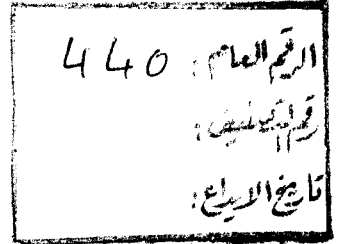


Ain-Shams University  
Institute of Post-Graduate Childhood Studies  
Medical Department

# Psychiatric Assessment of Children of Parents With Obsessive Compulsive Disorder (OCD)

Thesis  
Submitted for Fulfillment of the  
Ph.D. Degree in Childhood Studies  
Medical Department



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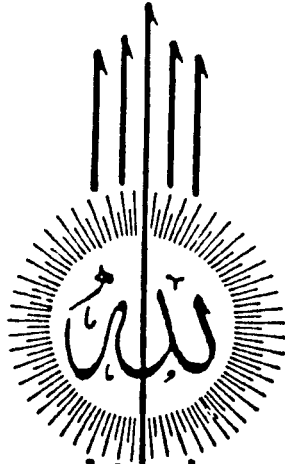
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2000







بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

قَالُوا سُبْحَانَكَ لَا عِلْمَ لَنَا إِلَّا مَا  
عَلَّمْتَنَا إِنَّكَ أَنْتَ الْعَلِيمُ الْحَكِيمُ

سَدَقَ اللَّهُ الْعَلِيمُ  
البقرة - ٣٢





To Dad



# ACKNOWLEDGEMENT

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**TO YOU DAD, I DEDICATE THIS WORK  
AND I SHALL ALWAYS BE LOOKING UP  
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**MAHA**



## **ABSTRACT**

In the field of psychiatry, family processes and interaction, as an etiological factor for most of psychiatric disorders, have typically been examined by many researchers. Comparative to this, few researchers have studied the impact of the presence of psychiatrically ill member on the rest of the family members (*especially children*), or to what extent they cope with their various psychosocial problems. Children of OCD parents accommodate their parental rituals through either participation in behaviors related to such rituals or through modification of daily functioning. They may also be negatively affected by such adverse life experiences and develop emotional or behavioral problems. Nineteen OCD parents and their children (n=42) and thirteen psychologically and organically free parents as well as their children (n=35) were compared as regard the presence of anxiety, depressive, and OC symptoms, and disorders among their children using specially organized symptom check-lists and the different DSM IV diagnostic criteria of such disorders. Most of children (*of both sexes*) of OCD parents showed significant anxiety, depressive and, obsessive compulsive symptoms and disorders with variable degrees. Males reported anxiety and depressive symptomatology in reaction to such stress, while females reported more depressive and obsessive compulsive reactions to such adverse life experiences. Conclusion; There is a significant correlation between parental OCD and the appearance of many symptoms and disorders especially anxiety, depressive and obsessive compulsive symptoms and disorders among their children. Absence of symptomatology of such disorders among the control group children, prove the correlation between parental OCD and the presence of child problems

### **Key Words**

OCD Parents – Children – Anxiety – Depression – OCD



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# LIST OF ABBREVIATIONS

AC	Age Class.
ANOVA	Analysis Of Variance.
ANS	Autonomic Nervous System.
C.G.P	Control Group Parents.
C-F-Chi	Control Female Children.
C-G-Chi	Control Group Children.
C-M-Chi	Control Male Children.
Co	Complain.  Disorders (Third Edition).
DSM III	Diagnostic and Statistical Manual of Mental
DSM-III-R	Diagnostic And Statistical Manual Of Mental Disorders Third Edition – Revised.
DSM IV	Diagnostic And Statistical Manual Of Mental Disorders Fourth Edition.
DZ Twins	Dizygotic twins.
FAD	Family Assessment Device.
GAD	Generalized Anxiety Disorder.
GMT	Chronic Motor Tics.
GTS	Gilles de la Tourette’s Syndromes.
Misc	Miscellaneous.

MZ Twins	Mono Zygotic Twins.
N	Number.
n.	Number.
NIMH	National Institute of Mental Health.
No	Number.
OC	Obsessive Compulsive.
OCD	Obsessive Compulsive Disorder.
OCS	Obsessive Compulsive Syndromes.
P.G.P	Patient Group Parents.
P-F-Chi	Patient Female Children.
P-G-Chi	Patient Group Children.
P-M-Chi	Patient Male Children.
S.D.	Standard Deviation.
Sig.	Significance.
SPSS	Statistical Package for Social Sciences.
TS	Tourette's Syndromes.
Y-BOCS	Y-Brown Obsessive Compulsive Scale



# Introduction



## Introduction

In the field of psychiatry, family processes and interactions, as an etiological factor for most of psychiatric disorders, have typically been examined by most researchers. Comparative to this, few researchers have studied the impact of the presence of psychiatrically ill member on the rest of the family, or at how extent they cope with their new situations.

There is no doubt that living with psychiatrically ill patient at home affect to a great extent the other family members especially children, who are at an increase risk to various psychosocial problems.

The majority of parents are able to provide conditions for their children, that are adequate or more than adequate to enable them to thrive physically, emotionally and intellectually. A significant minority are, however, unable to provide this level of care [Graham, 1994].

Of course, parental mental illness, is one of the most important risk factors in the family that should alter the professional to the possibility that care might be inadequate.

It is a central task for the professional to monitor any significant psychiatric or social problem, especially when the child is at risk for inadequate or reasonable parental care.

The main aim of those involved in ensuring the care and protection of children is to support the cohesiveness of the family unit and prevent family breakdown.

Many studies (*e.g. in the USA, UK, Germany ...*) have investigated the impact of living with an OCD father or mother

on the other family members. In Egypt this emphasis a very unnoticeable support. The possible psychosocial problems are very important to be investigated among relatives of OCD probands especially children and spouse.

The whole family members are in need for social and psychological support to prevent any possible harm from the inadequate care that could be present due to the parental mental illness. Also their families are in need for support to invest the possible resources within the family.

# Review of literature



## REVIEW OF LITERATURE

Obsessive compulsive disorder (*OCD*) is an anxiety disorder in which the obsession ... the intrusive thought ... is a source of anxiety, and the compulsion .... The ritualistic behavior ... is undertaken to alleviate such anxiety.

Children commonly adopt rituals during certain stages of their development, and most of us occasionally have intrusive thoughts or repeat certain actions during our life.

However, to reach the diagnosis of *OCD*, such thoughts have to be persistent and disturbing our life, and the rituals must be repeated, often for hours, until the person feels comfortable. The obsessions and / or compulsions must significantly disrupt the person's life.

Obsessive compulsive disorder (*OCD*) has recently undergone a dramatic change in status, once considered a relatively rare example of the neuroses [**Rubin, 1953**]. It now occupies a central position in contemporary psychiatry.

Obsessional disorder was believed to be a rare condition until the national institute of mental health (*NIMH*) catchment area survey, (*initiated in 1970s*) yielded results which startled the academic community. Obsessive compulsive disorder was found to be 50 to 100 times more common than previously believed, making it the fourth most common psychiatric disorder after phobias, substance abuse and major depression [**Myers et al, 1984, Robin et al, 1984**].

## Prevalence of OCD in the General Population

Many epidemiological studies concerning the occurrence of both adult and childhood OCD in both inpatient and outpatient community is relatively variable.

OCD has a lifetime prevalence rate of 2.5% and is somewhat more frequent in females than in males [**Van-Valiet, 1999**].

**Rasmussen and Eisen (1992)**, suggested that 10% of subscribing outpatients exhibited obsessive compulsive symptoms according to DSM III.

The prevalences of OCD and subclinical OCD were found to be 3% and 19% respectively. Prevalences were similar in males and females [**Garrison et al, 1995**].

A large French survey including 4363 consecutive patients consulting in and outpatient psychiatry, obtained the result of about 9.2% for OCD (*according to DSM-III-R*) and 17% for OCS (*obsessive compulsive syndromes*).

**Samuels and Nestadt (1997)** estimated the prevalence of 2-3% in the community which is approximately the same as the results of **Thomsen (1997)** with the prevalence rate of 1-3% of the adult population.

The cultural background of OCD was discussed by many investigators. There may be up to 5 millions with OCD in the USA and 1 million in the UK [**Rapoport, 1989 a**].



As regard the Egyptian Community, a study conducted by Ain Shams Department of Psychiatry in 1968 on 1,000 psychiatric patients attending the university clinic, showed an incidence of OCD of 2.5%. [Okasha and Hassan, 1968). A replication of the study in 1991 showed a constancy of the incidence of 2.3% indicating the stability of the disorder [Okasha and Raafat, 1991].

Okasha (1998) proved also that 0.5% of the general population and 1% of psychiatric outpatient and 4% of the neurotic group are obsessive.

### **Prevalence of Children OCD**

As previously mentioned, many studies considered adult OCD a significantly common psychiatric disorder, other studies proved its prevalence among childhood population.

The third international obsessive compulsive disorder conference discussed childhood OCD and the relative paucity of research in children and adolescents with obsessive-compulsive disorder (OCD) in comparison to adults and the unique potential for research in children to provide answers to important questions about the etiology, subtypes, pathophysiology, and treatment of OCD [Riddle, 1999].

Based on psychiatric clinic populations childhood-onset obsessive compulsive disorder was considered to be rare. However, according to many researches in the past, OCD might show the prevalence rate of about 0.5 – 4% of children and adolescents [Pollitt, 1957; Ingram, 1961; Lo, 1967; Vaisaner,

**1975; Hollingswarth et al, 1980], Coryell, 1981; Rasmussen and Tsuang, 1984].**

**Flament and Colleagues (1988)** in a survey of 5596 high school students, demonstrated that the disorder had a lifetime prevalence rate of at least 0.4%. When the sample was weighed to reflect sampling design, this lifetime prevalence rate approached 1.0% ( $\pm 0.5\%$ ) making it clear that childhood-onset OCD is not uncommon.

The early age of onset of OCD was also emphasized by **Bebbington, (1998)**. A large proportion of adults with OCD perhaps as high as 80%, have their onset during childhood or adolescence. Prevalence estimate of OCD in children is at least (2- 4%) and an even larger number may have subclinical OCD [**Grados et al, 1997**].

Because affected probands tend to keep their ritualistic behaviors hidden, researchers have tended to underestimate the prevalence of the condition, which authorities now believe is 20-40 times more common in youth than previously estimated [**Clarizio, 1991**].

**Vermeiren and Deboutte (1999)**, stressed on the importance of early recognition of OCD in children and adolescents, as such disorders does not get the attention it deserves. All health professionals of all branches should be aware of this condition.

A large-scale population survey suggest that OCD is fairly common and fairly few individuals receive adequate treatment [**Pigott, 1998**].

## **CLINICAL ASPECTS OF OCD**

Obsessive compulsive disorder is a neuro-behavioral process characterized by a strong desire to control the outer environment, to engage in forceful, unwanted, repetitive thoughts, and to perform irresistible mental or motor activities, all within a substratum of doubting.

Historically, OCD symptoms remain unchanged. This observation indicates the distinctness of permanent symptoms unmodifiable by bio-psychosocial variables that could emerge in time. However, parallel morbidity may overlap it to conform to a set of clinical entities that are self-incorporated with OCD's pathophysiology [Tobias and Neziroglu, 1997].

However, the obsessional content may vary according to the patient's intellectual profile, values and cultural factors.

**OCD symptomatology can be classified into two major groups.**

- I. Primary Symptoms.
- II. Secondary Symptoms.

## I: PRIMARY SYMPTOMS

### (A) Obsessions

Westphal, (1872) described obsessions as parasitic ideas in an intact intellect that introduce into normal thought processes or ideation against the will. Schneider, (1930) defined obsessions as *“content of consciousness which, when they occur, are accompanied by the experience of subjective compulsions, and which can not be gotten rid of, though, on quiet reflection they are recognized as senseless”*.

Lewis, (1936) found Schneider’s definition practical and acceptable. However Lewis believed that OCD patient needed to resist the obsession. Schneider’s and Lewis’s definitions were encompassed by Pollitt, (1957), who described the obsession as *“thoughts, images, feelings, impulses, recurring or persistent movements, that are accompanied by immediate sensation of subjective compulsion, and a desire to oppose it”*.

Although many other contributory definitions have been proposed to foster an understanding of OCD [Janet, 1903; Freud, 1917; Kanner, 1948; Green, 1965; Kringlen, 1965], Westphal’s definition still stands on solid ground.

Obsessions are persistent thoughts, impulses, or images that are unwanted, causing anxiety and distress [Tallis, 1995]. An obsessive thought appears in an invasive, intrusive manner that can not be stopped and may stay for long period. At the beginning, it can be justified, but later the patient realizes their thoughts are parasites, purposeless and impractical. The

thoughts have an interactive quality, and the patient may not be able to switch off obsessive thoughts. Although the patient tries to resist, the thought persists and can not be erased from the mind [Yaryura – Tobias and Neziroglu 1997].

Minor obsessional symptoms are considerably more common than OCD itself [Bebbington, 1998].

Contamination, religious, sexual and morbid thought contents was found to be the most common [Yaryura-Tobias and Neziroglu, 1997]. Also, fear of contamination by dirt or germs, constant checking, repetitive intrusive thoughts of somatic, aggressive or sexual nature, extreme slowness and inordinate concern with orderliness and symmetry are considered [Sasson et al, 1997].

Jakes, (1996) added arrangement of objects in a set way in the patient's environment to be another obsessive thought (*e.g. all objects of a given kind are lined up, or all books are placed parallel to the edge of the table they have been placed on*). Such practices may be accompanied with superstitious thinking.

Obsessional thinking might be magical in the patients believe, they can change events just by the thought process. These thoughts may relate to superstition or religious practices and are reminiscent of ceremonial compulsions, where magical thinking on superstitious believes are common. Moreover, magical thinking may be associated with delusional believes, when that occurs, a psychiatric process must be ruled out.

**Kaplan and Sadock, (1991)** classified four major symptom patterns in obsessive compulsive disorder:

1<sup>st</sup>: An obsession of contamination followed by a compulsion of washing and cleansing (*the most common*).

2<sup>nd</sup>: An obsession of doubt followed by a compulsion of checking (*the second most common*).

3<sup>rd</sup>: An intrusive repetitious obsessional thoughts of some sexual or aggressive act (*that is responsible to the patient without a compulsion*).

4th: Obsessional slowness: The obsession and the compulsion seem to be united into the slow carrying out of daily behaviors. An important aspect of the obsession is conflicting doubt.

An important aspect of the obsession is conflicting doubt. Patient believes and yet don't believe in his obsession (*i.e. when asked whether the thoughts is logical, patient hesitates to answer*) such doubtfulness may trap the patient in the hypothetical premise that his thought turn into a circular perpetual mobility, the patient's incompatibility lead him to social isolation [Tamarin, 1977].

## **(B) Compulsions**

According to **Yaryura-Tobias and Neziroglu 1997**, compulsions can be divided into:

1. Mental or ideational compulsions and

## 2. Motor compulsions.

**1. Ideational Compulsion:** Is an urge to perform an act in one's mind. (*e.g. arithmomania*).

They are more discrete because they are invisible. Patient uses them to avoid having witnesses of his condition. Many patients double-check visually; others count objects, possessions, coins, or stamps. Some configure letters, words or even complete sentences in their mind.

Arithmomania, a common form in which patient engages in addition, division, subtraction and multiplication endlessly.

## **2. Motor Compulsions:**

*Are further subdivided into:*

### **(1) Aggressive Compulsions:**

Which are urges to act out verbally as in coprolalia, or physically as in self-mutilation.

Self-mutilation includes (*hair pulling, eyebrow plucking, slashing, and head banging, self-punching, self-slapping, self biting, picking and digging*).

### **(2) Physiological Compulsions:**

Includes defecation, urination, eating, drinking, smoking, swallowing and performing sex acts endlessly.

These compulsive activities seem to result from obsessions pertaining to bodily physiology. These physiological modifications affect the bio-psychosocial profile of the patient [Table (2-1) shows such OCD physiological changes].

**Table (2-1) OCD PHYSIOLOGICAL CHANGES**

Characteristics	How Affected
Eating habits	Normal to abnormal
Thirst	Normal to increased
Death	Non suicidal
Life coping mechanisms	Poor
Urination	Normal to pollakiuria
Defecation	Abnormal patterns
Sleep	Normal/severe hyper-vigilance
Sexual activity	Decreased copulation Masturbation

**(3) Bodily Movement Compulsions**

Consist of touching, tics, clapping, sneezing, jumping, stretching, throat clearing, rocking, rubbing, and stereotyped movements.

**(4) Ceremonial Compulsions**

Relate to purification and decontamination rituals. They include cleanliness forms, hand washing and showering, as well as clothing and house cleaning.



### **(5) Other compulsions**

Include ordering, arranging, collecting, list making, echolalia, retracing, rereading, and rewriting.

After all the goal of any type of compulsion is to prevent or reduce anxiety or distress. They may be performed repetitively without purpose, or to undo some anticipated disastrous consequence.

However, according to **Yaryura – Tobias and Neziroglu 1997**, the two major compulsions are washing and double-checking. Where as **Garrison (1995)**, reported that the most common compulsions were arranging (56%), counting (41%), collecting (38%) and washing (17%).

## II: SECONDARY SYMPTOMS

Many authors touch on secondary OCD symptomatology such as anxiety, anger, depression and phobias [Kendell and Discipio, 1970; Beech, 1971; Cammer, 1973; Yaryura-Tobias, 1977; Yaryura-Tobias and Neziroglu, 1978; Yaryura-Tobias et al, 1979].

Secondary symptoms may overlap OCD spectrum phenomenology. This requires close attention for differential diagnosis purposes and consequent therapeutic treatment.

**Table (2-2) Shows Incidence of Secondary Symptoms In 100 OCD Patients (By Yaryura-Tobias And Neziroglu 1997)**

Symptoms	%
Depression	94
Anxiety	90
Aggression	65
Dysperception	60
Phobias	58
Checking	55
Other rituals	54
Sleep disorders	49
Family disturbance	45
Washing	41
Sexual dysfunction	34
Appetite disorder	33
Meticulosity	27
Self Mutilation	16
Tics	1

## **1. Major depression and depressive symptoms**

Major depression and OCD have been associated for many years. At times, the presence of comorbidity has been an important observation. A major depressive episode was diagnosed in 56.9% of OCD patients [Karno et al, 1988]. Depression also has been reported as the most common form of comorbidity [Rasmussen and Tsuang, 1986].

Zitterl et al, (1990) suggest that secondary depression is the most important form of depression present in OCD and so it is not a comorbid entity. Secondary depression is a common symptom in OCD, as a result of the devastation and incapacity affecting patients in their work, emotionality and social life.

Yaryura-Tobias and Neziroglu, (1983) estimated about 90% of OCD patients experienced secondary depression. Major depression as a comorbid condition was proved to be with minor prevalence as shown in epidemiological studies. On the opposite Samuels and Nestadt, (1997) encountered major depression as a comorbid disorder with OCD. Also, Garrison et al, (1995) proved about (45%) of OCD to have major depressive disorders and (29%) to have dysthymia.

An Egyptian transcultural study carried out on 90 cases (*aged 12-42 years*) by Okasha et al, (1994) revealed that one third of cases had a comorbid depressive disorder.

Prospective follow-up studies showed continued disability from OCD and continued comorbidity with affective disorders [Rapoport, et al 1992].

On the other hand, **Sasson et al, (1997)** considered depression to be the most common complication of OCD.

However, ruminations, obsessions or obsessive compulsive symptoms have been accompanied by depressive cases [Vaughan, 1976; Peselow et al, 1990; Rasmussen and Eisen, 1990].

## 2. Anxiety

Separation anxiety were encountered in about 34% of OCD cases [Garrison et al, 1995].

A follow up study of cases with childhood OCD suggested that most of the patients with chronic course of OCD had symptoms of anxiety and / or depression without any delusional symptoms [Thomson, 1994].

A High rate of comorbidity with anxiety and depressive disorders and with disorders related to the large OCD spectrum (*Somatoform disorders, eating disorders, impulse control disorders, compulsive buying...*) were obtained. **Hantouche et al, 1996.**

**Rasmussen and Eisen, (1992)** proved the co-occurrence of anxiety and depressive disorders with OCD which may contribute to misdiagnosis. Also, many coexisting mood or

anxiety disorders are frequently diagnosed in OCD but may remit with effective anti-obsessional treatments [Pigott, 1998].

### 3. Phobias

Present in about 50% of OCD patients. These phobias modify the patient's attitude towards handling the illness. The patients use avoidance behavior and may ritualize to undo fear.

There is a close affinity between phobias and compulsions: both involve avoidance behaviors and anxiety as a response to a feared object. The difference is that, the phobic individual usually avoids anxiety provoking situation more readily than the compulsive individual, where the fears are all pervasive, and so the individual has to engage in rituals to undo the fear [Yaryura-Tobias and Nezierglu, 1997].

Rachman and Hodgson, (1980) suggested that compulsive cleaners engage more in passive avoidance (*i.e. directly avoiding the feared situation*) than compulsive checkers with active avoidance (*i.e. engaging in behaviors to undo the fear*).

It was also hypothesized that compulsive cleansers are more likely to have concurrent phobias or a history of earlier phobias. Theoretically, this assumption may be sound, but practically, most compulsive cleaners engage in active avoidance (*cleaning*). Further research is needed to determine the accuracy of this hypothesis.

#### **4. Anger**

Is another common secondary symptom. Its pathogenesis might relate to psychological and biochemical components (*low brain serotonin level trigger anger, this has been seen in animal experiments and indirect observation in human*). OCD causes frustration because of the inability to function and to socialize. Frustration can then be channeled into outer or inner anger. Outer anger is verbally manifested, whereas inner anger becomes depression [Yaryura-Tobias and Neziroglu, 1997].

#### **5. Speech Pattern**

OCD linguistic patterns can be examined as expressive behavior [Lorenz, 1955]. The speech is usually iterative, stuttering, stammering, circumstantial, circular or redundant and can be fast or slow. Tone and its modulation vary from high to low pitch. Patients usually express themselves carefully. Their words often contain a lot of information [Yaryura-Tobias and Neziroglu, 1997].

Compulsive patients demonstrated more explaining verbal behavior compared with control subjects. They also used more negatives, retractors and evaluators. They also used fewer non-personal references and more expression of feeling but not significantly [Weintraub and Aronson, 1974].

#### **6. Other Characteristics (Psychosocial Sequence)**

According to Yaryura and Neziroglu, (1997). Seriously ill patients present four major characteristics: strong dependence needs, social isolation, school failure and job loss. This

psychosocial sequence in OCD is important for better understanding of patient needs.

Disturbances in the family constellation are common and expected. Living with OCD patient is difficult. OCD patients are self centered, demanding and ungrateful, and their mood changes and anger aggravate matters. Because of their inability to make decisions and doubtfulness involving their actions, they develop a strong dependency on family. An over protective parent, spouse, relative or friend will make decision for him or her.

Therefore, treating family disturbances to achieve better prognosis is important, if a family member living with the patient has OCD or obsessive compulsive personality, the patient behavior may be reinforced.

Patients have serious difficulties interacting socially. Several factors influencing socialization: low self esteem, fear of ridicule, thought rigidity, inability to accept others' values systems, inflexible moral codes and a need to control others' behaviors and ways of thinking. The presence of social phobias in many patients should not be overlooked.

The condition may also affect the ability to work either to maintain a job or in school or academic setting. Continuous obsessions cause distraction and prevent the patient from performing perfectionism. Double-checking and doubting seriously reduce productivity.

On the other hand, intense and lasting obsessions prevent the patient from listening in class or studying. Long hours spent in ritualization activities make it difficult to do homework or get sufficient sleep. All this interference lead to school or college failure.



## **CHILDHOOD ONSET**

### **OBSESSIVE COMPULSIVE DISORDER**

A common question is whether obsessive compulsive disorder in children and adolescents is different from that in adults. There seem to be no symptom differences in phenomenology literature.

In general, **Rettew et al, (1991)** reported that children with OCD presented with both rituals and obsessions and the content of these obsessive compulsive behaviors changed over time in 95% of subjects. There is no significant age related trends with any type of symptoms, although patients with early illness onset (*before age 6*) were more likely to have compulsions.

Very young children (*ages 6-8 years*) in particular, would have elaborate washing or checking rituals without cognitive obsessions. For example, a 7 years old boy repeatedly washed his hands to the point where they cracked and bleed. When asked about what he was doing, he denied any preceding obsessional thought, but an urge to wash or lick his hands [**Swedo et al, 1989**].

So, childhood OCD is generally similar to that of adults but compulsions or pure ritualizers are more considered, and may present in absence of obsessions [**Rapoport et al, 1992; Rettew et al, 1992**].

## **Rituals, Superstitions, Obsessions And Compulsions A Developmental Approach**

Childhood OCD differs from normal developmental rituals and superstitions in its severity, content and associated distress.

Many children engage in rituals or superstitious games (*e.g. counting cars of certain colors, touching certain street signs...*). These are games rather than compulsions and can be stopped without anxiety [Yaryura-Tobias and Neziroglu, 1997].

Simons, (1974) reported that some compulsive behaviors appear around the age of (2) in normal children and continue for 4 to 5 years. He further noted that changes in physical surrounding or daily routines normally upset two-year-old children. Such rigidity may be attributed to the child's attempt to control his/her demanding environment. The child may ritualize daily activities such as eating, dressing and washing and then make them distorted reflections of parental demands.

Yaryura-Tobias and Neziroglu, 1997 stated that normal childhood compulsive behaviors usually revolve around bedtime rituals. The rituals commence between ages 3 and 6, and may focus on checking or touching or checking various objects, saying goodnight to parents or following a sequence of events, such as, going to the bathroom, getting a glass of water and putting it by the bed, placing slippers at a chosen side of the bed... and so on, before finally getting in bed. In most children these rituals disappear rapidly.

## EARLY SIGNS OF OCD

The onset may be slow and the disorder only gradually comes to notice or they may be a fairly rapid onset [Rapoport, 1986]. Children as young as six years may be affected but the condition is commoner in mid-childhood and adolescence [Graham, 1994].

## OVERT SIGNS

There are certain behaviors that may indicate to teachers and parents that a child has or is developing OCD.

Some of the Overt Signs that should be further investigated are: day dreaming, declining grades, increased reactions and concerns about minor issues, slowness (*in tests, simple tasks, projects or reading*), excessive poorly explained absences, excessive time in bathroom, repetitive questions, excessive need for reassurance, prolonged bed time rituals to adjust and readjust the bed cloths and objects around him, complaints of fatigue or of life being too stressful.

If any of the warning signs are noticed it is important to question the child to elicit the obsessions or compulsions that may be provoking these behaviors. The child may be severely embarrassed and trying to conceal the compulsions, but sometimes they can not hide them, and parents or teachers notice strange behaviors.

Unfortunately, these behaviors are often attributed to normal childhood and adolescent habits, but if investigated many of

them would be considered persistent, pervasive, and distressing to the child, and the child is silently crying for help.

Once the problem is identified, treatment should be sought before the symptoms generalize and the child engage more in the problem [Yaryura-Tobias and Neziroglu, 1997].

### **GENERAL APPEARANCE**

The child is likely to be generally quiet and shy as well as perfectionist. In some cases, there is a great variation in behavior, the child being excessively neat and tidy in some respects, but slapdash in others [Rapoport, 1986].

Considerable sadness and misery accompanying the child's feelings of helplessness in the face of his own behaviors may also be present [Graham 1994].

The child may be able to explain how his rituals arise- perhaps on the basis of superstitious thoughts. Unless he carries them out, he feels some terrible event will occur. Feelings of "*internal resistance*" (i.e. *sensation of internal struggle against obsessional thoughts or compulsive behavior*) described by adults are not commonly expressed by children.

## CHILDHOOD OBSESSIONS

Obsessional thoughts are less common and may only be elicited on direct questioning. They take the form of unwelcome aggressive or depressive ideas

Children with OCD have rigid ideas of right and wrong, and have a morbid fear of making errors. They may be exceedingly slow in completing work assignments [**Graham, 1994**].

Typical obsessions involve themes of aggression, contamination, sex, and order [**Clarizio, 1991**]. **Adam et al, (1994)** added fear of harm, illness or death, to the previous obsessions, and found them to be often associated with corresponding compulsions (*washing rituals, checking, repeating and symmetry*).

Thoughts of religion, fear of harm, and fear of inanimate – impersonal objects were significantly more commonly reported for children than for adults [**Khanna and Srinath, 1998**].

Thoughts of contamination, violent images, sexual thoughts and religious ruminations were also described by **Riddle et al (1990)** and **Thomson (1995)**.

## CHILDHOOD COMPULSIONS

As mentioned earlier, compulsions are much commoner than obsessions in children. The majority of OCD symptoms in children appeared to be compulsive rituals, particularly involving washing and specific activities such as counting [Khanna and Srinath, 1988]. Among school youth, compulsions center besides washing and counting also on checking [Clarizio, 1991].

Brynska, (1998) added repeating, touching and scrupulosity to the childhood rituals.

Washing rituals were the most common OCD symptom affecting over 85% of children at some point of time. The excessive washing could be manifested as either increased frequency (10 to 20 times / hour) of hand washing or elaborate ritualized washing patterns that took several minutes or longer to complete. No child reported excessively long or frequent baths. On the other hand several teenagers complained of troublesome showering rituals, which are required to wash in a particular pattern to do it perfectly [Swedo et al, 1992].

Repeating rituals were present in one half of the sample. Many children would have to repeatedly draw a letter or number until it was "perfect". Their teachers noticed the abrupt onset of erasure holes in their papers, whereas parents observed increasing amounts of time being spent on homework assignments [Swedo et al, 1989].

Whenever possible, the child may resist the urge to repeat, but when unable to do, would disguise their repeating as “forgetting” their books by the chair, turning back to engage someone in conversation in order to re-enter the door way.

**Checking rituals** also were common and were reported by about 46% of the Swedo’s et al (1992) sample. In general, there was no set ending to the checking rituals.

The child may check until it “fell right” or the urge had dissipated. This checking is also characterized by “rational irrationality” for a 14 year old girl, who has to check the home’s smoke detectors, for obsessional fear that an appliance would cause a fire and injure her parents.

**Miscellaneous compulsions** include rituals of writing, moving, or speaking (26%) and ordering and arranging (17%). Some children would blink and carry a bad thought away to a safe corner with a staring ritual [Yaryura- Tobias and Neziroglu 1997]

All the previously mentioned odd behaviors may be manifested in the OCD child, and any attempt to change or interrupt the child’s behavior by parents or others are met by resistance.

There may be a transient improvement followed by relapse. In severe cases the child will try, often succeeds to insist that family members alter their behavior to fit in with his obsession. Manipulative behavior may consist, for example, getting the family to sit at table in a particular grouping [Graham, 1994].

## **CHILDHOOD OCD AND ASSOCIATED COMORBID DISORDERS**

Only one quarter of children (26%) had OCD as their sole diagnosis ( $n = 70$  under 18 years) and the co-occurrence of depression and anxiety was common [Swedo et al, 1989].

Associated diagnosis seen most frequently were depression (39%), other anxiety disorders [*simple phobia (17%) – over anxious disorder (16%) – separation anxiety disorder (7%)*], developmental disabilities (24%), oppositional disorder (11%) and attention deficit disorder (10%) [Swedo et al, 1992].

**Thomson, (1994)** suggested that most of the chronic OCD cases had symptoms of anxiety and / or depression without any delusional symptoms.

Depression and suicidal thoughts were commonly encountered in 20 OCD patients aged 8-18 years. While Empathy disorder was present only in one-fourth of the cases [Thomson , 1994].

The vast majority of children with OCD have concurrent neuro- psychiatric disorders including tic disorders beside anxiety and mood disorders [Grados et al, 1997].

Most of OCD cases aged (6-18 years) ( $n = 70$ ) have associated depression and anxiety [Swedo et al, 1992].

Traits commonly associated with childhood OCD was separation anxiety, risk aversion, submissiveness and perfectionism [Rasmussen and Eisen 1992].



**Brynska, (1998)** added eating disorders to depression and anxiety disorders, but no convincing relation appeared to be present between OCD and schizophrenia

Specific fears are relatively common, such children do not show aggressive behavior but occasionally episodes when the child's obsessional behavior is less prominent may be accompanied by increased rudeness and disobedience [**Graham, 1994**].

## **Factors Contributing and Precipitating Obsessive Compulsive Disorder**

There is a wide range of studies suggesting that OCD is determined, at least in part by biological factors. In fact, the evidence for the genetic inheritance and the environmental factors especially social transmission are also very important.

As far as research into familial incidence is concerned, the information is of interest. The presence of obsessions and compulsions in close relatives of diagnosed OCD patients does not prove the genetic component. On the other hand, the absence of obsessional problems in close relatives may weaken the environment component that is based on observational learning. The observation of an elevated rate of obsessional disorders in close relatives, taken in isolation, can be easily interpreted as evidence for a genetic or an environmental contribution.

### **A. Genetic Contribution**

Proponents of the argument that there is a significant direct genetic contribution to the development of OCD have not proven their case. There is however, possible support for the argument that there is an important genetic contribution to general emotional over-sensitivity and neuroticism [**Eysenck, 1967; Rosenthal, 1970; Slater and Cowie, 1971; and Shields, 1973**]. In addition to their relevance for analysis of the causation of the OCD, genetic studies can make an indirect contribution to nosology [**Rochman and Hodgson, 1980**].

Many investigators agree that there is a strong genetic component to its development [Nicolini et al, 1999]. A number of analyses have been conducted to determine if possible subtypes of OCD exists, including analysis of age of onset, cluster analysis, factor analysis, and segregation analysis. These methodologies, and possibly others, could aid in identifying the genes involved in the development of OCD, and may help to determine the possible genetic background of such disorder [Pauls, 1999].

The genetic evidence of obsessive compulsive disorder was proved by three main ways of studies:

1. Studies of familial incidence.
2. Studies on monozygotic and dizygotic twins.
3. Studies of adoptive parents and children.

Although these methods have produced valuable clarification of the genetic contribution of many psychiatric disorders, relatively little research has been undertaken on the genetics of OCD.

### **I. Studies of familial incidence**

During the past decade some well-conducted family studies, using uniform diagnostic criteria, have been performed. On the other hand several investigators have investigated familial inheritance [Brown, 1942; Rubin 1953; Kringlen 1965; Lo 1967; Shields, 1973; Insel et al, 1983; Rasmussen and Tsunag, 1986; Mckeeon and Murray, 1987; Swedo et al, 1989].

But although almost all these studies have showed a remarkable level of agreement about familiarity of OCD, many of them were difficult to interpret because of differences in diagnostic criteria and methods of assessment. Most studies did not interview the relatives directly and others failed to include comparison groups.

On other hand, some new researches directly interviewed the relatives and standard diagnostic criteria were used. Those studies were supporting the hypothesis that there is a familial component important for the expression of this disorder. Some of these studies focussed on families of children with obsessive compulsive disorders, others investigated families of adults.

**Lenane et al, (1990)** conducted one of these results in which about 30% of probands with the diagnosis of severe primary OCD (*48 children and adolescents aged 6–18 years*) had at least one 1st degree relative with OCD; 25% of fathers and 9% of mothers received this diagnosis. Also 45% of fathers and 65% of mothers received one or more other psychiatric diagnoses.

In another study, the parents of 21 clinically referred children and adolescents with OCD were interviewed. 15 of 42 (35.7%) of parents received a diagnosis of clinical ( $N = 4$ ) or subthreshold ( $N = 11$ ) OCD [**Riddle et al, 1990**].

About one third of children of OCD parents (16 of 84 OCD parent) have the same diagnosis. Also the condition is common among siblings of OCD cases [**Okasha, 1992**].

A third study conducted by **Leonard et al, (1992)** examined 170 first-degree relatives of 54 probands with childhood onset OCD. 13% of all the 1st degree relatives met the criteria for OCD.

**Bellodi et al, (1992)** studied the families of 92 adults with OCD. The rate of the disorder among the parents and siblings was only 3.4%. However, when the probands were separated on the basis of age at onset, the rates were significantly higher among the relatives of probands with onset before age 14. The morbid risk for OCD among the relatives of the early onset probands was 8.8, compared to 3.4% among the relatives of the later onset probands.

**Black (1992)** supported the familial tendency. 21- 25% of family members of probands with OCD have this condition. 32 adults with OCD and 33 normal individuals were studied and found no evidence that OCD was familial. The risk of a more broadly defined obsessive compulsive disorder (*i.e. subthreshold disorder*) was greater among the parents of the probands with OCD than among the parents of the normal subjects.

**Thomson, (1997)** confirmed also the fact that OCD in relatives of patients is much more common than the general risk for OCD in the population.

In agreement with all these previous results, more recent results concluded the familial loading of OCD and the positive family history for psychiatric disorders [**Geller et al, 1998**].

In the Mexican Institute of Psychiatry (*Mexico*), 71 probands with OCD were investigated 61 of them as well as 366 of their 1st degree relatives (*who have accepted to participate*) showed a higher frequency of OCD in the OCD family members. Approximately one third of OCD cases demonstrated a positive family history [Nicolini et al, 1998].

Another point of investigation was that there is an increased risk for subthreshold OCD in relatives of OCD patients than for controls. Earlier age of onset seems to be related to degree of familiarity of OCD [Grados et al, 1997].

However the weak support of familiarity of OCD was also examined by some other researchers where psychiatric histories of first degree relatives (*fathers, mothers and siblings*) yielded a prevalence rate of 7.7% for OCD, and this does not support the notion that OCD aggregates with families [Flament and Rapoport, 1984; Last et al, 1989; Rapoport et al, 1990].

Another family study conducted on 446 first-degree relatives aged (*1 – 91 years*) of 100 probands with OCD proved to be a heterogeneous condition. Some cases were familial and related to tic disorders, others were familial but unrelated to tic disorders and in other cases no family history appeared to be significant to either OCD or tics [Pauls et al, 1995].

A significant methodologic weakness of some of the previously mentioned studies was the lack of a comparison group. Thus the investigators could not determine whether the rates of OCD or sub-threshold OCD observed among the family members were significantly higher than the rates that would

have been observed by these investigators using the same diagnostic methods in a group of comparison subjects.

Also failure of the researchers to interview the relatives directly may adversely affect the accuracy of the obtained results.

Almost all the previously mentioned familial studies of OCD provides an additional evidence that some forms of OCD are familial. But family studies by themselves can not demonstrate the importance of the genetic factors for the manifestation of the illness. So, if the data obtained from the family studies are consistent with a fairly simple mode of inheritance, the results can be taken as an indirect evidence for the importance of genes in etiology of the disorder.

**Nicolini et al, (1991)** performed segregation analysis on data collected from 24 OCD families to examine whether transmission patterns were consistent with simple Mendelian models of inheritance. These investigators were unable to distinguish between autosomal dominant and recessive models. However, the dominant model was statistically more significant and most compatible with observed patterns. Thus at least in the families studied by these investigators, the transmission could be explained by simple genetic models.

A recent suggestion that Gilles de La Tourette's syndrome (GTS) and OCD are alternative phenotypic expressions of the same underlying genetic trait. Indeed, efforts have been made to locate candidate genes, especially those that modulate both

serotonergic and dopaminergic system [Leckman and Chittenden, 1990].

On support of the same suggestion Pauls [1992] found a higher rate of OCD among relatives of probands with Tourette's disorder. This suggests some forms of OCD might be etiologically related to Tourette's disorder (*genetically linked*). Furthermore, expression of OCD and/or Tourette's disorder appears to be related to the gender of the relative. The rate of OCD alone (*without Tourette's disorder or tics*) is higher among female relatives, than among male relatives while the rate of Tourette's disorder and tics is higher among male relatives.

Leonard, [1992] discussed the opposite of the previous results but supporting the genetic link between OCD and GTS. A higher rate of Tourette's and tics disorders was reported among families of OCD probands.

107 Italian families with probands with OCD were examined for the possible mode of genetic transmission. Two different phenotypic definitions of affection were used (1) OCD, (2) OCD plus Tourette's syndrome / chronic motor tics (CMT) (because of their potential relationship). For the 107 OCD families, the best fit was a dominant model of transmission (with a higher penetrance for females). When the phenotype boundaries were widened (OCD + CMT + TS), an unrestricted model of transmission became the best fit [Cavallini et al, 1999].



## II. Twin studies

Another potential means of studying any psychiatric disorder in relation to environmental factors is to study monozygotic twins discordant for particular disorder. Such pairs are genetically identical, so any environmental difference between them may be casually related to the fact that one of them has become ill while the other has not [**Rutter, 1985**].

Although the twin method, particularly when separated pairs have been traced, has produced valuable results in other spheres, the few twin studies on OCD are disappointing. In accounts of which a high concordance rate between monozygotic twins has been claimed, there are doubts about the quality of the diagnostic conclusions.

For example **Inouye, [1965]** claimed on 80% concordance rate for ten monozygotic obsessional patients. Together with this result was that of **Tienari, [1963]** where concordance rate reached 91%. Both studies were unsatisfactory as regard the supporting case material, where there was no support for the diagnosis of OCD in a single case [**Black, 1974**].

**Markos et al, 1969** study, both twins was diagnosed as OCD, one of them was receiving treatment since he was 10, the other received no treatment at all. **Markos and Colleagues** referred that to the same genetic as well as environmental background (*in Negma, 1985*)

**Carey, [1981]** estimated that only 30% concordant and 13% discordant MZ pairs, and no concordant but 14 discordant DZ pairs had been reported in the world literature at that time. Moreover, these figures have to be treated with some caution, as

in many cases, both the diagnosis and the zygosity are in doubt [Tallis, 1995].

**Carey and Gottesman, [1981]** found that 87% of MZ twins were concordant for OCD compared with only 47% of DZ pairs. These individuals were taken from Maudsley register, which ensures both reliable zygosity and diagnosis.

**Rasmussen and Tsuang, [1986]** proved approximately similar results with concordance rate 53% for monozygotic twins and 22% for dizygotic twins. **Nemiah and Uhde, 1989** in their study on identical twins, found one of them to have OCD and the other to have obvious obsessional traits. Recent twin study conducted by **Reiss, [1991]**; **Samuels and Nesadt, [1997]**, also suggest the evidence of inheritance.

Another point of investigation supporting the genetic emphasis in transmission and expression of some forms of OCD was the twin and family studies of **Gilles de La Tourette's Syndrome**, and the high rates of OCD and OC symptoms among Tourette's disorder families [Pauls et al, 1986; Leckman, 1986; Robertson et al 1988; Eapen et al, 1993].

### **III. Adoptive studies**

Assessment of the behavioral disorders of adoptive children and their biological and adoptive parents, which has been so valuable in research for many psychiatric disorders, has not yet made a mark on research in obsessions.

**Polmin et al, [1988]** estimated the importance of the environment and concordance rates for adopted siblings, who share no genes, provided a more exacting test of the effect of shared environment. Here similarities could only be explained by common or shared environmental influences.

According to **Reiss, [1991]** the environment may have a direct pathogenic role of its own, or may protect the individual from developing disorders to which they are genetically vulnerable.

It will be also extremely interesting to study the development of children who are adopted by people with marked obsessional traits and / or identified obsessional compulsive disorder.

## **B. Social Transmission**

Family is the most fundamental, universal social institution that provide the individual with initial social status, love and emotional affection. It is the environment in which the individual grows up, his personality being affected constructively and adversely by the impact of the other individuals and by difficulties in the environment surrounding him [**Toffler, 1970**].

Family is a feedback system designed among other things to maintain a relatively stable state. Family is usually bound together by intense and long lasting ties of past experience, social roles, mutual support and expectations [**Glick and Kessler, 1974**].

The figures neither confirm nor disconfirm the hypothesis that there is a significant genetic contribution to obsessional disorders. However, they do bear on the hypothesis that obsessional symptoms are transmitted by observational learning [**Rachman and Hodgson, 1980**].

It is well known that we learn basic rules of how and what to think, feel and do, primarily as a result of early experiences. General style of interacting and fundamental attitudes towards ourselves and the environment are also developed in us, in our early and repeated transactions with our parents.

If direct social transmission, by observational learning and indeed by instruction, were a major factor in the development of OCD, then the figures on familial incidence, especially those of the parents, should be considerably higher than those recorded.

If direct social transmission were the main vehicle for obsessional disorders, we might also have expected the siblings of OCD patients to show a far higher incidence of obsessional symptoms than they do [**Rachman and Hodgeson, 1980**].

So, it is important here to discuss how children of obsessional parents can be affected. On the available evidence, the hypothesis of direct social transmission of OCD receive little support. On the other hand, there is possible gene-environmental interaction, as families share not only genes, but also common environment as well. Most researches suggest a dynamic combination of genetic and environmental factors.

## **I. Children Of Obsessional Parents**

There is no doubt that living with a psychiatrically ill parent at home often affect the children and the whole family members to a great extent. Whatever the mechanisms, it seems reasonably well established that the whole family members are at increase risk for various psychiatric morbidity as well as many psychosocial stresses and burdens.

The individual is not living on his own, but in a family, in which he is one of its members, and so he has to adapt with it. The individual behavior is influenced by the whole family system and so, he / she is reacting to any stress within the family, which may adversely affect him leading to psychiatric problems especially in reaction to severe stress [Minuchin, 1974].

Obsessive compulsive disorder is a devastating illness that alters the lives of both patients and their family members. People with the disorder are plagued by repeated obsessions or compulsions, as well as by thoughts and behavior that seem senseless and frequently repugnant, and greatly restrict their occupational and social functioning. Many are dependent completely on their family members for care [Marlene, 1996].

Although the evidence on familial incidence does not encourage the view that the disorder is transmitted socially, it is not conclusive because the information is indirect, approximate and largely unconfirmed.

Investigation of the obsessive compulsive problems in children of obsessional parents provides a more direct test of the hypothesis.

If direct and vicarious social transmission contributes in any significant degree to the genesis of obsessions or compulsions, then the children of OCD parents should display a significantly elevated incidence of such problems.

To sum up, specific patterns of obsessive compulsive thought and /or behavior are transmitted by observational learning or by direct instruction. There remains, however, a strong possibility that these social learning processes play an important part in generating and maintaining general behavior tendencies such as timidity, overdependence and the like. These dispositions provide fertile soil for the growth of obsessions and compulsions [Rachman and Hodgson, 1980].

Rutter, (1966) compared nine children of obsessional parents with children of other types of psychiatric patients. Those children of OCD parents were suffering from widespread psychological dysfunctions. Eight out of nine were showing signs of excessive anxiety and disturbed maternal relationships. Sleeping and eating disorders were also evident. Six of the children were overly aggressive and disobedient, four of them had obsessional symptoms and another four had signs of depression.

It seems that a high percentage of obsessional parents transmit behavior that emerges as a general maladjustment rather than as a specific problem with an obsessional character. The attributes

most likely to be influenced by these parents are timidity, overdependence and anxiety, rather than specific obsessional preoccupations [Cowie, 1961; Rutter, 1966].

## **II. Geno-environmental Interaction**

Environmental contributors to any acquired pathological trait or illness can be divided into two groups:

1. Those shared by members of a family or sibship (common environment)

And 2. Those which are specific to the Individual (special environment) [Smith, 1974].

As mentioned earlier, family shares common genes and common environment, and so there is a dynamic interplay between the relevant genes and the relevant environmental stimuli at a point of time.

Monozygotic twins are genetically identical but environmental differences between them may casually be related to the illness of one and not the other [Rutter, 1985].

Scarr and McCartney, (1983) hypothesized a developmental trend as regard gene-environmental correlation. In the early childhood, children are exposed to their parents and siblings primarily so that the passive gene-environmental correlations are the most important in infancy. In middle childhood and adolescence, the individuals are much exposed to a broader range of environments, where the active and evocative gene-environmental correlations gradually replace passive interaction.

### **1. Passive gene–environmental correlations**

Here genes which produce certain patterns of parental behavior is also responsible for certain characteristics in the child, For instance, when a child of an anxious mother develops anxiety, one would say it is only due to heredity. In fact, it may also be due to the longstanding contact with the mother with consequent learning of her pattern of behavior.

### **2. Active gene–environmental correlations**

Genetically shaped behavior in the offspring actively selects and shapes the environment. The individual is not only influenced by the environment but also he influence it and may manipulate it for his own thought or behavior.

