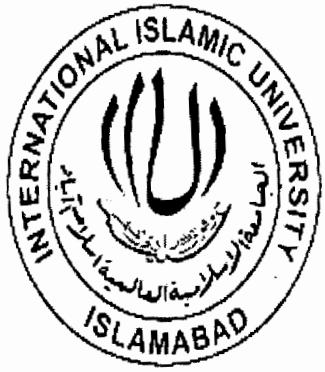
QUALITY OF LIFE OF PATIENTS WITH OBSESSIVE COMPULSIVE DISORDER



MS THESIS

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1. Obsessive - Compulsive disorder

In the Name of **ALLAH**

The Most Merciful and Compassionate, the Most Gracious and Beneficent, Whose help and guidance we always plead for at every step, at every moment.

DEDICATED

To

My Family

APPROVAL CERTIFICATE

Certified that the contents and form of thesis entitled, "**QUALITY OF LIFE OF PATIENTS WITH OBSESSIVE COMPULSIVE DISORDER**", submitted by Ms. Tamkeen Saleem toward the partial fulfillment of the MS Degree Program has been approved for the submission to International Islamic University, Islamabad.

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ABSTRACT

The present study was aimed to explore the relationship of obsessive compulsive disorder and quality of life. The quality of life (QOL) in patients with Obsessive compulsive disorder was measured, and the role of the socio-demographic and clinical factors that may be associated with QOL were explored. The instruments used to measure the severity of OCD and quality of life were Yale Brown Obsessive Compulsive Scale (Y-BOCS) and World Health Organization Quality of Life Bref (WHOQOL Bref) respectively. The sample consisted of a total of 80 (40 male and 40 female) adult diagnosed patients of obsessive compulsive disorder ranging from ages 25 to 40 years. To analyze the data, the correlation and t-test were applied. Severe Obsessive compulsive disorder, Obsessional severity and compulsion severity were found to have a significant relationship with QOL of patient. Comorbid psychological disorders were the notable predictor of poor QOL. It was concluded that Obsessive compulsive disorder is associated with poor quality of life.

Keywords: Obsessive compulsive Disorder, Obsessions, Compulsions, Quality of life, and comorbidity

INTRODUCTION

INTRODUCTION

During the past few decades the interest of the researchers and clinicians in the quality of life of the patients with mental disorders has developed progressively. In the field of psychiatry the notion of quality of life transpired in the research literature in early 1980s which began with the humanization of mental health care facilities and practices and trends towards community psychiatry in Sweden (Malm, May & Dencker, 1981) which started an era of research to improve the quality of life of the patients and to establish humane form of treatments to cure the patients.

In current times it is vital to identify and evaluate the impact of disease on the social and psychological health, physiological and socioeconomic outcomes of the patient. Quality of Life (QOL) has attained a significant status in patient management system in the clinical world. The value of impact of healthcare interventions on everyday life of patient is progressively more recognized rather than the health of patient only (Hall & Kalra, 2001).

The concept of quality of life is employed to assess the general well-being of individuals and societies. The terminology of quality of life is utilized in an extensive range of contexts, comprising the fields of healthcare, societal development, and political science. The concept of standard of living and quality of life should not be confused as standard of living is primarily based on income. Whereas, standard index of the quality of life consists not only financial concerns and employment, rather also the environment, physical and mental health, education, recreational activities, and social relationships.

Defining Quality of Life

The conception of' quality of life' (QOL) has been widely adopted both publicly and academically due to its perfuse nature and relevance to all human beings. Perhaps as a consequence of its broadly applicablility, yet elusive character, little consensus has been reached regarding an acceptable definitional standard for this construct, either between or

within various disciplines (Cummins, McCabe, Gullone, & Romeo, 1994). As noted by Cummins (1996), operational definitions and models of QOL exceed 100 in the research literature, both reflecting and resulting in significant variation in approach towards QOL.

Zebrack (2000) defines quality of life in terms of a gap between the hopes, expectations, and desires of persons during a particular period of time and their present life experiences. Cella (2003) describes quality of life as as evaluation and satisfaction of the patients regarding their current degree of functioning in contrast with what they perceive to be achievable or ideal. The greater the gap between the actual and the ideal situation, the lower a person's quality of life will be. The perception of a person's quality of life varies between individuals. This means that people with different expectations will report a different quality of life, even when they have the same objective health status. Therefore, insight into a patient's quality of life can only be obtained by asking a patient's perspective. Quality of life encompasses several life domains, usually physical, psychological and social well-being (Folkman , 1997; Lechner et al., 2003).

The World Health Organization (1994) defines Quality of Life as:

"An individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relation to his/her goals, expectations, standards and concerns. It is a broad-ranging concept, incorporating in a complex way the person's physical health, psychological state, social relationships, and their relationship to salient features of their environment" (p24).

Objective versus Subjective Quality of Life

In the beginning the concept of QOL was treated by researchers as referring to the objectively definable circumstances of people's lives. Measures such as the Gross National Product, rate of unemployment, or cost of housing were given as standards by which various groups could be compared (Campbell et al., 1976). However, it has since become accepted that QOL can be more informatively represented as a subjective experience reliant on a person's evaluation of their own circumstances (Andrews, 1991). This subjective measure, variously termed subjective quality of life (Cummins, 1996), subjective well-being (Andrews,

1991), psychological well-being (Chamberlain & Zika, 1992), happiness (Brickman, Coates, & Janoff-Bulman, 1978), positive and negative affect balance, and satisfaction, typically demonstrates minimal correlation to objective life circumstances (Cummins, 1996). The finding indicates that the two dimensions of objective and subject quality of life need to be conceptually discriminated.

Encircling the research considerations comprehensively, Cummins (1996) has defined QOL as both objective and subjective, each measure being the accumulation of seven domains: health, material well-being, productivity, safety, intimacy, community, and emotional well-being. The objective domains comprise of culture-associated evaluation of objective well-being. And the subjective domains consist of satisfaction felt by the individual.

Domains of Quality of Life

On the basis of prevalent literature, the perception of an individual regarding quality of life can be measured in the following domains: Physical, Psychological, Social Relationships, and Environment.

Physical Domain investigates an individual's ability to carry out everyday living activities, dependence on medication, vigor, zeal and stamina to perform the essential activities of daily life, ability to go from one place to another, unpleasant physical sensations which are distressing, problems regarding sleep and rest.

Psychological Domain examines the person's view of body, self-esteem, beliefs, memory, thinking, learning and ability to make decisions. The facet also inspects the negative feelings including guilt, gloominess, hopelessness, feelings to weep, lack of pleasure in life, nervousness, and anxiety as well as the constructive feelings of hopefulness, contentment, happiness and peace. The focus is to investigate the impact of these on day to day functioning of the person.

Domain of Social Relationships investigates the degree to which people experience the companionship, love and support they wish from the intimate relations in their life. This facet explores to what extent a person feels the commitment, approval, and readily

accessibility of practical support from family and friends. It tends to explore to what extent family and friends share in responsibilities and work as a team in order to solve issues at personal or family level. It involves a concern regarding the individual's inclination and desire for sex and the level to which the individual is expressive and enjoys his/her sexual desire.

Environmental Domain explores the person's view of his/her financial resources and the degree to which these resources fulfill the requirements for a healthy and comfy mode of living. The focal point is the affordability of the person which might influence the quality of life. The perceived feelings of safety and security are also evaluated in environmental domain. It explores the person's perception of the physical condition and social care in the close vicinity and home environment. The facet also deals with the exploration of the advantageous circumstances and aspiration to learn new skills, acquire latest information, knowledge about what is going on, inclination to participate in leisure and recreation as these affect quality of life. Some specific aspects of the environment may have awfully noteworthy impact on quality of life, for instance availability of water or air pollution. Another focus measures to what extent the available transport permits the person to execute the essential tasks of daily living and in addition to that the freedom to perform selected activities.

Phenomenology of Obsessive-Compulsive Disorder

Current usage of terms such as "obsessive" and "compulsive" refer negatively to behavior or thinking that appears indulgent or excessive. An individual is described as obsessional if he or she spends a disproportionate amount of time, interest or effort on some behavior, object or thought, to the detriment of other important areas of functioning. The lay use of these terms often reflects the observer's personal judgment about the worth of such pursuits or efforts, rather than the pathological qualities of the behaviour itself (Reed, 1985).

Terms such as obsessionality and compulsivity gained their psychiatric implications in the mid nineteenth century in France and Germany (Berrios, 1996). Early theorists described obsessionality as involving involuntary intrusive thoughts. For example, Esquirol in 1838 described a patient suffering from thoughts that were "involuntary", "irresistible' and felt not to "be her's" (Berrios, 1996).

By the late nineteenth century, the description of obsessionality broadened to include personality features, affective experience and behaviors. Berrios (1996) emphasised that obsessional patients were insightful and had an absence of cognitive impairment, but suffered from frequent somatic and anxiety symptoms, which were alleviated by compulsive actions. Thus, obsessionality has been recognized as a psychiatric syndrome for more than 300 years. Primitive researches focused on different characteristic of the disorder suggesting the existing traditions of observers. The phenomenologist in France highlighted the importance of doubt and loss of will, whereas the German psychiatrists concentrated on the irrational characteristic of the thoughts (Okasha, Saad, Khalil, Dawla, & Yehia, 1994). In the present era these aspects are mutually designated as the common indications of OCD patients.

Obsessive-Compulsive Disorder (OCD)

Obsessive compulsive disorder is an Anxiety Disorder , defined by the occurrence of unwanted and intrusive obsessive thoughts or distressing images; these are frequently accompanied by compulsive acts and rituals which are performed to neutralize the obsessive thoughts or images or to avoid some anxiety provoking situation. More specifically, according to DSM-IV-TR, obsessions implicate recurrent and persistent intrusive thoughts, images, or impulses that are experienced as disturbing and inappropriate. People who have such obsessions try to resist or suppress them, or to neutralize them with a few other thought or acts. Compulsions can involve either overt repetitive behaviors (such as washing, checking, ordering or hoarding) or more covert mental acts (such as counting, praying or saying certain words silently). A person with obsessive compulsive disorder usually feels driven to perform this compulsive ritualistic behavior in response to an obsession and there are often very rigid rules regarding how the compulsive act should be executed. The aim of performing the compulsive behaviors is to prevent or reduce the distress or avert some dreadful event or situation (Carson et. *al.*, 2008).

Apart from the presence of obsessions or compulsions, the diagnosis of OCD is predicated on the impairment and distress caused by the symptoms, the etiological basis of the symptoms and to some extent, the presence of insight. For instance, the diagnosis of OCD is applicable only when the obsessions or compulsions trigger significant distress, take more than one hour a day, or markedly interfere with the individual's daily schedule, work & academic functioning, social activities or relationships (American Psychiatric Association,

2000). The diagnosis of OCD is not applicable if the symptoms are due to the direct physiological effects of a substance or general medical condition, or are restricted to another Axis 1 disorder that is present (American Psychiatric Association, 2000). Finally, for adults, the diagnosis of OCD is relevant only for individuals who realize and understand that the obsessions and compulsions are excessive or unreasonable (American Psychiatric Association, 2000).

