Pakistan Journal of Psychological Research, 2009, Vol. 24, Nos. 1-2, 27-42

OCD in a Cultural Context: A Phenomenological Approach

Sadia Saleem and Zahid Mahmood
Government College University, Lahore

This study is an attempt to investigate the phenomenon of Obsessive Compulsive Disorder (OCD) in our culture. Initially, presenting symptoms of OCD were elicited from 20 firmly diagnosed clients through semi structured interviews. The symptoms were validated for their diagnostic relevance by 10 experienced clinicians. A final list of 27 symptoms were individually given to 113 OCD participants. The results showed that the most frequently reported obsessions were repetitive negative thoughts (97%), fear of developing mental illness (92%), indecisiveness (87%), and fear of germs (82%) followed by sexual thoughts (81%). The most frequently occurring compulsions were hand washing (90%), compulsive slowness (86%), counting (73%), checking (64%), and symmetry (53%). It was found that while the types of compulsions were similar to those reported in other studies, the form and the content of obsessions were seem to be influenced by social and religious backgrounds. The phenomenon of OCD is discussed in cultural context, its comorbidity and presenting symptoms.

Keywords: Phenomenology, clinical presentation, comorbidity, anxiety, depression

Obsessive Compulsive Disorder (OCD) is an Anxiety Disorder which is usually characterized by two types of symptoms, namely, obsessions and compulsions (American Psychiatric Association, 2000), that are irrational but irresistible, distressing but uncontrollable and time consuming but pointless. Obsessions are recurrent thoughts and persistent impulses regarding fear of harming others, fear of contamination, concern about body wastes, forbidden or perverse thoughts, and preoccupations. Compulsions are repetitive mental acts

---

Sadia Saleem and Zahid Mahmood, Department of Clinical Psychology, Government College University, Lahore.

Correspondence concerning this article should be addressed to Sadia Saleem, Department of Clinical Psychology, Government College University, Katchery Road, Lahore. E-mail: sadia_saleem07@yahoo.com

or behaviors including repetitive checking doors or locks, washing, collecting (hoarding) old newspapers or mail, maintaining precision or symmetry, pursuing cleanliness and orderliness, avoiding particular objects and performing repetitive, magical, protective practices such as counting or uttering phrases or words. The symptoms of OCD cause distress and interfere with the normal functioning of the individual (APA, 2000).

Several epidemiological studies (Hanna, 1995) indicate that OCD is more common in children and adolescents than previously thought. It affects between 2 to 3% of the general population and 3 to 4% in the clinical population of adolescents (Montgomery & Zohar, 2000). Prevalence of OCD is slightly higher among females than males (Emmelkamp, de Hann, & Hoogduim, 2001). The age of onset can be as early as 7 years with average age of onset in males is 13 to 15 and in females 20 to 24 (Karano & Golding, 1991; Rasmussen & Eisen, 1990).

Assarian, Biqam, and Asqarnejad (2006) found that the frequency of OCD cases is almost identical across cultures, but it is vital to determine whether the difference of culture actually affects the frequency or in fact, the way in which the symptoms are expressed. Many obsessive symptoms appear to be exaggerated and enhanced elements of everyday actions, and therefore, it would be reasonable to believe that cultural, social, and religious background contributes strongly to the nature of the symptoms. For example, obsessive washing is more frequent in societies where cleanliness is given priority (Thomsen, 1999). Okasha, Saad, and Khalil (1994) described religious obsessive thoughts being common amongst religious societies. Trans-cultural comparisons between Europe and the USA have found few differences. It has been observed that while the core features of OCD may remain the same across cultures, however the content and presentation of the obsessions may not (Akhter, Wig, & Verma, 1979; Fontenelle, Mendlowicz, Marques, & Vesiani, 2004).

In order to investigate the phenomenological profile of OCD, Shooka, Al-Haddad and Raees (1998) carried out a study in Bahrain. They identified six types of obsessions including doubts, thoughts, fears (phobia), images, impulses and miscellaneous. Yielding and controlling were the two types of compulsions found. The content of the obsessions were classified into eight broad categories as related to, dirt and contamination, germs, aggression, sex, religion, blasphemy, illness, and indecisiveness. Out of the 50 participants, 38% displayed thoughts related to dirt and contamination, 40% showed blasphemous and religious obsessional thoughts and doubts whereas 56% showed

compulsions out of which 36% were with multiple compulsions, while 20% were with single compulsions. This study also emphasized the role played by socio-cultural and religious factors in shaping the character of obsessional thought content.