### **3. Evocative gene –environmental correlations**

Genetically shaped behavior in a child or adult stimulates or evokes certain forms of behavior in the environment that helps the original evocator, e.g. a genetically predisposed child for depression will evoke withdrawal from his / her parent, while a child with genetic propensity for activity evoke a more stimulating environment.

So, it is never unidirectional correlation between the individual and environment, but rather bi-directional or transactional [Tienari, 1992].



### **III. Parental Functioning and Childhood OCD**

Parental functioning is one of the important points concerning the family-related influence (*especially the mother-child relations*) in the etiology of obsessive-compulsive disorder. There is an important parental role in the development of obsessional thought and behavior [**Hana, 1964**].

The way the parents do their role may affect the child functioning more than the chronicity of parental illness or the number of its relapses. The chronicity of parental OCD affect child competence especially as regard academic tasks [**Harder et al, 1989**].

Strict, authoritarian and constricting upbringing plays a significant role in the genesis of obsessive-compulsive symptoms. On the other hand, an overprotected, spoiled, inconsistent upbringing are anxiety inducing and are all again proposed by either anxious or / and compulsive mothers [**Knolker, 1983**].

The relatively high incidence of a symbiotic mother-child relationship in the obsessive-compulsive family is another important factor [**Knolker, 1983**]. This might possibly superimposed on a constitutional vulnerability to psychiatric disturbance especially OCD, where parental symbiotic needs combined with perfectionist family styles predispose to such disorder [**Hoover and Insel, 1984**].

On the other hand, parents of OCD reported significantly more ritualized, rigid and demanding parental behavior, together with religious that are strict and ritualistic than did parents of control in a systematic comparison of 38 child aged (7-18 years) with severe primary OCD and 22 matched normal controls aged (9-18 years) [Fitz, 1990].

Leonard et al, (1990) supported the same high significance of ritualized behavior among parents of OCD children.

Mothers were less caring and more somatizing (*reported higher scales on somatization scale*) in Hofner et al, (1990) research. The OCD patients reported significantly less dissatisfaction with their family life and described either anxiety or obsessive compulsive symptoms in one or both parents in about 40% of the investigated subjects.

Patients with OCD exhibit specific parental traits associated with obsessive compulsive personality. The OCD patients (*aged 10-79 years*) were perceiving their mothers as highly organized, more overprotective, and their fathers as less demanding [Merkel et al, 1993].

Parents of OCD probands were: more rejecting, overprotective, less warm and over interfering [Honjo et al, 1989]. Some families come from cultures emphasizing cleanliness and perfection which may contribute to OCD development [Hoover and Insel, 1984].

OCD's invasive nature causes familial level of frustration and criticism [Tynes et al, 1990].

Family responses range from support and empathy, to excessive accommodation and overinvolvement, to hostility and rejection [Stekette et al, 1998].

Conflict with parents, separation and detachment must be also in consideration as they may contribute to OCD development [Klosinski, 1990].

### **C. Demographic Variable**

#### ***I. Age of onset***

A review of this literature suggests that OCD has a bimodal incidence pattern, with one peak of onset at approximately 10 years of age and another during adulthood [Geller et al, 1998].

A large proportion of adults with OCD perhaps as high as 80%, have their onset during childhood or adolescence [Grados et al, 1997; Samueles and Nestadt, 1997]. The majority of cases have onset before the age of 25.

Pigott, (1998); Geller et al, (1998) and Last & Strauss, (1989) supported the earlier age of onset in boys while Honjo, (1989) and Bebbington, (1998) emphasized its earlier onset in girls (10.4 for girls and 12.4 for boys in Honjo's study).

## ***II. Sex***

Boys outnumbered girls in juvenile onset OCD in contrast to equal ratio in later onset symptomatology during adulthood [Swedo et al, 1989; Last and Strauss, 1989]. On the other hand, OCD was more prevalent among women [Samueles and Nestadt, 1997].

Among a community sample of young adolescents, investigated for the frequency of OCD and subclinical OCD, equal prevalence between boys and girls, but females reported more symptoms for compulsions and males were for obsessions and 55% reported both [Garrison et al, 1995].

The British national survey of psychiatric morbidity based on clinical interview schedule-revised gave a month prevalence of 1% in males and 1.5% in females [Bebbington, 1998].

## ***III. Personal Factors***

This includes duration of OCD symptoms, severity in childhood, comorbid symptomatology, and parental mental illness. This might play an important role in vulnerability for either episodic or chronic OCD [Thomsen, 1995].

*Another group of factors related to the development of OCD includes:*

1- Inflated responsibility and guilt

- 2- Obsessive compulsive personality traits
  - 3- Excessive need for control over the environment
  - 4- Exaggerated responsiveness to emotional provocation
- [Gibbs, 1996].

## A Developmental Model of Emotions and Stress

Fear, anxiety and depression develop in characteristic fashion during childhood. Their causes, the way in which they manifest themselves, and their adaptive function change as the child progress from infancy, through childhood to adolescence. As most morbid or abnormal mood states are probably only extremes of normal mood, so the nature of mood disorders changes over this time.

Observing the development of the emotional process in young children can help us to explain how emotions function and interact with each other.

Emotions may occur alone in a simple form such as anxiety or anger, or may be mixed and much more complicated as in grief which contain anxiety, anger as well as sadness [Pearce, 1998].

It should be remembered that, in the individual child, there is often considerable overlap between fear, anxiety and depression (both normal and abnormal). The experience of one mood state is likely to be accompanied, at least to some degree by the presence of the other [Graham, 1994].

Parents recognize by marked differences between the way their children react emotionally. Even within the same family, there might be quite marked variation. It is possible to link a particular emotional reaction style to another member of the family and there is some evidence for genetic component in the way in which emotions are expressed [Robinson et al, 1992].



These differences can be recognized from early infancy onwards.

The combination of intense emotional reactions, being slow to adapt to change and general unpredictability have been recognized as a combination of characteristics that make children may be difficult to manage [Chess and Thomas, 1991]. Such children are significantly more likely to have anxiety states, and temper tantrums of high intensity and frequency.

The negative emotions such as misery, anger, anxiety, sadness, tend to concern us more, as it is commoner and easier to become a problem and to develop into a disorder.

**Pearce, (1998)** described a developmental model of emotional responses which can be used to explain the relationship between stress and emotions (See Figure 2- 1).

According to **Pearce (1998)**. the first emotion to be experienced at low levels of stress is anxiety. As the stress increases the anxiety may develop into anger, but it is only at very high levels of stress that a depressive reaction will develop. This explains why anxiety is the most frequently experienced emotion and why all other emotional reactions contain an element of anxiety.

Naturally there is considerable individual variation in the way emotions are experienced. Some children are much more emotionally vulnerable than others and have high levels of arousal even when resting, and are slow to habituate to repeated

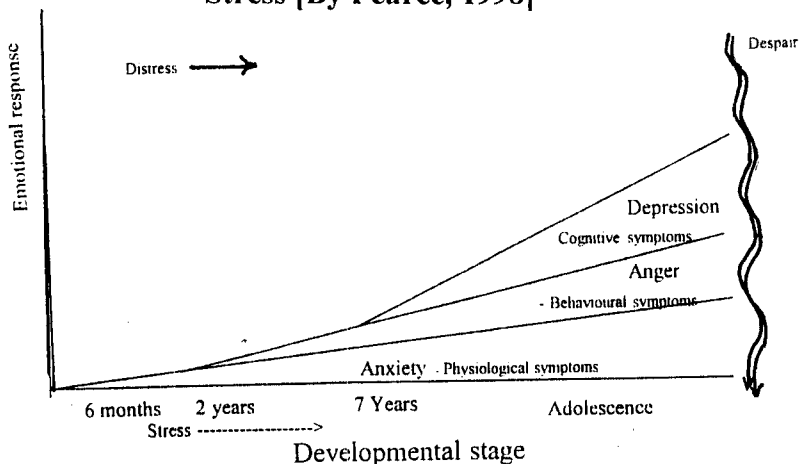
stressful stimuli, such children are much more likely to experience anxiety and to have a lower threshold for anger and depressive feelings.

Other children, who have been exposed to repeated adverse life events can easily develop a negative view of themselves and of the world and will therefore be more vulnerable to depressive thoughts and feelings.

A further factor in the way emotions are experienced is the effect of normal changes during adolescence. This has the effect of heightening the experience of all emotions and therefore increasing the frequency of feelings of anxiety, anger and depression.

The precise reason for this is not known, but it is reasonable to assume that the sex hormones sensitize neuro transmitter systems in the brain. It is interesting to note that emotional problems occur with similar frequencies in boys and girls up to adolescence but after that stage, emotional problems are more common in females.

**Figure (2-1): A Developmental Model Of Emotions And Stress [By Pearce, 1998]**





## **Development of Fear and Anxiety** **(Both normal and abnormal)**

### ***Definition***

Fear and anxiety are terms used relatively interchangeably, to describe unpleasant emotional states, accompanied by physiological changes (*such as tachycardia*), in which there is anticipation of an undesired outcome.

In order to be sure that anxiety is really present, one must be able to tell both that a person is experiencing an emotion and what it is, he is worried about. Obviously infants and very young children cannot talk about their feelings, but their behavior in certain situations often makes it clear that they are indeed anxious, and why this is, even though they are themselves unable to describe their emotions [Graham, 1994].

### **Anxiety in the early years**

#### ***1. Communicated anxiety***

Infants can be seen to respond from their first few days of life to the emotions of the caring individuals usually their mothers (*e.g. a baby hold by anxious mother will appear mostly tense and anxious specially during feeding*) [Graham, 1994].

#### ***2. Separation anxiety***

Around the age of four to eight months, babies start to show a very specific emotional response as opposed to the more general

emotions of smiling and crying expressed before this age. Here, emotional attachment to the parent started to develop. Separation anxiety is now developmentally the first specific emotion and represent the fundamental link between emotions and relationships [Pearce, 1998].

### *According to DSM IV*

The manifestations of the disorder may vary with age, younger children may not express a specific fears of definite threats to parents, home, or themselves. As children get older, worries or fears are often of specific dangers (*e.g. kidnapping*). Anxiety and anticipation of separation become manifest in mid-childhood. Adolescent with this disorder, especially males, may deny anxiety about separation, and it may be reflected in their limited independent activity and reluctance to leave home.

Separation anxiety may develop after some life stress (*e.g. illness of a relative especially parents*). Its onset may be as early as preschool age and may occur at any time before age of 18 years (*see DSM IV diagnostic criteria for separation anxiety, (Appendix VII B)*).

### *3. Stranger anxiety*

By about the age of 4 months, using special observational techniques, infants can be seen obviously unhappy and distressed immediately when strangers or strange situations are present [Graham, 1994].

Separation and stranger anxiety are separate phenomena, and one can occur without the other. Their course runs parallel. Both emerge around 6-9 months. Their peak around 12-18 months and decline between 2 and 3 years.

#### ***4. Temper tantrums***

Around the age of eighteen months to 3 years, temper tantrums started to appear. It means that the child is not just angry in a general and unfocused way, but that the anger is definitely directed against a specific person. As in the case of separation anxiety, the environmental trigger will make the angry nature of emotional response quite clear [Pearce, 1998].

#### **Later development of anxiety**

As children get older, the range of possible outcomes that may make them feel anxious increases considerably, they will continue to be afraid of dangerous and unfamiliar situations and of separation, together with fears about physical illness, and fears of death as well as excessive Shyness.

Each of these factors may make a child anxious, whether this occurs or not, will depend on the individual characteristics of the child, his previous experience and the degree of personal threat the future hold for him. Apparently, irrational anxiety may become readily explicable if one obtains a better picture of the child's view of a situation. [Graham 1994].

## **Normal defence mechanisms against anxiety**

On the other hand, child like adults may deal with his anticipatory anxiety by the use of various “*defense mechanisms*”. Although each of these would be abnormal if carried to extremes, most can be observed at least transiently in normal children.

These defense mechanisms as enumerated by **Graham 1994** were:

### ***1. Regression***

The child may regress in the face of an anxiety-provoking situation, behaving like normally fearful younger child, and therefore eliciting greater protection from those around him.

### ***2. Ritualization***

He or she may develop obsessional behavior such as checking rituals to pass his own anxiety e.g. child may start to count all his toys for his anxiety about his mother rituals.

### ***3. Somatization***

Some children “*Somatize*” their anxiety. They may develop aches, abdominal pains, vomiting, and nausea... These pains may be due to muscular tension to unde sensitivity to normal abdominal sensation or to seeking attention.

## **Children fears at various age level**

Fears are states of acute anxiety linked to the presence of particular objects, persons or situations. They result in avoidance behavior [Graham 1993].

Fears are found in children from infancy through adolescence. Those seen in infancy typically occur as a reaction to something taking place in the infant's environment. As the child grows older into the early school years, his / her fears broaden and involve darkness, supernatural figures and particular persons, objects and events. With increasing age, the child's fears turn more towards imaginary figures, objects and events as well as the future (*e.g. school*) [Jersild, 1968].

**Some of the fears reported by researches to be often found in children at various age levels are presented below:**

- 0-6 months:** Loss of support, loud noise, pain.
- 7-12 months:** Fear of strangers, fear of sudden unexpected and looming objects, fear of heights.
- 1 year:** Separation from parents, toilet, injury, strangers.
- 2 years:** Loud noise (*e.g. vacuum cleaners*), animals (*e.g. large dogs*), dark room, separation from parents, large objects / machines, change in personal environment.
- 3 years:** Masks, dark, animals, separation from parents.
- 4 years:** Parent separation, animals, dark, noises (*including at night*).
- 5 years:** Animals, bad people, dark, separation from parents, bodily harm.
- 6 years:** Supernatural beings (*e.g. ghosts*) bodily injury, thunder and lightening, dark, sleeping or staying alone, separation from parents.
- 7-8 years:** Supernatural beings, dark, fears based on media events, staying alone, bodily injury.
- 9-12 years:** Tests and exams at school, school performance bodily injury, physical appearance, thunder and lightening, death, dark (*low percentage*). These data are proved by [*Jersild and Holmes, 1935a; Ilg and Ames, 1955; Lapouse and Mank, 1959; Scarr and Salapatek, 1970; Kellerman, 1981; Marks 1987*].

**\* Clinical features according to age.**

**A. Preschool children (below 6 years).**

**Generalized anxiety and fearfulness**

Preschool children with undue general fearfulness and anxiety will often show problems in even brief separation from their parents especially their mothers. They will tend to follow their mothers around and scream if separated, even if this is for a short time and with a relatively familiar person. They are often generally miserable, and cry easily.

Their general irritability and tension results in a tendency to have frequent temper tantrums. Separation difficulties at night when going to sleep, are also common.

Anxiety between those children may take the form of sleep problems (e.g. nightmares, night terrors), psychosomatic manifestations (e.g. vomiting, colic, appetite loss) and other neurotic manifestations such as nail biting, thumb sucking, and tics.

Attendance at playground is an unhappy experience, they may spend days or weeks to settle down or never do so and have to be removed. They tend to mix poorly with other children [Graham, 1994; Hamouda 1998].

Specific fears are very common, as mentioned earlier, they differ with the child age. Abnormality of the fear can only be judged by its severity, persistence, and the social disability

produced. Phobias are then to be considered, if it interferes with the child's life and last more than six months (*according to DSM IV criteria for specific phobias*).

## **B. Middle childhood (6 to 12 years)**

The child of this age with an anxiety state will often show the following:

### **(1) Tension and worry throughout the day**

The anxiety will often vary depending on the situation the child is expected to face. Minor illness either in the child or a close family member (*especially the mother*), change of the teacher, test at school ...etc., are all likely to increase the child's anxiety. Such generalized anxieties and worries often concern the quality of their performance or competence at school, even when their performance is not being evaluated by others.

Children with such disorder may be overly conforming, perfectionist and repeat tasks because of excessive dissatisfaction with less-than-perfect performance. They also need excessive reassurance about their performance and their other worries. It is categorized under the generalized anxiety disorder which includes overanxious disorder of childhood in DSM IV criteria (*Appendix, VII A*).

### **(2) Physical complaints without underlying organic cause:**

May also be present (*e.g. headaches, stomach-aches, recurrent cough ... etc*). The ordinary bodily sensations are misinterpreted.



**(3) Separation fears:**

Undue concern about separation from parents is particularly common. The anxious school child is likely to worry about going to school, and may refuse to go to school for fear of separation from home, or one or both parents [Bowlby, 1975].

**(4) Regression to immature behavior:**

Separation anxiety can be seen as a form of regression, but other manifestations of regression are also common. Undue dependence on parents for self care, in washing and feeding may occur. Wetting and soiling, and insistence on sleeping with parents may occur [Graham, 1994]. Enuresis and encopresis may occur as a part of generalized anxiety state.

**(5) Obsessional behavior:**

As a response to anxiety, the child may develop rituals which form part of a general anxiety state rather than a full blown obsessional disorder. This occur uncommonly, but a number of anxious children do become preoccupied, for example with checking doors or with cleanliness of the toilets [Rapopat, 1986].

**(6) Tics:**

Occasionally anxious children show these rapid, repetitive movements as part of an anxiety state.

### **(7) Specific fearfulness**

School refusal which is an irrational fear to attend school, either for fear of separation from parents or home or to any other school factor is common. Depressed mother or anxious mother, had a close relationship with the development of children specific fears and Phobias [Skynner, 1974].

Handicapping specific fearfulness or phobias may be present. Fears related to sleep are common (*e.g. fear of going to bed alone, fear of ghosts coming from an open window .... etc*).

Other fears specific to such age group such as Self injury phobia and social fears and phobias may also be present [Hamouda 1998].

### **C. Adolescence (above 12 years)**

As well as general tension, some other features may be present:

**(1) A sense of mental unease** exists without attachment to any particular object, person or situation, together with a sense of depersonalization (*a sensation of uncertainty about personal identity and body integrity*), and derealization (*a more or less acute sense of unreality*). Anxious feelings related to his capacity to make real choices and about the meaning of life may also be present.

**(2) Hypochondriasis:** Headaches and stomach-aches with no organic basis are likely to be replaced by a more adult form of hypochondriasis with unusual concern over bodily health.

**(3) Specific fearfulness** related to social situations start to be present, loss of friendship, sexual unattractiveness and other situations may lead to social phobia (*see DSMIV diagnostic criteria of social phobia appendix, VII D*). Death phobias, phobias related to the futures may also be present [**Graham, 1994**].

## **II. Development of Depressive Feelings, Behavior, Beliefs and Depressive Disorders**

The concept of depression includes a number of different components. They include depressive feelings, depressive behavior, depressive cognitions or beliefs, as well as depressive disorders. Although both in normal development and in psychiatric disorders, these are often linked together, they require separate description.

### **A. Depressive Feelings**

It is only by about the age of 6 years that children begin to use the language of emotional affect in adult fashion. At this age the child gains capacity to experience feelings of sadness and depression, or being miserable. Such children experience such emotions when they feel unhappy, but the knowledge of normal depressive feelings in very young children is limited because of lack of introspective information [Graham, 1994].

By 10 years of age, about 11% of boys and 13% of girls were reported by their parents to "*often appear miserable, unhappy, tearful or distressed*" [Rutter et al, 1970 a]. By 14 years of age, 21% of boys and 23% of girls were reported themselves as often feels miserable and / or depressed [Rutter et al, 1976 b].

## **B. Depressive Behavior**

There is no doubt that younger children experience sadness and may feel miserable, but there is non-specific emotional response to distress. This generalized distressed response is present from an early age and only gradually develops into specific depressive reaction.

### **Characteristic depressive behavior includes both verbal and non verbal element:**

- **Verbal element:** usually include the expression of feelings of despair, hopelessness and various depressive beliefs.
- **Non-Verbal element:** specially crying and sad facial expression (i.e. not all crying is a sign of depression) [Graham, 1994].

The key elements of depressive emotional response are thoughts of hopelessness and worthlessness. These two cognitions require a level of maturity and self awareness that does not crystallize until around seven or eight years. The concept of time is required in order for a child to feel hopeless about the future and this does not develop fully until around the age of seven years [Pearce, 1998].

Sadness may be present when a child temporarily goes quiet, does not want to play with his friends or develops irritability on mild frustration. Self destructive threats and behavior may also be present with increasing frequency throughout late childhood and adolescence. 33% of 12-13 year olds had at least occasional thoughts of harming themselves and 8% of 14% years olds had definite suicidal ideas over the previous year [Rutter, 1976].

The concept of death requires an understanding of “forever” as well as an awareness of the uniqueness of the individual self, which can’t be changed or replaced. Children below the age of seven are gradually developing an understanding of death, but it is not until after this age that it becomes reasonably well established. Fortunately suicidal behavior is rare in young children, but around the age of eight years, clear suicidal impulses do occasionally occur [Pearce, 1998].

### **C. Depressive Cognitive Beliefs**

Unrealistically negative beliefs about oneself, one’s future, and of the world in general are a prominent feature of depressive disorders [Beck, 1967]. Transient thoughts of this nature appear normally during childhood.

By the age of 7-8 years, children can experience a devalued view of themselves as worthless. By early puberty they can have views that their future holds little for them. In children with depressive disorders, such beliefs are held intensely and persistently [Graham, 1994].

### **D. Depressive Disorders**

Depressive disorders are conditions in which persistent lowering of mood (*dysphoria*) and lack of a sense of pleasure in life (*anhedonia*) are prominent and persistent features.

**The DSM IV classification system include either:**

**(1) Major depressive episode**

In which somatic complaints, irritability and social withdrawal are particularly common in children whereas psychomotor retardation, hypersomnia and delusions are less common in prepuberty than in adolescence. In prepubertal children, it occur in conjunction with other mental disorders (*especially anxiety disorders*), than in isolation (*see diagnostic criteria Appendix, VIII A*).

**(2) Dysthymic disorder**

It occurs equally in both sexes and often results in impaired school performance and social interaction. Children and adolescents with dysthymic disorder are usually irritable as well as depressed. They have low self esteem, poor social skills and are pessimistic (*see diagnostic criteria Appendix, VIII B*).

**\* *Clinical features according to age***

According to **Graham 1994**, there is a little evidence that, in childhood, the different subtypes of depressive disorders can be clearly defined from each other. It is likely that in childhood "*dysthymia*" merges imperceptibly into ordinary sadness and misery. In adolescents and very occasionally in younger children, dysthymia emerges also in its more severe form, into depressive episode or disorder.

### **A. Preschool children (below 6 years)**

Although it is difficult or impossible to apply some of the features, such as low self-esteem, hopelessness and recurrent thoughts of death, to classify depression in this age groups, there is no doubt that babies, toddlers and other preschool children can appear depressed over a significant period of time. When depressed infants and toddlers are apathetic and refuse food, they are miserable, unhappy and irritable and may spend a lot of time crying, they may go to pediatricians because of failure to thrive.

Such children may show mild developmental retardation. Such picture may be a result of obvious neglect or deprivation [Graham, 1994].

### **B. Middle childhood (6 to 12 years)**

Depressive states at this age are often poorly differentiated from emotional disorders in which both anxiety and depressive features are prominent.

The depressed child more commonly presents with psychosomatic symptoms, especially headache or stomach-ache, failure to make progress in school, with poor concentration or / and inattention. Irritability, social withdrawal and incapacity to cope with minor frustration may be also present.

Very occasionally, however prepubertal children present with more classical features of depressive disorder – apathy, verbal and motor retardation, loss of appetite, feelings of low self-esteem and wishes they were dead on response to questioning may be present.



Depressed children at this age group are more likely to complain of being “*bored*” and of lack of interest in usual activities. They are likely to say they feel bored most of the time.

The depressed child always looks miserable and unhappy and appears lacking vitality and energy [Graham, 1994].

### **C. Adolescence (above 12 years)**

Depressive states in such age group are more similar to those in adults, the teenager often complain of feeling of sadness and apathy as well as lack of energy. Appetite and sleep disturbances are also common. A sense of hopelessness may be experienced. Suicidal thoughts are relatively common, although suicidal threats are less usual. Substance abuse may be another presentation at that age group [Graham, 1994].

#### **Anger**

Developmental term anger forms a bridge between anxiety and depression. Conduct problems are very closely related to anger, which is often characterized by aggressive behaviors [Pearce, 1998].

## **Family Participation and Burden Some Symptoms of Relatives of OCD Parents**

### ***The concept of burden***

The burdens of caring for a patient at home are considerable. They often affect the caring relative's social and leisure activities, and financial problems arise frequently with a subsequent disruption of normal family activity and the production of stress symptoms in family members other than the patient [Kuipers and Bebbington, 1990].

The existence of a burden indicates the breakdown of the reciprocal arrangements that the people maintain in their life and their relationships, (e.g. one person is doing more than their fair share). This merely results in them taking on a greater proportion or a number of shared tasks, but it may also restrict their activities outside the relationship. This change in pattern can be assessed against approximate norms. In addition, it is often accompanied by subjective dissatisfaction.

This concept shares characteristics with that of social performance, for one person's poor social performance is another person's burden. Both concepts are relative to social expectation, which are likely to be very variable [Platte, 1985].

Hoeing and Hamilton, (1969) distinguished between "objective" burden (e.g. effects on health, financial, social aspects). And "subjective" burden (the extent to which relatives feel they carry a burden).

## Psychiatric Morbidity Among OCD Relatives

Most studies of the families of psychiatric patients have been etiological. Family processes have typically been examined because of an interest in the effect of the family on the patient's illness. Comparatively few workers have looked at the impact of psychiatrically ill member on the rest of the family, or at how they cope with their situation as a type of burden reflected on the whole family system [Creer and Sturt, 1982].

Mental illness can be a crippling burden on the emotional resources of the relatives and the current policy of community care often means in practice that the task of caring for the ill person is allocated to the family without adequate backup from the medical services [Kuipers and Bebbington 1990].

In order to maintain a family equilibrium, symmetrical and complementary relationships are essential. If any part of the family system is subjected to disequilibrating force, the system will operate to restore the pre-existing equilibrium. Changes in one family member often bring about changes in other members. For instance, illness of a mother or a father (*for example an OCD mother*) can cause others (*children*) to de-compensate and become over anxious or depressed. As the mother improves, the child improves [Glick and Kessler, 1974].

People in general have certain habitual problem-solving mechanisms in order to encounter something that may disturb their usual balance. When the usual habitual responses are inadequate in response to something that is major situation, this

may lead to a state of a disorganization and crisis accompanied by fear, guilt, anxiety, or any other unpleasant feelings that contribute more to the disorganization. This state of disequilibrium does not remain forever and within days or weeks some equilibrium reestablished. The new balance achieved may promotes personal growth and maturation (*healthy adaptation*) or precipitate a state of psychological deterioration and decline (*maladaptive response*) with the development of psychiatric symptoms [Rudolf, 1979].

Many researches revealed that children of psychiatric patients are at high risk for psychiatric disorders and dysfunction. Genetic factors, upbringing by emotionally "*disordered*" parents and the secondary stressors and burdens are all factors that coalesce for such risk [Rutter, 1987].

Orvaschel et al, (1981) determined that 43% of 28 children of parents with psychiatric disorders had psychiatric disorders themselves. Another study supported approximate results; about 39% of 306 children of parents with psychiatric disorders had received psychiatric diagnoses. Despite this very high rate of psychiatric morbidity among children of psychiatrically ill parents, Investigations had reported that many of these children were neither identified nor receiving needed services [Feldman, 1987].

Many of the offspring of OCD individuals were reported to be complaint with the abnormal demands of the affected parent, but none of them developed obsession, or compulsions. On the other hand, in the absence of the affected parent (*e.g. admitted to*

*hospital*), their behavior quickly return to normal [**Rachman and Hodgson, 1980**].

## **I. Parent Illness and Childhood Anxiety**

Parental illness as mentioned before has many hazardous side effects. It affects not only the parent but also all the individuals surrounding him.

Because the patient's behavior at any given situation is very unpredictable and it is so hard for any body to expect the possible patient's behavior at any time, the general home atmosphere become so tense and jumpy [**Creer and Wing, 1988**].

On an everyday level, patient's unpredictable habits could disrupt the routine of the household. Relatives were found to be constantly on a "*knife edge*" and "*living on their nerves*". This constant fear of the unexpected was particularly severe when a relative remembered something terrible has happened by the patient without apparent reason. Another constant fear mentioned also by the relatives was the possible harm that could happen to the patient himself [**Creer and Wing, 1988**].

Another worry that also affects the family is the possibility that children may inherit the tendency to the disorder [**Kuipers And Bebbington, 1990**]. This risk is real as mentioned before, because of the interplay of the family interaction, as each part affect the other parts of the family system, and all the emotions and behaviors among the family are the outcome of numerous factors [**Epstein et al, 1981**].

Children of obsessional parents was found to have widespread psychological problems. Signs of excessive anxiety, sleeping and eating disorders, aggression and disobedience as well as disturbed maternal relationships [Rutter, 1966].

## **II. Parent Illness and Childhood Depression**

For many reasons, relatives are at high risk to develop major depression or depressive symptoms. This vulnerability may be genetically based and become precipitated by a number of factors including early life experience, personality variables and life events.

The degree of family competence may also be involved by a variety of factors including family composition, socio-economic status, social support, presence of any psychiatric or medical illnesses and the current life events [Gobor et al, 1990].

Children of OCD parents were adversely affected by their parental illness and this may take the form of moderate to severe depressive episode [Rachman and Hodgson, 1980].

Four of nine OCD parents were found to have their children showing signs of depression and obsessional symptomatology. Hantouche et al, (1996) in a large survey study proved high rate of interfamilial psychiatric comorbidity for OCD, depression and anxiety disorders among relatives of OCD patients.

Mansour, (1993) found about (60%) of children of OCD mothers compared to (40%) of children of OCD fathers to show

depressive symptoms. On the other hand, major depression was diagnosed among 20% and 40% of children of OCD fathers and mothers respectively.

## Family Accommodation in Obsessive Compulsive Disorder

Family accommodation is defined as family participation and modifications of functioning because of the potentially negative effects. Such behaviors may have its effects on the patients and their family members (*Spouse, children, parents, siblings ... etc*) [Calvocoressi, et al 1995].

Relatives of patients with OCD accommodate patients through participation in behaviors related to patient rituals and through modification of daily routine [Rachman and Hodgson, 1980]. Clinicians report that such accommodation can be stressful for relatives especially children and adversely affect family functioning [Livingston et al, 1990].

Van-Vliet (1999), presented an example of family involvement in 34 years old OCD patient where the partner and the family were used to co-operate in his compulsive behaviour, and they were the sufferers and the one who seek advice.

Only in the very recent literature has the suffering of the family of an OCD patient received notice. MacGregor, (1994) enumerated the many losses experienced by families of the mentally ill. **In the external sphere these include:** Loss of: income, privacy, normal family activities, pleasure and freedom for care givers. **Internally** and more subtly the losses are of: self-esteem, sense of competence and control, pleasure in a child's success; hope, security, and certainty about both the illness and the future, religious faith and a positive sense of the past life of the family.



**MacGregor 1994**, concluded that families of the mentally ill need validation for their grief if they are to overcome helplessness. **Cooper (1993)** with an ongoing psycho-educational group for families of OCD patients supports the same belief.

OCD families are extremely distinguished from the other families of the mentally ill in the inextricable way that they are brought into the illness. Compulsions involve the whole family members and the home itself. Nearly all affected children involve their parents and sometimes siblings in their rituals, thus dominating family life. Obsessive doubting and indecision also lead to family involvement and the patient's search for reassurance leads to an ultimately dependent state. On the other hand, the patient rituals might be so severe to the extent that patient force his / her relatives in the rituals for fear of contamination [**Marks, 1987**].

**Cooper, 1996**, found about four-fifth of respondents reported disruption in the personal life of a family member. Disruption of family social life was experienced by about 75% of the sample and 72% noted loss of interpersonal relationships. 45% of respondents listed their greatest concern as coming to terms with the lost potential of their OCD relative. Nearly 40% cited worry over what would happen to their relative once they themselves were unable to care for them. Those with OCD children under age 18 showed significantly more (59%) concern.

Families of 19 OCD parents (*with at least one child between 7 and 18 years*) suffered impaired functioning compared to

control subjects. They had extremely higher scores in all FAD scales (*Family Assessment Device*), although only communication and general functioning scales varied significantly. Also the result of this study paint a picture of family life disrupted by the annoying symptoms of OCD patients [Black et al, 1998].

**Calvocoressi et al, (1995)** assessed the nature and frequency of family accommodation in obsessive compulsive disorder and the consequences of not participating in patients symptoms and rituals. Most relatives accommodated the patient's symptoms. Such accommodations were often minimal or infrequent, but some involved time-consuming participation or extreme modifications of functioning. Family accommodation occurs in the context of global family dysfunction and stress.

Several studies support the extensive family involvement and accommodation of OCD symptomatology, as well as considerable burden placed on families who reduce their social activities and increase their isolation and distress [Steketee, 1997].

**Graham et al, (1989)** explained an extreme example of such cases in which children might be forced to remove all their clothing before entering the house for fear of contamination by germs. The consequences for family life of such behavior could be quite disastrous. The family might refuse to participate in rituals leading to constant atmosphere of disharmony and discord.

Parents may request or even demand family participation to answer repetitive questions in ritual performance, in general to become an actor and take a role in the illness [Clark and Bolton, 1985].

## **Impaired Social Functioning Among OCD Families**

The social consequences of OCD can be severe. The obsessions and compulsions affect not only the individual patient, but also his or her family and their total social relationships. Rituals and fear of contamination may lead to family isolation and mental breakdown [Graham et al, 1989].

The chronicity of OCD, coupled with the intrusive ego-dystonic nature of its primary symptoms, can cause severe distress in the personal and family life of sufferers, with a marked social disruption. For example, the fear of contamination may force the patient and the family to move house regularly. In less severe cases, it may lead to social isolation because visitors are barred from the home for fear of contamination [Marks, 1987].

Mansour, (1993) recorded about 30% of families of OCD mothers and 20% of families of OCD fathers have a degree of impaired social functioning and disturbed family relationships compared to the control group.

*Both short and long term studies indicate that OCD especially in the untreated state leads to restricted life style. This can be characterized by chronic OCD symptomatology which lead to social isolation, impaired social functioning and comorbid illnesses of the affected proband such as anxiety, depression and panic disorders [Thomson, 1998]. This will be greatly reflected on the whole family function.*

**Aim of the work**



## AIM OF THE WORK

### **Importance of the study**

Family processes and interaction, as an etiological factor for many emotional and behavioral disorders in children, have been investigated by many researchers abroad. Comparative to this few investigators looked at such problem in our country.

Children of parents with obsessive compulsive disorder are considered at a high risk for various psychiatric symptoms and disorders.

The assumption is that the existence of mother or father with obsessive compulsive disorder, creates an adverse environment for the whole family members. Such undesirable life experiences mostly will be reflected on children with the possibility of development of many psychiatric manifestations.

Parental OCD with its underlying anxious behaviour and / or depressed mood can be easily picked up especially by children. Thus having an anxious parent can make the difference to how young people manage their feelings of anxiety and depression.

Furthermore, children of OCD parents accommodate their parental rituals through either participation in behaviors related to such rituals, modification of daily functioning or development of various emotional and behavioral problems.

Investigating children of OCD parents is very important from various view points. The following are some aspects of the importance of the present research:

- [1] Decision as to whether the children of OCD parents and their various psychiatric manifestations (anxiety, depression and OCD) are related to their parent's illness by comparing such

children manifestations with children of normal control parents.

- [2] Various psychiatric symptoms and disorders manifested among children must be made with reference to both the normal and abnormal developmental patterns of emotions, as well as the normal superstitious rituals.
- [3] Assessment of psychiatric manifestations among children under investigation should be viewed in terms of various demographic variables especially age and sex.

### **Aim of the study**

**The present study was designed to test the following hypotheses:**

- 1- Children of OCD parents compared to children of control parents are at high risk for various psychiatric symptoms especially:
  - (1) Anxiety symptoms.
  - (2) Depressive symptoms.
  - (3) Obsessive compulsive symptoms.
- 2- There are differences in psychiatric symptoms between male and female children of both patient and control parents.
- 3- There are differences in different psychiatric disorders (according to DSM IV) between children of OCD parents in comparison to children of normal control parents as regard their age and sex.



# Method and procedures



## METHOD AND PROCEDURES

This chapter is mainly concerned with detailed description of the method and the main procedures of the present study, which include: the subjects under investigation, the tools used and the main statistical methods used for analysis of data.

### **Method**

It is a quasi-experimental design of research. Here the examiner has to choose OCD cases and their families and compare them to normal controls. As in such psychological problems, it is very difficult to apply in a completely designed experimental model.

### **The Procedures**

*As mentioned earlier, the procedures of the present study will include:*

- (I) Sample
- (II) Tools
- (III) Statistical procedures

#### **(I) Sample**

*The sample consisted of two main groups:*

- A. Patient group
- B. Control group

#### **A. Patient Group [OCD Probands]**

- **Size and selection**

The patient group consisted of the first nineteen parents (*mothers = 15 and fathers = 4*) attending the outpatient

psychiatric clinic of Institute of Psychiatry, Ain Shams University Hospitals and some private clinics, who accepted to participate in the research program for the period from January 1997 to August 1999, and fulfilling the DSM IV criteria for obsessive compulsive disorder (*Appendix IX*).

All the OCD probands were interviewed directly, and after establishing their primary diagnosis of OCD, a permission were taken to contact all their children aged three up to fifteen years (*children No. = 42; females = 25 and males = 17*) and a full history concerning each child was obtained.

- **Criteria**

### **1- Inclusion Criteria**

*Each one of the OCD parents [fathers or mothers] should fulfill the following criteria:*

- [1] OCD parents should accept to participate in the research program.
- [2] The parents should be Egyptian (*for cultural background*) regardless of their age, sex, educational level and social background.
- [3] The parents should be diagnosed according to DSM IV criteria for obsessive compulsive disorder.
- [4] The OCD parents should have children of either / or both sexes from three up to fifteen years of age.
- [5] The OCD father or mother should be continuously living with his / her children until being assessed for at least six months.

## **2. Exclusion Criteria**

*The following were excluded from the study:*

- [1] Parents refused to participate and / or refused to include their children in the research programme.
- [2] OCD parents with children out of the included age group.
- [3] OCD parents with children having any other mental illness.
- [4] Unmarried OCD probands.
- [5] OCD parents having no children.

### **N.B.**

During the mentioned period for collection of cases, many OCD cases were available, but most of them were excluded as follows:

- \* 20 cases refused to participate in the research.
- \* 9 cases refused to include their children in the research.
- \* 3 cases did not come again.
- \* 4 cases were in-cooperative in giving reliable data.
- \* 10 cases were unmarried or does not have children.
- \* 5 cases were having children out of the included age group.

b. Mothers were much more included in the research than fathers because they are more available, more complaining and more caring than fathers do. This explains why the number of mothers exceed that of fathers (*many fathers refused to participate*).

## **B. Control Group**

- **Size and selection**

Thirteen psychiatrically and organically free subjects (*Mothers = 9, fathers = 4*) volunteered for the ongoing study, matched as much as possible with the patient group as regard age, sex, social level, educational level and their children age (*children number = 35; females = 17, males = 18*).

*The control group was subjected to the same structured interview schedule.*

- **Criteria**

### **1. Inclusion Criteria**

*The control subject should fulfill the following criteria:*

- (1) Should be an Egyptian parent (*for cultural background*).
- (2) Should be free from any physical or psychiatric disorders, or receiving any treatment program for either physical illness, psychiatric disorder including substance abuse and addiction.
- (3) Should have children from 3 - 15 years of age.
- (4) Should be continuously living with his / her children for the last six months until being assessed.

### **2. Exclusion Criteria**

*The following were excluded from the study:*

- (1) Any control subject refused to participate and / or refused to include his / her children in the research programme.

- (2) Subjects with history of any long life medical or psychiatric problem or treatment for either the control subject or their families including drug abuse and addiction.

## **Consent**

After prolonged explanation of both the steps and the importance of the research programme to each of the included parents (either patient or control parent), their acceptance to participate were taken. All parents and controls as well as the interviewed caregivers or relatives, gave voluntary informed consent. If consensus could not be achieved, the subject was excluded.

## **II. Tools**

### **(1) Tools For The Parents**

*\* All parents (both OCD and control parents) were subjected to the following:*

- (1) Collection of personal data, according to the parent evaluation sheet (*Appendix I*).
- (2) DSM IV criteria for obsessive compulsive disorder (*Appendix IX*).
- (3) The Arabic version of the Yale Brown Obsessive Compulsive Scale (*Y-BOCS*) to obtain information about lifetime occurrence and the severity of obsessive and compulsive symptoms (*Appendix III*).

### **(2) Tools For the children**

All children under investigation (*either children of OCD parents or control parents*) were assessed first for collection of their personal data using the child and adolescent evaluation

sheet (*appendix II*). Then each child was supposed to be submitted to a battery of Arabic psychometric tests according to age, to assess some childhood psychiatric problems specially anxiety, depression and OC symptoms and disorders.

**Those tests were:**

- (1) Children obsession scale (*The Arabic version of the Leyton Obsessional Inventory-child version*) [by **El-Rakhawy, 1992**] for assessment of obsessions and compulsions in infancy and childhood.
- (2) Children Anxiety Scale [**By Mousaa, 1987**].
- (3) Children Depression Inventory [*CDI*] [**By Ghareeb**] for infant and childhood depression.

## **Description Of Tools**

### **I. Parents Assessment Scales**

#### **1. The parent evaluation sheet**

*It includes:*

- (1) Personal data: Which include.  
Name, age, date of birth, sex, address, telephone No.
- (2) Duration of illness.
- (3) Education of the patient.
- (4) Martial status.
- (5) Number of children.



- (6) Education of the spouse.
- (7) General home atmosphere.
- (8) Quality of patient spouse relationship.
- (9) Quality of parent–child relationship.

## **2. The Yale-Brown obsessive compulsive scale (Y-BOCS)**

The (*Y-BOCS*) was designed to provide a specific measure of the severity of OCD symptoms that is not influenced by the type or number of obsessions or compulsions present.

The Y-BOCS symptom check-list includes more than 70 example of obsessions and compulsions, which are organized into 15 larger categories according to their thematic content as follows:

- (1) Aggressive obsessions.
- (2) Contamination obsessions.
- (3) Sexual obsessions.
- (4) Hoarding saving obsessions.
- (5) Religious obsessions.
- (6) Obsessions with need for symmetry or exactness.
- (7) Miscellaneous obsessions.
- (8) Somatic obsessions.
- (9) Cleaning / washing obsessions.

- (10) Checking compulsions.
- (11) Repeating rituals.
- (12) Counting compulsions.
- (13) Ordering / arranging compulsions.
- (14) Hoarding / collecting compulsions.
- (15) Miscellaneous compulsions.

Current obsessions and compulsions have to be identified as well as the past symptoms as they may re-emerge during a subsequent rating sessions.

It is also important in this study to identify current and past symptomatology of the parents to determine its significant effect on children living with the interviewed subject for the last six months.

## **II. Children Assessment Scales.**

### **1. Children obsession scale**

It is the adapted Arabic version of the Layton obsessional Inventory (*child version*).

#### **Inventor:**

El-Rakhawy 1992,

#### **Producers:**

The scale consists of 21 items for assessing both obsessions and compulsions in children (*age range 6- 13 years*) (*mean age 8.87*).

### **Scoring:**

Scoring depends upon the time spent in different obsessions or compulsions as follows:

1. No time is consumed.
2. Long duration of time is consumed.
3. Average duration of time is consumed.
4. Little duration of time is consumed.

### **Reliability:**

Using the split half method which showed high level of significance at (0.001) level.

### **Validity:**

Two methods were used for assessing validity of the scale:

- (1) *Content Validity*: Five Judges agreed for the validity of items to assess childhood obsessions and compulsions.
- (2) *Construct validity*: Using contrasted groups. T. test was used to compare between cases and controls having the same age and sex. The significance was at (0.06) level ( $N = 194$ ).

## **2. Children anxiety scale**

### **Inventor:**

Mousa 1987.

### **Procedures:**

The scale may be applied either individually or on groups. The child has to read all the items first and then starts to put his / her answer.

**Scoring:**

The scale is composed of 42 items, in addition to 11 items for reliability of data. It is a true / false test. The children with scoring more than (6) in reliability items should be excluded. The range for scoring is from 0 to 42:

0 = no apparent anxiety.

42 = high degree of apparent anxiety.

**Limitations:**

It is only suitable for children aged 10 - 15 years.

**Reliability:**

- a- *Split-half method*: was used to test the reliability of the scale in assessing anxiety symptoms in children. The reliability by this technique was highly significant at (0.01) level.
- b- *Internal consistency*: Positive correlation (*statistically significant*) was obtained between each item score and the total score.

**Validity:**

*Two methods were used:*

- 1- Discriminative validity.
- 2- Factorial validity.

Both methods showed high validity for the scale.

**3- Children Depression Inventory (CDI)**

**Inventor:**

Ghareeb, 1995.

### **Procedures:**

The Child Depression Inventory covers many depressive symptoms. It include 27 item which represents most of the depressive symptoms (*e.g, sadness, loss of interest, eating problems, social withdrawal ...* ).

It is applied individually in the clinical practice with help from the examiner by reading the items for the examined child. The child follow the examiner and then put his answer in the proper site. The examined child should only give one answer for each item.

It can be applied for groups, but for younger children the groups should be small as much as possible to get the best results.

### **Scoring:**

0 = If the item is not present.

1 = If average presence of the item.

2 = If severe presence of the item.

*The total score ranges from 0 - 54.*

### **Validity:**

*Construct validity:* Two groups of children were compared to each other in the CDI. The test have significant validity at 0.02 level.

### **Reliability:**

*Two methods were used:* Test – retest and internal consistency. both methods were highly reliable at (0.001) level.

### **Limitations:**

The scale is suitable for children 6 - 16 years of age.

## Pilot Study

### Subjects:

The previously mentioned psychometric tests were conducted on five OCD parents and their children (*No. = 8*) fulfilling the inclusion criteria of the present research.

### Results:

*The following results were obtained as regard the Arabic Psychometric Tests of the children:*

#### (A) The Anxiety scale

When the anxiety scale was used to assess the presence of anxiety symptoms, the following was concluded:

- (1) The test was not suitable for children below the age of ten (*the test cover only the age range from 10-15*) and no other Arabic Tests were found to cover the younger age group especially the preschool period and early childhood.
- (2) The test was difficult to be understood by children especially younger ones, and some items were in need to be repeated or explained by the examiner.
- (3) The scale was too long as regard the item itself and the number of items (*53 item*).
- (4) Many anxiety symptoms were deficient in such anxiety scale, which was very necessary to be investigated and assessed such as: separation anxiety, different types of phobias, poor friend relations, some anxiety symptoms common in children such as: nail biting, thumb sucking, temper tantrums, psychosomatic symptoms and others .....etc.

- (5) It was better to investigate children according to their developmental age, as anxiety symptoms (*according to the previous literature*) may vary significantly according to the child age. For example, school problems starts to appear with school entry. Also, school refusal and school phobias are more common among emotionally vulnerable children. On the other hand, social phobias appears more with older children....etc.

*So, according to the previously mentioned qualitative data, the researcher started to built a new anxiety symptom checklist, collecting its data from the previous possible psychometric tests and review of literature.*

### **(B) The children Depression Inventory**

Children included in the pilot study were assessed by this scale and it was found to be:

- (1) Unsuitable to assess depressive feelings or depressive behavior in younger age group below the age of seven.
- (2) It is a self rating scale, each of its items has three alternatives for answer. It was very difficult for children (*especially young children*) to differentiate the meaning and the difference between each sentence, and so needed to be explained by the examiner, again and again (*especially to the young children*).
- (3) As previously mentioned, it was better to assess children according to their age, as depressive symptoms vary with age, as mentioned by all the previous literature.

According to that, a new symptom checklist for depression was built on. It contains different depressive symptoms according to each age group separately.