Researchers have found that most patients with OCD do not attempt to combat their compulsions (Catapano, Sperandeo, Perris, Lanzaro, & Maj, 2001). Further, researchers have found that resistance against compulsions correlates negatively with the severity of OCD (Catapano et al., 2001). Some research also has suggested that resistance is low amongst OCD sufferers who possess poor insight about their symptoms (Catapano et al., 2001) or who present with hoarding compulsions (Damecour & Charron, 1998).

Obsessions

Obsessions are "persistent ideas, thoughts, impulses or images that are recurrent and experienced, at some point during the disturbance, as intrusive and inappropriate and cause significant anxiety and distress ... the contents of the obsession is extraterrestrial and not within the control of person" (American Psychiatric Association, 2000). This intrusive and inappropriate quality of the obsession has been referred to as "ego dystonic". The thoughts, impulses or images are not merely unwarranted suspicions about real-life problems. They are recognized by the individual as products of his or her own mind rather than the product of some external entity or force. The sufferer typically attempts to ignore or suppress these intrusions or sometime neutralize them with some complementary thought or action.

In OCD, these obsessions are typically about repugnant, aggressive or catastrophic events. Largely the widespread obsessions are repeated thoughts about contamination, repetitive doubts about having made a mistake or being careless, a drive to retain things in a particular order, horrific or aggressive impulses and sexual imagery (American Psychiatric Association, 2000).

Individuals with OCD usually have multiple obsessions (Akhtar, Wig, Verma, Pershod, & Verma, 1975; Rasmussen & Tsuang, 1986). Reed (1985) summarizes his clinical

observations saying "obsessionals seldom suffer from a single, discrete obsession" but have a "veritable network of obsessional ideas, doubts and fears" just as a "cancer which can extend in all directions".

There are various ways in which obsessions are experienced. Researchers have employed a wider range of constructs such as fears and conviction in defining obsessions. For instance, Girishchandra and Khanna (2001) reported an array of obsessional phenomena in their sample of OCD participants, including doubts, thoughts, fears, urges, images and convictions. Akthar et *al.* (1975) reported that among 82 Hindu obsessional patients in Northern India, 75% reported doubts, 34% thoughts, 25% fears, 17% impulses, and 7% images. Reed (1985) found that in his sample of 50 non-depressed OCD patients, 65% complained of fears, 40% of rumination and 38% of doubts.

Compulsions

According to DSM-IV TR (American Psychiatric Association, 2000), compulsions are recurring and ritualistic practices or at times mental acts that the individual feels driven to carry out in response to an obsession, and in accordance with the characterized rules that must be followed decisively. Compulsions are conducted generally in order to prevent a dreaded event or situation, or to alleviate distress, but they are usually not associated in a reasonable way with whatever they are intended to neutralize or restrain, or are evidently excessive. Further, compulsions are never performed for pleasure (American Psychiatric Association, 2000).

Most patients who suffer obsessions engage in extreme rituals, or compulsions. Carrying out these compulsions does not necessarily give them pleasure, but it tends to help them feel a lesser amount of anxiety or distress. Compulsions can be extremely severe and may entail elaborated stages. Usually they are either not realistically linked with what they are destined to prevent or they are extremely beyond any reason.

Chiefly the prevalent compulsions involve cleaning and washing, counting, checking, ordering, repeating actions and requesting or demanding assurances. In a review of 65 studies within the behavioral treatment literature, 75% of OCD treatment population was found to have cleaning or checking compulsions (Ball, Baer, & Otto, 1996).

Researches indicate that nearly half of patients of obsessive compulsive disorder suffer from more than one ritual. Rasmussen and Tsuang (1986) found that 41% of their OCD sample exhibited more than one ritual. Reed (1985) found that two thirds of his sample of 36 OCD patients suffered from more than one compulsion, with each patient having an average of 2.3 rituals. Saha & Gupta (2000) studied phenomenology of OCD with a cross-cultural perspective. 40 patients of OCD (as per ICD- 10) were studied using YBOC checklist. The common obsessions noticed were contamination (52%) and aggression (32.5%). Washing (57.5%) and checking (42.5%) rituals were the common compulsions. Gadit (2003) reported regarding the compulsions in the fisherman community in Pakistan that checking, washing and counting were the most common.

The Difference Between Obsessions and Compulsions

According to the DSM IV criteria for the diagnosis of Obsessive compulsive disorder either obsessions or compulsions causing interference in the life of patient are clinically significant for the diagnosis (American Psychiatric Association, 2000). Although obsessions and compulsions play their role complementing each other in their association to distress and anxiety, the diagnosis of OCD does not require both the phenomena to be present (American Psychiatric Association, 2000). For instance, people may carry out strict or stereotyped actions according to their distinctively elaborated rules and patterns. And many times they have no awareness or answers that may indicate why they do them. Numerous studies have found that sexual and religious obsessions do not always exist with compulsions. Weissman et *al.* (1994) reported that most sufferers have only obsessions and no compulsions.

Owing to the definitional independence of obsessions and compulsions, it is understandable that there is considerable range in the reported estimates about the number of patients with obsessive compulsive disorder who experience obsessions only or compulsions only. For example, one study reported that only approximately 5% of OCD sufferers present with both obsessions and compulsions (Karno, Golding, Sorenson, & Burnam, 1988). This estimate starkly contrasts with those from other studies that report between 82 and 91% concordance between obsessions and compulsions (Foa et *al.*, 1995) (Rasmussen & Tsuang, 1986). For instance, Rasmussen and Tsuang (1986) found that 83% of patients with contamination obsessions had cleaning rituals, while 82% of patients with aggressive obsessions had checking rituals.

Prevalence of OCD

OCD was once regarded as relatively rare in the general community. Prevalence rates were estimated to be between 0.03% and 0.06% (Rudin, 1953; Templer, 1972). Since the publication of the USA National Epidemiological Catchment Area surveys and the British National Survey of Psychiatric Morbidity, OCD is known to be at least 50 times more prevalent than originally believed (Jenkins et *al.*, 1997).

Recent community studies have estimated OCD to be associated with a lifetime prevalence between 1.9% and 3.1%, and a 1-year prevalence of between 0.5% and 2.1% in adults (American Psychiatric Association, 2000). Epidemiological studies have shown that between 1% and 2% of the general population suffers from OCD at any given time (Karno et *al.*, 1988). These prevalence estimates make OCD the fourth most common psychiatric disorder in the United States after phobias, substance abuse and major depressive disorder and twice as common as schizophrenia and panic disorder (Karno et *al.*, 1988).

A national survey of the mental wellbeing of adults in Australia was conducted in 1997. The survey included approximately 10, 600 people aged 18 years or above. It provided information on the prevalence of a range of major mental disorders in Australia, such as OCD, major depressive disorder and alcohol abuse. OCD was found to be rare, being associated with a one-year prevalence of 0.4%. In the 12 months prior to the survey, the prevalence of OCD was less common than GAD, Post-Traumatic Stress Disorder, Panic Disorder and Agoraphobia (Australian Bureau of Statistics, 1998). Thus, the 1-year prevalence of OCD in Australia is lower than found in the US or British studies, although methodological differences in the surveys are likely to account for such differences.

The Onset of OCD

The onset of OCD is generally in adolescence or early adulthood, and for the most part, onset is gradual (Rasmussen & Tsuang, 1986). Rasmussen and Tsuang (1986) found that 8% of OCD sufferers have acute onset of OCD. The average age of onset for OCD shows a discrepancy among men and women. Men may be subjected to the onset during childhood, between ages 6 and 15, whereas women in general experience onset during adult life that is between ages 20 and 30. Koran and his colleagues conducted a study in which two-thirds of all adult patients with OCD had developed symptoms before the age of 15, 80% of these

patients also had symptoms of depression. It is assumed with the likelihood of early onset, that the average age at which a person seeks treatment is 27 (Koran et *al.*, 2007).

Although for the majority of sufferers, OCD begins in adolescence or early adulthood, it is often only reported in the 25 - 40 year old age group (Feinstein et *al.*, 2003). Thus, the onset of OCD symptoms itself may be considerably earlier than the clinical disorder. For example, one study found that the mean age for symptom onset was 11.8 for males and 12.7 for females (Sobin et *al.*, 1999). Onset of OCD after the age of 45 is rare (Rachman & Hodgson, 1980). In one study, only 3 out of 40 OCD patients experienced the onset of symptoms after the age of 35 (Rasmussen & Tsuang, 1986).

Even though OCD generally develops gradually, many psychosocial stressors can cause a sudden and unexpected onset which may include changes in living situations or financial status, disruption in family or other social relationships, or occupational problems like discord at work, stressful work or job dissatisfaction. Around 70% of patients with obsessive compulsive disorder suffer a chronic and lifelong illness, with deteriorating and improving symptoms. About 5% come across episodic symptoms with partial or complete remission between episodes (Koran et *al.*, 2007).

Demographic Indicators of OCD

The prevalence and phenomenology of OCD is similar for males and females (Weissman et *al.*, 1994). Males and females are equally at risk for OCD and present with similar types of OCD symptoms (Sobin et *al.*, 1999). Although early studies reported that washing compulsions were overrepresented in females, while checking rituals and symmetry obsessions were more prevalent in males (Akhtar et *al.*, 1975; Rasmussen & Tsuang, 1986; Stern & Cobb, 1978), such gender related differences have not been supported in recent studies (Noshirvani, Kasvikis, Marks, Tsakiris, & Monteiro, 1991).

Nevertheless, there are a number of other gender related differences in OCD. First, the onset of OCD appears to be earlier for males than females (Noshirvani et *al.*, 1991). The average age of onset is between 6 and 15 years for males and between 20 and 29 years for females (American Psychiatric Association, 2000). More females with OCD have a history of depression and eating disorders than males, while more males with OCD have a history of

anxious or meticulous personality traits or substance use disorders, than females (Sobin et *al.*, 1999).

The impact of culture and society on many aspects of OCD is evident. A number of diversified symptoms associated with the religiosity are more widespread in clinical populations from the countries in which religion is the primary foundation of the society, predominantly in Muslim and Jewish cultures, as compared with clinical populations from the West (Bilbabo & Giannakopoulos, 2005). Okasha et *al.* (1994) report that the religious nature of upbringing and education in Egypt explains the high prevalence of religious obsessions and repeating rituals in their Egyptian OCD patients, and the high prevalence of sexual preoccupations in female OCD sufferers (Okasha et *al.*, 1994). Likewise, Rasmussen and Tsuang (1986) found that many patients in their OCD sample presented with obsessive thoughts and rituals that were reminiscent of these patients' inordinately strict or orthodox religious upbringing. Despite some cross-cultural differences in the presentation of some symptoms, the basic types and frequencies of obsessive-compulsive symptoms are mostly consistent across cultures (Girishchandra & Khanna, 2001; Okasha et *al.*, 1994).

