lifetime prevalence of 1-2% (Kiejna A et al. (2002))[(1)] worldwide. In India it was found to be 0.6% (Y J Reddy et al. (2010)).[(3)]OCD is characterized by the presence of persistent and recurrent irrational thoughts (obsessions), resulting in marked anxiety and/or repetitive excessive behaviors (compulsions) as a way to try to decrease that anxiety. The presence of recurrent obsessional thoughts or compulsive acts or both, which must have been present for most days for a period of at least two weeks is required to make a diagnosis. At least one (obsession or compulsion) is felt to be excessive or unreasonable, that the individual tries to resist them and fails to resist at least one, and that carrying out the obsession or compulsion is not a pleasurable experience. The obsessions and/or compulsions cause significant distress and interfere with the individual's functioning and the symptoms are not due to other disorders, such as schizophrenia or other affective disorders. The purpose of this study is to investigate the association of duration of illness and degree of insight with the treatment outcome of obsessive-compulsive disorder (OCD) in our clinical setting.

## II. Patients And Methods

**Study Design**: This is a prospective study done for evaluating the variables effecting outcome in patients with OCD.
**Area Of Study**- Institute of mental health , Erragadda, Hyderbad.
**Sample Size** : All patients attending the out patient services and inpatients at Institute of mental health, diagnosed as having OCD at the hospital, fulfilling inclusion and exclusion criteria are considered.
**Inclusion Criteria:** 1. Males and Females aged between 18-60yrs. 2. With primary diagnosis of OCD according to ICD 10.
**Exclusion criteria**. 1. Age less than 18 and more than 60 years. 2. Pregnancy or lactation. 3. Psychiatric comorbidities

**Procedure:** Patients from IP / OP departments with their main diagnosis as OCD (according to ICD – 10) fulfilling inclusion and exclusion criteria are included in the study. At the time of entry into study, after taking written informed consent socio-demographic details are taken through an intake proforma. At the time of

entry the following tests were administered. 1.Mini International Neuropsychiatric Interview plus(MINI-Plus) to diagnose OCD and rule out comorbidpsychiatric illness. 2.Y-BOCS(Yale brown obsessive compulsive scale) severity scale for disease severit. 3. BABS(brown assessment of beliefs scale) to evaluate insight. Pharmacological treatment is started in drug naive patients and necessary escalation and adjustments made in those on treatment already according to standard guidelines. After 12 wks of treatment, Y-BOCS severity scale and BABS are re-administered. A 35% reduction in Y-BOCS score is considered response. On that basis, patients are grouped into responders and non-responders and above variables evaluated. **Statistics :** The findings are tabulated and analysed using Microsoft excel and SSPS (Statistical Package for the Social Sciences) version 22.

## III. Results

A total of 63 patients with OCD were interviewed. 55 patients were included in to the study and 8 patients were ruled out as they did not fulfill the inclusion and exclusion criteria. 4 patients were lost to follow up. The final sample consisted of 49 participants. Based on treatment response, patients were divided into two groups(Diagram 1). The responded group (>35% treatment response) contained 20(40.7%) patients of total sample. The non responded group (<35% treatment response) had 29(59.3%) patient of total sample.

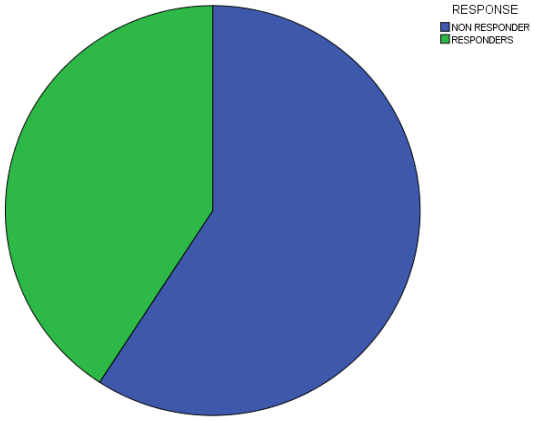


**Diagram 1:** Responders and Nonresponders

**Sociodemographic variables among the responder and non responder groups**: (Table 1)
No significant differences between responders and non-responders were observed in terms of gender, socioeconomic status, educational status, occupation, domicile , marital status and religion.