Juang and Liu (2001) designed a study to assess the phenomenology of OCD in Taiwan. They found that the most common obsession were contamination, followed by pathological doubt, and need for symmetry. The most common compulsion was checking, followed by washing, and orderliness. Participants with somatic obsessions were more likely to have major depressive disorder. They concluded that out of the two hundred OCD participants 41.50% had depressive disorders, 8.0% met the criteria for major depressive disorder and 33.50% had dysthymic disorder

Another cross-cultural study conducted by Oguzhanoglu, Özdel, Atesci, Amuk, and Tarkan, (2006) in a Turkish sample found that the most commonly occurring obsessions were contamination (56.70%), aggression (48.90%), and somatic (24.10%), followed by religious (19.90%), symmetry (18.40%), and sexual imagery (15.60%). While symmetry, sexual obsessions and checking compulsions and rituals, tended to be more common in male participants, dirt and contamination obsessions and washing compulsions were slightly more common in females. Majority of the participants with religious obsessions (83.0%), and half of them with sexual obsessions had compulsions that included religious practices.

Robert (2003) examined the symptomatology of 19 OCD patients in Bali, Indonesia. Participants were assessed using a semi-structured clinical interview. The most common obsessional themes emphasized patients' obsessional need to know about their social network. Somatic obsessions and religious themes around witchcraft and spirits were also prominent. In describing the phenomenology of OCD in Eastern Saudi Arabia, Mahgoub and Abdel-Hafeiz (1991) found that among 32 Muslim OCD clients, 78% showed compulsive acts and 66% had obsessions

In an interesting study to assess the effect of religion on the symptomatology of OCD in Pakistan, Nazar and Shafique (1999) identified five distinct types of obsessions including doubts, thinking, fear, impulses, and images. Compulsions included repetition of prayers and associated washing, cleaning, and checking rituals. The content of obsessions and compulsions were religious, contamination, inanimate impersonal, aggression, sex, and death.

It seems that religious, cultural and historical background can influence the specific content of obsessions, while the core themes of

OCD compulsions may remain the same. The experience, expression and presentation of psychological problems may vary from time to time, place to place and culture to culture. Cultural specific presentation of symptoms is important in order to study the phenomenology of the disorder and essential for further understanding of the diagnosis and the treatment of the disorder. It is also important to consider that cross-cultural studies are difficult to compare because of the variation in the definition of the disorders, methodologies used, assessment methods adopted and the cultural background where the studies were carried out. Therefore, the present study is an attempt to investigate the phenomenology of religious and cultural specific presentation and manifestation of OCD symptoms.

OCD has always been found from its earlier days, coexisting and overlapping with disorders like anxiety and depression. Therefore, it is very essential to address this important issue for differential diagnosis. It is likely for patients with OCD to suffer from other disorders (Tynes, White, & Steketee, 1990), ranging from extreme worry in generalized anxiety disorder (GAD) and stereotype in autism (Morton, 2004). There are other disorders which share some similarities such as hypochondiasis (Tynes, White, & Steketee, 1990), body dysmorphic disorder (Brady, Autin, & Lydiard, 1990), and trichotillomania, eating disorder (Hudson, Pope, Jonas, & Frankenburg, 1987; Ksavikis, Tsakiris, Marks, Basoglu, & Noshirvani, 1986), and phobia (Rasmussen & Tsuang, 1986).

Recent researches have concluded that major depression is the most comorbid feature of OCD (Angst et al., 2003; Bhattacharyya, Janardhan, Reddy, & Khanna, 2005; Juang & Liu, 2001; Millet et al., 2004; Nazar & Shafique, 1999; Oguzhanoglu et al., 2006; Rasit, Handan, Ahmet, Alper, & Olcay, 2006; Thomsen, 1994).

