Pakistan Journal of Psychological Research, 2011, Vol. 26, No. 1, 61-71

Gender Differences in Perceived Quality of Life of Patients Suffering From Obsessive-Compulsive Disorder

Yasmin Nilofer Farooqi and Faiza Rasul
University of the Punjab

The present research was conducted to explore gender differences in perceived quality of life of patients suffering from Obsessive-Compulsive Disorder (OCD). A sample of diagnosed patients of OCD (N = 60) was selected from psychiatry departments of different hospitals of Lahore city. Urdu version of the World Health Organization Quality of Life Scale (WHOQOL-BREF; Khan, Akhtar, Ayub, Alam, & Laghari, 2003) was administered. The female patients reported better overall quality of life as compared to the male patients. However, female and male patients reported more problems in their social and environmental domains than the physical and psychological domains of life. The findings indicated significant positive relationship between different domains of quality of life and monthly income of OCD patients.

Keywords: perceived quality of life, OCD, physical domain, psychological domain, social domain, environmental domain

Obsessive-Compulsive Disorder (OCD) is one of the most debilitating of all psychiatric illnesses in terms of loss of income and poor quality of life of patients. Veale and Willson (2005) report that after depression, alcohol dependency, substance abuse and social phobia; OCD is the world's fourth most common mental disorder. Clinically, OCD manifests itself through a number of different patterns of thought and behavior which are classified as obsessions and compulsions. Together, these can become a destructive cycle which brings great distress to many people with OCD as well as to their relatives and friends (Bobes et al., 2001; Calvocoressi, Libman, Vegso, McDougle, & Price, 1998; Veale & Willson, 2005).

There is sufficient empirical and clinical evidence that OCD impairs patients' quality of life. Koran, Thienemann, and Davenport

Yasmin Nilofer Farooqi and Faiza Rasul, Department of Applied Psychology, University of the Punjab, Lahore, Pakistan.

Correspondence concerning this article should be addressed to Yasmin Nilofer Farooqi, Department of Applied Psychology, University of the Punjab, New Campus, Pakistan. Email: dryasminfarooqi@yahoo.com

(1996) reported that medication free patients with moderate to severe OCD reported worse social functioning and performance in work and other activities as compared to the general population and the patients with diabetes. They further found that more severe the OCD, the more impaired the patients' social functioning was; even after controlling for effects of concurrent depression.

The negative effects of psychiatric disorders like OCD on social, occupational, physical, and psychological aspects of life are well known (Grabe et al., 2000; Rodriguez-Salgado et al., 2006; Veale & Willson, 2005). Similarly, Bystritsky et al. (2001) found that the patients suffering from OCD reported lower quality of life which indicates significant functional impairment in this population. The research findings of Rodriguez-Salgado et al. (2006) suggest that OCD had significant negative repercussion on perceived quality of life of the OCD patients. Consequently, the importance of assessing quality of life in psychiatric disorders, especially in case of OCD is growing. According to American Psychiatric Association (APA) the prevalence of OCD has been estimated at 2% in the general population (APA, 2000). Therefore, APA has emphasized the role of quality of life in psychiatric disorders; especially OCD and its importance in therapeutic effectiveness in Diagnostic Statistical Manual of Mental Disorders-IV Text Revised (DSM-IV TR; APA, 2000). Traditionally, OCD is believed to be a much more uncommon psychiatric disorder. It has been hypothesized that patients suffering from OCD are reluctant to disclose their symptoms in medical consultations and would deliberately hide them from the clinicians. Consequently, only the most severe cases are evaluated by a specialist.

