

Socio-Demographic and Clinical Features of Patients with Obsessive-Compulsive Disorder in City of Mosul, Iraq

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ABSTRACT

Aim: To estimate the Prevalence of Obsessive-Compulsive Disorder (O.C.D.) among individuals in the City of Mosul, Iraq. As well as to identify the severity of the problem and the factors that are associated with O.C.D.

Methods: In the present study, a cross-sectional study design was conducted. ninety-two patients were collected purposively for a period of twelve months from outpatients' clinics in Al Salam and Ibn Sina Teaching Hospitals in the City of Mosul -Iraq. **Y Y-BOCS scale** was used for evaluation of the patients as well as an information sheet was prepared to collect the socio-demographic characteristics of them. The data were analyzed by S.P.S.S. 25

Results: Most of the participants were young adults (25.16 ± 2.8 years) and single females with a university level of education who are initially from Nineveh governorate. The Prevalence of O.C.D. symptoms was 2.3%. When the association between O.C.D. and different demographic characters was tested, a significant relationship between O.C.D. and age, gender, and family history factors.

Conclusion: This research analyzed the obsessive and compulsive disorders of a group of patients in terms of socio-demographic features.

Keywords: Prevalence, Obsessive-Compulsive Disorder, Iraq

INTRODUCTION

According to the American Psychiatric Association, Obsessive-compulsive disorder (O.C.D.) was defined as "an anxiety disorder characterized by the presence of intrusive thoughts, impulses or images (obsessions) or repetitive behaviors, rituals or mental acts (compulsions) that cause significant distress interference with daily functioning¹."

In the Diagnostic and Statistical Manual of mental disorders (DSM IV, 1994), O.C.D. is grouped along with other anxiety disorders, outlining the central role of anxiety and distress, usually accentuated by obsessions and compulsions^{2,3,4}. There has been an improved appreciation that more attention needs to be given to O.C.D. Globally, the World Health Organization has stated that 2.5% of O.C.D. lost due to disability^{5,6}.

The disorder rate in the general population is between 2-3%. Worldwide studies found the same rate in different countries⁷. Many community-based surveys involving adults showed either a similar gender distribution or a slight female preponderance among O.C.D.s. This trend varies from other anxiety disorders (e.g., common anxiety disorder, phobias, panic disorder, agoraphobia), which are substantially higher in women. O.C.D. was listed as DSM-IV anxiety disorders but is identified in a separate category of "O.C.D. and associated disorders" in DSM-5^{8,9,10}.

METHODOLOGY

A descriptive design was applied in the present study to achieve the objective of the current study. A purposive sample consisted of (92) patients who attend the outpatient of mental health in Al Salam and Ibn-Sina teaching hospitals in Mosul City, Iraq. The subject was chosen according to the following inclusion and exclusion standards for a period of 12 months.

Inclusion criteria

1. The patients diagnosed with O.C.D. based on I.C.D. 10 criteria.
2. The duration of diagnosis for more than one year.
3. Freeform organic disease.
4. Agree to participate and assign the consents.

Exclusion criteria.

1. The duration of diagnosis for less than one year.
2. Disagree to participated
3. have organic disease.

Y Y-BOCS scale¹¹ The Yale-Brown Addictive Compulsive Scale is a standardized rating scale with available clinician-administered and self-report variants, assessing 10 Likert-scale obsessive and compulsive objects. Scores range from 0 (no symptoms) to 4 (severe symptoms), and a total score is determined by summing items 1 to 10, and the varies between 0 and 40.