Thus, it is important to understand how the high comorbidity of depression and other anxiety disorders with OCD can sometimes lead to misdiagnosis. The most common misdiagnoses are depression and schizophrenia (Yaryura & Neziroglu, 1983). The confusion of depression and OCD has been an issue throughout the history. Maudsley in 1895 (as cited in Thomsen, 1999) made no distinction between the two, preferring instead to include obsessional features as part of depressive illness.

Several researches have also found a significant association between the development, frequency and intensity of OCD symptoms and some demographic variables. For example, it was found that symmetry, sexual obsessions, and checking compulsions and rituals, tended to be more common in males, whereas dirt and contamination

obsessions and washing compulsions were slightly more common in females. Female OCD patients have more depressive symptoms than males (Ghassemzadeh et al., 2002; Hanna, 1995; Khanna, & Channabasavanna, 1987; Oguzhanoglu et al., 2006; Rudin, 1953; Yaryura & Neziroglu; 1983). It has also been found that there are more single clients than married who suffer from OCD, education was also significantly related to the high incidence of OCD among more educated individuals (Cillicilli et al., 2004).

In order to understand the phenomenon of OCD in Pakistani culture, it would be necessary to explore the presentation and manifestation of symptoms, comorbidity with anxiety and depression and their relationship with some of the demographic variables implicated in the western studies following research questions were investigated:

1. How do the OCD patients present and manifest their symptoms and contents?
2. How does the intensity of OCD symptoms relate to the levels of Anxiety and Depression?
3. How do these symptoms relate to demographic variables?

Method

This research was carried out in a series of three phases.

Phase I: Generating OCD symptoms from diagnosed OCD clients

Sample

The sample comprised of 20 firmly diagnosed OCD participants (10 males and 10 females) with the age range of 16-50 years ($M = 25.60$, $SD = 6.09$).

Procedure

In order to generate items from diagnosed OCD participants, phase I was carried out. Consultant psychiatrists of outpatient departments of three hospitals of Lahore were requested to refer those

participants who were firmly diagnosed as having Obsessive-Compulsive Disorder (300.3) according to DSM-IV TR (2000). All the participants were informed about the purpose of the research and they were assured that all information will be kept confidential and will be used only for research.

Then all the participants were interviewed on the Semi Structured Interview Schedule (SSIS). SSIS was developed in the light of literature and covered most domains of the obsessions and compulsions. Participants were asked to present their symptoms and complaints. They were asked open ended questions. Each client was interviewed individually and their responses were recorded in verbatim.

Initially a list of 42 items was collated and with some linguistic modifications, a final list of 36 items were established. Final list of 36 items were given the name of Obsessive-Compulsive Symptoms Checklist (OCSC). OCSC included some obsessions (fear of contamination, germ, dirt, fear of hurting someone, fear of death and illness) and compulsions (hand washing, checking and exactness). In order to validate the symptoms phase II was carried out.

Phase II: Validating the Obsessive-Compulsive Symptom Checklist

In phase II, the final list of 36 symptoms (OCSC) was validated through experts' ratings.

Sample

Ten clinical psychologists were selected as judges to rate the items of OCSC. These psychologist had a minimum of three years of clinical experience.

Instrument

Obsessive Compulsive Symptom Checklist (OCSC). The OCSC consisted of 36 items as experienced and expressed by clients in the study 1 was used for experts' ratings. A 7 point rating scale (0-6) was used for rating in which 0 indicate "Not at all" and 6 for "A lot".

Procedure

To further validate the list of OCD symptoms extracted from phase I, ten experienced clinical psychologists were asked to rate OCSC for the diagnostic relevance to OCD. The experienced clinical psychologists were informed about the purpose of the research. They were all asked to rate each symptom to the extent in which it was considered relevant for the diagnosis of OCD.

All those items that were rated on diagnostic relevance less than 50% by the experts were excluded. A final list of 27 items was established.

Phase III: Main Study

The purpose of the phase III was to assess the frequency and severity of symptoms found in clients with OCD and its relationship with some of the demographic variables

Sample

The sample of the study consisted of 113 firmly diagnosed OCD clients with the age range of 16-50 years. These were 67 male and 46 female clients.