The high co morbidity of OCD with other psychiatric disorders (mainly anxiety and depression) has also contributed to the under diagnosis and under treatment of OCD patients (Rodriguez-Salgado et al., 2006). Hollander et al. (as cited in Akdede, Alptekin, Akvardar, & Kitis, 2005) found that OCD is a chronic mental disorder which affects academic, occupational, social, and family functions of the patients leading to disability in different domains of their life; particularly in the social and environmental domains. Grabe et al. (2000) explored the prevalence, quality of life, and psychosocial functioning of the OCD patients in northern Germany and found significant reductions in overall quality of life of the OCD patients and especially in the psychosocial domain. Sorensen, Kirkeby, and Thomsen (2004) studied quality of life of the members of the Danish OCD association and found significant impact on their academic, occupational, and social functions and thereby a corresponding influence on their quality of life in general.

The concept of perceived quality of life may be defined in different ways. It reflects the subjective satisfaction from life and general well being as opposed to the quantitative evaluation of life (Angermeyer & Killian, 1997; Mendlowics & Stein as cited in Akdede et al., 2005). Indeed, without physical health, psychological health, social life, and satisfaction with environment individual will not be able to spend contended and fulfilled quality of life. Thus, it may be argued that when a person perceives that he/she has sufficient means to meet his/her physiological, psychological, and social needs then the possibility of better quality of life is enhanced. According to Maslow's (1964) hierarchy of need theory, the first lower levels of primary needs are physiological needs and together in the group named as deficiency needs and the topmost or upper needs are associated with psychological needs termed as growth needs. Maslow (as cited in Smith, 2002) further argues that the deficiency needs must be fulfilled and always come first. The higher needs in this hierarchy only come into focus when the lower needs in the pyramid are satisfied, and consequently, affect the overall quality life of an individual.

Stengler-Wenzke, Kroll, Riedel-Heller, Matschinger, and Angermeyer (2007) examined the differential impact of obsessions and compulsions on the quality of life of patients with OCD. They found that compulsions reduced patients' quality of life in the physical, psychological, and environmental domains, whereas obsessions did not have any impact on quality of life ratings. Moritz et al. (2005) found that patients suffering from OCD reported lower physical well being apart from low social and emotional quality of life. Eisen et al. (2006) reported that all aspects of quality of life are markedly affected in individuals with OCD and are associated with the severity of OCD. Moreover, there is sufficient empirical evidence that suggests gender differences in quality of life of male and female patients suffering from OCD. In comparison to the male patients; the female patients of OCD reported lower physical, but not mental, quality of life (Bobes et al., 2001; Ong et al., 2006; Swinson, 2001). However, Maini, Hakko, Niemela, Koivukangas, and Rasanen (2006) found that the level of overall quality of life in female patients is lower than the male patients and also found depression to be the main predictor for the worse quality of life in the OCD patients at all measurements. Matsunaga et al. (2000) establish that gender differences in OCD patients were prominently observed in social or interpersonal features and the male patients had a higher rate of major impairment in social or occupational functioning as compared to the female patients. However, Tukel, Polat, Genc, Bozkurt, and Atli

(2004) did not find any significant gender differences in the Turkish OCD patients.

It may be argued that socialization process provides better privileges, status, and roles to men as compared to women across the globe. This is all the more evident in the traditional patriarchal society of Pakistan which promotes assignment of specific masculine and feminine gender roles and status to the Pakistani men and women. Moreover, the mobility and autonomy of Pakistani women is often restricted due to their assigned roles and duties by the patriarchal Pakistani society. Thus, it may be hypothesized that the Pakistani female patients suffering from OCD would report relatively better overall quality of life as compared to their male counterparts. It is probably because that woman has restricted social and occupational domains of life in Pakistan as a result of the specific gender roles and status assigned by the society. Moreover, the social and environmental domains of life of the female patients would be less impaired as compared to the male patients with OCD. It may be further argued that the stigmas and taboos attached to mental disorders in our society would adversely affect the quality of life of the Pakistani male patients suffering from OCD more seriously as compared to their female counterparts.

The present study explored gender differences in perception of overall and physical, psychological, environmental, and social domains of quality of life among OCD patients.