RESULTS

Table 1: Demographical and pt characteristics of the study sample

Age in groups	Frequency	%age	P value
10-19 year	9	9.7	0
20-29 year	27	29.3	
30-39 year	15	16.3	
40-49 year	24	26	
50-59 year	8	8.6	
60-69 year	6	6.5	
70-79 year	3	3.2	
Total	92	100	
Gender			
Male	38	41.3	0.095
Female	54	58.7	
Total	92	100	
Marital status			
Single	28	30.4	0.0001
Marriage	64	69.5	
Total	100	100	

Education level			
Illiterates	17	18.47	0.15
Primary	29	31.52	
Secondary	28	30.43	
College	18	19.56	
Residency			
Urban	46	50	0.0001
Suburban	34	36.9	
Rural	12	12.1	
Number of children			
No children	35	38	0.019
One to two children	17	18.5	
Three to children	24	26	
Six or plus	16	17.5	
Total	92	100	

Table 2: clinical features of obsessive-compulsive

Type of O.C.D. Symptoms	F	%age
Cleaning	35	38
Religious	16	17.4
Fears	13	14.1
Vague	9	9.7
Mixed	8	8.8
Sexual Images	6	6.5
Order	5	5.4
Prominent associated psychiatric manifestations		
Anxiety	42	45.6
Depression	28	30.4
Tension	21	22.8
Sleep	10	10.8
Duration of illness		
0-1 year	9	9.7
1-2 years	20	21.7
Up to 5 years	41	44.5
More than 5 years	42	45.6
Family history of psychological problems		
OCD	28	30.4
Anxiety	16	17.3
Psychosis	5	5.4
Depression	4	4.3
Total	53	57.6

Table 3: drug effect after four weeks follows up

Treatment	After four weeks of substantial improvement in obsessive-compulsive features according to (Y-BOCS)	Total
Sertraline + CBT	46	53
Venlafaxine + CBT	20	39

DISCUSSION

Obsessive-compulsive disorder (O.C.D.) is a condition that, despite reports of successful treatment, appears to be under-diagnosed and under-treated. The prevalence rate of O.C.D. found in the City of Mosul is (2.3%), which was comparable to the prevalence rates of many epidemiological studies¹²⁻¹⁵. A recent study in Iran by Mohammadi¹³ replicated and concluded that O.C.D. prevalence is not unusual in the Iranian culture and other countries. One of the Iranian studies has found that Iranian women are more affected by obsessive-compulsive disorder than men, especially the unemployed. In Turkey,

Ali S et al¹⁴ conducted a family survey of 3,012 adults aged 18 and more to evaluate the Prevalence of DSM-IV (O.C.D.) in urban zones in Konya. In a 12-month Turkish study, the Prevalence of O.C.D. was three percentage. The mean age of beginning of O.C.D. was 25.9±12.5 years. Women in Turkey also had a higher rate of occurrence than men, while the difference was not significant. In Mansoura University Hospital, Egypt, a study was conducted by Samar et al¹⁶ found that 55 out of 500 patients with dermatological disorders were diagnosed with O.C.D., and the Prevalence of O.C.D. in patients with dermatological diseases was 10.6%. Our results were in correlation with previous studies in which patients were assessed by DSM-IV and Y.B.O.C.S., such as in studies done in Iran by Abkhaz et al¹⁶, where the prevalence rate was 14%, and Omranifard et al¹⁷, where the prevalence rate was 22.1%. There are significant variations in research prevalence and gender ratio. In the recent data, O.C.D. was 1.8%. Our findings showed that O.C.D. was higher in women than men with female to male ratio 1.42/1, most of them were married, which were similar to other studies like in Saudi Arabia¹⁸ that examined the pattern of O.C.D. in K.S.A. and found to be similar to those reported in Western studies¹⁹⁻²². The current study found that patients whose ages ranged from 20-49 years were more susceptible to disease than those whose ages ranged between 50-79 years. These results were consistent with previous studies²³⁻²⁵. The degree of education and O.C.D. were linked. Nonetheless, education level is not an O.C.D. risk factor; previous epidemiological report did not classify subjects with O.C.D. at the higher rates. In the Educational credential assessment study, the Prevalence of O.C.D. remained higher in patients that unsuccessful in completing a schooling level^{25,26,27}. In Tehran, the percentage of highly educated people is lower²⁸. Following them, most O.C.D. subjects in the current study were at lower educational levels. In the present research, It is important to observe that 57.6% of O.C.D. patients have a family history of psychiatric disorder, the close and positive family history of O.C.D. among patients was substantially different compared to non-OCD cases Thus according to Kaplan and Sadock²⁹, 35% of the first-degree families of O.C.D. patients have OCD.2 Geller et al³⁰ found a strong family history of O.C.D. in 18 – 30% of O.C.D. patients. Studied urban/rural variations in the occurrence of Six anxiety illnesses: O.C, B, social phobia, agoraphobia, panic disorder, simple phobia, and widespread anxiety during data collected from 3,648 adult neighborhood residents (age 18 +). Findings suggest that two agoraphobia, anxiety disorders, and panic disorder were substantially correlated with residence, with higher Prevalence between urban residents. Specific analyzes explored the mark to which urban/rural disparities differed across demographic subgroups. Studies say rural living is more beneficial for whites, younger people, and better trained against anxiety disorders. The correlation between O.C.D. and married status was significant in current research, and the incidence was greater in widowed patients and the lowermost in separated patients or divorced, and moderate in married subjects or unmarried. Furthermore, the incidence of O.C.D. was not substantially different in marital status after changing socio-demographic factors.

