

Clinical Phenomenology of OCD: A Study from Kashmir

Mohammad Maqbool Dar¹, Majid Shafi Shah², Fazl E Roub³, Mohd Altaf Paul⁴, Shahid Sulayman⁵

ABSTRACT

Introduction: Obsessive Compulsive Disorder is a chronic and disabling psychiatric disorder characterized by recurrent intrusive thoughts, images and impulses known as obsessions which are usually accompanied by repetitive acts or behaviors known as compulsions. The clinical presentation of this disorder has been found to be vary from one region to other; being highly influenced by social, cultural and religious factors. We aimed to study the symptom pattern of the patients presenting to our institute from Muslim majority region of Kashmir valley.

Materials and Methods: Our study was a cross sectional observational study. Obsessive Compulsive Disorder was diagnosed as per DSM IV TR criteria. A total of 156 patients were included in this study. Clinical phenomenology and severity were assessed using Yale Brown Obsessive Compulsive Check list and Scale respectively. Data analysis was done with the help of SPSS, version 20.

Result: Contamination was the commonest obsession in 55.76% patients. Religious obsessions in 25.00%, Aggressive obsessions in 21.15%, Symmetrical obsessions 20.51%, Sexual obsessions in 16.02%, Somatic in 15.38% miscellaneous in 32.69% patients were the other types of obsessions. Cleaning in 51.92%, Checking 32.69%, repeating 28.28%, counting in 6.41%, ordering in 4.48% and miscellaneous in 15.38% patients were the type of compulsions found in our study.

Conclusion: Contamination was the commonest obsession while as cleaning was the commonest compulsion

Keywords: Kashmir, Obsessive Compulsive Disorder, OCD, Phenomenology.

INTRODUCTION

Obsessive – compulsive disorder (OCD) is a neuropsychiatric disorder, characterized by recurrent intrusive ideas, impulses, or urges (obsessions) along with overt or covert behaviours (compulsions) aimed at reducing the distress.¹ Reported as the one of leading cause of disability in the world by the World Health Organization (WHO), OCD causes disrupted development, social withdrawal, family and relationship problems, difficulties with concentration and academic performance.² About 2-3% of World's population suffers from OCD. There is only one epidemiological study from India. The study found lifetime prevalence of 0.6%.³ About 30-50% of adult with OCD recall the onset of their symptoms beginning before the age of 18 years with males having an earlier onset than females.⁴ Although standard nomenclature regards OCD as a unitary nosological entity, patients typically display a wide variety of obsessions and/or compulsions of varying severity. The symptomatology is influenced by social, cultural and religious factors.⁵ People of a particular area and religion share similar concerns which are

reflected in the kind of obsession and compulsion that area and people have. One's beliefs are largely determined by his religion.⁵ We did this study to understand the pattern of OCD in Kashmir, a Muslim majority region in India.

MATERIAL AND METHODS

This study was carried amongst patients attending OCD clinic of Department of Psychiatry, Institute Of Mental Health and Neurosciences Srinagar which is the lone tertiary psychiatric hospital in Kashmir and caters to whole Kashmir region, along with some adjoining areas of Jammu and Ladakh region. Ethical Committee of the institute approved the study.

Study Design: Our study was a non interventional cross sectional observational study.

Patient's selection: Diagnosis of OCD was made as per DSM IV TR criteria.⁶ Each Patient was informed about the purpose of the interviewing. All the data of the patients including general description, demographic data was recorded in the semi structured case sheet especially designed for this study. All the new patients registered during the time period of March 2014 to May 2015 were screened and those who fulfilled the following criteria were taken up for the study.

Inclusion Criteria

OCD as per DSM IV TR criteria.⁶
OCD as primary psychiatric disorder.
Age at least 18 years.
Those who gave consent.

Exclusion Criteria

1. Presence of organic brain/medical disorders.
As a result, 156 patients were recruited.
Patients were assessed with the help of following instruments:
- 1) **Semi structured proforma** for recording socio demographic variables including details of chief complaints, psychiatric history and mental status examination.
- 2) **Kuppaswamy's socioeconomic status:** This is an impor-

¹Associate Professor and Head of the Department, ²Senior Resident, ³Post Graduate Student, ⁴Clinical Psychologist, ⁵MBBS Student, Department of Psychiatry, Institute Of Mental Health and Neurosciences, Kathi Darwaza, Srinagar, India.