Method

Participants

The research sample comprised 60 diagnosed patients suffering from OCD including male (n = 30) and female (n = 30) patients within age range of 18-30 years. The purposive sampling technique was used to select the sample. The inclusion criteria were based on already diagnosed patients for OCD by their treating psychiatrists and psychologists as per the diagnostic criteria of DSM-IV-TR (APA, 2000) for the last 6-30 months without any history of comorbidity. Comorbidity was specifically controlled as none of the sample has been a case of dual diagnosis or comorbidity, and patient's willingness to participate in the present research project.

The sample included patients from the indoor units (n = 15) and outpatient units (n = 45) of the psychiatry departments of Mayo

Hospital, Sir Ganga Ram Hospital, Fountain House, and Jinnah Hospital of Lahore city of Pakistan.

Instrument

The World Health Organization Quality of Life Scale (WHOQOL-BREF). The Scale was developed by the World Health Quality of Life Group (WHOQOL Group) in 1998. According to Skevington, Lotfy, and O'Connell (2004) the WHOQOL-BREF was the result of 10 years of development research on quality of life and health care. According to the WHOQOL Group (1998) the WHOQOL-BREF assesses how disease impairs the subjective well-being of a person across four domains of life i.e., physical, psychological, social, and environmental domains. Skevington et al. (2004) reported that the analyses of internal consistency, item-total correlations, discriminate validity, and construct validity through confirmatory factor analysis, indicated that the WHOQOL-BREF has well to excellent psychometric properties of reliability and perform well in preliminary tests of validity. They further reported significantly high reliability from .70 to .93 for all the domains of WHOQOL-BREF.

Khan et al. (2003) as members of WHOQOL Group and collaborators translated the English version of WHO-QOL-BREF in Urdu. They further evaluated the translated version of WHOQOL-BREF to check linguistic equivalence, concept equivalence, and scale equivalence. Their findings suggested that WHOQOL-BREF is a reliable and valid version to measure the quality of life of the Pakistani population with Cronbach alpha coefficient .88. The WHOQOL-BREF consisted of 26 items which were scored on 5-point Likert scale ranging from *Extremely Satisfied* (5) to *Extremely Dissatisfied* (1). The WHOQOL-BREF comprised four domains, including physical domain (7 items), psychological domain (6 items), social domain (3 items), and environmental domain (8 items) whereas the first two items measure the overall perceived quality of life of the respondents (Skevington et al., 2004). The total score on the four domains of WHOQOL-BREF denotes an individual's overall perception of quality of life. The higher overall score on WHOQOL-BREF suggest higher quality of life perceived by the respondent. Moreover, all the scores in the four domains of life were scaled in positive direction; thus the higher scores on each domain show higher quality of life in each domain. The authors found satisfactory reliability for all the four domains with Cronbach alpha coefficients as .81 for physical domain, .77 for psychological domain, .42 (low

reliability perhaps due to three items only) for social domain; and .75 for environmental domain.

Procedure

Official permission was sought from the outdoor and indoor units of the psychiatry departments of the public hospitals of Lahore city (Mayo Hospital, Sir Ganga Ram Hospital, Fountain House, and Jinnah Hospital) for data collection. Written permission was granted by the WHOQOL Group and Collaborators (Khan, et al., 2003) for the use of the Urdu version of WHOQOL-BREF in the present research project. The researchers further obtained written consent from all the participants after assuring them of the privacy and confidentiality of the information obtained from them. Following the brief instructions to the participants. Urdu version of WHOQOL-BREF was individually administered to all the research participants.

Results

Independent sample *t* test was performed to determine the significance of gender differences in overall perceived quality of life of patients suffering from OCD.

