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A CROSS-SECTIONAL STUDY ON THE PREVALENCE OF DEPRESSION AND ITS IMPACT ON THE QUALITY OF LIFE IN PATIENTS WITH OCD.

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Abstract

Background:

A complex and challenging mental health condition due to which millions of people are affected worldwide is depression. It extends well beyond mere sadness or occasional spells of low mood. Instead, depression is a persistent and pervasive sense of despair, hopelessness, and emotional pain that can significantly disrupt a person's life.

Objective:

Anxiety disorders can significantly diminish a person's quality of life (QOL), as this appears to be especially pertinent in the case of individuals dealing with obsessive-compulsive disorder (OCD). This research delves into how obsessions, compulsions, and the presence of depression uniquely influence the life quality of individuals living with OCD.

Methods:

A group of 86 individuals who had been diagnosed with OCD based on DSM-IV criteria and were dealing with significant compulsions and obsessions participated in this study. The completed assessments related to their quality of life, the intensity of their obsessive- compulsive symptoms, and the severity of their depression.

Results:

Severity of obsessive compulsive disorders was found to significantly predict patients with depression, a significant relationship between obsession severity and sickness intrusiveness was also found ($t = 2.09$, $P<0.05$), higher obsession severity being associated with higher illness intrusiveness.

Conclusion:

Considering the importance of these symptoms, there is a clear need for OCD sufferers to get therapies that focus on obsessions and related depression symptoms. It's crucial to remember that these results should be verified in prospective cohort research. The current cross-sectional approach does not establish the temporal order or causal links between obsessions, depression, and quality of life (QOL), but it does allow for the analysis of association between obsession depression, and QOL. Consequently, a longitudinal study is necessary to comprehend the chronological context of these components.

Recommendations:

The best treatment for OCD is a combination of CBT and SSRIs, especially if OCD symptoms are severe.

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1. Introduction.

A very crippling anxiety disease, obsessive-compulsive disorder (OCD) affects roughly 1 in 40 adults, or roughly 2.5% of the population, at some point throughout their lives. This prevalence places it as the fourth most frequent psychiatric disorder, making it two times as common as illnesses like schizophrenia and bipolar disorder [1]. In severe instances, affecting over twenty percent of diagnosed patients, compulsions and obsessions may dominate an individual's entire day, resulting in profound disability [2]. When left untreated, the likelihood of symptom remission is exceptionally low. Among anxiety disorders, OCD stands out for its characteristic pattern of chronic, fluctuating symptoms [3].

Obsessive-Compulsive Disorder (OCD) is a condition in which mental health is affected and characterized by intrusive and persistent thoughts (obsessions) that cause "repetitive actions" (compulsions) [4]. An individual's daily life can be severely disrupted and distressed by these obsessions and compulsions. Following are the key aspects of OCD:

1. **Obsessions:** These intrusive, upsetting, and persistent ideas, visions, or desires are known as obsessions. They frequently cause discomfort or worry. Obsessions that are common include worries about symmetry and order, contamination, and harming others.

2. **Compulsions:** Repetitive behaviors or mental acts that individuals with OCD perform in response to their obsessions. These actions are often intended to reduce anxiety or prevent a fearful event.

3. **Severity:** The degree of OCD ranges from mild to severe. When obsessions and compulsions are strong, they can take up a large portion of a person's day, making it difficult for them to carry out their regular obligations.

4. **Impact on Daily Life:** OCD can significantly affect a person's quality of life. It may affect one's relationships, career, and general well-being. Due to the stigma associated with their diagnosis, people with OCD may experience social isolation.

5. **Onset:** OCD often manifests in early adult- hood or during adolescence. Although the precise causation of OCD is unknown, it is thought to be a result of a confluence of neurological, environ- mental, and hereditary variables.

Only a little amount of study has been done on how persistent obsessions and compulsions affect OCD sufferers' quality of life (QOL). There are significant emotional, societal, and monetary consequences associated with anxiety disorders, according to a recent analysis focusing on how these diseases affect quality of life (QOL). However, it pointed out that there was very few research done especially on OCD individuals [5].

A survey conducted by Hollander and his team revealed compelling statistics: 73% of OCD patients reported impaired family relationships, 62% experienced difficulties in their friendships, 58% faced challenges in academic performance, 47% encountered interference with their work, and 40% were either chronically underemployed or unemployed [6].

In summary, these studies underscore the profound influence of OCD on the QOL of individuals, revealing significant impairments across various facets of their lives, including relationships, academic performance, work, and social functioning [1-6]. This research highlights the critical need for comprehensive support and intervention strategies to improve the quality of life of those living along with obsessive compulsive disorders. The independent effects of obsessions and compulsions on the quality of life (QOL) of OCD sufferers have not yet been properly studied in any studies. Obsessions and compulsions are common among OCD sufferers, although obsessions may worsen the condition more than time-consuming routines because of how invasive they are [7]. This research aims to understand how obsessions, compulsions, and the presence of depression uniquely influence the life quality of individuals living with OCD.