Obsessive Compulsive Disorder in Pakistani Society

The values, attitudes, beliefs, thinking patterns and rituals prevalent in a culture can most likely influence the form and content of obsessions and the description of compulsions (Kiev, 1972).

The religious education plays a vital role in the phenomenology of OCD. The psychosocial and cultural factors can affect the onset, phenomenology and consequence of Obsessive Compulsive Disorder as well as to the therapeutic treatment and prognosis. The emphasis on religious rituals and unspiritual thoughts through recurring religious phrases and acts could explain the high prevalence of religious obsessions and repeating compulsions among Muslim population.

Pakistani population which constitutes 97% of Muslims, are required to pray five times a day (Library of congress country studies on Pakistan, 2005). The religious education is imparted from the very beginning of life. From a very young age of 10 years a Muslim should pray five times a day, before which his/her body and clothes must be clean Each

prayer is preceded by a ritualistic purification and cleansing procedure (*Wudu* or ablution), which entails cleaning and washing a number of parts of the body in a particular order, each three times. This wudu or ablution is nullified by any type of excretion or ejaculation, urination, defecation or contamination by either nocturnal emission, sexual intercourse. Women are not permitted to offer prayers or touch the Quran during the period of their menstruation, after which they are supposed to clean their bodies completely through a ritualistic bath called *ghussal*. The prayers themselves also show a discrepancy in duration and consist of certain phrases and *suras* from the Holy Quran which have to be read in a definite sequence. The highlighting on cleanliness and hygiene or ritual purity is the keystone of the majority of the compulsive rituals. The number of prayers and their subject matter can be the issue of accurateness, checking and repetition. The ritualistic cleansing processes can also be a source of obsessions and compulsions about religious purity. (Okasha, 2004 & Mahgoub and Hafeiz, 1991)

The Pakistani culture seems to have a prominent impact on phenomenology of obsessive compulsive disorder and religious themes are frequent. A known notion of impurity followed and shared by the people in Pakistani society is the concept of Napak. The concept of "Napak" is a mixture of unpleasant feelings of contamination and uncleanliness with strong religious connotations of dirtiness. A study revealed that the types of compulsions were similar to those reported in other studies, but the form and the content of obsessions seemed to be influenced by social and religious backgrounds (Saleem & Mahmood, 2009).

Explanatory Models for Obsessive Compulsive Disorder

Neurobiological Model of OCD

The researchers have fabricated evidence for the involvement of biological factors for causing obsessive compulsive disorder through the various studies (Stein, 2002). According to biological perspective, the symptoms of OCD occur due to the impaired functioning in neurochemistry, neuroanatomy and/or neurofunctioning. But still there remains considerable disagreement in the discipline about the assumed biological mechanisms involved in the etiology of OCD.

Some researchers initially advocated that OCD results from low levels of serotonin (Yaryura-Tobias, 1977). Conversely, more recently, researchers have put forward that OCD is associated with increased serotonergic activity (Dolberg et. *al.*, 1996; Murphy et. *al.*, 1996; Pogarell, Homann, Popperl, et *al.*, 2003). However it is also turning out to be apparent that dysfunction in serotonergic systems cannot fully explain this complex disorder. Other neurotransmitters also seem to be involved in the development of OCD (Baxter et. *al.*, 2000; Hollander et *a*l., 1992).

A discrepancy has also been found regarding the role of structure of brain in OCD. The primitive researches indicated that the structural brain abnormality lying behind obsessive compulsive disorder was limited to basal ganglia. With the help of imaging technology, these studies reported lesions and atrophies in the basal ganglia structures of patients with compulsive behaviors (Hoehn-Saric & Greenberg, 1997). On the other hand many other investigations confirmed that the structural brain abnormalities in OCD were more widely distributed than previously thought. For instance Garber and colleagues found abnormalities in frontal white matter, implicating frontal lobe and anterior cingulate involvement in OCD symptoms (Garber, Ananth, Chiu, Griswold, & Oldendorf, 1989). Regardless of some support for abnormal brain structure in patients with OCD, approximately 40% of controlled studies have failed to find a major difference between OCD subjects and controls (Cottraux & Gerard, 1998). Such incongruity in the literature has consequently confronted the view that OCD necessarily involves differences in brain anatomy.

The disordered brain functioning has also been a focus in causing obsessive compulsive symptoms. The researches indicate patients with OCD reflect impairments in functions linked to the orbito-frontal and basal ganglia regions (Hoehn-Saric & Greenberg, 1997).

Genetic Model of OCD

The evidence for the genetic transmission of OCD is ambivalent. The familial tendency of OCD has been observed since the 1930s using genetic studies of OCD. These

included the studies of twins, family history, family studies, segregation, and association studies, and revealed that some specific genes have an effect on the development of OCD (Wolff, 2000). Carey and Gottesman found in their study in 1981, 87% concordance rate of obsessive symptoms and tendencies among monozygotic twins and 47% in dyzygotic twins. Riddle et. al. reported that 71% of the clinically referred children with OCD had a parent with either OCD or OC symptoms. Bellodi and collegues concluded that the morbidity risk for OCD in patients' families accounted for 3.4%. (Bellodi, Sciuto, Diaferia, Ronchi, & Smeraldi, 1992)

On the other hand, other researches have obtained no support for the genetic transmission of OCD. For instance, Rosenberg (1967) found that only two of 547 relatives of 144 obsessionals had OCD. The relatives of 50 OCD subjects and the relatives of 50 controls were assessed by McKeon and Murray in 1987 and no difference in the rates of OCD were found among the both groups. Similarly Black and colleagues were unable to find multiple number of OCD or OCD symptoms in relatives or parents of OCD patients (Black, Noyes, Goldstein, & Blum, 1992), compared to the relatives of parents of normal controls.

The different methodologies employed in these researches have contributed to discrepant findings and turn out comparisons complicated. Therefore, it is probable that high rates of concordance in twins and families are due to environmental and rearing practices, rather than genetic influences (Jakes, 1996).

Behavioral Model of OCD

The dominant behavioral view of obsessive disorder is the conditioning mechanisms which are claimed to be involved in the acquisition and maintenance of Obsessive compulsive disorder (Dollard & Miller, 1950; Mowrer, 1960; Rachman & Hodgson, 1980). Classical conditioning is associated with the acquisition of OCD, whereas operant conditioning processes are believed to lie beneath the maintenance of OCD (Rachman & Hodgson, 1980; Teasdale, 1974).

The maintenance of OCD lean on operant conditioning, where the individual puts his efforts to keep away from distress or danger by avoiding stimuli related to the thought, by

suppressing the thought itself, or by engaging in compulsive rituals. The behavioral theory of OCD is precious as it grants a theoretical justification for the most effective intervention to date for OCD which is Exposure and Response Prevention (Franklin & Foa, 1998).

Even though the behavioral model of OCD seems satisfactory in explaining the acquisition and maintenance of symptoms of obsessive compulsive disorder, it has also been criticized on a few grounds. According to Salkovskis (1998), the behavioral perspective fails to differentiate between OCD and different other anxiety disorders. The same two conditioning processes in the acquisition and maintenance of fear have been implicated in all anxiety based problems. As a result, the model does not account for why some individuals develop intrusive thoughts and compulsions, while others develop different symptoms (e.g., phobic avoidance). In short, the behavioral model does not illuminate features involved in the susceptibility for Obsessive compulsive disorders. Moreover it does not describe that why do individuals respond differently to stimuli despite similar conditioning experiences? For example, individuals may respond differently to intrusions that occur in association with aversive stimuli.

Cognitive Model of OCD

The cognitive model of OCD encloses obsessions and compulsions as products of catastrophic misinterpretations of one's thoughts, images or impulses (Rachman, 2002). According to the cognitive perspective, appraisals (interpretations) and avoidance behaviours (e.g., neutralizations) are collaboratively engrossed in the development and maintenance of OCD symptoms. Salkovskis (1985) argues that individuals with OCD appraise automatically occurring interfering thoughts as posing a threat for which the individual is personally responsible. Rachman (1997) highlights in his studies, that the patients with OCD interpret disturbing thoughts as having negative implications for moral standards or real world outcomes. Consequently, compulsions are performed in order to satisfy the sense of threat that results from these appraisals.

According to cognitive theorists such as Beck (1967), Salkovskis (1985) and Rachman (1997), such interpretations are influenced by beliefs and assumptions about the self, world and others, which in turn are shaped by early life experiences and relationships. A range of beliefs and assumptions have been nominated as guiding these appraisals. According

to Wollersheim and McFall (1978) the individuals with OCD overestimate the significance of upholding high standards with the intention to avert criticism and punishment.

Psychodynamic Models of OCD

Psychoanalysis and psychodynamically oriented theories for obsessions and compulsions have raised a number of interesting hypotheses in the area.

Freud (1987) believed that obsessions and compulsions result from instinctual forces, sexual or aggressive that is not under control because of overly harsh toilet training. The person is thus fixated at that stage may become compulsively neat, clean and orderly. He also argued that the obsessions grow in opposition to the circumstances of superstitious beliefs and cravings for certainty. Freud projected that individuals with obsessions overrate the supremacy of thoughts, feeling and wishes, and demonstrate a preference for dwelling on unresolved issues. Freud believed that obsessions and compulsions signified the patient's defences against unconscious aggressive impulses and death wishes towards the patient's parent. Similarly, Freud viewed compulsions as a defense against unwanted fantasies and impulses (Davison & Neale, 2001).

According to Alfred Adler (1931), obsessive compulsive disorder results due to feelings of incompetence. He believed that when children are kept from development a sense of competence by doting or excessive dominating parents, they developed inferiority complex and may unconsciously adopt compulsive rituals in order to carve out a domain in which they exert control and feel proficient (Davison & Neale, 2001).

Nemiah and Uhde (1989) observed that, from a psychoanalytic approach, three most important psychological defense mechanisms verify the form and quality of obsessive-compulsive symptoms and character traits which are isolation, undoing, and reaction formation. The role of defense mechanism isolation is to safeguards a person from anxiety-provoking impulses. Obsessive compulsive patients go through a partial knowledge of the impulse without completely being familiar with its meaning or importance. The people with OCD may be obsessed with images and thoughts; the power from the partially repressed

impulse provides the thoughts their compelling feature. Undoing is associated to a compulsive act that is carried out in an effort to stop or undo the consequences that the patient unreasonably foresee from a threatening obsession.Reaction formation involves evident patterns of behavior and consciously experienced feelings and thoughts that are particularly contrary of the underlying impulses. Frequently such behaviors appear to be extremely overstated and occasionally pretty inappropriate. Reaction formation is considered to be accountable for many of the personality traits which are related features of obsessive-compulsive personality disorder.

