

Point Prevalence Rates of Obsessive Compulsive Symptoms and Obsessive Compulsive Disorder in a Sample of Secondary School Students in A Rural Area in Egypt

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Abstract:

To determine the point prevalence rates of obsessive compulsive symptoms and OCD; and the associated risk factors for a sample of secondary school students located in an Egyptian rural community, a two stages cross sectional study was carried out. In the first stage, the Arabic form of Symptom Checklist Questionnaire (the portion that have the questions that screen for obsessive compulsive symptoms "OCS portion of SCL-90"), was administered to 1000 randomly selected students (49.9% of them were males, and 50.1% were females, with mean age of 16.6 ± 1.23 years). The subject was considered positive if he/she had scores 21 points and above on the screening questionnaire. In the second stage, a semi-structured clinical psychiatric interview based on DSM-IV criteria was carried out for all students that considered positive in the first stage. *Results* revealed that 18.4% of the sample had scores above 20 points on the "OCS portion of SCL-90", with the earlier the age the more the affection. Of this portion of the sample, 91 students (9.1%) were fulfilling the DSM-IV diagnostic criteria of OCD. There were comorbid psychiatric disorders in 43% of OCD patients, and the most prevalent comorbid condition was major depression, then dysthymia, with prevalence rates were 15.5% and 9.9% respectively. Type of communication inside the family, death of one of the parent, family history of a psychiatric disorder, history of childhood psychiatric disorder, presence of physical illness and presence of a precipitating factor, were significantly associated with OCD. On the other hand, the sex, age of the student, family size, and birth order had no statistically significant association with OCD.

Introduction

Obsessive-compulsive disorder (OCD) is characterized by obsessions (recurrent troublesome thoughts) and compulsions (ritualized thoughts or behaviors performed repetitively in response to an irresistible urge). OCD is a common psychiatric condition that usually emerges during childhood or adolescence. Over 80% of individuals with OCD have their onset before age 18 years. Epidemiologic studies suggest a prevalence of 1-2% for adolescents (Riddle M., 1998). The worldwide prevalence of OCD is approximately 2% of the general population Sasson Y. et. Al., 1997.

Although most research on OCD pertains to adults, studies of the disorder in children and adolescents have burgeoned over the last decade. A review of this literature suggests that OCD has a bimodal incidence pattern, with one peak of onset around puberty and another in early adulthood, and that the juvenile and adult forms are equally prevalent. Important similarities and differences between the juvenile- and adult-onset forms of OCD can be seen. Both forms show the same clinical phenotype, diagnostic nosology, and dose responsively, but the early-onset disorder differs in being clearly male preponderant,

more highly familial, and associated with a distinct pattern of comorbid psychopathology, including disruptive behavior and specific developmental disorders (*Geller DA, et al., 1998*) and (*Zohar AH., 1999*). Male female ratio changed with age of onset, with males predominating in early onset and increasing numbers of females occurring during adolescence (*Bry'nska A. (1997)*). The natural course of the disorder is fairly stable, with a complete remission rate of 10% to 15% (*Zohar AH., 1999*). In 1978, and in a replication on 1991, Okasha et al. found that the prevalence rates of OCD among psychiatric patients attending the Ain Shams University clinic were 2.5% and 2.3% respectively (*Okasha et al., 1994*). These data derived from two Egyptian studies on the same type of population confirmed the stability of the disorder.

Carl Westphal, the professor of psychiatry in Berlin in 1877, was the first who drew our attention to the fact that obsessions and compulsions are common in the community but rare in mental hospitals, a finding that goes with the recent observations (*Abserg, 1989*). Although the OCD concept has long been established, research diagnostic criteria are relatively recent developments. This is partly due to that the OCD symptoms occur in the context of other disorders and it is arguable to what extent they are relatively discrete phenomena.

A diagnosis of subthreshold obsessive-compulsive syndrome (sOCS) was made for individuals who had obsessive and/or compulsive symptoms but who failed to meet one of the severity criteria of impairment. (*Maina G. et al. 1999*) found in their study that the average rate of both the point and lifetime prevalence of the (sOCS) was 12.3%. No differences were found when

examining prevalence rates according to area of residence or occupational status of the subjects. These findings suggest that sOCS, being commonly endorsed in a general adolescent population, may represent a normal phenomenon in older adolescents.

