



CODEN [USA]: IAJPBB

ISSN: 2349-7750

**INDO AMERICAN JOURNAL OF
PHARMACEUTICAL SCIENCES**<http://doi.org/10.5281/zenodo.1291540>Available online at: <http://www.iajps.com>**Research Article****A CROSS-SECTIONAL ANALYSIS OF OBSESSIVE
COMPULSIVE DISORDER (OCD) AND SELF-ESTEEM WITH
CONFOUNDING VARIABLES****¹Dr. Muhammad Haroon, ²Dr. Muhammad Awais Latif, ³Dr. Muhammad Haris Ghous**¹Medical officer, DHQ Hospital, Kasur²FMH College of Medicine and Dentistry³Services Institute of Medical Sciences Lahore/Services Hospital Lahore**Abstract:**

Objective: The objective of this particular research was the exploration of the correlation between obsessive compulsive disorder and self-esteem in country where income is low, we also analyzed this relation with the identification of the confounding variables in detail which may have an existence.

Method: The design of research was cross-sectional which was carried out on 65 thirty controls and 65 obsessive compulsive disorder cases at OPD of Allied Hospital, Faisalabad (February – April, 2016). All the cases were fulfilling the criteria of Rosenberg Self-esteem and Field and Janis Social Adequacy scales. Data was analyzed through SPSS software.

Results: Both the scales measured significantly variant scores of the self-esteem between controls and patients with a significant P-value for each as (< 0.001). Even in the presentation of very low self-esteem scores the comparison between patients and controls was made.

Conclusions: Our outcomes replicated the earlier outcomes of the countries with high income.

Keywords: Obsessive compulsive disorder (OCD), Self-esteem, Controls, Adequacy and Psychiatry.

Corresponding author:**Dr. Muhammad Haroon,**

Medical officer,

DHQ Hospital, Kasur

QR code



Please cite this article in press Muhammad Haroon et al., A Cross-Sectional Analysis of Obsessive Compulsive Disorder (OCD) and Self-Esteem with Confounding Variables, Indo Am. J. P. Sci, 2018; 05(06).

INTRODUCTION:

OCD is a debilitating and severe disorder which is linked with the individual's distress and anxiety. It is characterized by a persistent, pervasive and repetitive idea that is actually perceived as inappropriate and affects the health of the individual including professional and private life (office and social gatherings with friends, family and colleagues).

According to WHO it is among the top ten disabling cause with a prevalence of 1 – 3 percent in the countries with high income (WHO) with geographical variations (such as marital status, gender and ethnicity) [1 – 4]. It is indicated by the high-income countries research that OCD can cause psychiatric-morbidity, mood disorder and anxiety. In the light of this strong correlation low self-esteem and OCD relation is valid, depression and anxiety are among associated psychological health symptoms [5 – 7]. Few reports state that low self-esteem is linked with the psychiatric condition's etiological factor [8, 9], but there is uncertainty in the actual association that self-esteem is consequential or casual [7].

According to Fava low self-esteem is among the numerous possible disorder prodromal symptoms which suggests low self-esteem as factor of general vulnerability which is supported by Ehntholt [10, 11]. We can debate on these outcomes in association to OCD cognitive hypothesis that attributes in the compulsions progression of intrusive thoughts that lead in to an ineffective intrusion management strategy [12]. An impaired perception of the self may also lead into a dysfunctional response like a catastrophic intrusive thought interpretation and a potential harming response [13 – 16].

High income countries have made numerous advancements regarding OCD with scare data on the clinical presentations of the data and low-income population's phenomenology. Therefore, cross-cultural epidemiological research studies have forwarded about OCD that its clinical features and prevalence is same in both Non-Western and Western countries [17]. In a local research thirteen percent prevalence was observed [18].

Culture has an effect on the psychopathology and perception which may affect management, reaction and findings of disorder that requires comprehensive

understanding as beliefs are of vital importance [19 – 21]. The objective of this particular research was the exploration of the correlation between obsessive compulsive disorder and self-esteem in country where income is low, we also analyzed this relation with the identification of the confounding variables in detail which may have an existence.

METHOD:

The design of research was cross-sectional which was carried out on 65 thirty controls and 65 obsessive compulsive disorder cases at OPD of Allied Hospital, Faisalabad (February – April, 2016). All the cases were fulfilling the criteria of Rosenberg Self-esteem (social situations, anxiety, personal worthlessness feelings and self-consciousness) and Field and Janis Social Adequacy scales (self-conception), both are accepted across multiple cultural settings [9, 24, 25]. Patients were short listed through DSM-IV (Diagnostic & Statistical Manual) OCD criteria through clinical interviews and prevalent state [22, 23]. We did not include all the cases with organic illness and comorbid-psychiatric state [30].