Family and Socio-Cultural Theories of OCD

Researches indicate that the parenting practices play a vital role in the development of the OCD symptoms. The parenting practices and attitudes characterized by overprotection, over-critical features, lack of emotional warmth and lack of caring have variously been implicated in the development of OCD (Cavedo & Parker, 1994; Rachman & De Silva, 1978). There is evidence that OCD patients think of their parents as overly rejecting, protective, emotionally distant (Chambless, Gillis, Tran, & Steketee, 1996; Frost et al., 1994; Turgeon, O'Connor, Marchand, & Freeston, 2002). It was argued by Guidano and Liotti (1983) that individuals, who experience confusing and ambivalent prototype of attachments with their parents, grow up with the risk for obsessional illnesses.

Families acquire OCD symptoms in many ways and to diverse levels. According to Shafran and colleagues (1995) through concern, the load of care and distress at their limited ability to help the person with OCD the other family members also get hold of the obsessive and compulsive patterns. Calvocoressi et *al.* (1999) advocates that a number of times family members get involved in rituals of the patients with OCD. Similarly they may possibly respond to repetitive queries and requirements for reassurance. This kind of help for the patient is eventually obstructive as family members are over-involved in sustaining the disorder in some ways.

Horwath & Weissman (2000) state that research investigations from different cultures disclose similar prevalence rates and uniformity in the types, forms and rituals of obsessions and compulsions. According to Fontenelle et. *al.* (2004) socio-cultural factors shape the expression of OCD in some ways. For instance, the religious obsessions and compulsions

indicate the religious viewpoint of the individual and conceivably of the society. Such patterns are usually established on mainly some firm rather extreme collections of beliefs or practices which are not extensively common among the other members of the society (Tek & Ulug, 2001).

Substantial impairment in Quality of life Associated with OCD

OCD is ranked as the most disabling anxiety disorder and the tenth most disabling condition across all medical and psychological conditions, after mood disorders, iron deficiency anaemia, falls, alcohol use, chronic obstructive pulmonary disease, congenital abnormalities, osteoarthritis and schizophrenia (World Health Organization, 1996).

Obsessive compulsive disorder may critically impair self-care, social relationships, occupational functioning, family and marital relationships, child-rearing capacities, and use of recreations or spare time. Consequently, it may be useful to include an evaluation of incapacity in various fields of life while diagnosing and dealing with the patients. However, a few patients may not be able to correctly identify the extent of their disability and incapacity until they obtain a successful treatment (American Psychological Association, 2007).

Obsessive-compulsive disorder largely effects on the lives of patients. Numerous surveys established the fact that the OCD significantly interferes with the daily activities of the patient; disturb family, social, and occupational life; and muddle up the emotional well-being, which results in poor quality of life (Sorensen, Kirkeby & Thomsen, 2004)

Koran and associates (1996) found that patients with the obsessive compulsive disorder have poor quality of life as compared to the depressed patients. Obsessive compulsive disorder is associated with worse quality of life than for any other patient group, except schizophrenics (Bobes et. *al.*, 2001). Bobes et *al.* (2001) argued that the quality of life for OCD patients was exactly as poor as that of schizophrenic patients.

In a comparative study of U.S population, Koran and associates (1996) found that patients with Obsessive compulsive disorder are somewhat healthy in the domains of physical health but have diminished abilities and impairment in the territories of mental health as well as social functioning. A Spanish study revealed (Bobes et. *al.*, 2001), that patients with obsessive-compulsive illness had rigorous impairments in all domains apart from physical

functioning. Similar findings emerged from the studies of Moritz (2005) and Eisen (2006), which exposed that the patients with obsessive compulsive disorder have poor health-related quality of life in almost all domains with the exception for physical health when compared to general population.

Various studies indicate occupational, marital and social maladjustments among people with obsessive compulsive disorder. Leon and associates (1995) reported in their study that 22% of men and 13% of women with OCD were receiving disability payments. Women with OCD were more likely to be receiving welfare payments (14% versus 3% for men), so that overall, 25% to 30% of both men and women with OCD received some type of government financial assistance. In a comparative study of OCD patients with normal samples, 22% of OCD patients were found to be unemployed (Bellodi, Sciuto, Diaferia, Ronchi & Smeraldi 1992)

According to Calvocoressi and associates (1998), 67% of OCD inpatients in their research appeared to have fair to poor family relationships. Higher rates of non-marriage for OCD patients compared with community samples and for inpatients compared with outpatients are likely due to differing severity and chronicity, with more severe OCD symptoms impairing social and sexual skills and, consequently, the likelihood of marriage. Men may be especially prone to remaining single: several studies reported that up to three quarters of male patients with OCD were unmarried, compared with half this number for women (Bellodi et. *al*, 1992; Freund & Steketee, 1989; Khanna, Rajendra & Channabasavanna, 1986).

The British National Survey of Psychiatric Morbidity surveyed approximately 10,000 people living in the United Kingdom, discovered that there were increased rates of OCD in people who were divorced and separated, in people who were unemployed and economically "inactive", and in one-parent or single person households (Jenkins et *al.*, 1997). Similarly, Sobin et *al.* (1999) found that 46% of their sample was never married, while 19% were financially supported on disability pensions. Approximately 25% were still living with their family of origin or in an assisted environment. In the same study, the impact of OCD on males was greater than females.

European and American studies have indicated that approximately half of married OCD sufferers reported experiencing marital distress. A considerable number of obsessive-compulsive patients were observed to have marital problems; with the help of behavioral interventions the patients with obsessive-compulsive disorder showed improvement regardless of quality of marital relationship and involvement of spouse in the therapy (Emmelkamp, 1990). Kringlen (1970) reported the results of a 20-year follow-up of 91 patients who had been hospitalized with obsessive compulsive disorder and stated that marital problems and occupational difficulties were common among compulsive patients.

Furthermore, obsessive compulsive disorder arrives on the literary scene as to impair family functioning in numerous ways. Researches indicate that the families of patients with obsessive-compulsive disorder are frequently more involved in the illness than the families of patients with other psychiatric disorders. Because the compulsive acts typically engage family members (Cooper, 1996; Renshaw, Steketee & Chambless, 2005). Van Noppen and colleagues (1997) assumed that the families of patients with obsessive-compulsive disorder suffer by playing several roles that vary from participating and assisting in the rituals of the patients to resisting and explicitly acting out to oppose the rituals.

The awareness and opinion in patient shows a discrepancy regarding the perception of the quality of life. The perception of quality of life varies in OCD patients and the general population. Quality of life perception is related to severity of the disorder, physical and psychiatric comorbidity and employment status (Salgado et. *al*, 2006). Obsessive compulsive disorder has been reported to co-occur with other psychological disorders specifically depression and anxiety (Saleem & Mahmood, 2009; Millet et *al*., 2004; Angst et *al*., 2003 & Kringlen, 1965) and phobia (Rasmussen & Tsuang, 1986).

The similarity in behavior between many obsessive compulsive patients and their parents probably reflects the influence of both genetic and environmental variables (Hudziak et *al*., 2004; Wolff, Alsobrook, & Pauls, 2000). OCD often occurs in families with a significant degree of unhealthy functioning (Steketee, 1997). Black and his associates (1998) examined systematically the overall functioning abilities of 15 partners of patients with obsessive-compulsive disorder. And 60% reported that attending and taking care for the relative with the illness of obsessive-compulsive was oppressive, and almost the two-thirds directly partake in the rituals of the patients.

Most sufferers (75%) reported a significant disruption in social activities and indicated the cost of treatment and the loss of wages were a significant financial burden on family (77%). These data suggest that OCD presents ongoing challenges to both the patient and the family system. Marital problems, family conflict, isolation, and financial strain are common results of the stress that OCD places on both the sufferer and the family (Hart & Björgvinsson, 2009).

Another study compared the quality of life of 60 OCD outpatients with patients suffering from depression or diabetes (Koran et *al.*, 1996). This study found that OCD outpatients were worse on instrumental role performance and social functioning than patients with diabetes and the general population. However, quality of life ratings were similar for patients with OCD and depression.

Rationale of the study

The present study aims to increase the understanding of functioning of the patients with obsessive compulsive disorder in four domains of life. The four domains include the physical health, psychological health, social relationships and the environment of the patients they live in. It also tends to explore the relationship of various demographic variables and the quality of life of obsessive compulsive patients. The researcher will meet the objective to explore the quality of life of patients with obsessive compulsive disorder by administering psychometric scales on patients with obsessive compulsive disorder.

It would focus on identifying the major problematic areas of the life of obsessive compulsive disorder patients. It would be supportive in the development of treatment methods aimed at improving quality of life. The study would make an attempt to grow evidence that obsessive compulsive disorder leads to impoverished quality of life. It would also generate understanding that comorbid symptoms can further aggravate the quality of life of patients. The researcher would probe the comorbid symptoms to explore the relationship of these symptoms with quality of life. It would also facilitate in comprehending the gender differences in quality of life among the obsessive compulsive patients. It would provide the different types and rate of common obsessions and compulsions suffered by the patients. For the accomplishment of this objective the researcher would explore the frequency of the types of obsessions and compulsions of patients with obsessive-compulsive disorder. The researcher would also examine the effects of duration of illness on the quality of life of the patients with the obsessive compulsive patients.

It would focus that ample attention should be paid to quality of life while, diagnosing and providing the therapeutic treatment to the patient with obsessive compulsive disorder. By giving a consideration to all these vital aspects the quality of life of patient could be enhanced. However, such an effort requires quality assessment on a regular basis to confirm it is accomplishing what it is intended to. At present, there is no comprehensive system for regularly monitoring quality of life for each patient in Pakistan. The gap necessitates a need to achieve a world class care for the mentally disturbed segment of the population.

A contemporary benefit would be that it would open new horizons for research on the subject of obsessive compulsive disorder. It would equip as well as inspire the present and

next generation of clinical researchers to develop clinical assessment devices, methods and techniques of greater reliability and validity with reference to obsessive compulsive disorder and various aspects of life considered clinically significant. It would be helpful in understanding through comparing the cultural variability, issues and current practices of diagnosis and treatments of obsessive compulsive patients in Pakistan with the other societies.

The present study would be helpful in assessing, diagnosing, educating and intervening patients with obsessive compulsive disorder, their families and groups. It would be beneficial for the mental health clinicians, policy makers, agencies and organizations for development of new programs and evaluative services and rehabilitation centers.

