



Original Research Article

OBSESSIVE- COMPULSIVE DISORDERS AND SYNDROMES IN THE GENERAL POPULATION

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ABSTRACT

Background: The objective is to determine the frequency of occurrence of obsessive-compulsive symptoms in the general population, common patterns and demographic characteristics of symptoms.

Materials and Methods: A quantitative cross-sectional study was performed on 150 people from the general population. Participants aged 18 years and more were recruited through a convenience sampling technique. Data were obtained using a structured self-administered questionnaire that comprised data on demographic information and items that were used to assess obsessive compulsive symptoms. Informed consent was, prior to data collection, obtained from all participants. The data were coded and analysed using the statistical package of the software, immediate. Descriptive statistics, such as the number and percentage, and inferential statistical analysis were performed to look at associations between obsessive-compulsive symptoms and demographic variables.

Results: The study found that a large fraction of the number of participants reported obsessive-compulsive symptoms. Contamination fears (32 %) and persistent doubts (26.7 %) were the most frequently reported obsessive symptoms, while repeated checking (30.7 %) and excessive hand washing (28 %) were the most common compulsive behaviours. In terms of severity, 36 % of participants had no significant symptoms, 32 % had mild symptoms, 21.3 % moderate, and 10.7 % severe. The analysis also found a significant link between obsessive-compulsive symptoms and demographics such as gender and age, with more sufferers being females and younger participants.

Conclusion: The study found that obsessive compulsive symptoms are rather prevalent in the general population and occur in varying degrees of severity. Early identification and increased public awareness may lead to prevention of progression of mild symptoms to clinically important obsessive-compulsive disorder. These findings indicate the need for community-based mental health screening and intervention strategies.

Keywords: Obsessive-compulsive disorder, obsessive symptoms, compulsive behaviours, general population, prevalence, mental health.

INTRODUCTION

Obsessive-compulsive disorder (OCD) is a chronic psychiatric disorder that tends to restrict everyday existence. It is characterized by recurring thoughts, images or urges as obsessions, and repetitive behaviours or mental acts called compulsions.^[1] People typically engage in these behaviours in response to anxiety-provoking thoughts with the hope of decreasing distress and/or preventing a

feared outcome. OCD can have a serious impact on the work, social relations, and overall mental well-being. In recent diagnostic manuals, it is classified under "Obsessive-Compulsive and Related Disorders" which makes it distinct on its signs and association with other compulsive conditions.^[2] About 1-3% of the world's population suffers from OCD, making it one of the most common mental health disorders.^[3]

Obsessive-compulsive disorder used to be considered rare and only found in clinical settings, but studies done in the community have found that symptomatology of obsessive-compulsive behaviour is quite common outside of the clinic.^[4] Large surveys show that a surprising number of people experience intrusive thoughts or repetitive actions at some time, even if they do not fully meet the criteria for OCD. For example, the National Comorbidity Survey Replication revealed that 2.3% of adults meet the lifetime criteria for OCD, but that the number of people reporting having obsessive or compulsive experiences is significantly higher.^[4,5] These data provide support for a conception of obsessive-compulsive phenomena along a continuum, ranging from mild, subclinical symptoms to full-blown disorder.

In community samples, much higher is the rate of obsessive-compulsive symptoms than the rate of official diagnosis of OCD.^[6] Studies show that more than one-fourth of the general population suffers from obsessions or compulsions at some point in their lives (although only a small percentage develop the complete disorder).^[7] Population research suggests that one or another obsessive or compulsive symptom, occurring over the lifetime, occurs in as many as 14 % of community samples, indicating the dimensional nature of obsessive-compulsive experiences.^[8] Understanding symptoms in the clinical population is a necessary step to understand the real distribution and causes of the symptoms in the general population.^[9]

