

Self-esteem and obsessive compulsive disorder

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Abstract

Objective: To explore the association between self-esteem and obsessive compulsive disorder in a low-income country, and to conduct an in-depth analysis into the said relationship by identifying any confounding variables that might exist.

Method: The cross-sectional study was conducted at the psychiatry out-patient clinic of Civil Hospital, Karachi, from January to March 2008, and comprised 65 patients diagnosed with obsessive compulsive disorder and 30 healthy controls. The participants completed the Janis and Field Social Adequacy scale and the Rosenberg Self-esteem scale. SPSS 15 was used for statistical analysis.

Results: Significantly different scores were reported on both measures of self-esteem between the patients and the controls ($p < 0.001$ each), indicating reduced levels of self-esteem in the patients compared to the controls.

Conclusions: Data replicated earlier findings from populations in high-income countries.

Keywords: Self-esteem, Obsessive compulsive disorder, Psychiatry. (JPMA 64: 64; 2014).

Introduction

Obsessive compulsive disorder (OCD) is a severe and incapacitating disorder associated with anxiety and distress for sufferers. The illness is characterised by the constant presence of a repetitive or pervasive idea, one that the individual perceives as upsetting and inappropriate, and has been shown to affect the individual's health, along with their social and occupational functioning. The World Health Organisation (WHO), while explaining global disability, listed OCD as one of the top 10 causes.¹ Reports in high-income countries estimate the prevalence rates to be between 1-3%,² with OCD presenting itself across a variety of geographic and socio-economic populations.³ Nevertheless, there exists a gap in the data that links OCD with other demographic variables, such as ethnicity, gender and marital status.⁴

Research in high-income countries has indicated that OCD is associated with high levels of psychiatric co-morbidity, particularly with anxiety and mood disorders. Considering this strong association, it seems logical to consider the relationship between OCD and low self-esteem, a component of psychological health that has frequently been shown to accompany symptoms of both anxiety⁵ and depression.^{6,7} Some studies have suggested that low self-esteem may be an etiological factor in several psychiatric conditions.^{8,9} However, the actual nature of the relationship between self-esteem and most psychiatric disorders remains uncertain; it is not clear whether low self-esteem is a causal or consequential factor of other characteristic symptoms.⁷

In relation to OCD, Fava et al.¹⁰ reported that low self-esteem was one of a number of possible prodromal symptoms of the disorder, suggesting that low self-esteem may perhaps act as a general vulnerability factor. Ehntholt et al.¹¹ provided further support for this notion, reporting that patients with OCD differed significantly from non-clinical controls on generalised self-esteem assessments, and that

self-esteem and OCD appeared to have a link independent of the effect of mood. These findings can be discussed in relation to current cognitive theories of OCD which attribute the development of compulsions to the misappraisal of intrusive thoughts, leading to ineffective strategies to manage the intrusions.¹² It has been suggested that individuals with OCD may have impaired self-perceptions which may lead to such dysfunctional responses, such as catastrophic interpretations of the significance of intrusive thoughts^{13,14} and an overinflated personal responsibility for harm.^{15,16}

While there have clearly been significant advances in the study of OCD in high-income countries, there is little data regarding its clinical features and phenomenology from low-income populations. This is despite the fact that cross-cultural epidemiological studies have indicated that OCD is generally similar in prevalence and clinical characteristics in both Western and non-Western cultures.¹⁷ A recent community-based study in Karachi reported a prevalence rate of 3%.¹⁸ It is clear that a more thorough investigation of self-esteem issues relating specifically to OCD could increase our understanding of the disorder and subsequently the efficacy of targeted interventions. However, to the best of our knowledge, no such research has been conducted in non-Western cultures to date; neither has there been a replication of a simple association between OCD and lowered self-esteem. Research has shown that culture does affect perception and psychopathology. Culture may affect the reaction, management and outcome of the disorder¹⁹ and is, therefore, important to understand. Cultural beliefs are linked to the responses of the individual, which are often reliant upon the cultural framework which enables them to comprehend their experiences and make sense of them.^{20,21} It is proposed that this preliminary investigation is necessary prior to a more in-depth analysis of the relationship, in order to eliminate potentially confounding cultural factors. The present study, therefore, aimed at replicating previous findings from samples from high-income countries indicating a relationship between OCD and self-esteem using a sample obtained from Karachi, Pakistan.