METHOD

METHOD

Objectives of the study

1. The objective of the pilot study was to investigate the quality of life of patients with obsessive compulsive disorder.
2. To explore the reliability and the suitability of the scales for the research sample/Pakistani population.
3. To identify the relationship between obsessive compulsive disorder severity and quality of life.
4. To identify the relationship between high obsessional severity and quality of life.
5. To identify the relationship between compulsion severity and quality of life.
6. To investigate the frequency of the types of obsessions and compulsions of patients with obsessive-compulsive disorder.
7. To study the gender differences in the quality of life of the patients with the obsessive compulsive patients.
8. To examine the effects of duration of illness on the quality of life of the patients with the obsessive compulsive patients.
9. To study the effects of comorbid disorder on the Quality of Life of patients with primary obsessive compulsive disorder.
10. To investigate the frequency of the types of obsessions and compulsions of patients with obsessive-compulsive disorder.
11. To explore the gender differences in the types of obsessions.
12. To explore the gender differences in the types compulsions.

Hypotheses

Following Hypotheses have been formulated for the present research.

1. Patients with obsessive compulsive symptoms will have poor quality of life.
2. Patients with high obsessional severity will indicate low quality of life.
3. Patients with high compulsion severity will show low quality of life.

4. Females with obsessive compulsive disorder have poor quality of life as compared to male with obsessive compulsive disorder.
5. Longer the duration of illness of obsessive compulsive disorder lower will be the quality of life
6. Patients with obsessive compulsive disorder have poor psychological health as compared to physical health.
7. Patients with obsessive compulsive disorder having comorbid symptoms have poorer quality of life as compared to obsessive compulsive patients without comorbid symptoms.

Research Design

The present study is comprised of three stages.

Stage I: Measuring Reliability of Scales/ Pilot Study

Study I intended to identify the reliability of the items in the scales used for the present study: Yale-Brown Obsessive Compulsive Scale and World Health Organization Quality of Life Bref.

Stage II: Measuring Quality of Life of Patients with Obsessive Compulsive Disorder

Study II aimed to study the quality of life in terms of physical health, Psychological health, social relationships and environment of the patients with obsessive compulsive disorder.

Stage III: Measuring Frequency of Obsessions and Compulsions

Study III involved reading of literature and interviews of patients to find out the common types of obsessions and compulsions. The objective was to explore the frequency of the types of obsessions and compulsions, of patients with obsessive-compulsive disorder.

Operational Definitions

Quality of Life

According to Orley and Kuyken, "An individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relation to his/her goals, expectations, standards and concerns. It is a broad-ranging concept, incorporating in a complex way the person's physical health, psychological state, social relationships, and their relationship to salient features of their environment". (The World Health Organisation, 1994). For the present study quality of life was operationally defined in terms of World Health Organization Quality of Life Bref (WHOQOL Bref).

Obsessive compulsive disorder

According to Carson (2008), Obsessive compulsive disorder is an Anxiety Disorder, defined by the occurrence of unwanted and intrusive obsessive thoughts or distressing images; these are frequently accompanied by compulsive acts and rituals which are performed to neutralize the obsessive thoughts or images or to avoid some anxiety provoking situation. For the present study Obsessive compulsive disorder was operationally defined in terms of Yale Brown Obsessive Compulsive Disorder Scale (Y-BOCS).

Obsessions

According to DSM-IV TR, obsessions are the continuous and persistent ideas, thoughts, impulses or images that are recurrent and experienced, at some point during the disturbance, as intrusive and inappropriate and cause significant anxiety and distress ... the contents of the obsession is extraterrestrial and not within the control of person (American Psychiatric Association, 2000). For the present study Obsession was operationally defined in terms of obsession scale of Yale Brown Obsessive Compulsive Disorder Scale (Y-BOCS).

Compulsions

According to DSM-IV TR, compulsions are recurring and ritualistic practices or sometimes mental acts that the person feels driven to act upon in response to an obsession, and in accordance with the characterized rules that must be followed decisively (American Psychiatric Association, 2000). For the present study Compulsion was operationally defined in terms of compulsion scale of Yale Brown Obsessive Compulsive Disorder Scale (Y-BOCS).

Sample

The sample of the present study consisted of a total of 80 (40 male and 40 female) adult diagnosed patients of obsessive compulsive disorder ranging from ages 25 to 40 years. Patients were included in the sample despite the presence of concurrent diagnosis (schizophrenia, affective disorder, anxiety disorders) with the aim to assess the effect of comorbid symptoms. The participants belonged to low (*n=17*), average (*n=43*) and high socio-economic status (*n=20*). The sample included literates (till matriculation) belonging to working (*n=29*), non-working (*n=35*) and student class (*n=15*). Purposive sampling was used for the study. The data was collected from the Outpatient Department and Inpatient Department of the government and private hospitals/clinics of Rawalpindi and Islamabad (Armed Forces Institute of Mental Health, Rawalpindi General Hospital, National Institute for Handicaps and Pakistan Institute of Medical Sciences).

Instruments

Following instruments were used in the present study:

1. ***Demographic Data Sheet***

A demographic data sheet was created to collect comprehensive data from the respondents. It consisted of variables related to the characteristics of the sample population as used in the study. The demographic data sheet comprised of variables like age, gender, education, occupation, salary income, socio-economic condition. The demographic data sheet

also included some attributes of clinical profile; length of illness, family history of illness, seeking treatment and any comorbidity.

2. Yale- Brown Obsessive Compulsive Scale (Y-BOCS)

The Yale- Brown Obsessive Compulsive Scale (Y-BOCS) developed by Goodman et, al. is a standardized, scale for measuring the severity of symptoms of obsessions and compulsions. It consists of 10 items relevant to obsessions and compulsions, presented with a 5-point Likert scale. The rating scale ranges from 0 (no symptoms) to 4 (severe symptoms). The scale consists of questions with reference to the amount of time the patient spends on obsessions, level of impairment or distress they experience, and degree of resistance and control they have over their obsessions. Additionally, the same sort of questions about time spent, interference, resistance and control are asked regarding compulsions. The total score of the scale is 40, which is the sum of 1-10 items. The total scoring reveals the severity of the symptoms of obsessions and compulsions. Each scoring range is categorized as: 0–7 sub clinical; 8–15 mild; 16–23 moderate; 24–31 severe; and 32–40 extreme.

The internal consistency for the items of Yale-Brown Obsessive Compulsve Scale is .89, inter-rater reliability is .98 and test-retest reliability is .61.

For the present study, the purpose of using Y-BOCS was two-fold. It was used as a screening device to confirm the diagnosis of patients for OCD and was also used to assess the severity of obsessions and compulsions.

3. The World Health Organization Quality Of Life (WHO QOL – Bref)

The WHOQOL-bref produces a quality of life profile. It is possible to derive four domain scores, 24 specific facet scores, and one general facet score that measures overall quality of life. For overall general health there are two items that can be examined separately: item number 1 look for the individual's overall perception of quality of life and item number 2 inquire regarding the overall perception of an individual's health. The scores of the four domains signify an individual's perception of quality of life in the subsequent domains: Physical, Psychological, Social Relationships, and Environment. Most of the domain and

facet scores are scaled in a positive direction which represents that higher score refer to higher quality of life. Some facets like pain and discomfort, negative feelings and dependence on medication are not scaled in a positive direction, denoting that for these facets higher scores do not indicate higher quality of life.

The facets are scored by means of summative scaling. Each item plays a part equally to the score. Scaling is in the direction of the facet, determined by whether the facet is positively or negatively framed. Significant numbers of facets contain questions which need to be reverse scored. For a positively framed facet, any negatively framed constituent questions are reverse scored (item no. 3, 4 and 26). None of the three negatively framed facets (Pain and Discomfort, Negative Feelings, Dependence on Medication) has any positively framed questions.

The domain score is calculated by computing the mean score of items within each domain. The method for the manual calculation of scores of each domain is as under:

Physical domain= (Q3 + Q4) + Q10 + Q15 + Q16 + Q17 + Q18)
Psychological domain= (Q5 + Q6 + Q7 + Q11 + Q19 + Q26)
Social Relationships domain= (Q20 + Q21 + Q22)
Environment domain= (Q8 + Q9 + Q12 + Q13 + Q14 + Q23 + Q24 + Q25)

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If overall 6 items are missing from a completed assessment, the assessment has to be discarded. If two items are omitted in a domain, the mean of other items in the domain is substituted. But if more than two items are omitted from the domain, the domain score should not be estimated (with the exclusion of social relationship domain, where the score should be only calculated if less than 1 item is missing).

The Cronbach alpha for each one of the four domain scores ranged from .66 to .84, indicating good internal consistency and the test-retest reliability was ranging from .68 for the Safety facet to .95 for Dependence on Medication.

Pilot Study

At preliminary level pilot study for the research was conducted for n=20. The sample of the pilot study consisted of a total of 20 (10 male and 10 female) adult diagnosed patients of obsessive compulsive disorder ranging from ages 25 to 40 years. Patients were included in the sample despite the presence of concurrent diagnosis (schizophrenia, affective disorder, anxiety disorders) with the aim to assess the effect of comorbid symptoms. The participants belonged to low (n=*4*), average (n=*8*) and high socio-economic status (n=*8*). The sample included literates (till matriculation) belonging to working (n=*4*), non-working (n=*13*) and student class (n=*3*). Purposive sampling was used for the study. The data was collected from the Outpatient Department and Inpatient Department of the government and private hospitals/clinics of Rawalpindi and Islamabad (Armed Forces Institute of Mental Health, Rawalpindi General Hospital, National Institute for Handicaps and Pakistan Institute of Medical Sciences).

The pilot subjects included the complete range and features of the subjects in the full study. It was conducted to identify the reliability of the items in the scales. It was run to estimate the probability, of the obsessive compulsive disorder and quality of life in the Pakistani population and the suitability of the scales for the research sample.

The informed consent was taken from all the patients before the administration of the scales. The respondents were informed that the study involved exploring the patient's quality of life in terms of physical health, Psychological health, social relationships and environment of the patients and that their questionnaires and results would be kept completely anonymous.

In order to estimate the reliability of the scales for the pilot study (n=20) Cronbach's alpha was computed. Cronbach alpha was used to measure internal consistency among the items. Cronbach alpha for Y-BOCS was .93 and for WHOQOL it was .91 indicating high internal consistency and suitability for the sample population.

Procedure

The informed consent was taken from all the included sources for access to the patients in order to start the process of data collection. The respondents were informed that

the study involved looking at the patient's quality of life in terms of physical health, Psychological health, social relationships and environment of the patients and that their questionnaires and results would be kept completely anonymous.

The total sample size of the study was 80, including male (n=40) and female (n=40). The sample was collected from the Outpatient Department and Inpatient Department of various government and private hospitals/clinics of Islamabad and Rawalpindi with a primary diagnosis of obsessive compulsive disorder according to DSM IV-TR. Patients were included in the sample despite the presence of concurrent diagnosis (schizophrenia, affective disorder and anxiety disorders) with the aim to assess the impact of comorbid symptoms on quality of life of patients with primary obsessive compulsive disorder.

