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Quality of Life and Functional Impairment in Patients With Obsessive-Compulsive Disorder: A Cross-Sectional Observational Study

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Abstract

Background: Obsessive–compulsive disorder (OCD) is a chronic psychiatric disorder that affects emotional well-being, interpersonal relationships, and day-to-day functioning. In addition to symptom severity, assessment of quality of life and disability offers a broader understanding of the burden of illness. ***Objectives:*** To assess quality of life and functional impairment in patients with OCD and to describe their demographic and clinical profile in a tertiary-care hospital setting. ***Methods:*** This cross-sectional observational study was conducted from January 2025 to December 2025 in the Departments of General Medicine and Psychiatry, Rajmata Shrimati Devendra Kumari Singhdeo Government Medical College, Ambikapur. One hundred adults with clinically diagnosed OCD were included. Data were collected using a structured proforma, the Yale-Brown Obsessive Compulsive Scale, WHOQOL-BREF, and the Sheehan Disability Scale. Descriptive statistics were used for analysis. ***Results:*** Most participants were aged 26–35 years (34%) and 56% were male. Mixed obsessive and compulsive symptoms were present in 50% of patients. Moderate OCD severity was observed in 46%, while 38% had severe illness. Among quality-of-life domains, psychological health had the lowest mean score (48.2 ± 11.4), whereas the environmental domain had the highest score (56.7 ± 9.8). Moderate to severe impairment was common in work/school, social, and family functioning, with social life showing the greatest severe impairment (32%). ***Conclusion:*** Patients with OCD experienced substantial reduction in quality of life and meaningful functional disability across major life domains. Psychological well-being and social functioning were most affected. Routine evaluation of quality of life and disability, alongside symptom severity, can support more comprehensive clinical assessment and guide rehabilitation-oriented care.

Keywords: functional impairment; obsessive-compulsive disorder; quality of life; WHOQOL-BREF; Y-BOCS

INTRODUCTION

Obsessive–compulsive disorder (OCD) is a chronic and often disabling psychiatric disorder characterized by intrusive obsessions and repetitive compulsions that consume time, generate marked distress, and interfere with social and occupational functioning. Although symptom severity remains central to clinical assessment, the burden of OCD extends beyond the presence of obsessions and compulsions alone. Over the last two decades, growing attention has been directed toward patient-centered outcomes such as quality of life and disability, because these domains reflect how illness affects lived experience, interpersonal roles, productivity, and daily adaptation [5,12].

Earlier work demonstrated that individuals with OCD report poorer quality of life than community populations, with especially marked deficits in mental health, social functioning, and role performance [5,6]. Studies from different settings have consistently shown that health-related quality of life in OCD is compromised across multiple domains, and that these impairments are often related to illness severity, depressive symptoms, and psychosocial burden [7-10]. A meta-analysis further confirmed that adults with OCD have significantly lower global, emotional, work, social, and family quality-of-life outcomes than healthy controls, underscoring the broad impact of the disorder [14].

Functional impairment is another major dimension of OCD-related burden. Even when patients remain ambulatory and cognitively intact, ritualistic behaviors, avoidance, indecisiveness, and internal preoccupation can substantially disrupt work, study, social participation, and family responsibilities. Previous research has shown that disability in OCD is not limited to severe or treatment-resistant cases; impairment can be substantial even in routine clinical populations and is often amplified by comorbid emotional symptoms [9,13]. Therefore, assessment of disability is essential

when evaluating the overall impact of OCD and the real-world consequences of symptoms.

Instruments such as the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), WHOQOL-BREF, and Sheehan Disability Scale provide a useful multidimensional framework for such evaluation. The Y-BOCS remains one of the most widely used clinician-rated measures of OCD severity [1,2], while WHOQOL-BREF captures physical, psychological, social, and environmental dimensions of quality of life [3]. The Sheehan Disability Scale offers a brief and practical estimate of impairment in work or school, social life, and family life [4]. Together, these tools allow a clinically meaningful appraisal of both symptom burden and its broader functional consequences.

Despite the expanding literature, data from tertiary-care settings in India that jointly examine quality of life and functional impairment in OCD remain comparatively limited. Such information is relevant for understanding the psychosocial burden of illness in routine practice and for planning comprehensive management beyond symptom reduction alone. The objective of the present study was to assess quality of life and functional impairment in patients with OCD and to describe their demographic and clinical characteristics in a tertiary-care teaching hospital.

MATERIALS AND METHODS

Study design and setting

This cross-sectional observational study was conducted from January 2025 to December 2025 in the Department of General Medicine and the Department of Psychiatry, Rajmata Shrimati Devendra Kumari Singhdeo Government Medical College, Ambikapur. The study was designed to evaluate the quality of life and degree of functional impairment among adult patients diagnosed with obsessive–compulsive disorder in a tertiary-care hospital setting.