### **(C) Arabic version of Leyton Obsession Inventory for children**

*While assessing children by this scale the following was obtained:*

- (1) Difficulty was observed in interviewing children especially younger ones below 8 years.
- (2) Many items were difficult to be understood by children because of the difficult Arabic Language as well as the long items e.g. تجيب الحظ كويس، ما بتستحملش، تتكلم كلمات معينة علشان (تبعث النحس، بتحاسب نفسك) and examples was sometimes essential to be used to make it easier for application.
- (3) It was difficult to ask children especially the young ones about their obsessional thoughts by direct questioning like ( فيه كلام أو أفكار معينة بتحس إنها بتقعد تدور وتلف فى دماغك على طول )

According to that, it was better to ask about different types of obsessions and compulsions, especially common in children, by giving more examples and direct questioning of the common symptomatology according to the previous literature to pick up any abnormality and any of the overt OCD symptomatology.

### **Development Of The New Tools**

According to the results of the pilot study, and according to the previous literature, a new symptom check-list for each of the psychiatric disorder under investigation (*anxiety, depression and OCD*) was built on by the researcher.

### **Validity and reliabilty of the new scales**

The psychomatic properties of the new symptom checklists were estimated as follows:



## **1. Validity**

### *Content validity*

After collecting the possible symptomatology of each disorder and differentiating it according to the child age, especially when assessing anxiety and depression (*OCD symptomatology was difficult to be differentiated according to age, because obsessions and rituals are part of the children development and they are more or less the same among childhood and adolescence (Rutter, 1994)*), the new symptom check-lists were given to 10 professors of psychology and psychiatry (*see appendix X*) to judge them, and either add, remove or rearrange any item that was found to be inapplicable or unsuitable.

The criterion for item selection was that the item should be judged as relevant by at least 75 % of the judges. According to this criterion, the results of judgement were collected and the proposal for change were done.

The modified scales were rejudged by 5 professors of psychology and psychiatry after doing the possible modifications. They all agreed that the new sets of items are relevant and efficient in assessing different symptoms and disorders concerned (*Anxiety, depression and OCD*).

## **2. Reliability**

Reliability of the symptom checklists with its subscales, constructed by the researcher were tested using the alpha-cronbach technique as follows:

### **a- Reliability for the anxiety symptom check-list**

Table (4-1) shows the reliability co-efficients of the anxiety symptom check-list.

**Table (4-1)**

<b>Variable</b>	<b>No. of cases</b>	<b>Reliability co-efficient</b>
- Poor friend relation.	77	0.87
- Psychosomatic Co.	77	0.72
- Sleep problems.	77	0.60
- Other neurotic symptoms.	77	0.62
- Regression symptoms.	49	0.68
- Fears in children > 12 years.	19	0.73

**b- Reliability for the depression symptom check-list**

Table (4-2): Shows the different reliability coefficients of depression symptom check-list.

**Table (4-2)**

<b>Variable</b>	<b>No. of cases</b>	<b>Reliability co-efficient</b>
- Depression 3- 6 y.	28	0.61
- Depression 6- 12 y.	30	0.77
- Depression above 12 y.	19	0.79

**c- Reliability for OC symptom check-list**

Table (4-3): shows the different reliability coefficients of the obsessive compulsive symptom check-list.

**Table (4-3)**

<b>Variable</b>	<b>No. of cases</b>	<b>Reliability co-efficient</b>
- General appearance.	77	0.70
- Counting compulsions.	77	0.63
- Bed-time rituals.	77	0.81
- Eating rituals.	77	0.79
- Cleaning obsessions & compulsions.	77	0.65
- School related rituals.	77	0.83
- Checking compulsions.	77	0.61
- Ordering-arranging compulsions.	77	0.60
- Miscellaneous obsessions.	77	0.42

All reliability coefficients were significant at (0.01) level which means that each symptom check-list is suitable for use for assessment of the disorder used for it.

**The new organized scale:**

- (1) Use as much as possible the colloquial Arabic to be easier, for understanding purposes especially for younger children.
- (2) Give examples especially for items difficult to be understood.

- (3) Ask about symptoms of different disorders directly, and this was more essential for clinical purposes.
- (4) Beside the reorganized scales for children, the international diagnostic criteria (*DSM IV*) was used for better diagnosis of different psychiatric disorders.

**The tools used will be as follows:**

As mentioned above both patients and control parents as well as their children, will be subjected to a series of tests as follows:

**I. Tests for parents**

*Both patient and control subjects (fathers or mothers), were subjected to:*

- (1) The parent evaluation sheet for collection of personal data (*Appendix I*).
- (2) The DSM IV diagnostic criteria of OCD (*Appendix IX*).
- (3) The Arabic version of the Yale-Brown obsessive compulsive scale (*Y-BOCS*) (*Appendix III*).

**II. Tests for children**

Children of both patient and control subjects, were submitted to the following:

1. Child and adolescent evaluation sheet (*Appendix II*).
2. Assessment of anxiety symptoms and disorders using:
  - a- Anxiety symptom check-list for children [*Appendix IV*].
  - b- The DSM IV diagnostic criteria for different anxiety disorders and phobias: (*Appendix VII*).
  - (1) Generalized anxiety disorder (*including over anxious disorder in children*) [*Appendix VII- A*].
  - (2) Separation anxiety [*Appendix VII-B*].
  - (3) Specific phobia [*Appendix VII- C*].
  - (4) Social phobia [*Appendix VII- D*].
  - (5) Agoraphobia [*Appendix VII-E*].

**3. Assessment of depressive symptomatology and disorders using:**

- a. Depression symptom check-list for children [*Appendix V*].
- b. The DSM IV criteria for depressive disorders: major depressive Episode [*Appendix VIII-A*] and dysthymic disorder [*Appendix VIII-B*].

**4. Assessment of obsessive compulsive symptoms, obsessional traits and obsessive compulsive disorder using:**

- a- Obsessive compulsive symptom check-list for children [*Appendix VI*].
- b- The DSM IV criteria for OCD [*Appendix IX*].

**Children Assessment Scales**

After collecting the personal data of each child, the child was subjected to a series of scales to assess anxiety, depression and obsessive compulsive–symptoms and disorders as follows:

***A. Anxiety symptom checklist for children***

Although this list is designed to be applied to children according to their age, older children have to be asked about anxiety symptoms that may appear at earlier age, as many symptoms usually arise at a younger age and continue even up to adolescence (*e.g. adolescent anxiety states have many features in common with those occurring at younger age, but there is some different symptomatology specially related to adolescence age group*).

Information has to be obtained as regard the severity of different anxiety symptoms and fear reactions, as well as the degree to which they disable the child socially. It is quiet important to mention the situations in which the anxiety is experienced and the coping mechanisms the child uses to deal with emotion when it occurs for more confirmed diagnosis.

### **1. Pre-school anxiety symptom checklist (3 to 6 years)**

**The anxiety symptoms included in the check-list were:**

- (1) Tension and worry throughout the day.
- (2) Poor peer relations.
- (3) Somatic symptoms: which include any bodily symptoms that have been thought to be participated by psychological events, or which is being maintained or prolonged by psychological factors (*e.g. vomiting, diarrhea, loss of appetite etc ...*).
- (4) Sleep problems, commonly insomnia separation difficulties at night when going to sleep, nightmares, night terrors, crying while asleep, and bed wetting.
- (5) Specific fears: They are very common in the preschool period and should be discriminated from phobias as the abnormality of fears can only be judged by its severity, persistence and the social disability produced (*If present DSM IV diagnostic criteria for specific phobias has to be applied*).
- (6) Other neurotic symptoms includes: nail biting, thumb sucking, tics, trichotillomania, general irritability and tension and temper tantrums.

### **2. Anxiety symptom checklist (above 6 to 12 years)**

Beside the symptoms commonly presented in the previous age group, the following symptoms may reflect anxiety at such age range:

- (1) Social anxiety and phobias, for example: fears of ghosts, fears of eating outside home etc... (*if present DSM IV diagnostic criteria for social phobia has to be applied*).

- (2) School phobias: by its all pictures for example, fear of the teacher, of punishment at school, fears of poor academic performance etc... (If present DSM IV diagnostic criteria for school phobia has to be applied).
- (3) Self-injury phobia.
- (4) Regression which may take the form of wetting and soiling, complete dependence on parents on daily own activities and excessive crying unrelated to the child age.
- (5) Vocal tics.

### **3. Anxiety symptom checklist (above 12 to 15 years)**

Beside the symptoms of the previous two age groups, the following are included:

- (1) Fears related to loss of friendship.
- (2) Fears of sexual unattractiveness.
- (3) Fears of the teenage personal future.
- (4) Fears about the future of the world.
- (5) Fears of death of him / her self.
- (6) Fears of death of others specially parents and others close to him.

### ***B. Depression symptom check-list for children***

The depressive symptomatology vary greatly according to the child age and so the symptoms are classified according to the child age as follows:

**(1) Depression symptom checklist (3 to 6 years)**

It includes:

- 1- Apathy, loss of energy and easy fatigue.
- 2- Flatness and emotionless.
- 3- Always feel miserable, unhappy and tearful.
- 4- Excessive crying.
- 5- Easy crying with no reason.
- 6- Excessive slowness.
- 7- Psycho-somatic complaints.
- 8- Agitation or irritable mood.
- 9- Diminished interest or pleasure in all or almost all activities.
- 10- Poor appetite.
- 11- Over eating.

**(2) Depression symptom check-list (above 6 to 12 years)**

- 1- Feel sad, unhappy or miserable and tearful.
- 2- Easy fatigue, apathy and loss of energy.
- 3- School failure.
- 4- Inattention.
- 5- Poor concentration.
- 6- Social withdrawal.
- 7- Incapacity to cope with minor frustrations.
- 8- Lack of interest in all or almost all activities.
- 9- Sleep problems (*insomnia or hypersomnia*).
- 10- Feelings of low self esteem.
- 11- Conduct problems (*e.g. stealing ... etc.*).
- 12- Guilt feelings and self-blame.
- 13- Flat emotions.
- 14- Excessive slowness (*e.g. reading, writing, eating ... etc.*).
- 15- Poor appetite.
- 16- Over eating.



**(3) Depression symptom check-list (above 12 to 15 years)**

- 1- Feel miserable, unhappy, sad and / or tearful look.
- 2- Lack of vitality and easy fatigue.
- 3- Flatness.
- 4- Poor appetite.
- 5- Overeating.
- 6- Worthlessness.
- 7- Suicidal ideas.
- 8- Suicidal attempts.
- 9- Substance abuse.
- 10- Excessive shyness.
- 11- Excessive slowness in daily activities (*e.g. studying*).

***C. Obsessive compulsive symptom Check-list***

It is subdivided into 9 main subscales

**I. General appearance**

- 1- Perfectionism and mastery.
- 2- Carelessness and slapdash.
- 3- Cleanliness and tidiness.
- 4- Excessive care about general appearance.

**II. Counting compulsions**

- 1- Ordering things (*e.g. cars, windows ... etc.*).
- 2- Ordering things more than one time.
- 3- Ordering to specific number.

**III. Bed-time rituals**

- 1- Rituals related to sleep.
- 2- If such rituals are not completed, feel a degree of anxiety and tension.

#### **IV. Eating rituals**

- 1- Special arrangement of eating utensils.
- 2- Starting eating with special behavior or word, significantly important to him.
- 3- Sitting in special place and its change lead to anxiety and tension.
- 4- Excessive worry if forget something important to him related to eating.
- 5- Use his own eating utensils only.
- 6- If others use his eating utensils lead to feelings its spoiled and unclean.

#### **V. Cleaning obsessions and compulsions**

- 1- Always, feel unclean.
- 2- Excessive hand washing.
- 3- Washing compulsions (repeated washing to prevent contamination).

#### **VI. School-rituals and compulsions**

- 1- Special arrangement of the school bag.
- 2- Repeated checking of the homework.
- 3- Studying in particular place other wise feel tense and anxious.
- 4- Studying related compulsions.

#### **VII. Checking compulsions**

- 1- Checking and double checking of the performed tasks.
- 2- Checking doors and windows.

#### **VIII. Ordering-arranging compulsions**

- 1- Arranging things in a perfect way.
- 2- Arrangement and rearrangement of things.
- 3- Putting things in specific orders (e.g. Toys).

### **IX. Miscellaneous obsessions**

- 1- Special concern about other things rather than ordering.
- 2- Spending longer time in bathroom.
- 3- Repeated questioning.
- 4- Walking rituals.
- 5- Indecisiveness.

### **The Use of DSM IV In Diagnosis of Different Disorders**

The DSM IV diagnosis is usually applied to the individual current presentation and is not typically used to denote previous diagnosis from which the individual has recovered.

The presentation of symptoms of different disorders should be described as mild, moderate or severe according to:

- 1-Intensity of the signs and symptoms of the disorder and
- 2-Any resulting impairment in occupational and / or social functioning.

*For the majority of disorders, the following guidelines may be used:*

- a. Mild:** few, if any symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairment in social or occupational functioning.
- b. Moderate:** symptoms or functional impairment between “mild” and “severe” are present.
- c. Severe:** many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

According to such criteria, severity of each disorder can be identified after the application of its diagnostic guidelines.

## Application of The Tools

### A. Way and time of application

The whole period spent for searching for cases and control subjects, as well as application of the research programme was approximately about two and half years.

Tools were applied individually on subjects. Both the parents, their children and the spouse (*or the caring relative*) were interviewed as such.

Application of the tools on each individual takes from 30-45 minutes and sometimes there was a need to reassess some cases.

At first the researcher has to introduce herself to the whole family and to the children. After brief interview with the whole family members, each of them has to be interviewed separately.

The application started with the patient group (*the OCD parents, their children and the spouse or the caring relatives*) in a structured interview. The referred OCD parents from the out patient clinics of either private clinics or of the Ain Shams University Psychiatric Clinics, were first diagnosed by the referral professional then reassessed by the researcher using the DSM IV criteria for OCD. Then, the parent evaluation sheet and the Yale- Brown obsessive compulsive scale were applied.

After interviewing the parent, each child was interviewed separately or with his / her mother if refused to stay alone with the researcher. However, data were to be collected from both the child and the mother (*or the caring relative*) for confirmation, especially with the young subjects.

## I. Application Difficulties

- 1- The most important problem of application of this research was the difficulty of searching for the OCD cases in terms of the inclusion criteria and the acceptance of the referred OCD cases to be included in the research programme.
- 2- The problem of refusal of parents to include their children in the research and to participate in the programme was the second important problem of this research.
- 3- Most of the parents or almost all of them was denying any problem related to their children, as they said "*They are Ok*" and "*They have no difficulties*". After interviewing them, many problems appeared, with marked difficulty to obtain data especially from the affected partner, usually the child or the spouse or the caring relative were more cooperative.
- 4- It was not only interviewing the child, but also confirming the data especially from the caring parent and the spouse or the relative to obtain the most valid and true results.
- 5- The problem of application on the children of young age (*3-10 years*), to make sure that the children understood the meaning of the items.
- 6- The problem of application of this research on obsessive cases who are usually so obsessive about their children that they deny the presence of any problem as regard their children.

### III. Statistical Procedures

For the purpose of testing the hypotheses of the present research (page ...), t-test and ANOVA techniques were used to compare two means of two groups. SPSS package was used for statistical analysis of data using the above techniques.

#### 1. t-test

The formulae of t-test for independent groups assuming homogeneity of variances is as follows:

$$t = \frac{M_1 - M_2}{\sqrt{\frac{\Sigma x_1^2 + \Sigma x_2^2}{N_1 + N_2 - 2} \left( \frac{N_1 + N_2}{N_1 N_2} \right)}}$$

where  $M_1$  and  $M_2$  = Means of the two samples

$\Sigma x_1^2$  and  $\Sigma x_2^2$  = Sum of squares in the two samples

$N_1$  and  $N_2$  = number of cases in the two samples

When homogeneity is not assumed the following formula is used:

$$t = \frac{M_1 - M_2}{\sqrt{\frac{V_1}{N_1} + \frac{V_2}{N_2}}}$$

Where  $V_1$  and  $V_2$  = variances of the two samples.

## 2- ANOVA

Analysis of variance was used for comparison between more than two means, between and within groups as follows:

### (1) within groups mean squares

$$(MS)_w = \frac{(SS)_w}{K(n-1)} = \frac{\sum X_s^2}{K(n-1)} = \frac{\sum X_s^2}{(N-K)}$$

where  $(SS)_w$  = within groups sum of square

$X_s$  = a deviation of an observation from its set mean

### (2) Between groups mean squares

$$(MS)_b = \frac{(SS)_b}{K-1} = \frac{n \sum d_s^2}{K-1}$$

where  $(SS)_b$  = sum of squares for between sets

$$F = \frac{\text{Between groups mean squares}}{\text{Within groups mean squares}} = \frac{(MS)_b}{(MS)_w}$$





# Results



## Results

The present study was designed to test the following hypotheses:

- 1-Children of OCD parents compared to children of control parents are at high risk for various psychiatric symptoms especially:
  - (1) Anxiety symptoms.
  - (2) Depressive symptoms.
  - (3) Obsessive compulsive symptoms.
- 2- There are differences in psychiatric symptoms between male and female children of both patient and control parents.
- 3- There are differences in different psychiatric disorders between children of OCD parents in comparison to children of normal control parents as regard their age and sex.

To test the previously stated hypotheses, data were collected using the previously described tools. The results are presented in this chapter according to the order of hypotheses.

The statistical analysis was processed using the SPSS 98 statistical programme.

***For statistical analysis purposes, the subjects were grouped as follows:***

### **1- Parent groups**

- *Parents were grouped into:*
  - Patient group parents → OCD parents (P.G. P.)
  - Control group parents → psychiatrically and organically free parents (C.G. P.)

## 2- Children groups

- *The children of the two parent groups were classified as follow:*
  - Patient group children = P\_G\_Chi
  - Control group children = C\_G\_Chi
  
- *Children of the two parent groups were divided according to their age into:*
  - Age class I = AC I = Children aged 3 to 6 years
  - Age class II = AC II = Children aged above 6 to 12 Years
  - Age class III = AC III = Children aged above 12 to 15 years
  
- *Children of the two parent groups were also divided according to their sex as follows:*
  - Female children of patient group are called [P\_F\_Chi].
  - Male children of patient group are called [P\_M\_Chi].
  - Female children of control group are called [C\_F\_Chi].
  - Male children of control group are called [C\_M\_Chi].

The following tables show the socio- demographic variables of both patient and control groups.

**Table (5-1-A)**  
**Personal data of both patient and control groups**

	P.G.P		C.G.P		T- test	
	Mean	SD	Mean	SD	t.	Sig.
*Age	38.58	6.05	38.08	3.30	0.272	0.788
*Duration of illness	10.68	6.58	0.00	0.00	5.821	0.000***
*Marital status	1.00	0.00(a)	1.00	0.00(a)	---	---
*Education	5.53	2.20	7.54	0.52	10.937	0.060
*Children age	8.43	3.88	8.43	3.62	0.001	0.977

Table (5-1-A) shows the primary descriptive analysis of personal data of parents of both groups as regard, age, duration of illness, marital status patient education and children age, the results show no statistical significance between the two groups as regard patient age, marital status, patient education and children age. The duration of illness was statistically significant, as it is higher in the patient group. The restriction of the inclusion criteria of both groups may give a plausible explanation, as most of the variables were more or less similar in both groups. As regard marital status, it was equal in both group (all cases and controls were married) and so standard deviation was 0 (no difference).

N.B.

(a) =cannot be computed because the standard deviations of both groups are 0

\* = significant at 0.05 level

\*\* = significant at 0.01 level

\*\*\* = significant at 0.001 level

As regard the total number of children in both patient and control groups table (5-1-B) shows their more or less equality in number as regard their age and sex.

**Table (5-1-B)**  
**Male children of both OCD and control parents**

Age class	P-M-Chi	C-M-Chi	Total
Ac I	7	4	11
AC II	6	9	15
AC III	4	5	9
Total	17	18	35

**Female children of both OCD and control parents**

Age class	P-F-Chi	C-F-Chi	Total
AC I	10	7	17
AC II	9	6	15
AC III	6	4	10
Total	25	17	42

**Table (5-1-C)**  
**Differences between the patient and control parents**  
**as regard general home atmosphere**

Home atmosphere	P.G.P.		C.G.P		T- Test	
	Mean	SD	Mean	SD	t.	Sig.
* Harmonious	0.26	0.45	0.69	0.48	-2.571	0.015**
* Quarrelsome	0.37	0.50	0.00	0.00	2.666	0.012**
* Cold	0.05	0.32	0.00	0.00	0.823	0.417
* Competitive	0.00	0.00(a)	0.00	0.00(a)	---	---
* Overprotection	0.21	0.42	0.15	0.38	0.392	0.698
* Warm	0.11	0.32	0.38	0.51	-1.927	0.063
* Over criticism	0.21	0.42	0.00	0.00	1.803	0.081
* Over involvement	0.11	0.32	0.07	0.28	0.262	0.795
* Communications	0.05	0.23	0.00	0.00	0.823	0.417
* Exclusions	0.05	0.23	0.00	0.00	0.823	0.417

Table (5-1-C) shows the descriptive statistics and t-test of different types of general home atmospheres that may passively affect children upbringing.

The two groups showed significant difference between the 1<sup>st</sup> and 2<sup>nd</sup> types of home atmospheres where, the OCD parents were less harmonious and more quarrel compared to the control group parents.

**Table (5-1-D)**  
**Different patterns of parental management of children of**  
**both patient and control parents**

Parental Pattern	P.G.P		C.G.P		T. test	
	Mean	S.D	Mean	S.D	t.	Sig.
* Positive interaction	0.37	0.50	0.92	0.28	-3.651	0.001***
* Parental level of criticism	0.47	0.51	0.15	0.38	1.919	0.064
* Hostility	0.00	0.00(a)	0.00	0.00(a)	---	---
* Rejection	0.11	0.32	0.00	0.00	1.197	0.241
* Isolated parent	0.21	0.42	0.00	0.00	1.803	0.081
* Overprotection	0.37	0.50	0.00	0.00	2.666	0.012**
* Sharing attitudes towards child problem	0.42	0.51	0.77	0.44	-2.011	0.053*

Table (5-1-D) shows the significant difference between the two groups as the OCD parents were less interactive with their children, more over protective and showed less sharing with their spouses as regard various children problems compared to the control parents.

**Table (5-1-E)**  
**The statistical difference between patient and control  
 parents in the Yale-Brown obsessive compulsive scale  
 (Y-BOCS)**

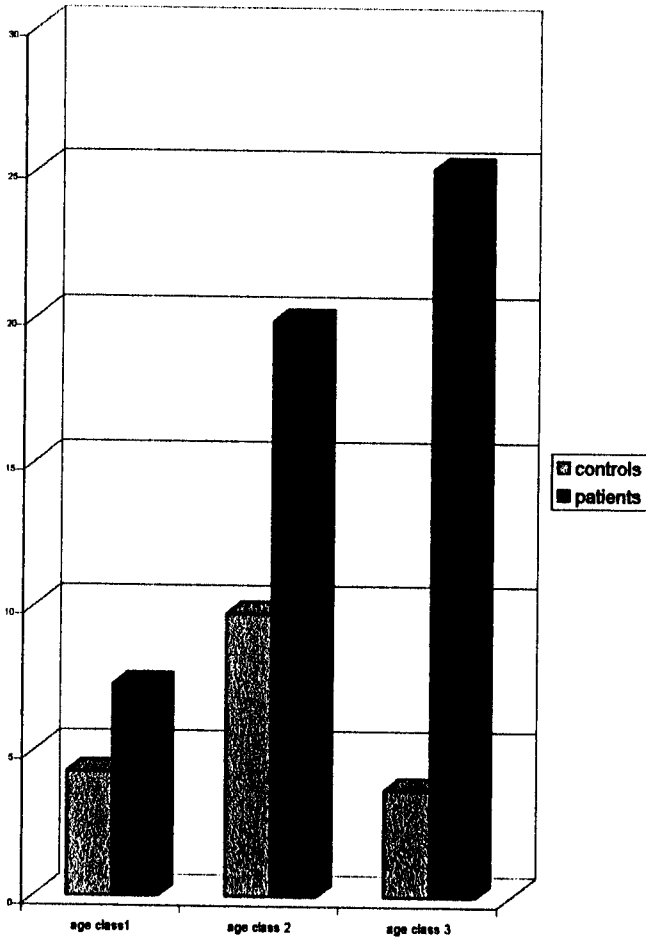
Items	P.G.P		C. G.P		T. test	
	Mean	S.D	Mean	S.D	t.	Sig.
*Aggressive obsessions.	7.11	6.43	0.77	1.74	3.452	0.002***
* Contamination obsessions.	10.89	6.85	2.77	2.45	4.081	0.000***
* Misc. obsessions.	9.74	6.85	3.15	2.38	3.315	0.002***
* Somatic obsessions.	2.84	2.29	0.69	0.95	3.188	0.003***
* Cleaning washing obsessions.	7.68	5.21	0.23	0.83	5.091	0.000***
*Checking compulsions.	5.37	3.76	0.69	1.38	4.274	0.000***
* Repeating rituals.	1.74	1.73	0.38	0.96	2.557	0.016**
*Counting compulsions.	1.37	1.38	0.00	0.00	3.549	0.001***
* Ordering arranging compulsions.	1.37	1.50	0.00	0.00	3.275	0.003***
* Sexual obsessions.	1.37	3.35	0.00	0.00	1.464	0.154
* Hoarding saving obsessions.	0.53	1.07	0.15	0.55	1.147	0.261
*Religious obsessions.	3.63	2.22	0.15	0.55	5.514	0.000***
* Symmetry and exactness obsessions.	3.26	2.23	0.15	0.55	4.896	0.000***
* Hoarding collecting compulsions.	0.26	0.81	0.00	0.00	1.172	0.251
*Misc. compulsions	4.21	3.71	0.77	1.24	3.214	0.003***

OCD parents scored significant level among all the scale items except the recording of sexual obsessions, the hoarding- saving obsessions and the hoarding-collecting compulsions which showed no significant difference between the two groups and this shows how the research was very restricted in collecting cases and application of the research criteria. (Table 5-1-E).





### Anxiety symptoms according to child age



When children of both OCD and control parents were considered, the following tables summarize the difference anxiety, depression and obsessive compulsive symptoms and disorders reported among them.

### **I- Anxiety symptoms and disorders.**

Anxiety symptoms and disorders. Were analyzed according to the organized symptom checklist and the DSM IV criteria for different anxiety disorders as follows:-

#### **A- Anxiety symptoms according to child age.**

The following tables will present different anxiety symptoms according to age and the symptom checklist used for collection of data.

**Table (5- 2)**  
**Anxiety symptoms among children of both patient and control groups according to age.**

Age Class	P_G_Chi		C_G_Chi		t-Test	
	Mean	SD	Mean	SD	T	Sig.
AC I	7.294	10.947	4.273	3.438	0.882	0.386
AC II	19.867	12.586	9.733	8.276	2.605	0.015**
AC III	25.100	12.279	3.667	4.416	5.162	0.000***

Table (5- 2) shows the presence of anxiety symptoms among children of the OCD parents group with significant presence among the 2<sup>nd</sup> and 3<sup>rd</sup> age groups.

Table (5-3-A) Anxiety symptoms in the first age group

Item	P_G_Chi		C_G_Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
1. Tension and worry through out the day.	0.65	1.00	0.09	0.30	3.199	0.085
2. poor peer relationship.	1.059	2.861	0.000	0.000	1.487	0.234
<b>3. Psycho somatic symptoms.</b>						
(1) Vomiting.	0.24	0.75	0.36	0.92	0.162	0.690
(2) Colic.	0.12	0.49	0.09	0.30	0.027	0.872
(3) Diarrhea.	0.24	0.75	0.09	0.30	0.363	0.552
(4) Constipation.	0.12	0.49	0.09	0.30	0.027	0.872
(5) Loss of appetite.	0.47	1.07	0.09	0.30	1.308	0.263
(6) Head ache.	0.00	0.00	0.00	0.00	---	---
(7) Sweating.	0.00	0.00	0.00	0.00	---	---
(8) Palpitation.	0.00	0.00	0.00	0.00	---	---
<b>4. sleep problems</b>						
(1) Insomnia.	0.47	1.01	0.00	0.00	2.369	0.136
(2) Awake and search for mother.	0.47	1.07	0.45	1.04	0.002	0.969
(3) Crying while asleep.	0.18	1.53	0.18	0.60	0.001	0.980
(4) Awake in panic.	0.35	0.86	0.00	0.00	1.820	0.189
(5) Night- mares.	0.05	0.24	0.18	0.40	1.019	0.322
(6) Night terrors.	0.24	0.75	0.18	0.60	0.039	0.845
(7) Bed wetting.	0.24	0.75	0.09	0.30	0.363	0.552
(8) Hypersomnia.	0.12	0.49	0.00	0.00	0.638	0.432
5. Specific phobia.	0.82	1.33	0.45	1.04	0.603	0.444
<b>6. Other neurotic symptoms.</b>						
(1) Nail biting.	0.00	0.00	0.36	0.81	3.508	0.072
(2) Thumb sucking.	0.00	0.00	0.27	0.90	1.579	0.220
(3) Tics.	0.00	0.00	0.00	0.00	---	---
(4) Trichotillomania.	0.12	0.49	0.00	0.00	0.638	0.432
(5) Irritability and tension.	0.71	1.05	0.91	1.14	0.236	0.631
(6) Temper tantrums.	0.65	1.06	0.40	0.70	0.431	0.517

Table (5-3-A) shows the absence of significant difference in anxiety symptoms among children of the first age group of both patient and control parents of children.

**Table (5-3-B)**  
**Anxiety symptoms among children of the second age group.**

Item	P G Chi		C G Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
1. Tension and worry throughout the day	1.13	0.92	0.13	0.35	15.594	0.000***
2. Poor peer relationship.	0.733	2.840	0.7333	1.579	0.000	1.000
<b>3. Psycho somatic symptoms.</b>						
(1) Vomiting	0.20	0.56	0.27	0.59	0.100	0.754
(2) Colic	0.60	1.12	0.47	0.74	0.147	0.704
(3) Diarrhea	0.20	0.56	0.13	0.35	0.152	0.699
(4) Constipation	0.06	0.26	0.47	0.92	2.653	0.155
(5) Loss of appetite	1.60	1.24	0.67	1.18	4.469	0.04*
(6) Headache	0.40	0.91	0.53	0.99	0.147	0.704
(7) Sweating	0.27	0.80	0.20	0.77	0.054	0.818
(8) Palpitation	0.47	1.06	0.06	0.26	2.016	0.167
<b>4. Sleep problems</b>						
(1) Insomnia	0.40	0.91	0.27	0.80	0.182	0.673
(2) Awake searching for mother	0.73	1.28	0.13	0.52	2.835	0.103
(3) Crying while asleep	0.27	0.80	0.00	0.00	1.672	0.207
(4) Awake in panic	0.47	1.06	0.00	0.00	2.907	0.099
(5) Night-mares	1.00	1.31	0.13	0.35	6.130	0.020*
(6) Night terrors	0.27	0.70	0.00	0.00	2.154	0.153
(7) Bed wetting	0.53	1.13	0.27	0.70	0.605	0.443
(8) Hypersomnia	0.27	0.70	0.00	0.00	2.154	0.153
5. Specific phobias	2.00	1.46	0.87	1.30	5.020	0.033*
<b>6. Other neurotic symptoms</b>						
(1) Nail biting	0.20	0.77	0.00	0.00	1.000	0.326
(2) Thumb sucking	0.00	0.00	0.00	0.00	----	----
(3) Tics	0.00	0.00	0.00	0.00	----	----
(4) Trichotillomania	0.00	0.00	0.00	0.00	----	----
(5) Irritability and tension	1.67	1.45	0.73	0.96	4.328	0.047*
(6) Temper tantrums	1.67	1.45	0.73	0.96	4.328	0.047*
7. Social fears and with drawl	0.73	1.10	0.53	0.74	0.341	0.564
8. School phobias	1.93	1.28	1.40	1.18	1.404	0.246
9. Self injury phobia	0.73	1.28	0.20	0.77	1.906	0.178
<b>10. Regression.</b>						
(1) Bed wetting and soiling.	0.53	1.13	0.27	0.70	0.605	0.443
(2) Complete dependence on parents.	1.00	1.31	0.20	0.41	5.091	0.032*
(3) Crying in unsuitable situations.	1.33	1.50	0.20	0.41	7.996	0.009***
11. Vocal tics.	0.00	0.00	0.00	0.00	---	---

Table (5-3-B) shows the presence of anxiety symptoms among children of OCD parents of the second age group with significant presence of tension and worry all over the day, psychosomatic loss of appetite, night mares, specific phobias, irritability and tension, temper tantrums and regression.

**Table (5-3-C)**  
**Anxiety symptoms among children of the third age group.**

Item	P chi group		C chi group		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
<b>1. Tension And Worry throughout The Day</b>	<b>1.80</b>	<b>1.03</b>	<b>0.33</b>	<b>0.71</b>	<b>12.737</b>	<b>0.002***</b>
<b>2. Poor Peer Relationship.</b>	<b>1.500</b>	<b>2.068</b>	<b>0.667</b>	<b>2.000</b>	<b>0.793</b>	<b>0.386</b>
<b>3. Psycho Somatic Symptoms</b>						
(1) Vomiting	0.40	0.84	0.00	0.00	2.013	0.174
(2) Colic	0.20	0.63	0.00	0.00	0.895	0.357
(3) Diarrhea	0.20	0.63	0.00	0.00	0.895	0.357
(4) Constipation	0.30	0.67	0.22	0.67	0.064	0.804
(5) Loss Of Appetite	0.20	0.63	0.22	0.67	0.006	0.941
(6) Headache	0.50	0.85	0.00	0.00	3.096	0.096
(7) Sweating	0.10	0.32	0.00	0.00	0.895	0.357
(8) Palpitation	0.10	0.32	0.00	0.00	0.895	0.357
<b>4. Sleep Problems</b>						
(1) Insomnia	1.20	1.40	0.00	0.00	6.589	0.020*
(2) Awake Searching For mother.	0.60	1.07	0.11	0.33	1.705	0.209
(3) Crying While Asleep	0.60	1.07	0.00	0.00	2.787	0.113
(4) Awake In Panic	0.40	0.97	0.00	0.00	1.534	0.232
(5) Night-Mares	1.00	1.15	0.00	0.00	6.711	0.019**
(6) Night Terrors	0.50	0.85	0.00	0.00	3.097	0.096
(7) Bed Wetting	0.10	0.32	0.00	0.00	0.895	0.357
(8) HyperSomnia	1.20	1.55	0.00	0.00	5.368	0.033*
<b>5. Specific Phobias</b>	<b>2.10</b>	<b>1.29</b>	<b>0.22</b>	<b>0.67</b>	<b>15.385</b>	<b>0.001***</b>
<b>6. Other Neurotic Symptoms</b>						
(1) Nail Biting	0.60	1.26	0.00	0.00	2.013	0.174
(2) Thumb Sucking	0.00	0.00	0.00	0.00	----	----
(3) Tics	0.20	0.63	0.00	0.00	0.895	0.537
(4) Trichotillomania	0.60	1.07	0.00	0.00	2.787	0.113
(5) Irritability And Tension	1.30	1.34	0.22	0.67	4.759	0.043*
(6) Temper Tantrums	1.10	0.14	0.22	0.67	2.763	0.115
<b>7. Social Fears And With Drawl</b>	<b>0.40</b>	<b>0.70</b>	<b>0.33</b>	<b>0.71</b>	<b>0.043</b>	<b>0.839</b>
<b>8. School Phobias</b>	<b>1.90</b>	<b>1.37</b>	<b>0.44</b>	<b>0.88</b>	<b>7.378</b>	<b>0.015**</b>
<b>9. Self Injury Phobia</b>	<b>0.90</b>	<b>1.29</b>	<b>0.00</b>	<b>0.00</b>	<b>4.378</b>	<b>0.052*</b>
<b>10. Regression</b>						
* Bed wetting and soiling	0.00	0.00	0.00	0.00	----	----
* Complete dependence on parents	0.90	1.29	0.00	0.00	4.378	0.052*
* Excessive crying in unsuitable situations	0.40	0.97	0.11	0.33	0.723	0.407
<b>11. Vocal tics</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>----</b>	<b>----</b>
<b>12. Fears of friendship loss</b>	<b>0.30</b>	<b>0.67</b>	<b>0.22</b>	<b>0.67</b>	<b>0.064</b>	<b>0.804</b>
<b>13. Fears of sexual unattractiveness</b>	<b>0.40</b>	<b>0.52</b>	<b>0.00</b>	<b>0.00</b>	<b>5.368</b>	<b>0.033*</b>
<b>14. Fears of teenage personal future</b>	<b>0.70</b>	<b>0.82</b>	<b>0.22</b>	<b>0.67</b>	<b>1.904</b>	<b>0.186</b>

Item	P_G_Chi		C_G_Cji		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
<b>15. Fears about future of the world.</b>	<b>0.10</b>	<b>0.32</b>	<b>0.11</b>	<b>0.33</b>	<b>0.006</b>	<b>0.941</b>
<b>16. Fears of death.</b>	<b>0.80</b>	<b>1.14</b>	<b>0.00</b>	<b>0.00</b>	<b>4.443</b>	<b>0.050*</b>
<b>17. Fears of death of others.</b>	<b>1.50</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>9.764</b>	<b>0.006***</b>

Table (5-3-C) shows the presence of anxiety symptoms among children of OCD parents more than the children of the control parents with significant presence of tension and worry throughout the day, insomnia, night mares, HyperSomnia, specific phobias, irritability and tension, school phobias, self injury phobia, complete dependence on parents, fears of sexual unattractiveness, fears of death and fears of death of others (especially the mother) among the patient group children.



## **B- anxiety symptoms according to child sex**

Anxiety symptoms were analyzed according to children age and sex of both groups as follows:

**Table (5-4-A)**

**Anxiety symptoms between male children of both patient and control groups according to age**

Age Class	P_M_Chi		C_M_Chi		T- Test	
	Mean	SD	Mean	SD	t.	Sig.
AC I	6.429	5.287	2.750	2.062	1.311	0.222
AC II	23.833	15.562	6.111	5.947	3.137	0.008***
AC III	23.250	14.009	5.200	5.586	2.665	0.032*

**Table (5-4-B)**

**Anxiety symptoms among female children of both patient and control groups according to age**

Age Class	P_F_Chi		C_F_Chi		T- Test	
	Mean	SD	Mean	SD	t.	Sig.
AC I	7.900	13.908	5.143	3.891	0.595	0.564
AC II	17.222	10.305	15.167	8.727	0.401	0.695
AC III	26.333	12.209	1.750	1.258	3.933	0.004***

According to the anxiety symptoms checklist, anxiety symptoms were significantly present among children of OCD parents especially male children of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups as well as females of the 3<sup>rd</sup> age group

**Table (5-5-A)**  
**Sleep problems among patient and control male children**

Age Class	P_M_Chi		C_M_Chi		T-Test	
	Mean	SD	Mean	SD	t.	Sig.
AC I	1.571	2.299	1.000	0.817	0.471	0.649
AC II	6.167	2.483	0.333	0.707	5.604	0.002***
AC III	4.000	1.155	0.200	0.447	6.219	0.004***

**Table (5-5-B)**  
**Sleep problems among patient and control female children**

Age Class	P_F_Chi		C_F_Chi		T-Test	
	Mean	SD	Mean	SD	t.	Sig.
AC I	2.500	4.577	1.143	1.215	0.894	0.391
AC II	2.444	2.920	1.500	1.643	0.715	0.487
AC III	6.667	4.457	0.000	0.000	3.664	0.015**

Tables (5-5-A) and (5-5-B) show the presence of significant sleep problems among children of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups. Such problems were much more prominent between males of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups followed by the female of the 3<sup>rd</sup> age group.

**Table (5-6-A)**  
**Neurotic symptoms among patient and control children of various age groups**

Age class	P_Chi_G		C_Chi_G		T- Test	
	Mean	SD.	Mean	SD.	t.	Sig.
AC I	1.471	2.239	1.909	2.343	-0.497	0.623
AC II	3.533	3.182	1.467	1.885	2.164	0.041*
AC III	3.800	3.765	0.444	1.333	2.640	0.022**

**Table (5-6-B)**  
**Neurotic symptoms among patient and control male children**

Age class	P M Chi		C M Chi		T- Test	
	Mean	SD.	Mean	SD.	t.	Sig.
AC I	2.714	2.215	0.500	1.000	1.861	0.096
AC II	4.166	3.601	0.333	1.000	2.543	0.047*
AC III	4.500	3.873	0.800	1.789	1.919	0.096

**Table(5-6-C)**  
**Neurotic symptoms among patient and control female children**

Age Class	P F Chi		C F Chi		T- Test	
	Mean	SD.	Mean	SD.	t.	Sig.
AC I	0.600	1.897	2.714	2.564	-1.961	0.069
AC II	3.111	3.019	3.167	1.602	-0.046	0.964
AC III	3.333	3.983	0.000	0.000	2.050	0.096

Neurotic symptoms (e.g. nail biting, thumb sucking, tics, irritability and tension, temper tantrums) were significantly present between patient children of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups. Such neurotic symptoms were more significant among males of the 2<sup>nd</sup> age group. (Table 5-6-A, B and C).

**Table (5-7-A)**  
**Regression between male children of various age groups**

Age Class	P M Chi		C M Chi		T- Test	
	Mean	SD.	Mean	SD.	t.	Sig.
AC II	3.000	2.757	0.111	0.333	2.54	0.050*
AC III	1.250	1.500	0.200	0.447	1.353	0.258

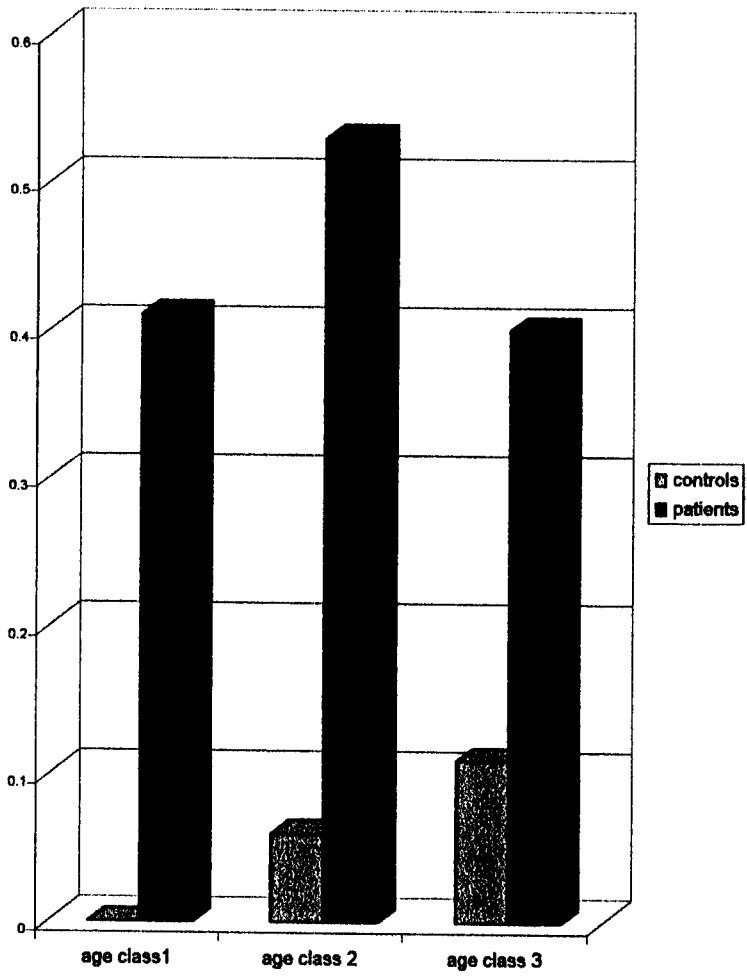
**Table (5-7-B)**  
**Regression between female children of various age groups**

Age class	P_F_Chi		C_F_Chi		T- Test	
	Mean	SD.	Mean	SD.	t.	Sig.
AC II	2.778	3.270	1.500	1.975	0.853	0.409
AC III	1.333	2.422	0.000	0.000	1.348	0.235

Tables (5-7-A) and (5-7-B) show the significant presence of regression symptomatology between children of OCD parents of the 2<sup>nd</sup> age group especially male children (Table 5-7-A).



### Separation anxiety disorder according to age



## **C- Anxiety disorders according to DSM IV criteria**

Many anxiety disorders were assessed especially separation anxiety, generalized anxiety disorder (including over anxious disorder of children), specific phobias, school phobias, agoraphobia and social phobia, they will be presented according to both child age and sex.

### **1-Separation anxiety disorder**

Separation anxiety disorder were significantly present among children of OCD parents as follows:

**Table (5-8-A)**  
**Separation anxiety among children of various groups according to DSM IV**

Age class	P_G_Chi		C_G_Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
AC I	0.41	0.62	0.00	0.00	4.812	0.037*
AC II	0.53	0.83	0.06	0.26	4.287	0.048*
AC III	0.40	0.52	0.11	0.33	2.043	0.171

**Table (5-8-B)**  
**Separation anxiety according to child age and sex**

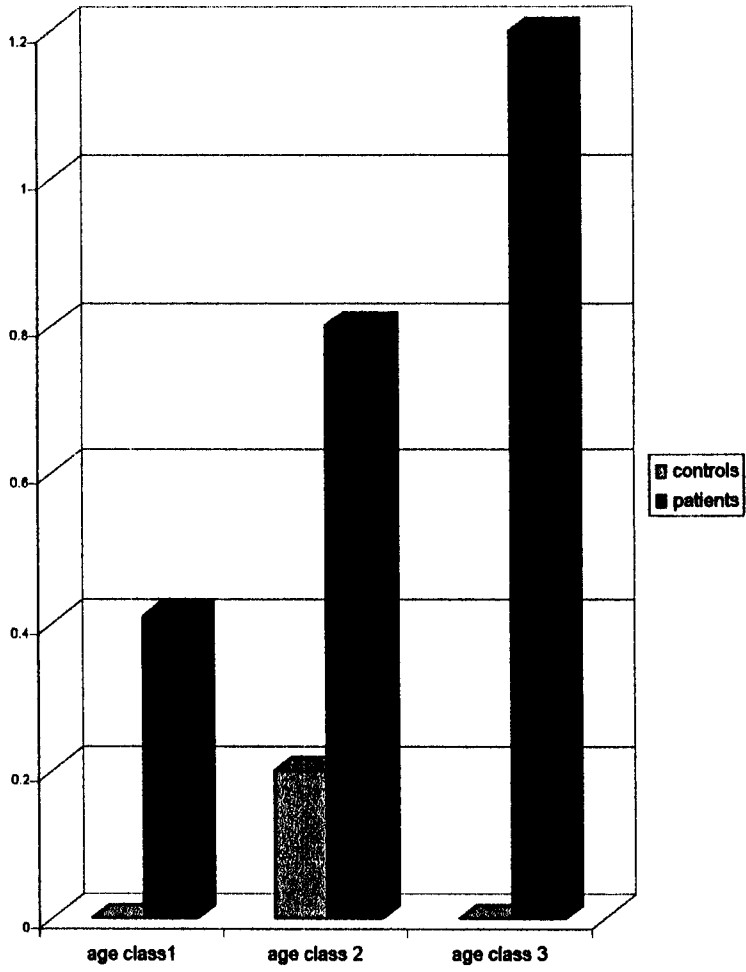
Age class	Sex	P G Chi		C G Chi		ANOVA	
		Mean	SD	Mean	SD	F.	Sig.
Ac I	Male	0.29	0.49	0.00	0.00	1.309	0.282
Ac I	Female	0.50	0.71	0.00	0.00	3.431	0.084
Ac II	Male	0.83	0.98	0.11	0.33	4.266	0.059*
Ac II	Female	0.33	0.71	0.00	0.00	1.300	0.275
Ac III	Male	0.25	0.50	0.20	0.45	0.025	0.879
Ac III	Female	0.50	0.55	0.00	0.00	3.200	0.111

Table (5-8-A) and (5-8-B) show the significant presence of separation anxiety among children of OCD parents compared to children of control parents. Separation anxiety were more significant among children of the 1<sup>st</sup> and 2<sup>nd</sup> age groups and was not significant among the 3<sup>rd</sup> age group. Male children of OCD parents belonging to the 2<sup>nd</sup> age group significantly reported such disorder.