Worldwide epidemiological studies have demonstrated significant differences in OCD prevalence between countries and cultures.^[10] Previous studies from other countries estimated that around 2% of the world's population have OCD, but rates may differ depending on diagnostic criteria, cultural attitudes and study methods.^[4,11] Recent cross-national studies with the World Mental Health Surveys have documented prevalences for OCD as high as 4.1% over one's lifetime in several countries, showing that OCD is a widespread public health problem. Despite this variety of evidence, the similarities are all pointing at the importance of OCD on a global scale.^[12,13]

OCD usually begins in early adulthood, often in childhood or teenagers and many people develop this disorder before they reach 25 years of age. More than 80% of people with OCD experience symptoms of the disorder before the age of 25, thereby emphasizing the developmental nature of this disorder.^[14] Early onset is associated with a more chronic course and higher levels of comorbidities, such as depression, anxiety disorders, substance use and impulse control disorders. These sub syndromic conditions make the mood disorder OCD challenging to diagnose and treat, adding to the burden of OCD.^[15]

There are several other disorders that share intrusive thoughts and repetitive behaviour, including hoarding, body dysmorphic disorder,

trichilemmoma and excoriation disorder. Understanding these conditions in the broad group of obsessive-compulsive and related conditions has led to a greater understanding of shared brain and psychological mechanisms. Genetic research indicates that first degree relatives of individuals with OCD have a 10-11 % chance of developing the disorder, thus there is a strong genetic component.^[16]

Because the prevalence of obsessive-compulsive disorder is relatively high and the symptoms can impact a person's mental health, it is important to study OCD's epidemiology in the general population to facilitate public health planning, including early intervention. The results of quantitative research on prevalence, risk factors and symptoms patterns help denote at-risk groups and determine prevention and treatment strategies. Studying obsessive compulsive disorders and related syndromes in the community offers valuable insights into how they spread, what causes them, and how they affect wider society.

Aim of the study

This study is intended to define the prevalence of obsessive-compulsive disorder and related syndromes among the general population and their geographical distribution.

Objective

To determine the frequency of occurrence of obsessive-compulsive symptoms in the general population, common patterns and demographic characteristics of symptoms.

MATERIALS AND METHODS

A quantitative cross-sectional type of study was employed in order to assess the prevalence of obsessive-compulsive disorder and its syndromes in the general population. The reason for the design was that researchers could collect and analyse the data from a targeted group at a single point in time; to determine how frequent and widespread the occurrence of obsessive and compulsive symptoms is in the community. The study was conducted in the community in urban and semi-urban settings in schools, workplaces and residential neighbourhoods in India. Data was collected by means of structured questionnaires distributed in easy to access public places. This approach ensured that people of a broad range of socio-demographic backgrounds could be part of it. The selected settings helped to obtain accurate responses from the wider general population.

This study involved 150 adults who were living in selected areas of the community during the study period. Only people of 18 years or more could join. The study's participants were representative of a range of educational backgrounds, employment and socioeconomic background, and so will provide a broad picture of the community. A sample of population was composed from the target population

by using non probability conveniences sampling technique. Those willing to participate and who gave information consent were included. Study participants with severe cognitive impairment or who could not complete the questionnaire were excluded. The final sample included individuals who completed the assessment tool that was designed to measure the symptoms of obsessive and compulsive disorder. The data collected were then analysed using suitable statistical methods to find the prevalence and distribution of the symptoms of obsessive-compulsive behaviour among the population sampled.

Inclusion Criteria

Participants were eligible if 18 years and over and were living in the selected community settings for the duration of the study. Those who were able to understand and provide answers to the questionnaires were considered for inclusion. Only volunteers who provided informed consent were recruited. We also included individuals of all genders and with varying types of education and occupation to represent the wider population.

Exclusion Criteria

Participants were excluded from the study if they met any of the following conditions:

- Individuals below 18 years of age.
- Individuals who were unable to comprehend or complete the questionnaire due to language barriers or cognitive difficulties.
- Individuals with diagnosed severe psychiatric disorders that could interfere with their ability to provide reliable responses.
- Individuals who were not willing to participate or did not provide informed consent.
- Participants who submitted incomplete questionnaires or missing responses that could affect the accuracy of the data analysis.

