

Quality of Life in OCD: Differential Impact of Obsessions, Compulsions, and Depression Comorbidity

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Objective: An anxiety disorder severely affects the sufferer's quality of life (QOL), and this may be particularly true of those with obsessive-compulsive disorder (OCD). This study examines the differential impact of obsessions, compulsions, and depression comorbidity on the QOL of individuals with OCD.

Method: Forty-three individuals diagnosed with OCD according to DSM-IV criteria and experiencing clinically significant obsessions and compulsions completed measures of QOL, obsessive-compulsive symptom severity, and depression severity.

Results: Obsession severity was found to significantly predict patient QOL, whereas the severity of compulsive rituals did not impact on QOL ratings. Comorbid depression severity was the single greatest predictor of poor QOL, accounting for 54% of the variance.

Conclusions: Given the importance of these symptoms, treatments that directly target obsessions and secondary depression symptoms in OCD are warranted. However, replication of these findings in a prospective cohort study is required, because although the current study's cross-sectional design allows for the examination of the associations among obsessions, depression, and QOL, it cannot establish their temporal framework (that is, causal relations).

(Can J Psychiatry 2003;48:72-77)

Information on funding and support and author affiliations appears at the end of the article.

Clinical Implications

Clinical obsessions and compulsions are both associated with poor quality of life (QOL). When the covariation between obsessions and compulsions is taken into account, obsessional severity appears to account for the decrements in QOL observed in those with obsessive-compulsive disorder (OCD).

The presence of comorbid depression in OCD is the greatest predictor of poor QOL.

Treatments that directly target obsessions and secondary depressive symptoms in OCD are required.

Limitation

The cross-sectional examination of the relation between obsessions, compulsions, secondary depression, and QOL does not provide the opportunity to determine causal relations among these variables.

Key Words: *obsessive-compulsive disorder, OCD, obsessions, compulsions, quality of life, QOL, illness intrusiveness*

Obsessive-compulsive disorder (OCD) is a severe and debilitating anxiety disorder afflicting about 1 adult in 40, or approximately 2.5% of the population, at some time in their lifetime (1-3). It is twice as prevalent as schizophrenia and

bipolar disorder, and the fourth most common psychiatric disorder (4). In severe cases, which may define upward of 20% of those with the diagnosis (5), obsessions and compulsions can occupy the entire day and result in profound disability. If un-

treated, the probability of symptom remission is extremely low (6). Perhaps more than any other anxiety disorder, OCD is characterized by a chronic waxing and waning of symptoms.

There has been little examination of the extent to which the presence of persistent obsessions and compulsions impact on the QOL of persons with OCD. A recent review of the impact of anxiety disorders on QOL enumerated the profound personal, social, and financial costs associated with anxiety disorders, although there was a striking dearth of studies conducted on patients with OCD (7). A survey study by Hollander and others demonstrated that 73% of OCD patients have impaired family relationships, 62% have impaired friendships, 58% experience academic underachievement, 47% experience interference with work, and 40% are chronically underemployed or simply unemployed (8). Two subsequent studies with more reliable and valid QOL measures have also found important decrements in the QOL of those with OCD. Koran and colleagues found that QOL (that is, instrumental role performance and social functioning) was more severely impaired in those with OCD than in those with chronic medical conditions (for example, diabetes) or in the general population (9). Antony and colleagues examined the extent of impairment in multidimensional aspects of QOL in OCD and other disorders of the anxiety spectrum, including panic disorder and social phobia, and found that all 3 groups had equivalent and significantly more impaired scores than did patients experiencing a range of chronic medical conditions (10). Selective aspects of QOL were found to be especially affected in OCD, such as the ability to read and carry out other tasks that require deliberate and sustained focus (10).

To date, no study has examined whether obsessions and compulsions produce independent effects on QOL. While most patients with OCD experience both obsessions and compulsions, it may be that individuals with OCD are more affected by the intrusive, obsessional aspect of the disorder than they are by the time-consuming, interfering rituals. On the one hand, obsessions may be particularly disruptive because they interfere in conscious, intentional activities such as reading, writing, counting, and simply sustaining concentration. Antony and colleagues found that the QOL dimension that most distinguished patients with OCD from patients with other anxiety disorders was the level of impairment in intentional activities (10), an impairment that could be hypothesized to relate to the occurrence of obsessions, rather than compulsions.

Conversely, time-consuming overt and covert rituals often prevent the initiation and pursuit of life goals and, therefore, may be the more pernicious factor. Getting “stuck” in repetitive hand-washing, checking, and other rituals leads individuals to miss out on social occasions, to fail to accomplish tasks within the work setting, to experience distress and tension in

their important relationships, and to experience recurrent embarrassment and shame. One of this study’s the primary aims was to assess the unique and additive effects of obsessions and compulsions on QOL in individuals with OCD.