The boundary of the diagnosis of OCD is not always easy to determine, and individuals may meet threshold and subthreshold criteria at different times. This might explain the disagreement of results of some other studies *Zohar AH. 1999. Stein MB. et al., 1997*, for example, reported in their survey that the one month prevalence estimate of OCD was 0.6%, and concluded that OCD may be somewhat less prevalent than had been believed on the basis of previous surveys. On the same direction *Bebbington PE., 1998*, in his review of the existing epidemiological surveys based on standardized tools concluded that OCD is fairly rare in the general population. Furthermore, he reported that community Surveys show an excess of females and emphasis the early age of onset.

Additional studies are needed to substantiate these findings and to delineate precisely the extent of disability and reduced quality of life attributable to OCD (and OCD variants) in the community (*Stein MB, et al., 1997*). Good epidemiological studies from different parts of the world are also, needed to determine if prevalence is equally high (*Bry'nska A., 1997*). Another important point has to be considered, that the OCD patients often attempt to conceal their symptoms, and hence it is incumbent on clinicians and researchers to pay special attention on screening for OCD (*Sasson Y. et. Al., 1997*).

Purpose of the research

The overall purposes of this study were:

1. To find out the point prevalence rates of obsessive compulsive symptoms (OCSs) in a sample of adolescents of secondary school students in a rural area in Egypt, according to the Arabic form of Symptom Checklist Questionnaire (the questions that screen for obsessive compulsive symptoms). See later about this screening tool.
2. To find out the point prevalence rate of OCD.
3. To determine the possible risk factors associated with OCSs and OCD.

Method

A two stages epidemiological study designed to investigate the point prevalence rates of OCSs and OCD; and the associated risk factors among secondary school students in a rural residence was conducted. The survey covers 4 secondary schools selected out of 8 secondary schools located in Shebeen El-Kanater, El-Kalubia Governorate, that is 37 km faraway from Cairo, Egypt. In the first stage, the Arabic form of Symptom Checklist Questionnaire "SCL-90"; (the questions that screen for obsessive compulsive symptoms (OCSs) (*Al-Behairy A. 1984*). This OCSs portion of SCL-90 consists of 10 statements out of 90 statements. The SCL-90 questionnaire represents a wide variety of psychiatric symptoms. Leonard R. Derogatis; Ronald S. Lipman and Lenocovi were the original designers for SCL-90, then it was translated and standardized according to the Egyptian culture by Abd-Alrakieb Albehairy (*Al-Behairy A., 1984*). The SCL-90 has been widely used in research and has got reasonable validity and reliability, on populations similar to ours, so that the investigators were quiet confident by its previously documented validity and reliability (*Lotfy M. 2000*). Every statement

of the 10s has 5 options, namely seldom, rare, sometimes, often, always; with a corresponding scoring ranges from 0 to 4 points. This "OCSs portion of SCL-90" was administered to 1000 randomly selected students. In this sample, as shown in Table 1., males and females were almost equally represented, where their proportions were 49.9% and 50.1% respectively. The age range of the sample was 14 to 19 years old, and the mean age was 16.69 ± 1.23 . The subject was considered positive if he/she had scores 21 points and above on the screening tool. In the second stage, a semi-structured clinical psychiatric interview based on DSM-IV criteria was carried out for all students that considered positive in the first stage.

Permission was obtained from the Ministry of Education as well as verbal consent from the study subjects.

Data were managed using a database software program (Epi-Info Version 6.) in which rates, and Chi Square, with P. values were calculated

Results and Discussion

According to OCSs portion of SCL-90, Table 1. showed that the majority of the sample (81.6%) had scores below 21 points (-ve candidates on OCS portion of SCL-90), whereas, 18.4% of the students had positive scores (21 and above on the same tool). This result was almost similar to what *Valleni, et al., 1994* found that OCSs were prevalent in 18.4% of their study group. It was also near to the point prevalence rate of what *Maina G. et al., 1999*, called it a subthreshold obsessive compulsive syndrome (sOCS); a diagnosis they made for individuals who had obsessive and/or compulsive symptoms but who failed to meet one of the severity criteria of impairment. They found the prevalence of

