How Common Is Obsessive-Compulsive Disorder in a Dermatology Outpatient Clinic?

Naomi A. Fineberg, M.R.C.Psych.; Connor O'Doherty, M.S.C., F.R.C.P.; Sundararajan Rajagopal, M.R.C.Psych.; Karen Reddy, B.Sc.; Annabelle Banks, M.R.C.Psych.; and Tim M. Gale, Ph.D.

Background: This study was prompted by reports suggesting a high prevalence of unrecognized obsessive-compulsive disorder (OCD) in the dermatology clinic.

Method: 92 consecutive dermatology referrals were screened for DSM-IV OCD using the Mini-International Neuropsychiatric Inverview (MINI), the Yale-Brown Obsessive Compulsive Scale (YBOCS), and the 5-item screening questionnaire from the International Council on OCD. Illness severity was rated on the YBOCS, and symptom profiles and dermatologic diagnoses were established for screen-positive cases.

Results: 18 patients (20%) qualified for a DSM-IV diagnosis of OCD, of whom 17 were previously undiagnosed. The range and type of OCD symptoms covered the normal clinical spectrum. Most patients had more than 1 symptom, and among obsessions (including somatic obsessions), checking, washing, and symmetry were common. The mean total YBOCS score was 16/40 (SD = 7.2), indicating moderate OCD, and 40% of the positive cases scored 16 or higher. Dermatologic diagnoses were various and did not seem to bear a direct relationship with the OCD.

Conclusion: These results suggest that there is a high prevalence of clinically relevant OCD in the dermatology clinic. This is an area that merits attention with regard to better recognition and treatment for OCD sufferers.

(J Clin Psychiatry 2003;64:152–155)

Received Feb. 20, 2002; accepted May 22, 2002. From the Hertfordshire Partnership, NHS Trust (Dr. Fineberg); the Department of Psychiatry (Drs. Fineberg, Banks, and Gale and Ms. Reddy) and the Department of Dermatology (Dr. O'Doherty), Queen Elizabeth II Hospital, Welwyn Garden City, U.K.; the Division of Psychology, University of Hertfordshire, Hatfield, U.K. (Drs. Fineberg and Gale); and the Department of Psychiatry, Guy's Hospital, London, U.K. (Dr. Rajagopal).

Supported by British National Health Service (NHS) Research and Development funding from the NHS Executive Eastern Region, U.K.

The authors are grateful to Kim Fox for administrative support and also to 2 anonymous reviewers for their helpful comments.

Corresponding author and reprints: Naomi A. Fineberg, M.R.C.Psych., Department of Psychiatry, QEII Hospital, Howlands, Welwyn Garden City, Hertfordshire, AL7 4HQ, UK (e-mail: kim.fox@hpt.nhs.uk).

Obsessive-compulsive disorder (OCD) affects between 2% and 3% of the general population.[1,2] Although there are effective and easily accessible treatments for OCD, only a small proportion of sufferers receive appropriate treatment.[3] Many individuals are ashamed to divulge their symptoms and keep them secret. While most sufferers go completely unrecognized, some seek the help of other medical services due to problems related to their OCD.[4] It has been suggested that a large number of obsessional patients consult dermatologists.[5] Skin damage resulting from excessive, ritualized washing or picking or somatic obsessions about bodily appearance may directly lead to a dermatologic referral. If there is a preponderance of OCD in the dermatology clinic, then this may be a fertile area for screening in order to identify, and treat as appropriate, hitherto undiagnosed OCD.

METHOD

Participants

The study sample screened for inclusion were consecutive attenders at the routine dermatology outpatient clinic at Queen Elizabeth II Hospital, a district general hospital based in the United Kingdom. Recruitment took place over 2 periods: January 14, 2000, to February 25, 2000, and May 26, 2000, to June 16, 2000. The patients were aged between 18 and 65 years and hailed from the local, mainly urban, population. All participants gave written consent before entering the study.