Instruments

The following tools of measurement were used in the phase III.

Demographic Performa. A Demographical Performa was prepared in the light of literature in which the significant variables that shown to have relation with OCD, comprised of information about age, gender, parental relationship, and age of onset and any family history of the present illness.

Obsessive-Compulsive Symptom Checklist (OCSC). In order to assess the frequency and intensity of OCD symptoms, OCSC was used which was derived from the clients in phase 1 and then validated by the experts in phase II. A 4-point rating scale was used to rate the frequency and severity of symptoms, options included "Never", "Sometimes", "Often" and "Always"

The Symptom Checklist R (SCL-R. To investigate the level of anxiety and depression among OCD patients, three subscales of Symptom Checklist R (Rehman, Dawood, Jagir, Rehman, & Mansoor, 2000) was used which were developed in the Center of Clinical Psychology, Lahore. SCL-R (2000) comprises of six sub-scales which includes Depression, Anxiety, Obsessive-Compulsive Disorder, Somatoform, Level of Frustration Tolerance and Schizophrenia. In this phase, three subscales of SCL-R (2000) were used which included Anxiety, Obsessive-Compulsive Disorder (OCD) and Depression. OCD scale was used to establish concurrent validity of OCSC.

Procedure

In phase III, the sample was collected from the psychiatric out-patient departments of four different hospitals of Lahore. Consultant psychiatrists of these four hospitals were requested to refer all those clients to the researchers, who were suffering from Obsessive-Compulsive Disorder, according to DSM-IV TR (2000). All the clients who agreed to participate and who met the inclusion criteria were informed about the purpose of the research.

The clients were assured that their information and responses would be kept confidential and their identity will not be disclosed, and their responses and information would only be used for the research purposes. All the clients were given OCSC, three subscales of SCL-R along with the demographic performa.

Results

Table 1 provides the demographic information collected from male and female OCD participants (n = 113) in the main study. Sample description indicates that gender difference was slightly but not significantly in favor of males.

There was a predominance of singles among males but not in females. Both genders perceived their relationship with their parents as more satisfactory. Almost half of the sample reported familial history of OCD. The mean age of onset was reported as the same for both genders.

Table 1

Sample Description of OCD clients (N=113)

Variables	OCD		
	Male (n=67)	Female (n=46)	Total
	%	%	%
Gender	59.29	40.71	100
Education			
Below Primary	5.97	26.09	14.16
Secondary	53.73	47.82	51.33
College or more	40.30	26.09	34.51
Marital Status			
Single	73.13	47.83	62.83
Married	26.87	52.17	37.17
Perception of Parental relations			
Unsatisfactory	25.37	21.74	23.89
Satisfactory	74.64	78.26	76.11
Perception of relations with others			
Unsatisfactory	32.84	28.26	30.97
Satisfactory	67.16	71.74	6.03
Familial history			
Yes	40.30	43.48	41.59
No	59.70	56.52	58.41

Table 2

Means, Standard deviations and t-value on total scores of OCSC of male and female OCD clients

Variable	*Gender*	*N*	*M*	*SD*	*t*	*p*
OCSC	Male	67	60.40	18.11		
					1.757	0.082
Scores	Female	46	54.20	18.95		

df = 111 $p>0.05$

Table 2 shows that there is no significant difference between males and females on their scores on OCSC.

Table 3

Most frequently reported obsessions and compulsions by OCD clients (N = 113)

Symptoms	*f*	*%*
Obsessions		
Repetitive negative thoughts	110	97.35
Fear of mental illness	104	92.04
Fear of unknown	100	88.49
Indecisiveness	99	87.61
Guilt	97	85.84
Uncertainty about future	93	82.30
Memory impairment	93	82.30
Fear of germs	92	82.00
Sexual thoughts	92	81.42
Fear of loosing control	91	80.53
Fear of dirt	88	77.88
Feelings of regret	83	73.45
Fear of physical illness	81	71.68
Napak	76	67.26
Negative thoughts related to God and religion	74	65.49

Continued...