Corresponding author: Dr Fazl E Roub, Department of Psychiatry, Institute of Mental Health and Neurosciences, Kathi Darwaza, Srinagar 190003, India.

How to cite this article: Mohammad Maqbool Dar, Majid Shafi Shah, Fazl E Roub, Mohd Altaf Paul, Shahid Sulayman. Clinical phenomenology of OCD: a study from Kashmir. International Journal of Contemporary Medical Research 2016;3 (2):431-434.

tant tool in hospital and community based research in India. It was proposed in 1976 and revised in 2007. This scale takes account of education, occupation and income of the family to classify study groups in to five social classes: Upper (I), Upper Middle (II), Lower middle (III), Lower lower (IV) and lower (V) socioeconomic statuses.⁷

3) DSM-IV-TR diagnostic criteria for OCD: (Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Text Rev. Washington DC: American psychiatric association). Diagnostic and statistical manual of mental disorders (DSM) is the psychiatric classification developed by American Psychiatric Association in collaboration with other groups of mental health professions.⁶

4) Yale brown obsessive compulsive Scale (Y-BOCS): The scale was developed by WK Goodman et al in 1989. The scale is clinician rated, 10 item scale, each item rated from 0 (no symptoms) to 4 (extreme symptoms) with a total range of 0 to 40 and separated subtotals for severity of obsession and compulsions. The first five items concern obsessions: the amount of time they consume, the degree to which they interfere with normal functioning, the distress they cause, the patient's attempts to resist them, and the patient's ability to control them. The remaining five items ask parallel questions about compulsions.⁸

STATISTICAL ANALYSIS

The data about various parameters was categorized according to age, sex, education, socioeconomic status, clinical phenomenology etc. The information thus generated was presented in tables. Statistical analysis was carried out with a commercial software package (SPSS, version 20), Appropriate statistical methods were applied and statistical significance was set at $P < 0.05$.

RESULTS

Table 1 shows sociodemographic profile of patients. Majority of patients were Males, in the age group of 18 to 27 years, of rural background, belonging to nuclear families, were married, students by occupation, educated upto high classes (class 10th) and belonging to class III Socioeconomic class. As shown in table 2; contamination were the most common obsession in 55.76% patients. Religious (25.00%), Aggression (21.15%), Symmetry (20.51%), Sexual (16.02%), Somatic (15.38%) and Miscellaneous (16.02%) were the other types of obsessions. The types of compulsions were Cleaning (51.92%), Checking (32.69%), repeating (28.28%), counting (6.41%), ordering (4.48%) and miscellaneous (15.38%).

Variable	Subgroup	Frequency	Percentage	P (Chi Square test)
Sex	Male	86	55.13	0.23
	Female	70	44.87	NS
Age distribution	18-27	67	42.95	<0.0001
	28-37	58	37.18	
	38-47	22	14.10	
	48 and above	09	5.77	
Dwelling	Rural	81	51.92	0.69
	Urban	75	48.08	NS
Family Back ground	Nuclear	81	51.92	0.69
	Joint	75	48.08	NS
Marital status	Unmarried	46	29.49	<0.001
	Married	100	64.10	
	Divorcee/Separated	10	6.41	
Occupation	Student	42	26.92	<0.001
	Unemployed	21	13.46	
	Self employed	39	25.00	
	Govt. Services	18	11.54	
	Housewife	36	23.08	
Education	Illiterate	19	12.18	<0.001
	Primary	06	3.85	
	Middle	19	12.18	
	High school	49	31.41	
	Higher secondary	34	21.79	
	Graduation	13	8.33	
	Post-Graduation and Above	16	10.26	
Socio economic Class	I	09	5.77	0.004
	II	35	22.44	
	III	53	33.97	
	IV	33	21.15	
	V	26	16.67	
Religion	Muslim	156	100	
	Others	0	0	

Table-1: Sociodemographic profile of patients

Mean age of patients was 29.58 years while as mean age of onset of OCD was 22.6 years as shown in table 3.

As shown in table 4; the severity of OCD which was assessed by YBOCS scale shows most patients (32.69%) having Mild variety of OCD while as only 4.49% patients had extreme OCD.