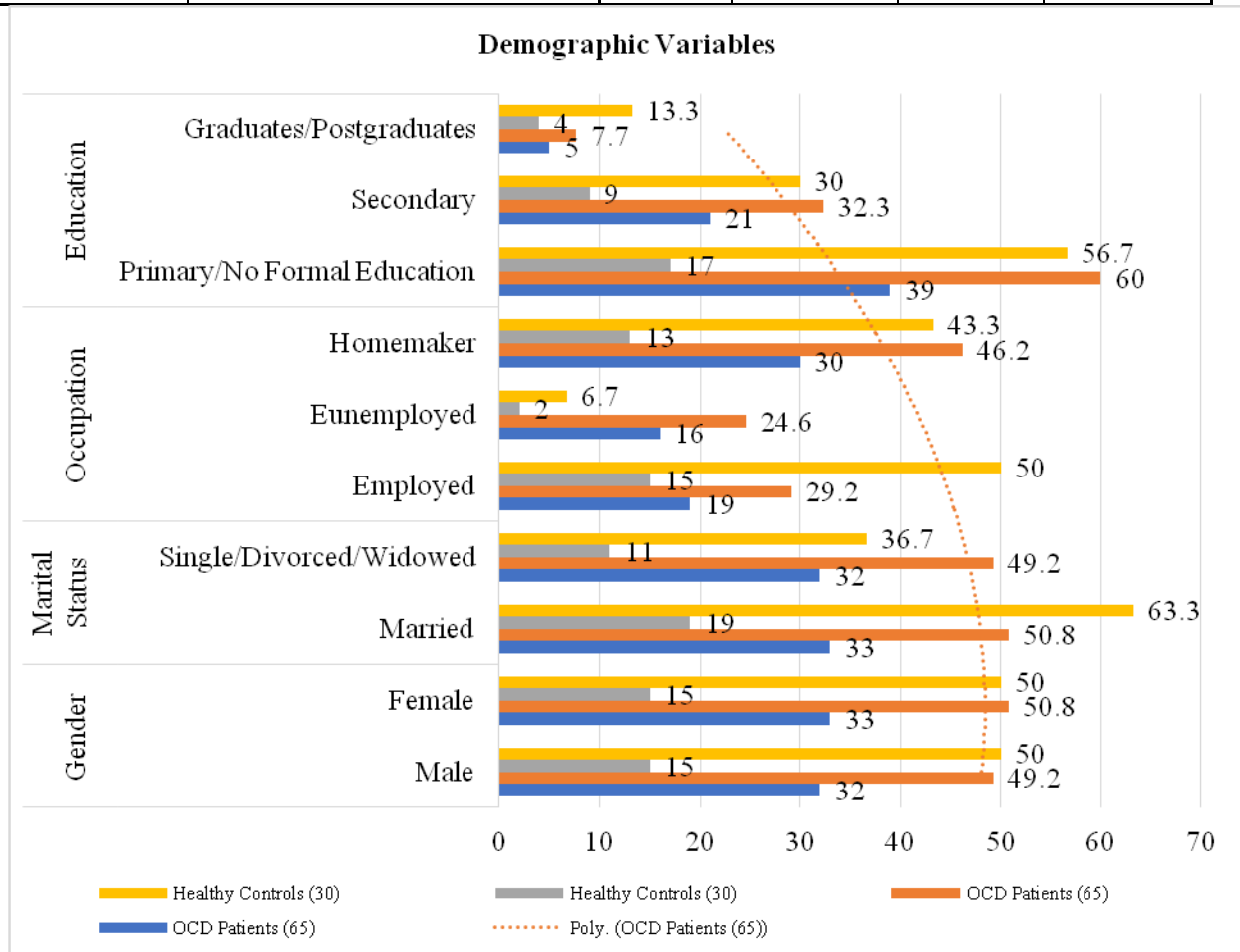
Formalities of the research were met before the commencement of the research. Informed and written consent from literate and illiterate patients was taken before the commencement of this research. Rosenberg Self-Esteem Scale (Urdu Version) and Ten items Linkert scale were respectively used for the measurement of personal worthlessness and overall self-esteem and satisfaction degree [9, 11, 24]. Statistical analyses were conducted using SPSS 15. Group variations were analyzed through independent sample T-test.