**GAD according to child age**



## 2- Generalized anxiety disorder (Including over anxious disorder in children)

Generalized anxiety disorder as a diagnosis were significantly present among children under investigation as follows:

**Table (5-9-A)**  
**GAD among children of patient and control Subjects**

Age Class	P_G_Chi		C_G_Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
All children	0.74	0.80	0.085	0.28	21.114	0.000***
AC I	0.41	0.71	0.00	0.00	3.627	0.068
AC II	0.80	0.77	0.20	0.41	7.000	0.013**
AC III	1.20	0.79	0.00	0.00	20.707	0.000***

**Table (5-9-B)**  
**GAD according to child age and sex**

Age Class	Sex	P_G_Chi		C_G_Chi		ANOVA	
		Mean	SD	Mean	SD	F.	Sig.
Ac I	Male	0.29	0.76	0.00	0.00	0.545	0.479
Ac I	Female	0.50	0.71	0.00	0.00	3.431	0.084
Ac II	Male	0.50	0.55	0.11	0.33	2.963	0.109
Ac II	Female	1.00	0.87	0.33	0.52	2.836	0.116
Ac III	Male	1.25	0.96	0.00	0.00	8.838	0.021*
Ac III	Female	1.17	0.75	0.00	0.00	9.224	0.016**

Tables (5-9-A) and (5-9-B) Show the statistically significant difference of generalized anxiety as a disorder between patient and control children groups especially among children of the second and the third age groups. The sex difference was not significant except for the children of the 3<sup>rd</sup> age group, as both sexes experienced such disorder, with slightly more significance among females.

### 3- Specific phobia

Such diagnosis were present among children under investigation. The following tables will show its significance.

**Table (5-10-A)**  
**Specific phobias among Children all groups**

Age class	P G Chi		C G Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
All children	1.55	1.47	0.57	1.09	10.579	0.002***
AC I	0.82	1.33	0.45	1.04	0.603	0.444
AC II	2.00	1.46	0.87	1.30	5.020	0.033*
AC III	2.10	1.29	0.22	0.67	15.385	0.001***

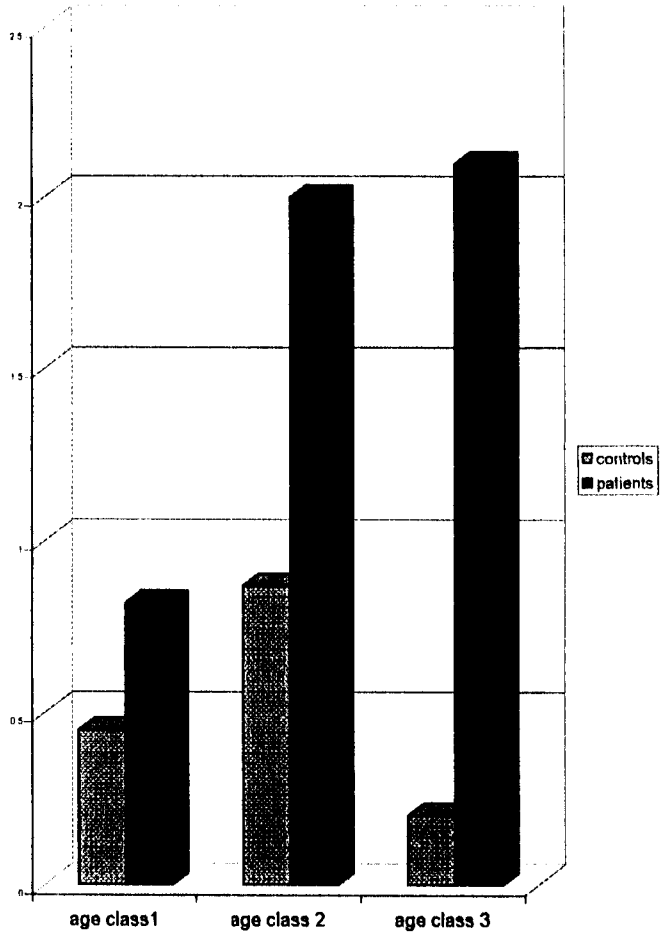
**Table (5-10-B)**  
**Specific phobias according to child age and sex**

Age class	Sex	P_G_Chi		C_G_Chi		ANOVA	
		Mean	SD	Mean	SD	F.	Sig.
Ac I	Male	0.71	1.25	1.25	1.50	0.406	0.540
Ac I	Female	0.90	1.45	0.00	0.00	2.647	0.125
Ac II	Male	2.50	1.22	0.56	1.13	9.984	0.008***
Ac II	Female	1.67	1.58	1.33	1.51	0.166	0.690
Ac III	Male	2.00	1.41	0.00	0.00	10.370	0.015**
Ac III	Female	2.17	1.33	0.50	1.00	4.507	0.067

Table (5-10-A) and (5-10-B) Show the presence of specific phobia as a diagnosis among children of OCD parents. It was more present among the 3<sup>rd</sup> age group ( above 12 years) followed by those of the 2<sup>nd</sup> age group (6- 12 years) compared to normal controls. Specific phobias were more prevalent among males of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups.



### Specific phobia according to age



**Table (5-11-A)**  
**School phobia among the second and the third age groups**

Age	P G Chi		C G Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
All children	1.92	1.32	1.09	1.16	5.223	0.027*
AC II	1.93	1.28	1.40	1.18	1.404	0.246
AC III	1.90	1.37	0.44	0.88	7.378	0.015**

**Table (5-11-B)**  
**School phobia according to child age and sex**

Age Class	Sex	P G Chi		C G Chi		ANOVA	
		Mean	SD	Mean	SD	F.	Sig.
Ac II	Male	1.33	1.51	1.22	1.30	0.023	0.881
Ac II	Female	2.33	1.00	1.67	1.03	1.560	0.234
Ac III	Male	2.00	1.41	0.40	0.89	4.329	0.076
Ac III	Female	1.83	1.47	0.50	1.00	2.467	0.155

Table (5-11-A) and (5- 11-B) show the significant presence of school phobia among children of OCD parents with specific significance among children of the 3<sup>rd</sup> age group. Such disorders has no sex difference between both groups.

#### **4- Other phobias**

Other phobias such as agoraphobia and social phobia were absent between children under investigation as follows.

**Table (5-12)**  
**Agoraphobia among children of both groups**

Age Class	P G Chi		C G Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
AC I	0.00	0.00	0.00	0.00	---	---
AC II	0.00	0.00	0.00	0.00	---	---
AC III	0.00	0.00	0.00	0.00	---	---

**Table (5-13)**  
**Social phobia among children of both groups**

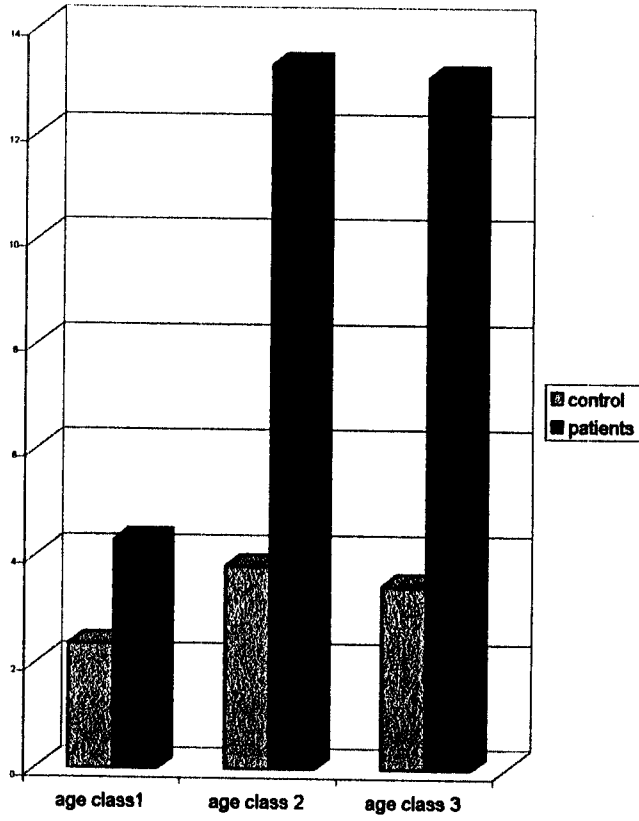
Age Class	P G Chi		C G Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
AC I	0.00	0.00	0.00	0.00	---	---
AC II	0.00	0.00	0.00	0.00	---	---
AC III	0.00	0.00	0.00	0.00	---	---

Tables (5-12) & (5-13) show the complete absence of social phobia and agoraphobia as diagnoses among children of both patient and control parents.





### Depressive symptoms according to age



## **II. Depressive symptoms and disorders.**

Depressive symptoms and disorders were analyzed according to the depression symptom checklist for children and the DSM IV criteria for different depressive disorders as follows:

### **A- Depressive symptoms according to age.**

In the following tables depressive symptoms were analyzed according to the symptoms checklist and children age as follows:

**Table (5-14)**  
**Depressive symptoms among children of both patient and control groups according to age.**

Age Class	P_G_Chi		C_G_Chi		T- Test	
	Mean	SD	Mean	SD	t.	Sig.
Ac I	4.294	4.180	2.364	3.472	1.272	0.215
Ac II	13.333	6.433	3.800	4.411	4.734	0.000***
Ac III	13.100	5.216	3.444	2.963	4.881	0.000***

Depressive symptoms were significantly present among children of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups (table (5-14)).

**Table (5-15-A)**  
**Depressive symptoms among children of the first age group.**

Item	P G Chi		C-G Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
1- Easy Fatigue.	0.24	0.75	0.09	0.30	0.363	0.552
2- Flat emotions.	0.12	0.49	0.00	0.00	0.638	0.432
3- Feel miserable.	0.29	0.85	0.00	0.00	0.303	0.264
4- Excessive crying.	0.41	0.94	0.45	1.04	0.013	0.911
5- Crying with no reason.	0.59	1.12	0.36	0.81	0.329	0.571
6- Excessive slowness.	0.71	1.16	0.36	0.67	0.780	0.385
7- Psychosomatic complains.	0.24	0.75	0.00	0.00	1.061	0.312
8- Agitation and irritable mood.	0.88	1.27	0.73	1.10	0.110	0.743
9- Loss of interest of beloved daily activities.	0.00	0.00	0.00	0.00	---	---
10- Poop appetite.	0.82	1.33	0.36	0.81	1.049	0.315
11- Over eating.	0.00	0.00	0.00	0.00	---	---

Table (5-15-A) shows the presence of depressive symptoms among children of OCD parents of the first age group but the difference between them and the control children was insignificant.

**Table (5-15-B)**  
**Depressive symptoms among children of the**  
**second age group.**

Item	P_G_Chi		C_G_Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
1- Feel unhappy, miserable and fearful.	1.13	0.92	0.00	0.00	22.989	0.000***
2- Easy fatigue.	1.73	1.22	0.27	0.59	17.464	0.000***
3- School failure.	0.066	0.26	0.13	0.35	0.350	0.559
4- Inattention.	1.60	1.35	0.40	0.83	8.591	0.007***
5- Poor concentration.	1.67	1.35	0.33	0.62	12.174	0.002***
6- Social withdrawal.	0.27	0.80	0.20	0.56	0.070	0.793
7- Lack of coping with minor frustrations.	0.47	1.06	0.00	0.00	2.907	0.099
8- Lack of Interest of daily activities.	0.33	0.90	0.00	0.00	2.059	0.162
9- Insomnia or hypersomnia.	0.47	0.99	0.20	0.77	0.675	0.418
10- Low self esteem.	0.93	1.22	0.73	1.16	0.211	0.650
11- Conduct problems.	0.33	0.90	0.00	0.00	2.059	1.621
12- Guilt feeling and self blame.	0.53	1.13	0.27	0.59	0.659	0.424
13- Flat emotions.	0.33	0.90	0.00	0.00	2.059	0.162
14- Excessive slowness.	1.47	1.30	0.33	0.90	7.692	0.010**
15- Poor appetite.	1.60	1.24	0.67	1.18	4.469	0.044*
16- Over eating.	0.40	1.06	0.27	0.70	0.166	0.687

Table (5-15-B) shows the presence of depressive symptoms more among children of OCD parents with significant emphasis of the following symptoms:

- Feeling unhappy and miserable.
- Easy fatigue, apathy and loss of energy.
- Inattention.
- Poor concentration.
- Excessive slowness.
- Poor appetite.

**Table (5-15-C)**  
**Depressive symptoms among children of the third age group.**

Item	P-G Chi		C-G Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
1- Feel miserable, unhappy and tearful.	1.60	1.07	0.11	0.33	15.813	0.001***
2- Easy Fatigue.	2.20	1.03	0.44	0.73	17.955	0.001***
3- Flat emotions.	1.50	1.35	0.22	0.67	6.556	0.020*
4- Poor appetite.	1.50	1.43	0.89	1.17	1.023	0.326
5- Over eating.	0.30	0.95	0.22	0.67	0.042	0.840
6- Worthlessness.	1.50	1.43	0.00	0.00	9.794	0.006***
7- Suicidal ideas.	0.60	0.97	0.00	0.00	3.451	0.081
8- Suicidal attempts.	0.10	0.32	0.00	0.00	0.895	0.357
9- Substances abuse.	0.30	0.67	0.00	0.00	1.768	0.201
10- Excessive shyness.	1.70	1.16	1.00	1.12	1.785	0.199
11- Excessive slowness.	1.80	1.14	0.56	0.88	6.997	0.017*

Table (5-15-C) shows the presence of depressive symptomatology among children of OCD parents more than control parents do with significant presence of the following symptoms:

- Feeling miserable and unhappy.
- Easy fatigue and loss of energy.
- Flat emotions.
- Worthlessness.
- Excessive slowness.

## **B- Depression symptoms according to child sex**

The following tables show the difference between patient and control group children in the depressive symptoms according to age and sex.

**Table (5-16-A)**

**Depressive symptoms between male children of both patient and control groups according to age.**

Age Class		P M Chi		C M Chi		T- Test	
		Mean	SD	Mean	SD	t.	Sig.
Ac	I	5.143	3.716	0.250	0.500	3.430	0.013**
Ac	II	12.833	6.735	1.889	2.804	3.768	0.009***
Ac	III	14.250	4.113	3.200	3.962	4.090	0.005***

**Table (5-16-B)**

**Depressive symptoms among female children of both patient and control groups according to age.**

Age Class		P F Chi		C F Chi		T- Test	
		Mean	SD	Mean	SD	t.	Sig.
Ac	I	3.700	4.572	3.571	3.910	0.060	0.953
Ac	II	13.667	6.614	6.667	5.047	2.192	0.047*
Ac	III	12.333	6.089	3.750	1.500	2.714	0.027*

Table (5-16-A) Shows the significant presence of depressive symptoms among males of the OCD parents of all age groups. On the other hand females of the OCD parents showed such symptoms among the 2<sup>nd</sup> and 3<sup>rd</sup> age groups only (Table 5-16-B).

## C- depressive disorders according to DSM criteria.

As regard depressive disorders, the following tables show its presence among children under investigation.

### 1-Dysthymia

Dysthymia as a diagnosis was significantly present among children under investigations. The following tables will show such results.

**Table (5-17-A)**

**Dysthymia among children of both groups according to age.**

Age Class	P G Chi		C G Chi		T- Test	
	Mean	SD	Mean	SD	T.	Sig.
Ac I	0.05	0.24	0.00	0.00	0.638	0.432
Ac II	0.87	0.74	0.06	0.26	15.508	0.000***
Ac III	1.70	0.82	0.00	0.00	38.151	0.000***

**Table (5-17-B)**

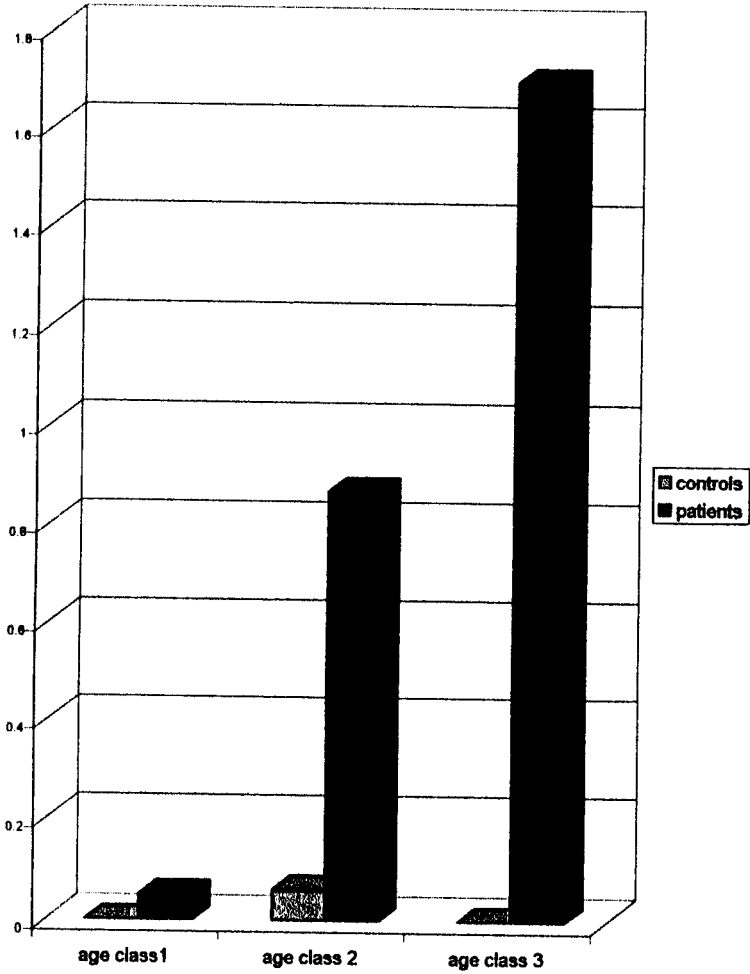
**Dysthymia according to child age and sex.**

Age Class	Sex	P G Chi		C G Chi		ANOVA	
		Mean	SD	Meam	SD	F.	Sig.
Ac I	Male	0.14	0.38	0.00	0.00	0.545	0.479
Ac I	Female	0.00	0.00	0.00	0.00	---	---
Ac II	Male	1.00	0.63	0.00	0.00	23.400	0.000***
Ac II	Female	0.78	0.83	0.17	0.41	2.736	0.122
Ac III	Male	2.00	0.82	0.00	0.00	31.111	0.001***
Ac III	Female	1.50	0.84	0.00	0.00	12.343	0.008***

Tables (5-17-A) and (5-17-B) Show the significant presence of dysthymia as a diagnosis among children of OCD parents. Such diagnosis was more prominent between older children (2<sup>nd</sup> and 3<sup>rd</sup> age group children). Such disorder was present among males of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups and females of 3<sup>rd</sup> age group only.



### Dysthemia according to child age





## 2- Major depressive episode.

Major depressive episode as a diagnosis was completely absent among children of both OCD parents and normal controls (Table 5-18).

**Table (5-18)**  
**Major depressive episode among children**  
**of various Groups.**

Age Class	P_G_Chi		C_G_Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
AC I	0.00	0.00	0.00	0.00	---	---
AC II	0.00	0.00	0.00	0.00	---	---
AC III	0.00	0.00	0.00	0.00	---	---

### **III. Obsessive compulsive symptoms and disorders.**

While analyzing the data of the present research as regard obsessive compulsive symptoms and disorders, data were investigated according to different OC symptoms according to child age, sex and according to the DSM IV Criteria for OCD as follows:

#### **A- OC Symptoms according to child age**

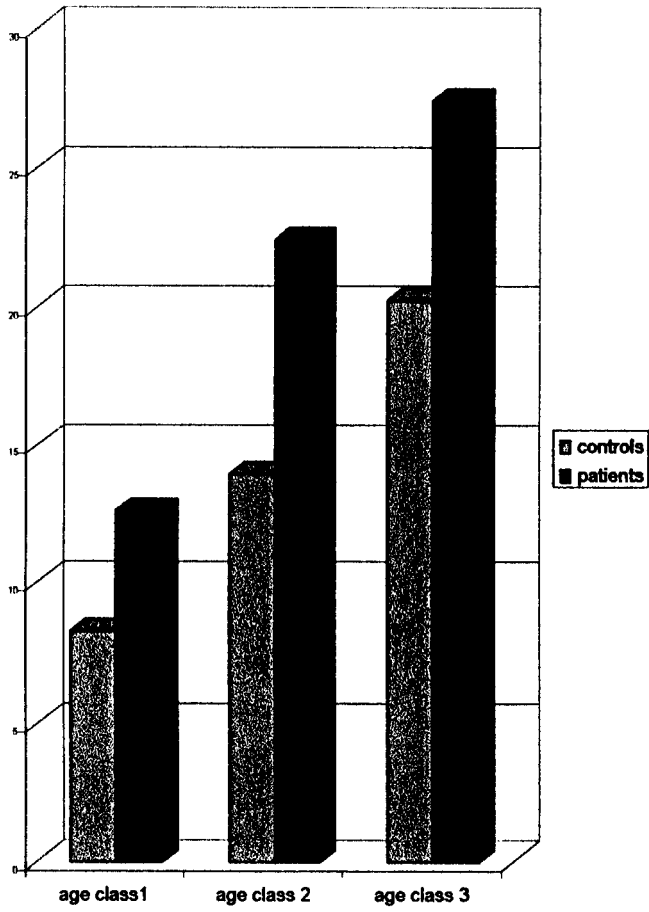
The following tables will show in details the different OC symptoms between children of both OCD and control parents, according to their age.

**Table (5-19)  
OC symptoms among children of both patient and control groups according to age**

Age Class	P-G-chi		C-G-chi		T- Test	
	Mean	SD	Mean	SD	t.	Sig.
AC I	12.589	17.628	8.273	8.890	0.855	0.401
AC II	22.400	20.318	13.933	14.878	1.302	0.203
AC III	27.400	16.433	20.222	19.360	0.874	0.394

Table (5-19) Shows the complete absence of significant difference between total OC symptoms among the three age classes of both patient and control group children as a total score.

### Obsessive compulsive symptoms according to age





**Table (5-20-A)**  
**Obsessive and compulsive symptoms among children**  
**of the first age group**

Item	P-G-chi		C-G-chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
<b>1- General appearance.</b>						
- Perfectionism and mastery.	0.76	1.25	0.73	1.01	0.007	0.934
- Carelessness.	0.00	0.00	0.27	0.90	1.579	0.220
- Cleanliness and tidiness.	0.71	1.16	0.18	0.60	1.895	0.180
- Over concern about external appearance.	0.59	1.12	0.73	1.27	0.092	0.763
<b>2- Counting compulsions.</b>						
- Counting things.	0.53	1.01	0.00	0.00	2.998	0.095
- Counting things until being sure.	0.41	0.94	0.00	0.00	2.085	0.161
- Counting to specific number.	0.18	0.73	0.00	0.00	0.638	0.432
<b>3- Bed time rituals.</b>						
- Rituals related to sleep.	0.47	1.07	1.36	1.12	4.499	0.044*
- Anxiety when such rituals not completed.	0.35	0.86	0.00	0.00	1.820	0.189
<b>4- Eating rituals.</b>						
- Specials arrangement of eating utensils.	0.53	1.18	0.00	0.00	2.189	0.151
- Special behavior related to started eating.	0.29	0.85	0.00	0.00	1.303	0.264
- Rituals related to setting.	0.82	1.33	0.45	1.04	0.603	0.444
- Forgettnes of important task related to eating lead to anxiety.	0.53	1.18	0.00	0.00	2.189	0.151
- Use own utensils only.	0.24	0.66	0.27	0.90	0.016	0.900
- Feelings of uncleanness of utensils when others use it.	0.65	1.06	0.00	0.00	4.066	0.054*
<b>5- Cleaning obsessions and compulsions.</b>						
- Uncleanness	0.47	1.07	0.00	0.00	2.109	0.158
- Excessive hand washing.	0.71	0.99	0.00	0.00	5.571	0.026*
- Washing compulsions.	0.00	0.00	0.00	0.00	---	---
<b>6- School rituals.</b>						
- special arrangement of the school bag.	0.53	1.18	1.00	1.41	0.910	0.349
- Checking homework.	0.35	0.86	0.45	1.04	0.079	0.780
- Studying in special place.	0.00	0.00	0.27	0.90	1.579	0.220
- Studying related compulsions.	0.00	0.00	0.00	0.00	---	---
<b>7- Checking compulsions.</b>						
- Checking and double checking.	0.47	1.07	0.00	0.00	2.109	0.158
- Checking doors and windows.	0.29	0.85	0.55	1.04	0.493	0.489
<b>8- Ordering arranging compulsions.</b>						
- Arranging things in a perfect way.	0.71	1.21	0.64	1.03	0.025	0.877
- Arrangement and rearrangement.	0.00	0.00	0.00	0.00	---	---
- Putting things in specific order.	0.29	0.85	0.27	0.90	0.004	0.950

Item	P_G_Chi		C_G_Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
<b>9- Miscellaneous obsessions.</b>						
- Specific concern of other things rather than ordering.	0.47	1.07	0.00	0.00	2.109	0.158
- Prolonged duration in bathroom.	0.12	0.49	0.09	0.30	0.027	0.872
- Repeated questioning.	0.47	1.07	0.45	0.82	0.002	0.967
- Walking rituals.	0.18	0.73	0.09	0.30	0.136	0.716
- Indecisiveness.	0.47	1.07	0.45	1.04	0.002	0.969

Table (5-20-A) shows the presence of different OC symptomatology between children of both groups, with significant emphasis of the presence of bed time rituals (between control group children) and eating rituals as well as cleaning obsessions and compulsions (between OCD parent children).



**Table (5-20-B)**  
**OC symptoms among children of the first age group**

Item	P-G-chi		C-G-chi		T- Test	
	Mean	SD	Mean	SD	t.	Sig.
- Perfectionism.	2.058	3.112	1.909	2.256	0.138	0.892
- Counting compulsions.	1.118	2.027	0.000	0.000	2.273	0.037*
- Bed time rituals.	0.824	1.918	1.364	1.120	-0.845	0.406
- Eating rituals.	3.059	5.043	0.727	1.849	1.735	0.097
- Cleaning obsessions and compulsions.	1.177	1.845	0.000	0.000	2.629	0.018**
- School rituals.	0.882	1.900	1.727	2.867	-0.941	0.355
- Checking compulsions.	0.765	1.787	0.546	1.036	0.368	0.716
- Ordering- arranging compulsions.	1.000	1.904	0.910	1.814	0.126	0.901
- Misc- obsessions.	1.706	2.733	1.090	1.137	0.824	0.418

Table (5-20-B) shows the presence of different OC symptoms among patient group children with significant emphasis of the presence of counting compulsions and cleaning obsessions among such age group.

**Table (5-21-A)**  
**Obsessive and compulsive symptoms among children of the**  
**second age group**

Item	P-G-chi		C-G-chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
<b>1- General appearance.</b>						
- Perfectionism and mastery.	1.93	1.28	0.73	1.03	7.986	0.009***
- Carelessness.	0.40	1.06	0.00	0.00	2.154	0.153
- Cleanliness and tidiness.	1.33	1.50	0.47	1.06	3.351	0.078
- Over concern about external appearance.	1.53	1.51	0.73	1.10	2.762	0.108
<b>2- Counting compulsions.</b>						
- Counting things.	0.53	0.99	0.40	0.91	0.147	0.704
- Counting things until being sure.	0.27	0.59	0.00	0.00	3.027	0.093
- Counting to specific number.	0.00	0.00	0.00	0.00	---	---
<b>3- Bed time rituals.</b>						
- Rituals related to sleep.	0.67	1.18	1.33	1.11	2.545	0.122
- Anxiety when such rituals not completed.	0.60	1.12	0.40	0.51	0.396	0.534
<b>4- Eating rituals.</b>						
- Special arrangement of eating utensils.	0.60	1.24	0.67	1.23	0.022	0.884
- Special behavior related to started eating.	0.20	0.56	0.60	1.12	1.527	0.227
- Rituals related to setting.	0.67	1.18	1.00	1.31	0.538	0.469
- Forgettness of important task related to eating lead to anxiety.	0.33	0.82	0.20	0.56	0.272	0.606
- Use own utensils only.	0.73	1.28	0.00	0.00	4.924	0.035*
- Feelings of uncleanness of utensils when others use it.	0.80	1.21	0.00	0.00	6.588	0.016**
<b>5- Cleaning obsessions and compulsions.</b>						
- Uncleanness - Excessive hand washing.	0.87	1.30	0.47	0.83	1.004	0.325
	0.93	1.28	0.07	0.26	6.609	0.016**
- Washing compulsions.	0.40	1.06	0.33	0.90	0.035	0.854
<b>6- School rituals.</b>						
- Special arrangement of the school bag.	1.13	1.46	1.33	1.29	0.158	0.694
- Checking homework.	0.73	1.03	1.07	1.28	0.616	0.439
- Studying in special place.	0.47	0.92	0.73	1.16	0.487	0.491
- Studying related compulsions.	0.33	0.72	0.00	0.00	3.182	0.085
<b>7- Checking compulsions.</b>						
- Checking and double-checking.	0.67	1.18	0.20	0.77	1.649	0.210
- Checking doors and windows.	0.40	0.74	0.73	1.28	0.764	0.389
<b>8- Ordering arranging compulsions.</b>						
- Arranging things in a perfect way.	1.33	1.40	0.67	0.90	2.414	0.123
- Arrangement and rearrangement.	0.20	0.77	0.00	0.00	1.000	0.326
- Putting things in specific order.	0.80	1.26	0.00	0.00	6.000	0.021*

Item	P_G Chi		C_G Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
<b>9- Miscellaneous obsessions.</b>						
- Specific concern of other things rather than ordering.	0.47	0.99	0.27	0.70	0.406	0.529
- Prolonged duration in bathroom.	0.87	1.30	0.27	0.59	2.637	0.116
- Repeated questioning.	1.33	1.50	0.80	1.21	1.155	0.292
- Walking rituals.	0.27	0.80	0.00	0.00	1.672	0.207
- Indecisiveness.	0.60	1.12	0.47	0.99	0.119	0.733

Table (5-21-A) shows the presence of most of the assessed obsessive and compulsive symptomatology with significant presence of perfectionism, eating rituals (*especially using own utensils only and feelings of spoiling of utensils when others use it*), excessive hand washing and ordering compulsions (*in the form of putting things in specific order*).

**Table (5-21-B)**  
**OC symptoms among children of the second age group**

Item	P-G-chi		C-G- chi		T- Test	
	Mean	SD	Mean	SD	t.	Sig.
- Perfectionism.	5.200	3.189	1.933	2.865	2.951	0.006***
- Counting compulsions.	0.800	1.424	0.400	0.910	0.917	0.369
- Bed time rituals.	1.267	2.283	1.733	1.487	-0.644	0.512
- Eating rituals.	3.333	5.314	2.467	3.583	0.524	0.605
- Cleaning obsessions and compulsions.	2.200	2.651	0.867	1.727	1.632	0.114
- School rituals.	2.667	3.638	3.133	3.314	-0.367	0.716
- Checking compulsions.	1.067	1.388	0.933	1.792	0.228	0.821
- Ordering- arranging compulsions.	2.333	2.820	0.667	0.899	2.181	0.044*
- Misc.-obsessions.	3.533	3.292	1.800	1.699	1.812	0.081

Table (5-21-B) shows the presence of different OC symptomatology among patient group children of the second age group with significant presence of obsessions related to perfectionism in the form of excessive cleanliness, tidiness and over-concern about general appearance as well as ordering-arranging compulsions.

**Table (5-22-A)**  
**Obsessive and compulsive symptoms among children**  
**of the third age group**

Item	P-G-chi		C-G-chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
<b>1- General appearance.</b>						
- Perfectionism and mastery.	2.00	1.25	0.89	1.36	3.441	0.081
- Carelessness.	0.20	0.63	0.33	0.71	0.188	0.670
- Cleanliness and tidiness.	1.00	1.15	0.78	1.20	0.169	0.689
- Over concern about external appearance.	2.10	1.20	1.11	1.45	2.643	0.122
<b>2- Counting compulsions.</b>						
- Counting things.	0.70	1.06	0.67	1.12	0.004	0.948
- Counting things until being sure.	0.80	1.14	0.33	1.00	0.895	0.357
- Counting to specific number.	0.10	0.32	0.00	0.00	0.895	0.357
<b>3- Bed time rituals.</b>						
- Rituals related to sleep.	0.80	1.32	1.44	1.01	1.404	0.252
- Anxiety when such rituals not completed.	0.70	1.25	0.67	1.00	0.004	0.950
<b>4- Eating rituals.</b>						
- Special arrangement of eating utensils.	0.50	0.85	0.78	1.30	0.310	0.585
- Special behavior related to started eating.	0.10	0.32	0.33	0.71	0.895	0.357
- Rituals related to setting.	0.40	0.97	1.22	1.30	2.480	0.134
- Forgettness of important task related to eating lead to anxiety.	0.30	0.67	0.67	1.12	0.768	0.393
- Use own utensils only.	1.30	1.25	0.22	0.44	5.975	0.026*
- Feelings of uncleanness of utensils when others use it.	1.40	1.51	0.22	0.44	5.088	0.038*
<b>5- Cleaning obsessions and compulsions.</b>						
- Uncleanness.	1.10	1.10	0.78	1.30	0.342	0.566
- Excessive hand washing.	1.30	1.25	0.33	0.71	4.157	0.057*
- Washing compulsions.	0.30	0.67	0.11	0.33	0.576	0.458
<b>6- School rituals.</b>						
- special arrangement of the school bag.	1.20	1.32	1.33	1.32	0.048	0.829
- Checking homework.	1.20	1.23	1.22	1.20	0.002	0.969
- Studying in special place.	0.80	1.23	1.11	1.36	0.274	0.608
- Studying related compulsions.	0.60	1.07	0.67	1.12	0.018	0.896
<b>7- Checking compulsions.</b>						
- Checking and double checking.	1.20	1.23	0.44	1.01	2.107	0.165
- Checking doors and windows.	1.20	1.40	0.56	1.13	1.202	0.288
<b>8- Ordering arranging compulsions.</b>						
- Arranging things in a perfect way.	1.30	1.34	1.00	1.32	0.241	0.630
- Arrangement and rearrangement.	0.30	0.67	0.00	0.00	0.768	0.201
- Putting things in specific order.	1.40	1.17	0.67	1.32	1.640	0.217

Item	P G Chi		C G Chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
<b>9- Miscellaneous obsessions.</b>						
- Specific concern of other things rather than ordering.	1.00	1.33	1.00	1.22	0.00	1.000
- Prolonged duration in bathroom.	0.60	1.07	0.67	0.87	0.22	0.884
- Repeated questioning.	0.60	1.07	0.33	1.00	0.311	0.584
- Walking rituals.	0.10	0.32	0.00	0.00	0.895	0.357
- Indecisiveness.	0.80	1.14	0.33	0.71	1.124	0.304

Table (5-22-C) shows the presence of some OC symptoms among children of OCD parents such as eating rituals and cleaning obsessions and compulsions.

**Table (5-22-B)**  
**OC symptoms among children Of the third age group**

Item	P-G-chi		C-G-chi		T- Test	
	Mean	SD	Mean	SD	t.	Sig.
- Perfectionism.	5.300	2.946	3.111	4.197	1.327	0.202
- Counting compulsions.	1.600	2.319	1.000	2.000	0.600	0.556
- Bed time rituals.	1.500	2.549	2.111	1.833	-0.593	0.561
- Eating rituals.	4.000	3.127	3.444	3.469	0.367	0.718
- Cleaning obsessions and compulsions.	2.700	2.627	1.222	1.922	1.385	0.184
- School rituals.	3.800	4.077	4.333	4.528	-0.270	0.790
- Checking compulsions.	2.400	2.591	1.000	1.581	1.437	0.171
- Ordering- arranging compulsions.	3.000	2.261	1.667	2.062	1.338	0.199
- Misc.- obsessions.	3.100	3.036	2.333	2.291	0.616	0.546

Table (5-22-B) shows the absence of any significant OC symptoms among children of both patient and control groups of the 3<sup>rd</sup> age group as a total score of different items.

## **B- OC symptoms according to child sex**

The following tables will show the presence of different OC symptoms among both patient and control group children according to their sex as follows:

### **1- Male children**

Boys revealed some significant OC symptomatology as follows:

**Table (5-23)**  
**OC symptoms between male children of both patient and control groups according to age**

Age Class	P-M-chi		C-M-chi		T- Test	
	Mean	SD	Mean	SD	t.	Sig.
Ac I	9.429	14.842	10.250	8.500	-0.100	0.922
Ac II	24.167	25.733	12.556	11.854	1.035	0.338
Ac III	26.000	11.860	34.600	12.973	-1.025	0.340

Table (5-23) shows the absence of significant OC symptoms among males of the different age groups as a total score in the obsessive compulsive symptom checklist.

When data were further analyzed according to each of the sub-scales, the following results were obtained as shown in the following tables.



**Table (5-24-A)**  
**OC symptoms among males of the first age group**

Item	P-M-chi		C-M-chi		T- Test	
	Mean	SD.	Mean	SD.	t.	Sig.
- Perfectionism.	1.429	2.992	3.500	2.380	-1.179	0.269
- Counting compulsions.	0.286	0.756	0.000	0.000	0.739	0.479
- Bed time rituals.	0.000	0.000	2.000	1.414	-3.908*	0.004***
- Eating rituals.	2.000	3.651	0.500	1.000	0.788	0.451
- Cleaning obsessions and compulsions.	1.571	2.149	0.000	0.000	1.934	0.101
- School rituals.	0.143	0.378	0.750	1.500	-0.795	0.481
- Checking rituals.	1.286	2.360	0.000	0.000	1.441	0.200
- Ordering arranging compulsions.	1.143	2.268	2.000	2.708	-0.564	0.586
- Misc. obsessions.	1.571	2.070	1.500	1.291	0.062	0.952

**Table (5-24-B)**  
**OC symptoms among males of the second age group**

Item	P-M-chi		C-M-chi		T- Test	
	Mean	SD.	Mean	SD.	t.	Sig.
- Perfectionism.	5.000	3.847	0.778	0.972	2.633	0.043*
- Counting compulsions.	1.000	1.673	0.222	0.667	1.083	0.320
- Bed time rituals.	1.167	1.835	2.222	1.302	-1.310	0.213
- Eating rituals.	3.833	6.338	2.111	2.935	0.623	0.555
- Cleaning obsessions and compulsions.	2.333	2.875	0.779	1.642	1.342	0.203
- School rituals.	3.333	3.670	3.111	3.296	0.122	0.904
- Checking rituals.	0.833	1.330	0.889	2.028	-0.059	0.954
- Ordering arranging compulsions.	2.167	2.483	0.556	0.882	1.526	0.179
- Misc. obsessions.	4.500	3.886	1.889	1.965	1.732	0.107

**Tables (5-24-C)**  
**OC symptoms among males of the third age group**

Item	P-M-Chi		C-M-chi		T- Test	
	Mean	SD.	Mean	SD.	t.	Sig.
- Perfectionism.	4.500	3.109	5.600	4.219	-0.433	0.678
- Counting compulsions.	0.000	0.000	1.800	2.490	-1.616	0.181
- Bed time rituals.	0.750	1.500	3.200	1.643	-2.307	0.064
- Eating rituals.	3.500	2.646	5.000	4.062	-0.634	0.546
- Cleaning obsessions and compulsions.	3.250	2.500	2.200	2.168	0.676	0.521
- School rituals.	4.000	5.745	7.800	2.683	-1.151	0.287
- Checking rituals.	3.000	2.944	1.800	1.789	0.716	0.508
- Ordering arranging compulsions.	2.250	1.708	3.000	1.871	-0.620	0.555
- Misc. obsessions.	4.250	3.500	4.200	0.837	0.028	0.979

Tables (5-24-A, B, C) show the presence of some OC symptoms among males of the 2<sup>nd</sup> age group in the form of perfectionism and mastery, cleanliness and tidiness and over concern about general appearance. On the other hand, control parent's male children of the first age group showed the significant presence of bedtime rituals.

## **2- Female children**

Female children revealed some significant OC symptoms as shown in the following tables.

**Table (5-25)**  
**OC symptoms among female children of both patient and control groups according to age**

Age Class	P-F-chi		C-F-chi		T- Test	
	Mean	SD	Mean	SD	t.	Sig.
Ac I	14.800	19.810	7.143	9.564	1.059	0.308
Ac II	21.222	17.456	16.000	19.657	0.540	0.598
Ac III	28.333	19.977	2.250	0.500	2.558	0.034*

Table (5-25) shows the significant presence of OC symptoms among females of the patient group belonging to the 3<sup>rd</sup> age group only.

When data were further analyzed according to each of the sub-scales, the following results were obtained.

**Table (5-26-A)**  
**OC symptoms among females of the first age group**

Item	P-F-chi		C-F-chi		T- Test	
	Mean	SD.	Mean	SD.	t.	Sig.
- Perfectionism.	2.500	3.275	1.000	1.732	1.102	0.288
- Counting compulsions.	1.700	2.452	0.000	0.000	2.193	0.056*
- Bed time rituals.	1.400	2.366	1.000	0.817	0.494	0.630
- Eating rituals.	3.800	5.903	0.857	2.268	1.433	0.177
- Cleaning obsessions and compulsions.	0.900	1.663	0.000	0.000	1.711	0.121
- School rituals.	1.400	2.366	2.286	3.408	-0.636	0.534
- Checking rituals.	0.400	1.265	0.857	1.215	-0.745	0.468
- Ordering arranging compulsions.	0.900	1.729	0.286	0.756	0.877	0.395
- Misc. obsessions.	1.800	3.225	0.857	1.069	0.860	0.407

**Table (5-26-B)**  
**OC symptoms among females of the second age group**

Item	P-F-chi		C-F-chi		T- Test	
	Mean	SD.	Mean	SD.	t.	Sig.
- Perfectionism.	5.333	2.916	3.667	3.932	0.946	0.362
- Counting compulsions.	0.667	1.323	0.667	1.211	0.000	1.000
- Bed time rituals.	1.333	2.646	1.000	1.549	0.277	0.786
- Eating rituals.	3.000	4.899	3.000	4.648	0.000	1.000
- Cleaning obsessions and compulsions.	2.111	2.667	1.000	2.000	0.867	0.402
- School rituals.	2.222	3.768	3.167	3.656	-0.481	0.638
- Checking rituals.	1.222	1.481	1.000	1.549	0.280	0.784
- Ordering arranging compulsions.	2.444	3.167	0.833	0.983	1.195	0.253
- Misc. obsessions.	2.889	2.892	1.667	1.366	0.958	0.356

**Table (5-26-C)**  
**OC symptoms among males of the third age group**

Item	P-F-chi		C-F-chi		T- Test	
	Mean	SD.	Mean	SD.	t.	Sig.
- Perfectionism.	5.833	2.994	0.000	0.000	3.817	0.005***
- Counting compulsions.	2.667	2.503	0.000	0.000	2.609	0.048*
- Bed time rituals.	2.000	3.098	0.750	0.957	0.924	0.389
- Eating rituals.	4.333	3.615	1.500	1.000	1.818	0.118
- Cleaning obsessions and compulsions.	2.333	2.875	0.000	0.000	1.988	0.104
- School rituals.	3.333	3.077	0.000	0.000	2.654	0.045*
- Checking rituals.	2.000	2.530	0.000	0.000	1.936	0.111
- Ordering arranging compulsions.	3.500	2.588	0.000	0.000	3.312	0.021*
- Misc. obsessions.	2.333	2.733	0.000	0.000	2.092	0.091

Tables (5-26- A, B, C) Show the presence of many OC symptoms among female children of OCD parents. Among the 1<sup>st</sup> age group, female patient's children showed the presence of counting compulsion. While females of the 3<sup>rd</sup> age group showed the presence of multiple traits such as perfectionism, counting compulsions, school rituals as well as ordering-arranging compulsions.

### C- Obsessive compulsive disorder according to DSM IV.

When obsessive compulsive disorder as diagnosis was considered the following results were obtained as shown in the following tables.

**Table (5-27-A)**  
**DSM IV criteria for OCD among patient and control children according to age.**

Age class	P-G-chi		C-G-chi		ANOVA	
	Mean	SD	Mean	SD	F.	Sig.
Ac I	0.00	0.00	0.00	0.00	---	---
Ac II	0.47	0.64	0.33	0.49	0.412	0.526
Ac III	0.90	0.57	0.56	0.73	1.341	0.263

Table (5-27-A) shows the presence of OCD as a diagnosis among both patient and control children at different ages, but the difference between them was statistically insignificant.

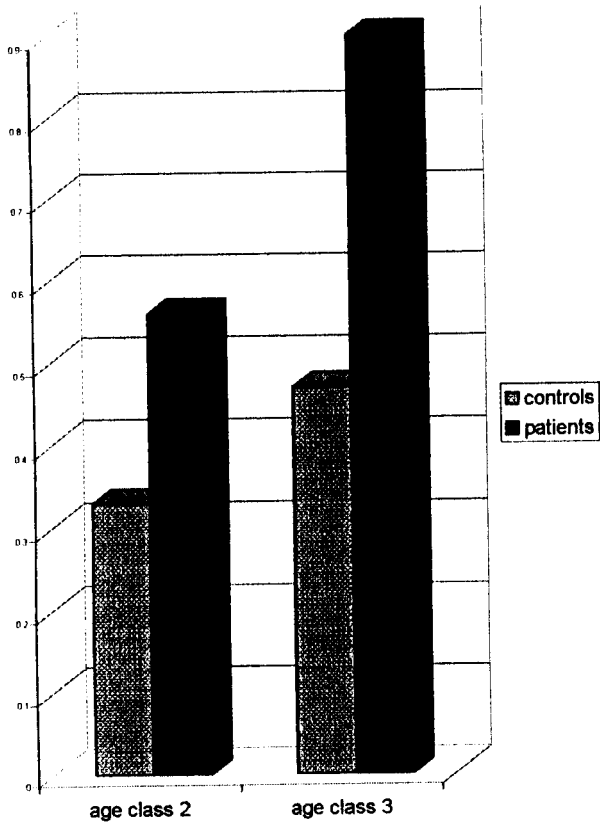
**Table (5-27-B)**  
**OCD according to children age and sex**

Age Class	Sex	P-G-chi		C-G-chi		ANOVA	
		Mean	SD	Mean	SD	F.	Sig.
Ac I	Male	0.00	0.00	0.00	0.00	---	---
Ac I	Female	0.00	0.00	0.00	0.00	---	---
Ac II	Male	0.67	0.82	0.33	0.50	0.975	0.341
Ac II	Female	0.33	0.50	0.33	0.52	0.000	1.000
Ac III	Male	1.25	0.50	1.00	0.71	0.354	0.571
Ac III	Female	0.67	0.52	0.00	0.00	6.400	0.035*

Table (5-27-B) shows the presence of OCD as a diagnosis among children under investigation. Such diagnosis was statistically significant only among females of the 3<sup>rd</sup> age group.



## OCD according to age





# DISCUSSION



## DISCUSSION

Family problems don't cause OCD, but the way families react to the symptoms, can affect the disorder, just as the symptoms can cause a great deal of disruption and many problems especially for children, OCD rituals can tangle up family members including children endlessly.

It is sometimes necessary for the whole family to go through therapy with the affected partner.

Parental obsessive compulsive disorder is not uncommon in comparison to the rest of adult psychiatric population. Mostly OCD parents experience anxiety and \ or depression in addition to their primary obsessions and \ or compulsions. Such disorders are always related to adverse social circumstances.

Children of OCD parents accommodate their parental rituals through either participation in behaviors related to such rituals or through modification of their daily routines [Rachman and Hodgson, 1980].

On the other hand, many clinicians reported that such accommodation can be stressful for most of the OCD families and adversely affect family functioning [Livingston et al, 1990].

A more comprehensive investigation of family participation and modifications of functioning is warranted because of the potentially negative effects such behaviors may have or both the patients and their relatives.

The impact of parental mental illness on the other family members especially the children has been studied **abroad**

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[Rutter and Quirton, 1984], but unfortunately receive very little support in our country.

All types of mental disorders are linked to a raised rate of behavioural and emotional problems in children. Children of parents with all types of anxiety disorders, depression and alcoholism are more likely to show such problems [Mansour, 1993].