| Variable | | Non responder N(%) | Responder N(%) | Chi square value λ2 | p value |
|---|---|---|---|---|---|
| Gender | Male (32) | 20(69.0) | 12(60) | 0.420 | 0.517 |
| | Female (17) | 9(31.0) | 8(40) | | |
| Socioeconomic status | Lower (27) | 14(48.3) | 13(65) | 1.338 | 0.247 |
| | Middle (22) | 15(51.7) | 7(35) | | |
| Education | Illiterate (5) | 2(6.9) | 3(15) | 8.845 | 0.115 |
| | Primary (10) | 3(10.3) | 7(35) | | |
| | SSC (6) | 4(13.8) | 2(10) | | |
| | Intermediate (5) | 3(10.3) | 2(10) | | |
| | Graduation (20) | 16(55.2) | 4(20) | | |
| | Post graduation (3) | 1(3.4) | 2(10) | | |
| Occupation | Unemployed (12) | 11(37.9) | 1(5) | 3.101 | 0.683 |
| | Unskilled laborer (2) | 1(3.4) | 1(5) | | |
| | Skilled laborer (9) | 1(3.4) | 8(40) | | |
| | House wife (11) | 6(20.7) | 5(25) | | |
| | Unprofessional (11) | 6(20.7) | 5(25) | | |
| | Professional (4) | 4(13.8) | 0(0.00) | | |

| | | | | | |
|---|---|---|---|---|---|
| Residence | Rural (23) | 12(41.4) | 11(55) | 0.882 | 0.348 |
| | Urban (26) | 17(58.6) | 9(45) | | |
| Marital status | Married (24) | 16(55.2) | 8(40) | 2.084 | 0.353 |
| | Unmarried (24) | 12(41.4) | 12(60) | | |
| | Divorced (1) | 1(3.4) | 0(0.00) | | |
| Religion | Hindu (39) | 24(82.8) | 15(75) | 0.439 | 0.508 |
| | Muslim (10) | 5(17.2) | 5(25) | | |

**Table 1:** Socio-demographic variables among responders and non-responders

**Age , age of onset and duration of illness**: (Table 2), (Diagram 2)

The age of the subjects ranged from 20 years to 60 years, the mean age of subjects being 31.42 years (SD+/-9.46) years. The mean age of the non-responded group was 32.31 years (SD+/-10.09) years, while the mean age of responded group was 30.15 years (SD+/-8.56) years. The average age of onset of OCD was 26.24 years and the average duration of illness was 5.14 years. The mean age of onset of illness in the non-responded group was 25.37 years (SD+/-8.70) years, while the mean age of onset in responded group was 27.5 years (SD+/-9.00) years. No significant difference was observed with respect to mean age or mean age of onset among the groups. The mean duration of illness in the non-responded group was 6.93 years (SD+/-6.68) years, while the mean age of onset in responded group was 2.54 years (SD+/-2.05) years. Duration of illness was found to have statistically significant difference among the two groups with t (35.872) = 3.082, p = 0.004 on T test for equality of means.(Diagram 2)

| | Responders Mean(SD) | Nonreponders Mean(SD) | t(df) = t statistic | p value |
|---|---|---|---|---|
| Age (in years) | 30.15(8.56) | 32.31(10.09) | t(47) = 0.844 | 0.403 |
| Age of onset (in years) | 27.5(9.00) | 25.3(8.70) | t(47) = -0.66 | 0.512 |
| Duration of illness (in years) | 2.54(2.05) | 6.93(6.68) | t(35.472) = 3.082 | 0.004 |
| BABS 1 | 7.8(4.95) | 11.65(6.46) | t(45.52)= 2.054 | 0.046 |