Data Collection: Data were obtained using a self-administered structured questionnaire aimed at measuring obsessive-compulsive symptoms within a sample of the general population. There were two sections in the questionnaire. The initial part collected socio - demographic data about age, gender, education level, and occupation. The second section enquired about the presence and frequency of obsessive and compulsive behaviour, using items

adapted from well known screening tools. Prior to beginning, participants were informed about the nature of the research and the confidentiality of the answers to be given and gave informed consent to participate. The questionnaires had been distributed in community settings and participants had sufficient time to complete them. Every returned questionnaire was kept carefully on check for its completeness before feeding it for the analysis.

Data Analysis: The collected data were entered, coded and analysed using Statistical Package for Social Sciences (SPSS) software. Descriptive statistical methods were used to summarize the demographic characteristics of the participants and determine the prevalence of obsessive and compulsive symptoms in the study population. Frequencies and percentages were generated for categorical variables and means and standard deviations for continuous variables, as appropriate. Inferential statistical tests were used to test possible associations between the Obsessive-Compulsive symptoms and demographic variables. The results were presented in tables and graphical representations in order to make the interpretation and comparison of the results easy.

RESULTS

The socio- demographic characteristics of the 150 participants are presented in [Table 1]. The largest age group was 18–25 years (40 %), followed by 26–35 years (28 %), 36–45 years (18.7 %) and those over 45 (13.3 %), indicating that younger adults made up most of the sample. Gender was almost evenly split, with females at 52 % and males at 48 %. Nearly half were single (46.7 %) and nearly as many were married (45.3 %); divorced or widowed respondents comprised only 8 %. Regarding education, 42.7 % held undergraduate degrees, 28 % had graduate degrees, 21.3 % had secondary education, and 8 % were postgraduates. In terms of occupation, 41.3 % were employed, 38.7 % were students, 10.7 % were self-employed, and 9.3 % were unemployed. These results show the sample was a diverse range of socio- demographic backgrounds.

Table 1: Socio-Demographic Characteristics of Participants

Variable	Category	Frequency (n)	Percentage (%)
Age Group	18–25 years	60	40.0
	26–35 years	42	28.0
	36–45 years	28	18.7
	Above 45 years	20	13.3
Gender	Male	72	48.0
	Female	78	52.0
Marital Status	Single	70	46.7
	Married	68	45.3
	Divorced/Widowed	12	8.0
Education Level	Secondary	32	21.3
	Undergraduate	64	42.7
	Graduate	42	28.0
	Postgraduate	12	8.0
Occupation	Student	58	38.7

	Employed	62	41.3
	Self-employed	16	10.7
	Unemployed	14	9.3

Table 2: Prevalence of Obsessive Symptoms among Participants

Obsessive Symptoms	Frequency (n)	Percentage (%)
Fear of contamination	48	32.0
Fear of causing harm to others	30	20.0
Intrusive religious or moral thoughts	24	16.0
Need for symmetry or exactness	28	18.7
Persistent doubts (e.g., locking doors, safety)	40	26.7
Unwanted aggressive thoughts	18	12.0

[Table 2] reports the frequency of occurrence of each obsessive symptom among the participants. The most typical symptom was fear of contamination, reported by 32% of the respondents (which showed a fear of cleanliness and germs is widespread). The next most common one was persistent safety doubts, such as repeatedly checking locks or appliances - reported by 26.7%. Fear of harming others was listed by 20% (thoughts of

accidentally harming others). Sixty-one percent said they needed symmetry or exactness and preferred orderliness and perfectionism. Intrusive religious or moral thoughts were experienced by 16%, and unwanted aggressive thoughts were experienced by 12%, which was the least frequent obsessive symptom. Overall, it is evident from the data collected that obsessive thoughts frequencies were different for each type of symptoms.