RESULTS:

Questionnaire was completed by 65 / 80 individuals (81.25%). Male to female participation was respectively 32 males (49.23%) and 33 females (50.76%) and respective mean age was (32.8 ± 11.5) years in females) which was just above males as (29.3 ± 8.8) years). Int healthy controls fifty percent each males and females were measured respective mean age as (34.0 ± 10.6) years) and (38.9 ± 12.2) years). No significant variation was observed in both the groups in terms of demographic variables (marital status, gender, education level and occupational status) (Table – I).

Table – I: Demographic Variables

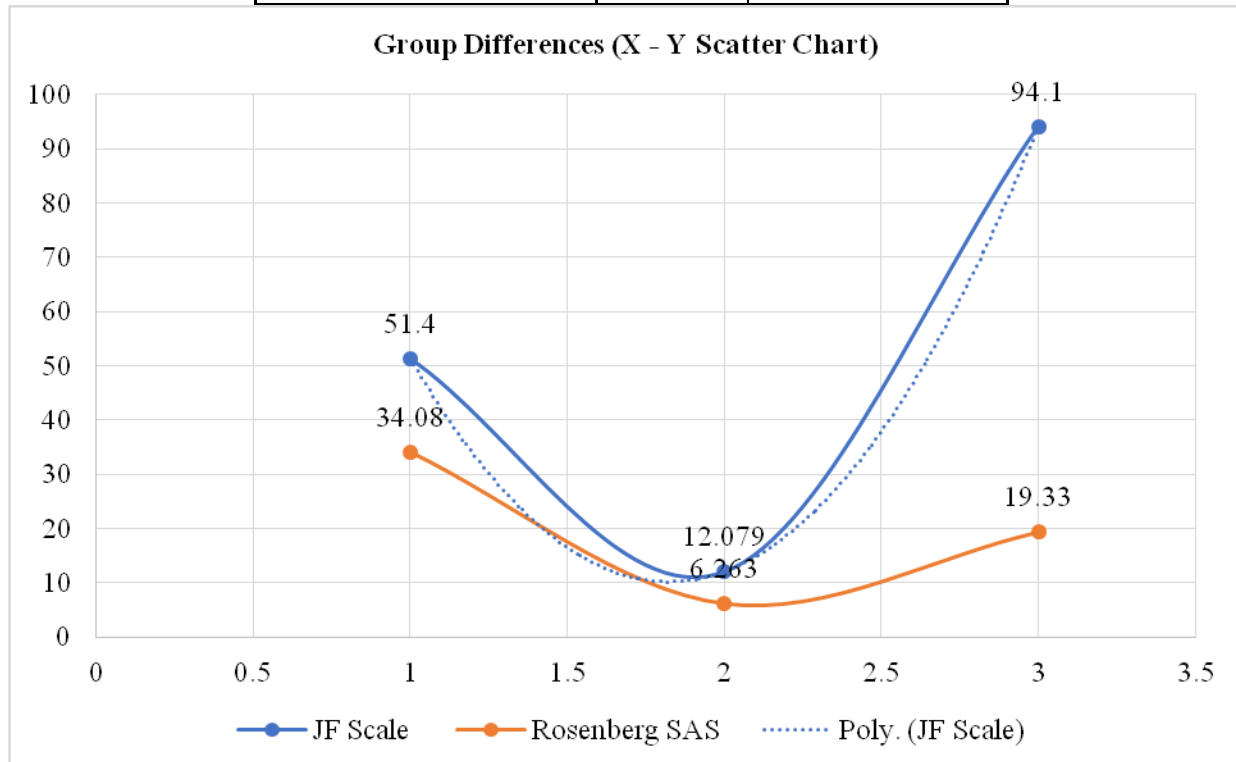
Demographics		OCD Patients (65)		Healthy Controls (30)	
		Number	Percentage	Number	Percentage
Gender	Male	32	49.2	15	50
	Female	33	50.8	15	50
Age		31.52		36.47	
Marital Status	Married	33	50.8	19	63.3
	Single / Divorced / Widowed	32	49.2	11	36.7
Occupation	Employed	19	29.2	15	50
	Unemployed	16	24.6	2	6.7
	Homemaker	30	46.2	13	43.3
Education	Primary/No Formal Education	39	60	17	56.7
	Secondary	21	32.3	9	30
	Graduates/Postgraduates	5	7.7	4	13.3



Age difference was significant between controls and OCD group with higher mean age in the control group (P-value < 0.05). Table – II compares the self-esteem scores of controls and OCD group.

