

A Study of Socio-Demographic and QOL of Patients with Obsessive Compulsive Disorder

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Abstract

Background: Obsessive Compulsive Disorder (OCD) is a chronic and disabling condition that negatively affects quality of life (QoL) of patients with this disorder attributable to socio-demographic, clinical and illness-specific factors. *Aim and Objectives:* To study correlation between phenomenology and socio demographic variable and to assess QOL and its correlation with phenomenology of OCD. *Place of Study:* The study was conducted at Department of Psychiatry, JLN Medical College, Ajmer (Raj). *Study Design:* It was a cross sectional hospital based analytical study. *Observation and Discussion:* Male gender, lower education and unemployment were significantly associated with OCD and scores related to physical, psychological, social and environmental domains of WHOQOL BREF were significantly lower in OCD. All grades of satisfaction levels differ significantly between sub-items of 4 domains of QoL of OCD. *Conclusion:* The preliminary results of this study are partially comparable to international data on QoL of patients with OCD and call for a research with a larger sample in community setting.

Keywords: Obsessive Compulsive Disorder; Subjective Quality of Life; WHOQOL-BREF Scale.

Introduction

Obsessive-compulsive disorder (OCD) is an intriguing and disabling illness characterized by the presence of obsessions (unwanted thoughts, images or impulses) and/or compulsions (repetitive behaviours) [1]. However, despite the high prevalence only a minority of the sufferers seek professional help because of the secretive nature of the illness. Those who suffer from OCD often find it embarrassing to talk about their unwanted thoughts resulting in considerable delay in seeking treatment. By the time medical help is sought, many years of illness would have elapsed. World Health Organization (WHO) also offered a comprehensive definition of QoL, which subscribes to the individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations standards, and

concerns [2]. Evidently, the concept of QoL subjective as well as objective - has globally achieved an important place in research not only in physical diseases including old age and cancer but also in mental health problems [3-4].

Tools of Study

Socio Demographic Profile including Kuppuswamy's Socio-Economic Status Scale, Yale - Brown Obsessive Compulsive Scale and the World Health Organisation Quality of Life - Bref (WHO QOL - BREF) and Global Assessment Functioning Scale were used.

Aim and Objective

The aim and objectives of this study were to study correlation between phenomenology and socio demographic variable and to assess QOL and its correlation with phenomenology of OCD.

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Ethical Consideration

The authors submitted research protocol and obtained approval from the Ethical Committee of Institute. All participants were informed in nontechnical language the objectives of this study and they gave verbal as well as written informed consent for participation in this study.

Study Design

It was a cross sectional hospital based analytical study.

Material and Method

The study was conducted at Department of Psychiatry, JLN Medical College, Ajmer (Raj). 50 consecutive patients suffering from OCD, diagnosed by consultant psychiatrist in outdoor as well as in psychiatric wards, JLN Medical College & Associated Group of Hospital Ajmer, and gave informed consent were selected for the study. All the patients were thoroughly evaluated on socio demographic profile Proforma, YBOCS scale and YBOCS symptoms checklist, WHOQOLBREF, Global Assessment Functioning (GAF) scale. Subjects in control group evaluated on socio demographic Performa and WHOQOL-BREF.

Observation and Discussion

Table 1: Socio demographic profile of patients

Socio demographic	Profile	N	Male	Female
Age	18 - 60	50	36 (72%)	14 (28%)
	Mean \pm S.D.	35.12 \pm 8.98	34.89 \pm 9.87	35.71 \pm 6.75
Education	Up to middle	10 (20%)	4 (11%)	6 (43%)
	Above middle	40 (80%)	32 (89%)	8 (57%)
Marital status	Married	38 (76%)	26 (72%)	12 (86%)
	Unmarried/ separated	12 (24%)	10 (28%)	02 (14%)
Locality	Rural	12 (24%)	12 (33%)	00 (0%)
	Urban	38 (36%)	24 (67%)	14 (100%)
Family type	Nuclear	26 (52%)	18 (50%)	08 (57%)
	Joint	24 (48%)	18 (50%)	06 (43%)
Occupation	Employed	26 (52%)	24 (67%)	02 (14%)
	Unemployed	24 (48%)	12 (33%)	12 (86%)
Socioeconomic status	Upper	2 (4%)	2 (56%)	0 (0%)
	Upper middle	14 (28%)	8 (22%)	6 (43%)
	Lower middle	10 (20%)	8 (22%)	2 (14%)
	Upper lower	24 (48%)	18 (50%)	6 (43%)
	Lower	00 (0%)	0 (0%)	0 (0%)

Data Analysis

Statistical analysis was performed using the Statistical Package of Social Sciences (SPSS) version 20.

