

## **OCD in Egyptian Adolescents: The Effect of Culture and Religion**

By Ahmed Okasha, M.D., Ph.D.

| April 15, 2004

Dr. Okasha is chairperson of the department of neuropsychiatry at Ain Shams University in Cairo, Egypt. He is also director of a World Health Organization collaborating center.

---

Obsessive-compulsive disorder was once believed to be a rare condition. The prevalence rate of OCD in three catchment areas in a U.S. study ranged between 1.9% and 3.3% (Robins et al., 1984). In comparison, a study conducted in Cairo, Egypt, of 1,000 psychiatric patients attending a university clinic showed an incidence of OCD of 2.5% (Okasha et al., 1968). A replication of this study showed an incidence of 2.3%, indicating the stability of the prevalence of the disorder over time (Okasha and Raafat, 1991).

Previous Egyptian studies on psychiatric phenomenology have shown a prevalence of culturally determined symptomatology, where religion and prevailing traditions seemed to color not only the clinical picture of the condition, but also patients' attitudes about their disorder (Okasha, 1966).

In one of our studies, 90 patients suffering from OCD (diagnosed according to the *ICD-10*) attending our outpatient clinic were followed from 1991 to 1992 (Okasha et al., 1994). The patients were assessed by the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) for symptomatology and severity of symptoms. Sixty-nine percent of the patients were males and 32% were females. The mean age was 23.7, with a mean duration of OCD of 3.2 years. Twenty percent of patients had positive family histories for OCD. Forty percent of patients presented with a mixture of obsessions and compulsions, whereas 29% presented with only obsessions and 31% with only compulsions. Religious and contamination obsessions (60%) and somatic obsessions (49%) were the most common. The most common compulsions were repeating rituals (68%), cleaning and washing (63%), and checking (58%), mostly related to religious beliefs. Seventy-one percent of patients were rated as severe on the Y-BOCS. While all patients showed some lack of insight into their disorder, 9% had no insight whatsoever. One-third of patients had a comorbid depressive disorder. Regarding premorbid personality disorders, 14% had obsessive personality disorder, 34% had paranoid, anxious or emotionally labile personality disorders, and 52% had no specific premorbid personality disorder.

The role of religious upbringing has been evident in the phenomenology of OCD in Egypt. The psychosociocultural factors are so varied that they can affect the onset, phenomenology and outcome of OCD. They can even affect response to treatment. The emphasis on religious rituals and the warding-off of blasphemous thoughts through repeated religious phrases could explain the high prevalence of religious obsessions and repeating compulsions among our Egyptian sample. This is true even if the participants in the study were not practicing their religious duties.

To elaborate further, Moslems, who constitute almost 90% of the Egyptian population, are required to pray five times a day. Each prayer is preceded with a ritualistic cleansing process (*Wudu* or ablution), which involves washing several parts of the body in a specific order, each three times. This ablution is invalidated by any form of excretion or ejaculation and, for some radical Moslems, by any contact with the opposite sex. Women are not allowed to pray or touch the Koran during their menstruation, after which they should clean their bodies through a ritualistic bath. The prayers themselves vary in length and consist of certain phrases and *suras* from the Holy Koran that have to be read in a certain sequence.

The emphasis on cleanliness or ritual purity is the cornerstone of most of the compulsive rituals. The number of prayers and their verbal content can be the subject of scrupulousness, checking and repetition. The ritualistic cleansing procedures can also be a source of obsessions and compulsions about religious purity. Other evidence of the religious connotation inherent in OCD in Moslem culture lies in the term *weswas*. This term is used in reference to the devil and, at the same time, is used as a name for obsessions. It is also characteristic of a conservative society like Egypt to expect sexual obsessions to be among the most frequent in female patients. Although it is accepted socially (but prohibited religiously) for Egyptian males to have a wide range of sexual freedom in all stages of their lives, sexual matters remain an issue of prohibition, sin, impurity and shame for Egyptian women. The female gender is surrounded by so many religious and sexual taboos that the issue becomes a rich pool for worries, ruminations and cleansing compulsions in women susceptible to developing OCD.

Christians represent approximately 10% of the population in Egypt, which was equivalent to the percentage in our study sample population. The presenting symptoms for these patients were almost similar in terms of obsessions, where religious and sexual thoughts were predominant. However, there was a marked difference in rituals, which were more frequent in Moslems. This emphasizes the role of ritualistic Islamic upbringing, as compared with a Christian upbringing, in our community.