Symptoms	*f*	*%*
Obsessions		
Fear of harming others	72	63.72
Religious thoughts	71	62.83
Germs	71	62.83
Repetitive thoughts	66	58.41
Avoidance of certain things	65	57.52
Compulsions		
Hand washing	102	90.27
Compulsive slowness	98	86.73
Repetitive behavior	83	73.45
Repetition for specific numbers	73	64.60
Checking	61	53.98
Symmetry	60	53.09
Repetitive phrases	48	42.48

Table 3 provides a description of most frequently reported obsessions and compulsions from 113 OCD participants in descending order.

Discussion

The expression of human behavior is inextricably linked to the social and cultural realities in a way that gives individual differences as well as inter and intra cultural variations. Some pathological behaviors (e.g., biochemical or organic in origin) are manifested in a more or less universal way possibly because of their uniform pathology. However, some other form of psychological disorders is more likely to be a product of individual's experiences, familial, social, and cultural environment. In order to study the phenomenon of a psychological disorder in a particular culture, one has to take into account the experience, expression and the presentations of its clinical symptoms in the social, cultural and linguistic context in which these exist. Failure to do so could lead to serious errors of judgments in

terms of diagnosis, etiological explanation of the condition and the efficacy of any therapeutic intervention may be undermined.

In OCD, both obsessive compulsive symptoms may show considerable variation both in the form as well as the content from one culture to another. For example, there is ample evidence to support the view that culture does influence the content of obsessions and to some extent compulsions studies (e.g. Akhter et al., 1979; Fontenelle et al., 2004; Ghassemzadeh et al., 2002; Juang & Liu, 2001; Nazar & Shafique, 1999; Oguzhanoglu et al., 2006; Okasha et al., 1994). It has been difficult to compare such variations symptom by symptom, because researchers in presenting their results have formed "clusters" of symptoms based on some arbitrary method. Moreover, symptoms not defined clearly, overlapping symptoms or vaguely described behaviors could lead to misleading classification making a comparison unreliable. For example, in one study "Fear: has been mixed with "Phobia" "fear of harming self or others" was described as "aggressive obsessions" (Juang & Liu, 2001; Shooka et al., 1998; Oguzhanoglu et al., 2006).

The examples of obsessions that generally top the list include contamination and in religious societies religious obsessions (De-Bilbao & Giannakopoulos, 2005; Oguzhanoglu et al., 2006; Okasha et al., 1994). In some secular societies need for symmetry and perfectionism appear to be more common (Juang & Liu, 2001; Robert, 2003). Such diverse findings of unclear methodological approaches may in fact mask cultural idiosyncrasies. It may be that a symptom by symptom comparison provides a more in-depth study of inter-cultural variations of the experience, presentation and manifestations of symptoms of OCD.

The phenomenological picture of OCD symptomatology emerging in the current study is detailed here. The mean age of OCD participants is 28.97 (SD = 8.78), and out of them 67(59.29%) were male. There was a predominance of single participants i.e., 71 (62.83%), and the onset of OCD symptoms is earlier in males than females. The most frequently reported obsessions were repetitive negative thoughts (97%), fear of developing mental illness (92%), indecisiveness (87%), and fear of germs (82%), followed by sexual thoughts (81%). The most frequently reported compulsions were hand washing (90%), compulsive slowness (86%), counting (73%), checking (64%), and symmetry (53%). It is also interesting that in our sample of 113 OCD participants no gender difference was found with regard to intensity of symptoms. Anxiety and Depression were found to be associated features of OCD. 90.91% participants scored 2 *SD*

above the mean score (M = 22, SD = 16) on Depression scale and 78.38% clients scored 2 SD above the mean score (M = 22, SD = 16) on Anxiety scale. A significant positive correlation of 0.69 (p<0.01) was found between OCSC and OCD scale. Thus, it added to the concurrent validity of OCSC.

It was also observed that 67% clients added the concept of "Napak", other than the broader category of contamination which is evident from literature. The concept of "Napak" in Islamic culture is a mixture of an unpleasant feeling of contamination and uncleanliness with strong religious connotations of dirtiness or unholiness. The state of being Napak precludes one from undertaking any religious ritual like saying prayers or reading The Holy Quran. It requires one to take ablution, washing self in a particular way of preparation for religious ritual. Therefore, a state of being Napak causes a personal feeling of uncleanliness and profanity in obsessional person, preoccupied with the fear of contamination.

