

The Prevalence of Obsessive Compulsive Symptoms in a Sample of Egyptian Psychiatric Patients

Thesis

**Submitted for partial fulfillment of the
M.D. Degree in Psychiatry**

By

Ghada Abdou El-Kholy

Supervised By

Professor. Ahmed Okasha

Professor. of Neuropsychiatry
Emeritus Chairman Institute of Psychiatry
Faculty of Medicine - Ain Shams University

Professor. Farouk Lotaief

Professor. of Neuropsychiatry
Faculty of Medicine - Ain Shams University

Professor. Abdel Monneim Ashour

Professor. of Neuropsychiatry
Faculty of Medicine - Ain Shams University

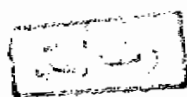
Dr. Naglaa El-Mahalawy

Assistant. Professor. of Neuropsychiatry
Faculty of Medicine - Ain Shams University

Dr. Aida Seif El-Dawla

Assistant. Professor. of Neuropsychiatry
Faculty of Medicine - Ain Shams University

**Faculty of Medicine
Ain Shams University
1997**



616.85227
G.A.

61282

A. Okasha

Farouk

Abdel Monneim

Dr. Naglaa El-Mahalawy
Aida



The Prevalence of Obsessive Compulsive Symptoms in a Sample of Egyptian Psychiatric Patients

Thesis

**Submitted for partial fulfillment of the
M.D. Degree in Psychiatry**

By

Ghada Abdou El-Kholy

Supervised By

Professor. Ahmed Okasha

Professor. of Neuropsychiatry
Emeritus Chairman Institute of Psychiatry
Faculty of Medicine - Ain Shams University

Professor. Farouk Lotaief

Professor. of Neuropsychiatry
Faculty of Medicine - Ain Shams University

Professor. Abdel Monneim Ashour

Professor. of Neuropsychiatry
Faculty of Medicine - Ain Shams University

Dr. Naglaa El-Mahalawy

Assistant. Professor. of Neuropsychiatry
Faculty of Medicine - Ain Shams University

Dr. Aida Seif El-Dawla

Assistant. Professor. of Neuropsychiatry
Faculty of Medicine - Ain Shams University

**Faculty of Medicine
Ain Shams University**

1997



بسم الله الرحمن الرحيم

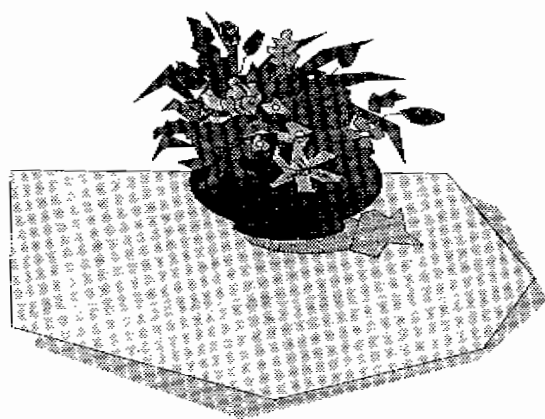
"قالوا سبحانك لا علم لنا إلا ما علمتنا
إنك أنت العزيز الحكيم"

صدق الله العظيم

سورة البقرة - آية (٢٢)

To The Memory of My Grandmother
To My Family with Lots of Love and Gratitude
To Everyone Who I Love and Respect

Ghada



ACKNOWLEDGMENT

I wish to express my sincere appreciation to Professor. Ahmed Okasha, Professor of Neuropsychiatry, Emeritus Chairman Institute of Psychiatry, Ain Shams University for suggesting the topic of this thesis, his enthusiastic support, encouragement and supply of recent literature which have expanded my review greatly. I hope one day I can deserve the trust to be one of his students as this was the wish I have always longed for.

It is an honor for me to carry out this work under the supervision and guidance of Professor Farouk Lotaief, Professor of Neuropsychiatry, Ain Shams University. Thanks for his support care, and valuable time he had devoted generously all through the work. He has kindly reviewed this thesis and gave many helpful suggestions. Thanks for all he has taught me not only in the art of science but also in the art of life.

My deepest gratitude to Professor Abdel Monneim Ashour, Professor of Neuropsychiatry, Ain Shams University for his kind help, meticulous, objective directions and constructive comments. I have learned from him how the scientific research could be. He gives the ideal image of a professor having a fatherly role and a cooperative spirit.