Inclusion Criteria

Patient diagnosed as OCD according to ICD-10 (DCR) criteria, Patient aged between 18-60 years,

Exclusion Criteria

Any co-morbid long standing major medical illness, any co-morbid psychiatric illness and substance use disorder except nicotine, those having organic brain disease and head injury.

Discussion

The present study was aimed at phenomenology of OCD and its impact on patients, study shows the distribution of subjects according to age group. It is evident from the table that 80% (40) of patients were below 40 yrs of age and only 20% (10) were of above 40 yrs of age. The mean age of OCD patients was 35.12 \pm 8.98yrs. 72% (36) patient were male where as 28% (14) were female. The mean

Table 2: Distribution of patients according to phenomenology

OCD Phenomena	N (%)	Male	Female
Aggression obsession	42 (84%)	32 (89%)	10 (71%)
Contamination obsession	38 (76%)	24 (67%)	14 (100%)
Sexual obsession	18 (36%)	14 (39%)	04 (28.5%)
Hoarding obsession	16 (32%)	14 (39%)	02 (14%)
Religious obsession	32 (64%)	24 (67%)	08 (57%)
Need for symmetry obsession	28 (56%)	22 (61%)	06 (43%)
Miscellaneous obsession	46 (92%)	34 (94%)	12 (86%)
Somatic obsession	30 (60%)	22 (61%)	08 (57%)
Cleaning compulsion	36 (72%)	22 (61%)	14 (100%)
Checking compulsion	40 (80%)	32 (89%)	08 (57%)
Repeating compulsion	26 (52%)	26 (72%)	00 (0%)
Counting compulsion	14 (28%)	10 (28%)	04 (28.5%)
Ordering compulsion	16 (32%)	12 (33%)	04 (28.5%)
Hoarding compulsion	20 (40%)	16(44%)	04 (28.5%)
Miscellaneous compulsion	40 (80%)	28 (78%)	12 (86%)

Table 3: Severity Rating of OCD

Severity of OCD in YBOCS Score	N (%)	Male	Female
Mild	4 (8%)	4 (11%)	0 (0%)
Moderate	08 (16%)	02 (6%)	06 (43%)
Severe	14 (28%)	08 (22%)	06 (43%)
Profound	24 (48%)	22 (61%)	02 (14%)
Mean ± S.D.	28.72 ± 8.29	30 ± 8.76	25.43 ± 7.25

Table 4: Correlation between Socio-demographic profile and Phenomenology of OCD

Socio-demographic profile and Phenomenology		N	Mean YBOCS Score	Std Dev	t Value	p Value
Gender	Male	36	30	8.76	1.22	0.23
	Female	14	25.43	7.25		
Marital status	Married	38	28.79	8.46	0.07	0.94
	Unmarried/separated	12	28.5	10.01		
Occupation	Employed	26	26.31	11.41	1.235	0.22
	Unemployed	24	31.33	8.57		
Family type	Nuclear	26	27.15	8.46	0.97	0.34
	Joint	24	30.42	8.39		
Locality	Rural	12	28.33	7.865	0.1822	0.8562
	Urban	38	28.84	8.62		

Table 5: Correlation between phenomenology of OCD and particular domain of QOL of patients