Conclusion

Most of the clinical characteristics were found to be consistent with previous literature but the variability exists in the experience, expression and manifestation of OCD symptoms. The variability in symptom presentation suggests that a social, cultural and religious background does affect the symptom manifestation.

The present study has contributed significantly by adding more understanding of the phenomenology of OCD in our culture. This study has provided a particular thought pattern and content of obsessions which are specific to a typical society where religion plays a significant role in the shaping of behaviors. It has also provided a scientific methodology for establishing a symptom checklist.

Suggestions

1. Most importantly, these research findings could be used as a base for developing OCD assessment and screening checklists.
2. The findings of the current research indicating a strong impact of religion in shaping the content of obsessions, so it would be useful to investigate and further discover the relationship between religiosity and OCD.

3. As the present work on OCD is the first of its kind with reference to Pakistan, many other clinical issues can be addressed by following the methodology in this study.
4. This study exemplifies the use of phenomenological approach which can further be used to investigate such aspects.

References

Akhtar, S., Wig, N. N., & Verma, V. K. (1979). Socio-cultural and clinical determinants of symptomatology in obsessional neurosis. *International Journal of Social Psychiatry*, *24*(3), 157-162.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders TR*. Washington DC: American Psychiatric Association,

Angst, J., Gamma, A., Endrass, J., Goodwin, R., Ajdacic,V., Eich, D. et al., (2003). Obsessive-compulsive severity spectrum in the community: prevalence, comorbidity, and course. *European Archives of Psychiatry and Clinical Neuroscience*, *254*(3), 156-164.

Assarian, F., Biqam, H., & Asqarnejad, A. (2006). An epidemiological study of obsessive-compulsive disorder among high school students and its relationship with religious attitudes. *Archives of Iranian Medicine*, 9(2), 104-107.

Bhattacharyya, S. S., Janardhan, Y. C., Reddy, Y., & Khanna. K. S. (2005). Depressive and Anxiety Disorder Comorbidity in Obsessive Compulsive Disorder. *Psychopathology, 38*(6), 315-319.

Brady, K. T., Autin, L., & Lydiard, R. B. (1990). Body dysmorphic disorder: The relationship to obsessive-compulsive disorder. *Journal of Nervous and Mental Disease, 178*, 538-539.

Cillicilli, A. S., Telcioglu, M., Askin, R., Kaya, N., Bodur, S., & Kucur, R. (2004). Twelve-month prevalence of obsessive-compulsive disorder in Konya, Turkey. *Comprehensive Psychiatry, 45(*5), 367-374.

De-Bilbao, F., & Giannakopoulos, P. (2005). Effect of religious culture on obsessive compulsive disorder symptomatology: A Trans-cultural study in monotheistic religions. *Revue medicale, 1*(43), 2818-2821.

Emmelkamp, P. M., de Hann, E., & Hoogduim. C. L. (2001). Marital adjustment and obsessive-compulsive disorder. *British Journal of Psychiatry, 156*, 55-60.

Fontenelle, L. F., Mendlowicz, M. V., Marques, C., & Versiani, M. (2004). Trans-cultural aspects of obsessive-compulsive disorde: A description of

a Brazilian sample and a systematic review of international clinical studies. *Journal of Psychiatric Research, 38*(4), 403-411.

Ghassemzadeh, H., Mojtabai, R., Khamseh, A., Ebrahimkhani, N., Issazadegan, A. A., & Saif-Nobakht, Z. (2002). Symptoms of obsessive-compulsive disorder in a sample of Iranian patients. *International Journal of Social Psychiatry, 48*(1), 20-28.

Hanna, G. L. (1995). Demographic and clinical features of obsessive-compulsive disorder in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*(1), 19-27.

Hudson, J. L., Pope, H. G., Jonas, J. M., & Frankenburg, F. R. (1987). A controlled study of anorexia nervosa and obsessive nervosa. *British Journal of Psychiatry, 27,* 57-60.

