

Obsessive-Compulsive Symptoms among Clients Attending Psychiatric Outpatients' Clinic in Duhok

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Abstract

Background: Obsessive-compulsive disorder (OCD) is a neuropsychiatric illness, develops in childhood, and can result in considerable impairment to an individual's lifespan. The persons suffer from OCD do not seek treatment in medical settings and remain undiagnosed or misdiagnosed, and consequently, the person faces persistent untreated symptoms over time leading to considerable disturbance in familial, academic, or social functioning. Therefore, careful assessment of OCD symptoms is seminal to clinical practice. OCD among clients attending the outpatient clinic of Azadi Teaching Hospital in Iraq was assessed in the current study. **Methods:** This cross-sectional study that consisted of 465 consecutive clients who visited an outpatient psychiatric clinic of Azadi Teaching Hospital in Iraq was designed, and face-to-face interview was performed using a translated Arabic version of Padua Inventory-Washington State University Revision in order to assess the OCD symptoms. **Results:** The study confirmed previously unrecognized symptoms of obsessions and compulsions in those who visited the psychiatric outpatients' clinic. In addition, it was shown that among total obsessions and compulsions, obsessions included contamination, thoughts of harm to self/others, impulses to harm self/others and compulsions included checking and dressing/grooming and washing which were more prevalent in males, those completed primary school education, completed higher education, and divorced/married clients. The study did not show any significant difference among different age group and employment aspects. **Conclusion:** The study confirmed that some individuals are unaware of their obsessions and compulsions and clinical screening would give us a golden opportunity to their issue recognition and immediate treatment commencement.

Keywords: Assessment, compulsion, obsession, symptoms

INTRODUCTION

Obsessive-compulsive disorder (OCD) is a neuropsychiatric illness, develops in childhood, and can result in considerable impairment to an individual's lifespan. It is a public health concern and between 1% and 2% of population are affected by this disorder across the world.^[1] Individuals with OCD feel the requirement to recheck substances frequently and conduct certain rituals repeatedly or own certain thoughts in a frequent way. These persons are unable to overcome either the thoughts or their activities for a long period.

OCD is a debilitating and expensive mental disorder related with impairment extending into the familial, occupational, and social domains of persons.^[2] Recurrent, unwanted, and intrusive thoughts (obsessions) and/or engagement in repetitive ritualistic behaviors (compulsions) are experienced by persons suffering from OCD. The obsessional experiences

would include irrational or nonrealistic concerns, suspects, or visions inducing anxiety or upset. Obsessions could include excessive worries toward contaminations, fear of harm to self or others, and suspect on conducting actions like closing the door. The compulsions are frequently conducted in order to respond to these kinds of obsessions to prevent, alleviate, or remove distress, concern, and consequences. The compulsions include washing or cleaning, counting, praying, and checking.^[2] It is noteworthy to mention that rituals performed to relieve the distress have only temporary consequences, which is followed by engagement of person to future rituals.^[3]

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Persons suffering from OCD do not seek treatment in medical settings and remain undiagnosed or misdiagnosed despite the existence of effective therapeutic methods.^[2] Fullana *et al.*^[4] estimated that between 21% and 25% of the general population accept to have subclinical symptoms of OCD. Consequently, the person faces persistent untreated symptoms over time leading to considerable disturbance in familial, academic, or social functioning.^[5] Therefore, continuous assessment of the populations attending outpatient clinics will provide a golden opportunity to improve diagnosis as a valuable focal point of clinical practice. Due to the prevalence and its related expenditures, OCD is considered an important public health issue;^[3] however, this disorder remains underrecognized among persons of all ages.^[6] OCD among clients attending the outpatient clinic of Azadi Teaching Hospital in Iraq was assessed in the current study. The authors projected that there are some under- or un-recognized symptoms of obsessions and compulsions in clients visiting the psychiatric outpatient clinic in Azadi Teaching Hospital.