sOCS was 12.3%. They also concluded from their representative sample of older adolescents living in Piedmont, Italy, that sOCS, being commonly endorsed in a general adolescent population, may represent a normal phenomenon in older adolescents. On the other hand, the prevalence of OCS of the current study, was lower than that found by *Ismail R. (1998)*, and *Al-Kholey Gh. (1997)*, which were 43.1% and 38% respectively, and it was much more higher than what was found by *Nestdt, G., et al., 1994*, where the OCSs were prevalent in 1.5% only of their study population. The difference in results in prevalence rates of OCS might be explained by what *Zohar AH., 1999* pointed out that although the natural course of OCD is fairly stable, fluctuations in symptom level may make short-term apparent outcome unreliable, and individuals may meet threshold and subthreshold criteria at different times. Also, differences in the methodology, population studied, and tools used in a certain study may account for these different results. Transcultural factors such as the relative tolerability of OCSs (as the case in our culture) or in the contrary its rejection in other cultures, might further explain the difference in results.

As regards sex, although there was no statistically significant difference, however the percentage is higher in case of males more than females. The percentages were equal in *Thomsen P. H., 1993* and *Valleni et al., 1994*'s studies. However, it was more in case of females in *Ismail R., 1998*'s study. The difference again may be due to transcultural factors and the type of community from which the sample was drawn. In the rural community, which was the case in our study, there were more responsibilities in case of males than

females. This may result in more identity confusion with many psychiatric symptoms including OCSs in part of males more than females. On the other hand, when the sex variable was stratified according to different age intervals, females had more prevalence rates compared to males, in the earlier age interval, as in table 2. (see later)

As regard age, there was relative increase in reporting OCSs in the age interval from 16 to 17 years, either for the students with -ve or +ve results on OCS portion of SCL-90. For the positive students, 146 out of 184 students (79.3%) were in the age intervals of 14 to 15 and 16 to 17 years old, and only 20.7% were in the age interval 18 to 19 years, and the differences were highly significant denoting that the age variable was an important risk factor for presence of OCSs. This was in agreement with *Ismail R., 1998*'s study, where the earlier the age, the more the OCSs. This was also supported by the findings of *Karno, M. and Golding, J., 1990*, *Rasmussen, S., 1990*, that 50% to 70% of OCD patients date back the onset of OCSs around the start of their adolescence. This might be explained by the considerable physical, hormonal and psychological changes that first experienced in the early adolescence.

Table 2. showed that the prevalence of +ve OCS scores among females was more than that among males in the age interval of 14 to 15, however this was reversed in the age intervals 16 to 17, and 18 to 19, indicating early female preponderance then change to more males later on. Also, there was gender difference as regard positive scorers, as mentioned above, (53.8% and 46.2% for males and females respectively), however, the differences were not significant. This was in agreement with *Bebbington PE., 1998*, but, it differed with *Bry'nska A. (1997)*.

Although both *Bebbington PE., 1998*, and *Bry'nska A. (1997)* reviewed the available literature on epidemiology of OCD, the first investigator, however included all studies irrespective to the age, contrary to the later who included only the literature of children and adolescents. Furthermore, *Bebbington PE., 1998*, reviewed only surveys based on standardized instruments.

Table 3. showed the prevalence rates of psychiatric disorders according to semistructured clinical psychiatric interview based on DSM-IV criteria. This was the second stage of the study in which the investigators interviewed students labeled positive on the screening tool(OCS portion of SCL-90) in the first stage. According to table 3, the most prevalent psychiatric disorder was OCD (49.5%), then generalized anxiety disorder, major depressive episode, dysthymia which were 18.5%, 15.1%, and 13% respectively, from those labeled positive in the first stage. The prevalence of OCD in the current study (9.1% of the whole sample), was supported by the results of *Degonda M. et al., 1993*, *Ismail R., 1998*, where the prevalence rates of OCD were 5.5%, 8.4%, respectively. However it was higher than that were found by *Nestdt et al., 1994*, and *Eisa A., 1998*, where they were 1.5%, and 0.82%, respectively. As was mentioned in the context of differences in prevalence rates of subthreshold OCS, the differences between the studies mentioned here, as regard the prevalence rates of OCD, might be explained by what *Zohar AH. (1997)* said that the boundary of the diagnosis of OCD is not always easy to determine, and individuals may meet threshold and subthreshold criteria at different times. The differences might also due to use of different tools and/or cultural differences as *Lottfy, M. 2000*, stated that

cultural and life style factors might affect the results of different studies of OCD by 10 folds.