DISCUSSION

This is the first study from Kashmir on OCD, a heterogeneous disorder characterized by a wide variety of symptoms. The difference in symptom pattern of OCD is only speculative and no definite reason is provided for the same. We undertook this study to analyse the symptom pattern that OCD patients present to our hospital.

A total of 156 patients were included in our study. Sex ratio was tilted slightly towards the male gender with 55.13% (86) males and 44.87% (70) females comprising the whole sample. There are other studies, which have slightly greater percentage of males as compared to females in their respective studies.⁹⁻¹¹ The male preponderance is explained due to the socio-cultural taboos, prevalent in conservative society like Kashmir, in which women feel hesitant to consult a doctor especially a psychiatrist.

The majority of the patients belonged to young and the middle age groups. Mean age of patients was 29.58 years and mean age of onset of OCD was 22.6 years. This is in agreement with Khanna et al who reported 29.5 years as mean age of assessment.¹⁰ Most of Indian studies report similar results.^{9,11-13}

While the percentage of different symptoms varies widely between different studies, their frequency with regard to pattern is somewhat broadly uniform. Contaminations predominate the kind of obsessions with 55.76 % among patients in our study. Contaminations predominated the obsession pattern in most Indian studies^{9,11,13} except study by Mahajan et al¹² who found aggressive obsessions to be commonest. Our study is fairly consistent with The Brown Longitudinal Obsessive Compulsive Study by Pinto et al¹⁴ (who reported 57.5% contamination obsession in adults). In our study, obsessions of contamination were followed by religious (blasphemous) obsessions. Our results match those of Rahman MH and Kamal AHMKM¹⁵ in Bangladesh and of Rady et al¹⁶ in Egypt, two Muslim majority areas like Kashmir with regard to type of obsession as in both studies religious obsessions followed contamination obsessions in terms of type of obsession. Muslims have to pray five times every day and observe one month of fasting (Ramadhan) during day hours unlike other religions which could possibly explain for higher prevalence of religious obsession in Muslims and hence our study. Symmetrical, sexual and somatic obsessions are less prevalent obsessions as compared to other types of obsessions which is in accordance with studies done in different parts of the world.^{9,11,13-15} Miscellaneous obsessions formed about 34.78% of total patients. These include musical obsessions, intrusive images or words, need to know certain numbers and mathematical figures etc.

In our study, cleaning was the commonest compulsion fol-

Symptom (S)	Frequency	Percentage
Obsession		
Contamination	87	55.76
Religious	39	25.00
Aggression	33	21.15
Symmetry	32	20.51
Sexual	25	16.02
Somatic	24	15.38
Miscellaneous	51	32.69
Compulsion		
Cleaning	81	51.92
Checking	51	32.69
Repeating	44	28.28
Counting	10	6.41
Ordering	7	4.48
Miscellaneous	24	15.38
More than one obsessions /compulsion were present in some patients.		

Table-2: Phenomenology of OCD among patients

Variable	Mean (in years)	SD	Range
Age at assessment	29.58	9.72	50 (18-68)
Age at onset	22.60	6.65	32 (43-11)

Table-3: Mean age of assessment and Onset of OCD

YBOCS score	Severity	Number of Patients	%
8-15	Mild	51	32.69
16-23	Moderate	48	30.77
24-31	Severity	50	32.05
32 and above	Extreme	7	4.49
Total		156	100

Table-4: Severity of OCD as per YBOCS score

lowed by Checking. Cleaning was reported to be most common compulsion in studies by Parmar MC and Shah NP⁹ and Khurana et al¹¹ and second common by Mahajan et al¹² and Khandelwal et al.¹³ Checking predominates most of the Western studies^{17,18} and some Indian studies like Mahajan et al¹² and Khandelwal et al.¹³ Counting and ordering are least common compulsions which was also found in our results. This is in accordance with Indian as well as Western.^{9,11-14,17,18} Our study did not have any case of hoarding. Indian studies^{9,11-13} have reported hoarding to be the least common OCD pattern as compared to western studies reflecting a markedly lesser prevalence as compared to Western studies^{14,17,18} which have found higher percentage of hoarding.