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2. Methods.

2.1. Study Design and Participants.

This study included 86 participants for this study who were sequentially referred and who satisfied the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) standard for obsessive-compulsive disorder (OCD). The Structured Clinical Interview for Axis 1 Disorders (SCID-1/P, version 2.0) was used to diagnose. A tertiary care centre in Bihar served as the recruitment site for all participants.

In order to qualify for participation in the research, individuals needed to meet the following criteria: 17 to 67 years of age, and exhibit symptoms of clinical significance associated with obsessions and compulsions. Participants who had simultaneous diagnoses of schizophrenia, bipolar disorder, or an ongoing medium use disorder were not considered eligible for inclusion in the study. A summary of the demographic and clinical characteristics of the patient sample can be seen in Table 1.

2.2. Clinical measures.

The Yale-Brown Obsessive Compulsive Scale (Y-BOCS), which was administered by a physician, was one of three standardised tests that each participant in the study completed. Y-BOCS, Scale A validated scale called the Y-BOCS is used by therapists to assess how severe clinical obsessions and compulsions are in OCD sufferers. It consists of 10 obsession and compulsion-related items, each of which is rated on a 5-point Likert scale from 0 (no symptoms) to 4 (severe symptoms). The Y-BOCS has shown itself to be highly valid and internally consistent.

These assessments were utilized to comprehensively evaluate the intensity of OCD symptoms, the impact of OCD on various life domains, and the existence and severity of depressive symptoms in the study participants.

2.3. Statistical measures.

This study used "linear regression" analysis with the SPSS, version 10.0, to investigate which symptoms could predict the degree of illness intrusiveness in people with OCD. Two distinct regression techniques made up this analysis. The initial study sought to identify any demographic or clinical factors that might be used to predict how obtrusive an illness is. In the second analysis, we used a multiple regression equation that included the independent variables Beck Depression Inventory (BDI) scores, Yale-Brown Obsessive Compulsive Scale (Y-BOCS) obsession scores, and Y-BOCS compulsion scores. The Y-BOCS scores for preoccupation and Y-BOCS compulsion scores. The Y-BOCS scores for preoccupation and compulsion, as well as a favourable association between these Y-BOCS scales and the degree of depression, were what we expected to find. In order to account for multicollinearity among these variables, the linear regression analysis was performed.

3. Results.

This study included 86 participants. At the initial stage a number of 173 patients were examined for eligibility, however 87 patients were excluded from this study due to not being eligible. Present age, marital status, age of onset and sex as a group to see if clinical or demographic characteristics had any predictive value for illness intrusiveness were evaluated. Additionally, none of these factors were included in the final equation (t-scores 1.04; not significant). In order to investigate the effect of obsessive compulsive disorders symptoms and "concomitant depression" on disease intrusiveness, we did not factor in clinical and demographic factors.

Then, using zero-order Pearson correlation analysis, we investigated the connections amongst the Y-BOCS compulsion and obsession scores as well as disease intrusiveness. The findings showed a strong and positive association of the Y-BOCS compulsion and obsession scores ($r = 0.63$, $P > 0.01$) as well as between the two scores ($r = 1.51$, $P > 0.01$). We performed a hierarchical regression analysis to evaluate the distinct contributions of Y-BOCS obsession and compulsion scores in predicting sickness invasiveness while also taking into

Table 1: **Clinical and Demographic characteristics of the participants with depression**

Variables	**All (n= 86) (n%)**
Sex	
Male	37 (43.02)
Female	49 (56.97)
Marital status	
Single	31 (36.04)
Married or cohabiting	32 (37.20)
Separated, divorced, or widowed	23 (26.74)
Age Mean (SD)	
Onset age (years)	13.4 (7.6)
Y- BOCS obsessions	8.7 (8.0)
Y-BOCS compulsions	18.6 (4.2)

account the relationship connecting depression scores and illness intrusiveness. In this analysis, it was regarded as the BDI scores and Y-BOCS obsession and compulsion scores as separate predictors that were all entered as a block. Severity of obsessive compulsive disorders was found to significantly predict patients with depression, a significant relationship between obsession severity and sickness intrusiveness was also found ($t = 2.09$, $P<0.05$), higher obsession severity being associated with higher illness intrusiveness.

When the individual variables were examined, it was clear that the Beck depression Inventory (BDI) strongly predicted the intrusiveness of the disease ($t = 4.17$, $P>0.0001$), where higher depression scores were linked to higher illness intrusiveness. A significant relationship between obsession severity and sickness intrusiveness was also found ($t = 2.09$, $P< 0.05$), higher obsession severity being associated with higher illness intrusiveness. However, there was no discernible correlation between sickness intrusiveness and compulsive severity ($t = 1.13$, $P = 0.87$, r (partial) = -0.01). The previously noted connection between the intrusiveness of the illness and the severity of the compulsions was accountable to the shared variation in the severity scores of obsessive-compulsive disorders has been determined by the latter findings.