Study population

The study population comprised adult patients attending the psychiatry services and referred cases evaluated jointly with the general medicine department when required for overall clinical assessment. Patients of either sex, aged 18 years and above, with a clinical diagnosis of OCD established by the treating psychiatrist on standard diagnostic criteria, were considered eligible. Only those who were clinically stable enough to participate in an interview-based assessment and who provided informed consent were enrolled.

Inclusion and exclusion criteria

Inclusion criteria were: confirmed diagnosis of OCD, age 18 years or older, willingness to participate, and ability to understand and respond to the study instruments. Patients with psychotic disorders, bipolar disorder in an acute phase, severe cognitive impairment, intellectual disability, severe neurological illness, major unstable medical illness interfering with assessment, or inability to complete the interview were excluded. Patients with severe agitation or poor cooperation at the time of evaluation were also not included.

Sample size and sampling

A total sample size of 100 patients was included. Consecutive sampling was used, and eligible patients fulfilling the study criteria during the study period were recruited until the required sample size was achieved. Sociodemographic details such as age, sex, marital status, and education were recorded using a structured case-record proforma. Clinical variables included duration of illness, predominant symptom pattern, and severity of OCD symptoms.

Study tools and data collection

Severity of obsessive–compulsive symptoms was assessed using the Yale-Brown Obsessive Compulsive Scale, a clinician-administered instrument with established reliability and validity [1,2]. Quality of life was evaluated using the WHOQOL-BREF, which measures four domains: physical health, psychological health, social relationships, and environment [3]. Functional impairment was assessed using the Sheehan Disability Scale, which evaluates disability in work or school functioning, social life, and family life [4]. All participants underwent a structured clinical interview, after which the scales were administered in a standardized manner by trained clinicians or under direct supervision of the investigators.

Statistical analysis

The collected data were entered into a predesigned database and analyzed using standard statistical software. Continuous variables were summarized as mean and standard deviation, while categorical variables were expressed as frequency and percentage. The present manuscript focuses on descriptive analysis of demographic profile, clinical characteristics, quality-of-life domains, and functional impairment patterns in the study population.

Ethical considerations

The study was conducted in accordance with institutional ethical standards and the principles of the Declaration of Helsinki. Written informed consent was obtained from all participants prior to enrolment, and confidentiality of personal and clinical information was maintained throughout the study.

RESULTS

A total of 100 patients diagnosed with obsessive-compulsive disorder were included in the present cross-sectional observational study. The demographic profile of the study participants is summarized in Table 1.

Table 1. Demographic characteristics of the study population (N = 100)

Variable	Category	n	%
Age group (years)	18-25	22	22.0
	26-35	34	34.0
	36-45	26	26.0
	>45	18	18.0
Sex	Male	56	56.0
	Female	44	44.0
Marital status	Married	52	52.0
	Unmarried	42	42.0
	Divorced/Widowed	6	6.0
Education	Secondary school	28	28.0
	Graduate	46	46.0
	Postgraduate	26	26.0

Most participants belonged to the age group of 26-35 years (34%), followed by 36-45 years (26%). Male participants accounted for 56% of the sample and females for 44%. More than half of the participants were married (52%), whereas 42% were unmarried and 6% were divorced or widowed. With regard to educational status, 46% were graduates, 28% had studied up to secondary school, and 26% were postgraduates.

The clinical characteristics of OCD in the study cohort are presented in Table 2.

Table 2. Clinical profile of OCD among participants (N = 100)

Variable	Category	n	%
Duration of illness	<1 year	18	18.0
	1-5 years	44	44.0
	>5 years	38	38.0
Predominant symptom type	Obsessions	28	28.0
	Compulsions	22	22.0
	Mixed symptoms	50	50.0
Severity of OCD (Y-BOCS)	Mild	16	16.0
	Moderate	46	46.0
	Severe	38	38.0

Duration of illness was between 1 and 5 years in 44% of patients, while 38% had illness duration greater than 5 years and 18% had been symptomatic for less than 1 year. Mixed obsessive and compulsive symptoms were the most frequent presentation, observed in half of the participants. Predominantly obsessional symptoms were seen in 28% and predominantly compulsive symptoms in 22%. Assessment of symptom severity using Y-BOCS showed that 46% had moderate illness and 38% had severe illness, whereas 16% had mild severity.

Quality-of-life domain scores measured by WHOQOL-BREF are shown in Table 3.

The psychological domain had the lowest mean score (48.2 ± 11.4), indicating comparatively greater impairment in emotional well-being, self-esteem, and internal psychological functioning. Social relationships also showed a relatively low mean score (50.3 ± 12.1). The physical health domain score was 54.8 ± 10.6, while the environmental domain recorded the highest mean score (56.7 ± 9.8), suggesting relatively better perception of environmental support than other aspects of life.