Table – II: Group Differences in Self Esteem / Social Adequacy Scoring

Scoring System	JF Scale	Rosenberg SAS
OCD (65)	51.4	34.08
	12.079	6.263
Healthy Controls (30)	94.1	19.33
	11.804	4.253
Statistics (t)	11.692	-16.13
P-Value	< 0.001	< 0.001



Low social adequacy was highlighted by mean JF scale scores with social adjustment as (51.4 ± 12.07) in comparison to controls as (94.10 ± 11.80). Low global self-esteem was highlighted by Rosenberg SES scores in the group of OCD against controls respectively (34.08 ± 6.26) and (19.33 ± 4.25). Differences were indicated through independent Samples T-tests for JF and Rosenberg SES scale respectively “t” as (11.692 and 16.130) and P-value as (< 0.001 for both).

DISCUSSION:

The objective of this particular research was the exploration of the correlation between obsessive compulsive disorder and self-esteem in country where income is low, we also analyzed this relation with the identification of the confounding variables in detail which may have an existence. This research was simple but its major focus was on the eradication of the potential cultural factors which confound and raise queries in the role of OCD and self-esteem.

There was a significant variation in the self-esteem outcomes as measured through Rosenberg Scale between clinical group and non-clinical controls group. Both groups also differed in terms of social

adequacy and self-esteem when measured on JF scale [27]. These outcomes are comparable with the previous research studies conducted on controls and OCD group [10, 11].

According to Wand and Staley clinical features and prevalence of OCD is same across various cultures; whereas, disorder expression and phenomenology may be influential on the concerns and cultural beliefs [17]. Same association has been established in self-esteem and OCD in the high-income countries, design has no role to play in the accuracy of the outcomes. Religious and cultural influence have

already been established in the past research studies [28, 29].

A multidimensional approach for OCD has been adopted to study self-esteem in the high-income countries [30]. Kyrios and Doron reported that an individual holds sensitive self-related domains such as a feeling of incompetency that leads to social inadequacy, intrusive thoughts and catastrophic interpretations with harming intentions [13 – 16]. The outcome of the self-sensitivity may bring intrusive thoughts misappraisal and ineffective management strategies [12]. Our research was not consistent with social inadequacy and low self-esteem in OCD because of the incompetent feeling such as demoralization which is a self-domain.

No doubt research had few limitations such as its design which cannot ascertain the anxiety and vulnerability as the cause of social inadequacy and low self-esteem. Whereas, numerous research studies have already established the association of anxiety and general vulnerability with the psychological disorders significant to OCD [11].

However, evidence also suggests about the guilt and embracement feelings in the OCD patients with reluctance to take helpful assistance with associated feelings of powerlessness and shame [32, 33]. Further investigative work is required in these domains for a clear comprehension of the issue. Size of the sample population was also one of the associated limitations along with sampling technique. There was a significant variation in the control and clinical groups in terms of mean age. We were very cautious about the recruitment of the research sample.

CONCLUSION:

We observed that almost the same outcomes were repeated in our research as earlier research outcomes in the countries with low income and high-income populations suggesting an association between social adequacy, low self-esteem and OCD which is not specific to culture. It is recommended that more research work is required in this particular subject for the increased comprehension and to build a comprehensive association between the said factors which would complement specific signs and culture.

REFERENCES:

1. Okasha A, Saad, A, Khalil AH, El Dawla AS, Yehia N. Phenomenology of obsessive-compulsive disorder: A transcultural study. *Compr Psychiatr* 1994; 35: 191-7.