Table 1

Comparison of Male and Female Patients of OCD on WHOQOL-BREF total and its subscales

	Male (n = 30)	Female (n = 30)			95% CI		
Variables	*M (SD)*	*M (SD)*	*t(598)*	*p*	*LL*	*UL*	Cohen's *d*
Physical	7.23(1.9)	7.82(1.4)	1.38	.17	-1.44	0.26	.35
Psychological	5.93(2.9)	6.44(1.4)	0.85	.40	-1.71	0.69	.22
Social	5.57(1.29)	6.53(1.6)	2.56	.01	-1.70	-0.21	.65
Environmental	5.42(1.2)	6.14(1.1)	2.40	.02	-1.31	-0.12	.52
WHOQOL-BREF Total	24.16(5.0)	26.93(3.9)	2.41	.02	-5.07	-0.47	.61

Note. CI = confidence interval; LL = lower limit; UL = upper limit

The results in Table 1 indicate significant gender differences in overall quality of life of OCD patients and female patients reported better overall quality of life as compared to the male patients. Moreover, the female patients reported relatively better social and environmental quality of life as compared to their male counterparts. However, non significant gender differences were found on physical and psychological domains of the OCD patients.

Discussion

The findings of the present study suggest significant gender differences in quality of life of OCD patients. The female patients reported relatively better overall quality of life as compared to the male patients with OCD. These findings are inconsistent with the prior research findings of Gamma and Angst (2009) which suggest lower overall quality of life and higher distress in the female patients with OCD than the male patients. The present findings indicated that female patients reported relatively better social and environmental quality of life when compared to the social and environmental domains of their male counterparts. In context of Pakistan, it may be argued that female patients with OCD are already accustomed to the restricted mobility, financial dependency, and under-privileged feminine status due to the traditional stereotypical roles assigned to women by the patriarchal Pakistani society. Consequently, their scores on the social and environmental domains of life were not as adversely affected by OCD as was in case of the male patients with OCD.

The findings of the present research supported the research hypothesis that the Pakistani male patients suffering from OCD would report more dissatisfaction with their social and environmental domains of life as compared to the female patients with OCD. It may be argued that owing to the multiple stigmas and taboos attached to mental disorders (such as, OCD) and demands of the gender specific status role assignments, men are considered to be the primary bread winners of their families; therefore, OCD would more seriously impair the social and occupational life of male patients as compared to those of the female patients with OCD.

These findings are consistent with the prior researches conducted (Bobes et al., 2001; Calvocoressi et al., 1998; Matsunaga et al., 2000) which found that gender differences in OCD subjects were prominently observed in social or interpersonal features and the males had a higher rate of major impairment in social or occupational functioning as compared to the females. However, contrary findings

are also reported which did not find any gender differences (Tukel et al., 2004).

Fontenelle et al. (2010) evaluated the impact of different dimensions of obsessive-compulsive symptoms, of comorbid anxious depressive symptoms, and of socio-demographic characteristics on the quality of life of patients with OCD. Findings revealed that the OCD patients displayed significantly lower levels of perceived quality of life in all dimensions measured by the Short Form Health Survey (Ware & Sherbourne, 1992), except bodily pain. Solanki, Singh, Midha, Chugh, and Swami (2010) conducted a cross-sectional study on disability and quality of life of patients suffering from schizophrenia and obsessive-compulsive disorder. Results indicated deleterious effects of illness on the psychological and social domains of quality of life and overall functioning of the patients suffering from schizophrenia and obsessive-compulsive disorders.

Conclusions

It can be concluded from the above discussion that male patients with OCD reported overall poorer quality of life; especially in the social and environmental domains of quality of life as compared to the female patients. Moreover, all the OCD patients reported relatively poorer quality of life for social and environmental domains of life as compared to the physical and psychological domains of life.

Limitations

Sample size for the male and the female patients was relatively small within the age range of 18-30 years. Therefore, it would be difficult to analyze the impact of age on the quality of life of the male and female patients with OCD. The sample was drawn from the public hospitals of Lahore city only. Comparison between the hospitalized and outdoor patients suffering from OCD could not be explored due to the relatively small size of the male and female sub-samples in each category.