I am greatly indebted to Dr. Naglaa El Mahalawy, Assitant Professor of Neuropsychiatry, Ain Shams University for her great support, supervision and backup. I enjoyed her being one of my supervisors.

I wish to extend my thanks to Dr. Aida Seif El Dawla, Assitant Professor of Neuropsychiatry, Ain Shams University for her help, support and guidance throughout this work.

My sincere appreciation and much thanks goes for every one who shared in bringing this work to birth, among those I remember Dr. Ahmed Saad, Lecture of Psychiatry, Ain Shams University, Dr. Tarek Asaad Lecture of Psychiatry, Ain Shams University, Dr. Rehab, Dr. Samer, Dr. Mostafa and Dr. Ahmed Samir and never forget the help of the secretary staff as well as the nursing staff.

Very special thanks go to all the patients and persons who were the subjects of this work and who cooperated in this research at a time of great difficulty of their lives.

Last but not least, my thanks go to my family and friends who gave me the chance to pursue my dreams. Thanks for their support and encouragement throughout this work.

Ghada EL Kholy

1997

CONTENTS

	Page
Introduction and aim of the work	1
Review of literature	
<i>Historical Considerations.....</i>	<i>5</i>
<i>OCS in the General population.....</i>	<i>20</i>
<i>OCS and different Neuropsychiatric Disorders:..</i>	
<i>Organic disorders.....</i>	<i>22</i>
<i>Substance Use disorders.....</i>	<i>25</i>
<i>Schizophrenic disorders</i>	<i>29</i>
<i>Mood disorders.....</i>	<i>36</i>
<i>Neurotic disorders.....</i>	<i>44</i>
<i>Eating disorders.....</i>	<i>50</i>
<i>Personality disorders.....</i>	<i>63</i>
Subjects and Methods.....	64
Results.....	74
Discussion.....	99
Conclusion and Recommendations.....	124
Summary.....	129
References.....	134
Appendix	
Arabic Summary	

LIST OF TABLES

Page

Tables of the Review of Literature

Table (1)	Percentage of anorexia nervosa patients (n=19) endorsing specific obsessional and compulsive behaviors on the Y-BOCS symptom checklist (Goodman et al., 1989)	54
-----------	---	----

Tables of the Subjects and Methods

Table (1)	مفتاح تصحيح مقياس الوعي الديني الصورة (أ)	72
Table (2)	مفتاح تصحيح مقياس الوعي الديني الصورة (ب)	73

Tables of the Results

Table (1)	Description of the different diagnostic categories and their subtypes according to ICD (10) research criteria	74
Table (2)	Age, Gender, Religion and Education of the patients and the control groups (selected background variables for matching in this study)	76
Table (3)	Comparing the patients group and the control group regarding other sociodemographic variables	77
Table (4)	Occupation, Marital state and Income of the family per month in the patients group and the control group	78
Table (5)	The Prevalence of Obsessive Compulsive Symptoms (OCS) as assessed by Y-BOC Checklist, in the Patients and the Control groups	79
Table (6)	The Prevalence of Obsessive Compulsive Symptoms (OCS), as assessed by Y-BOC Checklist, in different diagnostic categories, according to ICD (10) compared to the control group	80
Table (7)	The prevalence of Obsessive Compulsive Symptoms (OCS), as assessed by Y-BOC checklist in schizophrenia subgroups compared to the control group	81
Table (8)	The Prevalence of Obsessive Compulsive Symptoms (OCS), as assessed by Y-BOC Checklist, in the mood disorders subgroups compared to the control group	82
Table (9)	The Phenomenology of Obsessive-Compulsive Symptoms (OCS), as assessed by the fifteen groups of symptoms in the Y-BOC checklist in both the patients and the control groups	83
Table (10)	The Phenomenology of Obsessive-Compulsive Symptoms (OCS), as assessed by the fifteen groups of symptoms in the Y-BOC checklist in different diagnostic categories according to ICD (10) and in the control group	84