METHODS

Sampling and eligibility criteria

The current cross-sectional study was conducted among 482 clients consecutively visiting the Psychiatric Outpatient Clinic of the public Azadi Teaching Hospital apart from the visiting times in Duhok city in Iraq. Verbal consent was taken from all clients prior to the study participation. All clients of both genders aged 18 years and older who visited the outpatient clinic between November 30, 2014, and March 2, 2015, regardless of their sociodemographic characteristics with guarantee of their right to reject the participation, were eligible to partake in the study. Those persons with chronic diseases such as cardiovascular diseases, epilepsy, diabetes, or overt mental disorders apart from OCD were excluded from the study through the self-report method and those previously diagnosed and recorded in their medical records with severe intellectual disability or were not willing to participate in the study or had more than 20% missing information in their questionnaire due to not responding to some questions were also excluded from the study analysis and, finally, 465 questionnaires with all eligible criteria were analyzed in the current study. In order to reduce the possible measurement bias, following complete study of the scale, all the interviews were conducted by the first author of the study only and a psychiatric nurse, and all information was recorded into the questionnaire subsequently. The required time to complete the questionnaire was 30 min only.

The study was approved by the Faculty of Medical Sciences, University of Duhok. Verbal consent was taken from each client at the time of interview. In addition, personal information of the patients recruited in the study was kept confidential throughout the study process and the participants were assured confidentiality at the publication stage.

Measurement criteria

The Padua Inventory-Washington State University Revision (PI-WSUR) is a self-reported structured questionnaire

used to measure obsessive-compulsion symptoms according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.^[7] The designed scale was used to measure five dimensions as follows: 1 – obsessional thoughts about harm to oneself or others (items 24–30); 2 – obsessional impulses to harm oneself or others (items 31–39); 3 – contamination obsessions and washing compulsions (items 1–10); 4 – checking compulsions (items 14–23); and 5 – dressing/grooming compulsions (items 11–13).^[8] The scale has 39 items rated from 0 to 4, indicating 0 for not at all, 1 for a little, 2 for quite a lot, 3 for a lot, and 4 for very much, and the test-retest correlation of the total PI-WSUR was found to be 0.76.

Some validated sociodemographic aspects such as gender, age, religion, education level, occupation, and marital status were added to the questionnaire.

The PI-WSUR was translated into Arabic by a bilingual translator and was checked by the second author for the psychiatric clinical perspectives. The reliability of the translated scale was established through using Guttman split-half method. In this regard, the scale was split into two halves so that the first half formed the first part of the entire scale and the second half formed the remaining part of the scale. The reliability estimation based on these two halves was applied on thirty clients and calculated by Guttman split-half coefficient. The results revealed split-half coefficient to be $r = 0.82$.

Statistical analysis

The descriptive aspects of the participants including sociodemographic and obsessive and compulsive symptoms were identified through frequency, percentage and mean, and standard deviation, respectively. The difference between OCD symptoms of clients' aspects was determined through the independent *t*-test in normality cases and Mann-Whitney U-test in nonnormality cases and one-way ANOVA test. Statistical significance was set at $P < 0.05$. The Statistical Package for the Social Sciences version 23.00 (IBM SPSS version 23.00, IBM, USA) was used for statistical analysis.

RESULTS

The present study was conducted in order to assess obsessive-compulsive symptoms in patients attending psychiatric outpatients' clinic of Azadi Teaching Hospital. The mean age of the sample size was 28.85 ± 8.00 years with the range 42 years from 18 to 60. Majority of the participants were male (57.6%), with male-to-female ratio of 1:36. With respect to education level, more than one-third (37.8%) of them had secondary school level education followed by higher education (26.9%), illiterate (15.3%), and primary school education (15.1%), and the lowest percentage abled to read and write only (4.9%). More than half of them were married (52.7%) and employed (86.0%), as shown in Table 1.

The severity of each content of obsession and compulsions was calculated and depicted in Table 2. The results showed that the total obsessive-compulsive severity symptom was

62.90 ± 22.66 of the total score of 156. The mean severity of contamination obsession was 14.90 ± 9.61 of 40, checking compulsion was 16.49 ± 8.86 of 40, obsessional thoughts of harm to self or others was 15.77 ± 6.10 of 24, obsessional impulses of harm to self or others was 8.40 ± 5.25 of 34, and median dressing or grooming compulsions was 9.00 ± 8.00 of subscore 12. The current study showed that contamination obsessions and washing compulsions ($P = 0.027$), checking compulsions ($P = 0.000$), obsessional thoughts of harm to self/others ($P = 0.003$), obsessional impulses to harm self/others ($P = 0.000$), dressing/grooming compulsions ($P = 0.004$), and total OCDs were more prevalent in male population in comparison with female population.