A second, related aim was to assess the effect of comorbid depression symptoms on the QOL of persons with primary OCD. This is an extremely important issue, given that more than any other anxiety disorder, OCD is often complicated by depression comorbidity. Epidemiologic studies have documented the naturally occurring high rates of comorbidity between these disorders in the community. In the Epidemiologic Catchment Area (ECA) study, 31.7% of OCD patients were diagnosed with a concurrent comorbid major depressive disorder (MDD) (1). In the National Collaborative Group study, the lifetime comorbidity of MDD and OCD extended to 60.3%, depending on the country (11). Similarly, rates of concurrent major depression in those presenting to treatment clinics with OCD have been in the range of 28% to 38% (4,6,12–14). In addition to categorical assessment of diagnosable comorbid major depression, it has been estimated that upward of 75% of patients with OCD experience subclinical depressive states (15). Studies have also linked depression to greater chronicity (16,17) and severity (16,18) of the course of OCD.

In summary, this study aimed to examine the QOL of individuals with OCD and the specific impact of the obsessions, compulsions, and depression comorbidity. We hypothesized that the severity of obsessions and compulsions would directly impact on QOL ratings, so that the more severe these symptoms, the poorer the patient’s QOL. We also hypothesized that the presence of depression would impact negatively on QOL.

Methods

Clinical Sample

For this study, we recruited 43 consecutively referred patients meeting DSM-IV (19) criteria for OCD, based on the Structured Clinical Interview for Axis I Disorders (SCID-1/P, version 2.0) (20). All patient participants were recruited from the Anxiety Disorders Clinic at the Centre for Addiction and Mental Health, Clarke Site (a large, university-based, teaching hospital in Toronto, Ontario). To be eligible for inclusion, participants had to be between the ages of 18 and 65 years and experiencing clinically significant obsessive and compulsive symptoms. Patients were excluded if they had a concurrent diagnosis of schizophrenia, bipolar disorder, or current substance use disorder. Table 1 summarizes the demographic and clinical characteristics of the patient sample.

Table 1 Demographic and clinical characteristics of the study participants with OCD (n = 43)

	n (%)
Sex	
Male	18 (41.9)
Female	25 (58.1)
Ethnicity	
European	42 (97.7)
East Indian	1 (2.3)
Marital status	
Single	25 (58.1)
Married or cohabiting	16 (37.3)
Separated, divorced, or widowed	2 (4.7)
Level of education completed	
Did not complete high school	3 (7)
Completed high school	17 (39.5)
Completed college or university	17 (39.5)
Completed graduate or profess. degree	6 (14)
	Mean (SD)
Age (years)	34.9 (8.0)
Onset-age (years)	14.4 (9.0)
Y-BOCS obsessions	9.9 (4.5)
Y-BOCS compulsions	9.7 (4.2)
Y-BOCS total	19.7 (8.4)
BDI	16.7 (12.0)
IIRS	45.7 (17.7)
BDI = Beck Depression Inventory; IIRS = Illness Intrusiveness Rating Scale; OCD = obsessive-compulsive disorder; Y-BOCS = Yale-Brown Obsessive Compulsive Scale	

Clinical Measures

All participants completed the clinician version of the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) (21,22), the Illness Intrusiveness Rating Scale (IIRS) (24), and the Beck Depression Inventory (BDI) (27). The Y-BOCS is a standardized, clinician-administered scale for assessing severity of clinical obsessions and compulsions. It comprises 10 items pertaining to obsessions and compulsions, rated on a 5-point Likert scale ranging from 0 (no symptoms) to 4 (severe symptoms); it has been shown to possess high internal consistency and validity (21,22). The IIRS is designed to measure objective and perceived interference of symptoms across 13 life domains considered important to QOL. These domains include health, diet, work, active and passive recreation, financial situation, relationship with spouse, sex life, family and other social relationships, self-expression, self-improvement, religious expression, community involvement, and civic involvement. Ratings are according to a 7-point Likert scale ranging from 1 (not very much) to 7 (very much). Individual item ratings are summed to provide an overall index of illness intrusiveness. The total scale ranges from 13 (minimum intrusiveness) to 91 (extreme intrusiveness) (23,24). The IIRS

has been the measure of choice in other studies examining QOL in OCD (10). It has also received psychometric validation in the spectrum of anxiety disorders (25). Finally, the BDI is a 21-item (4-point scale), self-report instrument designed to assess depressive symptom severity. The BDI has been shown to be a reliable and well-validated measure of depressive symptomatology (26,27).