A comparison was also drawn between the most prevalent symptoms in our sample and those of other studies performed in India, England and Jerusalem. Contamination obsessions were the most frequent in all studies. However, the similarities of the contents of obsessions between Moslems and Jews, as compared with Hindus and Christians, signify the role played by cultural and religious factors in the presentation of OCD. The obsessional contents of the samples from Egypt and Jerusalem were similar, dealing mainly with matters of religion, cleanliness and dirt. Common themes between the Indian and British samples, on the other hand, were mostly related to orderliness and aggressive issues (Akhtar et al., 1975; Greenberg, 1984; Khanna and Channabasavanna, 1988; Pollitt, 1957).

Another cultural characteristic of Egyptian psychiatric patients is reflected in the Y-BOCS rating of the severity of OCD in our sample. The majority of patients rated between moderate and severe, and the total Y-BOCS score was severe in most of the cases, indicating high tolerance for psychiatric morbidity before seeking help. Native healers, religious people, friends and family elders are the primary caregivers for psychologically disordered individuals. When those interventions fail, seeking out the general practitioner, and then the psychiatrist, are the next resorts.

A surprising finding in our study was the fact that none of the patients had excellent insight into their disorder. Insight was mildly affected in 26% of cases, moderately affected in 50% and severely affected in 14.4%. This contrasts with the historically accepted characteristics of OCD--that patients recognize the absurdity of their obsessions and compulsions. However, our findings echo those of Lelliott et al. (1988), who found that one-third of their 49 ritualizers perceived their obsessive thoughts as rational and believed that rituals warded off some unwanted or feared event. The more bizarre the obsessive belief, the more strongly it was defended, and 12% made no attempt at all to resist the obsession.

Regarding the comorbidity of OCD with other psychiatric disorders, our results showed that one-third of patients had an associated depressive disorder and another third had various other diagnoses. The remaining one-third of patients did not show any psychiatric comorbidities (Okasha et al., 1994). These results can be compared to those obtained by Rasmussen and Eisen (1992), who found that two-thirds of their sample also had major depressive disorder.

Another study was conducted to determine the prevalence of obsessive-compulsive symptoms (OCS) among Egyptian students (Okasha et al., 2001). The multistage, stratified, random sample of students came from the El Abasseya educational area in Cairo. The tools used in this study included the General Health Questionnaire for screening of psychiatric morbidity and the Arabic Obsessive Scale for obsessive traits. The Y-BOCS was used to determine the profile of OCS and the *ICD-10* was used for diagnosis of OCD. Prevalence rates for psychiatric morbidity, obsessive traits and OCS were 51.7%, 26.2% and 43.1%, respectively. Obsessive-compulsive symptoms were more prevalent among younger students, females and first-born participants. Aggressive, contamination and religious obsessions and cleaning compulsions were the most common. Nineteen percent of participants with OCS fulfilled *ICD-10* criteria for OCD. This work presented data from a field study among adolescents in secondary schools and university students between the ages of 15 and 24. The prevalence of probable minor psychiatric morbidity was 51.7%. This high prevalence rate could be explained by the many biological and social factors that are associated with adolescence and early adulthood. This is especially true in a country such as Egypt, where the socioeconomic situation prolongs the duration of dependence on family and where attempts at independent living are met with major challenges (mostly economic). Furthermore, the last two years of school in the Egyptian educational system determine the student's future career, mainly whether or not they can have a university education. This is a crucial indicator of social status, even in the absence of economic resources.

In another study, we looked at the prevalence of OCS in a sample of Egyptian psychiatric patients (Okasha et al., 2000). Obsessions can occur in many psychiatric disorders, or they may constitute the entire illness. This is referred to as an *obsessional state*. The relationship of OCS to different psychiatric disorders still remains controversial. This work was undertaken to study the co-occurrence and phenomenology of OCS with other psychiatric disorders.

We examined a sample of 372 psychiatric outpatients and 308 controls using the Arabic version of the Y-BOCS checklist. Participants were additionally assessed by the obsession symptom section of the Present State Examination, the Eysenck rigidity scale and the religious orientation scale. Obsessive-compulsive symptoms were found to be significantly higher in psychiatric patients than in the non-psychiatric controls. Eighty-three percent of patients with neurotic, stress-related and somatoform disorders; 51% of patients with mood disorders; and 47% of patients with schizophrenia, schizotypal and delusional disorders were found to have OCS in their symptomatology. Furthermore, the data suggest that OCS in psychiatric patients has a distinct phenomenology from that in controls. The results did not, however, reveal a relationship between OCS and either rigidity or religious orientation.