Moreover, two factors were found to be associated with anxiety and depression in school-age children: mothers who are emotionally unsupported and mothers who report emotional symptoms in themselves [Goodyer et al, 1988]. Both factors are relatively chronic stresses in the lives of children, and in their presence acute events continue to exert effects of importance on the probability of emotionally disturbed. The presence of two or more stresses significantly increases the risk of emotional disorder in children, suggesting that family stresses summate each other's effects [Goodyer, 1990].

Interestingly there is no particularly patterning of their adversities that discriminates between anxious and depressed cases. There are different psychological and statistical forms of interaction between social factors. The main point is that recent adversities are important in exerting psycho-pathological effects. The over all probability of being emotionally disturbed, however is explained by the combination of effects of different forms of undesirable life experiences [Goodyer, 1990].

The findings on the association between different forms of social adversity including parental mental health problems and emotional problems in children are few. The patterning and interactions of both acute and chronic family factors require more investigation.

On the other hand, such high rates of psychopathology and dysfunction among relatives of psychiatric patients may sometimes be identified, but do not receive the needed services. This may be attributed not only to a defect in the services available for the family, but also to some cultural background.

Better services for the needs of children of the mentally ill parents will result in primary prevention with respect to the relatives especially children, and in secondary prevention with respect to the patients.

Our discussion aims mainly at concentrating on detection of psychiatric morbidity among children of OCD parents, with special consideration of anxiety, depression, and obsessive compulsive disorders.

For such purposes, the samples were highly selective as regard both parents and their children. Two groups of parents (*OCD parent group and control parent group*) as well as their children were highly selected according to the previously mentioned inclusion and exclusion criteria.

Some of the parents socio-demographic characteristics as regard: age, duration of illness, marital status, education, their children age and sex, general home atmosphere and lastly characteristics of parent-child relationship were shown in Tables [(5-1) (A, B, C, D, and E)].

It was found that, there were no statistically significant difference between the two groups as regard parent age, education, marital status and children age, but there was a highly significant difference as regard the duration of parent illness. This can be explained by the highly restricted inclusion criteria for the present study, which reflects the sample selection [Table (5-1-A)].

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When children subjects were concerned, Table (5-1-B) shows the more or less equality in: number as well as age and sex of both patient and control children.

As regard general home atmosphere of both patient and control parents, OCD parents were found to be less harmonious and more quarrelsome [Table (5-1-C)]. **Bebbington, (1981)** reviewed marital disharmony to be a common problem among mentally ill parents and this will lead to a failure to create a homogenous marriage. Which may eventually lead to marital problems such as separation and divorce as well as children problems.

On the other hand, OCD parents were found to be more over protective, less interactive and less sharing attitudes towards child problems [Table (5-1-D)].

Many researches agreed with such result, as it was found that OCD parents were less warm, poor interactive and over interfering with their children [**Hanjo et al, 1989**].

Over protectiveness has been defined as provision of excessive physical contact, prolongation of infantile care, prevention or discouragement of independent behavior and insistence on refairing control. An over protective upbringing were found to be anxiety provoking [**Knolker, 1983; Merkel et al, 1993**]. This might explain the significant presence of many anxiety symptoms among children of OCD parents.

As mentioned earlier, children are not involved by the nature of their parent illness (*i.e. obsessions and compulsions*) only, but also its possible comorbid symptomatology (*i.e. Anxiety and \ or depression*). This will reflect itself on the nature of parental care the children are receiving.



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As parental OCD is usually accompanied by anxiety and / or depression, and secondary depression was found to be the most important form of depression present with OCD, as a result of devastation and incapacity affecting parents in their work, emotionality, and social interactions [Yarura-Tabias and Neziroglu, 1983]. A depressed mother is likely to be less responsive to the needs of her children, less able to provide consistent discipline and less likely to initiate interaction [Weissman and Paykel, 1974; Mills et al, 1984] (*90% of patients with OCD experience secondary depression. Depression may also accompany parental OCD as a comorbid disorder*).

On the other hand comorbidly over anxious OCD mother often transmits her anxiety to the children by example. Less usual forms of direct impact of illness occur when a child is involved in parent obsessional rituals [Graham, 1994].

A depressed OCD mother is usually separated and isolated from her children, less giving attention as well as affection. This was reflected to a great extent among children under investigation, as most of the OCD parents were found to be less interactive with their children. Such undue paternal care may give a good explanation of presence of many symptomatology among children of OCD parents.

On the other hand, the significant presence of many anxiety symptoms such as separation anxiety, school problems, complete dependence on parents on daily activities, etc, may be highly correlated to the over protectiveness of OCD parents under investigation. Such way of upbringing, as mentioned earlier, is anxiety provoking and lead to complete dependence on parents [Table (5-1-D)].

Moreover, less harmonious sharing of OCD couples, as regard child problems might fortunately lead to marital disharmony. Such problem was greatly manifested among such families, as quarrel, some or less harmonious atmosphere. This will lead to marital problems as well as children emotional problems [Table (5-1-C)].

## Psychiatric Morbidity Among Children of OCD Parents

As mentioned earlier, the present research is concerned of detection of psychiatric morbidity among children of OCD parents with special emphasis on:

- I. Anxiety symptoms and disorders.
- II. Depressive symptoms and disorders.
- III. Obsessive compulsive symptoms and disorders.

Many researches agreed with the positive correlation of such symptomatology and parental OCD [Cowe 1961; Rachman and Hodgson, 1980].

### I. Anxiety Symptoms and Disorders

Anxiety is the first emotion to be experienced even at low level of stress (*i.e. parental illness*) [Pearce, 1998]. It is a symptom of almost all psychiatric disorders and can be precipitated by all types of emotional stress [Ghanem, 2000].

Furthermore, anxiety is often a normal and necessary part of life. Indeed in many situations it is abnormal not to experience anxiety. Thus, to call anxiety is "*abnormal*" many factors such as: frequency of occurrence, chronicity and duration of occurrence, rationality of the response, one's ability to control its effects and disruption of normal life routines, must be considered. Each of these factors must be evaluated separately and in combination [Kleinknecht, 1991].

There is a general agreement that living with a mentally ill family member is associated with increased dysphoria

and irritability, particularly for the children and the spouse. Children of parents with anxiety disorders were more anxious and fearful and reported more school difficulties than the control group [Turner et al, 1987]. This could explain the significant presence of many anxiety symptoms and disorders among children of OCD parents under investigation.

Anxiety may become symptomatic at any age when it prevents or limits developmentally appropriate adaptive behavior. The child's ability to recover from anxiety and to remain anxiety-free when the provoking situation is absent, are essential for diagnostic purposes.

For example, in a separation paradigm, it is not usually deviant for a young child to respond with distress to the parent's departure. What are no longer unremarkable are:

- (1) The inability to recover promptly once the separation is affected (*the proper care is available to the child*).
- (2) Compromised functioning during normal separation experiences.
- (3) Concerns about future separations and vigilance or even avoidance of activities potentially associated with separation.

[Rutter et al, 1994].

Therefore, inflexibility of affective response is an important indicator, in addition, the degree of distress and dysfunction influences diagnostic standards.

It is difficult to specify guidelines since these vary with age, as well as, with cultural and familial standards.

The best is to judge the child's ability to participate in expected age appropriate social and academic activities [Rutter et al, 1994].

In brief, three clinical features impringe on the definition on pathological anxiety. Two of these, distress and dysfunction, vary in importance as a function of developmental stage. The third, symptomatic inflexibility, is a diagnostically important regardless of age. [Klein, 1978].

Because anxiety has normal adaptive forms through development, the identification of pathology may pose difficulty in ambiguous cases. Inflexibility of affect is suggested as a key feature of symptomatic anxiety [Rutter et al, 1994].

Although children and adolescents can experience the same anxiety disorders as adults, they also display some other patterns somewhat specific to them because of their unique developmental and life situations. However, the most specific childhood and adolescent categories include: over anxious disorder, separation anxiety disorder, school phobia or refusal and social phobia.

Anxiety symptoms and disorders among children under investigation were tested according to child age, sex and DSM IV criteria as follows:

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### **A. Anxiety Symptoms According to Child Age**

On reviewing the results of the present research children of OCD parents showed the presence of many anxiety symptoms, (*as assessed by the anxiety symptom checklist*). Such symptomatology were significantly more prominent among children of the second and third age groups (*above 6 to 12 and above 12 to 15 years respectively*) [Table (5-2)].

When data were further analyzed, according to the anxiety symptom checklist, children of the OCD parents of the first age group (*3 to 6 years*) showed the absence of any significant anxiety symptoms among them [Table (5-3-A)]. On the other hand, children of the 2<sup>nd</sup> age group showed the presence of many statistically significant anxiety symptoms such as: tension and worry throughout the day, sleep problems (*nightmares*), psychosomatic symptoms (*loss of appetite*), specific phobias, irritability and tension, temper tantrums and regression symptoms (*in the form of complete dependence on parents in daily activity and excessive crying in unsuitable situations*) [Table (5-3-B)].

Furthermore, children of the OCD parents of the age 3<sup>rd</sup> age group reported significant presence of many anxiety symptoms such as: tension and worry throughout the day, sleep problems (*insomnia, night mares and hypersomnia*), irritability and tension, regression and specific phobias including school phobias, and others (*self injury phobia, fears of death and fears of death of others especially mothers*) [Table (5-3-C)].

Otherwise no significant differences were detected between the two groups as regard other anxiety symptoms.

The absence of significant anxiety symptoms among children of the 1<sup>st</sup> age group might be explained by the less ability of such young children to express themselves verbally. Also, such young children are more distracted and involved in their play, so less liable to show such symptoms. The poor co-operation of the parents with examiner may give another explanation.

As anxiety is the first expression of reaction to stress (*living with an OCD parent*) [Pearce, 1998]. Children of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups revealed many anxiety symptoms. Such symptomatology are mostly related to parental illness, because of their absence among children of control parents.

The first mentioned significant anxiety symptom were the tension and worry all over the day as expressed by the children with restless feelings and excessive worry about performance and competence at school and parental dissatisfaction.

Sleep problems were another presentation of anxiety among children of OCD parents. Insomnia and night mares are not uncommon, such experiences may well explain why the child often attempts to sleep with his or her parents. Such behavior was expressed by many of our children subjects. Such symptomatology may reflect separation problems. Younger children when separated, may become extremely homesick, may yearn to return home, and may become preoccupied with fantasies of returning. But older children may deny needing the parent on account of their embarrassment, even though their behavior denies their lack of concern [Kleinchrecht, 1991]. Simonds and Parraga, (1982) reviewed sleep problems to be a common manifestation among children of mentally ill parents. It may take the form of restless sleep (28%), sleep talking (13%), and fear of dark (10%).

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On the other hand, sleeping problems was a common problem among children of obsessional parents directly related to disturbed maternal relationship [Rutter 1966]. Also 10% of children of OCD parents have sleep problems [Mansour, 1993].

Richman (1981), revealed awaking at night and its association with maternal illness especially anxiety and depression as well as stress within the family. In the present research, awaking at night and searching for mother was a frequent symptomatology among children of OCD parents, and this may be explained by separation difficulty of over anxious children.

Kleinknecht (1991), reported difficulty in falling asleep to be characteristic of an over anxious child.

Moreover, hypersomnia was significant among children of the 3<sup>rd</sup> age group (*above 12 years*). Kaplan and Sadock, (1995), correlated hypersomnia to either already manifested anxiety disorder or as an initial stage of depressive disorder. Depressive symptoms among children of such age group were highly significant in the present study, which is with accordance of Kaplan's results.

All the previously mentioned results might give good explanation of the presence of many sleep problems among children of OCD parents especially insomnia, hypersomnia and night mares as well as separation difficulty at night (*presented as separation anxiety*) and specific fear of darkness.

Significant loss of appetite among children of OCD parents of the 2<sup>nd</sup> age group may be also directly correlated to poor appetite significantly present among such children (*of the same age group*), as a depressive manifestation in reaction to stress



[Table (5-15-B)]. Poor appetite is one of the depressive symptoms among children. It is also one of many psychosomatic symptoms that may be related to school problems [Graham, 1994]. Psychosomatic symptoms were also prominent among children of OCD mothers than OCD fathers [Mansour, 1993]. On the other hand, a study investigating psychiatric morbidity in children taken to their primary care physicians, showed that almost one of three of cases with somatic complains had emotional disturbance and the presentation was significantly associated with stress in lives of the child and their parents [Garraida and Bailey, 1986].

Specific phobias and school phobias were another manifestation of anxiety among children of OCD parents. Many phobias were expressed by children under investigations, such as: fear of darkness, insects, animals, fear of dolls (*expressed by one of our sample - a young boy aged 9 years*).

Specific fears were also significant among children of obsessional parents [Cawei, 1961]. Specific fearfulness among such children may be correlated to maternal anxiety and / or depression [Skynner, 1974].

School phobia is well known to be the most common phobia among school children in Egypt [Abou Hatab, 1994]. It has been estimated to involve between 1-2% of school aged children [Kleinknecht, 1991]. In the present study, it was a manifestation of both patient and control children, but it was more significant among children of OCD parents. School problems, phobias and refusal may rather be correlated to an anxious and perhaps depressed mother (*anxiety and depression always present with OCD*), who has, for some years had an overly close relationship with the child in question together with an over protective parenting [Skynner, 1974].

On the other hand, when a child becomes fearful of separation, refusal to go to school often follows. School refusal may represent a case of school phobia. However, often the school refusal is part of the larger picture of separation anxiety; that is, it is not school that they fear but separation from parents (*usually the caring mother - in our case the OCD mother*) [Kleinknecht, 1991].

In keeping with recommendation of DSM III- R., it would seem more appropriate to retain the term school phobia for those cases in which the anxiety and fear reactions occur in account of school per-se. When school refusal is due to fear of being separated more generally, separation anxiety is more appropriate term.

The problem usually showed itself first at a time of change of school or after a period of absence (*e.g. minor illness*) [Graham, 1994]. It appears to peak during periods of major traumas and transitions, such as when first beginning school (*5-8 years of age*) and junior high or high school (*11-14 years of age*) [Kleinknecht, 1991].

Such prevalent school phobias may also be correlated to the excessive worry about performance and competence at school expressed by children of OCD parents belong to the 3<sup>rd</sup> age group, as well as the perfectionist life style characteristic of OCD families as well as their children, which was another significant result of the present research [Table (5-26-C)].

Irritability and tension, temper tantrums and regression were another significant anxiety symptoms among children of OCD parents of the second and third age groups.

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**Cowei (1961)**, was in accordance with that, as excessive excitability, temper tantrums and inclination to cry easily (*a sign of regression*) were significantly present among children of obsessional parents. This might be explained by the excessive dependence on the mother as well as the anxious atmosphere among OCD families.

Behaviorally, the child may exhibit such nervous habits such as restlessness, tantrums, nail biting, hair pulling as a part of over-anxious disorder [**Kleinknecht, 1991**].

Fears of death and fears of death of others especially the mother (*the sick mother*) were another prominent manifestations among children of OCD parents aged 12 and above. This might be explained by either depressive feelings manifested among such children, separation problems or feelings of rejection and lack of closeness in the mother-child relationship. Such close relationship is very important for such children as they need more attachment and more emotional support. Such fears were extremely expressed by female children which were sometimes tearful for their mothers.

**Kaplan and Sadock, (1995)** explained the authoritarian, rigid and strict upbringing to be highly related to childhood depression which may be presented in the form of fear of death of the child himself or his mother. Such upbringing styles are characteristic to OCD families.

However, the fear of death, fear of death of others (*especially the mother*) and self injury phobia, were reported by children of the 3<sup>rd</sup> age group, such specific fears and phobias were also considered a part of generalized anxiety with its cognitive (*worry*), behavioral (*clinging and refusal*) and physiological (*aches and pains or psychosomatic complaints*) manifestations, that appears to be a form of phobia (*a phobia of: being left, illness, or injury*) occurring to themselves or to their families. For

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younger children, the fears are quite general and non specific. As children age, their fears become more specific, often centering on concerns of danger and death [Kleinknecht, 1991].

On the other hand, Adam et al, 1994 described fear of death or illness (*which might also corresponds to self-injury phobia in the present study*) as a typical obsession among older children.

### **B. Anxiety Symptoms According to Child Sex**

When children were investigated according to their sex, male children of OCD parents were more significant to show anxiety symptoms than females. Males of the second and third age groups (*above 6 to 12 and above 12 to 15 respectively*) showed significant presence of anxiety symptoms, while females started to show such symptoms after the age of 12 years [Tables (5-4-A) and (5-4-B)].

Sleep problems were more significantly apparent among males above six (*second and third age group children*) while such problems were only significant among females above the age of twelve [Tables (5-5-A) and (5-5-B)].

On the other hand, other neurotic symptoms such as irritability and tension, temper tantrums, nail biting were also prominent among children of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups with special significance of the males of the 2<sup>nd</sup> age group [Tables (5-6-A), (5-6-B) and (5-6-C)].

Regression were another significant neurotic symptomatology of the male children of OCD parents belonging to the 2<sup>nd</sup> age group [Tables (5-7-A) and (5-7-B)].

Most of childhood psychiatric disorders are much more common among males than females on the contrary of the adult psychiatric disorders [Kaplan and Sadock, 1995].

There is considerable data to show that boys are more likely than girls to develop emotional or behavioral disturbance when exposed to marked family discord [Rutter, 1982].

The evidence suggests, however, that girls take longer to respond to discord and that sex differences in different disorders diminish with time [Rutter, 1986a].

Boys may be more vulnerable because of a biologically determined greater susceptibility to social hazards. For example, family discord may have a qualitatively more adverse impact on boys. Thus boys are more likely to go into care than girls at the time of break-up [Packman, 1986]. Also, boys are exposed to more parental quarrels than girls [Hetherington; Cox and Cox, 1982].

On the other hand, boys are more likely to respond to adversity with aggressive behavior, while girls are more likely to disengage and withdraw [Rutter, 1982; Masten et al, 1988]. Such male reaction may elicit a negative response from parents and may become a coercive cycle of disruptive-aggressive response patterns [Patterson, 1986a, b].

These intrinsic response patterns may reflect the biological component of sex differentiated responses in response to adverse life experience.

Male children of the present research expressed their reaction to their parent's illness, in the form of anxiety,

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earlier than females. This might also be related to the juvenile onset OCD in which males outnumbered girls in contrast to equal ratio in later onset symptomatology [Swedo, 1989].

### **C. Anxiety Disorders According to DSM IV**

Using more strict criteria for diagnosing anxiety disorders, the following were obtained as regard:

#### **1. Separation anxiety disorder**

Separation anxiety disorder was very significant among children of OCD parents especially of the 1<sup>st</sup> and 2<sup>nd</sup> age groups (*3-6 and above 6-12 respectively*) [Table (5-8-A)]. On the other hand, males of the 2<sup>nd</sup> age group reported significant presence of such disorder than females [Table (5-8-B)].

According to DSM IV, the onset of the disorder should be before 18 years of age, and its manifestations might vary with age. Younger children may not express specific fears of definite threats to parents, home or themselves. As children get older, worries or fears are often of specific dangers (*e.g. Kidnapping*).

Separation anxiety, is at some time a normal expectation in children's developmental experiences. Anxiety at being separated from family becomes classified as a disorder only when it is severe and persists beyond what is expected for a child's normal age and expected developmental level [Kleinknecht, 1991].

Separation anxiety disorder is characterized by excessive anxiety to the point of panic when a child is separated

from parents or parent figures, from home, or from familiar surrounding.

Such children are expected to report sleep disturbances. Such problems are not uncommon, and often involve insomnia and night mares. These experiences may well explain why the child often attempts to sleep with his or her parents. In the present study sleep problems were significantly present among children of OCD parents above 6 years age.

The presence of adverse ongoing social experiences in the life of the family may well alter the likely impact of separation. Thus, infants and children, who experience poor relationship with their care-givers, may exhibit substantial distress at the time of separation [Rutter 1985a, b]. Therefore the impact of separation is increased because of the absence of an adequate relationship with a caregiver (*in our case the OCD mother*). This suggests that such a relationship confers important psychological effects of protection against the negative impact of separation.

Separation anxiety disorder was the only significant anxiety manifestations among children under 6 years of age. This may be related to complete dependence of such young children (*belong to that age group*) on their parents especially mothers. Disturbance in mother-child relationship as well as overprotective parenting proposed by OCD mothers may predispose to such anxiety disorder among children especially younger ones (*3 up to 12 years*), such children are in need for strong attachment links.

On the other hand, separation anxiety was encountered in about 34% of OCD cases [Garrison et al, 1995]. Also depressed and anxious mothers have reported increased

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rates of separation anxiety in their children compared to controls (10 versus 0% respectively) [Weissman et al, 1984b].

On the other hand, childhood OCD was commonly associated with separation anxiety, risk aversion, submissiveness and perfectionism [Rasmussen and Eisen, 1992].

## **2. Generalized Anxiety Disorder (GAD) (including over anxious disorder of childhood)**

GAD was significantly present among children of OCD parents especially of the second and third age groups [Table (5-9-A)]. Both males and females above 12 were significantly having the disorder with almost equal figures.

Children with GAD tend to worry more excessively about their competence or the quality of their performance, and are mostly perfectionist, as well as unsure of themselves (*DSM IV*).

Typically the child will worry about future events, exams, being injured, being included with other children. In these children, there is often an element of perfectionistic tendencies, obsessional self-doubts, conformity and approval-seeking from others, along with concern over what others think of them.

This chronic worry, results in continuous states of ANS activation, including feelings of a lump in the throat, headache, stomachache, nausea, difficulty falling asleep. Behaviorally, the child may exhibit some nervous habits such as restlessness, tantrums, nail biting and hair pulling [Kleinknecht, 1991].



In the present research, children above 6 years, showed such perfectionistic tendencies, psychosomatic symptoms as well as other neurotic manifestations such as tantrums, general irritability and tension and others. Such neurotic symptomatology were significantly present among the children of the 2<sup>nd</sup> and the 3<sup>rd</sup> age groups [Table (5-6-A)].

Severe performance anxiety, frequently have its onset in late childhood [Öst, 1987]. However, it is known that overanxious children are typically not brought to clinics for treatment until they are about 13 years old. Perhaps by such age, it is clear to parents that the worry is beyond what might be expected for children and that it is not likely to go away on its own. Thus treatment may be seen as necessary to further the child's social development [Kleinknecht, 1991].

On the other hand, over anxious disorder co-occurred in 29% of children selected for separation anxiety disorder ( $n = 21$ ), but the onset of over anxious disorder never preceded that of the separation anxiety [Klein et al, 1992b]. This chronological sequence raises the possibility that, at times, symptoms subsumed in overanxious disorder simply may be complications of a specific anxiety diagnosis, and may represent a severity dimension rather than additional discrete disorder.

In our case, OCD parent's children showed both separation anxiety and generalized (*over anxious*) anxiety disorders among children aged 3 and above and 6 and above respectively. This may be explained in terms of the previous overlap in different comorbid anxiety disorder, especially among children above 6 years.

When the gender of the child is considered, it has been suggested that the onset of anxieties may differ developmentally between the genders, with girls having

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earlier onsets than boys [Abe and Masui, 1981]. However, the evidence on this point is contradictory, as males were found to have over anxious disorder in about 2 to 1 ratio over females [Kleinknecht, 1991]. Problematically, means of assessment are different, so inconsistent data are presented.

As regard children of OCD parents. Mansour, (1993) found GAD as a diagnosis to be present among 50% and 70% of children of OCD fathers and mothers respectively. On the other hand, Brynsk, (1998) convinced relation between childhood OCD and other anxiety disorders.

In the present study, both separation anxiety, specific phobias and overanxious disorder were significantly present among children of OCD parents. In a recent study, on a randomly selected group of 210 children aged 8-17 years, 21% of the sample was having one or more anxiety disorder [Kashani and Orvaschel, 1990]. Of those with the anxiety disorder 36% had more than one diagnosis, with the most frequent diagnosis being separation anxiety and over-anxious disorders.

Younger children were troubled mostly by bad dreams, separation from family, presence of strangers, and more often sick to their stomachs. Older children in their teens were more concerned with social fears, past imperfections, and tended to worry a great deal [Kleinknecht, 1991]. Such results were more or less in accordance with the results of the present research.

### **3. Specific phobias**

According to DSM IV criteria for specific phobia, children of OCD parents of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups were having such diagnosis [Table (5-10-A)], with specific emphasis of school phobia which were significant

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among OCD parent's children with no sex difference [Tables (5-11-A) and (5-11-B)].

Such phobias were in the form of fear of darkness, insects, animals, earthquake, self-injury phobia fears related to death, school phobia, and phobias related to sleep.

This might be a manifestation of anxiety or an early manifestation of obsessive compulsive disorder [Rachman and Hodgson, 1980]. Phobic disorder is always associated with an increased family history of anxiety disorders [Ghanem, 2000].

Many children experience specific or simple phobias. About 2 percent of children have clinical-level phobias [Melamed and Segal, 1985], the most common childhood phobias are of animals (*dogs, cats, mice, spiders and the like*) and of illness or injury. If such phobic fears are not treated or do not go away early on, they are unlikely to simply disappear on their own. [Kleinknecht, 1991].

Phobias of animals, darkness and imaginary creatures, frequently have their onset in early childhood [Öst, 1987]. Concerns about performance are reported to being in late childhood [Bauer, 1980]. Whereas interpersonal, social anxiety does so in early adolescent [Öst, 1987]. Such developmentally appropriate fears can be influenced by their context, which include maternal behavior. It would be simplistic to view children's fear as a function of age exclusively [Rutter et al, 1994].

#### 4. Other phobias

Other phobias were also assessed in the present research such as social phobia and agoraphobia. Both disorders were absent statistically among all children of both patient and control groups [Tables (5-12) and (5-13)].

Although many manifestations of social fears were present among children under investigation, they do not fulfill the DSM IV criteria for social phobia. On the other hand, no data were recorded regarding criteria for Agoraphobia.

Social phobia characteristically occurs with greatest frequency during adolescence which is in any case a time of acute self consciousness. Although shyness is very common during adolescence [*OCD parent's children was showing such symptom (shyness) among them above the age of 12 (Table (5-15-C))*]. True social phobia with typical avoidance reactions, that are disabling occurs in 1% of young people [McGee et al, 1990].

Also, agoraphobia is extremely rare before adolescence [Kaplan and Sadok 1995]. In the present research OCD parent's children were mostly attached to their parents despite of their illness, as separation anxiety were significantly present among them.

## **II – Depressive Symptoms and Disorders**

Sadness is part of the normal range of emotional reactions. The symptom of depression, however is not synonymous with sadness or unhappiness. Although unhappiness is a prominent component of the depressive mood state, the negative mood of depression may be represented more by features such as feeling of flatness [Hamilton, 1982].

Depression as a disorder implies more than just an isolated symptom such as feeling sad or unhappy. The term syndrome or disorder requires the combination of many symptoms to form a symptom complex. In most classification systems, the syndrome of depression is defined by the combination of depression mood with certain associated symptoms, particularly a negative style of thinking, loss of enjoyment, and somatic symptoms such as loss of energy, reduced sleep and others [Rutter et al, 1994].

It will be appreciated that to define the syndrome of depression in terms of number of symptoms only, may give rise to error. For example, one person with many minor symptoms causing no impairment may be seen as suffering from the depressive syndrome, while another person with few symptoms causing much impairment may not be so regarded.

Accordingly most diagnostic systems include additional criteria that are intended to sharpen the differentiation between depressive symptoms and disorder. For instance, the DSM IV definition of major depressive episode requires that symptoms have been present during the same 2-weeks period and there is an impairment.

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The idea that children can develop conditions that are the same as these depressive disorders of adults has been controversial [Rutter, 1986a; Harrington, 1989].

Indeed, until recently it was widely believed that depressive disorders could not occur in childhood or that if they did occur then they took a "masked" form, being expressed through symptoms such as delinquency, phobias, enuresis and others. However, the use of symptom-oriented personal interviews with children has now led to widespread recognition that disorders resembling adult depression can and do occur in childhood. Indeed, in DSM IV the criteria for pre-pubertal, adolescent and adult depression are identical [Rutter et al, 1994].

However, perhaps more importantly, the strategy of applying unmodified adult criteria to children has been criticized because it ignores developmental research on age changes in the frequency and expression of affective phenomena.

Three developmental issues are especially relevant. Firstly, there are substantial age differences in the occurrence of most forms of affective phenomena [Rutter, 1986b; Angold, 1988a,b]. Secondly, children differ from adults in their ability to experience some of the cognitive features said to characterize adult depression, such as guilt. Thirdly, the valid application of adult criteria to children requires not only that they are capable of experiencing depression, but also they can report it accurately [Rutter, 1986a]. It seems that young children have limitations in this last respect, frequently confusing emotion such as sadness and anger.

Clearly, then it is better to identify age-appropriate symptoms of depression. That take into account the child's level of functioning in various cognitive and

affective domains [Carlson and Garber, 1986; Harrington, 1991]. So, developmental approaches to the diagnosis and classification of affective conditions among the young require more investigation, though they are going to be difficult to define [Rutter et al, 1994].

The present research is a trial to solve such problem, as most of the symptoms under investigation were classified according to child age.

As mentioned earlier, depressive reaction to stress between children start to appear with a very high level of stress. When considering living with an OCD parent a chronic negative life adversity, children of such parents may respond to such life experience with the development of such symptomatology.

So, the risk for development of depressive symptoms and disorder among relatives of OCD parents may be attributed not just to maternal or paternal psychopathology and genetic factors but also to the concurrent chronic stress within the family.

On the other hand, about two third of OCD patients have a lifetime history of major depression. The majority (85%) of those who are depressed have a mood disorders secondary to their OCD [Rasmussen and Eisen, 1988].

Having a depressed parent, probably doubles the risk for the offspring having depressive symptoms or disorders before 18 years [Kaplan and Sadock, 1995].

Threats to the child's well being that arise because of an event at home or at school, will have a more powerful effect if the child is emotionally vulnerable because of his personality or other adverse background [Goodyer et al, 1987].

So, children of OCD parents are not only involved by the nature of their parent's illness (*obsessions and compulsions*), but also by the other adverse circumstances and parental mood changes usually presented with OCD.

### **A. Depressive Symptoms According to Child Age**

On reviewing the results of the present study, depressive symptoms were found to be present among children of OCD parents with significant predominance among children of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups (*above 6 to 12 and above 12 to 15 years respectively*) [Table (5-14)].

The absence of significant depressive symptoms among children of the 1<sup>st</sup> age group (*3-6 years*) was also supported by many other researchers. **Kaplan and Sadock (1995)** reported that mood disorders among preschool children are extremely rare, while **Rutter et al, (1970-a)** stated that depression in such age group is uncertain, largely because of lack of agreed criteria appropriate for this age group. Also, there is an increase in rates of depression with age [**McGee et al, 1992**].

In the preadolescent period, 10-15% of children show depressed mood [**Rutter et al, 1970a**]. Meanwhile **Kaplan and Sadock (1995)** estimated that about 5% of prepubertal and 15% of adolescents have mood disorders.

The depressive symptoms experienced by OCD parent's children of the 2<sup>nd</sup> age group (*above 6 to 12 years*) were mainly: feeling miserable and unhappy, easy fatigue, inattention and poor concentration, excessive slowness and poor appetite.



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While children of the 3<sup>rd</sup> age group (*above 12 to 15 years*) showed the significant presence of: unhappy feelings, easy fatigue, flat emotions, worthlessness as well as excessive slowness.

Depressive symptoms were present among 50% of children of OCD parents [Mansour, 1993].

According to Pearce (1998), depressive reaction among children start to appear with a very high level of stress, and this could explain why parental OCD in the present study affected mainly the older children especially when duration of illness of the parental OCD were considered (*Mean duration of parental OCD in the present study was = 10.68 years and SD was = 6.85*) which is so long to affect the older children.

Graham (1994) described many depressive symptoms among children aged 6 and above. Among such symptomatology was: poor concentration and inattention, apathy, appetite loss, sense of hopelessness and miserable and unhappy look.

Mostly, symptoms such as poor concentration, inattention, apathy, slowness and poor appetite are masked symptomatology for depression and does not attract parental attention for underlying psychopathology.

Barker (1988) described depressed mood that is a mood of sadness and gloom together with tearfulness as an essential feature for depressive disorder. Such symptomatology was significantly present among children of both the 2<sup>nd</sup> and 3<sup>rd</sup> age groups. On the other hand, self blame and feelings of unworthiness and guilt, of a degree not justified by circumstances are often present among depressed children. Such worthlessness was significantly reported among older children (*above 12 years*).

According to **Pearce (1998)**, children who suffer from depression will always have other symptoms as well as just being miserable. It is more helpful to divide the symptoms into those that are specific to depression and those that are not. The specific symptoms of depression are hopelessness and worthlessness. So it is not surprising that suicidal feelings and fears related to death are commonly associated with depression. The non-specific symptoms of depression are alternations in sleep and appetite, which, in most cases are reduced but in a few cases they are increased. Other associated symptoms include anxiety, hypochondriasis, irritability and relationship difficulties, poor concentration and loss of interest [Pearce, 1998].

Most of such non-specific symptoms for depression were reported by children under investigation (*OCD parent's children*). Sleep problems, appetite loss, poor concentration and inattention, irritability and tension, temper tantrums as well as many other anxiety symptoms and phobias.

The key symptoms of hopelessness and worthlessness can only develop in children who are at least seven or eight years of age. This is because to be hopeless requires the child to have developed a clear understanding of time and what "*forever*" means. Children do not develop an accurate understanding of time and are not able to tell the time until they are around 7 years of age. Also, at this age children develop a clear understanding of what kind of person they are. This is when children develop self-worth and self-esteem [Pearce, 1998].

Worthlessness was significantly present among children above twelve years of age. Such old children, are more

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likely to show depressive reaction to parental illness, as an effect of long term life adversity.

**Goodyer, et al, (1988)**, suggested that recent adversities (*such as family marital, accident or illness which occurred in the 12 months prior to the onset of disorders in children*) continue to exert pathological effects on children and adolescents in the presence or absence of more chronic social adversities in the child's life. In the present research parental OCD may be considered a chronic life adversity (*The mean duration of illness of parental OCD was = 10.68 years and SD = 6.58*).

Children younger than eight years may become depressed, but they must have been subjected to the most appealing stress that has prematurely forced them into a state of misery and depression. Alternatively, young children can sometimes pick up depression from somebody else, most likely from a parent. Depression just like other powerful emotions can be caught from other people. This type of "*second hand*" depression usually disappears whenever the child spends some time away from the depressed parent. Research shows that parents are often unaware of their child's depression. On the other hand, few parents are convinced that their children are depressed when they are not [**Pearce, 1998**].

**Forehand et al (1987)**; Looked at the relationship between parental depressive mood and child functioning. There was an association between the severity of parental depressed mood and problematic behavior in their children, and that process was bi-directional. **Weissman et al, (1987)** investigated 125 children (*aged 6-23 years*), of 56 depressed parents and compared them with control group who had non-depressed parents. The children of depressed parents were more likely to suffer from depression themselves and at an earlier age than children of non-depressed parents.

When considering parental OCD a chronic life adversity, children of such parents are more likely to have their mothers having poor confiding relationships with their children, more neglecting and depriving their children from affection. Such children are more likely to develop depressive states characterized by apathy and withdrawal [Graham, 1994].

Also, child psychiatric attenders with depressed mood have more commonly previously sustained parental loss or separation [Caplan and Douglas, 1969]. Such results were also experienced by many children under investigation, who described their mothers (*who were continuously living in the same place with their children*) as isolated mothers.

A high level of psychopathology was also reported if the mothers were currently experiencing depressive symptomatology, even if not diagnosed as having a depressive disorder, and diagnosed by other diagnoses especially anxiety disorders. Also depression in the mother is more strongly linked with psychopathology in children than depression in the father [Hammen et al, 1987].

Also children of depressed mothers differed from controls on having inattention, unhappiness and withdrawal in the teacher's rating scales [Rutter, 1990].

As mentioned earlier, secondary depression is the most important form of depression present with parental OCD as a result of many adversities associated with their primary diagnosis [Yarura-Tobias and Neziroglu, 1983]. The presence of many depressive symptomatology among children of OCD parents in the present research may be related to such parental secondary depression.

According to **Pearce (1998)**, depression can be caught from others. Depression leads to isolation, giving up previous activities and generally adopting a lifestyle where there are likely to be few positive and rewarding experiences. Such manifestations may be transmitted to children of OCD parents, leading to the development of depressive symptoms among them. This is not to say that living a life of pleasure will protect against depression but high self-esteem and a good level of confidence will.

The development of self-esteem in children might be impaired by being in painful or unpleasant situation (*living in adverse back ground*) over which they have no control. An important aspect of self esteem is a sense of mastery over the environment. Children brought up in environment in which events occur in random fashion and can not be predicted or anticipated, might lack a sense of mastery and so predisposed to depression [**Seligman and Peterson, 1986**]. So, after several unsuccessful attempts have been made by the child to escape from unpleasant circumstances, lack of motivation and apathy may supervene. A number of depressed children in what, seem to them "*to be hopeless*" fit with this model well. This is what is called "*learned helplessness*" [**Barken, 1988**].

Considerable sadness and misery may accompany the child's feelings of helplessness in the face of his own behaviors (*obsessions or compulsions*) [**Graham, 1994**]. It is important here to notify that among children of OCD parents of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups many OC symptomatology were significantly present such as cleaning obsessions and compulsions, ordering- arranging compulsions and eating obsessions.

On the other hand, OCD children were considered exceedingly slow in completing work assignments

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**[Graham, 1994]**. The presence of excessive slowness in daily activities such as reading, writing, eating, studying, etc, among children of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups of the present study, may fit with Graham's results, such children were extensively anxious and worried about making errors and so they may be either depressed or developing OCD.

**Graham (1994)**, considers excessive slowness one of the children obsessions. On the other hand, such symptomatology may be one of the manifestations of childhood depression **[Hamouda, 1998]**.

Children of OCD parents are mostly vulnerable to develop symptoms and disorders during the course of their parent illness together with their social adversity. Such children may develop depression as a comorbid disorder. **Swedo et al, (1989)** described 26% of children under 18 years to have concurrent anxiety and / or depression with their OC symptoms and disorders. In the present study, many anxiety and OC symptoms were significantly present among children of OCD parents [(Tables(5-21-A), (5-21-B), (5-22-A) and (5-22-B))].

Also, depression symptoms and disorders may be secondary to other child psychiatric disorders such as separation anxiety **[Barker, 1988]**, which was significantly present among children of OCD parents of the present study.

The observation that when anxiety and depression co-occur, onset of the anxiety syndrome typically precedes that of the affective disorder **[Kovacs et al, 1989; Klein, 1990]**. Such observation has implications regarding the developmental relationship between the two affects.

Varying co-occurring symptoms on disorders may reflect a single underlying disorder, or represent different clinical phases of the same disorder over time.

An extensive New Zealand study of 11 year olds reported a 17% rate of depression among children with anxiety disorder. Also, of the 15-year-olds a 14% comorbid rate of depression with anxiety disorder was revealed [McGee et al, 1992].

If children and adolescents with a depressive disorder are selected, rates of comorbid anxiety were very elevated, but differed between childhood and adolescence; 71% and 33% respectively [Harrington et al, 1990].

The present research also suggest the presence of both anxiety and depression among OCD parent children with earlier onset of anxiety symptoms and the later development of depression.

### **B. Depressive Symptoms According to Child Sex**

On reviewing the results of the present study, male children of OCD parents showed significant presence of depressive symptomatology among the all age groups under investigations [Table (5-16-A)]. Comparative to this female children of OCD parents showed the significant presence of depressive symptomatology among the 2<sup>nd</sup> and 3<sup>rd</sup> age groups only [Table (5-16-B)].

There is considerable data to show that boys are more likely than girls to develop emotional and behavioral problems when exposed to marked family disturbances [Rutter, 1982].

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As previously mentioned many mechanisms may operate in explanation of the possibility of development of different anxiety symptoms and disorders in males more than females, which indicate that female protection may depend on biological factors in males and the socio-cultural aspects of gender difference rather than specific differences in the psychology of males and females. Such mechanisms for boys and girls in relation to stress may operate under different conditions and are not mutually exclusive. Biological vulnerabilities may need to be considered in the context of family disorder. The chain of effects that follows may bias further the risk to boys as a consequence of socio-cultural mechanisms.

The diminution of sex differences in depressive symptoms among children under investigation can also be seen in children attending the clinic. The rate of new onset depressive illness is approximately equal in boys and girls [Goodyer et al, 1988].

**Garrison et al, (1989)** supported the previous result as there is little difference between school children and preadolescent boys and girls in the rate of depressed mood and depressive disorders.

Furthermore, boys and girls are equally likely to be exposed to severe recent life events, suggesting that gender does not protect or promote exposure to these types of recent social adversities [Goodyer et al, 1988].

This suggests that protective effects of femininity, biological and socio-cultural, have thresholds for their effects. Cases attending clinics represent the severe end of disorder, where gender effects have been overcome, at least as far as the development of significant psychopathology is concerned.



What is not clear is what are the mechanisms which operate to overcome the effects of gender. For example, biological factors may unfold both genetic and acquired factors such as parental damage. Females from families with high genetic loading for affective disorder may have a greater biological propensity towards psychopathology than females with no such genetic loading [Goodyer, 1190].

On the other hand, many characteristics may attribute to the prevention of psychopathology. Competitiveness and self-aggrandizement are seen as components of "maleness", whereas characteristics such as empathy, nurturance and warmth as "femaleness" [Spence and Helmreich, 1978]. Concepts defined as masculine may be stronger correlate with positive mental health [Taylor and Hall, 1982].

Recent findings indicate that depressive symptoms in females are correlated with a low level of masculine attributes [Wilson and Cairns, 1988]. Thus low masculinity was related to depression in both sexes in that study. The results do not support a direct effect of sex-role attributes on depressive symptoms, as the level of masculinity was constant across all ages, but the prevalence of depressive symptoms showed a significant increase with age. The findings suggest that the origins of sex-role attributes will be found in pre-school and preadolescent years but their effects as an indirect vulnerability factors only become apparent during the teenage years.

It seems that among the depressed children, the sex ratio is about equal, or there is a male predominance, but by adolescence the female predominates as the adult population. However, data from clinical samples

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suggested that the switch of sex ratio begins around the age of 10 years, with rates of depression increasing steadily in both boys and girls, but with the increase of age, being more marked in girls [Angold and Rutter, 1992].

Possible explanations for these age trends and sex difference reviewed by, Rutter (1991), include an increase in risk factors (*e.g. hormonal changes, genetic factors, increased adverse life events*), a decline in protective factors (*e.g. loss of social support, changes in ability to experience depressive cognitions*) and measurement artifacts.

Rutter, (1986) also pointed out that, before puberty there are about twice as many as boys as girls with depressive symptoms. Whereas after puberty the situation is reversed.

This might explain the higher significance of depressive symptomatology among males of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups (*6 and above*) compared to females of the same age range.

### **C. Depressive Disorders According to DSM IV**

The two depressive disorders described by DSM were Dysthymia and major depressive episode.

#### **1. Dysthymia**

Dysthymia was significantly present among OCD parent's children of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups (*above 6 to 12 and above 12 to 15 years respectively*) [Table (5-17-A)].

According to DSM IV, children and adolescents with dysthymic disorders usually describe their mood as

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irritable, cranky rather than depressed or sad and unhappy. Both the irritable and unhappy moods were significantly present among children of OCD parents. Irritable mood were significantly present among children of the 2<sup>nd</sup> and 3<sup>rd</sup> age groups, also the unhappy feelings, sadness and tearful look were characteristics of such children.

Dysthymic criteria also, attribute the significant present of two or more of the following symptomatology: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self esteem, poor concentration or difficulty making decisions and feelings of hopelessness.

Most of the previously mentioned symptomatology were significantly present among children of OCD parents. For example, poor appetite was significantly present among the children of the 2<sup>nd</sup> age group, insomnia and hypersomnia together with apathy and easy fatigue were reported by children aged 6 up to 15. Also, poor concentration and inattention were significant depressive manifestations of children of the 2<sup>nd</sup> age group.

On the other hand, dysthymic disorder has an early and insidious onset (*i.e. childhood and adolescents*). This was proved in the present study, as dysthymia started to be significantly present among children aged 6 and above.

Dysthymia was significantly present among both boys and girls of the second and third age groups [Table (5-17-B)].

Such disorders were significant among males of the 2<sup>nd</sup> age group (*6 to 12 years*) and both males and females of the third age group [Table (5-17-B)].

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This is in accordance with data which outnumbered school age boys than girls in depressive disorders. Such difference disappears with adolescents [Kaplan and Sadock, 1995].

The Dysthymic disorder according to DSM IV applies to longstanding (*1 year for children and adolescents*) mood disorders characterized by mild depressive symptoms.

Carlson and Cantwell (1980), found that 60% of referred children had depressive symptoms, 49% had a depressive syndrome and 28% had an affective disorder. Kolvin et al, (1991) estimated that 1 in 3 outpatients at a child psychiatric department had significant depression and 1 in 4 had major depression.

Research on the psychosocial correlates of childhood emotional problems are at an early stage. In the presence of acute adversity it seems that children are equally likely to become anxious as they are to become depressed [Goodyer et al, 1988]. Also, the needs to know about the mechanisms by which such external psychosocial stressors lead to internal mood state of depression. Many psychological models have been devised to explain these links, but perhaps the most influential among investigators of childhood depression has been the idea of learned helplessness.

It is asserted that the expectation of uncontrollable adverse events leads to depression, but only if the person attributes them to internal, stable and global causes [Rutter et al, 1994]. The reformulated learned helplessness theory has many similarities with the so-called cognitive theories of depression, the depressed people were characterized by a negative cognitive set: They had a negative view of themselves, of the world and of the future.

## **2. Major depressive disorder**

As a diagnosis, major depressive episode (*between children under investigation*) was absent. This was also proved by many researchers as major depressive conditions are considerably less common among children [Kashani et al, 1983].

### III. Obsessive Compulsive Symptoms and Disorders.

Until, recently, obsessive compulsive disorder (*OCD*) was unfamiliar to most child psychiatrists, even though, classic description of the disorder featured cases with childhood presentation. The recognition that OCD was more common in adults than previously believed, and the retrospective reports suggest that one-half to one-third of adult subjects had their onset in childhood or adolescence, focused the attention of the child psychiatric community on this chronic and often disabling disorder [Karno et al, 1988].

Children of OCD parents are soaked in their parents rituals and abnormal behaviors and thinking, that may negatively alter their behavior. However, there is normal superstitious behavior and developmental rituals, that can occur normally in children. The absence of compulsive traits among control children, supports to a great extent the relation between parent's illness and compulsive behavior among their children.

Although the clinical presentation in young children is similar to that in older children and adolescents. Familial OCD appears to be increased among young children, suggesting that genetic factors may be more prominent in this subgroup [Rutter et al, 1994].

Obsessional symptoms among children have been seen as an unconscious defense against internal anxiety, or as learned avoidance responses to anxiety provoking situations. They can also be seen as exaggerations of adaptive behavior, for repeated checking against danger, that is of survival value [Graham, 1994].

As mentioned earlier, children of obsessional parents are at high risk for various psychiatric morbidity including OCD. If direct and vicarious social transmission contribute in any significant degree to the genesis of obsessions and/ or compulsions, then the children of OCD parents should display a significantly elevated incidence of such problems.

Also, many investigators agree to the strong genetic component to its development [Nicolini et al, 1999]. Three main ways of studies concluded the genetic basis of such disorder: studies of familial incidence, of monozygotic and di-zygotic twins and studies of adoptive parents. Mostly it is a bi-directional gene-environmental correlation.

There is often a strong family history with about two thirds of parents of OCD children showing obsessional tendencies and about 5% obsessional disorders [Clark and Bolton, 1985].

The presence of OC symptoms among children of OCD parents may play an important role in vulnerability for either episodic or chronic OCD later on, according to the duration of OC symptoms, its severity, comorbid symptomatology, and the severity of their parent's illness [Thomson, 1995].

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**A. Obsessive Compulsive Symptoms**  
**According to Child Age**

On reviewing the results of the present study, children of OCD parents of the first age group (*3 to 6 years*) showed the significant presence of some OC symptoms which were: cleaning obsessions and compulsions (*excessive hand washing*), eating rituals, and counting compulsions. On the other hand, children of control parents showed significant presence of "*bed time rituals*" among them [Tables (5-20-A) and (5-20-B)].