The verbal informed consent of the patients was taken prior to the administration of the instruments for the research. The instruments were administered to measure the demographic variables and clinical characteristics of the sample patients. The patients were administered the self-designed Demographic Data Sheet to measure demographic variables. All patients completed the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) and The World Health Organization Quality Of Life (WHO QOL – Bref). The severity of obsessive compulsive symptoms was measured by using Y-BOCS. The Quality of life was measured using WHO QOL-BREF.

The literature related to obsessive compulsive disorder was extensively explored through extensive browsing on internet, and excessive exploration of books, researches, journal articles from various sources. The available literature helped to identify the common obsessions and compulsions of patients.

The clinical profile and diagnosis of the patients were also checked to explore the type of obsession and compulsion being suffered by the patients. The patients were interviewed before the administration of the scales to classify their obsessions and compulsion.

Statistical analysis was used according to the data through required statistical techniques and tools. Statistical Package for Social Sciences software (SPSS -15) was used for coding and analysis of the data.

To examine the types and frequency of obsessions and compulsions in the sample, frequency distribution was tabulated. The descriptive statistics were attained for all independent and dependent variable indicators. Descriptive statistics readings include mean and standard-deviation.

Pearson product moment correlation coefficient was calculated to assess the relationship between clinical features of OCD (such as severity of obsessive compulsive disorder; obsessional severity; compulsion severity; duration of illness; comorbid disorders) and quality of life and psychological health and physical health. T-test was estimated to study the group differences.

RESULTS

RESULTS

Table 1

Reliability Analysis of Yale-Brown Obsessive Compulsive Scale (Y-BOC) and World Health Organization Quality of Health Bref (WHO QOL Bref) (N=80)

Scale	No. of Items	Cronbach Alpha
Y- BOC	10	0.96
WHO QOL	26	0.92

Table 1 shows that Cronbach Alpha for Yale-Brown Obsessive Compulsive Scale is 0.968 which shows that the items have relatively high internal consistency. The table also indicates that alpha reliability for World Health Organization Quality of Health Bref (WHO QOL Bref) is 0.928. Both the scales are reliable.

Table 2

Pearson's Product Moment Correlations for severity of obsessive compulsive disorder, Obsessional severity, compulsion severity, duration of illness, comorbid symptoms and quality of life. (N=80)

	Quality of life	
	r	Sig.
Obsessive Compulsive Disorder Severity	-0.637**	.000
Obsessional Severity	-0.621**	.000
Compulsion Severity	-0.611**	.000
Duration of Illness	-.171	.129

The table 2 indicates that the results are highly significant at 0.01level. The sample data supports the hypothesis i.e. "Patients with obsessive compulsive symptoms will have poor quality of life." The results show that the severity of obsessive compulsive disorder has a negative correlation with Quality of life of patients. The table indicates that the results are highly significant at 1% level of significance. The sample data supports the hypothesis i.e. "Patients with high obsessional severity will indicate low quality of life." The results of the study show that obsessional severity has a highly significant negative correlation with Quality of life of patients with obsessive compulsive disorder. The table indicates that the results are highly significant at the 0.01 level of significance. The sample data supports the hypothesis i.e. "Patients with high compulsion severity will show low quality of life." The findings of the study reveal that compulsion severity has a negative correlation with Quality of life of patients with obsessive compulsive disorder. The table indicates that the results to some extent support the hypothesis i.e. "Longer the duration of illness of obsessive compulsive disorder lower will be the quality of life." The results of the study bring to light that duration of illness of obsessive compulsive disorder has a slightly negative correlation with quality of life of patients with obsessive compulsive disorder.

Table 3

Mean, Standard deviation and t-value for Obsessive compulsive disorder severity and Quality of life. (N=80)

	Gender					
	Male (n=40)		Female (n=40)			
Scale	***M***	***SD***	***M***	***SD***	***t***	***p***
Obsessive Compulsive Disorder Severity	30.71	7.12	30.12	7.69	0.35	0.72
Quality of Life	66.58	13.81	69.95	19.5	-0.88	0.379.

df=78

The table 3 reveals the t-test results computed to asses the gender differences among the patients with obsessive compulsive disorder regarding the severity of the symptoms and quality of life. The result yielded a relatively low degree difference between male and female on both the variables. The result indicates a slightly insignificant differences in the severity of obsessive compulsive disorder between males (M = 30.71, SD = 7.12) and females (M =30.12, SD = 7.6), t = 0.35, p = 0.721. The results also show an insignificant difference in the quality of life among the male (M = 66.58, SD = 13.81) and females (M =69.95, SD = 19.5), t= -0.88, p = 0.379.

Table 4

Pearson's Product Moment Correlations for psychological health and physical health with obsessive compulsive disorder. (N=80)

	Obsessive Compulsive Disorder	
Domains	***r***	**Sig.**
Physical Health	-.539*	.061
Psychological Health	-.602**	.000

The Table 4 reveals that as hypothesized the score of the patients fell significantly lower on the psychological health facet as compared to physical health. Thus, the results support that the patients with obsessive compulsive disorder have poor psychological health as compared to physical health.

Comparison of Obsessive Compulsive Patients With and Without Comorbidity

Table 5

Mean, Standard deviation and and t-value of patients with comorbidity and without comorbidity on quality of life scale and its subscales. (N=80)

	Comorbidity					
	Patients With Comorbidity (n=37)		*Patients Without Comorbidity (n=43)*			
Scale	***M***	***SD***	***M***	***SD***	***t***	***p***
Quality of Life	62.40	17.94	73.39	14.40	-3.03**	.003
Physical Health	16.45	4.45	19.00	3.48	-2.80	.007
Psychological Health	15.32	4.15	16.97	3.73	-1.85	.067
Social Relationship	6.32	2.59	8.02	2.79	-2.81	.006
Environment	19.72	7.76	23.62	6.42	-2.42	.018

df=78

Table 5 indicates that there is a highly significant difference between the two groups of patients i.e patients of OCD with comorbidity (n=37) and without comorbidity (n=43). The scores indicate that there is significant difference between quality of life of the patients with comorbidity (M = 62.40, SD = 17.94) and patients without comorbidity (M =73.39, SD = 14.40), t= -3.03, p = 0.003. The results suggest that OCD patients either with or without comorbidity, both have poor quality of life. But OCD patients with comorbidity have significantly decreased total quality of life as compared to OCD patients without comorbidity.

The scores indicate that there is significant difference between physical health of the patients with comorbidity (M = 16.45, SD = 4.45) and patients without comorbidity (M =19.00, SD = 3.48), t = -2.80, p = 0.007. The results suggest that OCD patients either with or without comorbidity, both have poor physical health. But OCD patients with comorbidity have significantly decreased score on physical health as compared to OCD patients without comorbidity.

The results reveal a significant difference in the scores of psychological health of the OCD patients with comorbidity (M = 15.32, SD = 4.15) and OCD patients without comorbidity (M =16.97, SD = 3.73), t = -1.85, p = 0.067. The results suggest that OCD patients either with or without comorbidity, both have poor psychological health. But OCD patients with comorbidity have significantly decreased psychological health as compared to OCD patients without comorbidity.

The results reveal the comparison of OCD patients with comorbidity and OCD patients without comorbidity on the domain of social relationships. There is a significant difference in the scores of social relationship of the OCD patients with comorbidity (M = 6.32, SD = 2.59) and OCD patients without comorbidity (M =8.02, SD = 2.79), t = -2.81, p = 0.006. The results suggest that OCD patients either with or without comorbidity, both have poor social relationships. But OCD patients with comorbidity have significantly reduced social relationships as compared to OCD patients without comorbidity.

The results indicate that there is a significant difference in the scores of environmental domain of the OCD patients with comorbidity (M = 19.72, SD = 7.76) and OCD patients without comorbidity (M =23.62, SD = 6.42), t = -2.42, p = 0.018. The results suggest that OCD patients either with or without comorbidity, both have poor social relationships. But OCD patients with comorbidity have significantly reduced social relationships as compared to OCD patients without comorbidity.

The results indicate the difference of the two groups of patients in the four domains of quality of health i.e. physical health, Psychological health, social relationship and environment. It is evident from the results that the patients with comorbid symptoms have poorer quality of life in all the domains as compared to patients without comorbid symptoms.

Table 6

Frequency & Percentage of Types of Obsessions. (N=80)

Types of Obsessions	Total Sample (N=80)	
	f	%
Dirt & Contamination	50	62.5
Fear of losing & insecurity	6	7.5
Checking	3	3.8
Religious thoughts	2	2.5
Arrangement & order	2	2.5
Miscellaneous Obsessions	8	10.0
Multiple Obsessions	9	11.3
Total	80	100.0

Table 7 reveals the obsessional patterns of the 80 patients. The results indicate that 62% patients displayed obsessions related to dirt and contamination, Fear of losing & insecurity 7.5%, Checking 3.8, Religious thoughts 2.5, arrangement & order 2.5, Miscellaneous Obsessions 10%, Multiple Obsessions 11.3 % (Multiple obsessions i.e percentage of sample exhibited more than 1 obsessions).

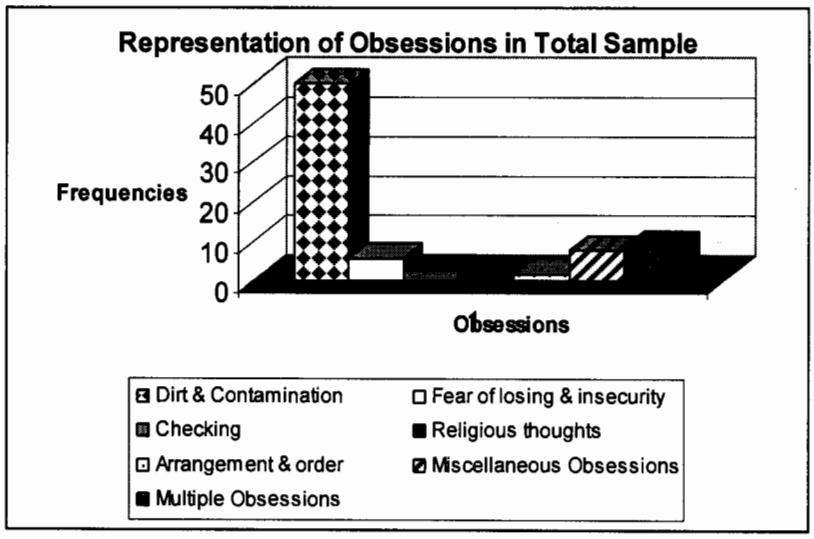


Table 7

Gender wise Frequency & Percentage of obsessions (N=80).