Table (11)	The Phenomenology of Obsessive-Compulsive Symptoms (OCS), as assessed by the fifteen groups of symptoms in the Y-BOC checklist in the Schizophrenia, schizotypal and delusional disorder subgroup compared to the control group	85
Table (12)	The Phenomenology of Obsessive-Compulsive Symptoms (OCS), as assessed by Y-BOC checklist in different diagnostic categories within the subgroup of schizophrenia, schizotypal and delusional disorders.	86
Table (13)	The Phenomenology of Obsessive-Compulsive Symptoms (OCS), as assessed by the fifteen groups of symptoms in the Y-BOC checklist in the Mood (affective) subgroup compared to the control group	87
Table (14)	The Phenomenology of Obsessive-Compulsive Symptoms (OCS), (as assessed by Y-BOC checklist) in different diagnostic categories within the subgroup of Mood (affective) disorders	88
Table (15)	The Phenomenology of Obsessive-Compulsive Symptoms (OCS), as assessed by the fifteen groups of symptoms in the Y-BOC checklist in Neurotic, stress-related and somatoform disorders subgroup compared to the control group	90
Table (16)	The Phenomenology of Obsessive-Compulsive Symptoms (OCS), as assessed by the fifteen groups of symptoms in the Y-BOC checklist in different diagnostic categories, according to ICD (10), within the subgroup of Neurotic, stress-related and somatoform disorders	91
Table (17)	The Prevalence of Obsessive Compulsive Symptoms and Obsessive Compulsive Traits in the Patients group with its different diagnostic categories and in the control group	93
Table (18)	Time relationship between the onset of the different diagnostic categories and the onset of Obsessive Compulsive Symptoms (OCS)	94
Table (19)	Effect of the current psychiatry disorder on pre-existing OCS (assessed by Y-BOC checklist)	95
Table (20)	Comparing the different groups on ERS	96
Table (21)	The relationship between religion and OCS in the patients and the control group	97
Table (22)	The relationship between religion and OCS in different diagnostic categories	98

Tables of the Appendix

Table (1)	Socio-demographic data of those with OCS and those without OCS in the patients and control groups	153
Table (2)	Socio-demographic data of patients with OCS and those without in different diagnostic categories	155

LIST OF ABBREVIATIONS

5-HT	:	☞ Serotonin
ADAMHA	:	☞ Alcohol Drug Abuse and Mental Health Administration
AN	:	☞ Anorexia Nervosa
BDD	:	☞ Body Dysmorphophobic Disorder
BN	:	☞ Bulimia Nervosa
BZ	:	☞ Benzodiazepines
CDDG	:	☞ Clinical Descriptions and Diagnostic Guidelines
DA	:	☞ Dopamine
DCR	:	☞ Diagnostic Criteria for Research
DEP	:	☞ Depersonalization
DSM-III-R	:	☞ Diagnostic Statistical Manual for Mental Disorders, Version III- Revised
ECA	:	☞ Epidemiological Catchement Area
ECT	:	☞ Electro-Convulsive Therapy
EPI	:	☞ Eysenck Personality Inventory
GABA	:	☞ Gamma Amino Butyric Acid
MCMi	:	☞ Millon Clinical Multiaxial Inventory
MMPI	:	☞ Minnesota Multiphasic Personality Disorder
MOCI	:	☞ Maudsely Obsessive Compulsive Inventory
OCD	:	☞ Obsessive Cmpulsive Disorder
OCP	:	☞ Obsessive Compulsive Personality
OCPD	:	☞ Obsessive Compulsive Personality Disorder
OCPT	:	☞ Obsessive Compulsive Personality Traits
OCRDs	:	☞ Obsessive Compulsive Related Disorders
OCS	:	☞ Obsessive Compulsive Symptoms
OCT	:	☞ Obsessive Compulsive Traits
PANSS	:	☞ Positive and Negative Syndrome Scale
PD	:	☞ Personality Disorder
PDQ	:	☞ Personality Disorder Questionnaire

PSE	:	☞ Present State Examination
SCID-II	:	☞ Structured Clinical Interview for Diagnosis of Axis II disorders
SIDR-R	:	☞ Structured Clinical Interview for DSM-III-Revised
SIPD	:	☞ Structured Interview Personality Disorder
SSRIs	:	☞ Selective Serotonin Releasing Inhibitors
WCST	:	☞ Wisconsin Card Sorting Test
WHO	:	☞ World Health Organization
WPA	:	☞ World Psychiatric Association
YBOCS	:	☞ Yale Brown Obsessive Compulsive Scale

