

## FAMILY FACTORS IN THE DEVELOPMENT OF OBSESSIVE-COMPULSIVE DISORDERS IN YOUTH

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According to diagnostic criteria described in classification DSM-IV (1994), the essential features of Obsessive-Compulsive Disorder (OCD) are recurrent obsessions and compulsions that are severe enough to be time consuming (i.e. they take more than 1 hour a day) or cause marked distress or significant impairment in a person. The obsessions are defined as a persistent, intrusive, senseless thoughts and impulses, while compulsions are intentional and repetitive behaviors. At some point during the course of the disorder, most of the persons have recognized that the obsessions and compulsions are excessive and unreasonable. As a result, they make hard efforts in order to resist them. The most common obsessions are repeated thoughts about possible contamination (e.g. becoming contaminated by touching hands of other people), repeated doubts (e.g. a person is uncertain whether he/she left a door locked or turned off the gas stove), a need to keep things in a particular order (e.g. intense distress when objects are disordered in some way) and sexual images. Usually the individuals with obsessions attempt to ignore or suppress such thoughts and impulses or neutralize them with some other thought or action. An example will someone plagued by doubts about having locked the doors who attempts to neutralize them by checking several times in order to ensure himself that it is properly closed (Radochoński 1996).

According to epidemiological surveys carried out in various countries, the lifetime prevalence of OCD is estimated to be 1-3 % of general population (Karno, Golding 1991; Weissman et al. 1994). Although the disorder affects people of all ages, it usually begins in adolescence or early adulthood. In some cases it may begin in childhood. Mean age at onset is different in males to that in females (it is

the number of siblings in the families. The OCD families have on average 2.2 children, while in control families the mean number was 2.4. The comparison shows that the numbers of siblings in both types of families were not significantly different ( $t = 1.67, p > 0.05$ ).

## RESULTS

### PREVALENCE OF OCD SYMPTOMS IN THE FAMILIES

Table 3 presents distribution of OCD symptoms in members of families included to two examined groups. The prevalence of definite OCD syndrome was

Table 3

Prevalence of OCD symptoms in relatives

Type of symptoms	Relatives of OCD persons (N=217)		Relatives of control persons (N=231)		p
	N	%	N	%	
obsessions:					
definite	26	12.0	8	3.4	0.01
probable	35	16.1	13	5.6	0.01
compulsions:					
definite	41	18.9	14	6.1	0.01
probable	54	24.9	28	12.1	0.01
OCD syndrome:					
definite	24	11.1	7	3.1	0.01
probable	32	14.7	15	6.5	0.02

significantly higher in first-degree relatives in the case group (11.1 %) than in control group (3.1 %). Very similar proportion applies to prevalence of probable OCD syndrome (14.7 % vs. 6.5 %). The prevalence of definite obsessions was 12.0 % in case group and 3.4 % in control group, whereas for probable obsessions respectively 16.1 % and 5.6 %.

Also meaningful differences were found for the compulsions: 18.9 % of the OCD group relatives vs. 6.1 % of the control group relatives were diagnosed with definite compulsions. On the other hand 24.9 % of the OCD group relatives vs. 12.1 % of the control group relatives had probable compulsions. The occurrence of the definite OCD syndrome in the relatives of the case group is almost 3.5 times greater than in control relatives ( $p < 0.01$ ). This proportion indicates that first-degree relatives of case group met clinical criteria for OCD syndrome significantly more often than first-degree relatives of controls. In both groups a higher frequency of compulsions than obsessions was observed.

Obtained data have revealed that the age of onset of obsessive-compulsive symptoms in relatives ranged from 7 to 35 years. However the median age at onset of symptoms in the OCD group was about 13 years. More than 65 % of probands

from that group had onset by age 13 years and 90 % by age 16 years. There is some difference, although not significant, between the mean age of onset in girls (12.4 years) and boys (11.7 years) ( $t = 0.64$ ;  $p > 0.05$ ).

### COMMENT

The study reported in this paper has revealed some interesting findings. First of all, the OCD syndrome seems to be family determined. Close relatives of persons diagnosed with OCD had a nearly 3.5-fold higher lifetime prevalence than relatives representing a general population. The obtained results are also significant when we take into consideration probable diagnoses. The existing difference in proportions between case and control relatives should be estimated from the vantage point of prevalence rates of OCD in general population. In this study prevalence rate in the control relatives was similar to those obtained in the already published epidemiological studies (Weissman et al. 1994). In other words, the findings of this study are generally consistent with the most recent study on familial correlates of OCD (Pauls et al. 1995).

Another interesting finding was that compulsions are more specific to the familial correlates of OCD than are obsessions. Indeed, first-degree relatives of case probands are at higher risk for both obsessions and compulsions, but frequency of compulsions is greater than obsessions. This finding may indicate a significant role of heterogeneity for development of compulsions.

We are aware of some methodological limitations of our study. First of all, the case group (persons with diagnosis of OCD syndrome) seems to be not big enough). In order to obtain a representative sample of OCD persons, we would have had to screen thousands of subjects what is, at the moment, a very difficult task. We have tried to minimize selection bias by including in the study all probands with OCD syndrome who were available in selected high schools. The same objection could be formulated about the selection of control group. In order to reduce the likelihood of a bias, we tried to select the control probands and their relatives (parents and siblings) from the same community. This way the controls were representative of persons living in the communities in which the OCD persons lived.

The conclusion that OCD is family determined is very important, when we consider its consequences, although it does not necessary mean that the disorder is genetically transmitted. More detailed clarification of contribution of genetic and environmental factors in its etiology and course requires further intensive studies.

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