That is different from previous research^{5,19}. These results may indicate that persons with O.C.D. will not be a reduced amount of possible to marry and conceive a child or marry constant. While analysis of this matter requires studies to evaluate personality type, the extent of O.C.D., course, and rehabilitation, this result contrasts with Hafner's study²⁰. O.C.D. level in urban zones is higher than in rural. The residential area is O.C.D.'s risk factor^{13,22}, Rural life has different significantly over the previous two decades, however, and the typical features of rural life have been influenced by factors such as financial transformation, younger group, migration to towns, quick access to information such as the internet, and ready access to urban locations through improved transport. So, we possibly will not concentrate on quantitative issues on whether illnesses are prevalent in urban or rural areas. There is a robust correlation among occupation and O.C.D. and it is a risk factor for O.C.D. in Iran. Nevertheless, the Educational credential assessment study found no alteration between O.C.D. and non-OCD patients in relations of current unemployment or occupation or job status. Nevertheless, O.C.D. incidence was higher in patients who had been unemployed for at least 6 months in the previous 5 years [5, 19]. In our analysis, O.C.D. levels in unemployed subjects were lower than housewife subjects. Perhaps this is one of the two studies' big variances. More details and clinical features of the patients were reviewed using a special interview form, and the patients' mental state was examined. Of 92 patients, 13 had "contamination anxiety," and an equal number had "washing" compulsion. Most research in India and the world find that fear of contamination is the most common addiction, and washing is the most common compulsion among O.C.D. patients. In our sample, four patients had compulsion-checking pathological doubt. Two of four patients had mixed obsessive (sexual obsessions) characteristics. Three patients thought about injuring others (aggression). Three patients had symmetry fixation. Participants' compulsions included: cleaning/washing, testing, repeated actions, order and balance, mental compulsions, and counting. Such clinical characteristics are close to what most Obsessive-Compulsive Disorder research studies observe. Of the 92 O.C.D. patients, percent spent 3-8 hours per day on their compulsions. The same percentage of patients experienced impaired levels of function due to compulsions. Around half (percent) of O.C.D. patients had extreme distress as an adverse outcome of their compulsions. Two-thirds (percent) of each studied O.C.D. client also yielded or yielded to their compulsions. Over half (percent) of O.C.D. patients did not regulate their compulsions.

CONCLUSION

This research analyzed the obsessive and compulsive disorders of a group of patients in terms of socio-demographic features—also, three distinct behaviors: mentally, psychologically, or both, listed common compulsions. Controlling, cleaning, bathing, avoiding, and questioning was the most common compulsive behavior.

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