The higher prevalence of OCS in the clinical psychiatric population (62.4%) tends to confirm the validity of the subsyndromal forms of OCD. All the symptoms in the Y-BOCS checklist were significantly more prevalent in the clinical population than in the general population, except for hoarding-saving obsessions. This suggests that OCS in the clinical population differs from that in the general population. It remains an issue for future exploration whether those subgroups would require treatment. However, the 62.4% prevalence of OCS in our clinical population could be compared to the study done by Hantouche and Bourgeois (1995), who found OCS in 17% of their clinical population.

There is still controversy about whether lack of insight should be regarded as the hallmark of a delusional or psychotic subtype of OCD or as a dimension that is present with different degrees of severity. It seems that the categorical diagnosis of OCD is not very satisfactory. The dimensional approach may better account for the variability in degree of insight and resistance and for the relationship between OCD and OCD spectrum disorders.

There is still incomplete evidence that OCD spectrum disorders are a separate cluster, as the similarity between them is greater than their similarity with OCD if we use proper diagnostic criteria. The fact that these patients may respond to selective serotonin reuptake inhibitors is not a valid criterion for similarity (Okasha, 2000).

Further research is also required to explore the biological and psychosocial correlates of OCD associated with depression, anxiety, psychosis, basal ganglia disorders and streptococcal infection. Should they be considered as different diagnostic subtypes?

Finally, we should have reliable tools to differentiate between OCS, traits that are prevalent in many traditional societies where religious rituals play a major role in people's lives, obsessive-compulsive personality disorder and OCD. The Y-BOCS scale has a cutoff point to differentiate between obsessive-compulsive personality disorder and OCD, but none for obsessive symptoms or traits (Okasha, 2000).

## References

1. Akhtar S, Wig NN, Varma VK et al. (1975), A phenomenological analysis of symptoms in obsessive-compulsive neurosis. *Br J Psychiatry* 127:342-348.
2. Greenberg D (1984), Are religious compulsions religious or compulsive: a phenomenological study. *Am J Psychother* 38(4):524-532.
3. Hantouche EG, Bourgeois M (1995), [Obsessive-compulsive disorders versus obsessive-compulsive syndromes. Comparative study of two surveys of the general population and of psychiatric consultants.] *Ann Med Psychol (Paris)* 153(5):314-325.
4. Khanna S, Channabasavanna SM (1988), Phenomenology of obsessions in obsessive-compulsive neurosis. *Psychopathology* 21(1):12-18.
5. Lelliott PT, Noshirvani HF, Basoglu M et al. (1988), Obsessive-compulsive beliefs and treatment outcome. *Psychol Med* 18(3):697-702.
6. Okasha A (1966), A cultural psychiatric study of El-Zar cult in U.A.R. *Br J Psychiatry* 112(493):1217-1221.
7. Okasha A (2000), Diagnosis of obsessive-compulsive disorder: a review. In: *Obsessive-Compulsive Disorder, Evidence and Experience in Psychiatry*, vol. 4. Maj M, Sartorius N, Okasha A, Zohar J, eds. New York: Wiley & Sons.
8. Okasha A, Kamel M, Hassan AH (1968), Preliminary psychiatric observations in Egypt. *Br J Psychiatry* 114(513):949-955.
9. Okasha A, Lotaief F, Ashour AM et al. (2000), The prevalence of obsessive compulsive symptoms in a sample of Egyptian psychiatric patients. *Encephale* 26(4):1-10.
10. Okasha A, Raafat M (1991), The biology of obsessive compulsive disorder, an evidence from topographic EEG. *Arab Journal of Psychiatry* 2(2):106-117.
11. Okasha A, Ragheb K, Attia AH et al. (2001), Prevalence of obsessive compulsive symptoms (OCS) in a sample of Egyptian adolescents. *Encephale* 27(1):8-14.

- 12.** Okasha A, Saad A, Khalil AH et al. (1994), Phenomenology of obsessive-compulsive disorder: a transcultural study. *Compr Psychiatry* 35(3):191-197.
- 13.** Pollitt J (1957), Natural history of obsessional states. *Br Med J* 26:194-198.
- 14.** Rasmussen SA, Eisen JL (1992), The epidemiology and clinical features of obsessive compulsive disorder. *Psychiatr Clin North Am* 15(4):743-758.
- 15.** Robins LN, Helzer JE, Weissman MM et al. (1984), Lifetime prevalence of specific psychiatric disorders in three sites. *Arch Gen Psychiatry* 41(10):949-958.