Statistical Methods

To identify the symptoms predicting illness intrusiveness in OCD, we conducted linear regression analyses with the Statistical Package for the Social Sciences (SPSS), version 10.0 (28). Two regressions were conducted. The first aimed to determine whether any of the clinical or demographic variables predicted illness intrusiveness. In the second analysis, the independent variables in the multiple regression equation included BDI, Y-BOCS obsession, and Y-BOCS compulsion scale scores. Not only did we expect the Y-BOCS obsession and compulsion scores to correlate highly, we also anticipated that the Y-BOCS scales would correlate positively with depression severity. Thus, the linear regression analysis would control for the multicollinearity among these variables.

Results

To determine whether clinical or demographic variables predicted illness intrusiveness, we entered current age, age of onset, marital status, sex, and education as a block. Collectively, these variables were shown not to predict illness-intrusiveness scores: $F_{5,41} = 0.91$, $R = 0.33$, $P = 0.49$, and none of the variables entered the final equation (all t 's < 1.6 ; ns). Therefore, we did not include clinical and demographic variables in the equation examining the impact of OCD symptoms and comorbid depression on illness intrusiveness.

Next, we explored the pattern of associations between Y-BOCS obsession and compulsion scores and illness intrusiveness via zero-order Pearson correlation analyses. Both Y-BOCS obsession ($r = 0.62$, $P < 0.01$) and compulsion ($r = 0.53$, $P < 0.01$) scores were found to correlate significantly and positively with greater illness intrusiveness. To gauge the independent contribution of Y-BOCS obsession and compulsion scores in predicting illness-intrusiveness scores, and to examine at the same time the association between depression scores and illness intrusiveness, we conducted a hierarchical regression analysis. In this analysis, Y-BOCS obsession and compulsion scores and BDI scores served as the independent predictors, entered as a block. Illness-intrusiveness scores represented the dependent variable. The results from the regression analysis indicated that, overall, the model significantly predicted illness intrusiveness: $F_{3,42} = 22.69$, $R = 0.80$, $P = 0.0001$. When we examined the individual variables that entered the equation, depression severity was shown to significantly predict illness intrusiveness (BDI) ($t = 5.15$, $P <$

0.0001), with higher depression scores associated with greater illness intrusiveness. Obsessional severity also entered the final model and was found to significantly predict illness intrusiveness ($t = 2.09, P < 0.05$), with greater illness intrusiveness associated with greater obsessional severity. Finally, compulsions severity was entirely not significantly associated with illness intrusiveness ($t = -0.12, P = 0.91$, partial $r = -0.01$). This latter finding suggests that the previous association observed between compulsion severity and illness intrusiveness was attributable to the shared variance in obsession and compulsion severity scores.

To better determine the relative predicted variance of depression severity and obsessional severity on illness-intrusiveness scores, we repeated linear regression analyses by reversing the order of the independent predictors. This was intended to provide an index of the variance afforded to obsessional severity after accounting for the variance attributed to depression severity, and vice versa. In the first analysis, and at the first step, BDI scores entered the model and were shown to account for 54% of the variance in illness-intrusiveness scores: *Change* $R^2 = 0.54$, *Change* $F_{1,41} = 47.24, P < 0.0001$, partial $r = 0.50$. At the second step, the Y-BOCS obsession scores also entered the model: *Change* $F_{1,40} = 11.01, P < 0.002$. They were shown to add an additional 10% variance: *Change* $R^2 = 0.10$, partial $r = 0.32$. In the second analysis, we reversed the order of entry of the independent predictors. At the first step, Y-BOCS obsession scores entered the model and accounted for 39% of the variance in illness-intrusiveness scores: *Change* $R^2 = 0.39$, *Change* $F_{1,41} = 26.01, P < 0.0001$. At the second step, the BDI scores entered the model, *Change* $F_{1,40} = 27.17, P < 0.001$. They were shown to add an additional 25% variance: *Change* $R^2 = 0.25$. In summary, both obsessional and depression severity produced independent and cumulative effects, although greater variance was afforded to the latter.

Discussion

Previous research has shown the combined impact of obsessive and compulsive symptoms on QOL (9,10). In this study, we observed that the QOL of the person with OCD, as determined by multidimensional QOL aspects, is especially affected by obsessional severity. It is important to note that patients in this study were experiencing clinically significant obsessions as well as compulsions in the moderate-to-severe range of intensity; that is, the absence of predictive effects for compulsion severity on QOL ratings is not caused by the (over) representation in the study of patients experiencing only obsessions and no compulsions.