2. Harter S. The development of self-representations. *Handbook of child psychol* 1998; 3: 553-617.
3. Doron G, Kyrios M. Obsessive-compulsive disorder: a review of possible internal representations within a broader cognitive theory. *Clin Psychol Rev* 2005; 25: 415-32.
4. Torres AR, Prince MJ, Bebbington PE, Bhugra DK, Brugha TS, Farrell M, et al. Treatment seeking by individuals with obsessive-compulsive disorder from the British psychiatric morbidity survey of 2000. *Psychiatr Serv* 2007; 58: 977-82.
5. Simonds LM, Elliott SA. OCD patients and non-patient groups reporting obsessions and compulsions: Phenomenology, help-seeking and access to treatment. *Br J Med Psychol* 2001; 74: 431- 49.
6. Battle J. Relationship between self-esteem and depression. *Psychol Rep* 1978; 42: 745-6.
7. Fennell MJV. Low self-esteem: a cognitive perspective. *Behav Cogn Psychother* 1997; 25: 1-25.
8. Silverstone PH. Low self-esteem in different psychiatric conditions. *Br J Clin Psychol* 1991; 30:185-8.
9. Silverstone PH, Salsali M. Low self-esteem and psychiatric patients: Part 1- the relationship between low self-esteem and psychiatric diagnosis. *Ann Gen Psychiatry* 2003; 2: 2
10. Fava GA, Savron G, Rafanelli C, Grandi S. Prodromal symptoms in obsessive-compulsive disorder. *Psycho pathol* (1996; 29: 131-4.
11. Ehntholt KA, Salkovskis PM, Rimes KA. Obsessive-compulsive disorder, anxiety disorders, and self-esteem: an exploratory study. *Behav Res Ther* 1999; 37: 771-81.
12. Doron G, Kyrios M, Nedeljkovic M. Sensitivity of self-beliefs in obsessive-compulsive disorder. *Depress Anxiety* 2008; 25: 874-84.
13. Rachman S. A cognitive theory of obsessions. *Behav Res Ther* 1997; 35: 793-802.
14. Rachman S. A cognitive theory of obsessions: elaborations. *Behav Res Ther* 1998; 36: 385-401.
15. Salkovskis PM. Obsessional-compulsive problems: a cognitive behavioral analysis. *Behav Res Ther* 1985; 23: 571-83.
16. Salkovskis PM. Cognitive-behavioral factors and the persistence of intrusive thoughts in obsessional problems. *Behav Res Ther* 1989; 27: 677-82.
17. Staley D, Wand RR. Obsessive-compulsive disorder: A review of the cross-cultural epidemiological literature. *Transcult Psychiatr* 1995; 32: 103-36.

18. Gadit AA. Obsessive-compulsive disorder in a fishermen community. *J Coll Physicians Surg Pak* 2003; 13: 581-3.
19. Tseng Wen-Shing. Overview: culture and psychopathology. *Culture and Psychopathology: A Guide to Clinical Assessment*. Edited by Tseng WS, Streltzer J. New York: Brunner/Mazel, 1997; pp 1-27.
20. Patel V. Explanatory models of mental illness in sub-Saharan Africa. *Elsevier Ltd* 1995; 40: 1291-8.
21. Helman C. *Culture, health and illness*. London: Wright, 1994. *Diagnostic and statistical manual of mental disorders 4th ed*. Washington, DC: American Psychiatric Association; 1994.
22. Wing JK, Nixon JM, Mann SA, Leff JP. Reliability of the PSE (ninth edition) used in a population study. *Psychol Med* 1997; 7 3: 505-16.
23. Salsali M, Silverstone, PH. Low self-esteem and psychiatric patients: Part II-the relationship between self-esteem and demographic factors and psychosocial stressors in psychiatric patients. *AnnGen Psychiatry* 2003; 2: 3.
24. Schmitt DP, Allik J. Simultaneous administration of the Rosenberg Self-Esteem Scale in 53 nations: exploring the universal and culture-specific features of global self-esteem. *J Pers Soc Psychol* 2005; 89:623.
25. Rosenberg M. *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press, 1965.
26. Janis I, Field, P. Sex differences and personality factors related to persuasibility. In C. Hovland, & I. Janis (Eds.), *Personality and persuasibility*. New Haven, CN: Yale University Press, 1959.
27. Mahgoub OM, Abdel-Hafeiz HB. Pattern of obsessive-compulsive disorder in Eastern Saudi Arabia. *Br J Psychiatr* 1991; 158: 840-2.
28. World Health Organization. *Mental Health: Facing the Challenges, Building Solutions: Report from the WHO European Ministerial Conference*. Helsinki: World Health Organization Regional Office for Europe, (2005); pp 1-182.
29. Heyman I, Mataix-Cols D, Fineberg NA. Clinical review: Obsessive-compulsive disorder. *BMJ* 2006; 333: 424-9.3.
30. Clark DA. *Cognitive-behavioral therapy for OCD*. New York: The Guildford Press, 2004.
31. Antony MM, Downie F, Swinson RP. Diagnostic issues and epidemiology in obsessive-compulsive disorder. In:
32. Swinson RP, Antony MM, Rachman S, Richter MA. eds. *Obsessive- Compulsive Disorder: Theory, research and treatment*. New York: The Guildford Press, 1998; pp 3-32.
33. Hoffman SG. Cognitive factors that maintain social anxiety disorder: a comprehensive model and its treatment implications. *Cogn Behav Ther* 2007; 36: 195-209.