Table 2: Age, Age of onset, Duration of illness and insight in responded and non-responded

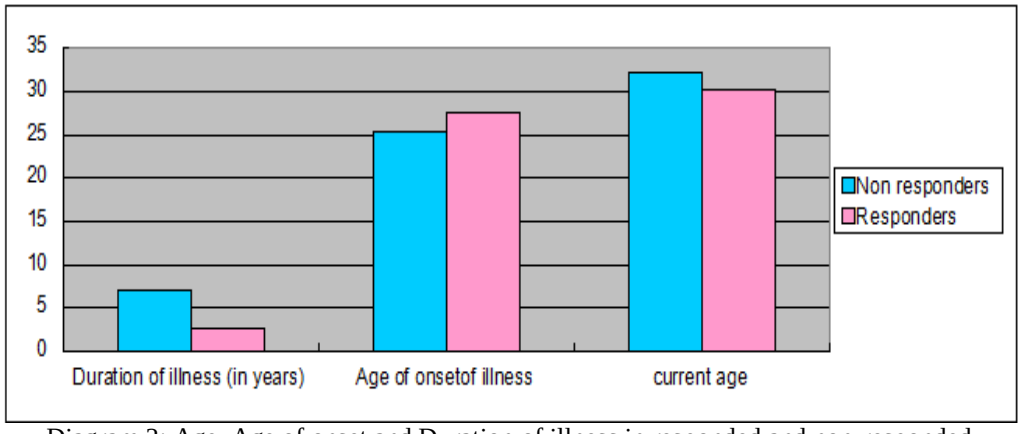


Diagram 2: Age, Age of onset and Duration of illness in responded and non-responded

**Insight :** The mean BABS score at baseline was 10.08(SD+/-6.14), and after three months of treatment was 7.122(SD+/-5.20). The BABS scores in responder and non responder sample was 7.8(SD-4.95) and 11.65(SD-6.46) respectively. This difference appears significant on T test for equality of means with t(45.52) = 2.054, p = 0.046. 9( Table 2).

## IV. Discussion

This prospective study investigated total duration of illness and degree of insight as prognostic predictors in patients with OCD. The predictors were studied as a function of treatment response in our study. 'Treatment response' was defined as at least a 35% reduction on the Y-BOCS total score at the end of 12 weeks, similar to previous studies(Rasit Tukel et al (2006)[4], Erzegovesi et al (2001)[5] , Alonso P et al (2001) [6] ). On that basis, patients are grouped into responders and non-responders and the above mentioned variables evaluated for their effect on improvement. In the present study, rate of response to treatment in OCD patients defined as at

least a 35% drop on the Y-BOCS score was 40.7% and was reported as 57% by Erzegovesi et al (2010) [5], 58.2% by Rasit Tukel et al (2006) [4], 49.7% by C H Kim et al (2011) [7].

The age of onset of OCD in our sample appears to be higher than that observed in other studies (Dellosso et al (2013)[8]) in which the mean age was around 20 and below. This difference could have been due to exclusion of adolescent OCD patients into our study and inability of patients to report the time at which their illness started exactly. The mean age of onset of illness in the non-responders group was lower than that of responders but the difference was not statistically significant(0.512) meaning that age of onset was not a predictor of outcome in our study. This result was parallel with the results of studies by Roseli G. Shavitt et al (2006) [9], SE Stewart et al (2006)[10] , Millet et al (2004)[11] which report no difference in final treatment outcome among patients with either early and late onset. Erzegovesi et al (2001),[5] Ravizza et al (1995)[12], Jakubovski et al (2012)[13] and Shetti CN et al (2005)[14] report that patients with OCD and early onset respond more poorly to treatment.

