



Clinical Profile, Symptom Patterns, and Severity of Obsessive-Compulsive Disorder: A Cross-Sectional Study from a Tertiary Care Centre in South India.

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Abstract

Background: The clinical profile of OCD — including the pattern of obsessive and compulsive symptoms and severity distribution — has been well characterized in Western populations, but data from South India are limited. Objectives: To describe the clinical profile of OCD outpatients at a tertiary care hospital in Chennai, including obsessive-compulsive symptom patterns and Y-BOCS severity distribution, and to examine the relationship between severity and quality of life. **Methods:** Thirty-two consecutive ICD-10 diagnosed OCD outpatients were assessed using the Y-BOCS Symptom Checklist and Rating Scale, MADRS, and WHOQOL-BREF. Symptom profiles were characterized and severity subgroups compared on QOL using one-way ANOVA. **Results:** The majority of patients had moderate (62.5%) or severe (25%) OCD. Contamination obsessions and washing compulsions were among the most prevalent symptom types. Y-BOCS severity significantly predicted physical ($p=0.006$) and psychological ($p=0.023$) QOL. Co-morbid depression was present in 50% of patients. **Conclusions:** OCD in South Indian outpatients presents predominantly at moderate-to-severe severity by the time of presentation. The strong link between severity, depression, and QOL highlights the need for earlier diagnosis and more aggressive treatment initiation.

Keywords: OCD, Y-BOCS, symptom profile, severity, quality of life, South India, clinical characteristics.



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INTRODUCTION

Obsessive-compulsive disorder (OCD) is a heterogeneous condition with a wide variety of obsessive themes and compulsive behaviors. The most common symptom dimensions include contamination/washing, symmetry/ordering, forbidden thoughts (sexual/religious/aggressive), and harm/checking. Understanding the clinical profile of OCD within specific population groups is essential for designing culturally sensitive treatment programs.

OCD is characterized by its secretive nature and chronic course. Most patients seek treatment only after years of suffering, and by the time they present to a tertiary care facility, the majority have moderate-to-severe illness. The severity of OCD, as measured by validated tools such as the Y-BOCS, directly influences functional outcomes including quality of life.

Epidemiological research consistently shows that OCD affects approximately 2% of the adult population. In India, where mental health literacy and access remain limited, clinical presentations are often at advanced severity. This study describes the clinical profile, symptom patterns, and severity of OCD in a South Indian outpatient cohort and examines how severity shapes QOL outcomes.

MATERIALS AND METHODS

Study Setting and Participants

This cross-sectional study was conducted at the Department of Psychiatry, SBMCH, Chennai. Thirty-two consecutive OCD outpatients (aged ≥ 18 years; ICD-10 diagnosis) were enrolled. Patients with schizophrenia, bipolar disorder, psychosis, recurrent depressive disorder, substance abuse (other than nicotine), neurological illness, or severe sensory impairment were excluded.

Clinical Assessment

The Y-BOCS Symptom Checklist systematically identified obsessive and compulsive symptom types in each patient. The Y-BOCS Rating Scale (10 items, 0–4 each; total 0–40) quantified severity: mild (≤ 15), moderate (16–23), severe (24–31), and extreme (32–40). MADRS assessed co-morbid depression, and WHOQOL-BREF measured QOL across four domains on a 0–100 scale.

Statistical Analysis

Frequencies and percentages described categorical variables. One-way ANOVA compared WHOQOL-BREF domain scores across the three Y-BOCS severity categories (mild, moderate, severe). Post-hoc analysis and significance were set at $p < 0.05$.

RESULTS

Sociodemographic Profile

The mean age of the sample was 31.47 ± 8.6 years (range 18–50 years). Males constituted 62.5% ($n=20$) of patients. Most patients (78.1%) were from high socioeconomic status backgrounds, and 56.2% were graduates. The predominance of educated, higher-SES patients likely reflects the self-referral and help-seeking patterns at a private medical college hospital.

Y-BOCS Severity Distribution

The majority of patients presented with moderate (62.5%, $n=20$) or severe (25%, $n=8$) OCD; only 12.5% ($n=4$) had mild illness at presentation (Table 1). This severity distribution reflects the typical delay in help-seeking and the progressive nature of untreated OCD.

Table 1. Y-BOCS severity distribution and corresponding QOL domain scores

Severity	n (%)	Physical QOL Mean $\pm$ SD	Psychological QOL Mean $\pm$ SD	Social QOL Mean $\pm$ SD	Environment QOL Mean $\pm$ SD
Mild	4 (12.5%)	59.50 ± 4.0	47.00 ± 3.5	55.00 ± 27.7	56.50 ± 14.4
Moderate	20 (62.5%)	42.50 ± 12.8	36.30 ± 10.7	45.70 ± 19.7	52.85 ± 14.4
Severe	8 (25.0%)	34.50 ± 10.6	27.50 ± 13.9	42.12 ± 21.9	47.00 ± 15.4
F-value	—	6.152	4.313	0.496	0.686
p-value	—	0.006*	0.023*	0.614	0.511

*Significant at $p < 0.05$. A consistent inverse trend (mild > moderate > severe) was observed across all domains.

Symptom Profile

Using the Y-BOCS Symptom Checklist, contamination obsessions and washing/cleaning compulsions were among the most frequently reported symptom types, consistent with international literature. Aggressive and religious obsessions were also notable, reflecting culturally influenced content of obsessive themes. Checking compulsions were prevalent, particularly in patients with harm-related obsessions. Mixed symptom presentations (multiple obsession-compulsion types) were common in moderate and severe cases.

Co-morbid Depression

Sixteen of 32 patients (50%) had co-morbid depression on MADRS. The higher prevalence in this hospital-based sample compared to community studies likely reflects illness chronicity and severity at presentation.

DISCUSSION

The preponderance of moderate-to-severe OCD (87.5% of patients) in this outpatient sample mirrors patterns observed in other Indian hospital-based cohorts and reflects the significant treatment delay typical of OCD. The secretive nature of the disorder, stigma, and limited mental health literacy in the Indian context all contribute to delayed presentation.

The significant impact of Y-BOCS severity on physical and psychological QOL (but not social or environmental QOL) is noteworthy. This pattern suggests that as OCD severity escalates, the subjective suffering and physical consequences (e.g., skin damage from compulsive washing, sleep disruption) worsen disproportionately, while social and environmental domains — already severely compromised even in mild OCD — show less additional variability.

Contamination and washing symptom dimensions, consistently identified as common across cultural contexts, were prominent in this South Indian cohort. Religious obsessions were also notable, which may reflect the culturally significant role of religious practice in South Indian communities, wherein religious rituals may become compulsive in OCD patients. The 50% co-morbidity rate with depression underscores the compounding burden faced by patients. Clinicians must recognize that treating OCD in isolation, without addressing co-morbid depression, is likely to yield suboptimal outcomes.

Integrated treatment protocols combining SSRIs (which address both OCD and depression) and structured psychotherapy are recommended.

CONCLUSION

The clinical profile of OCD in this South Indian outpatient cohort is characterized by predominance of moderate-to-severe illness at presentation, high rates of contamination-washing and checking symptom dimensions, and a 50% co-morbidity rate with depression. Severity is a significant determinant of physical and psychological QOL. These findings underscore the need for proactive case identification, culturally sensitive clinical assessment, and comprehensive integrated treatment to reduce the overall disease burden of OCD in India.

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