Table 4. showed that depressive syndromes (major depression, and dysthymia) were the more common comorbid disorders (25.4%), then generalized anxiety disorder (8.9%), then phobic disorders. This was in agreement with *Kilda, J.I., et al., 1994*, *Flament, M., 1990*, however it was lower than what was found by *Valleni, et al., 1994*, where major depression was the comorbid condition in 45%, then generalized anxiety disorder in 34% then dysthymia in 29%, then phobic disorders. The differences might explained by change in the cultural' s degree of tolerability of OCD, as the case in our study, so that a subsequent psychiatric disorder might be less common.

Table 5. showed the common risk factors and their degrees of association with OCD in the current sample. It was found that there were statistically significant association with OCD, as regard type of communication inside the family, death of one of the parent, family history of a psychiatric disorder, history of childhood psychiatric disorder, presence of physical illness and presence of a precipitating factor before the illness. On the other hand, the sex, age of the student, family size, and birth order had no statistically significant association with OCD.

The table indicated that the point prevalence of OCD was higher in case of males than females (51.6% and 48.4% respectively), but the difference was not significant. This difference was supported by *Ismail R., 1998*'s study, where the prevalence rates were 51.3% in males, and 48.7% in females. It also was in agreement with the results of *Valleni, et al., 1994*. On

the other hand the prevalence rates were more in females compared to males in *Eisa, A., 1997, Karno, M., et al., 1988, Nestdt, G., et al., 1994*. The difference might be due to different study populations, as in the current study as well as *Ismail, R., 1998*, and *Valleni, et al., 1994*, the target populations were adolescents. The reaction of males to a psychosocial stressor might differ than that of females based on cultural changes, and rural versus urban areas.

As regard age of the student, there were differences based on different age intervals with the 16 to 17 years old interval associated more with OCD (56%) then, the 14 to 15, and then the 18 to 19 intervals, which were (26.4%), and (17.6%) respectively. As we mentioned before -in our general comment on table 5-, these age differences were not statistically significant. These differences, however, were in agreement with *Degonda, M., et al., 1994*, and *Kilda, J.L., et al., 1994*'s findings and it differed with *Ismail R., 1998*, where the age interval 18 to 20 years had more prevalence than that of 16 to 18. The reason of difference in case of OCSs mentioned before could be applied here (see before).

As regards the family size, and birth order, although findings related to both were not statistically significant, however, the reported difference was in agreement with *Eisa, A., 1998*, and *Nistdt, G., et al., 1994*, concerning family size and they found that the increase in family size associated with the increased risk for psychiatric disorders in general. Concerning birth order, our finding that the OCD was associated more with the last birth order in 52.7% followed by the first births (27.5%). This finding was partially agreed with the findings of *Ismail, R., 1998* and *Abd-Elaziz, A., 1998* in the first order finding, but it differed with that of the last

birth order. This might be explained by either the parental overprotection, the overindulgence, or even the rejection attitude of the last birth order, if it was undesirable.

Presence of death for one of the parent was present in 25.3% of the OCD patients and it had a highly significant association. This was in agreement with almost all studies that reported the death of one of the parent and its association with the appearance of one of the psychiatric disorders (*Gelder M. et al., 1996*)

As regards positive family history of a psychiatric disorder, 29.7% of students diagnosed as OCD patients had a family history of psychiatric disorder, and the difference was highly significant. This was in agreement with *Eisa, A., 1997* and *Abd-Elaziz, A., 1998*, but it was higher than what *Ismail, R., 1998* found, namely 12.1%. The difference between these studies may be due to lack of proper information in part of the informant or due to denial for fear of stigma.

As regards presence of physical disease/s, 11% of OCD patients had physical diseases and this was supported by previous studies in that physical disease was one of the risk factors for the development of a psychiatric disorder *Lotfy, Mohamed, AK. (2000)*.

As regards of presence of a precipitating factor, our results in table 5. indicated that there were precipitating factors in 36.3% of OCD patients, and the difference was highly significant. This was in agreement with *Eisa, A., 1997*, but it was lower than that found by *Okasha, A., et al., 1994*, where it was in 69% of cases. This may be due to the difference in population studied; where they were outpatient clinic population in *Okasha A., et al., 1994*, where in this type of population, there is more tendency to report different psychosocial

stressors related to disease onset.