Psychometric Instruments

The primary screening instrument was item H of the Mini-International Neuropsychiatric Interview (MINI).[6] The MINI is a validated instrument and is administered as a brief, structured interview for the major Axis I disorders in DSM-IV.[7] Item H of the MINI screens for OCD and takes only 2 minutes to administer.

The secondary screening measure was a set of 5 screening questions for OCD, devised by the International Council on OCD[8] as a quick, user-friendly screening test. As far as the authors are aware, this test has not been validated in a clinical sample. By adopting this measure we therefore hoped to test its validity in relation to item H of

Table 1. Five Questions to Identify an OCD Sufferer[a]

1. Do you wash or clean a lot?
2. Do you check things a lot?
3. Is there any thought that keeps bothering you that you would like to get rid of but can't?
4. Do your daily activities take a long time to finish?
5. Are you concerned about orderliness or symmetry?

[a]Reproduced from the International Council on Obsessive Compulsive Disorder, with permission.[8]
Abbreviation: OCD = obsessive-compulsive disorder.

Table 2. Comparison Between Results of the MINI and the International Council on OCD 5-Question Measure

Comparator	MINI Positive	MINI Negative
5-question, positive	17	11
5-question, negative	1	63

Abbreviations: MINI = Mini-International Neuropsychiatric Interview, OCD = obsessive-compulsive disorder.

the MINI. The 5 screening questions are displayed in Table 1.

The severity of the disorder was evaluated in patients screening positive on the MINI by using the 10-item, observer-rated Yale-Brown Obsessive Compulsive Scale (YBOCS).[9] This is considered the standard severity-rating instrument for OCD. Obsessive-compulsive symptoms were recorded using a semistructured interview that included the YBOCS Symptom Checklist[9] in some cases.

Procedure

The screening was performed by 1 of 3 trained mental health professionals (1 registered mental health nurse, 2 psychiatrists). The patients were examined in a small room by the waiting area in the dermatology clinic either before or after their consultation with the dermatologist. The researchers were blind to the dermatologic diagnosis at the time of screening.

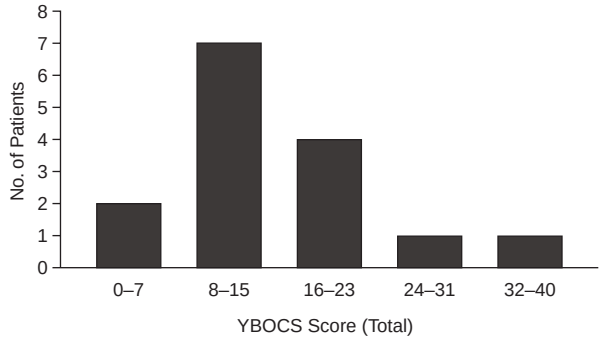
Where possible, patients were rated for the severity of their OCD (only 92 [75%] of the consecutive patient sample gave their consent to be interviewed). Obsessional symptoms were also recorded, and dermatologic diagnoses for this group were established by case note analysis and personal consultation with the dermatologist.

RESULTS

Of 123 consecutive dermatology patients, 92 consented to screening. Of these, 18 (20%) screened positive for OCD on the MINI and 17 were previously undiagnosed. Six were male and 12 female. This gender ratio was consistent with that of the total sample screened.

Fifteen positive cases consented to be rated for severity on the YBOCS, and the total YBOCS score ranged from 6 to 32 (maximum score = 40; Figure 1). The mean ± SD total YBOCS score was 16 ± 7.2, representing

Figure 1. Yale-Brown Obsessive Compulsive Scale (YBOCS) Scores in 15 Positive Cases



moderately severe OCD. Six cases (40% of those rated) scored 16 or more on the YBOCS, representing a degree of severity compatible with entry into a treatment study.

Table 2 shows the comparison between the results of the MINI and the 5-question instrument. Twenty-eight patients screened positive for OCD using the 5-question measure. Assuming the MINI as the criterion standard, the 5-question measure has a sensitivity of 94.4% and a specificity of 85.1%. The positive and negative predictive values for the 5-item questionnaire versus the MINI are 0.61 and 0.98, respectively. The kappa statistic for these 2 measurement tools is 0.66, indicating good agreement.