Suggestions and Implications

The future researches must be carried out on the larger samples of OCD patients from the public and private hospitals of different cities of Pakistan. Moreover, sub samples from the indoor and outdoor

patients of OCD and/or those OCD patients who have dual diagnoses or co morbidity must also be compared on quality of life so that it would be a more representative sample for the Pakistani patients suffering from OCD. Furthermore, the future researches must look into the differences in different domains of quality of life of the female and male patients within age range 18-60 years.

It is also recommended that the future researches may explore the impact of multiple factors; such as co morbid depression, severe obsession symptoms, perceived low social support, severe adverse effect of medication, combined use of mood stabilizers, and low social status which are specific to individual patients and influenced by interactions with treatment and the social environment. Moreover, it would be interesting to explore the gender differences in the content of the obsessions and compulsions of the OCD patients in the upcoming researches.

The present research findings have implications for promoting understanding of the mental health professionals about gender differences in the overall quality of life; especially in the social and environmental domains of quality of life of the patients with OCD in the Pakistani healthcare system. Moreover, it may help in purposing gender sensitive psychotherapeutic interventions for the patients suffering from OCD to promote their overall quality of life; especially in the social and environmental domains of life.

References

Akdede, B. B., Alptekin, K., Akvardar, Y., & Kitis, A. (2005). Quality of life in patients with OCD: Relations with cognitive functions and clinical symptoms. *Turkish Journal of Psychiatry, 16*(1), 13-19.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders.* (4th ed., Text Revision). Washington, DC: Author.

Angermeyer, M. C., & Killian, R. (1997). Theoretical models of quality of life for mental disorders, in H. Katschnig., H. Freeman., & N. Sartorius (Eds.), *Quality of life in mental disorders* (pp. 19-54). New York: John Wiley & Sons.

Bobes, J., Gonzalez, M. P., Bascaran, M. T., Arango, C., Saiz, P. A., & Bousono, M. (2001). Quality of life and disability in patients with obsessive compulsive disorder. *European Psychiatry, 16,* 239-245.

Bystritsky, A., Liberman, R. P., Hwang, S., Wallace, C. J., Vapnik, T., Maindment, K., & Saxena, S. (2001). Social functioning and quality of life comparisons between obsessive-compulsive and schizophrenic disorders. *Depression and Anxiety, 14*, 214-218.

Calvocoressi, L., Libman, D., Vegso, S. J., McDougle, C. J., & Price, L. H. (1998). Global functioning of inpatients with obsessive-compulsive disorder, schizophrenia, and major depression. *Psychiatry Services, 49,* 379-381.

Eisen, J. L., Mancebo, M. A., Pinto, A., Coles, M. E., Pagano, M. E., Stout, R., & Rasmussen, S. A. (2006). Impact of obsessive-compulsive disorder on quality of life. *Comprehensive Psychiatry, 47*(4), 270-275.

Fontenelle, I. S., Fontenelle, L. F., Borges, M. C., Prazeres, A. M., Rangé, B. P., Mendlowicz, M. V., & Versiani, M. (2010). Quality of life and symptom dimensions of patients with obsessive-compulsive disorder. *Psychiatry Research, 179*(2), 198-203.

Gamma, A., & Angst, J. (2009). Concurrent psychiatric co morbidity and multimorbidity in a community study: Gender differences and quality of life. *European Archives of Psychiatry and Clinical Neuroscience, 251*(2), 43-46.

Grabe, H. J., Meyer, C., Hapke, U., Rumpf, H. J., Freyberger, H. J., Dilling, H., & John, U. (2000). Prevalence, quality of life and psychosocial function in obsessive-compulsive disorder and subclinical obsessive-compulsive disorder in northern Germany. *European Archives of Psychiatry and Clinical Neuroscience, 250*, 262-268.

Khan, M. N., Akthar, M. S., Ayub, M., Alam, S., & Laghari, N. U. (2003). Translation and validation of Quality of Life Scale: The brief version. *Journal of College of Physicians and Surgeons Pakistan, 13*(2), 98-100.