Lastly, the presence of a harsh communication between the family members, and a past history of childhood psychiatric disorder were highly statistically significant risk factors for OCD. Table 5. showed that, 56% and 47.2% of OCD patients had a harsh discipline in the family and a past history of psychiatric disorder during childhood. The presence of

harsh discipline, rejection and lack of warmth in emotions were also associated with the presence of OCD in one or more of the family members, as was found by *Al-Khouly, Gh., 1997*, however, it was lower (11%) in *Lenane, M., 1990*'s study. As regards presence of childhood psychiatric disorder, *Nestdt G., et al., 1994*, found that 42% of his OCD patients had history of childhood psychiatric disorders.

Table 1. Point prevalence of obsessive compulsive symptoms according to Symptom Checklist, by age and sex among a sample of rural secondary school students in Egypt.

SL Score			From	From	Total	Chi	P.
The variable			1 to 20	21 to 40		Sq.	Value
Males		No.	400	99	499	1.37 DF:1	> 0.05 N.S.
		%	40	9.9	49.9		
Females		No.	416	85	501		
		%	41.6	8.5	50.1		
Total		No.	616	184	1000		
		%	61.6	18.4	100		
Age	14-15	No.	118	45	163	14.3 DF:2	0.001 H.S.
		%	11.8	4.5	16.3		
	16-17	No.	449	101	550		
		%	44.9	10.1	55		
	18-19	No.	249	38	287		
		%	24.9	3.8	28.7		
	total	No.	816	184	1000		
		%	81.6	18.4	100		

D.F.: degree of freedom; N.S.: not significant, H.S.: highly significant

Table 2. Point prevalence of "positive" scores (21 and above) according to Symptom Checklist; by sex versus age among a sample of rural secondary school students in Egypt.

Sex	Males		Females		Total N=194		Chi Square	P. value
Age	No.	%	No.	%	No.	%	1.29 DF:2	> 0.05
14 & 15	21	46.7	24	53.3	45	24.5		
16 & 17	56	55.4	45	45.6	101	54.9		
18 & 19	22	57.9	16	42.1	38	20.9		
Total	99	53.8	85	46.2	184	100		

Table 3. Point prevalence rates of psychiatric disorders according to DSM-IV criteria among a sample of rural secondary school students in Egypt.

Psychiatric Disorders	No. N=194*	% (positives)	% (all sample)
Non	50	27.1	5
OCD	91	49.5	9.1
Anxiety	34	18.5	3.4
Maj. depression	28	15.1	2.8
Dysthymia	24	13	2.4
Social phobia	23	12.5	2.3
Simple phobia	18	9.8	1.8

*The simple summation of the numbers exceeds the total numbers, as a result of the overlap between some of the reported psychiatric disorders and OCD.

Table 4. Point prevalence rates of comorbid psychiatric disorders according to DSM-IV criteria among OCD patients, from a sample of rural secondary school students in Egypt.

Psychiatric Disorders	No. N=91	% (Positives)
No comorbidity	52	57
Depression	14	15.5
Dysthymia	09	9.9
Anxiety	08	8.9
Social Phobia	05	5.5
Simple Phobia	03	3.2
Total	91	100

Table 5. The association between different risk factors and the presence of OCD in a sample of rural secondary school students in Egypt; the positive group in the screening stage.

Risk Factors	OCD Group	OCS Group	Total N=184	Chi Square	P-value
	N=91	N=93			
Sex: *Male	47	52	99	0.34 D.F.=1	>0.05 N.S.
*Female	44	41	85		
*Total	91	93	184		
Age: *14 & 15	24	21	45	1.14 D.F.=2	>0.05 N.S.
*16 & 17	51	50	101		
*18 & 19	16	22	38		
*Total	91	93	184		
Family size: single	5	5	10	3.42 D.F.=2	>0.05 N.S.
* < 5	32	45	77		
* 5 +	54	43	97		
*Total	91	93	184		
Birth order: *First	25	15	40	5.1 D.F.=2	>0.05 N.S.
*Middle	18	29	47		
*Last	48	49	97		
*Total	91	93	184		
Family Communication:				10.7 D.F.=1	<0.0001 H.S.
*Harsh					
*Fine	51	30	81		
*Total	40	63	103		
	91	93	184		
Death in the Family:				20.95 D.F.=1	<0.0001 H.S.
*Absent	68	91	159		
*Present	23	02	025		
*Total	91	93	184		
Family history:				17.1 D.F.=2	<0.001 H.S.
*-ve	64	87	151		
*Neurosis	19	05	024		
*Psychosis	08	01	009		
*Total	91	93	184		
Past History:				24.1 D.F.=1	<0.0001 H.S.
*-ve	48	80	128		
*+ve	43	13	056		
*Total	91	93	184		
Physical Illnesses:				4.22 D.F.=1	<0.05 S.
*Absent	81	90	171		
*Present	10	03	013		
*Total	91	93	184		
Precipitating Factor:				7.52 D.F.=1	<0.01 H.S.
*Absent	58	76	134		
*Present	33	17	050		
*Total	91	93	184		