Table 3: Prevalence of Compulsive Behaviours among Participants

Compulsive Behaviours	Frequency (n)	Percentage (%)
Excessive hand washing	42	28.0
Repeated checking behaviours	46	30.7
Counting rituals	22	14.7
Arranging objects symmetrically	26	17.3
Repeating words or prayers	20	13.3
Seeking reassurance repeatedly	24	16.0

The distribution of the reported compulsive behaviours of the participants as identified in [Table 3]. Repeated checking was the most common, reported by 30.7% and including actions such as double-checking doors, locks, or appliances for safety. Excessive hand washing followed, seen in 28% of participants, usually in response to contamination obsessions. Symmetrical arrangement of objects was reported by 17.3%, reflecting a preference for order and precision. Repeated

reassurance seeking was noted by 16%, indicating attempts to reduce anxiety through confirmation from others. Counting rituals were present in 14.7%, while repeating words or prayers was reported by 13.3%. These findings indicate that there is a significant proportion of the general population in which compulsive behaviours can be found, where checking behaviours and cleaning behaviours are the most common.

Table 4: Overall Severity of Obsessive-Compulsive Symptoms

Symptom Severity Level	Frequency (n)	Percentage (%)
No significant symptoms	54	36.0
Mild obsessive-compulsive symptoms	48	32.0
Moderate obsessive-compulsive symptoms	32	21.3
Severe obsessive-compulsive symptoms	16	10.7

The overall severity levels for the obsessive-compulsive disorder of the whole group of participants are summarized in [Table 4]. The results show that 36% reported no clinically significant symptoms, meaning more than one-third of the sample exhibited little or no OCD. A significant number, however, showed variable levels of symptoms. Mild symptoms were present in 32% of participants, making this the second largest group

in the study. Moderate symptoms were noted in 21.3% of individuals, indicating a noticeable but manageable level of severity. Only 10.7% were classified as having severe symptoms, a smaller but clinically important subgroup that might need professional assessment or treatment. Overall, severe OCD was less common, but a lot of people in the general population have mild to moderate symptoms.

Table 5: Association between Obsessive-Compulsive Symptoms and Demographic Variables

Variable	OCD Symptoms Present n (%)	OCD Symptoms Absent n (%)	p-value
Gender			
Male	30 (41.7%)	42 (58.3%)	0.041
Female	50 (64.1%)	28 (35.9%)	
Age Group			
18–25 years	38 (63.3%)	22 (36.7%)	0.032
26–35 years	22 (52.4%)	20 (47.6%)	
36–45 years	14 (50.0%)	14 (50.0%)	
Above 45 years	6 (30.0%)	14 (70.0%)	

[Table 5] shows the link between obsessive-compulsive symptoms and selected demographic variables such as gender as well as age group. The results of the analysis showed statistically significant relationship between gender and the presence of obsessive-compulsive symptoms ($p < 0.041$). Among male participants, 41.7% reported symptoms, while 58.3% did not. In contrast, 64.1% of female participants reported symptoms, and 35.9% did not, indicating a higher prevalence among females in the study population. In addition, there was a significant relationship between age group and obsessive-compulsive symptoms ($p = 0.032$). The highest proportion of symptoms was reported by individuals aged 18–25 years (63.3%), followed by 26–35 years (52.4%) and 36–45 years (50%). The lowest prevalence occurred among participants above 45 years (30%). These results indicate that obsessive-compulsive symptoms were more prevalent in younger people and women - in the subject sample.