Score		Physical domain	Psychological domain	Social relationship domain	Environment domain
YBOCS Score	r	- 0.5363	- 0.5641	- 0.326	- 0.206
OBSESSIVE Score	r	- 0.5623	- 0.5586	- 0.3018	- 0.2165
COMPULSIVE Score	r	- 0.455	- 0.506	- 0.311	- 0.1754

age was higher in females (35.71±6.75) than in males (34.89±9.87). In this regards findings of our study matched with the studies done by Chakraborty [5], they found 78% of patients were less than 40 yrs of age. Girishchandra [6] found that 68.8% were males and 31.2 % were females. Ages of patients ranged between 12 and 62 yrs with

a mean age of 29.50 + 10 yrs. Regarding marital status the findings of our study matched with the Chakraborty [5], who found that married and unmarried difference was not significant but married females and single males were significantly higher in study group; MA Mathis et al. [7] in meta-analytic studies found and

concluded that male patients were more likely to be single than females. One of the reasons why this finding has been more common in all Indian studies is that age of marriage is early in India. Therefore, by the time subjects develop illness they usually get married. Another possible explanation can be greater social acceptance and difficult divorce system. The possible reason why females were significantly more married as compared to males is because of the difference in the age of marriage of both sexes in the society, were females usually get married early as compared to males.

The domicile of patients suffered with OCD, it was found that 76% (38) of patients belonged to urban area, whereas 24% (12) belonged to rural area. Sex wise distribution shows that among males 67% (24) belonged to urban and 33% (12) belonged to rural. The respective figures in females were 100% (14) and 00%. On the domicile point of view, the difference in male and female was not significant. The findings of our study matched with the studies done by Manchanda et al. [9], who found that 83.3% of OCD patients belonged to urban area. Educational level, it can be inferred that 80% (40) of patients were having education above middle school level, 20% (10) below middle school level. Sex wise distribution shows that among males 89% (32) were above middle school level, the respective figures in female patients was 57% (8). This finding of our study is similar as reported by Chakraborty [5,8] who found that most of OCD patients were educated above middle school level; Habibollah et al. [9] found that female patients were older, more likely to be married and less educated than male patients.

Occupational status of patients suffered from OCD. It was seen that 52% (26) patients were employed and 48% (24) were unemployed, homemaker or student. Sex wise distribution among males 67% (24) was employed and 33% (12) were unemployed included 3.33% (4) students and 86% (12) female patients were housewives, 14% (2) were doing service. Regarding the occupational status our findings matched with Chakraborty [5, 8] who found that students and housewives were most affected with OCD. Elizabeth A. Nelson et al. [10] found that large proportion of patients was currently employed. Gender wise finding in our and other studies in Asian countries could be an artefact because in our setting major occupation of female sex is housewife.

The distribution of patients suffered from OCD according to socioeconomic status (SES) of family. It shows that 4% (2) patients were belong to upper SES, 28% (14) were belong to upper middle SES, 20% (10) were belong to lower middle SES, 48% (24) were belong to upper lower SES. Sex wise distribution in this study show respectively males were belong to 6% (2), 22% (8), 22% (8) and 50% (18); while in females respectively 0% (0), 43% (6), 14% (2), 43% (6). Chakraborty [5,8] all found in their studies suggest that most of the patients suffering from OCD belonged to middle and upper - middle socioeconomic status.

The distribution of patients suffered with OCD according to family type. 52% patients were belonging to nuclear family and 48% patients belonged to joint family. Sex wise distribution shows that among male patients 50% were from nuclear family and 50% from joint family. The respective figures in female patients were 57% and 43%. In this regard our study is in line with studies done by Manchanda et al [8] who found 63.3% of OCD patients belonging to nuclear family.

In this study shows distribution of OCD patients according to types of obsessions. Majority of the patients had obsessions of aggression (84% = 42) followed by contamination (76% = 38), religious (64% = 32), somatic (60% = 30), need for symmetry (56% = 28), sexual (36% = 18) and hoarding/saving (32% = 16). Karadag F et al. [13] found that the most commonly occurring obsessions were contamination (56.7%) followed by aggressions (48.9%), somatic (24.1%), religious (19.9%) symmetry (18.4%), sexual imagery (15.6%).

Gender distribution shows that obsessions of contamination were more in females as compared to males i.e. 100% (14) v/s 67% (24). Where as in males aggressive obsession (89% = 32) were found higher as compared to females i.e. 71% (10).