The level of total obsessions and compulsions was examined in different sociodemographic aspects of clients and presented in Table 3. The study showed that OCD is more prevalent in those persons with higher education and those graduated from primary school (67.73 ± 21.70 and 66.13 ± 20.35, respectively, $P = 0.003$) and in divorced and married persons (68.60 ± 16.89 and 68.12 ± 22.87, respectively,

$P < 0.0001$). However, the level of total obsessions and compulsions was not different substantially in employed and unemployed populations ($P = 0.261$) and in different age groups ($P = 0.053$).

DISCUSSION

The aim of this study was to assess the symptoms of obsessions and compulsions among patients visiting an outpatient clinic in one of the teaching hospitals in Iraq. The study confirmed that the individuals suffer from heterogeneous obsession and compulsion contents. In addition, it was shown that the obsessional contamination, thoughts of harm to self/others, impulses to harm self/others, and checking and dressing/grooming compulsions were more prevalent in male populations than female populations.

The symptoms of OCD are so diverse and the individuals often attempt to hide them due to the related stigma and their abnormality recognition by the surrounding or lack of insight. In particular, those persons with sexual themes and thoughts feel embarrassed in discussing the issue.^[9] Obsessions could be aggressive, religious, somatic, and/or sexually intrusive thoughts, symmetry worries, hoarding, and/or contamination and compulsions consisting of counting, washing, activity repeating, checking substances, hoarding, arranging ordering, and mental rituals.^[10] In the current study, obsessional contamination, thoughts of harm to self/others, impulses of harm to self/others, and two compulsions of dressing and checking were considered as documented by PI-WSUR. The current study confirmed that clinical screening of individuals seeking treatment for other mental disorders apart from OCD gives us a significant opportunity to recognize those persons who are unaware of their disease knowing that generally OCD issue is mostly under- or un-recognized in psychiatric outpatient clinics.^[9]

Obsessions or compulsions can substantially make distress, intervene in normal life and social or occupational functioning, are time-consuming,^[11,12] may persist or exacerbate over time without treatment,^[12] roughly 50% of the public have engagement in some rituals^[13] and most patients with OCD present to health settings when they are severely affected,^[14] and 2.77% of subclinical symptoms of obsessions and compulsions^[15] double the significance of screening process.

Table 1: Sociodemographic aspects of clients

Patients' characteristics (n=465)	Frequency distribution	
	n, mean	%, SD
Age* (minimum, maximum)	28.85 (18, 60)	8.00
Sex**		
Male	268	57.6
Female	197	42.4
Education level**		
Illiterate	71	15.3
Read and write	23	4.9
Primary school	70	15.1
Secondary school	176	37.8
Higher education	125	26.9
Marital status**		
Single	210	45.2
Married	245	52.7
Divorced	10	2.2
Employment**		
Employed	400	86.0
Unemployed	65	14.0

*Mean and SD, **Frequency and percentage were calculated for statistical calculations. SD: Standard deviation

Table 2: Obsession and compulsion subscales in all clients and gender

Obsessions and compulsions	Patients' gender			Test of difference
	Male (n=268)	Female (n=197)	Total (n=465)	
Total obsessive-compulsive symptoms	68.08±21.61	55.85±22.20	62.90±22.66 (minimum: 11.00, maximum: 134.00)	0.000*
Contamination obsessions and washing compulsions subscale	15.00±9.43	13.00±9.76	14.19±9.61	0.027*
Obsessional thoughts of harm to self/others subscale	16.47±6.30	14.82±5.68	15.77±6.10	0.003*
Obsessional impulses to harm self/others subscale	9.47±5.05	6.93±5.16	8.40±5.25	0.000*
Checking compulsions subscale	18.56±8.91	13.66±7.98	16.49±8.86	0.000*
Dressing/grooming compulsions subscale	11.00±5.00	8.00±9.00	9.00±8.00	0.004**

*Independent *t*-test and Mann-Whitney U-test were performed for statistical analysis

Table 3: Total scores of obsessive-compulsive disorder in sociodemographic characteristics