Types of Obsessions	Gender			
	Males *(n=40)*		Females *(n=40)*	
	f	%	*f*	%
Dirt & Contamination	24	30	26	32.5
Fear of losing & insecurity	3	7.5	3	7.5
Checking	1	2.5	2	5
Religious thoughts	2	5	0	0
Arrangement & order	1	2.5	1	2.5
Miscellaneous Obsessions	2	5	6	15
Multiple Obsessions	7	17.5	2	5
Total	40	100.0	40	100.0

Table 8 indicates the different patterns of obsessions among males and females. The most common obsession among the males and females appears to be regarding dirt and contamination i.e 30% and 32.5% respectively. A minor presentation of data exhibits a pattern of multiple obsessions. The results show that males and females have no major marked difference in the frequency of the various types of obsessions. But as far as multiplicity of obsessions is concerned, males have relatively high trends of multiple obsessions as compared to females.

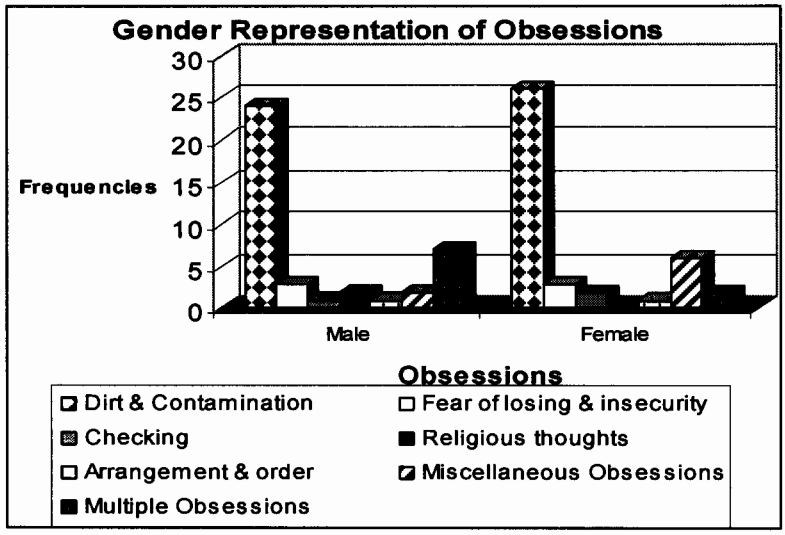


Table 8

Frequency & Percentage of Types of Compulsions (N=80).

Types of Compulsions	Total Sample (N=80)	
	f	%
Washing & Cleaning	51	63.8
Checking	7	8.8
Arrangement & Ordering	6	7.5
Hoarding	2	2.5
Miscellaneous Compulsions	3	3.8
Multiple compulsions	11	13.8
Total	80	100.0

Table 9 reveals the representation of compulsions. The results indicate that 63.8% patients displayed compulsions related to Washing & Cleaning, Checking 8%, Arrangement & Ordering 7.5%, Hoarding 2.5%, Miscellaneous Compulsions 3.8% and Multiple compulsions 13.8% (Multiple compulsions i.e % of sample exhibited more than 1 ritual).

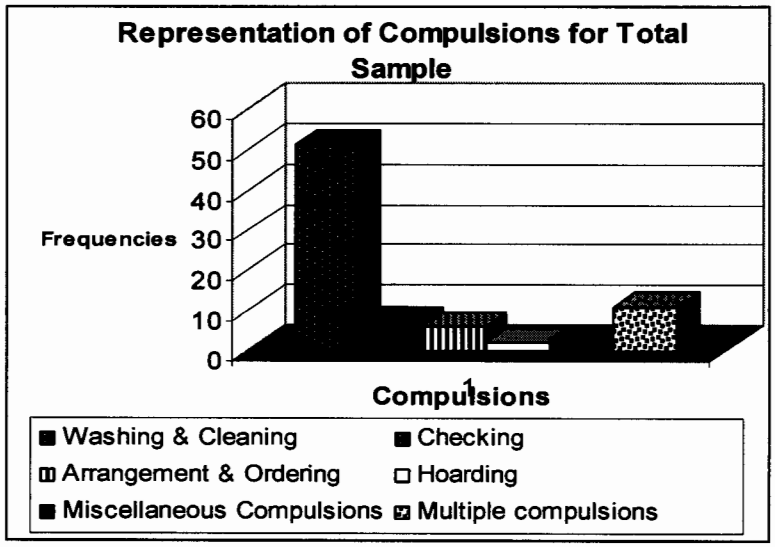
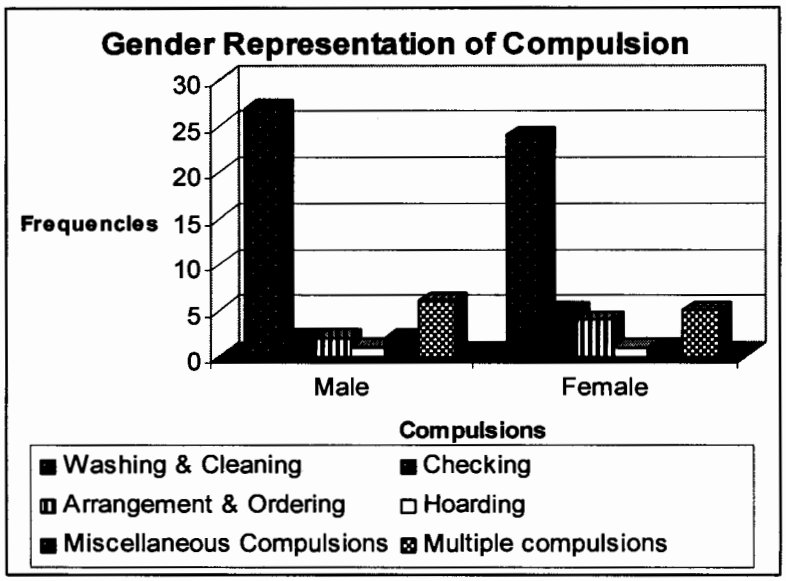


Table 9

Gender wise Frequency & Percentage of Compulsions (N=80).

Types of Compulions	Gender			
	Males (n=40)		Females (n=40)	
	f	%	*f*	%
Washing & Cleaning	27	67.5	24	60
Checking	2	5	5	12.5
Arrangement & Ordering	2	5	4	10
Hoarding	1	2.5	1	2.5
Miscellaneous Compulsions	2	5	1	2.5
Multiple compulsions	6	15	5	12.5
Total	40	100.0	40	100.0

The table 10 indicates the different patterns of compulsions among males and females. The most frequent compulsion found among the males and females of the present study emerges out to be washing and cleaning, 67.5% and 60% respectively. A minor occurrence of multiple obsessions is also revealed by the results. The table shows that males and females have no major marked differences in the frequency of the various types of compulsions.



DISCUSSION

DISCUSSION

The present study exhibits a considerable impairment in quality of life of the patients with obsessive compulsive disorder. Noticeable impairment was found in all the specific domains of Quality of Life that were considered for the measurement, including Physical, Psychological, Social Relationships, and Environment. Past studies have indicated that the patients with obsessive compulsive disorder show a greater impairment in many aspects of quality of life (Koran et al., 1996; Antony et al., 1998).

Obsessional thoughts, images, and impulses provide augmentation to distress and anxiety, while compulsions symbolize the approaches to reduce the distress anxiety that is produced by the obsessions (Rachman & Hobson 1980). This well-designed relation between obsessions and compulsions due to their association is considered as a part of the disorder's nosological explanation (American Psychiatric Association, 2000). Since obsessions are experienced as intrusive and uncontrollable, they generate distress, and compulsions—which, are recognized as irrational but indispensable by the patient to manage anxiety and distress, they have a greater association with QOL.

The present study included the investigation of demographic and clinical predictors of quality of life of patients with obsessive compulsive disorder. It revealed that age, gender, marital status, education did not have an effect on quality of life. But comorbidity had highly significant and duration of illness had somewhat significant association with quality of life. This suggests that above and beyond severity of symptoms some other factors related to demographics affect the quality of life of patients with obsessive compulsive disorder (Rapaport et al., 2005). Some studies quote that age, gender, marital status, education attained, and duration of illness had no impact on Quality of life (Koran, 1996; Salgado, 2006 & Solanki, 2010).

The findings of the present study reveal that the prevalence of obsessions related to dirt and contamination was the highest. The other common obsessions indicated by the results

were fear of losing & insecurity, checking, religious thoughts, arrangement & order, multiple obsessions. Saha & Gupta (2000) studied phenomenology of OCD and conclude that the most common obsessions were dirt and contamination (52%) and aggression (32.5%).

Predominantly the compulsions revealed by the results of the present study included washing & Cleaning, checking, arrangement and ordering, counting, checking, repeating actions, hoarding and multiple compulsions. The most frequent compulsion found was washing and cleaning. Literature review of 65 studies within the realm of the behavioral treatment researches indicate that, 75% of OCD treatment population was found to have cleaning or checking compulsions (Ball, Baer, & Otto, 1996). According to Gadit (2003) the most common compulsions in Pakistan community are checking, washing and counting. An occurrence of multiple obsessions is also revealed by the results. Researches indicate that nearly half of patients of obsessive compulsive disorder suffer from more than one ritual (Reed, 1985; Rasmussen and Tsuang 1986).

The results indicated different gender wise patterns of obsessions and compulsions. A significantly higher frequency of obsessions related to dirt and contamination in males and females was found. There was no significant difference in terms of the frequency of types of obsessions between the two groups. A minor presentation of data exhibited a pattern of multiple obsessions. But as far as multiplicity of obsessions is concerned, males had relatively higher trends of multiple obsessions as compared to females. Similar trends of higher frequency of fear of impurity and fear of contamination were found by Tükel, Polat, Genç, Bozkurt, & Atlı (2004).

The most frequent compulsion found among the males and females of the present study emerged out to be washing and cleaning. A less significant occurrence of multiple obsessions was also found by the results. The males and females had no major marked differences in the frequency of the various types of compulsions.

The results showed that the severity of obsessive compulsive disorder has a negative correlation with Quality of life of patients. The obsessive-compulsive disorder impairs the patients' quality of life (Koran 1996). Similar results were confirmed by various other researches describing that obsessive compulsive disorder leads to a decline in quality of life of patients (Masellis, Rector & Richter, 2003; Eisen et al., 2006).

The results of the study reveal that obsessional severity produces a significant impairment in the quality of life of patients with obsessive compulsive disorder. Many studies identified that obsessional severity has a significant impact on the quality of life of patient (Masellis, Rector & Richter, 2003; Eisen, 2006 & Salgado, 2006). The Obsessive Compulsive patients recognize that their thoughts are illogical and unreasonable, but still are persistent intrusive and are extremely distressing and annoying. Apart from their content, the excessive length of many rituals and frequency of obsessive thoughts are troubling and decrease QoL. When these remain untreated, obsessions are likely to get worse and stretch out over time (Moritz et al., 2002).

The results of the study confirmed that compulsion severity leads to lower quality of life of patients with obsessive compulsive disorder. Compulsions, as the most prominent characteristic of OCD are strongly correlated with quality of life in a number of studies (Wenzke, Kroll, Heller, Matschinger, & Angermeyer, 2007; Eisen, 2006 & Moritz et al., 2005).