Juang, Y. Y., & Liu, Y. C. (2001). Phenomenology of obsessive-compulsive disorder in Taiwan. *Psychiatry and Clinical Neurosciences, 55*(6), 623-627.

Karano, M. G., & Golding, J. M. (1988). The epidemiology of OCD in five U.S. communities. *Archives of General Psychiatry, 45,* 1094-1099.

Khanna, S., & Channabasavanna, S. M. (1987). Birth order in obsessive-compulsive disorder. *Psychiatry Research, 21*(4), 349-354.

Ksavikis, A. E., Tsakiris, C., Marks, B. T., Basoglu, Z., & Noshirvani, R. (1986). Obsessive-compulsive disorder and its relation to eating disorder. *Journal of Anxiety Disorders, 2,* 291-298.

Mahgoub, O. M., & Abdel-Hafeiz, H, B. (1991). Pattern of obsessive-compulsive disorder in eastern Saudi Arabia. *British Journal of Psychiatry, 158*(6), 840-842.

Millet, B., Kochman, F., Gallarda, T., Krebs, M. O., Demonfaucon, F., Barrot, I. et al., (2004). Phenomenological and comorbid features associated in obsessive compulsive disorder: Influence of age of onset. *Journal of Affective Disorders, 79*(13), 241-246.

Montgomery, S., & Zohar, J. (2000). *Obsessive-compulsive disorder.* London: Martun Dunitz Ltd.

Morton, J. (2004). *Understanding developmental disorders: A casual modeling approach.* New York: Blackwell Publishing.

Nazar, Z., & Shafique, M. (1999). Symptomatology of obsessive-compulsive disorder. *Journal of the College of Physicians and Surgeons Pakistan, 9*(3), 136- 138.

Oguzhanoglu, F. K., Özdel, K. N., Atesci, O., Amuk, C. F., & Tarkan, A. (2006). OCD symptoms in a sample of Turkish patients: A phenomenological picture. *Depression & Anxiety, 23*(3), 145-152.

Okasha, A., Saad, A., & Khalil, A. H. (1994) Phenomenology of obsessive-compulsive disorder: A trans-cultural study. *Psychopathology, 28,* 161-167.

Rahman, N. K., Jagir, S., Dawood, S., Mansoor, W., & Rehman, N. (2000). *Standardization and validation of symptom checklist R on psychiatric and non-psychiatric population.* Paper presented at the 6th National conference of Pakistan Association of Clinical psychologists (PACP) on Developing Pakistan; Challenging for Professionals, Lahore, Pakistan.

Rasmussen, S. A., & Tsung, M. T. (1986). Clinical characteristics and family history in obsessive-compulsive disorder. *American Journal of Psychiatry,* 143, 317-322.

Rasmussen, S. A., & Eisen, J. L. (1990). Epidemiology of obsessive-compulsive disorder. *Journal of Clinical Psychiatry, 51,* 10-14.

Rasit, T., Handan, M., Ahmet, K., Alper, T., & Olcay, Y. (2006). The clinical impact of mood disorder comorbidity on obsessive-compulsive disorder. *European Archives of Psychiatry & Clinical Neuroscience, 256*(4), 240-245.

Robert, L. (2003). Obsessive-compulsive Disorder in Bali: The cultural shaping of a neuropsychiatric disorder. *Transcultural Psychiatry, 40*(3), 377-408.

Rudin, E. (1953). Obsessive-compulsive disorder and marital status. *British Journal of Psychiatry, 11,* 131-136.

Shooka, A., Al-Haddad, M. K., & Raees, A. (1998). OCD in Bahrain: A phenomenological profile. *International Journal of Social Psychiatry, 44*(2), 147- 154.

Thomsen, P. H. (1999). *From thoughts to obsessions: Obsessive compulsive disorder in children and adolescents.* London: Jessica Kingslay Publishers.

Tynes, L. L., White, K., & Steketee, S. (1990). Towards a new nosology of OCD. *Comprehensive Psychiatry, 31,* 465-480.

Yaryura, J. A., & Neziroglu, F. (1983). *Obsessive-compulsive disorder: Pathogenesis-Diagnosis-Treatment.* New York: Marcel Dekker Inc.

Received June 10, 2008

Revision received May 4, 2009