Older children (*above 6 to 12 years*) showed the significant presence of perfectionism, eating rituals, cleaning obsessions and compulsions as well as ordering-arranging compulsions, among children of OCD parents [Tables (5-21-A) and (5-21-B)].

On the other hand, OCD parent's children above 12 years showed the significant presence of eating rituals as well as cleaning obsessions and compulsions only [Table (5-22-A)].

Rituals were more frequently the presenting complain than were obsessions. A combination of rituals and obsessions was most common, and pure obsessives were rare compared with the more frequent pure ritualizers [Swedo et al, 1989c].

Cleaning obsessions and compulsions were the most frequently presenting OC symptom among the three age groups under investigation. That result was in accordance with many other researchers' results.

Susan et al (1992), described washing rituals as the most common OC symptom, affecting over 85% of



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children at some point of time. Hand washing was slightly more frequent than showering [Goodman et al, 1989].

Washing and cleaning compulsions were much more common among children than obsessions. It may occur in its absence. Almost all cases at some time experience excessive washing as one symptom [Rapoport et al, 1995].

Children before 8 years, would have elaborate washing or checking rituals, without cognitive obsessions [Swedo et al, 1989].

The excessive washing was manifested by either increased frequency, ritualized washing patterns that took several minutes or longer to complete, or excessively slow hand washing. No child reported excessively long or frequent baths [Susan et al, 1992].

The present research proved such results as washing rituals, in the form of excessive hand washing, were reported by children of different age group. Neither uncleanness feelings nor washing compulsions were revealed although it was reported by some children. Such washing ritual may be either related to parental cleaning obsessions (*which were significantly a major manifestation among almost all OCD parents*) or related to an underlying cleaning obsession to the child or adolescent himself, which was difficult to be verbalized by children under investigation.

Many children reported that their excessive hand washing were related to their parental needs, others were participated in such parental compulsions against their will. Also some children especially younger one were participated in such rituals to prevent harm on themselves.

Some adolescents were refusing to use common bathrooms even if they are clean, for either fear of contamination, or according to parental needs.

**Grados et al, (1997)**, proved the close correlation between fear of contamination and cleaning compulsions, in terms of escape and passive avoidance.

The second most presenting symptom among children of all age groups, were the eating rituals. Such rituals can also be considered as a part of cleaning obsessions and compulsions. The OCD parent's children were highly concerned about the use of their own eating utensils only, and the feeling that they are contaminated if others use them.

This was very related to **Khanna and Srinath (1998)**, as fear of use of impersonal objects were significantly commonly reported among OCD children. Also, thoughts of contamination and uncleanness was described by **Riddle et al, (1990) and Thomson, (1995)**.

On the other hand, bed time rituals were experienced by control parent's children below six years. Such result was in accord with **Yaryura-Tobias and Neziroglu (1997)**, as bed time rituals were considered a normal childhood compulsive behaviour, that begins around the age of 3 and 6 and disappears rapidly, and can be considered as a part of normal development.

Counting compulsions were significantly experienced by OCD parent's children below 6 years, and was completely absent among control children. It could be related to parent illness as an avoidant response for anxiety provoking parental behaviour, as very young children may ritualize for facing their anxiety [**Graham, 1994**].

**Yaryura–Tobias and Neziroglu (1997)** consider arithmo-mania and counting compulsions a common form of ideational compulsions. In grade school years counting and symmetry were particularly common [**Rutter et al, 1994**].

Another OC symptom that was presented by OCD parent's children aged 6-12 years was ordering–arranging compulsions.

**Garrison, (1995)** considered arranging compulsion the most common compulsion (56%). Obsessional symmetry, ordering-arranging and exactness were experienced by about (17%) of young OC children [**Swedo et al, 1992**].

Such children were concerned about arranging things (*e.g. toys, cubs, cars*) according to their color, shape or nature, putting things in specific order, as well as arrangement and rearrangement of objects were also experienced by such children (*aged 6-12 years*).

Washing, checking and ordering rituals were particularly common among children according to DSM IV. This is in accordance with the results of the present research.

Another important obsessional behaviour experienced by children of the 2<sup>nd</sup> age group were perfectionist external appearance and the excessive need for mastery as well as tidiness. **Rapoport, (1986)** considered OC children as being excessively perfectionist as well as neat and tidy. This may also come with the perfectionist life style characteristic for OCD families.

Such perfectionistic character may be also a part of the generalized anxiety of such children, as over anxious disorder was manifested among children of such age group.

Only, about 26% of children having obsessive compulsive symptoms or disorders as a single diagnosis. Although a secondary diagnosis may be relatively mild, depression either life time or current and anxiety disorders were the most common associated disorders, and are equally likely to predate or follow the onset of OCD [Rutter et al 1994].

Fifteen of a total of 20 subjects received a life time diagnosis of OCD (*18 current and 2 with past illness*), had one or more other life time psychiatric diagnoses (*10 current*), with depression, bulimia, over anxious disorder most common [Whitaker et al, 1990].

As far as the present research is concerned, many of children of OCD parents revealed different diagnoses. Anxiety, depression and obsessive compulsive manifestations were significantly revealed with variable degrees. More investigation is needed to give a good explanation to the coalescence of such disorders as regard both the onset and the possible comorbidity of each of them and the others.

Also, a possible relationship between irrational fears particularly of cleanliness and contracting illness, and obsessive and compulsive behaviors were considered [Kleinkneef,1991].

Such irrational fears were considerably reported among children under investigation. The possible correlation of such fears, for example fear of death or fear of self-injury may also be considered with the manifested obsessions and compulsions especially cleaning obsessions. On the other hand fear of death and fear of something terrible happening (*e.g. fire, death, illness*) was one of the presenting obsessions of Goodman et al, (1989).

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To sum up, children of OCD parents reported many OC symptoms such as cleaning obsessions and compulsions, eating rituals, ordering-arranging compulsions, counting compulsion, as well as perfectionism.

Among Egyptian studies 50% of children of male OCD parents presented with ruminations compared to 30% having rituals. On the other hand 20% of children of female OCD parents have OC traits mainly rituals.

Early recognition of such early obsessive compulsive traits and disorders is very important, as further episodes are likely to develop at later time in about 20-60% of early onset cases [Zeitlin, 1990].

### **B. OC Symptoms According to Child Sex**

On discussing the relation between the OC symptom development and the child sex. Many literature described the correlation between the early OC symptomatology and the male sex [Swedo et al, 1989; Graham, 1994].

Among children below 6 years, females of OCD parents showed significant presence of counting compulsions, while control parent's showed the presence of bed time rituals among their male children [Tables (5-26-A) and (5-24-A)].

Perfectionism was the only significantly present OC symptom among males of the 2<sup>nd</sup> age group (*above 6 to 12 years*). It was the only OC symptom presented among male children of OCD parents [Table (5-B-24)].

Females above 12 years reported many OC symptoms that were: perfectionism, counting compulsion, school rituals as well as ordering-arranging compulsions [Table (5-26-C)].

The significant presence of counting compulsions among females of the 1<sup>st</sup> age group may be a response to anxiety – provoking environment, as living with an OCD parent is too stressful, and children may ritualize in response to such stress [Graham, 1994].

On the other hand, the presence of bed time rituals among male children of the first age group can go with the previously mentioned data, as bed time rituals were considered a normal compulsive behaviour that commences around such age [Yaryura –Tobias and Neziroglu, 1997].

Perfectionism was present among male children of OCD parents as part of their symptomatology. It may be part of their over-anxious behaviour or related to Juvenile onset OC symptomatology, as boys outnumbered girls, [Judith et al, 1992]. Also among obsessionals who do not have compulsive rituals, male predominate [Kleinknecht, 1991].

As children get older, female children (*above 12*) of OCD parent exceedingly have OC symptomatology compared to control group. Such symptoms were mainly compulsions (*counting compulsions, school related rituals, ordering-arranging compulsions*). This was in accordance with Garrison et al, (1995) as females were more likely to show compulsions than males.

School related rituals significantly present among females above twelve years may also be related to their over-anxious behavior with excessive worry about competence at school, school phobias as well as perfectionistic behaviour significantly reported among them.

### **C. Obsessive Compulsive Disorder According to DSM IV Criteria**

OCD as a diagnosis, was present among both patient and control group children, but without the presence of significant difference except for female children above 12 years of age.

Current debates about diagnostic criteria-including whether obsessions are inevitably present, and what degree of insight is required concerning the irrationality of symptoms are of particular importance for childhood OCD. DSM IV state that compulsions are designed to neutralize or prevent some dreaded event. This may be in error, about 40% of children with typical compulsive rituals deny associated obsessions [Swedo et al, 1989c], and surprisingly similar figures are also available for adults [Karno et al, 1988] suggesting that neutralization is not relevant at any age. While some children may not be willing or able to verbalize associated thoughts, long term contact with these subjects indicates that many children report only rituals accompanied by vague discomfort if these rituals are not carried out and without any associated thoughts.

The degree of insight needed for the diagnosis is also in dispute, as some young or even old patients, at least some of the time "*believe*" their obsessions.

However, generally children do not differ from adults in this respect. While in theory it might seem that young children would be particularly prone to "*believe*" their obsessional thoughts, experience to date suggests that the DSM IV adult criteria are appropriate for the diagnosis in childhood. It seems however that for both adults and children, diagnostic criteria must acknowledge that

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compulsions can and do occur in the absence of obsessions, and that partial “*belife*” in the necessity for these thoughts/behaviors is seen, particularly in severe cases [Rutter et al, 1994].

Among children, the fully developed OCD is much less common than different OC symptoms. It has been described as occurring in 1-2% of American high school students with a significant number describing their symptoms as having begun before puberty [Flament et al, 1988]. Preadolescent and adolescent females were revealed the same results.

Also Graham (1994), described children of OCD parents to have higher incidence for obsessional traits rather than a definite obsessive compulsive disorder, the fact that prove itself in the present study.

However, the diagnosis of OCD is straight forward even with very young subjects. Subjects with an early age at onset may begun their rituals or obsessions in easily recognizable fashion, with only minor allowances for developmental level. Young children with tantrums when there rituals become interrupted together with subjective distress at having to do them with lack of other behavioral abnormalities lead to the diagnosis of OCD.

However, the significant absence of OCD among OCD parent’s children may be related also to the fact that the affected probands tend to deny any symptomatology among their children (*there was difficulty in collecting data about OC symptoms from mothers and fathers*). Also children tend to keep their ritualistic behaviour hidden.

The improper data as regard time consumed in each ritual and the degree of impairment may also play a role in absence of such diagnosis among children of OCD parents.



Also, observation as a method for collection of data and investigating such children is very important, as many parents and children are not capable of providing the accurate information as regard child behaviour.



# Recommendations



## **RECOMMENDATIONS**

To help OCD families to best cope with their possible problems related to the presence of such disorders within the family with its possible symptomatology, and the impact of its hazardous involvement of each of the family member especially children in the parental obsessions and compulsions. The following are suggestions and recommendations

### **I. Education**

This is crucial in helping patients and families learn how best to manage OCD and prevent its complications and its possible hazards on both the patient and the other family members.

#### **A. For the parents and their families**

1- parents and their families as well as others close to them are in need to learn all about OCD, its possible symptomatology and possible treatments. Each of the OCD parents can help him / herself to get the best treatment, and the best support for his / her family, to keep the illness under control and prevent its possible hazardous side effects especially on children.

OCD parents should look at their compulsions, start a new strategy in management, as it is true that their illness is reflected on their children.

2- Helping the OCD parents to understand that there are treatments, that can help, is a big step towards getting the person and his / her family into treatment. This can be done through health education, radio and T.V programs, that could explain the disorder in its simplest way, to help

people know that they need help and need to ask professionals.

3- Reading books, attending lectures, talking to professionals (*family doctors or psychiatrists*) can help OCD families to solve their possible problem in the most rapid and perfect way.

4- An available booklet, to be written by psychiatric professionals may give a great help to OCD families to live with such devastating illness. Such booklet should give good advice and practical tips to help family members learn how to support their loved mother / father, and learn to cope with the disorder. Many families member feel frustrated and confused by the symptom of their parent illness. They don't know how to help their loved parent, help each other and help themselves.

### **B. For school teachers and school psychologist**

1- Both school teachers and school psychologists should be aware and understanding every thing about the disorder. They have an important role in identifying students at risk for OCD, through regular assessment using modified checklist and rating scales, child interview and direct observation (*The most important*).

2- School teachers and school psychologists should also be interactive in management of such problem together with the treating physician and other clinicians for best comprehensive management.

### **C. For the clinicians and medical health professionals**

1- It is important to raise the knowledge about the disorder among such health professionals. Many

clinicians don't know what's OCD, Its possible symptoms, and the ways of management. This will help to a great extent in early detection and management of many lost cases, which will then prevent many hazards on their families.

2- The therapist can help family member learn to become gradually disentangled from the parent's rituals, in small steps and with the patient agreement. The parental refusal to participate in treatment will not help the patient learn life long strategy for coping with OCD symptoms.

3- Family intervention and family therapy with some interactive education session and even a monthly group meeting (*to see several families together*) could give a great help.

#### **D. For the common people**

1- Every person should know what is OCD. most of us deal with individuals having the disorder. If our knowledge about the disorder is raised, we can help many of them in both early detection and prevention of further complications.

2- Pathology-free individuals need to be more co-operative with the research programs. This will reflect itself on all of us to obtain the best reliable results.

## **II. S.O.S. Obsessions**

An emergency line to help relatives for counseling and assistance.

### **III. Support Groups**

Support groups can be very helpful to OCD families. They could be either related to Governmental health institutes or non governmental social organizations.

### **IV. Financial Support**

It is also important to support such high-risk families (*OCD families*) financially, to gain the best treatment strategies, both the medical treatment and other ways of management.

### **V. Research Wise Recommendations**

1- Further researches should be directed to investigate the impact of mental illness on the rest of the family in every aspect.

2- Screening for child mental health problems. Such screening researches are very deficient in our country, especially when researches are concerned with children of mentally ill. Also, it is important to have working knowledge of the main risk and the protective factors for child psychiatric disorder. Most of which are family related.

3- Identification of risk and of disorder must be closely linked with the specialist multi-professional treatment services.



# summary and conclusion



## SUMMARY AND CONCLUSIONS

In the field of psychiatry, family processes and interaction, as an etiological factor for most of psychiatric disorders, have typically been examined by many researchers. Comparative to this, few researchers have studied the impact of the presence of psychiatrically ill member on the rest of the family members (*especially children*), or to what extent they cope with their various psychosocial problems.

Parents are responsible for providing adequate environment to make their children thrive physically, emotionally and intellectually. On the other hand, parental mental illness may alter to a great extent such healthy upbringing atmosphere, that may result in many psychosocial problems for children.

Moreover, parental obsessive compulsive disorder is not uncommon psychiatric illness, in comparison to the rest of adult psychiatric population. Anxiety and depression are common disorders that always experience themselves in addition to the original parental obsessions or compulsions. Such concomittant disorders are always provoking to many adverse psychosocial problems.

Children of OCD parents accommodate their parental rituals through either participation in behaviors related to such rituals or through modification of daily functioning. They may also be negatively affected by such adverse life experiences and develop emotional or behavioral problems.

Few studies have been carried out investigating the effects of family adversity of parental OCD on the preschool and school-age children especially in our country.

The aim of the present research is to find out the possible psychiatric morbidity that might be manifested among children of

obsessive compulsive parents with special emphasis on: anxiety, depressive and obsessive compulsive symptoms and disorders. Such illnesses were investigated according to the child age, sex and DSM IV criteria.

For such purposes two groups of parents as well as their children were highly selected and they were named.

- I. Patient group parents (*OCD probands*).
- II. Control group parents (*psychological and organically free comparison group*).

The two groups were selected according to restricted inclusion criteria as each of the parents (*either patient or control parents*) has to be:

- Egyptian regardless his / her age, sex or social background.
- Having children of either or both sexes, aged 3 to 15 years of age.
- Continuously living with their children for the last six months until being assessed.
- **For the OCD parents:** they should fulfill the DSM IV criteria for OCD.
- **For the control parents:** they should be free from any physical or psychiatric disorders as well as not receiving any medical treatment including substance abuse and addiction.

**Many parents were excluded from the research as follows:**

- Parents refused to participate or refused to include their children in the research programme.
- Unmarried OCD cases, or married and having no children or having children out of age under consideration.
- Parents having children with any other mental disorders especially mental retardation.

Consents were taken from each of the OCD parents and control parents after prolonged explanation of both the steps and the importance of the study. All parents as well as spouses and other caregivers gave voluntary consent. Subjects refused to participate were excluded from the study.

**The present study was performed on subjects as follows:**

**1- Patient group parents (*OCD parents*)**

The first nineteen OCD parents attending the outpatient clinics of Institute of Psychiatry, Ain Shams University and some private clinics, and fulfilled the DSM IV criteria for OCD, as well as their children [*children no. = 42: (males = 17, females = 25)*].

**2- Control group parents**

Thirteen psychologically and organically free subjects volunteered for the ongoing study, matched as much as possible with the patient group as well as their children [*children no. = 35: (males = 18, females = 17)*].

Pilot study was performed on (5) OCD parents as well as their children (*no. = 8*). According to the results of the pilot study, new symptom checklists for all the symptoms and disorders under investigation were organized.

Such symptom checklists classified children into three age classes (*for better assessment of different symptomatology according to child age*) as follows:

AC I = 3 to 6 years.

AC II = above 6 to 12 years.

AC III = above 12 to 15 years.

Psychometric properties of the new symptom checklist were estimated as follows:

**(1) Content validity:**

All the symptom checklists were given to 10 professors of psychology and psychiatry to judge the relevance of the items in each scale for assessment of the disorder under consideration. The judges either add, remove or rearrange any item that was found to be unsuitable or inapplicable.

The possible rearrangement of the scales was done, then the checklists were rejudged by 5 professors of psychology and psychiatry, after doing the possible modifications. They all agreed for the validity of items in assessing different symptomatology.

**(2) Reliability:**

Reliability of each of the symptom checklists, with its sub-scales were tested using the "*alpha cronbach*" technique. All the reliability coefficients were significant at 0.01 level.

That means that it is suitable for use for assessment of the disorders used for it.

**All OCD parents as well as control parents were subjected to:**

- 1-Parent evaluation sheet - for collection of personal data.
- 2-DSM IV criteria for OCD.
- 3-The Arabic version of Yale Brown obsessive compulsive scale (Y-BOCS).

**All children of either OCD or control parents were subjected to:**

- 1- Child and adolescent evaluation sheet.
- 2- Assessment of anxiety symptoms and disorders using:
  - a- Anxiety symptoms checklist for children.
  - b- DSM IV criteria for different anxiety disorders and phobias: [*GAD (including over anxious disorder in children), separation anxiety, specific phobias, social phobia and agoraphobia*].
- 3- Assessment of depressive symptoms and disorders using:
  - a- Depression symptom checklist for children.
  - b- DSM IV criteria for depressive disorders (*Dysthymia and major depressive episode*).
- 4- Assessment of obsessive compulsive symptoms and disorder using:
  - a- Obsessive compulsive symptom checklist for children.
  - b- DSM IV criteria for OCD.

Application of tools on each individual takes from 30-45 minutes, and sometimes there was need to reassess some cases.

Many application difficulties were faced such as, the problem of collection of cases in item of the restricted inclusion criteria and the problem of making the subjects agree to participate in the research and include their children. On the other hand, the problem of application of the tools on young children was very time consuming.

Data were collected and tabled then analysed using the SPSS computer programme. T-test and ANOVA techniques were the main statistical methods used for analysis of data.

The main results of the present research were classified according to the different disorders under investigation as follow:

**I- Anxiety symptoms and disorders**

Regarding anxiety symptoms and disorders, most of children of OCD parents reported such manifestations according to their age, sex and DSM IV criteria as follows:

**A- Children aged 3 to 6 years:**

Children of such age group did not show any significant anxiety symptoms except the separation anxiety disorder which was significantly present among such children with no sex difference.

**B- Children aged above 6 to 12 years**

Children belonged to such age group showed the significant presence of anxiety symptoms. Many anxiety symptoms were reported such as: tension and worry throughout the day, sleep problems (*especially night mares*), psychosomatic symptoms (*especially loss of appetite*), irritability and tension, temper tantrums, regression symptomatology and spesific phobias (*such as school related phobias, fear of animals, of insects, darkness.....*). Males reported such anxiety symptoms more than females.

Separation anxiety, generalized anxiety disorder and specific phobias as diagnoses (*according to DSM IV*) were significantly present among such age group children.

Both separation anxiety and specific phobias were more significant among males, whereas generalized anxiety disorder showed no sex difference.



## **C- Children aged above 12 to 15 years**

Children of such age group showed many anxiety symptoms which were highly significant among them. Such symptoms were in the form of: tension and worry throughout the day, sleep related problems (*especially insomnia, hypersomnia, nightmares*), irritability and tension, specific phobias especially: school related phobias, self injury phobia, and fear of death of themselves and the others (*especially mothers*).

Both male and female children revealed such anxiety symptoms with more significant symptomatology among females (*males = 0.03, females = 0.004 level of significance*).

Generalized anxiety disorder (*including over anxious disorder in children*) were significantly present among children of such age group with no sex difference. On the other hand, specific phobias were present among such children especially males.

Separation anxiety disorder was not significantly present among children of that age group.

Moreover, other phobias such as Agoraphobia and social phobia as diagnoses were not reported at all by any of the children under investigation of both patient and control parents.

## **II- Depressive symptoms and disorders**

When depressive symptoms and disorders were considered, children of OCD parents reported the following results according to the child age, sex and DSM IV criteria for different depressive disorders as follows:

### **A. Children aged 3 to 6 years**

Children of such age group showed no significant depressive symptomatology among them, but when sex of the child was

considered, male predominance was revealed. Both Dysthymia and major depressive episode were completely absent among such age group children.

### **B- Children aged above 6 to 12 years**

Depressive symptomatology were highly significant among children of such age. Such symptoms were in the form of; feeling unhappy and miserable, easy fatigue, inattention and poor concentration, excessive slowness and poor appetite. Both male and female children showed the significant presence of such symptomatology.

Also Dysthymia was highly present among such children with male predominance.

### **C- Children aged above 12 to 15 years of age**

Children of such age group showed the significant presence of depressive symptoms. Such symptomatology was: feeling miserable and unhappy, easy fatigue and loss of energy, flat emotions, worthlessness, poor appetite and excessive slowness. Both male and female children showed the significant presence of such symptomatology.

Moreover Dysthymia as a diagnosis was significantly present among children of the third age group. Both males and females reported such diagnosis.

Major depressive episode as a diagnosis was completely absent among children of both patient and control parents of the three age groups under investigation.

### **III- Obsessive compulsive symptoms and disorder**

Obsessive compulsive symptoms were significantly present among children of OCD parents according to their age and sex as well as DSM IV criteria as follows:

#### **A. Children aged 3 to 6 years**

Children of such age group showed many OC symptoms such as eating rituals, cleaning obsessions and compulsions (*excessive hand washing and counting compulsions*).

Females showed significant presence of counting compulsions while males showed no significant obsessions or compulsions among them.

On the other hand, OCD as a diagnosis was completely absent among children of both patient and control parents.

#### **B- Children aged above 6 to 12 years**

Children belonging to such age group showed the significant presence of perfectionism and mastery, eating rituals, excessive hand washing and ordering arranging compulsions.

Perfectionism was specifically present among males of such age group.

On the other hand, OCD was not significantly repeated among such age group children.

### **C- Children aged above 12 to 15 years**

Children of the third age group reported the significant presence of eating rituals as well as excessive hand washing as an obsessional traits among them.

Females of such age group showed the significant presence of many OC symptomatology such as counting compulsions, school related rituals, ordering arranging compulsions as well as obsessions related to perfectionistic general appearance.

Moreover females of such age group reported OCD as a diagnosis among them compared to controls and male children.

The previously mentioned results were discussed in terms of the previous literature. Many explanations were given in terms of such literature as well as social, cultural and demographic background.

As for conclusion, the present research proved the significant relation between parental OCD and the appearance of many symptoms and disorders especially anxiety, depressive and obsessive compulsive symptoms and disorders among their children. Absence of symptomatology of such disorders among the control group children, prove the correlation between parental OCD and the presence of child problems. Most of children (*of both sexes*) of OCD parents showed significant anxiety, depressive and obsessive compulsive symptoms and disorders with variable degrees. Males reported anxiety and depressive symptomatology in reaction to such stress, while females reported more depressive and obsessive compulsive reactions to such adverse life experiences.

Many recommendations and suggestions were enumerated directed to OCD families (*OCD parents, children and others close to them*), school teachers and school psychologists, medical health professionals as well as to the common people.

Such recommendations were related mainly to education of the OCD parents and their families through health education, radio and T.V. programs, reading books, attending lectures, talking to professionals, directed programs and others to help them know the disorder, its possible symptoms and ways of management.

Also, both medical health professionals and psychiatrists showed raise their knowledge about such disorder, for giving the best family support, as regard the needs of the children as a primary prevention and the needs of the OCD parents for the secondary prevention.

Other recommendations include financial support and, support groups which may be either related to the health institutes or to the non-govermental social organizations.

As for the future researches, the researchers should direct their attention to investigate the impact of parental mental illness on the rest of family members in all aspects (*social, psychological, financial, family attitudes modification of functioning and others*). Such researches are extremely lacking and deficient in our country and need more investigation.

Also family participation and accommodation in either patient obsessions or compulsions need more studies. The effect of patient symptom as well as its severity on family functioning and accommodation need further classification.

Lastly, family attitudes towards parent illness as well as the negative response, such attitudes might reflect on the parent illness are questioned. Further study of family accommodation and its relationship to family attitudes and patients outcome is of direct clinical relevance.



# References





## REFERENCES

**1. Abe K.; Masui T. (1981):**

*"Age- sex trend of phobic and anxiety symptoms in adolescent."*  
British Journal of Psychiatry. 138, 297- 302.

**2. Abou-Hatab M. (1994):**

*"A study of the common phobias among school children from 8 to 12 years"* .  
MSc Thesis Institute of Post Graduate childhood studies, Ain Shams University.

**3. Adams; Gail, B.; Wass Gregory, A.; March John, S.; Smith, M. Cecil, (1994):**

*"Obsessive compulsive disorder in children and adolescents: The role of child psychologist in identification, assessment and treatment"*,  
School-psychology Quarterly, Win., Vol. 9(4), 274-294.

**4. Akhtar, S.; Wig, N.H.; Verma, V.K.; Pershod, D.; Verma S.K., (1975):**

*"A phenomenological analysis of the symptoms of obsessive compulsive neuroses"*,  
British Journal of Psychiatry, 127, 342-48.

**5. Angold A (1988 a).**

*"Childhood and adolescent depression. I. Epidemiological and actiological aspects."*  
British Journal of psychiatry. 152, 601- 617.

**6. Angold A. (1988 b):**

*"Childhood and adolescent depression. II. Research in clinical populations."*  
British journal of psychiatry.153, 476- 492.

**7. Angold A. and Rutter M. (1992):**

*"Effects of age and pubertal status on depression in a large clinical sample."*

Development and psychopathological, 4, 5- 28.

**8. Barker, P., (1988):**

*" Basic child psychiatry "*,

Blackwell Scientific Publications, Oxford, London.

**9. Bauer D. (1980).**

*"Childhood fears in developmental perspective."* In:

Hersov L. & Berg I. (eds). out of school, P.P.189- 208.

John Wiley, London.

**10. Bebbington, (1987):**

*"Marital status and depression: A study of English national admission statistics"*,

Acta. Psychiatr. Scand., 75, 640-650.

**11. Bebbington, P.E., (1998):**

*" Epidemiology of obsessive compulsive disorder "*,

British Journal of Psychiatry, Aug., Vol. 173 (Suppl. 35), 2-6.

**12. Beck, A.T., (1967):**

*"Depression: clinical, theoretical and experimental aspects"*

Harper and row, New York.

**13. Beech, H.R., (1971):**

*"Ritualistic activity in patients"*,

J. psychosom. Res., 15 : 417-422.

**14. Bellodi, L.; Sciuto, G.; Diaferia, G.; Ronchi, P.; Smeraldi, E.; (1992):**

*"Psychiatric disorders in the families of patients with obsessive compulsive disorder"*,

Psychiatry, Res., 42 : 111 : 120.

- 15. Black, A., (1974):**  
“ *The natural history of obsessional neurosis* “,  
In *obsessional States*, Edited by H.R. Beech, London, Methuen.
- 16. Black, J.L., (1992):**  
“ *Obsessive-compulsive disorder. A clinical update* “,  
*Mayo Clin. Proc.*, 67 : 266-75.
- 17. Black, D.W.; Gaffney, G.; Schlosser, S.; Gabel, J., (1998):**  
“The impact of obsessive compulsive disorder on the family:  
preliminary findings “,  
*Journal of Nervous and Mental disease*, Jul., Vol. 186 (7), 440-422.
- 18. Bland, R.C.; Newman, S.C.; Orn, H. et al, (1988):**  
“ *Lifetime prevalence of psychiatric disorders in Edmonton* “,  
*Acta Psychiatrica Scandinavica*, 77 (Suppl. 338), 24-32.
- 19. Bowlby, J., (1975):**  
“*Attachment and loss.*”  
Volume 2, *Separation Anxiety and Anger*,  
Penguin Press, Harmondsworth.
- 20. Brown, F.W., (1942):**  
“*Heredity in the psycho neurotic.*”  
*Proc. R. Soc. Med.*, 35 : 785–790.
- 21. Brynska, A., (1998):**  
“ *Obsessive compulsive disorder in children and adolescents* “,  
A literature review, Part II, *Psychiatria Polska*, Jan.-Feb.,  
Vol. 32(1), 77-88.
- 22. Calvo Coressi, L.; Lewis, B.; Harsis, M. et al, (1995):**  
“*Family accommodation in obsessive–compulsive disorder* “,  
*Am. J. Psychiatry*, 152 : 3, March, 441–443.

**23. Cammer, L., (1973):**

*"Antidepressants as a prophylaxis against depression in the obsessive compulsive person"*,  
Psychosomatics, 14 : 201-206.

**24. Carey, G. and Gottesman, L.L., (1981):**

*"Twin and family studies of anxiety, phobia and OCD"*,  
In Klein D.F. and Rabk in J.G. (eds), *Anxiety New Research*,  
New York, Raven Press.

**25. Carelson G.A.; Cantwell D.P. (1980).**

*"A survey of depressive symptoms, syndrome and disorder in child psychiatric population."*  
Journal of child psychology, 21, 19- 25.

**26. Carlson G.A.; Garber J. (1986).**

*"Developmental issues in the classification of depression in children."* In: Rutter M., Izard C.E., Read P.B. (eds) *Depression in young people: Developmental and clinical perspectives*, 399-434, Guilford press New York.

**27. Cavallini, M.C.; Pasquale, L.; Bellodi, L.; Smeraldi, E., (1999):**

*"Complex segregation analysis for obsessive compulsive-disorder and related disorders"*,  
*American-Journal-of-Medical-Genetic, Neuropsychiatric-Genetics*, Feb. 05, 88/ 1 (38- 43).

**28. Chess, S.; Thomas, A., (1991):**

*"Temperament. In M. Lewis (Ed). Child and adolescent psychiatry"*,  
*A Comprehensive Text Book*, 145-159, Baltimore ,Williams and Wilkins.

**29. Clark, D.A.; Bolton, D., (1985):**

*"Obsessive compulsive adolescents and their parents: a psychometric study"*,

Journal of Child Psychology and Psychiatry, 26, 267-76.

**30. Clarizio, H.F., (1991):**

*"Obsessive compulsive disorder, the secretive syndrome: psychology in the schools"*,

Apr., Vol. 28 (2), 106-115.

**31. Cooke, D.J., (1986):**

*"Psychological variables and the life event / Anxiety depression link. A community study"*,

Acta. Psych. Scand., 74(3), 281-291.

**32. Cooper, M., (1993):**

*"A group for families of obsessive compulsive persons"* Families in Society, 74, 301 - 307.

**33. Cooper, M., (1996):**

*"Obsessive compulsive disorder effect on family members"*, American Journal on Orthopsychiatry, 66/2., pp. 296-304.

**34. Coryell, W., (1981):**

*"Obsessive compulsive disorder and primary unipolar depression: comparisons and background, family history, course and mortality"*,

Journal of Nervous Mental Diseases, (169) : 220-224.

**35. Cowie, V., (1961):**

*"The incidence of neurosis in the children of psychotics,"*

Acta. Psych. K. (1979). A comprehensive study of parents of emotionally disturbed and normal children "

Br. J. Psychi., 134, 406-411.

**36. Creer, C.; Start, E., (1982):**

*"The role of relatives in long term community Care"*,  
Psychological Medicine Monograph Supp. (2), In Fadden et al,  
(1987): The Burden of Care, Br. J. of Psychiatry, 150: 285-292.

**37. Creer, C.; Wing, J.K., (1988):**

*" Schizophrenia at home "*,  
National Schizophrenia Fellowship.

**38. Eapen, V.; Pauls, D.L.; Robertson, M.M., (1993):**

*" Evidence for autosomal dominant transmission in Tourette's  
Syndrome, United Kingdom cohort study "*,  
Br. J. Psychiatry, 162 : 593-596.

**39. Epstein, et al, (1981):**

*" Problem centered systems therapy of the family "*,  
Handbook of Family Therapy, Brunne / Mazel, New York.

**40. Eysenck, H.J., (1967):**

*"The biological basis of personality, "*  
Springfield, Ill, Charles C. Thomas.

**41. Fitz, Allan, (1990)**

*" Religious and familiar factors in etiology of obsessive  
compulsive disorder "*,  
Journal of Psychology and Theology,  
Sum-Vol (18) (2), 141 – 147.

**42. Flament, M.F.; Rapoport, J., (1984):**

*" Childhood obsessive compulsive disorder "*  
In Obsessive-compulsive Disorder (ed.T. Insel), p.p.23-43,  
Washington DC, American Psychiatric Press.

**43. Flament, M.F.; Whitaker, A.; Rapoport, J.L. et al, (1988)**

*"Obsessive compulsive disorder in adolescence an epidemiological  
study, "*  
J. Am. Acad. Child- Adolesc. Psychiatry, 27 : 764-771.

**44. Flament, M.F.; Koby, E.; Rapoport, J.L.; Berg, C.J. et al, (1991):**

“Childhood obsessive compulsive disorder: A prospective follow up study “,  
Annual Progress in Child Psychiatry and Child Development, 373-394.

**45. Freud, S., (1917):**

“ The standard Edition of the complete psychological works of Sigmund Freud “,  
Vol.16, Translated and Edited by Strachey, J., London, Hogarth Press, PP. 258-259.

**46. Forehand R.; Mc Combs A.; Brody G.H. (1987)**

*“The relationship between parental depressive mood states and functioning.”*

Adv Behav their 9: 1- 20.

**47. Garralda M.E.; Bailey D. (1986).**

*“Children with psychiatric disorders in day care.”*

Journal of child psychology and psychiatry, 27, 611- 624.

**48. Garrison, C.Z.; Valleni, B.L.; Jackson, K.L.; Waller, J.L. et al, (1995):**

“Frequency of obsessive compulsive disorder in a community, sample of young adolescents”,

Journal of the American Academy of Child and Adolescent Psychiatry, Feb., Vol. 34 (2), 128- 129.

**49. Geller, D.; Biederman, J.; Jones, J.; Park, K.; Schwartz, S.; Shapiro, S.; Coffey, B., (1998):**

*“Is Juvenile obsessive compulsive disorder a developmental subtype of the disorder ?, A review of pediatric literature “,*

Journal of the American Academy of Child and Adolescent psychiatry, 37 / 4 (420- 427).

**50. Ghanem M. (2000).**

*"An introduction to psychiatry"*.

Thabit publishing company.

**51. Gibbs, N.A., (1996):**

*"Non clinical population in research on obsessive compulsive disorder: A critical review"*,

Clinical Psychology Review, 16 / 8 (729-773).

**52. Glick, I.D.; Kessler, D.R., (1974):**

*"Marital and family therapy"*,

New York, San Francisco, London, pp. 11, 12, 114, 116, 126-131.

**53. Goodman, W.K.; Price, L.H.; Rasmussen, S.A.; Mazure, C.; Fleischmann, R.L.; Hill, C.L.; Herninger, G.R.; Charney, D.S., (1989):**

*"The Yale Brown obsessive compulsive scale, development, use and reliability"*,

Arch. Gen. Psychiatry, 46 : 1006-1011.

**54. Goodyer, I.M.; Wright, C.; Altham, P.M., (1987):**

*"The impact of recent life events in psychiatric disorders of childhood and adolescence"*,

British Journal of Psychiatry, 151, 179-85.

**55. Grados, M.A.; Labuda, M.C.; Riddle, M.A.; Walkup, J.T., (1997):**

*"Obsessive compulsive disorder in children and adolescents"*,

International Review of Psychiatry, Mar., Vol. 9(1), 83-98.

**56. Graham, D.; Norman, T.R. et al, (1989):**

*"Social aspect of obsessive compulsive disorder (in understanding OCD)"*,

An International Symposium held during the 8<sup>th</sup> World Congress of Psychiatry, Hogrefe and Huber Publishers, p. 24- 26.



**57. Goodman W.K.; Price L.H.; Rasmussen S.A. et al (1989).**  
*The Yale-Brown obsessive compulsive scale. Development, use and reliability.*

Archives of general psychiatry, 46, 1006- 1011.

**58. Goodyer I.M.; Wright C.; Altham P.M.E. (1988)**

*"Maternal adversity and recent life events in childhood and adolescent."*

Journal of Child Psychiatry, 5, 651- 669.

**59. Goodyer I.M. (1990).**

*"Life experiences, development and childhood psychopathology."*

John Wiley. London.

**60. Graham, P., (1994):**

*"Child psychiatry: A developmental approach "*,

Oxford Medical Publication, Oxford University Press.

**61. Green, A., (1965):**

*'Obsess et psychoneur obsess, "*

Encyclopedia Medico-chirurgicale psychiatrie.

**62. Hafner, R.J.; Miller, R.J., (1990):**

*"Obsessive compulsive disorder: An exploration of some unresolved clinical issues "*,

Australian and New Zealand Journal of Psychiatry, Dec., Vol. 24(4), 480-485.

**63. Hamilton M. (192).**

*"Symptoms and assessment of depression, "*

In: Payke E. (ed). Handbook of affective disorders. Pp. 3- 11.  
Churchill living stone, Edinburgh.

**64. Hammen C.; Adrian C.; Gordan D. et al (1987).**

*"Children of depressed mothers: maternal strain and symptom predictors of dysfunction."*

J Abnorm psychol 96: 190- 198.

**65. Hantouche, E.G.; Bourgeois, M.; Bouhassira, M.; Lancrenon, S., (1996):**

*“Clinical aspects of obsessive compulsive disorder and syndromes data from phase 2 of a large French clinical sample”*,  
Encephale, 22/4 (255-263).

**66. Harder, D.W. et al, (1989):**

*“ Child competence and Psychiatric risk: I.V. relationships of parent diagnostic classifications and parent psychopathology severity to child functionary”*,

The Journal of Nervous and Mental Disease, 168: 343-347.

**67. Harrington R.C. (1989).**

*“Childhood and adolescent depression: Recent developments.”*

Current opinion in psychiatry, 2, 480- 483.

**68. Harold, I.; Kaplan, M.D.; Benjamin J. Sadock, (1995):**

*“Synopsis of psychiatry, behavioral sciences, clinical psychiatry”*,

Williams and Wilkins.

**69. Hertherington E.M., Cox M., Cox R. (1982).**

*“Effects of divorce on parents and children.”*

In M.E. Lamb (ed), Non- traditional families: Parenting and child development. Erlbaum, Hillsdale. NJ.

**70. Higgins, N.C.; Pollard, C.A.; Merkel, W.T., (1992):**

*“ Relationship between religion-related factors and obsessive compulsive disorder “*,

Current Psychology Research and Reviews, Spr.,

Vol. (11), (1) 79 – 85.

**71. Hoeng, J.; Hamilton, M.W., (1966):**

*“ The schizophrenic patient in the community and his effect on the household “*,

International Journal of Social Psychiatry, 12 : 165-176.

**72. Honjo, S. et al, (1989):**

“ Obsessive compulsive symptoms in childhood and adolescence “,  
Acta Psychiatrica Scandinavica, 80 (1): 83-91.

**73. Hollingsworth, C.; Tanguay, P.; Crossman, L., (1980):**

“*Long-term outcome of obsessive compulsive disorder in childhood* “,  
Journal of American Academic Child Psychiatry, (9) : 134-144.

**74. Hoover, C.F.; Insel, T.R., (1984):**

“ *Families of origin in obsessive compulsive disorder* ”,  
Journal of Nervous and Mental Disease, Apr., Vol. 172 (4), 207-215.

**75. Hwuh, Y.E.; Chang, L. et al, (1989):**

“ *Prevalence of psychiatric disorders in Taiwan* ”,  
Acta Psychiatrica, Scandinavia, 79, 136.

**76. Ilg, F.L.; Ames, L.B., (1955):**

“*Child behavior*”

New York.

**77. Ingram, I.M., (1961):**

“ *Obsessional illness in mental hospital patients* ”,  
Journal of Mental Science, 107 : 382- 402.

**78. Inouge, E., (1965):**

“ *Similar and dissimilar manifestations of obsessive compulsive neurosis in monozygotic twins.* ”  
American. J. Psychiat., 121, 1117-75.

**79. Insel, T.R.; Pickar, D., (1983):**

“*Naloxane administration in obsessive compulsive disorder: report of two cases*”,  
Am. J. Psychiatric, 140 : 1219-1220.

**80. Jakes, L., (1996):**

*“ Theoretical approaches to obsessive-compulsive disorders”*,  
Cambridge University Press.

**81. James, J.M.; Patricia, L.S.; Dennis, P.C., (1993):**

*“Obsessive compulsive disorder in childhood and adolescence”*

Vol. 22, School Psychology Review, 01-01, pp. 243.

**82. Janet, P., (1903):**

*“Les obsessions et la psychasterie,”*

Vol. Paris, France, Alcan.

**83. Jersild, A.T.; Holmes, F.B., (1935-a):**

*“ Children’s fears”*,

New York: Teacher’s Collage, Columbia University.

**84. Jersild, A.T., (1968):**

*“Child psychology,”*

Enlewood Cliffs, N.J., Prentice Hall Inc., (6<sup>th</sup> ed.).

**85. Jose`, A.; Yaryura-Tobias; Fugen, A. Nezirogu, (1997):**

*“ Obsessive-compulsive disorder spectrum”*,

American Psychiatric Press, Inc., Washington, DC.

**86. Karno M.; Golding G.; Sorenson S.; Burnam A. (1988)**

*“The Epidemiology of obsessive-compulsive disorder in five us communities.”*

Archives of general psychiatry, 45, 1094- 1099.

**87. Kanner, L., (1948):**

*“Child psychiatry,”*

2<sup>nd</sup> Edition, Oxford, England, Blackwell.

**88. Kaplan, H.I. and Sadock, B.J., (1991):**

*"Comprehensive text book of psychiatry,"*

Williams, Wilkins, London.

**89. Karno, M.; Goldin, J.M.; Sorenson, S.B. et al, (1988):**

*" The epidemiology of obsessive-compulsive disorder in five US communities "*,

**Arch. Gen. Psychiatry, 45 : 1094 – 1099.**

**90. Kashani, J.H.; MCGee, R.D.; Clarkson, S.E. et al, (1983):**

*" Depression in a sample of nine year old children "*,

Archives of General Psychiatry, 40, 1217–1227.

**91. Kashani J.; Orvaschel H. (1990)**

*"A Community study of anxiety in children and adolescents."*

American Journal of psychiatry 147: 313- 318.

Anderson et al "DSM III disorders" "69- 76".

**92. Kellerman, J., (1981):**

*"Helping the fearful child,"*

New York: Norton.

**93. Kendell, R.E.; Discipio, W.J., (1970):**

*"Obsessional symptoms and obsessional personality traits in patients with depressive illness ."*

Psychol. Med., 1 : 65-72.

**94. Khanna, S.; Channabasavanna, S.M., (1987):**

*" Birth order in obsessive-compulsive disorder "*,

Psychiatr. Res., 21: 349-354.

**95. Khanna, S.; Srinath, S., (1988):**

*" Childhood obsessive compulsive disorder psychopathology "*,

Nov.-Dec., Vol. 21(6), 245- 258.

**96. King, R.A.; Scahill, L.; Vitulano, L.A.; Schwab Stone, M.;Tercyak Jr. K.; Riddle, M.A., (1995):**

*“Childhood trichotillomania: clinical phenomenology, comorbidity and family genetics “,*

Journal of the American Academy of Child and Adolescent Psychiatry, 34/11 (1451-1459).

**97. Klein R.G., Kopleulcz H.S., Kanner A (1992 b):**

*“Imipramine treatment of children with separation anxiety disorder.”*

Journal of the American academy of child and adolescent psychiatry. 31, 21- 28.

**98. Klein D.F. (1978):**

*“A proposed definition of mental illness.”*

In: Spitzer R.L. & Klein D.F. (eds). critical issues in psychiatry diagnosis, P.P. 41- 71. Raven press, New York.

**99. Klienknecht R.A. (1991)**

*“Mastering anxiety: The nature and treatment of anxious conditions.”*

New York: Plenum press.

**100. Klosinki, S., (1990):**

*“ Ecelesiogenic neuroses and psychoses in adolescence: On the rigorously moralizing, Christian-Religious movements complicated detachment problems of adolescents from”,* Acta Paedopsychiatrica, 53(1) : 71-77.

**101. Knolker, U., (1983):**

*“ Obsessive compulsive disorders in children and adolescents: Pathogenetic aspects in the context of family background”,*

Zeitschrift-Fur-Kinder-Und-Jugend Psychiatrie,

Vol. 11(4), 317- 327.

**102. Kolvin I., Barrett M.L., Bhate S.R. et al (1991):**

*"The New Castle child depression project: diagnosis and classification of depression."*

British journal of psychiatry, 159 (suppl. 11), 9 – 21.

**103. Kringlen, E., (1965):**

*"Obsessional neurotics,"*

Br. J. Psychiatry, 111 : 709-772.

**104. Kuipers, L., Bebbington, P., (1990):**

*"Living with mental illness "*,

A Book for Relatives and Friends, Souvenir Press, pp. 29, 37, 59, 60, 79, 80.

**105. Lapouse, R. and Mank, M.A. (1959):**

*"Fears and worries in a representative sample of children "*,

American Journal of Orthopsychiatry, 29, 803-818.

**106. Last, C.G.; Strauss, C.C., (1989):**

*" Obsessive compulsive disorder in childhood",*

Journal of Anxiety Disorders, Vol. 63(4), 295-302.

**107. Lenane, M.C.; Swedo, S.E.; Leonard, H.; Pauls, D.L. et al, (1990):**

*" Psychiatric disorders in first degree relatives of children and adolescents with obsessive compulsive disorder",*

Journal of the American Academy of Child and Adolescent Psychiatry, May, Vol. 29 (3), 407 – 412.

**108. Lenane, M.C.; Swedo, S.E.; Rapoport, J.L.; Leonard ,H. et al, (1992):**

*" Rates of obsessive compulsive disorder in first degree relatives of patients with trichotillomania: A research note",*

Journal of Child Psychology and Psychiatry and Allied disciplines, Jul., Vol. 33(5), 925-933.

**109. Leonard, H.L.; Goldberger, E.L.; Rapoport, J.L.; Cheslow, D.L. et al, (1990):**

*“ Childhood rituals: normal development of obsessive compulsive symptoms”*,

Journal of the American Academy of Child and Adolescent Psychiatry, Jan., Vol. 29 (1), 17-23.

**110. Leonard, H.L.; Lenane, M.C.; Swedo, S.E.; Rettew, D.C.; Gersh, E.S.; Raport, J.L., (1992):**

*“ Tics and Tourette disorder :2 to 7 year follow up of 54 obsessive-compulsive children”*

Am. J. Psychiatry, 149 :1244-1251.