Behavioural accounts of OCD have suggested that obsessional thoughts, images, and impulses give rise to anxiety and distress, whereas compulsions, both overt and covert, represent strategies to reduce the distress created by obsessions

(13). This functional relation between obsessions and compulsions is now part of the disorder's nosological description (19). Since obsessions are experienced as intrusive and uncontrollable and create the attendant distress, it may not be surprising to find that they have a greater impact on QOL than do the compulsions—which, after all, may be perceived as irrational but necessary to manage anxiety and distress. Importantly, current evidence-based psychological treatments for OCD give comparatively greater attention to reducing compulsions than to reducing obsessions (for example, 29). As such, they appear to be less helpful for those patients who have a predominantly obsessional presentation. Further, between 17% and 44% of clinic-based patients with OCD only experience obsessions and do not report overt compulsions (30). This suggests that treatments specifically aiming to reduce the occurrence and distress associated with obsessions may improve overall QOL for persons with OCD, especially for those presenting only with obsessions. Toward this end, cognitive therapy (6,30–32) has been introduced and shown to be effective in helping those with obsessions only (30), although no study has indicated whether this directly generalizes to improved QOL.

Past studies comparing anxiety disorders with depressive disorders have found that, while patients in both groups show greater impairment on such aspects of QOL as physical, social, and emotional functioning than do other medical and psychiatric patient samples, those with depressive disorders typically score even worse (33). The present study also demonstrates the overall impact of depression on the QOL of those with OCD. The greatest variance in QOL was accounted for by depression severity. Because estimates suggest that as many as 75% of patients presenting to clinics are experiencing significant depression, the reduction of depression in OCD seems essential for improved QOL.

To date, front-line psychological (that is, exposure and response prevention [ERP]) treatments appear to be less effective when depression comorbidity exists (34–36); when they are effective, they appear to create only modest change in the depressive symptoms. Despite the intuitive appeal of treating comorbidity with selective serotonin reuptake inhibitors (SSRIs), evidence from recent metaanalytic reviews suggests that SSRIs are no more effective than ERP in reducing comorbid depression (for example, 37).

The persistence of depressive symptoms at posttreatment predicts relapse status (13,38) and the probability of long-term remission from the disorder (6). Future attempts to more aggressively treat depression comorbidity in OCD will be of great importance.

This paper has several methodological strengths, including its employment of reliable and valid measures of QOL and

symptom functioning. However, this study also has several limitations. First, its cross-sectional nature precludes drawing causal relations between symptom functioning and QOL. For example, it is equally plausible that poor QOL determines symptom worsening as individuals become increasingly withdrawn and focused on their obsessions and compulsions. Second, it is also possible that ratings on the illness-intrusiveness scale are state-dependent, reflecting comparatively transient associations that move in tandem with the waxing and waning of obsessive (and depressive) symptoms. A longitudinal design is required to better identify the possible bidirectional pathways between symptom functioning and QOL, as well as the stability of these associations over time.

Further, while there was sufficient statistical power to assess the relations between symptom functioning and overall QOL, the sample was not large enough to assess the associations between obsessive compulsive symptoms and specific aspects of QOL. A final limitation concerns the confounding effects of comorbid diagnoses. Our study was not able to distinguish between the effects on QOL of other anxiety disorders comorbid with OCD. However, a recent study found that the presence of comorbid anxiety disorders did not affect the course or likelihood of symptom remission in OCD (6). Despite these limitations, this study demonstrates the direct association between obsessions, comorbid depression, and QOL.

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Manuscript received April 2002, revised, and accepted June 2002.

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Résumé : La qualité de vie avec le TOC : l'effet différentiel des obsessions, des compulsions et de la comorbidité de la dépression

Objectif : Un trouble anxieux affecte gravement la qualité de vie des personnes qui en souffrent, et ceci est particulièrement vrai pour celles qui souffrent du trouble obsessionnel-compulsif (TOC). Cette étude examine l'effet différentiel des obsessions, des compulsions et de la comorbidité de la dépression sur la qualité de vie des personnes souffrant du TOC.

Méthode : Quarante-trois personnes ayant reçu un diagnostic de TOC selon les critères du *DSM-IV*, et ayant des obsessions et des compulsions cliniquement significatives ont répondu à des mesures de la qualité de vie, de la gravité des symptômes obsessionnels-compulsifs et de la gravité de la dépression.

Résultats : La gravité des obsessions s'est révélée un prédicteur significatif de la qualité de vie du patient, tandis que la gravité des rites compulsifs n'avait pas d'effet sur les cotations de la qualité de vie. La gravité de la dépression comorbide était le seul meilleur prédicteur d'une qualité de vie médiocre, représentant 54 % de la variance.

Conclusions : Étant donné l'importance de ces symptômes, les traitements qui ciblent directement les obsessions et les symptômes secondaires de la dépression dans le TOC sont justifiés. Toutefois, il faut une reproduction de ces résultats dans une étude prospective de cohortes, parce que bien que le modèle transversal de la présente étude permette l'examen des associations entre obsessions, dépression et qualité de vie, il ne peut établir leur cadre temporel (c'est-à-dire, leurs relations causales).