INTRODUCTION

ياست الدنيا يا بيروت ..
يا حيث الوعد الأول .. والحب الأول ..
يا حيث كتبنا الشعر ..
وخبئناه بأكياس الخمل ..
نعترف الآن .. بأننا كنا يا بيروت ،
عجبك كالبدو الرجل
نعترف الآن .. بأننا كنا أسيين .
وكنا عجبك ما نفعل

• نزل قباني •

Obsessions are embedded in hard circuits in basal ganglia and frontal lobes. They are observed in both animals and human beings. They are part of the evolutionary process. This is consistent with many epidemiological studies assessing obsessions and compulsions in the non-clinical population. A total of 810 adults were examined by psychiatrists in the second stage of the Eastern Baltimore Mental Health Survey, using the semistructured standard psychiatric examination. The estimated prevalence of OCS in this population was 1.5% (Nestadt et al,1994). Another recent epidemiological studies were conducted in the general population, showing high rate prevalence of OCD, estimated between 2-3% in the community (Hantouche and Bourgeois, 1995).

The relationship between OCD and different psychiatric disorders takes three models in the literature, the first one is comorbidity between OCD and the different psychiatric disorders, the second one, is Obsessive-Compulsive Related Disorders (OCDs), and the third one, is the prevalence of Obsessive-Compulsive Symptoms (OCS) in different psychiatric disorders.

Regarding the first one: the prevalence of comorbid illnesses with OCD is very high. For example, approximately 80% of OCD patients may present with depressed mood, and 30% meet criteria for major affective disorder on admission (Rasmussen and Tsuang 1986). Comorbidity rates of OCD resulting from the ECA study were first published by Karno *et al.*, (1988). On the basis of 468 cases of OCD, the authors found the following rates of overlap of the disorder; with phobia, 46.5%; with major depressive episodes, 31.7%; with panic disorder, 13.8%; with schizophrenia, 12.2%; with schizophreniform disorder, 1.3%; with alcohol abuse and dependence, 24.1%; with other drug dependence or abuse, 17.6%. They concluded that there was no specific diagnostic association for the disorder, the risk of comorbidity was not distinctive. In the majority of the associated cases, schizophrenia, panic disorder, or phobia emerged as the first and OCD as the second disorder (Karno and Golding, 1991); substance abuse tended to follow the onset of OCD, suggesting that "these disorders may develop from efforts at self medication of distressing OCS" (Karno *et*

al., 1988) . Crum and Anthony (1993) found , in a one year follow up of the ECA study , that subjects actively using cocaine and marijuana had an increased relative risk of 7.2 for OCD . In Egypt, Okasha *et al.*, (1995) found OCD associated with OCPD in 6%, schizotypal personality disorders in 5% and psychosis of a non-schizophrenic nature in 8%. Also Okahsa and Raafat (1991) found OCD associated with topographic EEG abnormalities in 90% with evidence of hemispheric lateralization in 70% and generalized cerebral dysfunction in 13.3%.

In their study of children and adolescents , Flament *et al.*, (1988) found OCD associated with anxiety disorders in 35% of cases , with affective disorders 25% , with bulimia in 15% , and with obsessive compulsive personality disorder in 15% of cases . Fifteen out of 20 adolescent subjects (75%) had at least one other lifetime psychiatric diagnosis. In another study of adolescents , Hollander *et al.*, (1994) found an unexpected association between OCD and certain behavioural symptoms (lying , stealing, trouble at school, fights, ect). Moreover, adolescents with OCD displayed more antisocial symptoms and elevated rates of attempted suicide over a lifetime (15.0 vs 3.6%). In the longitudinal Zurich Study of young adults (Degonda *et al.*, 1993), a significant association between OCS and major depressive disorder was found in females but not in males (odds ratios 2.5 and 1.2, respectively), whereas in both sexes the association was clear between OCS and panic disorder, social phobia, and agoraphobia (odds ratio 2.3), dysthymia (2.8), and recurrent brief anxiety (1.9). Life time suicide attempts were found in 16.1% of subjects, with an odds ratios of 1.9 (Angst,1993).

Regarding the second one (OCDs), this notion was emerged on the basis of shared features with OCD, such as clinical symptoms, associated features (age of onset, clinical course and comorbidity), presumed etiology, familial transmission, and response to selective pharmacological or behavioural treatments (Hollander, 1993). This overlap provides evidence to support a relationship between OCD and OCDs, but doesn't establish a definitive relationship. Alternatively, the dimension of compulsivity and impulsivity may be viewed as a spectrum of disorders having in