**Duration of illness:** The average duration of illness was 5.14 years in our sample which was lower than that found in other studies(D Giacco et al - 7.3years, Rasit Tukel et al - 8.9years).[15,4] The mean duration of illness in the non-responder group was 6.93 years, while the mean age of onset in responder group was 2.54 years. Duration of illness was found to have statistically significant difference among the two groups( $p = 0.004$). Longer duration was found to be associated with poorer outcome. Longer duration of illness was reported to be associated with poor outcome by Dellosso et al, (2013)[8], Jakubovski et al (2012)[13] and J L Eisen et al (2013)[16] .

**Insight :** The BABS scores intended to know the delusionality of the beliefs the subjects held about their obsessions and compulsions and insight were found to be higher in non responders and this difference appeared significant( $p = 0.046$) indicating poor insight to be a predictor of non response. The results run parallel with that of Erzegovesi et al (2001)[5] who identified poor insight as one of the best predictor of drug treatment response along with family history for OCD and Catapano et al (2010)[17] who reported that poor insight was associated with poor response in his study . Indian studies carried by Ravi Kishore et al (2004)[18] and Shetti CN et al (2005)[14] also reported poor insight as a predictor of overall poor outcome. The findings of our study are against the findings of study by Eisen et al (2001)[19] who found that the degree of improvement of OCD symptoms to be similar in poor-insight and good-insight groups and by Rasit Tukel et al (2006)[4] who reported no difference in insight scores of responder and non-responder groups in his study sample.

## V. Conclusions

**Strengths of the study: a)**The study is a prospective study following the natural course of the disease. **b)** Being a prospective study, there are lesser chances of bias. **c)** The study enables us to know the predictors of response to treatment in the setting of our hospital.

**Weaknesses / limitations of this study: a)**This study was based on follow-up of data obtained from patients who visited only the Institute of Mental Health, Hyderabad. These results may not be generalized to all OCD patients. **b)** The sample size in the study is too small to establish robust results. This study is also limited by its inability to study long-term treatment effects because of its short duration of follow up. **c)** The study is not randomized. **d)** Patients received various types of medications and at different doses. The drug treatment was not supplemented by any psychotherapy as guided by standard guidelines. **e)** In this study, some variables which are known to predict the outcome in the literature such as co-morbid personality disorders, presence of tics and other comorbidities etc were not studied.

A study with a larger sample, with longer duration of follow up and more uniform and standardised treatment would yield better results.

## References


[1]. Kiejna A, Rymaszewska J, Kantorska-Janiec M, Tokarski W . Epidemiology of obsessive-compulsive disorder. Psychiatry Pol 36(2002): 539–548.

[2]. Karno M, Golding J, Sorensen S, Burnam A. The epidemiology of obsessive-compulsive disorder in five U.S. communities. Arch Gen Psychiatry. 1988;45:1094–9.

[3]. Reddy, YC Janardhan, Naren P. Rao, and Sumant Khanna. An overview of Indian research in obsessive compulsive disorder. Indian journal of psychiatry52.Suppl1 (2010): S200.

[4]. Tukel, Rasit, Oya Bozkurt, Aslihan Polat, Aysun Genc, and Hatice Atli. Clinical predictors of response to pharmacotherapy with selective serotonin reuptake inhibitors in obsessive–compulsive disorder. Psychiatry and clinical neurosciences 60, no. 4 (2006): 404-409.

[5]. Erzegovesi, Stefano, Maria Cristina Cavallini, Paolo Cavedini, Giuseppina Diaferia, Marco Locatelli, and Laura Bellodi. Clinical predictors of drug response in obsessive-compulsive disorder. Journal of clinical psychopharmacology 21, no. 5 (2001): 488-492.

[6]. Alonso, Pino, Jose M. Menchon, Josep Pifarre, David Mataix-Cols, Llanos Torres, Purificación Salgado et al. Long-term follow-up and predictors of clinical outcome in obsessive-compulsive patients treated with serotonin reuptake inhibitors and behavioral therapy. Journal of Clinical Psychiatry (2001).