Sociodemographic aspects	Total OCD (mean±SD)	Test of difference
Education level		
Illiterate	55.29±23.00	0.003*
Read and write	62.87±29.83	
Primary school	66.13±20.35	
Secondary school	61.25±22.23	
Higher education	67.73±21.70	
Marital status		
Single	56.53±21.04	0.000*
Married	68.12±22.87	
Divorced	68.60±16.89	
Employment		
Employed	64.71±23.29	0.261**
Unemployed	62.10±22.37	
Age groups		
18-25	59.71±22.82	0.053*
26-40	65.10±22.65	
41-60	63.90±20.11	

*ANOVA one-way, **Independent *t*-tests were performed for statistical analysis. OCD: Obsessive-compulsive disorder, SD: Standard deviation

With respect to gender-based obsessions and compulsions of the clients, the current study showed that the symptoms were more prevalent in male than female population in clinical-based settings. In this regard, the findings of the literature were not consistent in different settings. The clinical studies have documented that males have predominately the early onset of OCD and have a greater number of obsessions and compulsions [16], greater frequency of repetitive rituals, raises severity of obsessive-compulsive symptoms.^[16,17] Cilliçilli *et al.*^[18] reported a slightly higher prevalence of OCD in females (3.3% vs. 2.5% in males); however, the overall difference was not statistically significant. This is inconsistent with the current study which showed substantial greater symptoms in male than female clients, which may be due to the increased number of males (268) in comparison with females (197) despite a nonstatistical difference between genders as shown in the literature.^[6,19]

In addition, it was impossible to apply the homogeneity with respect to residency and gender in the present study. Therefore, the heterogeneous findings between males and females may not reflect the population-based situation inferring the sample study only. However, it is noteworthy to accent that contamination, insecurity or losing fear, checking, and symmetry obsessions^[20] and religious obsessions^[21] as well. It seems that obsessive content and form are influenced by social and religious backgrounds of each country.^[22]

Moreover, the study showed that the total OCD symptoms were more prevalent in clients graduated from primary school and high school and among divorced/married persons. However, the symptoms were not statistically different with respect to employment and age groups. The study of OCD

with respect to sociodemographic or socioeconomic aspects is so conflicting.^[6,23,24] The difficulties of these associations could be owing to comorbidity of anxiety or mood disorders with OCD.^[25] However, several life events such as changes in living conditions or experiencing major traumatic life events have been mentioned to have a catalytic role in the transition from subclinical obsessive-compulsive symptoms to symptomatic OCD.^[26] Moreover, it looks that some hereditary components could be responsible as identical twins are more affected than nontwins,^[27] and higher rates of both obsessions and compulsions have been found in persons with relatives compared with nonrelative persons ($P < 0.001$)^[28] and a child abuse history or other physical or psychological traumas originating from stressful events are considered as risk factors of OCD.^[27] Alghamdi and Awadalla^[29] found that male gender, lower level of education, and unemployment are substantially related with OCD, whereas age and marital status are not related. Nevertheless, the authors of the current study accent that the sociodemographic aspects of OCD are different across studies done in different countries with different settings and cultures.

Limitations of the study

The findings reported in the current study should be interpreted in the inference of the cross-sectional study design and methodological principles accenting that it was not possible to exclude the reverse causality nature. The findings reflect the clinical-based situation of obsessive-compulsive symptoms of those seek treatment for mental disorders; therefore, it is not inferred to the general populations or maybe other public or private health settings in Iraq. In addition, the discrepancies between findings reported in the current study and those seen in other studies may refer sampling and measurement criteria. Furthermore, the scale used for this study is of clinical based and it could be different from population-based ones.

CONCLUSION

The study confirmed that some individuals are unaware of their obsessions and compulsions and clinical screening would give us a golden opportunity in recognizing their issue and commencing immediate treatment. In addition, the symptoms of obsession and compulsions were more prevalent in males, those with primary school and high school education, and divorced/married clients. Prompt and appropriate recognition and quick treatment are required to patients with OCD to prevent consequent chronic disabilities and for better recognition of this disorder in the health system. Further research is needed to determine the causal pathway of the disorder.

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Conflicts of interest

There are no conflicts of interest.

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