Table 3. Quality of life among patients with OCD (WHOQOL-BREF domains)

Domain	Mean ± SD
Physical health	54.8 ± 10.6
Psychological health	48.2 ± 11.4
Social relationships	50.3 ± 12.1
Environmental domain	56.7 ± 9.8

The psychological domain had the lowest mean score (48.2 ± 11.4), indicating comparatively greater impairment in emotional well-being, self-esteem, and internal psychological functioning. Social relationships also showed a relatively low mean score (50.3 ± 12.1). The physical health domain score was 54.8 ± 10.6, while the environmental domain recorded the highest mean score (56.7 ± 9.8), suggesting relatively better perception of environmental support than other aspects of life.

Functional impairment across major life domains is presented in Table 4.

Table 4. Functional impairment among patients with OCD (Sheehan Disability Scale)

Domain	Mild n (%)	Moderate n (%)	Severe n (%)
Work/School functioning	24 (24.0)	46 (46.0)	30 (30.0)
Social life	20 (20.0)	48 (48.0)	32 (32.0)
Family life	28 (28.0)	44 (44.0)	28 (28.0)

Moderate impairment was the most frequent pattern in work or school functioning (46%), social life (48%), and family life (44%). Severe impairment was particularly notable in social functioning, where 32% of patients reported severe disability. In work or school functioning, 30% had severe impairment, and in family life 28% reported severe disability. Overall, the findings demonstrate that OCD in this cohort was associated with substantial psychosocial burden, extending beyond symptom severity into day-to-day functioning and perceived quality of life.

DISCUSSION

The present study demonstrates that obsessive–compulsive disorder is associated with considerable psychosocial burden in a tertiary-care clinical population. Most participants were young to middle-aged adults, and the largest proportion fell within the 26–35-year age group. This pattern is broadly consistent with the established clinical profile of OCD, which often becomes functionally prominent during early adult life and remains persistent over subsequent years if not adequately controlled [12,14]. The predominance of patients with illness duration beyond one year and the high proportion with mixed obsessive and compulsive symptoms further reflect the chronic and heterogeneous nature of the disorder seen in routine psychiatric practice.

A notable finding in the present study was the predominance of moderate to severe symptom burden, with 84% of patients falling into these categories on Y-BOCS. This is in line with prior clinical studies showing that treatment-seeking patients with OCD frequently present only after symptoms have become sufficiently intrusive to interfere with work, relationships, and routine functioning [5,6,9]. Earlier research has also emphasized that symptom severity alone does not fully explain the lived burden of OCD; rather, the disorder exerts a multidimensional effect that includes emotional distress, social withdrawal, role limitation, and family strain [7,10,12].

In the assessment of quality of life, the psychological domain had the lowest score in our study, followed by social relationships. This pattern is comparable with previous reports showing marked impairment in mental health, emotional well-being, and social functioning among patients with OCD [5,6,8,10,11]. Eisen et al. and Huppert et al. reported that patients with OCD experience significantly poorer quality of life than healthy controls, particularly in psychosocial domains [7,9]. Hou et al. also identified multiple correlates of reduced quality of life, including symptom severity and social factors [10]. The comparatively higher environmental-domain score in the present study suggests that external living conditions and access to basic supports are relatively less affected than internal psychological and interpersonal domains [11,12].

Functional impairment findings in the present study were equally important. Moderate to severe disability was common across work or school, social, and family domains, with social functioning showing the highest proportion of severe impairment. These observations closely mirror earlier evidence that OCD substantially disrupts real-world functioning, even in patients who remain engaged with family and health services [9,13]. Jacoby et al. highlighted that both quality of life and disability are meaningful outcomes in OCD and that impairment often persists in relation to obsessive distress, avoidance, and associated emotional symptoms

[13]. The current findings reinforce the view that social participation and role performance are especially vulnerable in OCD.

Taken together, the results support the need for a broader clinical approach to OCD. Symptom reduction remains essential, but routine evaluation should also address emotional well-being, social reintegration, family functioning, and occupational rehabilitation. The use of standardized tools for symptom severity, quality of life, and disability offers a more complete picture of illness burden and can help tailor multidisciplinary management strategies for affected individuals.

Limitations

This study has certain limitations. It was conducted at a single tertiary-care center and therefore does not fully represent community or primary-care populations. The cross-sectional design captures the burden at one point in time and does not define longitudinal change. The absence of a comparison group restricted direct estimation of excess impairment attributable to OCD relative to healthy individuals or other psychiatric conditions.

CONCLUSION

Obsessive–compulsive disorder in the present study was associated with marked reduction in quality of life and significant functional impairment across work or school, social, and family domains. A substantial proportion of patients had moderate to severe symptom burden, and the psychological and social domains emerged as the most adversely affected aspects of life. These findings show that the burden of OCD extends well beyond symptom counts and influences everyday performance, interpersonal relationships, and subjective well-being. Incorporating standardized assessment of symptom severity, quality of life, and disability into routine clinical practice can strengthen patient evaluation, support individualized treatment planning, and encourage rehabilitation-focused interventions aimed at improving long-term psychosocial outcomes.

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