D.F.=degree of freedom; N.S.=not significant; S.=significant; H.S.=highly significant

Future directions for research and other implications

* Although the students inside each school were randomly selected, the 4 secondary schools were selected on the basis of feasibility of the research, and not randomly, so that our results could be applied only to the selected schools themselves.

*The current research was lacking a standardized scale as Yale-Brown Obsessive Compulsive Scale, for example, in order to confirm our clinical diagnosis and to gauge the severity of OCD.

*Household surveys still needed in order to estimate the disorder in adolescents dropout from schools and adolescence not going to schools from the start; as those helping their parents in the farms in such rural areas.

Conclusion

The current study encourages undertaking more epidemiological studies in the community, especially for the household population, for determining the prevalence rates of both sOCS and OCD as well as other psychiatric disorders on a coordinated national strategy and better design. Yet within its limitations, it came with specific findings which could be used in planning and implementation of health services needed for similar rural communities in Egypt.

The two stages design of the current study with the clinical psychiatric assessment approach added helpful data about the possible risk factors of both OCS and OCD compared to previous studies which did not have this design.

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معدل انتشار أعراض واضطراب الوسواس القهري

لدى عينة من طلاب المدارس الثانوية

في منطقة ريفية

لقد تمت دراسة معدل الانتشار المحدد للأعراض الوسواسية فيما دون الإضطراب إضافة إلى تلك التي ترقى لتشخيص "اضطراب الوسواس القهري"، وعوامل الخطورة المرتبطة بهما. ولقد استخدمت الدراسة الجزء الخاص بالوسواس القهري من مقياس مجموعة الأعراض، النسخة المعربة لـ "عبدالرقيب البحيري"، كأداة مسح أولية لدى عينة من طلاب المدارس الثانوية في منطقة ريفية بمنطقة شبين القناطر - محافظة القليوبية - مصر. ولقد أتت بمقابلة إكلينيكية طب نفسية شبه مقننة معتمدة على التشخيص الأمريكي الرابع للاضطرابات النفسية لكل من حصل علي واحد وعشرين نقطة فأكثر في الأداة المسحية المذكورة آنفاً.

ولقد بلغ حجم العينة والتي اختبرت عشوائياً ١٠٠٠ تلميذ وتلميذة (٤٩,٩ % منهم ذكور ، ٥٠,١ % منهم إناث)، وكان المدى العمري للتلاميذ هو ١٤ - ١٩ عاماً بمتوسط $16,6 \pm 1,23$ سنة

وكانت النتائج كالآتي :- أن ١٨,٤ % من العينة حصلوا على ٢١ درجة فأكثر علي قائمة الأعراض الوسواسية (وهي الحالات الموجبة في المرحلة المسحية وهي تعكس معدل الانتشار المحدد للأعراض الوسواسية) . وكان معدل الانتشار أعلي في الشرائح العمرية الأقل.

وتمخضت المرحلة الثانية من البحث (مرحلة المقابلة الإكلينيكية) عن معدل انتشار محدد لاضطراب الوسواس القهري قدره ٩,١ %، كما أظهرت النتائج بأن هناك اضطرابات نفسية مصاحبة لاضطراب الوسواس القهري لدى ٤٣ % منهم، وكان أكثر تلك الاضطرابات شيوعاً هي (نوبة اكتئاب عظمي لدى ١٥,٥ % واضطراب عسر المزاج لدى ٩,٩ %)

ووجد أن سن التلميذ ، حجم العائلة التي يعيش معها، ووجود تاريخ أسري لاضطراب نفسي ، وجود ضغوط نفسية واجتماعية مرسية ، إلى جانب عوامل أخرى، هي عوامل خطر معتبرة إحصائياً، وترتبط مع ظهور أي من أعراض الوسواس القهري أو اضطراب الوسواس القهري.