In this regard our study is in line with Christoday et al. [11] who found that 94% of female patients had increased frequency of obsessions of dirt and contamination obsession were slightly more common in females.

Distribution of OCD patients according to type of compulsions show majority of patients had checking compulsion (80% = 40), followed by cleaning/washing (72% = 36), repeating (52% = 26), hoarding (40% = 20), ordering (32% = 16) and counting (28% = 14). 80% (40).

Rasmussen and Eisen [13] who found that most common compulsions were checking, cleaning, counting, ordering, repeating and hoarding;

Girishchandra B.G [6] found that most commonly occurring compulsions were hand washing, followed by bathing and grooming and the need to ask and need for reassurance; Miscellaneous compulsion constituted 9.5% of patients;

Sex wise distribution shows that male patients most common compulsion was checking (89% = 32) followed by cleaning and washing (72% = 26), repeating (72% = 26) where as among females it were 57% (8), 100% (14), 0% (0) respectively. Christoday et al (1996) [4, 11] both found that washing compulsions were most common in females 94% and 57% respectively.

Severity of OCD shows on YBOCS in Table 3. It is evident that 8% (4) of patients had mild and 16% (8) had moderate, 28% (14) had severe and 48% (24) had profound on YBOCS scale.

Gender wise distribution shows that severe (score 24-31) symptom category on YBOCS scale was found more in females (43% = 6) as compared to males (22% = 8) but the difference was not significant. In this regard our study is in line with Christoday et al. [11] who found that females had higher obsessive, compulsive and total scores on YBOCS indicating a more severe psychopathology. While in this study males have more profound severity compare to females (61% = 22 v/s 14% = 2) possibly because of unequal distribution of sample of patients.

There is no significant correlation between severity of OCD and Socio-demographic profile of patients shows in table 5. Modest sample size and hospital based study and unequal gender distribution may be the possible reasons.

The present study exhibits a considerable impairment in QOL of the patients with OCD (Table 6). Noticeable impairment was found in all the specific domains of QOL that were considered for the measurement, including Physical, Psychological, Social Relationships, and Environment.

Past studies Koran L et al. [15] have indicated that the patients with OCD show a greater impairment in many aspects of QOL. The results showed that the severity of OCD has a negative correlation with QOL of patients. The findings are similar to results of previous studies by Masellis M et al. [16].

This study also reveals that obsessional severity produces a significant impairment in the QOL of patients with OCD. Moritz et al. [17] found in their studies that compulsions, as the most prominent characteristic of OCD are strongly correlated with QOL in a number of studies.

Bobes J et al. [18] found that physical health seem to be affected to a lesser extent as compared to other aspects of QOL. Results got in this study suggest that environment domain is less affected than other domain of QOL while psychological domain is worst affected.

Conclusion

Obsessive-compulsive disorder (OCD) is a chronic psychiatric disorder. It affects approximately 2.5% of population. OCD is the fourth most common psychiatric illness & one of the 10 most disability causing medical condition worldwide. According to World Health Organization, Quality of Life is an individual's perception regarding his/her status in life in the perspectives of the principles, morals and culture systems in which one lives, and with regards to his/her aims, objectives, standards, desires and concerns. It is a wide-ranging concept, integrating in a multifaceted manner an individual's physical health, psychological state, social relationships, and their relationship to significant characteristics of their environment. The individual's perception about QOL can be measured in the following domains: Physical, Psychological, Social Relationships, and Environment. This preliminary research calls for a community-based study with a larger sample in order to map out the larger scenario of OCD - illness-related factors and their specific connectivity to quality of life.

Limitation of Study

Modest sample size, Hospital based study (Participants were treatment seeking, and therefore, our findings may not apply to those individuals with OCD who do not seek treatment), Subjects were evaluated at only one time point. The relationship between changes in OCD symptoms and changes in specific domains of QOL can best be assessed over time. Continued observation of the study participants will allow us to more fully understand the interaction between severity of OCD and its impact on QOL over time. There are not direct comparisons with community norms or individuals with other psychiatric disorders.

Competing Interests

Authors have declared that no competing interests exist.

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Ethical Approval

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