We were able to obtain a profile of obsessional symptoms on all 18 MINI-positive patients. Most reported more than 1 OCD symptom, and many patients reported similar symptoms. Multiple obsessions, checking, cleaning/washing, and symmetry were the most common symptoms reported. Two patients suffered with somatic obsessions (dysmorphophobia) of whom 1 appeared to qualify for a DSM-IV diagnosis of body dysmorphic disorder (BDD), since he did not divulge other significant obsessional psychopathology. Table 3 illustrates the distribution of obsessional symptoms in our sample, compared with that of a large clinical sample.[10] The distribution of obsessive-compulsive symptoms appeared consistent with clinical norms, notwithstanding the small sample size.

Table 4 shows the dermatologic diagnoses in the patients scoring positive on the MINI. The diagnoses varied widely and some patients had more than 1 diagnosis. Apart from 1 patient with BDD who had no identified dermatologic disorder, there did not appear to be a direct link between the dermatologic and the obsessional symptoms, nor was there a preponderance of pruritus, excoriation, or dermatitis.

DISCUSSION

The World Health Organization has recently declared OCD to be the 10th major cause of morbidity worldwide,

Table 3. Distribution of Obsessive-Compulsive Symptoms in MINI-Positive Sample, Compared With a Large Clinical Sample[a]

Comparator	Multiple Obsessions	Checking	Cleaning/Washing	Symmetry	Somatic Obsessions
MINI positive (N = 18)	10 (55%)	8 (44%)	7 (39%)	7 (39%)	2 (11%)
Clinical sample (N = 250)	(60%)	(63%)	(50%)	(28%)	(36%)

[a]Data from Rasmussen and Eisen.[10]
Abbreviation: MINI = Mini-International Neuropsychiatric Interview.

Table 4. Dermatologic Diagnoses in 18 MINI-Positive Patients and a Random Sample of 18 MINI-Negative Patients[a]

Condition	MINI Positive	MINI Negative
Eczema	5	3
Acne	2	4
Warts	2	2
Psoriasis	2	6
Basal cell carcinoma	2	0
Fungal infection	1	2
Keratosis	0	2
Papule	1	0
Varicose veins	1	0
Vitiligo	1	0
Urticaria	1	0
Prurigo	1	0
Pruritus	0	1
Indeterminate nasal lesion	1	0
No diagnosis	1	0

[a]Some patients had more than 1 condition.
Abbreviation: MINI = Mini-International Neuropsychiatric Interview.

and the economic cost to society by means of lost revenue from workplace, sickness benefits, and expenditure on ineffective treatment is high.[3] Better recognition of OCD is an important public health issue.

Few studies have investigated defined psychiatric disorders among dermatology patients. Hughes et al.[11] found that the prevalence of "psychiatric disorder" in dermatology outpatients and inpatients was higher than in the general population and medical inpatients, respectively. Wessely and Lewis[12] detected 40% psychiatric morbidity in a random sample of 160 new attendees at a dermatology outpatients clinic. Of these, the majority were cases of "minor affective disorder."

Even fewer studies specifically have investigated OCD in dermatology patients. Hatch et al.[13] found that 14% of patients who presented with chronic pruritus had previously undetected OCD. Arnold et al.[14] assessed 34 patients presenting with psychogenic excoriation and found that only a minority of subjects excoriated their skin as part of OCD. Woodruff et al.[15] assessed 32 consecutive referrals to the liaison psychiatric service within a dermatology clinic and found OCD to be among the less common diagnoses in these selected patients, with depressive illness and anxiety disorders being the most common.

The above studies have looked at general psychiatric morbidity, selective dermatologic conditions (chronic pruritus and psychogenic excoriation), or patients referred to the liaison psychiatrist who are more likely to have shown more acute or more easily recognizable psychiatric symptoms to have warranted the referral.