DISCUSSION

The present study aimed at examining the commonness of the obsessive-compulsive symptoms in the general population and the relationship of the symptoms with the demographic factors. The results showed that many of the community members have various obsessive and compulsive symptoms although there was a range in the severity of the symptoms reported by the participants. These results add to the accumulating evidence for the presence of obsessive-compulsive symptoms not only in clinical populations, but also among members of the nonclinical population. In this study, a lot of participants indicated being obsessed by having special thoughts, particularly having a fear of contamination and having persistent doubts. These findings are consistent with several previous epidemiological studies that demonstrated obsessions and checking concerns concerning contamination to be most common in community samples. Jalal and colleagues found similar trends with contamination fears and safety doubts being the most common symptoms reported by the general public.^[17] Studies in other countries also found intrusive thoughts regarding cleanliness, harm, and orderliness in people who do not meet the diagnostic criteria for OCD.^[18]

The study also found compulsory behaviours like repetition in checking and hand washing were prevalent. These results are consistent with the

previous study by Guazzini et al., documenting that checking and cleaning behaviours are the most common compulsions in the clinical and non-clinical samples.^[19] Stein and his colleagues pointed out that checking frequently is related to safety or responsibility doubts and that cleaning rituals are associated with contamination fears.^[20] The relatively high prevalence of these behaviours gives support to the notion that obsessive-compulsive tendencies have been shown to be on a continuum from patterns of mild importance to compulsions that are clinically significant. Another important finding was related to symptom severity. While over a third of the respondents did not report any significant symptoms, a substantial percentage of the respondents had mild to moderate levels of symptoms. Only a small percentage had severe symptoms. This pattern is consistent with study by Zheng et al., which reported higher rates of subclinical symptoms of obsessive-compulsive disorder (OCD) versus clinically diagnosed OCD.^[21] Research suggests that although 2–3% of the population meet OCD criteria, a larger proportion experience subclinical symptom, supporting a dimensional view of obsessive-compulsive phenomena.

The study also examined the link of symptoms to demographics. Females were found to have higher prevalence of obsessive-compulsive symptoms as compared to the other gender. This is consistent with previous studies which have reported gender differences in the expression of symptoms with females reporting higher contamination fears and cleaning behaviour whereas males report higher symmetry/checking behaviour. These differences may be due to psychological, biological and sociocultural differences resulting in differences in how symptoms are expressed and reported. Age differences were also demonstrated. Younger participants reported more symptoms than did older participants. This is consistent with previous study by Van Zandt et al., that confirm the onset of OCD happens frequently as an adolescent or young adult.^[22] According to the World Mental Health Survey, symptoms of obsessive disorder begin prior to the age of 25 years. Younger ones can be under more stress and pressure for school work and even pressure from their friends, which adds stronger obsessive-compulsive disorders.^[20]

The findings of the study have significant implications for the mental health of the public. Many of the participants only had mild to moderate symptoms, suggesting that early screening and

information may avoid those from progressing to more severe conditions. Increased awareness and lowered stigma may help individuals to seek professional help when needed. Although the research provides useful information, it has limitations. Convenience sampling leads to less generalisability and use of self-reports, which can be affected by social desirability or misunderstandings, can lead to under- or over-reporting. Future research should incorporate larger, randomized samples, as well as standardized clinical assessments in order to obtain more accurate prevalence estimates. Overall, the study adds evidence for the findings that obsessive-compulsive symptoms are present in the general population and appear on a spectrum of severity. Identification of demographic patterns and prevalence gives useful information for the creation of community-based mental health interventions as well as better early detection of OCD.

CONCLUSION

The research determined that obsessive-compulsive symptoms are common among the general population. Respondents described all kinds of obsessive thoughts and compulsive behaviour. Although many reported little or no symptoms, a large group reported mild to moderate symptoms. A smaller segment reported on severe symptoms that could require clinical intervention. Contamination fears and repeated doubts were the most common symptoms and repeated checking and excessive cleaning were the most common compulsions. The study also showed that gender and age affect the prevalence of symptoms. Females and younger subjects reported more symptoms of obsessive-compulsive disorders. These findings confirm that the occurrence of obsessive-compulsive phenomena occurs on a spectrum in the general population, and not limited to cases of clinically diagnosed individuals. Overall, the results of the current study highlight the need for early detection, public education, and accessibility to mental health services, to catch the initial signs and prevent the development of psychiatric disorders into more serious issues.

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