**111. Levy, D., (1943):**

*“ Maternal overprotection”*,

Columbia University Press, New York.

**112. Lewis, A.J, (1936):**

*“Problems of obsessional illness”*

Proc. Royal Society Medicine, 29, 325-36.

**113. Lieberman, J., (1984):**

*“ Evidence for a biological hypothesis of obsessive-compulsive disorder”*,

Neuro Psychobiology, 11 : 14-21.

**114. Livingston, Van Noppen, B.; Rasmussen, S.A.; Eisen, J.; Mc- Cartney, L., (1990):**

*“Family function and treatment in obsessive compulsive disorder: Theory and management”*,

2<sup>nd</sup> ed., Edited by Jenike, M.A.; Baer, L.; Minichiello, W.E.; Littleton, Mass, Year Book Medical.



**115. Lo, (1967):**

*"A follow up study of obsessional neurotics in Hong Kong Chinese"*,

British Journal of psychiatry, 113 : 822-832.

**116. Lorenz, M., (1955):**

*"Expressive behavior and language Patterns,"*

Psychiatry, 18 : 353-366.

**117. MacGregor, P., (1994):**

*" Crief: the unrecognized parental response to mental illness in a child"*,

Social Work, 39, 160–165.

**118. Mansour, M., (1993):**

*"Psychiatric morbidity in the families of mentally-ill patients"*,

M.D. Thesis, Psychiatry Faculty of Medicine, Ain Shams University.

**119. Masten A.S.; Garmezy N.; Tellegen A. et al (1988).**

*"Competence and stress in school children. The moderating effects if individual and families qualities."*

Journal of children psychology and psychiatry 6, 745- 764.

**120. Kolvin I.; Barrett M.L.; Bhate S.R et al (1991).**

*"The new castle child depression project: diagnosis and classification of depression."*

British Journal of Psychiatry, 159 (suppl. 11), 9- 21.

**121. Marks, I.M., (1987):**

*" Fear, Phobias and rituals in OCD"*,

Oxford University Press, In Understanding OCD, An International Symposium held during the 8<sup>th</sup> World Congress of Psychiatry, Hogrefe and Huber Publishers, p. 25-26.

**123. Marlene, C., (1996):**

*"Obsessive-compulsive disorder: effects on family members"*,  
American Journal of Orthopsychiatry, 66 (2), April, 296-304.

**124. McGee R.; Feetian M.; Williams S., Aanderson J. (1992):**

*"DSM III disorders from age 11 to age 15 years,"*  
Journal of the American academy of child and adolescent  
psychiatry, 31, 50- 59.

**125. Mc Gee R.; Fee M.; Williams S. et al (1990).**

*"DSM III disorders in a large sample of adolescents."*  
Journal of the American academy of child and adolescent  
psychiatry, 29, 611- 619.

**126. McKeon, P.; Murray, R., (1987):**

*"Familial aspects of obsessive compulsive neurosis,"*  
Br. J. Psychiatry, 151 : 528.٥٤٣ -

**127. Melamed B.; Segal L. (1985).**

*"Children's reactions to medical stresses", in anxiety and the  
anxiety disorders,"*  
A. Hussein Juma and Jack D. Maser ed. Lawrence Erlbaum  
Associates 369- 388.

**128. Merkel, W.T.; Pollard, C.A.; Wiener, R.L.; Staebler,  
C.R., (1993):**

*"Parental characteristics of patients with obsessive compulsive  
disorder, depression and panic disorder"*,  
Child Psychiatry & Human Development, Feb., Vol. 22(1), 49-  
57.

**129. Minuchin, S., (1974):**

*"Families and family theory"*,  
London: Tavistock Publications.

**130. Mors, O.; Sorensen, L.V., (1992):**

*"Distress in the relatives of psychiatric patients admitted for the first time,"*

*Acta. Pschiat. Scand.*, 85: 337-344.

**132. Myers, J.; Weissman, M.; Tischler, G.; Holzer, C.; Leaf, P.; Ovaschel, H.; Anthony, J.; Boyd, J.; Burke, J.; Kramer, M.; Stoltzman, R., (1984):**

*"Six-month prevalence of psychiatric disorders in three communities,"*

*Archives of General Psychiatry*, (41) : 959-967.

**133. Neziroglu, F.A., (1983):**

*"Symptomatology and symptoms in obsessive compulsive disorder: pathogenesis, diagnosis, treatment",*

Edited by Yaryura-Tobias, J.A.; Neziroglu, F.A., New York, Marcel Dekker, p.p. 7-17.

**134. Nicolini, H.; Hanna, G.; Baxter, L.; Schwartz, J.; Weissbacker, K.; Spence, M.A., (1991):**

*" Segregation analysis of obsessive compulsive and associated disorders: Preliminary results",*

*Ursus Medicine*, 1: 25- 28.

**135. Nicolini, H.; Orozco, B.; Mickalonis, L.; Mejia, J.M.; Paez, F.; Gomez, A.; De-La-Fuente, J.R., (1998):**

*" A phenomenological and family study of obsessive compulsive disorder",*

*Neuropsychiatrie-de L'enfance et de L'adolescence*, 46/3, (164-172).

**136. Nicolini, H.; Gruz, C.; Cammarena, B.; Paez, F.; De-La-Fuente, J.R., (1999):**

*" Understanding the genetic basis of obsessive-compulsive disorder",*

*CNS- Spectrums* 4/ 5 (32- 48).

**137. Okasha, A.; Hassan, A.H., (1968):**

*"Preliminary psychiatric observations in Egypt"*,  
Br. J. Psychiatry: 114, 949-955.

**138. Okasha, A., (1988):**

*"Clinical psychiatry"*,  
The Anglo Egyptian Bookshop, Cairo, pp 335, 342-344.

**139. Okasha, A.; Raafat, M., (1991):**

*"The biology of obsessive compulsive disorder: an evidence from topographic EEG"*,  
Arab J. Psychiatry, 2: 106-117.

**140. Okasha, A.; Saad, A.; Khalil, A.H.; Aida, S.E. et al, (1994):**

*"Phenomenology of obsessive compulsive disorder: A transcultural study"*,  
Comprehensive Psychiatry, May-Jun., Vol. 35(3), 191-197.

**141. Orly, J.; wing, J.K., (1979):**

*"Psychiatric disorders in two African villages"*,  
Archives of General Psychiatry, (36), 513.

**142. Öst L.G. (1987):**

*"Age of onset in different phobias."*  
Journal of abnormal psychology, 96, 223- 229.

**143. Packman J. (1986):**

*"Who needs care,"*  
Blackwell scientific, Oxford.

**144. Patterson G.R. (1986 a):**

*"The contributions of siblings to train for fighting. A micro-social analysis"*  
In D. Olweus, J. Block, and M. Radke-Yarrow (eds),  
development of antisocial and pro-social behavior. Research theories and issues, Academic press, New York P.P. 235- 261.

**145. Patterson, G.R. (1986 b).**

*“Performance models for antisocial boys,”*

American psychologist, 41, 432- 444.

American psychiatric association, diagnostic and statistical manual.

**146. Pauls, D.L.; Leckman, J.F., (1986):**

*“The inheritance of Gilles de la Tourette’s syndrome and associated behaviors: Evidence of autosomal dominant transmission”*,

N. Engl. Med., 315.: 993-997.

**147. Pauls, D.L.; Dowbin, K.E.; Leckman, J.F.; Zahner, G.E.P., Cohen, D.J., (1986):**

*“ Gilles de la Tourette’s syndrome and obsessive- compulsive disorder evidence supporting a genetic relationship”*,

Arch. Gen. Psychiatry, 43 : 1180-1182.

**148. Pauls, D.L.; Alsobrook, J.P.; Goodman, W.; Rasmussen, S. et al, (1995):**

*“ A family study of obsessive compulsive disorder”*,

American Journal of Psychiatry, Jan., Vol. 152(1), 76-84.

**149. Pauls, D.L., (1992):**

*“ The inheritance pattern, in Handbook of Tarette’s syndrome and related Tic and behavioral disorders”*,

Edited by Kurlan R., New York, Marcel Dekker.

**150. Pauls, D.L., (1999):**

*“ Phenotypic variability in obsessive- compulsive disorder and its relationship to familial risk”*,

CNS- spectrums 4/ 6 (57- 61.)

**151. Pearce, J., (1998):**

*“ Emotional disorders in young people”*,

**152. Peselow, E.D.; Figlia, C.; Fieve, R.R. (1990):**

*"Obsessive compulsive symptoms in patients with major depression: frequency and response to anti-depressant treatment"*,

Paper presented at the annual meeting of the American College of Neuro-psychopharmacology, San Juan, Puerto Rico, December.

**153. Pigott, T.A., (1998):**

*"Obsessive-compulsive disorder: Symptoms overview and epidemiology"*,

Bulletin of the Menninger Clinic, Fal., Vol. 62, (4, Suppl. A.)  
A4- A32

**154. Platte, S., (1985):**

*" Measuring the burden of psychiatric illness on the family , An evaluation of some rating scales"*,

Psychological Medicine, 15, 383-394.

**155. Pollitt, J., (1957):**

*" Natural history of obsessional states"*,

British Medical Journal, 1 : 194-198.

**156. Polmin, R.; Defries, J.E.; Fulker, D.W., (1988):**

*"Nature and nurture during infancy and early childhood "*,

Cambridge University Press.

**157. Rachman, S.J.; Hodgson, R.J., (1980):**

*" Obsessions and compulsions"*,

Englewood Cliffs, N.J., Prentice-Hall.

**158. Rapoport, J.L., (1986):**

*" Childhood obsessive compulsive disorders"*,

Journal of Child Psychology and Psychiatry, 27, 298-95.

**159. Rapoport, J.L., (1989 a):**

*"Obsessive compulsive disorder in childhood and adolescents"*,

Washington DC, American Psychiatric Press Inc.

**160. Rapoport, J.L.; Swedom, S.E.; Leonard, H.L., (1992):**

*"Childhood obsessive compulsive disorder"*,

Journal of Clinical Psychiatry, Apr., Vol. 53 (4 Suppl.), 11-16.

**161. Rasmussen, S.A.; Tsuang, M.T., (1984):**

*"Epidemiology of obsessive compulsive disorder: A review"*,

Journal of Clinical Psychiatry, (45) : 450-457.

**162. Rasmussen, S.A.; Tsuang, M.T., (1986):**

*"Clinical characteristics and family history in DSM III obsessive-compulsive disorder"*,

Am. J. Psychiatry, 143:317-322.

**163. Rasmussen, S.A.; Eisen, J.L., (1988):**

*"Clinical and epidemiologic findings of significance to neuropharmacologic trials in OCD"*,

Psychopharmacol, Bull., 24: 466-470.

**164. Rasmussen, S.A.; Eisen J.L., (1990):**

*"Epidemiological and clinical features of obsessive compulsive disorder, in obsessive compulsive disorders: Theory and management"*,

2<sup>nd</sup> edition, Edited by Jenike, M.A.; Baer, L.B.; Minichiello, W.E., Chicago, IL., Year Book Medical, PP. 10-27.

**165. Rasmussen S.A.; Eisen, J.L., (1992):**

*"The epidemiology and differential diagnosis of obsessive compulsive disorder"*,

Journal of Clinical Psychiatry, Apr., Vol. 53 (4, Suppl), 4-10.

**166. Rasmussen, S.A.; Eisen, J.L., (1992):**

*"The epidemiology and clinical features of obsessive compulsive disorder"*,

The Psychiatric Clinics of North America, (15) : 743-758.

**167. Rettew, D.C.; Cheslow, D.H.; Rapoport, J.L.; Leonard, H.L.; Lenane, M.C., (1992):**

*"Neuropsychological test performance in trichotillomania: a further link with obsessive compulsive disorder"*,

Journal of Anxiety Disorders, 5, 225-235.

**168. Riddle, M.A. et al, (1990):**

*"Obsessive compulsive disorder in children and adolescents: Phenomenology and family history"*,

J. Amer. Acad. Child psychiatry, 29 (5), 766-772.

**169. Riddle, M.A. (1999):**

*"Childhood and OCD,"*

The Third International Obsessive-Compulsive Disorder Conference CNS- Spectrums 4/ 5, Suppl. 3 (13- 15).

**170. Riess, L., (1991):**

*"Distress and disease"*,

British Journal of Psychiatry, 128, 3-18.

**171. Robertson, M.M.; Trimble, M.R.; Lees, A.J., (1988):**

*"The psychopathology of the Gilles de la Tourette's syndrome: a phenomenological analysis"*,

Br. J. Psychiatry, 152 : 383-390.

**172. Robin, L.; Helzer, J.; Wiessman, M.; Ovaschel, H.; Gruenberg, E.; Burke, J.; Reiger, D., (1984):**

*"Life time prevalence of specific psychiatric disorders in three sites"*,

Archives of General Psychiatry, (41) : 949-958.



**173. Robinson, J.A.; Kagan, J.; Reznick, J.S.; Cerley, R., (1992):**

*"The heritability of inhibited and uninhibited behaviour: A twin study"*,  
Developmental Psychology, 28, 1030-1037.

**174. Robinson, J.A.; Kagan, J.; Reznick, J.S.; Cerley, R., (1992):**

*"The heritability of inhibited and uninhibited behaviour: A twin study"*,  
Developmental Psychology, 28, 1030-1037.

**175. Rosenthal, D., (1970):**

*"Genetic Theory and abnormal behavior"*  
New York, Mc- Graw-Hill.

**176. Rubin, E., (1953):**

*"Ein Beitrag zur Frage der Zwangskrankheit insbesondere ihre hereditären beziehungen Archives psychiatrische"*,  
Nervenkrankheit, 191, 14-54.

**177. Rudolf H. Moss, (1979):**

*"Coping with physical illnesses"*,  
Plenum Medical Book Company, New York – London,  
P. 7-8- 193.

**178. Rutter, M., (1966):**

*"Children of sick parents"*,  
London, Oxford University Press, pp. 25-50.

**179. Rutter M. (1985 a):**

*"Family and school influence on behavioral development,"*  
Journal of child psychology and psychiatry, 3, 349- 368.

**180. Rutter M. (1985 b):**

*"Family and school influences. Meanings, mechanisms and implications."*

In A.R. Nicol (ed), longitudinal studies in child psychology and psychiatry. Wiley, chichester.

**181. Rutter M. (1986 a):**

*"Depressive feelings, cognition's and disorders: a research post script."* In: Rutter M., Izard C.E., Read P.B. (eds) Depression in young people:

Developmental and clinical perspectives, P.P.3- 32,  
Guilford press, New York.

**182. Rutter, M., (1987):**

*"Parental mental disorder as a psychiatric risk factor",*

In Michael S., Sandra J., Michael M., et al, (1991: Screening for dysfunction in the children,  
Am. J. Psychiat, 148 : 1031– 1036.

**183. Rutter, M., (1990):**

*"Commentary: Some focus and process considerations regarding effects of parental depression on children",*

Dev. Psychology, 26, 60-67.

**184. Rutter, M.; Tizard, J.; Whitmore, K., (1970-a):**

*"Education, health and behavior".*

Longmans, London.

**185. Rutter, M.; Quinton, D., (1984):**

*"Parental psychiatric disorder : effects on children",*  
Psychological Medicine, 14, 835-80.

**186. Rutter, M.; Hersov, L., (1985):**

*" Child and adolescent psychiatry modern approaches",*  
Oxford, London, Edinburgh, P. 30-32, 43-44, 64.

**187. Rutter M. (1986 a):**

*“Depressive feelings, cognitions and disorders:”*

A research post script. In: Rutter M., Izard C.E., Read P.B. (eds) depression in young people: Developmental and clinical perspectives, P.P. 491- 519.

Guilford press, New York.

**188. Rutter M. (1986 b).**

*“The developmental psychopathology of depression:”*

*Issues and perspectives.* In Rutter M., Izard C.E., Read P.B. (eds). depression in young people:

Development and clinical perspective, P.P. 3- 32, Guilford press, New York.

**189. Rutter M. (1991).**

*“Age changes in depressive disorder: Some developmental considerations”.* In Garber J and Dodge K.A. (eds).

The development of emotion regulation and psyregulation. P.P. 273- 300. Cambridge university press. Cambridge.

**190. Rutter M. (1982),**

*“Epidemiological longitudinal approaches to the study of development.”*

In: W.A. Collins (eds): the concept of development minnesota symposium on child psychology, vol. 15, Hillsdale, NJ.

**191. Rutter M. (1986 a).**

*“A developmental psychopathology of depression.”*

In. M. Rutter C. Izard and P. Read (eds), Depression in young people- developmental and clinical perspectives, Guilford press, New York.

**192. Rutter M.; Taylor E.; Hersov L. (1994)**

*“Child and adolescent psychiatry, modern approaches .”*

Blackwell Scientific Publications, Oxford. London.

**193. Samuels, J.; Nestadt, G., (1997):**

*"Epidemiology and genetics of obsessive-compulsive disorder"*,

International Review of Psychiatry, 9/1 (61-71).

**194. Sasson, Y.; Zohar, J.; Chopra, M.; Lustig, M.; Iancu, I.; Hendler, T., (1997):**

*"Epidemiology of obsessive-compulsive disorder: A world view"*,  
Journal of Clinical Psychiatry, Vol. 58, (Suppl. 12), 7-10.

**195. Scarr, S. ; Salapatek, P., (1970):**

*"Patterns of fears development during infancy,"*

Merrill-Palmer Quarterly of Behavior and Development,  
PP:16, 53-90.

**196. Scarr, S.; McCartney, K., (1983):**

*"How people make their own environment: a theory of genotype environment effects"*,

Child Development, 54, 424-432.

**197. Schneider, K., (1930):**

*"Psychologie der schizophrenen,"*

Leipzig, Germany, Thieme.

**198. Scuito, G.; Pasquale, L.; Bellodi, L., (1995):**

*"Obsessive compulsive disorder and mood disorders: A family study"*,

American Journal of Medical Genetics, Neuropsychiatric Genetics, 60/6 (475-479).

**199. Seligman, M.E.; Peterson, C., (1986):**

*"A learned helplessness perspective in childhood depression. in depression in young people"*,

200. Ed. M. Rutter, C.E. Izard and P.B. Read., New York: Guilford

**201. Shields, J., (1973):**

*"Heredity and psychological abnormality,"*

In Hand Book of Abnormal Psychology, 2<sup>nd</sup> ed., Edited by H.J. Eysenck, London, Pitmans.

**202. Simons, J.M. (1974):**

*"Observations on compulsive behavior in autism",*

J. Autism Child Schizophr, 4 : 1

**202. Skynner, R., (1974):**

*"School phobia: a reappraisal,"*

British Journal of Medical Psychology, 47, 1-16.

**203. Slater, E. and Cowie, V., (1971):**

*"The genetics of mental disorders,"*

London, Oxford University Press.

**204. Smith. C, (1974):**

*"Concordance in twins: methods and interpretation",*

Am. J. Human Gent., 26, 456-466. In Rutter M., (EDS) Child and Adolescent Psychiatry, (1985), Oxford London Press. P.32.

**205. Stekettee, G., (1997):**

*"Disability and family burden in obsessive compulsive disorder",*  
Canadian Journal of Psychiatry, 42/9 (919-928).

**206. Stekette, G.; Noppen, B.V.; Lam, J.; Shapiro, L.; (1998):**

*"Expressed emotion in families and the treatment of obsessive compulsive disorder",*

In-Session-Psychotherapy-In-Practice, 4/ 3 (73- 91).

**207. Swedo, S.E.; Rapoport, J.L.; Leonard, H.L.; Lenane, M. et al, (1989):**

*"Obsessive compulsive disorder in children and adolescents: clinical phenomenology of 70 consecutive cases",*

Archives of General Psychiatry, Apr., Vol. 46(4), 335- 341.

- 208. Swedo, S.E.; E.; Leonard, H.L.; Rapoport, J.L., (1992):**  
“*Childhood onset obsessive compulsive disorder*”,  
Psychiatric Clinics of North America, Dec., Vol. 15/4, 767-775.
- 209. Swedo S.; Rapoport J.L.; Leonard H.L. et al (1989 c).**  
“*Obsessive compulsive disorder in children and adolescents: clinical phenomenology of 70 consecutive cases*”,  
*Archives of general psychiatry*, 46, 335- 341.
- 210. Tallis, F., (1995):**  
“*The characteristics of obsessional thinking; difficulty demonstrating the obvious?*”  
*Clinical Psychology and Psychotherapy*, 2, 24-39.
- 211. Tamarin, G.R., (1977):**  
“*Some formal logical and social specificities of the obsessive and paranoid life style and thought organization*”,  
*Isr Ann Psychiatry Relate Discip.*, 15 : 1-11.
- 212. Thomsen Per-hove, (1994):**  
“*Children and Adolescents with obsessive compulsive disorder: An analysis of sociodemographic background: a case control study*”,  
*Psychopathology*, Nov-Dec., Vol. 27(6), 303-311.
- 213. Thomsen Per-hove, (1994):**  
“*Obsessive compulsive disorder in children and adolescents: A review of the literature*”,  
*European-Child and Adolescent Psychiatry*, Jul., Vol. 3(3),138-158.

**214. Thomsen Per-hove, (1994):**

*“ Obsessive compulsive disorder in children and adolescents: A 6-22 years follow up study: Clinical descriptions of the course and continuity of obsessive compulsive symptomatology”*,  
European Child and Adolescent Psychiatry, Apr.,  
Vol. 3(2), 82-96.

**215. Thomsen Per- Hove, (1994):**

*“ Obsessive compulsive disorder in children and adolescents: A study of phenomenology and family functioning in 20 consecutive Danish cases”*,  
European Child and Adolescent Psychiatry, Jan., Vol. 3(1), 29-36.

**216. Thomsen, P.H., (1995):**

*“Obsessive-compulsive disorder in children and adolescents : Predictors in childhood for long-term phenomenological course”*,  
Acta Psychiatrica Scandinavica, Oct., Vol. 92(4), 255-259.

**217. Thomsen, P.H., (1997):**

*“ Genetic aspects of obsessive compulsive disorder: A review”*,  
Nordic Journal of Psychiatry, 51/1 (15-20).

**218. Thomsen, P.H., (1998):**

*“Obsessive-compulsive disorder in children and adolescents: clinical guidelines”*,  
European Child and Adolescent Psychiatry, Mar.,  
Vol. 7(1), 1- 11.

**219. Tienari, P., (1963):**

*“Psychiatric illnesses in identical twins,”*  
Acta. Psychiat. Scan., Supplement 171.

**220. Tienari, P., (1992):**

*“ Geno-environmental interaction in adoptive families “*,  
Br. J. of Psych., 161: 52-58

- 221. Tynes, L.; Sains, C. and Winstead, D., (1990):**  
“*Obsessive compulsive patients: familial frustration and criticism*”,  
Journal of Louisiana State Medical Society, 142 (10),  
p.p 24–26, 28 – 29.
- 222. Vaisaner, E., (1975):**  
“*Psychiatric disorders in Finland*”,  
Acta Psychiatrica Scandinavica, 62 (Suppl. 263), 27.
- 223. Van-Valiet, I.M. (1999):**  
“*A hidden compulsion,*”  
NederLands- Tijdschrift-voor- Geneeskunde, Feb. 20; 143/ 8  
(385 – 388).
- 224. Vaughan, M. (1976):**  
“*The relationships between obsessional personality obsessions in depression and symptoms of depression*”,  
Br. J. Psychiatry, 129: 36-39.
- 225. Vermeiren. R.; Deboutte. D., (1999):**  
“*Prevalence and course of obsessive and compulsive behavior in children and adolescents: a review of literature*”,  
Tijdschrift- voor- psychiatrie, 41/ 2 (85- 94.)
- 226. Weintraub, W.; Aronson, J., (1974):**  
“*Verbal behavior analysis and psychological defense mechanisms*”,  
Arch. Gen. Psychiatry, (30), 297-300.
- 227. Weissman M.M.; Gammon G.D.; Gohn K. et al (1987)**  
“*children of depressed parents.*”  
Arch Gen. Psychiatry, 44: 847- 853.



**228. Weissman M.M.; Prusoff B.A; Gammon G.D. et al (1984 b):**

*"Psychopathology in the children (ages 6- 18) of depressed and normal parents."*

Journal of the American academy of child psychiatry 23, 78- 84.

**229. Wertlieb D. ; Weigel C.; Springer T.; Fledestien M. (1987):**

*"Temperament as a moderator of children's stressful expenses."*

Am. J. Orthopsychiatry. 57: 234- 245.

**230. Westphal, C., (1972):**

*"Ueber Zwangsvorstellungen,"*

Berlines Klinischen Wochenschrift, 3 : 390-397.

**231. Whitaker A.; Johnson J.; Schaffer D. et al (1990).**

*"Uncommon troubles in young people: pervlance estimates of selected psychiatric disorders in a non- referred adolescent population."*

Archives of general psychiatry 47, 487- 498.

**232. Willson R.; Cairns E. (1988):**

*"Sex rule attribute, perceived competence and the development of depression in adolescent,"*

Journal of Child Psychology and Psychiatry.

29, 635- 650.

**233. Yaryura-Tobias, J.A., (1977):**

*" Obsessive-compulsive disorders: A serotonergic hypothesis",*

Journal of Orthomolecular Psychiatry, 6 : 317-326.

**234. Yaryura-Tobias, J.A.; Neziroglu, F., (1978):**

*"Compulsions, aggression, and self mutilation: a hypothalamic disorder ?"*

Journal of Orthomolecular Psychiatry, 7 : 114- 117.

- 235. Yaryura-Tobias, J.A.; Neziroglu, F.; Fuller, B., (1979):**  
*“An integral approach in the management of the obsessive compulsive patient,”*  
Pharmaceutical Medicine, 2, 155-167.
- 236. Yaryura-Tobias, J.A.; Nezirolgu, F.A., (1983):**  
*“ Classification, in obsessive compulsive disorder: Pathogenesis, diagnosis, treatment”,*  
New York, Mercel Dekker, PP. 37-50.
- 247. Yaryura-Tobias, J.A.; Campisi, T.; Mckay, D., (1995):**  
*“Schizophrenia and obsessive compulsive disorder shared aspects of pathology”,*  
Neurology, Psychiatry, Brain Research, 3 : 143-148.
- 248. Yaryura-Tobias, J.A.; Neziroglu, F.A., (1997):**  
*“Obsessive compulsive disorder spectrum: pathogenesis, diagnosis and treatment”,*  
American Psychiatric Press. Inc., Washington D.C., London, England.
- 249. Zitterl, W.; Lenz, G.; Mairhofer, A. et al, (1990):**  
*“ Obsessive compulsive disorder: course and interaction with depression”,*  
Psychopathology, 23: 73-80.

## المراجع العربية

- ١- أحمد عكاشة، (١٩٩٨):  
" الطب النفسى المعاصر"،  
الأنجلو المصرية.
- ٢- رشاد عبد العزيز موسى (١٩٨٦):  
"مقياس القلق الظاهر للأطفال"  
دار النهضة العربية
- ٣- عمر شاهين ويحيى الرخاوى، (١٩٧٩)  
" مبادئ الأمراض النفسية"،  
القاهرة، مكتبة الأنجلو المصرية.
- ٤- غريب عبد الفتاح غريب (١٩٩٥):  
"مقياس الإكتئاب (د) للصغار CDI - الصورة العامة"  
دار النهضة العربية.
- ٥- محمد سامى هنا، (١٩٦٤):  
" التفكير التجريدي لدى العصائيين القهريين"،  
تقديم محمد عثمان نجاتى، القاهرة، دار النهضة المصرية.
- ٦- محمود حموده (١٩٩٨):  
"الطفولة و المراهقة- المشكلات النفسية و العلاج"

٧- مى يجىى الرخاوى (١٩٩٢):

بعض المتغيرات المرتبطة بالمظاهر و الأعراض الوسواسية لدى الأطفال المترددين على العيادات النفسية.

رسالة ماجستير- جامعه عين شمس - معهد الدراسات العليا للطفولة.

٨- نجمه يوسف ناصر، (١٩٨٥):

" سيكولوجية العصاب القهرى "

رسالة دكتوراة، جامعه عين شمس، كلية الآداب، صفحه ٧١.

# Appendices



# Appendix I

## *Parent evaluation sheet*

**\* Patient name:**

Sex:                      Female:                      Male:  
Age:                      Date of birth:  
Address:  
Telephone:

**\* Duration of illness**

**\* Education of the patient**

**Yes                      No**

01 Illiterate	.....	....
02 Reads and writes	.....	....
03 Primary school	.....	....
04 Preparatory school	.....	....
05 Secondary School	.....	....
06 Technical school	.....	....
07 University	.....	....
08 Post graduate	.....	....
09 Unknown	.....	....

**\* Occupation of The Patient**

**\* Marital status**

01 Married                      No. of marriages  
02 separated  
03 Divorced  
04 Widowed

**\* No. of children**        .....        **\* Males**        .....        **\* Females**        .....

**\* Education of the spouse**

**\* Occupation of the spouse**

<b>* General home atmosphere</b>	<b>Yes</b>	<b>No</b>
01. Harmonious	.....	.....
02. Quarrelsome	.....	.....
03. Cold	.....	.....
04. Competitive	.....	.....
05. Overprotection	.....	.....
06. Warm	.....	.....
07. Over criticism	.....	.....
08. Over involvement	.....	.....
09. Communication	.....	.....
10. Exclusion	.....	.....
11. Unknown	.....	.....

**\* Family Function**

<u><i>a. quality of parental relationship</i></u>	<b>Yes</b>	<b>No</b>
* Mutual affection	.....	.....
* Capacity to communicate about and resolve problems	.....	.....
* Sharing of attitudes over child's problems	.....	.....

<u><i>b. Quality of parents – child relationship</i></u>	<b>Yes</b>	<b>No</b>
01 Positive interaction	.....	.....
02 Parental level of criticism	.....	.....
03 Hostility	.....	.....
04 Rejection	.....	.....
05 Isolated parent	.....	.....
06 Overprotective	.....	.....



**Appendix II**  
***Child And Adolescent***  
***Evaluation Sheet***

1. Name :

2. Sex :

3. Age :

4. Birth date :

5. School :

6. Grade :

7. Birth order:

**\* School**

- First attendance
- Feelings towards school
- Feelings towards teachers
- Relation with his/her friends
- Educational progress

**\* Examination:**

- General appearance
- Motor development
  - \* Sit
  - \* Walk
- Language
  - \* Words
  - \* Sentence
- Interaction with the examiner (cooperative or not)
- Intelligence
  - \* Verbal
  - \* Draw a man

**\* Mood:**

- Depression / Hopeless
- Mania / Hypertalkative
- Anhedonia
- Social withdrawal

- Self esteem
- Sleep/ Dreams/ Nightmares/ Night terrors
- Appetite
- Weight gain
- Concentration
- Dissociation
- Suicide

### **\*Anxiety**

- School refusal
- Phobias
- Panics
- Psycho somatic symptoms
- Somatic Co.

### **\*Obsessions / Compulsions**

- Rituals
- Obsessions
- Perfectionism



**Appendix III**  
**Arabic version of Y-BOCS**

**AGGRESSIVE OBSESSIONS**

Past	Current	
...	...	١- هل يحدث أحيانا أن تراودك أفكار مخيفة عن إيذاء نفسك ؟
...	...	٢- هل يحدث أحيانا أن تراودك أفكار مخيفة عن إيذاء الآخرين ؟
...	...	٣- هل تسيطر على أفكارك صورة عنيفة أو مرعبة ؟
...	...	٤- هل يراودك خوف من أن تتنطق بألفاظ خارجة عن اللائق أو إهانات؟
...	...	٥- هل يراودك خوف من أن تفعل أى أشياء أخرى تكون مصدر إحراج؟
...	...	٦- هل يراودك خوف من تنفيذ فكرة لا ترغب فيها (مثل أن تطعن صديقك)؟
...	...	٧- هل يراودك خوف من أن تسرق شيئاً ما ؟
...	...	٨- هل يراودك خوف من أن تؤذى الآخرين نتيجة لعدم حرصك الكافي؟
...	...	٩- هل يراودك خوف من أن تكون مسئولاً عن أشياء رهيبه تحدث في مكان آخر (كالحرثاق أو السرقة مثلا) ؟

**CONTAMINATION OBSESSIONS**

...	...	١- هل يشغلك التفكير في/ أو الاشمئزاز من إفرازات الجسم أو مخلفاته (على سبيل المثال البول، البراز، اللعاب)؟
...	...	٢- هل يشغلك كثيراً التفكير في القذارة والجراثيم ؟
...	...	٣- هل تهتم اهتماماً مبالغاً فيه بملوثات البيئة (مثل الدخان أو عادم السيارات مثلاً) ؟
...	...	٤- هل تبدى اهتماماً زائداً بالمنظفات المنزلية ؟
...	...	٥- هل تبدى اهتماماً مبالغاً فيه بالحيوانات (الحشرات على سبيل المثال)؟
...	...	٦- هل يضايقك كثيراً التعامل مع مواد لزجة أو بقايا لزجة ؟
...	...	٧- هل ينشغل بالك باحتمال أن تمرض نتيجة للتلوث ؟
...	...	٨- هل يشغل بالك باحتمال أن تتسبب في مرض الآخرين عن طريق نشر تلوث ما (من منطلق عدواني) ؟
...	...	٩- هل يقتصر اهتمامك بالتلوث على ما سوف تشعر به لو أنك أصبت بالتلوث؟
...	...	١٠- أخرى

## SEXUAL OBSESSIONS

Current	Past	
...	...	١- هل تراودك أفكار أو صور أو اندفاعات جنسية محرمة أو شاذة ؟
...	...	٢- هل تدور هذه الأفكار حول الأطفال أو المحارم ؟
...	...	٣- هل لهذه الأفكار طبيعة شاذة جنسيا ؟
...	...	٤- هل تراودك أفكار بشأن اتیان سلوك جنسى عدوانى نحو الآخرين؟
...	...	٥- أخرى

## HOARDING / SAVING OBSESSIONS

...	...	١- هل تميل إلى تخزين الأشياء وتجميعها وحفظها حتى وان لم يكن في ذهنك تصور لكيفية استخدامها ؟ هل تجد صعوبة في التخلص من الأشياء حتى تلك التي لن تستخدمها ؟
-----	-----	--

((Distinguish from hobbies and concern with objects of monetary or sentimental value))

## RELIGIOUS OBSESSIONS

...	...	١- هل تمضى وقتاً طويلاً في التفكير في الكفر والخطيئة ؟
...	...	٢- هل تبدى اهتماماً بالغاً بالأخلاقيات وبما هو ثواب وخطأ ؟
...	...	٣- أخرى

## OBSESSIONS WITH NEED FOR SYMMETRY OR EXACTNESS

...	...	١- هل أنت شديد الترتيب والحرص على أن يكون كل شيء في مكانه وتتصور أن غياب هذا الترتيب قد يؤدي إلى كوارث ما (على سبيل المثال سوف تتعرض إلى كارثة ما إذا لم توضع الأشياء في مكانها الصحيح) ؟
...	...	٢- هل أنت شديد الترتيب والحرص على أن يكون كل شيء في مكانه حتى وإن لم يترتب على عدم الترتيب هذا أى حوادث أو مشكلات ؟

## MISCELLANEOUS OBSESSIONS

Current	Past	
...	...	١- هل أنت كثيرة الانشغال بما يجب عليك أن تعرفه أو تتذكره ؟
...	...	٢- هل تخاف من أن تقول بعض الأشياء التي لا تريد أن تقولها ؟
...	...	٣- هل تخاف أن تقول شيئاً لا يصح أن تقوله ؟
...	...	٤- هل أنت كثير الخوف من أن تفقد أشياء معينة ؟
...	...	٥- هل هناك صور معينة (غير عدوانية) تفرض نفسها عليك ؟
...	...	٦- هل هناك أصوات أو كلمات أو أنغام لا معنى لها تفرض نفسها على تفكيرك ؟
...	...	٧- هل تضايقت أصوات معينة ؟
...	...	٨- هل تعتقد في وجود أرقام تجلب الحظ وأخرى تجلب النحس ؟
...	...	٩- هل هناك ألوان مع معينة تحمل معنى خاص لك ؟
...	...	١٠- هل تعاني من مخاوف غيبية لا أساس لها في الحقيقة ؟
...	...	١١- أخرى

## SOMATIC OBSESSION

...	...	١- هل أنت كثير الإنشغال بالمرض
...	...	٢- هل تبدى إهتماماً مبالغاً فيه بجزء ما من جسمك أو جانب ما من شكلك (على سبيل المثال: هل تشعر أن جزء منك متغير أو مشوه) ؟
...	...	٣- أخرى

## CLEANING / WASHING OBSESSIONS

...	...	١- هل تغسل يديك بشكل طقسى أو مبالغ فيه ؟
...	...	٢- هل تبالغ في الإستحمام أو غسيل الأسنان أو مباشرة نظافة جسمك وهل لك طقوس معينة في ممارسة هذه المهام ؟
...	...	٣- هل تبالغ في الحرص على نظافة الأدوات المنزلية أو الأشياء الأخرى؟
...	...	٤- هل هناك طقوس معينة تمارسها لتتجنب الأشياء التي تعتقد أنها ملوثة أو لتتجنب تلويثها ؟
...	...	٥- أخرى

## CHECKING COMPLUSIONS

Past	Current	
...	...	١- هل تحتاج إلى التأكد أكثر من مرة من أنك قد أغلقت الأبواب أو الغاز الخ؟
...	...	٢- هل تحتاج إلى التأكد المتكرر من أنك لم / أو لن تؤذي الآخرين؟
...	...	٣- هل تحتاج إلى التأكد المتكرر من أنك لم تؤذي نفسك؟
...	...	٤- هل تحتاج إلى التأكد المتكرر من أن شيئاً بشعاً لم أو لن يحدث؟
...	...	٥- هل تحتاج إلى التأكد المتكرر من أنك لم ترتكب خطأ ما؟
...	...	٦- هل هناك أشياء تفعلها بشكل متكرر للتأكد من سلامة جسمك؟
...	...	٧- أخرى

## REPEATING RITUALS

...	...	١- هل تحتاج إلى قراءة أو كتابة الأشياء أكثر من مرة للتأكد من صحة ما قرأت أو كتبت؟
...	...	٢- هل تحتاج إلى تكرار بعض الحركات الروتينية كالخروج أو الدخول من البواب أو الجلوس على الكرسي والقيام من عليه؟

## COUNTING COMPULSION

...	...	١- هل تكثر من عد الأشياء؟
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## ORDERING / ARRANGING COMULSIONS

...	...	١- هل تكثر من ترتيب وإعادة تنظيم الأشياء؟
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## HOARDING / COLLECTING COMPULSIONS

Current	Past	
...	...	١- هل تفشل فى مقاومة جمع والإحتفاظ بالتوافه من الأشياء كأن تحتفظ بالجراند القديمة أو تفرز القمامة أو تجمع أشياء لا فائدة لها ؟

(Distinguish from nobbies and concern with objects of monetary or sentimental value)

## MISCELLANEOUS COMPULSIONS

...	...	١- هل تمارس طقوساً ذهنية معينة (بخلاف العد والتأكد من الأشياء) ؟
...	...	٢- هل تبالغ فى كتابة قوائم لكل ما تريد أن تفعله أو تتذكره ؟
...	...	٣- هل تشعر فى أحيان كثيرة بالحاجة إلى أن تتكلم أو تسأل أو تعترف بشيء ؟
...	...	٤- هل تشعر فى أحيان كثيرة بالحاجة إلى أن تلمس أو تحتك بالأشياء ؟
...	...	٥- هل تعاني من طقوس معينة فى الطريقة التى تنظر بها إلى الأشياء كان ترمش كثيراً أو تحملى كثيراً ؟
...	...	٦- هل تتخذ بعض الإجراءات (غير تكرر التأكد) كى تمنع الأذى عن نفسك... الأذى عن الآخرين... نتائج بشعة ؟
...	...	٧- هل تمارس طقوساً معينة أثناء تناول الطعام ؟
...	...	٨- هل يتحكم التناول والتشاوم فى تصرفاتك ؟
...	...	٩- هل تكثر من ننف شعرك ولا تستطيع أن تتوقف عن ذلك ؟
...	...	١٠- هل تقوم بأى تصرفات أخرى تسبب لك فى أذى أو تشوه ؟
...	...	١١- أخرى



## Appendix IV

### Anxiety symptom check-lists for children

قائمة ملاحظة أعراض القلق للأطفال من سن ٣-٦ سنوات

لا	نعم			البيان
	نادراً	أحياناً	غالباً	
				<p>أولاً: الشعور بالقلق والتوتر الدائم</p> <p>ثانياً: سلوك الطفل في مجموعه الأصدقاء:</p> <ol style="list-style-type: none"><li>١- عدم اندماج الطفل مع جماعه الأطفال وابتعاده عنهم.</li><li>٢- صعوبة تكوين علاقات مع الأطفال الآخرين.</li><li>٣- كثيراً ما يبقي الطفل وحيداً رغم وجوده مع زملاؤه.</li><li>٤- صعوبة الاختلاط و اللعب مع باقي الأطفال.</li><li>٥- صعوبة التركيز في اللعب.</li></ol> <p>ثالثاً: الأعراض النفسجسمية:</p> <ol style="list-style-type: none"><li>١- قيء.</li><li>٢- مغص.</li><li>٣- إسهال.</li><li>٤- إمساك.</li><li>٥- نقص الشهية ( قد تؤدي إلى نقص الوزن بدرجة كبيره ).</li><li>٦- الصداع .</li><li>٧- العرق الشديد.</li><li>٨- الشعور بدقات القلب.</li></ol> <p>رابعاً : اضطرابات النوم:</p> <ol style="list-style-type: none"><li>١- الأرق ( التأخر قبل الدخول في النوم ).</li><li>٢- الاستيقاظ المفاجئ أثناء النوم والبحث عن الأم / الأب.</li><li>٣- البكاء أثناء النوم.</li><li>٤- تكرار استيقاظه منزعجاً.</li><li>٥- الأحلام المزعجة.</li><li>٦- الفزعات الليلية والكوابيس.</li><li>٧- كثرة بلل الطفل لفرشه بعد أن يكون قد أنجز التحكم في عملية التبول أثناء النوم لعدة شهور .</li><li>٨ - كثرة النوم.</li></ol> <p>خامساً: المخاوف المرضية:</p> <p>خوف من شيء محدد بصورة غير عقلانية لا يمكن تفسيره منطقياً وقد يؤدي هذا الخوف إلى تجنب مصدر الخوف.</p> <p>تذكر .....</p> <p>(مثال: الحيوانات الأليفة/ الظلام/ النوم وحيداً/ الحشرات/ المدرسة...)</p>

لا	نعم			البيان
	نادراً	أحياناً	غالباً	
				<p>سادساً: أعراض عصابية أخرى:</p> <p>١- قضم الأظافر  ٢- مص الإبهام  ٣- هز الجسم أو الأطراف  ٤- جذب الشعر  ٥- سرعة الاستثارة والانفعال والغضب  ٦- ثورات غضب <b>Temper Tantrums</b> متكررة ومبالغ فيها دون سبب واضح (رد فعل أكبر من الموقف)</p>

## قائمة ملاحظة أعراض القلق للأطفال من سن ٦-١٢ سنة

بالإضافة إلى الأعراض السابقة في المرحلة السابقة ما يلي:

لا	نعم			البيان
	نادراً	أحياناً	غالباً	
				<p>أولاً : المخاوف الاجتماعية</p> <p>مثال:</p> <ul style="list-style-type: none"> <li>• الخوف من الكلام أمام الآخرين</li> <li>• الخوف من الضيوف</li> <li>• الخوف من الظهور في الإذاعة المدرسية</li> <li>• الخوف من الخروج لحفلة</li> <li>• الخوف من تناول الطعام خارج المنزل في مكان عام</li> </ul>
				<p>ثانياً : مخاوف مرتبطة بالمدرسة</p> <p>مثال:</p> <ul style="list-style-type: none"> <li>• رفض الذهاب للمدرسة لأول مرة</li> <li>• الخوف من المدرس في المدرسة</li> <li>• الخوف من العقاب في المدرسة</li> <li>• الخوف من زملائه في المدرسة</li> <li>• الخوف من الامتحان ( قلق الامتحان )</li> <li>• الخوف وعدم الشعور بالرضا والارتياح من تغيير المعلم في صورة: <ul style="list-style-type: none"> <li>- كراهية الفصل.</li> <li>- كراهية المدرسة.</li> <li>- كراهية المادة.</li> <li>- عدم التجاوب في الفصل.</li> <li>- الحصول على درجات منخفضة.</li> </ul> </li> </ul>

لا	نعم			البيان
	نادراً	أحياناً	غالباً	
				<p>ثالثاً: الخوف من الإصابة الجسدية</p> <p>رابعاً: النكوص</p> <p>١- التبول والتبرز على نفسه (بعد أن يكون قد أتم التحكم فيهما في مرحلة سابقة).</p> <p>٢- عودة الاعتماد الكلي على الوالدين في الأمور اليومية بما لا يتناسب مع عمر الطفل.</p> <p>٣- البكاء في مواقف لا تتناسب مع نمو الطفل.</p> <p>خامساً: اللزمات العصبية</p> <p>١- لزيمات صوتية (تذكر).</p> <p>٢- تحريك بعض أجزاء الجسم. (مثل البربشة بالعين / حركة الخدود).</p> <p>٣- أخرى (تذكر).</p>

## قائمة ملاحظة أعراض القلق أكبر من ١٢ سنة

بالإضافة إلى ما سبق في المرحلتين السابقتين يضاف ما يلي :

لا	نعم			البيان
	نادراً	أحياناً	غالباً	
				١- خوف من فقدان الأصدقاء ٢- قلق وخوف حول الجاذبية الجنسية للمراهق للجنس الآخر ٣- خوف حول المستقبل الشخصي ٤- خوف حول مستقبل العالم ( دمار البشرية / يوم القيامة ) ٥- قلق الموت للشخص نفسه ٦- قلق الموت أن يصيب أحد المقربين

**Appendix V**  
**Depressive symptom check-lists for children**

**قائمة ملاحظة أعراض الاكتئاب للأطفال من سن ٣-٦ سنوات**

لا	نعم			البيان
	نادراً	أحياناً	غالباً	
				١- الكسل ونقص الطاقة والنشاط.
				٢- التبدل الانفعالي وعدم المبالاة.
				٣- الشعور الدائم بالحزن واليأس.
				٤- كثرة البكاء.
				٥- البكاء بسهولة ولأتفه الأسباب.
				٦- البطء التام في التصرفات والأعمال المختلفة (استهلاك الكثير من الوقت لإنجاز المهام، الأكل مثلاً يأكل في ساعة).
				٧- أعراض جسمية دون سبب عضوى (قيء/إسهال/ صداع).
				٨- سرعة الاستثارة.
				٩- فقد الاستمتاع بكل أو أغلب الأنشطة اليومية والتي كانت ممتعة بالنسبة له سابقاً.
				١٠- نقص الشهية للطعام.
				١١- زيادة الشهية للطعام.



## قائمة ملاحظة أعراض الاكتئاب للأطفال من سن ٦-١٢ سنوات

لا	نعم			البيان
	نادراً	أحياناً	غالباً	
				١- الشعور الدائم بالحزن و اليأس و يبدو باكياً.
				٢- الكسل و نقص الحيوية و الطاقة.
				٣- الفشل في الدراسة و عدم إجرار تقدم في المدرسة.
				٤- نقص الانتباه.
				٥- نقص القدرة على التركيز .
				٦- الانسحاب الاجتماعي.
				٧- نقص القدرة على التعامل مع الإحباطات مهما كانت بسيطة.
				٨- نقص ملحوظ في الاهتمامات أو فقد الاستمتاع بأغلب الأنشطة اليومية و خاصة المحببة.
				٩- الأرق أو زيادة النوم.
				١٠- مشاعر بعدم القيمة و نقص تقدير الذات (الشعور بأنه أقل من أقرانه) (مقارنة الطفل بمن حوله من نفس سنه) (مقارنة الطفل بأخوته) (يسأل باستمرار عن حب والديه)
				١١- السلوك العدواني المضاد للمجتمع ( السرقة / تدمير ممتلكات الغير / إشعال الحرائق / الهروب من المدرسة.....)
				١٢- الشعور بالذنب و تائب الضمير ولوم الذات.
				١٣- التبدل انفعالي ولا مبالاة.
				١٤- البطء العام في المهام البسيطة (القراءة/ الكتابة/ الامتحان).
				١٥- نقص الشهية للطعام.
				١٦- زيادة الشهية للطعام.