[7]. Kim, Chan-Hyung, Jae-Wook Jeong, Eun Ju Kim, Yoon Shick Shin, Ho Suk Suh, Hong Shick Lee et al. Clinical Predictors of Drug Response in Patients with Obsessive-Compulsive Disorder. Clinical Psychopharmacology and Neuroscience 9, no. 1 (2011): 23-28.

[8]. Dell'Osso, Bernardo, Beatrice Benatti, Massimiliano Buoli, A. Altamura, Donatella Marazziti, Eric Hollander et al. The Influence of Age at onset and Duration of illness on long-term outcome in patients with obsessive-compulsive disorder: A report from the International College of Obsessive Compulsive Spectrum Disorders (ICOCS). European Neuropsychopharmacology 23, no. 8 (2013): 865-871.
[9]. Shavitt, Roseli G., Cristina Belotto, Mariana Curi, Ana G. Hounie, Maria C. Rosário-Campos, Juliana B. Diniz et al. Clinical features associated with treatment response in obsessive-compulsive disorder. Comprehensive psychiatry 47, no. 4 (2006): 276-281.
[10]. Stewart, S. Evelyn, Chen-Hsing Yen, Denise Egan Stack, and Michael A. Jenike. Outcome predictors for severe obsessive–compulsive patients in intensive residential treatment. Journal of psychiatric research 40, no. 6 (2006): 511-519.
[11]. Millet, B., F. Kochman, T. Gallarda, M. O. Krebs, F. Demonfaucon, I. Barrot, M. C. Bourdel, J. P. Olie et al. Phenomenological and comorbid features associated in obsessive–compulsive disorder: influence of age of onset. Journal of Affective Disorders 79, no. 1 (2004): 241-246.
[12]. Ravizza L, Barzega G, Bellino S, Bogetto F, Maina G. Predictors of drug treatment response in obsessive-compulsive disorder. J. Clin. Psychiatry 1995; 56: 368 – 373.
[13]. Jakubovski, Ewgeni, Juliana B. Diniz, Carolina Valerio, Victor Fossaluza, Cristina Belotto- Silva, Clarice Gorenstein et al. Clinical Predictors of Long term Outcome in Obsessive Compulsive Disorder. Depression and anxiety 30, no. 8 (2013): 763-772.
[14]. Shetti CN, Reddy YC, Kandavel T, Kashyap K, Singisetti S, Hiremath AS, et al. Clinical predictors of drug non-response in obsessive-compulsive disorder. J Clin Psychiatry. 2005;66:1517–23.
[15]. Giacco, D., F. Perris, M. Fabrazzo, V. De Santis, and F. Catapano. P-810-Duration of untreated illness and outcome of the OCD: a three-year prospective study. European Psychiatry 27 (2012): 1.
[16]. Eisen, Jane L., Nicholas J. Sibrava, Christina L. Boisseau, Maria C. Mancebo, Robert L. Stout, Anthony Pinto et al. Five-year course of obsessive-compulsive disorder: predictors of remission and relapse. The Journal of clinical psychiatry 74, no. 3 (2013): 233.
[17]. Catapano, Francesco, Francesco Perris, Michele Fabrazzo, Valeria Cioffi, Domenico Giacco, Valeria De Santis et al. Obsessive–compulsive disorder with Poor Insight: a three-year prospective study. Progress in Neuro-Psychopharmacology and Biological Psychiatry 34, no. 2 (2010): 323-330.
[18]. Ravi Kishore, V., R. Samar, Y. C. Janardhan Reddy, C. R. Chandrasekhar, and K. Thennarasu. Clinical characteristics and Treatment response in poor and good Insight Obsessive Compulsive disorder. European Psychiatry 19, no. 4 (2004): 202-208.
[19]. Eisen, Jane L., Steven A. Rasmussen, Katharine A. Phillips, Lawrence H. Price, Jonathan Davidson, R. Bruce Lydiard et al. Insight and Treatment Outcome in Obsessive-Compulsive disorder. Comprehensive psychiatry 42, no. 6 (2001): 494-497.

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