We decided that screening a comprehensive cohort of patients presenting to the skin clinic, irrespective of their dermatologic diagnosis, would be more meaningful and effective in identifying previously undetected OCD.

OCD Is Common in the Dermatology Clinic

This is the largest study investigating the prevalence of OCD in an unselected sample of dermatology outpatients. Using standardized instruments, we found a point-prevalence for DSM-IV OCD of 19.6%, with the majority of respondents experiencing clinically meaningful severity of illness. This result is at least 6 times higher than the prevalence in the general population and exceeds previous figures[1,2] for OCD in dermatologic settings. All but 1 individual were previously undiagnosed. We found a strong correlation between the MINI and the 5-question measure of the International Council on OCD. The 5-question instrument identified more patients as positive, while retaining sensitivity, suggesting it may be a useful preliminary screening tool for routine clinical practice.

Caveats. What are the caveats relating to this result? The numbers screened were relatively small by epidemiologic standards, and the result ought to be confirmed in a larger population. Because the instruments were chosen for their brevity, the study was easy to perform and acceptable to the vast majority of clinic attenders (92/123), thereby accessing a representative sample of routine dermatology patients. The tradeoff, however, was that the information obtained about screen-positive patients was limited. For example, we were unable to screen for psychiatric comorbidity or to learn about the natural history of the obsessional symptoms. We were only able to apply the rigorous YBOCS checklist in 3 probands, owing to time constraints.

The diagnosis of OCD may be difficult and confusing, especially if the patient is fearful of divulging symptoms to the interviewer. We believe some patients with OCD were missed by the brief screening procedure (e.g., 1 patient who had screened negative admitted to obsessional symptomatology at a follow-up appointment some weeks later), and our result may well have underestimated the true prevalence of the disorder in this population.

The MINI was less than ideal because its diagnostic range is limited and it can be relatively nonselective in this area of psychiatry. For example, the MINI is unable to

distinguish between OCD and certain other members of the "OCD-spectrum" of illnesses such as BDD. As it happened, all but 1 individual identified by the MINI separately reported several pathognomonic symptoms of OCD, and although 1 case of BDD may erroneously have been included as OCD, it is unlikely that this limitation substantially affected the overall findings. Moreover, most authorities acknowledge that BDD shares so many similarities with OCD that it may well represent a forme fruste of the disorder.[16]

Future studies would benefit from a more detailed analysis. While there are no ideal screening tools for OCD, the Anxiety Disorders Interview Schedule for DSM-IV (ADIS IV)[17] focuses specifically on the anxiety disorders and may be suitable for further exploration of this area. The ADIS IV has also been designed to evaluate highly comorbid diagnoses such as affective disorders and substance abuse disorders, while arguably more reliably diagnosing OCD than the SCID-IV.[18,19]

Finally, it is possible that some of the screen-positive patients in this study may have had the transient form of OCD (for example, see Nelson and Rice[20]), and this cannot be discounted since no longitudinal data were available for this group of patients.

Why Is OCD So Common in Dermatology Outpatients?

Why might so many dermatology patients suffer with OCD? Our preliminary observations are not in line with the suggestion that the skin problems are secondary to compulsive rituals, since so many of the dermatologic complaints appeared to be unrelated to the OCD. In particular, there was no overrepresentation of washing or skin-picking in the obsessive-compulsive sample. Further exploration of the cognitive psychology of OCD-positive respondents may provide a clue. Possibly, OCD sufferers are more than usually vigilant or preoccupied with the condition of their skin—or of their bodies in general—leading to a lower threshold for dermatologic consultation. It will be interesting to see whether this phenomenon applies specifically to the dermatology clinic, or whether there is a similar increase in the proportion of obsessional patients in other areas of the general hospital, as well. Indeed, a prospective comparison across a range of medical subspeciality clinics would be interesting. Alternatively, there may be a common factor underlying both the OCD and the dermatologic disease, such as a congenital predisposition to both illnesses. Population and family studies, looking at the dermatologic status of OCD probands and their families, may be a fruitful avenue to explore in the future.