4. Discussion.

This study found that the severity of obsessions had an impact (significant) on the multidimensional elements of QOL in OCD sufferers. It's important to stress that the subjects in our study had clinically significant obsessions and compulsions, and that the severity of these symptoms ranged from moderate to severe. As a result, the non-appearance of effects predicted for compulsion severity on quality of life ratings is not attributable to an excessive representation of participants in the study solely dealing with obsessions and not experiencing compulsions. The conjugated effect of symptoms of compulsive and obsessiveness on quality of life (QOL) has already been addressed by studies [8, 9].

According to behavioral explanations of OCD, obsessive thoughts, ideas, and impulses create worry and suffering while compulsive behaviors, whether overt or covert, act as coping mechanisms [10]. The clinical diagnosis of the condition now includes a critical discussion of the link between obsessions and compulsions.

Given that obsessions frequently cause significant distress, are viewed as invasive, and are difficult to control, it is not unexpected that it has a considerable effect on quality of life (QOL) than constraints. As unreasonable but necessary coping mechanisms for the worry and distress brought on by obsessions, compulsions can be contrasted with obsessions [11].

It's noteworthy that current evidence-based psychological treatments for OCD tend to prioritize the reduction of compulsions over obsessions. This focus may be less beneficial for individuals who primarily experience obsessions. Notably, a subset of patients with OCD, ranging from 17% to 44% in clinical settings, report experiencing only obsessions without overt compulsions [12].

This underscores the importance of therapeutic management specially designed to alleviate the incidents and distress associated with "obsessions", as it has the potential to enhance the overall QOL for individuals with OCD, especially those who predominantly have obsessional symptoms [13]. Cognitive therapy, for instance, has been introduced and has demonstrated effectiveness in assisting individuals with obsessions alone, although it remains to be seen whether this directly translates into improved QOL in this population.

Exposure and response prevention (ERP), a major psychological treatment, has so far been found to be less successful when coexisting depression is present [14]. Even when they do show promise, their influence on depressed symptoms is typically only marginal. While there is a natural tendency to use selective serotonin reuptake inhibitors (SSRIs) to treat comorbidity, recent meta-analytic analyses have shown that SSRIs are not more effective than ERP at reducing comorbid depression [15].

The persistence of depressive symptoms after treatment has been shown to be a predictor of relapse status [16] and can impact the likelihood of achieving long-term remission from OCD. Therefore, future efforts aimed at more aggressively addressing comorbid depression in individuals with OCD hold significant importance.

Although the use of trustworthy and valid measures to evaluate quality of life (QOL) and symptom functioning is one of the methodological strengths of this research, it is not without its flaws. First off, because of its cross-section character, causal correlations amongst symptom functions and QOL cannot be established. It is equally possible, for instance, that a lower QOL may contribute to the symptoms getting worse as people withdraw more and become more focused with their obsessions and compulsions. The evaluations on the illness-impulsiveness scale may also be state-dependent, reflecting relatively fleeting connections that fluctuate along with obsessive (and depressed) symptoms. A linear study design would be crucial to get a more thorough knowledge of the potential bidirectional linkages between symptoms functions and QOL, as well as the durability of connections over time.

5. Conclusion.

Considering the importance of these symptoms, there is a clear need for OCD sufferers to get therapies that focus on obsessions and related depression symptoms. It's crucial to remember that these results should be verified in prospective cohort research. The current cross-sectional approach does not establish the temporal order or causal links between obsessions, depression, and quality of life (QOL), but it does allow for the analysis of association between obsession, depression, and QOL. Consequently, a longitudinal study is necessary to comprehend the chronological context of these components.

6. Limitations.

The limitations of this study include a small sample population who were included in this study. The findings of this study cannot be generalized for a larger sample population. Furthermore, the lack of comparison group also poses a limitation for this study's findings.

7. Recommendation.

The best treatment for OCD is a combination of CBT and SSRIs, especially if OCD symptoms are severe.

8. Acknowledgement.

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9. List of abbreviations.

OCD- obsessive-compulsive disorder
QOL- quality of life
DSM- Diagnostic and Statistical Manual of Mental Disorders
CBT- Cognitive behavioural therapy
SSRI- Selective serotonin reuptake inhibitors
SCID- Structured Clinical Interview for Axis 1 Disorders
Y-BOCS- Yale-Brown Obsessive Compulsive Scale
SD- Standard Deviation
BDI- Beck Depression Inventory
ERP- Exposure and response prevention

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