Limitations our study

There were biases of referral pattern and selection criteria. Patients were recruited from single treatment centre only, so the degree to which the results can be generalised to other cohorts of OCD patients is uncertain. Also, OCD pattern may change overtime, which we didn't assess owing to the design of our study.

CONCLUSION

Contamination was the commonest obsession followed by religious obsession while as cleaning was the commonest

compulsion followed by checking compulsion. Kashmir culture differs from rest of India, that could affect the symptomatology of OCD in Kashmir valley. Further, studies need to be undertaken on this subject.

REFERENCES

1. Karno M, Golding JM, Sorensen SB, and Burnam MA. The prevalence of obsessive-compulsive disorder in five US communities. *Arch Gen Psychiatry* 1988;45: 1094–1099.
2. Murray CJ, Lopez AD. *The Global Burden of Disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020*. Cambridge, MA; Harvard School of Public Health, (Global Burden of Disease and Injury Series) 1996;1.
3. Khanna S, Gururaj G, Sriram TG. Epidemiology of obsessive-compulsive disorder in India. Presented at the First International Obsessive-Compulsive Disorder Congress, Capri 1993; 9-12.
4. Jaisooriya TS, Janardhan Reddy YC, Srinath S, Kandavel T. Gender differences in Indian patients with obsessive-compulsive disorder. *Compr Psychiatry* 2008;50:70–5.
5. Bhogra D and Bhui K. *Textbook of Cultural Psychiatry*. New York. Cambridge University Press;2007.
6. American Psychiatric Association and American Psychiatric Association Task Force on DSM-IV. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR*. Washington DC, USA: American Psychiatric Association; 2000.
7. Kumar N, Shekhar C, Kumar P and Kundu AS. Kuppuswamy's Socioeconomic Status Scale-Updating for 2007. *Indian J Pediatr* 2007; 74.
8. Goodman WK, Price LH, Rasmussen SA, Mazure C, Fleischmann RL, Hill CL, Heninger GR, Charney DS. The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. *Arch Gen Psychiatry* 1989;46:1006-11.
9. Parmar MC and Shah NP. Phenomenology of Obsessive Compulsive Disorder. *Inter Jour Pharma and Med Res* 2014;2.
10. Khanna S, Rajendra PN, Channabasavanna SM. Socio-demographic variable in obsessive-compulsive neurosis in India. *Int J Soc Psychiatry* 1987;32:47-54.
11. Khurana S, Bhargav SC, Kumar K, Purushottam, Gupta R. A clinical study of multi-dimensional model of Obsessive Compulsive Disorder (OCD). *Integ J Social Sciences* 2014; 1: 5-10.
12. Mahajan NS, Chopra A, Mahajan R. Gender Differences in clinical presentation of Obsessive Compulsive Disorder: a hospital based study. *Delhi Psychiatry Journal* 2014; 17.
13. Khandelwal A, Aggarwal A, Garg A, Jiloha RC. Gender Differences in Phenomenology of Patients with Obsessive Compulsive Disorder. *Delhi Psychiatry Journal* 2009;12.
14. Pinto A, Mancebo MC, Eisen JL, Pagano ME, Rasmussen SA. The Brown Longitudinal Obsessive Compulsive Study: Clinical Features and Symptoms of the Sample at Intake. *J Clin Psychiatry* 2006;67:703-711.
15. Rahman MH, Kamal AHMKM. Obsessive Compulsive disorder: A study on clinical phenomenology. *JAFMC Bangladesh* 2010; 6:2.
16. Rady A, Salama H, Wagdy M, Ketat A. Obsessive compulsive phenomenology in a sample of Egyptian adolescent population. *Eur J Psychiat* 2013;27:89-96.
17. Mataix – Cols D, Rauch S, Baer L, Eisen J, Shera D et al. Use of Factor-Analyzed Symptom Dimensions to Predict Outcome With Serotonin Reuptake Inhibitors and Placebo in the Treatment of Obsessive-Compulsive Disorder. *Am J Psychiatry* 1999; 156:1409–1416.
18. Rasmussen SA, Eisen JL. Epidemiological and clinical features of obsessive compulsive disorder. *Child Adolesc Psychiatr Clin N Am* 1992, 15, 744-58

Source of Support: Nil; **Conflict of Interest:** None

Submitted: 28-12-2015; **Published online:** 11-01-2016