REFERENCES

1. Robins LN, Helzer JE, Weissman MM, et al. Lifetime prevalence of specific psychiatric disorders in three sites. Arch Gen Psychiatry 1984; 138:949–958
2. Weissman MM, Bland RC, Canino GL, et al. The cross national epidemiology of obsessive-compulsive disorder. J Clin Psychiatry 1994;55 (3, suppl):5–10
3. Hollander E, Wong CM. Introduction to obsessive-compulsive spectrum disorders. J Clin Psychiatry 1995;56(suppl 4):3–6
4. Fineberg NA, Roberts A. OCD, a 21st century perspective. In: Fineberg N, Marazitti D, Stein D, eds. Obsessive Compulsive Disorder: A Practical Guide. Hove, UK: Martin Dunitz; 2001:1–14
5. Rasmussen SA, Eisen JL. The epidemiology and differential diagnosis of obsessive compulsive disorder. J Clin Psychiatry 1994;55(10, suppl): 5–10
6. Sheehan DV, Lecrubier Y, Janavs J, et al. Mini-International Neuropsychiatric Interview (MINI). Tampa, Fla: University of South Florida Institute for Research in Psychiatry, and Paris, France: INSERM-Hôpital de la Salpêtriere; 1994
7. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC: American Psychiatric Association; 1994
8. International Council on OCD: Update on OCD. Egham, UK: Medical Action Communications; 1995
9. Goodman WK, Price LH, Rasmussen SA, et al. The Yale-Brown Obsessive Compulsive Scale. Arch Gen Psychiatry 1989;46:1006–1011
10. Rasmussen S, Eisen JL. Epidemiology and clinical features of obsessive-compulsive disorder. In: Jenike M, Baer L, Mninchiello W, eds. Obsessive Compulsive Disorders, Theory and Management. Chicago, Ill: Year Book Medical Publishers Inc; 1990:10–27
11. Hughes JE, Barraclough BM, Hamblin LG, et al. Psychiatric symptoms in dermatology patients. Br J Psychiatry 1983;143:51–54
12. Wessely SC, Lewis GH. The classification of psychiatric morbidity in attenders at a dermatology clinic. Br J Psychiatry 1989;155:686–691
13. Hatch ML, Paradis C, Friedman S, et al. Obsessive-compulsive disorder in patients with chronic pruritic conditions: case studies and discussion. J Am Acad Dermatol 1992;26:549–551
14. Arnold LM, McElroy SL, Mutasim DF, et al. Characteristics of 34 adults with psychogenic excoriation. J Clin Psychiatry 1998;59:509–514
15. Woodruff PW, Higgins EM, du Vivier AW, et al. Psychiatric illness in patients referred to a dermatology-psychiatry clinic. Gen Hosp Psychiatry 1997;19:29–35
16. Van Ameringen M, Oakman J, Mancini C, et al. Obsessive compulsive spectrum disorders: from serotonin to dopamine and back again. In: Fineberg N, Marazitti D, Stein D, eds. Obsessive Compulsive Disorder: A Practical Guide. Hove, UK: Martin Dunitz; 2001:23–36
17. DiNardo P, Brown K, Barlow DH. Anxiety Disorders Interview Schedule for DSM-IV. San Antonio, Tex: Psychological Corp; 1994
18. First MB, Spitzer RL, Gibbon M, et al. Structured Clinical Interview for DSM-IV Axis I Disorders-Patient Edition. New York, NY: Biometric Research, New York State Psychiatric Institute; 1996
19. Goldsmith T, Shapira NA, Goodman WK. Assessment of OCD. In: Fineberg N, Marazitti D, Stein D, eds. Obsessive Compulsive Disorder: A Practical Guide. Hove, UK: Martin Dunitz; 2001:15–22
20. Nelson E, Rice J. Stability of diagnosis of obsessive-compulsive disorder in the Epidemiologic Catchment Area Study. Am J Psychiatry 1997;154: 826–831