The results indicated that obsessive compulsive disorder has a negative correlation with physical health, psychological health, social relationships and environmental domains of the life of patients with obsessive compulsive disorder. The results are statistically highly significant for the domains of quality of life i.e. physical health, psychological health, social relationship. The scores on physical health are relatively higher as compared to the other three domains. This reveals that obsessive compulsive disorder impairs the psychological health, social relationships and environment much more than physical health.

The results of the present study showed constancy with previous findings that patients with obsessive compulsive disorder have significantly decreased quality of life scores for psychological health as compared to physical health. Some prior researches confirm that OCD patients show relatively better scores on quality of life for physical health domain than psychological health (Chakrabarti, Kulhara & Verma, 1993; Salgado et al, 2006; Solanki, 2010). The areas of physical health seem to be affected to a lesser extent as compared to other aspects of quality of life (Bobes et al., 2001).

Obsessive-compulsive disorder, the obsessional thoughts and compulsive behaviors cause tremendous distress, take up a lot of time, and interfere with the daily routines, educational and occupational functioning and social relationships. Obsessive compulsive disorder can generate barriers in maintaining a healthy social life and participating in activities within as well as outside of the marital relationship. Many social interactions or activities are averted by the patients for the reason that they may require getting in touch with an OCD trigger.

The results also put forward that symptoms of OCD can be detrimental to social relationships of the patients. Correlation revealed that obsessive compulsive disorder was negatively correlated with the social relationships. This suggests that obsessional thinking and compulsive acts significantly interferes with the social relationship functioning. Conceivably individuals who have obsessive compulsive symptoms are preoccupied with their persistent thoughts and are mostly indulged in their compulsive rituals to such an extent that they have a lesser time and lesser mental energy to offer to their friends and family. The results are supported by the study of Koran (2000), which states that obsessive compulsive disorder may have a major negative influence on the social relationships of the OCD sufferers leading to frequent family and marital discord or dissatisfaction, separation or divorce (Koran, 2000). Several studies with reference to obsessive compulsive disorder have established lower rates of marriage among people with OCD (Matsunaga, 2000; Bellodi et. al, 1992; Freund & Steketee,1989). OCD renders the patient less likely to be sufficiently adaptive for marriage (Lensig, 1996). According to Antony and his associates, obsessive compulsive disorder also interferes with leisure activities and peer-group relationship (Antony *et al.*, 1998). It also interferes with an individual's ability to study or work, leading to diminished educational and/or occupational attainment and unemployment (Koran, 2000; Leon *et al.*, 1995 & Campbell et al., 1976).

The results revealed that any comorbidity with obsessive compulsive disorder has a negative correlation with Quality of life of patients. That is, prevalence of other psychological disorders with obsessive compulsive disorder is associated with lower quality of life. The comorbidity of OCD with other psychological disorders brings about a considerable worsening of quality of life (Hantouche et al., 1995 & Rasmussen & Eisen, 1992).

In harmony with previous researches, the present study observed that patients with obsessive compulsive disorder having comorbid disorders tend to have significantly lower quality of life than patients with Obsessive Compulsive Disorder without comorbidity, although both of the groups have significantly worse quality of life. The results of the present study regarding poorer quality of life among the comorbid patients is consistent with the studies of Sanderson & Andrews (2002), which exhibited that comorbidity in wide-ranging has a negative influence on nearly all aspects of life. The findings are also consistent with the studies of Quilty et al. (2003) and Salgado et al., (2006).

CONCLUSION

The present study confirms that obsessive compulsive disorder impairs the quality of life of patients. OCD hampers the activities and functioning of patients in various aspects of life which include physical health, psychological health, social relationships and environment. Quality of life is correlated with obsessional severity and compulsion severity. OCD patients require interventions that enhance the functioning in all areas of life and thus decrease the impairment. The clinicians should thoroughly explore for the comorbidity of psychological disorders so that they may be targeted to attain a complete successful treatment.

LIMITATIONS & RECOMMENDATIONS

The sample was not large enough to assess the associations between obsessive compulsive symptoms and specific aspects of QOL.The small sample size might have affected results, for example; association between duration of illness and quality of life may have reached a highly significant statistical significance in a larger sample.

There were no specific psychological instruments used for the screening of the comorbid psychological disorders.

The current study included patients with DOI of 2 years or more to make the sample homogenous, which limits the generalization of results to OCD patients having an acute illness.

The study had a mixed sample of individuals with varied history, patient seeking treatment as well as patients not seeking treatment and levels of current treatment. Therefore, the treatment may have minimized the full impact of symptom on Quality of life.

In addition, patients were assessed at only one time point. However, the relationship between changes in Obsessive Compulsive Disorder symptoms and changes in domains of Quality of life can best be evaluated over a period of time. The constant and repeated observation of the study participants will permit to more completely understand the interaction between severity of OCD and its relationship with QOL.

The medicines can have an impact on the quality of life of patients. The present study did not examine the effect of pharmacologic interventions on quality of life. The role of treatment in enhancing Quality of life in OCD patients certifies further investigation. Merely a couple of studies have observed change in QOL with treatment, commonly finding progress after pharmacologic intervention. Additional research is needed to measure which characteristics of Quality of life and psychosocial functioning are aided by pharmacological interventions and cognitive behavioral therapy. So that detailed and well-designed treatments can be directed to the particular psychosocial functioning deficits.

Despite these limitations, this study demonstrates the direct association between obsessive compulsive disorder and Quality of life.

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ANNEXURE

Before you begin we would like to ask you to answer a few general questions about yourself: by circling the correct answer or by filling in the space provided.

Age ☐ 25 – 30 ☐ 30 – 35 ☐ 35 – 40	
Gender ☐ Male ☐ Female	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐Widowed
Education	☐ Primary ☐ Matric ☐ Intermediate ☐ Bachelors ☐ Masters
Occupation	
Salary Income	☐ 5,000 – 15,000 ☐ 16,000 – 26,000 ☐ 26,000 – 30,000 ☐ 30,000 above
Social Economic Condition	☐ Above Average ☐ Average ☐ Below Average
Length of Illness	☐ 1 – 2yr ☐ 3 – 4yr ☐ 5 – 6yr ☐ 6 yr above
Seeking Treatment	☐ Yes ☐ No
Any Comorbidity	
Family History of Mental Illness	

Instructions

This assessment asks how you feel about your quality of life, health, or other areas of your life. **Please answer all the questions.** If you are unsure about which response to give to a question, **please choose the one** that appears most appropriate. This can often be your first response.
Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last two weeks.** For example, thinking about the last two weeks, a question might ask:

	Do you get the kind of support from others that you need?	Not at all	Not much	Moderately	A great deal	Completely
		1	2	3	4	5

You should circle the number that best fits how much support you got from others over the last two weeks. So you would circle the number 4 if you got a great deal of support from others as follows. You would circle number 1 if you did not get any of the support that you needed from others in the last two weeks. Please read each question, assess your feelings, and circle the number on the scale for each question that gives the best answer for you.

THE WHOQOL-BREF

1.	How would you rate your quality of life?	Very poor 1	Poor 2	Neither poor nor good 3	Good 4	Very good 5
2.	How satisfied are you with your health?	1	2	3	4	5
	The following questions ask about **how much** you have experienced certain things in the last two weeks.					
		Not at all	A little	A moderate amount	Very much	An extreme amount
3.	To what extent do you feel that (physical) pain prevents you from doing what you need to do?	1	2	3	4	5
4.	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5.	How much do you enjoy life?	1	2	3	4	5
6.	To what extent do you feel your life to be meaningful?	1	2	3	4	5
		Not at all	A little	A moderate amount	Very much	Extremely
7.	How well are you able to concentrate?	1	2	3	4	5
8.	How safe do you feel in your daily life?	1	2	3	4	5
9.	How healthy is your physical environment?	1	2	3	4	5
	The following questions ask about **how completely** you experience or were able to do certain things in the last two weeks.					
		Not at all	A little	Moderately	Mostly	Completely
10.	Do you have enough energy for everyday life?	1	2	3	4	5
11.	Are you able to accept your bodily appearance?	1	2	3	4	5
12.	Have you enough money to meet your needs?	1	2	3	4	5
13.	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14.	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5
		Very poor	Poor	Neither poor nor good	Good	Very good
15.	How well are you able to get around?	1	2	3	4	5

	The following questions ask you to say how **good or satisfied** you have felt about various aspects of your life over the last two weeks.					
		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16.	How satisfied are you with your sleep?	1	2	3	4	5
17.	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18.	How satisfied are you with your capacity for work?	1	2	3	4	5
19.	How satisfied are you with yourself?	1	2	3	4	5
20.	How satisfied are you with your personal relationships?	1	2	3	4	5
21.	How satisfied are you with your sex life?	1	2	3	4	5
22.	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23.	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24.	How satisfied are you with your access to health services?	1	2	3	4	5
25.	How satisfied are you with your transport?	1	2	3	4	5
	The following question refers to **how often** you have felt or experienced certain things in the last two weeks.					
		Never	Seldom	Quite often	Very often	Always
26.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Annexure B

Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

Note: Scores should reflect the composite effect of all the patient's obsessive compulsive symptoms. Rate the average occurrence of each item during the prior week up to and including the time of interview.

Obsession Rating Scale (circle appropriate score)

Item	Range of Severity				
1. Time Spent on Obsessions	0 hr/day	0–1 hr/day	1–3 hr/day	3–8 hr/day	> 8 hr/day
Score:	0	1	2	3	4
2. Interference From Obsessions	None	Mild	Definite but manageable	Substantial impairment	Incapacitating
Score:	0	1	2	3	4
3. Distress From Obsessions	None	Little	Moderate but manageable	Severe	Near constant, disabling
Score:	0	1	2	3	4
4. Resistance to Obsessions	Always resists	Much resistance	Some resistance	Often yields	Completely yields
Score:	0	1	2	3	4
5. Control Over Obsessions	Complete control	Much control	Some control	Little control	No control
Score:	0	1	2	3	4

Obsession subtotal (add items 1-5) _____

Compulsion Rating Scale (circle appropriate score)

Item	Range of Severity				
6. Time Spent on Compulsions	0 hr/day	0–1 hr/day	1–3 hr/day	3–8 hr/day	> 8 hr/day
Score:	0	1	2	3	4
7. Interference From Compulsions	None	Mild	Definite but manageable	Substantial impairment	Incapacitating
Score:	0	1	2	3	4
8. Distress From Compulsions	None	Mild	Moderate but manageable	Severe	Near constant, disabling
Score:	0	1	2	3	4
9. Resistance to Compulsions	Always resists	Much resistance	Some resistance	Often yields	Completely yields
Score:	0	1	2	3	4
10. Control Over Compulsions	Complete control	Much control	Some control	Little control	No control
Score:	0	1	2	3	4

Compulsion subtotal (add items 6–10) _____