قائمة ملاحظة أعراض الاكتئاب للأطفال أكبر من ١٢ سنة

لا	نعم			البيان
	نادراً	أحياناً	غالباً	
				١- الشعور بالحزن و الاكتئاب واليأس ويبدو باكياً.
				٢-فقدان الطاقة و الحيوية و الشعور بالإجهاد بسهولة.
				٣-التباعد الانفعالي واللامبالاة.
				٤-نقص الشهية للطعام.
				٥-زيادة الشهية للطعام.
				٦-الشعور بالتفاهة وعدم الأهمية وأنه غير مفيد.
				٧-أفكار انتحارية.
				٨-محاولات انتحار فعلية.
				٩-الإدمان وسوء استخدام الأدوية والعقاقير.
				١٠-الهدوء الشديد والخجل.
				١١-البطء العام فى المهام البسيطة(القراءة/ الكتابة/ الامتحان).

**Appendix VI**  
**Obsessive Compulsive Symptom check-list for children**  
**قائمة أعراض الوسواس القهري للأطفال**

لا	نعم			البيان
	نادراً	أحياناً	غالباً	
				<p style="text-align: center;"><b><u>General Appearance</u></b></p> <p>(١) الإلتقان المبالغ فيه.  (٢) الإهمال الزائد في كل شيء.  (٣) النظافة المبالغ فيها.  (٤) الاهتمام المبالغ بالمظهر الخارجي.</p>
				<p style="text-align: center;"><b><u>Counting Compulsions</u></b></p> <p>(١) العد  مثال * عد العربات ذات اللون الواحد.  * عد السلالم.  * عد النوافذ.  (٢) عد الأشياء أكثر من مرة.  (٣) عد الأشياء بعدد محدد.</p>
				<p style="text-align: center;"><b><u>Bed Time Rituals</u></b></p> <p>(١) هل لهذه الطقوس ترتيب محدد يذكر ؟  مثال: * الذهاب للحمام والتأكد من ذلك قبل النوم.  * عدم الذهاب للحمام قبل النوم يؤدي إلى الشعور بالتوتر والقلق.  * ترتيب الغطاء بطريقة معينة.  * أخذ كوب ماء بجوار السرير.  * التأكد أكثر من مرة من غلق نوافذ الحجرة.  * ترتيب الملابس بطريقة معينة.  (مثال : وضع حذاء المنزل في مكان محدد بجوار السرير قبل النوم).  (٢) عدم القيام بهذه الطقوس يؤدي إلى التوتر والقلق.</p>
				<p style="text-align: center;"><b><u>Eating Rituals</u></b></p> <p>(١) ترتيب أدوات المائدة بطريقة معينة.  (٢) بدء الطعام بكلمة أو تصرف محدد (مثال: لمس جوانب المائدة قبل جلوسه لتناول وجبته).</p>

لا	نعم			البيان
	نادراً	أحياناً	غالباً	
				<p>(٣) الجلوس في مكان ثابت على المائدة وتغييره يؤدي إلى القلق والتوتر.  (٤) القلق الشديد إذا نسي شئ معين مرتبط بالطعام يمثل له أهمية خاصة.  (٥) استخدام أدواته الخاصة وعدم استخدام أدوات الآخرين.  (٦) استخدام الآخرين لأدواته يؤدي إلى التوتر والقلق والشعور بأنها غير نظيفة.</p>
				<p><b><u>Cleaning Obsessions</u></b></p> <p>(١) الإحساس الدائم بعدم النظافة.  (٢) غسل اليدين أكثر من مرة للتأكد من نظافتها.  (٣) غسل اليدين بشكل طقوس.</p>
				<p><b><u>School Rituals And Compulsions</u></b></p> <p>(١) ترتيب شنطة المدرسة بطريقة معينة.  (٢) مراجعة الواجب عدة مرات للتأكد من صحته.  (٣) المذاكرة في مكان معين وتغييره يؤدي إلى قلق وتوتر واضح.  (٤) طقوس وحركات معينة مرتبطة بالمذاكرة تذكر.  (مثال: وضع الكتاب على يمين المكتب والأقلام في مكان محدد والكراسة في اليسار).</p>
				<p><b><u>Checking Compulsions</u></b></p> <p>(١) المراجعة والتأكد مما قام به الطفل أكثر من مرة.  (٢) التأكد من غلق الأبواب والشبابيك.</p>
				<p><b><u>Ordering Arranging Compulsions</u></b></p> <p>(١) النظام الزائد والإتقان المبالغ فيه.  (٢) ترتيب وإعادة تنظيم الأشياء أكثر من مرة.  (٣) وضع الأشياء بترتيب محدد (مثال - اللعب).</p>
				<p><b><u>Miscellaneous Obsessions</u></b></p> <p>(١) زيادة الاهتمام بأشياء أخرى غير العد.  (٢) قضاء وقت طويل في الحمام.  (٣) الأسئلة المتكررة.  (٤) المشي على البلاطات بالتبادل.  (٥) التردد وعدم القدرة على اتخاذ القرار.</p>

## APPENDIX VII-A

### “ Generalized Anxiety Disorder ”

#### ■ Diagnostic criteria for 300.02 Generalized Anxiety Disorder

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The person finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). **Note:** Only one item is required in children.
  - (1) restlessness or feeling keyed up or on edge
  - (2) being easily fatigued
  - (3) difficulty concentrating or mind going blank
  - (4) irritability
  - (5) muscle tension
  - (6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
- D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
- E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

## APPENDIX VII-B

### “ Separation Anxiety Disorder ”

#### ■ Diagnostic criteria for 309.21 Separation Anxiety Disorder

- A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:
- (1) recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
  - (2) persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
  - (3) persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
  - (4) persistent reluctance or refusal to go to school or elsewhere because of fear of separation
  - (5) persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
  - (6) persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
  - (7) repeated nightmares involving the theme of separation
  - (8) repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated
- B. The duration of the disturbance is at least 4 weeks.
- C. The onset is before age 18 years.
- D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder With Agoraphobia.

*Specify if:*

**Early Onset:** if onset occurs before age 6 years

# APPENDIX VII-C

## “ Specific Phobias ”

### ■ Diagnostic criteria for 300.29 Specific Phobia

- A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
- B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.
- C. The person recognizes that the fear is excessive or unreasonable.  
**Note:** In children, this feature may be absent.
- D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. In individuals under age 18 years, the duration is at least 6 months.
- G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder.

*Specify type:*

**Animal Type**

**Natural Environment Type** (e.g., heights, storms, water)

**Blood-Injection-Injury Type**

**Situational Type** (e.g., airplanes, elevators, enclosed places)

**Other Type** (e.g., phobic avoidance of situations that may lead to choking, vomiting, or contracting an illness; in children, avoidance of loud sounds or costumed characters)

## APPENDIX VII-D

### “ Social Phobia ”

#### ■ Diagnostic criteria for 300.23 Social Phobia

- A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. **Note:** In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.
- B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
- C. The person recognizes that the fear is excessive or unreasonable. **Note:** In children, this feature may be absent.
- D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. In individuals under age 18 years, the duration is at least 6 months.
- G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).
- H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

Specify if:

**Generalized:** if the fears include most social situations (also consider the additional diagnosis of Avoidant Personality Disorder)



## APPENDIX VII-E

### “Agora Phobia”

#### ■ Criteria for Agoraphobia

**Note:** Agoraphobia is not a codable disorder. Code the specific disorder in which the Agoraphobia occurs (e.g., 300.21 Panic Disorder With Agoraphobia [p. 402] or 300.22 Agoraphobia Without History of Panic Disorder [p. 404]).

A. Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.

**Note:** Consider the diagnosis of Specific Phobia if the avoidance is limited to one or only a few specific situations, or Social Phobia if the avoidance is limited to social situations.

B. The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a Panic Attack or panic-like symptoms, or require the presence of a companion.

C. The anxiety or phobic avoidance is not better accounted for by another mental disorder, such as Social Phobia (e.g., avoidance limited to social situations because of fear of embarrassment), Specific Phobia (e.g., avoidance limited to a single situation like elevators), Obsessive-Compulsive Disorder (e.g., avoidance of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., avoidance of leaving home or relatives).



## APPENDIX VIII-A

### “ Major Depressive Episode ”

#### ■ Criteria for Major Depressive Episode

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

**Note:** Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

- (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
  - (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
  - (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
  - (4) insomnia or hypersomnia nearly every day
  - (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
  - (6) fatigue or loss of energy nearly every day
  - (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
  - (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
  - (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- B. The symptoms do not meet criteria for a Mixed Episode (see p. 335).
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

## APPENDIX VIII-B

### “ Dysthymic Disorder ”

#### ■ Diagnostic criteria for 300.4 Dysthymic Disorder

- A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. **Note:** In children and adolescents, mood can be irritable and duration must be at least 1 year.
- B. Presence, while depressed, of two (or more) of the following:
- (1) poor appetite or overeating
  - (2) insomnia or hypersomnia
  - (3) low energy or fatigue
  - (4) low self-esteem
  - (5) poor concentration or difficulty making decisions
  - (6) feelings of hopelessness
- C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.
- D. No Major Depressive Episode (see p. 327) has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.
- Note:** There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder. In addition, after the initial 2 years (1 year in children or adolescents) of Dysthymic Disorder, there may be superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Episode.
- E. There has never been a Manic Episode (see p. 332), a Mixed Episode (see p. 335), or a Hypomanic Episode (see p. 338), and criteria have never been met for Cyclothymic Disorder.
- F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.
- G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

**Early Onset:** if onset is before age 21 years

**Late Onset:** if onset is age 21 years or older

Specify (for most recent 2 years of Dysthymic Disorder):

**With Atypical Features** (see p. 384)

## APPENDIX IX

### “DSM IV CRITERIA FOR OCD”

#### ■ Diagnostic criteria for 300.3 Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:

*Obsessions as defined by (1), (2), (3), and (4):*

- (1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
- (2) the thoughts, impulses, or images are not simply excessive worries about real-life problems
- (3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
- (4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

*Compulsions as defined by (1) and (2):*

- (1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
- (2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

*Specify if:*

**With Poor Insight:** if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable

## Appendix X

### List of scale judging professors

أستاذ ورئيس قسم الأمراض النفسية و العصبية و مدير مركز الطب النفسى - كلية الطب، جامعه عين شمس.	أ.د عادل صادق
أستاذ الأمراض النفسية و العصبية - كلية الطب، جامعه عين شمس.	أ.د محمد غانم
أستاذ الأمراض النفسية و العصبية - كلية الطب، جامعه عين شمس.	أ.د زينب البشرى
أستاذ الأمراض النفسية و العصبية - كلية الطب، جامعه الأزهر.	أ.د محمود حمودة
أستاذ الأمراض النفسية و العصبية - كلية الطب، جامعه عين شمس.	أ.د صفيه عفت
أستاذ الصحة النفسية - كلية التربية، جامعه عين شمس.	أ.د حامد زهران
أستاذ علم النفس - كلية الآداب، جامعه الإسكندرية.	أ.د أحمد عبد الخالق
أستاذ الصحة النفسية - كلية التربية بالفيوم، جامعه القاهرة.	أ.د مديحه العزبى
أستاذ ورئيس قسم علم النفس - كلية التربية، جامعه طنطا.	أ.د آمال باظه
أستاذ مساعد الصحة النفسية - كلية الطب، جامعه عين شمس.	أ.م.د نبيل حافظ

## ملخص البحث

تلعب العمليات الأسرية والتفاعل بين أفراد الأسرة دوراً هاماً في مجال الطب النفسي باعتبارهما من العوامل المسببة والمحدثة لمعظم الاضطرابات النفسية. وقد حظيت هذه العوامل الأسرية المسببة للأمراض النفسية باهتمام وعناية الباحثين في هذا الميدان. وفي مقابل ذلك فإن عدداً محدوداً من الأبحاث تناولت بالدراسة أثر وجود مريض نفسى من بين أعضاء الأسرة على باقي أعضائها (خاصة الأطفال منهم)، أو إلى أي حد يتعامل أفراد الأسرة الواحدة مع المشكلات النفسية والاجتماعية المختلفة المترتبة على ذلك.

ومن الحقائق الثابتة أن الوالدين مسئولان عن تهيئة بيئة ملائمة لتنشئة الأطفال تنشئة سليمة من النواحي الجسمية والانفعالية والعقلية. ومن ناحية أخرى فإن المرض النفسي لأحد الوالدين (خاصة الأم) يؤدي إلى تغيير هذا الجو الصحى المناسب لتنشئة سليمة، على نحو يؤدي إلى إحداث الكثير من المشكلات النفسية والاجتماعية للأطفال.

بالإضافة إلى ذلك يعد اضطراب الوسواس القهري لدى أحد الوالدين من الأمراض النفسية الشائعة إذا ما قورن بغيره من الأمراض النفسية لدى المرضى الراشدين. ويعاني هؤلاء الآباء عادةً بالإضافة إلى مرضهم الأصلي الذي يتميز بالوسواس والأفعال القهرية من أعراض القلق والاكتئاب، والتي في كثير من

الأحيان ما تؤثر فى إحداث هذه الاضطرابات المتلازمة وتؤدى إلى نشأة الكثير من المشكلات الاجتماعية والنفسية خاصة لدى الأطفال.

والأطفال الذين يعانى أبائهم من اضطراب الوسواس القهري كثيراً ما يتواءمون مع الطقوس الوالدية إما من خلال المشاركة فى أنماط سلوك يرتبط بمثل هذه الطقوس أو من خلال تعديل نشاطهم اليومي. كما أنهم قد يتأثرون بمثل هذه الخبرات الحياتية السلبية ويعانون من مشكلات سلوكية أو انفعالية.

وجدير بالذكر أنه قد أجريت دراسات محدودة العدد حول الآثار السلبية لاضطراب الوسواس القهري لأحد الوالدين على باقي أفراد الأسرة وخاصة الأطفال فى مرحلة ما قبل المدرسة ومرحلة المدرسة خاصة فى مصر.

والهدف من الدراسة الحالية هو التعرف على بعض الأعراض والاضطرابات النفسية التي يمكن أن يعانى منها أبناء الآباء الذين يعانون من مرض الوسواس القهري، مع التركيز على أعراض القلق والاكتئاب والوسواس القهري واضطراباتهما المختلفة.

وقد تناولت الدراسة هذه الأعراض تبعاً لمتغيرات العمر الزمني للطفل وجنس الطفل ومحكات الدليل التشخيصي والإحصائي الأمريكي الرابع للأمراض النفسية (DSM IV).



ولتحقيق هذا الهدف تم اختيار مجموعتين من الأباء والأمهات وأطفالهم كما يلي:

- ١- المجموعة المرضية: وتتألف من أولئك الأباء الذين يعانون من اضطراب الوسواس القهري كما تشمل أبنائهم.
- ٢- المجموعة الضابطة: وتتألف من أولئك الأباء الأسوياء باعتبارهم مجموعة المقارنة كما تشمل أبنائهم.

وقد تم اختيار هاتين المجموعتين بناء على محكات التضمن التالية:

- ١- أن يكون كل من الأباء سواء من المجموعة المرضية أو الضابطة مصرياً بغض النظر عن العمر أو الجنس أو المستوى الاقتصادي والاجتماعي.
- ٢- أن يكون لهؤلاء الأباء أطفالاً من الذكور أو الإناث أو كليهما تمتد أعمارهم بين ٣ إلى ١٥ سنة.
- ٣- أن يكون الوالد سواء المريض أو السوي مقيماً إقامة مستمرة مع الأطفال لمدة لا تقل عن ستة شهور قبل تقييمه بأدوات البحث.
- ٤- بالنسبة للأباء المرضى يجب أن تتوفر فيهم محكات الدليل التشخيصي والإحصائي الأمريكي الرابع (DSM IV) الخاصة باضطراب الوسواس القهري.
- ٥- بالنسبة للمجموعة الضابطة يجب أن يكون الأب أو الأم لايعانى أي اضطراب جسدي أو نفسي أو يعالج بأي عقاقير بصورة مستمرة ويشمل ذلك سوء استخدام العقاقير والإدمان.

وقد تم استبعاد العديد من الآباء للأسباب الآتية:

- ١- رفض الوالد (الأم أو الأب) المشاركة بنفسه أو رفضه مشاركة أبنائه في برنامج البحث.
- ٢- حالات اضطراب الوسواس القهري من غير المتزوجين، أو المتزوجين الذين ليس لديهم أبناء، أو لديهم أبناء في مرحلة عمرية خارج نطاق البحث.
- ٣- الآباء والأمهات الذين يعانون أبنائهم من اضطراب نفسي آخر خاصة التأخر العقلي.

هذا وقد حصلت الباحثة على موافقة كل والد (الأم أو الأب) من المجموعتين المرضية أو الضابطة بعد شرح مفصل لكل من خطوات البحث وأهميته. وقد جاءت هذه الموافقة صريحة وتطوعية من جميع الآباء والأمهات موضوع البحث، كذلك الزوج أو الزوجة أو الآخرين من القائمين على رعاية الأطفال في تلك الأسر.

وقد أجريت الدراسة على العينة التالية:

- ١- المجموعة المرضية: من الآباء والأمهات المرضى باضطراب الوسواس القهري. حيث تم اختيار تسعة عشر مريضاً من هؤلاء المرضى الذين توافرت لديهم محكات الدليل التشخيصي والإحصائي الأمريكي الرابع للأمراض النفسية (DSM IV) الخاصة باضطراب الوسواس القهري (بدون استبعاد أي من الحالات المترددة على العيادات سواء التابعة لمركز الطب النفسي التابع لكلية الطب، جامعة عين

شمس أو بعض العيادات الخاصة إلا في ضوء المحكمات السابقة، وقد بلغ عدد أبناء هذه المجموعة اثنين وأربعين من الذكور والإناث (ذكور = 17 ، إناث = 25).

٢- المجموعة الضابطة : تم اختيار ثلاثة عشر والداً أو والدته من الأسوياء والذين تطوعوا للمشاركة في البحث. وقد تمت المطابقة بينهم وبين المجموعة المرضية قدر الإمكان من حيث العمر والجنس والمستوى الاجتماعي وعدد الأبناء، وقد بلغ عدد أبناء هذه المجموعة خمسة وثلاثين طفلاً من الذكور والإناث (ذكور = 18 ، إناث = 17).

هذا وقد أجريت دراسة استطلاعية على خمس حالات من مرضى الوسواس القهري من الوالدين بالإضافة إلى أبناءهم (ن = 1). وقد أدت نتائج هذه الدراسة الاستطلاعية إلى إعداد أدوات البحث والتي تتضمن القوائم الخاصة بالتعرف على أعراض الاضطرابات المختلفة موضوع البحث.

وقد صنف الأطفال تبعاً لقوائم التعرف على الأعراض إلى ثلاث مجموعات عمرية وذلك للوصول إلى تقييم أفضل للأعراض المختلفة تبعاً للعمر الزمني للطفل.

وهذه المجموعات هي:

### المجموعة العمرية الأولى:

تتألف من الأطفال الذين تمتد أعمارهم بين ٣ و ٦ سنوات.

### المجموعة العمرية الثانية:

تتألف من الأطفال الذين تمتد أعمارهم بين أكثر من ٦ سنوات إلى ١٢ سنة.

### المجموعة العمرية الثالثة:

تتألف من الأطفال الذين تمتد أعمارهم بين أكثر من ١٢ سنة إلى ١٥ سنة.

وقد فحصت خصائص القياس النفسى لقوائم الأعراض المستخدمة فى البحث على النحو الآتى:

### ١- صدق المحتوى

حيث قامت الباحثة بعرض قوائم التعرف على الأعراض على عشرة أساتذة متخصصون فى مجالي الطب النفسى وعلم النفس للحكم على مدى ارتباط عبارات كل مقياس من المقاييس التي تتألف منها هذه القوائم بهذا المقياس، ومدى صلاحيتها لتقييم الاضطراب التي وضعت من أجله.

وقد قام الأساتذة المحكمون إما بإضافة بعض العبارات أو حذف بعضها أو إعادة ترتيبها، وبعد تعديل المقاييس عرضت مرة أخرى على خمسة من المحكمين من أساتذة الطب النفسى وعلم

النفس. وقد أبدوا جميعاً اتفاقاً كاملاً على صلاحية المفردات في صورتها الجديدة لقياس مختلف الأعراض والاضطرابات موضوع الدراسة.

## ٢- الثبات

تم حساب الثبات لكل مقياس من المقاييس الفرعية التي تتألف منها قوائم التعرف على الأعراض باستخدام طريقة "ألفا كرونباك" لحساب الثبات وقد كانت معاملات الثبات جميعها دالة عند مستوى (٠,٠١) ويعنى ذلك أن القوائم ملائمة من حيث درجة ثباتها لتقييم الاضطرابات المختلفة موضوع البحث.

وبعد التحقق من صلاحية جميع الأدوات، سارت إجراءات البحث بالنسبة لكل من الأباء والأبناء من المجموعتين المرضية والضابطة على النحو الآتي:

### أولاً : بالنسبة للأباء

**طبقت المقاييس على الأباء من المجموعتين المرضية والضابطة على النحو التالي:**

(١) قائمة تقييم الأباء والخاصة بجمع البيانات الشخصية لكل أب أو أم تم اختياره ضمن عينة البحث.

(٢) تطبيق قائمة محكات الدليل التشخيصي والإحصائي الأمريكي الرابع للأمراض النفسية (DSM IV) لتشخيص اضطراب الوسواس القهري.

(٣) الصورة العربية من مقياس ييل براون للوسواس القهري.

### ثانياً : بالنسبة للأبناء

تعرض الأبناء سواء أبناء الآباء من المجموعة المرضية أو أبناء الآباء من المجموعة الضابطة للإجراءات التالية:

(١) تطبيق قائمة تقييم الطفل أو المراهق.

(٢) تقييم أعراض القلق واضطراباته باستخدام ما يلي:

( أ ) قائمة أعراض القلق للأطفال.

(ب) قائمة محكات الدليل التشخيصي والإحصائي الأمريكي الرابع للأمراض النفسية (DSM IV) لتشخيص اضطرابات القلق والخوف وتشمل تشخيص كل من: اضطرابات القلق العام، اضطراب قلق الانفصال في الطفولة، الرهاب المحدد، الرهاب الاجتماعي، رهاب الساحة.

(٣) تقييم أعراض الاكتئاب واضطراباته باستخدام ما يلي:

( أ ) قائمة أعراض الاكتئاب للأطفال.

(ب) قائمة محكات الدليل التشخيصى والإحصائى الأمريكى  
الرابع للأمراض النفسية (DSM IV) لتشخيص الاكتئاب  
بصوره المختلفة (عسر المزاج، نوبة الاكتئاب الجسيم).

(٤) تقييم أعراض الوسواس القهرى واضطرابه باستخدام ما يلى:

( أ ) قائمة أعراض الوسواس والأفعال القهرية للأطفال.  
(ب) قائمة محكات الدليل التشخيصى والإحصائى الأمريكى  
الرابع للأمراض النفسية (DSM IV) لتشخيص اضطراب  
الوسواس القهرى.

وقد استغرق تطبيق الأدوات على كل فرد ما بين ٣٠-٤٥  
دقيقة، وقد كان من المتطلب فى بعض الأحيان إعادة تقييم بعض  
الأفراد.

هذا وقد واجهت الباحثة العديد من الصعوبات فى إجراء هذه  
الدراسة الميدانية من أهمها مشكلة جمع العينة باستخدام محكات  
التضمين، كذلك مشكلة إقناع المفحوصين بالموافقة على المشاركة  
فى البحث وتطبيق المقاييس وأدوات البحث عليهم وعلى أبنائهم.  
وكذلك مشكلة تطبيق الأدوات على الأطفال خاصة صغار السن  
منهم والتي تطلبت وقتاً طويلاً.

وقد تم جمع البيانات وجدولتها وتحليلها باستخدام المجموعة الإحصائية  
للدراستات الاجتماعية (SPSS) على الحاسب الآلى. وقد استخدمت الطرق

الإحصائية الآتية لاختبار فروض البحث: اختبار (ت) للتحقق من دلالة الفروق بين مجموعتين، وأسلوب تحليل التباين للتحقق من الفروق بين عدة مجموعات.

وقد كشف التحليل الإحصائي عن النتائج الآتية والتي سوف تصنف تبعاً للاضطرابات والأعراض المختلفة موضوع البحث:

### أولاً: أعراض القلق واضطراباته المختلفة

أوضحت الدراسة أن معظم الأبناء من آباء المجموعة المرضية (الذين يعانون من اضطراب الوسواس القهري) كانوا يعانون من أعراض القلق بصورها المختلفة تبعاً لكل من متغيرات العمر والجنس ومحكات الدليل التشخيصي والإحصائي الأمريكي الرابع للأمراض النفسية (DSM IV) كما يلي:

#### (١) الأطفال الذين تتراوح أعمارهم من ٣ إلى ٦ سنوات:

لم يظهر هؤلاء الأطفال أي من أعراض القلق المتضمنة في قائمة التشخيص. ولكن اضطراب قلق الانفصال كان ظاهراً بصورة واضحة بين أطفال هذه المجموعة دون ظهور فروق بين الجنسين.

#### (٢) الأطفال الذين تتراوح أعمارهم بين أكثر من ٦ سنوات إلى ١٢ سنة:

أظهر الأطفال من هذه المجموعة العمريه العديد من أعراض القلق المتضمنة في قائمة التشخيص خاصة: الشعور الدائم بالتوتر



والقلق معظم أوقات اليوم، المشكلات المرتبطة بالنوم ( خاصة الأحلام المزعجة)، الأعراض النفسجسمية ( فى صورة فقد الشهية للطعام)، سرعة الاستثارة والانفعال والغضب، ثورات لغضب، النكوص، الرهاب المحدد ( فى صورة المخاوف المرتبطة بالمدرسة، الخوف من الحيوانات، الخوف من الحشرات، الظلام...).

هذا وقد أظهر الأبناء من الذكور هذه الأعراض بصورة أوضح من الإناث فى هذه المجموعة العمرية عند المقارنة بين المجموعة المرضية والمجموعة الضابطة داخل كل جنس على حدة.

وقد كان كل من اضطراب قلق الانفصال، القلق العام، الرهاب المحدد متوافرا بصورة واضحة بين أبناء هذه المجموعة العمرية. وكان كل من قلق الانفصال، والرهاب المحدد أكثر بين الذكور بينما لم تظهر فروق بين الجنسين فى اضطراب القلق العلم.

### (٣) الأطفال الذين تتراوح أعمارهم بين أكثر من ١٢ إلى ١٥ سنة:

أظهر الأطفال الذين ينتمون إلى هذه المجموعة العمرية العديد من مظاهر القلق فى صورة: الشعور الدائم بالتوتر والقلق معظم أوقات اليوم، المشكلات المرتبطة بالنوم خاصة الأرق والأحلام المزعجة وكثرة النوم، سرعة الاستثارة والانفعال والغضب، المخاوف المحددة فى صورة المخاوف المرتبطة

بالمدرسة، الخوف من الإصابة الجسدية، والخوف من الموت أن يصيبه هو أو أحد المقربين إليه (خاصة الأم) وغيرها.  
هذا وقد أظهر كل من الذكور والإناث هذه الأعراض بصورة دالة إحصائياً. ولكن مستوى الدلالة عند الإناث كان أعلا منه عند الذكور (الذكور = ٠,٠٣)، (الإناث = ٠,٠٠٤).

وقد أظهر أبناء هذه المجموعة اضطراب القلق العام بينهم دون ظهور فروق بين الجنسين. كما ظهر الرهاب المحدد كتشخيص بين هؤلاء الأطفال خاصة الذكور منهم. ولم يُظهر اضطراب قلق الانفصال دلالة بين أبناء هذه المجموعة العمريه.

والجدير بالذكر أن الأنواع الأخرى للرهاب مثل الرهاب الاجتماعي ورهاب الساحة لم تظهر على الإطلاق بين أبناء المجموعتين المرضية والضابطة.

### ثانياً: أعراض الاكتئاب واضطراباتة المختلفة

عند عرض الأعراض الخاصة بالاكتئاب بين أطفال الأباء من ذوى اضطراب الوسواس القهرى تبعاً لكل من عمر وجنس الطفل ومحكات الدليل التشخيصى والإحصائى الأمريكى الرابع للأمراض النفسية (DSM IV) الخاصة بالاضطرابات المختلفة للاكتئاب تم التوصل إلى النتائج الآتية تبعاً للمجموعات العمريه المختلفة:

## (١) الأطفال الذين تتراوح أعمارهم بين ٣ الى ٦ سنوات

لم يظهر الأطفال من هذه المجموعة أيًا من أعراض الاكتئاب المختلفة المتضمنة في قائمة التقييم الخاصة بها ولكن عند تصنيف الأطفال تبعاً لمتغير الجنس، تبين أن الأطفال الذكور يعانون من هذه الأعراض أكثر من الإناث.

كذلك لم يظهر أي من عسر المزاج ونوبة الاكتئاب الجسيم لدى أطفال هذه المجموعة العمريه من أبناء المجموعتين المرضية والضابطة.

## (٢) الأطفال الذين تتراوح أعمارهم بين أكثر من ٦ سنوات إلى ١٢ سنة

ظهرت أعراض الاكتئاب بصورة واضحة بين أطفال هذه المجموعة العمريه وكانت هذه الأعراض في صورة الشعور الدائم بالحزن واليأس، الشعور بالإجهاد بسهولة، نقص الانتباه وعدم القدرة على التركيز، البطء العام في المهام المختلفة لمثل القراءة، الكتابة، المذاكرة ٠٠٠، فقد الشهية للطعام.

وقد ظهرت هذه الأعراض متساوية بين كل من الذكور والإناث من هذه المجموعة العمريه.

من ناحية أخرى فقد أظهر كل الذكور والإناث من هذه المرحلة العمريه اضطراب عسر المزاج بصورة واضحة وكان مستوى الدلالة عند الذكور أعلى من الإناث فى هذا الاضطراب.

### (٣) الأطفال الذين تتراوح أعمارهم بين ١٢ الى ١٥ سنة

أطفال هذه المجموعة العمريه أظهروا العديد من الأعراض الخاصة بالاكتئاب. وقد كانت هذه الأعراض فى صورة: الشعور الدائم بالحزن واليأس، الشعور بالإجهاد بسهولة، ونقص الحيوية والطاقة، التبدل الانفعالي، الشعور بعدم القيمة، فقد الشهية للطعام، البطء العام فى المهام المختلفة.

وقد ظهرت هذه الأعراض بين كل من الذكور والإناث من أبناء مرضى الوسواس القهري. بينما ظهر اضطراب عسر المزاج بين أطفال هذه المجموعة العمريه من الذكور والإناث ولكنه كان أكثر دلالة بين الأطفال الإناث.

هذا وجدير بالذكر أن نوبة الاكتئاب الجسيم لم تظهر على الإطلاق بين أطفال المجموعتين المرضية والضابطة من المجموعات العمريه المختلفة.

### ثالثاً: أعراض الوسواس القهري واضطرابه

ظهرت العديد من سمات الوسواس والأفعال القهرية بين أطفال مرضى اضطراب الوسواس القهري كما يلى:

### (١) الأطفال الذين تتراوح أعمارهم بين ٣ إلى ٦ سنوات

أظهر أطفال هذه المجموعة العمرية العديد من الوسواس والأفعال القهرية في صورة: طقوس مرتبطة بالطعام، وسواس مرتبطة بالنظافة. وكانت في صورة غسل اليدين بصورة مبالغ فيها، طقوس العد في صورة عد الأشياء أكثر من مرة.

وقد أظهر الأطفال من الإناث تلك الطقوس المرتبطة بالعد بصورة دالة إحصائياً. بينما لم يظهر البنون أيّاً من الطقوس والوسواس.

### (٢) الأطفال الذين تتراوح أعمارهم بين أكثر من ٦ سنوات إلى ١٢ سنة

أظهر أطفال هذه المجموعة العديد من الوسواس والقهورات في صورة الطقوس المرتبطة بالطعام، غسل اليدين بصورة مبالغ فيها، والطقوس المرتبطة بتنظيف وإعادة تنظيم الأشياء، بالإضافة إلى الرغبة الدائمة في الكمال والمظهر الخارجي المبالغ فيه والذي كان واضحاً بين الذكور في هذه المجموعة العمرية.

### (٣) الأطفال الذين تتراوح أعمارهم بين أكثر من ١٢ إلى ١٥ سنة

ظهرت طقوس النظافة والطقوس المرتبطة بالطعام بين أطفال هذه المجموعة العمرية. وقد أظهرت الدراسة العديد من الأعراض المرتبطة بالوسواس والقهورات حيث ظهرت طقوس العد، الطقوس المرتبطة بالمدرسة، الطقوس المرتبطة بتنظيم

وإعادة تنظيم الأشياء بالإضافة إلى المظهر الخارجي المبالغ فيه بين الإناث من أبناء مرضى اضطراب الوسواس القهري.

هذا ولم يظهر اضطراب الوسواس القهري بين أطفال المجموعات العمريه الأولى والثانية بينما ظهر فقط بين إناث المجموعة العمريه الثالثة مقارنة بالذكور من أطفال المجموعة السوية.

وقد تمت مناقشة هذه النتائج في ضوء الدراسات السابقة، وقدمت العديد من التفسيرات لهذه النتائج في ضوء البيئة الاجتماعية والثقافات المختلفة وفي ضوء البحوث السابقة.

ومن أهم استنتاجات الدراسة أن هناك علاقة وطيدة بين مرض الأب أو الأم باضطراب الوسواس القهري وبين ظهور العديد من أعراض القلق والاكتئاب والوسواس والأفعال القهرية بين أبناء هؤلاء المرضى مقارنة بالأباء والأبناء الأسوياء، وقد كانت معظم هذه الأعراض واضحة بين الأبناء من الذكور والإناث ولكن الذكور كانوا في معظم الأحيان يعانون أكثر من الإناث وظهر بينهم العديد من الأعراض والاضطرابات المختلفة موضوع الدراسة بدرجات متفاوتة خاصة الأعراض والاضطرابات الخاصة بالقلق والاكتئاب، أما الإناث فقد ظهر تأثيرهن السلبي بمرض الأب أو الأم بالوسواس القهري في ظهور العديد من الأعراض خاصة أعراض الاكتئاب والوسواس القهري واضطراباتهما المختلفة.

وقد قدمت الباحثة العديد من التوصيات التي وُجّهت في البداية للأسر التي يعاني أحد والديها من اضطراب الوسواس القهري. كذلك للمعلمين والأخصائيين النفسيين في المدارس والقائمين على الرعاية الصحية من الأطباء وغيرهم، وأخيرا إلى عامة الشعب باعتبار كل هؤلاء مسئولون عن تنشئة الطفل وعن إعطاء الرعاية الأولية والأساسية لكافة أبناء المجتمع.

وتهدف هذه التوصيات إلى رفع الوعي والثقافة العامة لكافة هؤلاء لمعرفة هذا الاضطراب، أسبابه، أعراضه والطرق المختلفة لعلاجيه. ويتم ذلك من خلال العديد من الوسائل مثل البرامج الموجهة من خلال الإذاعة والتلفزيون، قراءة الكتب المرتبطة بهذا الاضطراب، حضور محاضرات تنظمها الهيئات والمؤسسات الصحية المختلفة، كذلك مراجعة طبيب الأسرة، الأخصائي النفسي أو الطبيب النفسي عند ظهور هذه المشكلة. كل هذا يؤدي إلى رفع مستوى الوعي بمثل هذه المشكلة بحيث يمكن حلها وتجنب مضاعفاتها خاصة بالنسبة للأطفال. كما يهدف إلى الوقاية الأولية بالنسبة للأطفال من أثار الأعراض والتأثيرات السلبية لوجود أحد أفراد الأسرة يعاني من هذا الاضطراب بالإضافة إلى الوقاية الثانوية للمريض نفسه لمنع مضاعفات المرض وتقديم أحدث أساليب العلاج.

ومن التوصيات الهامة أيضا، المساندة المادية والمعنوية لهذه الأسر من خلال برامج محددة وبمساعدة مجموعات مساندة الأسر المضغوطة والتي قد تكون خاضعة إما للهيئات والمستشفيات الحكومية أو الجمعيات الأهلية.

واقترحت الدراسة أيضاً عدة توصيات أخرى خاصة بالبحوث المستقبلية، منها ضرورة الاهتمام بدراسة أثر وجود أحد أفراد الأسرة يعاني من الاضطرابات النفسية المختلفة على باقي أفراد الأسرة خاصة مرض الأب والأم وتأثير ذلك على الأبناء من كافة الاتجاهات مثل النواحي النفسية والاجتماعية والمادية واتجاهات باقي أفراد الأسرة نحو المرض وغيرها.

وكذلك فإن مشاركة باقي أفراد الأسرة في الوسواس والطقوس الخاصة بمرضى الوسواس القهري وتكيفهم مع الأعراض المختلفة لمرض أحد أفراد الأسرة (خاصة الأب أو الأم) باضطراب الوسواس القهري يعد من الموضوعات الهامة الجديرة بالدراسة. حيث أن موقف باقي أفراد الأسرة من أعراض المريض والتأثير السلبي لهذه الاتجاهات على مصير المرض وتطور حالة المريض تعتبر من الأمور وثيقة الصلة المرتبط بعضها ببعض والتي لها تأثير إكلينيكي مباشر على حالة المريض وتطورها.



## المستخلص

تلعب العمليات الأسرية والتفاعل بين أفراد الأسرة دوراً هاماً في مجال الطب النفسي بإعتبارها من العوامل المسببة والمحدثه لمعظم الاضطرابات النفسية ، وقد حظيت هذه العوامل الأسرية المسببة للأمراض النفسية بإهتمام وعنايه الباحثين في هذا الميدان ، وفي مقابل ذلك فإن عدداً محدوداً من الأبحاث تناولت بالدراسة أثر وجود مريض نفسي من بين أعضاء الأسرة علي باقي أعضائها خاصة الأطفال منهم ، أو إلي أي حد يتعامل أفراد الأسرة الواحده مع المشكلات النفسية والإجتماعية المختلفة المترتبة علي ذلك .

إهتمت الدراسة الحاليه بالتعرف علي بعض الأعراض والإضطرابات النفسية التي يمكن ان يعاني منها أبناء مرضي إضطراب الوسواس القهري مع التركيز علي أعراض القلق والإكتئاب والوسواس القهري وإضطراباتاها المختلفة .

وقد تناولت الدراسة هذه الأعراض تبعاً لمتغيرات العمر الزمني للطفل ومحكات الدليل التشخيصي والأحصائي الأمريكي الرابع للأمراض النفسية (DSMIV) .

ولتحقيق هذا الهدف تم اختيار مجموعتين من الآباء هما : -

**الجموعه المرضية :** وتتضمن مرضي إضطراب الوسواس القهري ( ن = ١٩ ) بالإضافة الي أبناءهم ( ن = ٤٢ ) .

**الجموعه الضابطة:** وتتضمن الآباء الأسوياء ( ن = ١٣ ) بالإضافة الي أبناءهم ( ن = ٣٥ ) .

تم تقييم هؤلاء الأبناء باستخدام العديد من الأدوات وهي :-

أداء جميع وتقييم الطفل والمراهق ، قوائم الأعراض لكل من القلق والإكتئاب والوسواس القهري والتي قسمت تبعاً للعمر الزمني للطفل ، بالإضافة الي المؤشرات التشخيصية الخاصة بمحكات الدليل التشخيصي والإحصائي الأمريكي الرابع للأمراض النفسية (DSMIV) لكل من إضطراب القلق العام ، قلق الانفصال ، الخوف المرضي ، الخوف الإجتماعي ، رهاب الساحة ، عسر المزاج ، نوبة الإكتئاب الجسيم ، إضطراب الوسواس القهري .



أظهر أبناء مرضي إضطراب الوسواس القهري العديد من الأعراض والإضطرابات النفسية موضوع البحث مقارنة بأبناء الأسوياء ، حيث ظهرت لديهم أعراض كل من القلق والإكتئاب الوسواس والأفعال القهرية بالإضافة الي ظهور بعض الإضطرابات مثل إضطراب القلق العام ، قلق الانفصال ، الخوف المرضي المحدد ، المخاوف المرتبطة بالمدرسة ، إضطراب عسر المزاج ، وإضطراب الوسواس القهري ، وكان الأبناء من الذكور يظهرون هذه الأعراض والإضطرابات في مرحلة عمرية مبكرة مقارنة بالإناث .

قدمت الدراسة العديد من التفسيرات لتلك النتائج في ضوء الدراسات السابقة والبيئة الإجتماعية والثقافات المختلفة ، كما قدمت العديد من التوصيات التي وجهت لأسر هؤلاء المرضى ، للأخصائيين النفسيين والمعلمين في المدارس ، كما أقتрحت العديد من التوصيات الخاصة بالبحوث المستقبلية في هذا المجال والتي تعتبر تكمله للدراسة الحالية .

### الكلمات المفتاحية:

الآباء - الأمهات - الأطفال - القلق - الإكتئاب - الوسواس القهري .



جامعة عين شمس

معهد الدراسات العليا للطفولة

قسم الدراسات الطبية

## نتائج

أشكر السادة الأساتذة الذين قاموا بالإشراف وهم:

• أ.د. عادل صادق أستاذ ورئيس قسم الأمراض النفسية والعصبية - كلية الطب - جامعة عين شمس

• أ.د. محمد غانم أستاذ الأمراض النفسية والعصبية - كلية الطب - جامعة عين شمس .

• أ.م.د. غادة الدري أستاذ مساعد دراسات الطفولة قسم الدراسات الطبية - معهد الدراسات العليا للطفولة

ثم الأشخاص الذين تعاونوا في البحث وهم:

\* السادة أساتذة الطب النفسي وعلم النفس والصحة النفسية محكمي أدوات البحث .

\* أ . د . بديوي علام - أستاذ مساعد علم النفس كلية التربية - جامعة عين شمس .

\* الآباء والأمهات والأطفال ( عينه البحث ) الذين تعاونوا معي في اجراء الدراسة .

وكذلك الهيئات الآتية:

\* مركز الطب النفسي كلية الطب جامعة عين شمس .



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## صفحة العنوان

أسم الطالب : مها فؤاد عبداللطيف أبو حطب .

الدرجة العلمية : الدكتوراه

القسم التابع له : القسم الطبي

اسم المعهد : معهد الدراسات العليا للطفولة

الجامعة : جامعة عين شمس

سنة التخرج : ١٩٩٠

سنة المنح : ٢٠٠٠





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قسم الدراسات الطبية

رسالة: ( دكتوراه )

اسم الطالب : مها فؤاد عبداللطيف أبو حطب .

عنوان الرسالة : " التقييم النفسي لأطفال مرضي اضطراب الوسواس القهري "

اسم الدرجة: ( دكتوراه )

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تاريخ البحث / ١٩٩٦/٣/٣١

الدراسات العليا

أجيزت الرسالة بتاريخ / ٢٠٠٠/٤/٢

ختم الإجازة /

٢٠٠٠ /

موافقة مجلس الجامعة

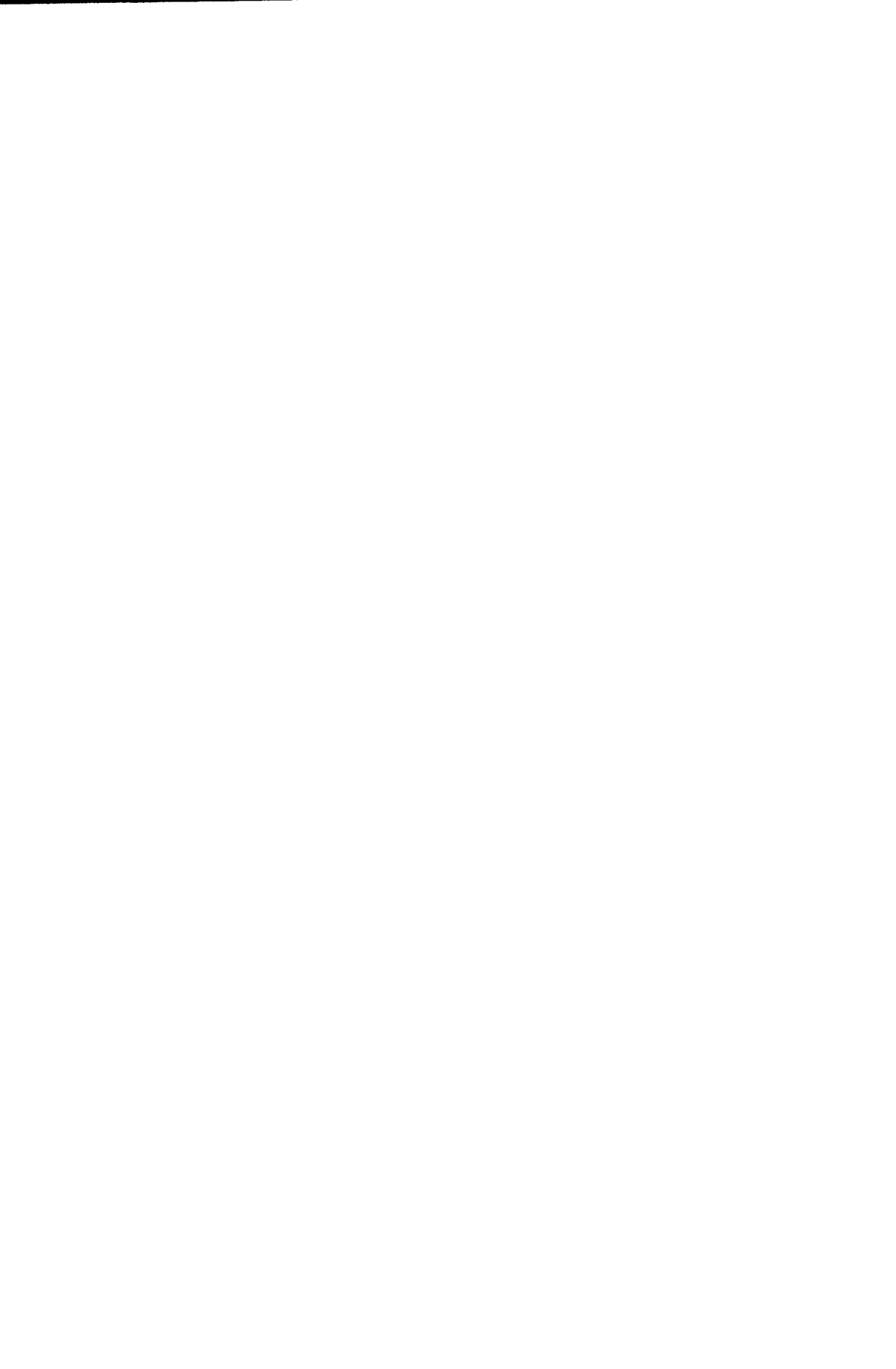
٢٠٠٠ / /

المحرر

موافقة مجلس الكلية

٢٠٠٠ / ٥ / ١٥





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قسم الدراسات الطبية

التقييم النفسي لأطفال مرضى اضطراب الوسواس القهري

رسالة مقدمة للحصول على درجة الدكتوراه  
في دراسات الطفولة  
(قسم الدراسات الطبية)

المقدمة من  
مها فؤاد عبد اللطيف أبو حطب  
بكالوريوس الطب والجراحة - كلية الطب جامعة عين شمس  
ماجستير دراسات الطفولة  
قسم الدراسات الطبية - معهد الدراسات العليا للطفولة جامعة عين شمس

تحت إشراف

الأستاذ الدكتور / عادل صادق

أستاذ ورئيس قسم الأمراض النفسية والعصبية

مدير مركز الطب النفسي

كلية الطب - جامعة عين شمس

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أستاذ الأمراض النفسية والعصبية

كلية الطب - جامعة عين شمس

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أستاذ مساعد دراسات الطفولة - قسم الدراسات الطبية

معهد الدراسات العليا للطفولة

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