Koran, L., Thienemann, M., & Davenport, R. (1996). The quality of life for patients with obsessive-compulsive disorder. *American Journal of Psychiatry, 153*(6), 783-788.

Maini, A., Hakko, H., Niemela, A., Koivukangas, J., & Rasanen, P. (2006). Gender difference in relation to depression and quality of life among patients with a primary brain tumor. *European Psychiatry, 21*(3), 194-199.

Maslow, A. H. (1964). *Religions values and peak experiences*. Colombus: Ohio State University Press.

Matsunaga, H., Kiriike, N., Matsui, T., Miyata, A., Iwasaki, Y., & Fujimoto, K. (2000). Gender differences in social and interpersonal features and personality disorders among Japanese patients with obsessive-compulsive disorder. *Comprehensive Psychiatry, 41*(4), 266-272.

Moritz, S., Rufer, M., Fricke, S., Karow, A., Morfeld, M., & Jelinek, L. (2005). Quality of life in obsessive-compulsive disorder before and after treatment. *Comprehensive Psychiatry, 46*(6), 453-459.

Ong, L., Irvine, J., Nolan, R., Cribbie, R., Harris, L., & Newman, D. (2006). Gender differences and quality of life in artial fibrillation: The mediating role of depression. *Journal of Psychosomatic Research, 61*(6), 769-774.

Rodriguez-Salgado, B., Dolengevich-Segal, H., Arrojo-Romero, M., Castelli-Candia, P., Navio-Acosta, M., Perez-Rodriguez, M. M., Jeronimo Saiz-

Ruiz1., Enrique, B. G. (2006). Perceived quality of life in obsessive-compulsive disorder: Related factors. *BioMed Central Psychiatry, 6*(20), doi:10.1186/1471-244X-6-20.

Skevington, S. M., Lotfy, M., & O'Connell, K. A. (2004). The World Health Organization's WHOQOL-BREF quality of life assessment: Psychometric properties and results of the international field trial. A Report from the WHOQOL Group. *Quality of Life Research, 13*, 299-310.

Smith, D. W. (2002). *Theory of spirituality*. Retrieved from http://www.housesofhealing.com/source/Spirarticle94.pdf

Solanki, R. K., Singh, P., Midha, A., Chugh, K., & Swami, M. K. (2010). Disability and quality of life in schizophrenia and obsessive compulsive disorder: A cross-sectional comparative study. *East Asian Arch Psychiatry, 20*, 7-13.

Sorensen, C. B., Kirkeby, L., & Thomsen, P. H. (2004). Quality of life with OCD. A self-reported survey among members of the Danish OCD association. *Nordic Journal of Psychiatry, 58*(3), 231-236. doi:10.1080/08039480410006287

Stengler-Wenzke, K., Kroll, M., Riedel-Heller, S., Matschinger, H., & Angermeyer, C. M. (2007). Quality of life in obsessive-compulsive disorder: The different impact of obsessions and compulsions. *Psychopathology, 40*(5), 282-289.

Swinson, R. P. (2001). *Obsessive compulsive disorder: Theory, research, and treatment.* New York: Guilford Press.

Tukel, R., Polat, A., Genc, A., Bozkurt, O., & Atlı, H. (2004). Gender related differences among Turkish patients with obsessive-compulsive disorder. *Comprehensive Psychiatry, 45*(5), 362-366.

Veale, D., & Willson, R. (2005). *Overcoming obsessive compulsive disorder.* London: Robinson Publishing.

Ware, J. E., & Sherbourne, C. D. (1992). The medical outcomes study: 36-item short form health survey. *Medical Care, 30*(6), 473-483.

WHOQOL Group. (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological Medicine, 28*, 551–558. Retrieved from http://journals.cambridge.org/download.php?file=%2FPSM%2FPSM28_03%2F0033291798006667a.pdf&code=a93349a28be8d0f93d961c531b3262e2

Received October 16, 2009
Revision received April 06, 2011