Method

The cross-sectional study was conducted at the psychiatric out-patient clinic at Civil Hospital, Karachi, between January and March, 2008. A consecutive sample of 80 patients fulfilling Diagnostic and Statistical Manual (DSM-IV) criteria for OCD were shortlisted.²² The diagnosis was made by the referring psychiatrist on clinical interview based on Present State Examination.²³ Patients with comorbid psychiatric conditions and organic illnesses were excluded. Besides, 30 healthy controls were recruited from families/carers accompanying the patients.

Since the study was exploratory in nature, no formal sample size calculations were conducted. The study was approved by the institutional review board. The study and its purpose were described to each potential participant with a witness present. After a complete description of the study, informed consent was obtained. Literate participants signed the consent but, those who could not write their name, placed a thumb print on the consent form which was counter-signed by the witness.

All the participants were required to complete two self-assessment questionnaires. The research assistants administered the questionnaires by reading out aloud the questions to all the participants to maintain consistency.

The Urdu version of the Rosenberg Self-Esteem Scale (Rosenberg SES) was used to measure global self-esteem and personal worthlessness. The 10-item Likert scale assesses the degree to which respondents are satisfied with their lives and feel good about themselves. A lower score reflects a higher level of self-esteem. The Rosenberg SES has been used regularly in previous studies examining self-esteem, including those in India and Bangladesh, with good reliability.^{9,11,24}

The Janis and Field Social Adequacy Scale (JF scale) is a 23-item self-rating scale, measuring anxiety in social situations, self-consciousness and feelings of personal worthlessness. A higher score indicates

stronger feelings of adequacy in social situations. The JF scale has been previously used in studies measuring multi-dimensional self-concept.^{9,24}

Both the Rosenberg and the JF scales have been widely used across different cultures and populations, providing evidence of good psychometric properties for use with the sample population.^{24,25}

Statistical analyses were conducted using SPSS 15. Independent Sample t-tests were used to assess group differences between mean scores obtained on the two scales.

Results

Of the 80 patients approached, 65 (81.25%) completed the questionnaires. Among them 32 (49.23%) were males and 33 (50.76%) were females. The female participants with a mean age of 32.8±11.5 years were slightly older than the male participants (29.3±8.8 years). Of the 30 healthy controls, 15 (50%) were females with a mean age of 38.9±12.2 years and 15 (50%) were males with a mean age of 34.0±10.6 years.

There were no significant differences between the groups on most of the major demographic variables, including gender, marital status, occupational status and highest level of education achieved (Table-1).

Table-1: Demographic variables.

	OCD patients n= 65		Healthy controls n= 30		Group differences	
		%		%		
Gender						
Male/Female	32/33	49.2/50.8	15/15	50/50	$\chi^2 = 0.000$	p = 1.0
Age, years ^a	31.52		36.47		t (93) = -2.165	p <
0.05						
^a Values shown as mean (S.D)	-9.758		-11.542			
Marital Status,ⁿ						
Married	33	50.8	19	63.3	$\chi^2 = 0.850$	p =
0.357						
Single/Divorced/ Widowed	32	49.2	11	36.7		
Occupation,ⁿ						
Employed	19	29.2	15	50	$\chi^2 = 6.00$	p =
0.050						
Unemployed/ Student	16	24.6	2	6.7		
Homemaker	30	46.2	13	43.3		
Education (highest level achieved),ⁿ						
No formal education/Primary only	39	60	17	56.7	$\chi^2 = 0.763$	p =
0.683						
Secondary	21	32.3	9	30		
Graduates/Postgraduates	5	7.7	4	13.3		

OCD: Obsessive compulsive disorder.

There was, however, a significant difference between the age of the OCD group and the controls (t (93) = (p <0.05) with a higher mean age in controls than in patients.

Scores on the two measures of self-esteem were compared between patients diagnosed with OCD and the controls (Table-2).

Table-2: Group differences in self-esteem/ social adequacy scores.

	OCD (n = 65)	Healthy Controls (n = 30)	Statistics
JF Scale	51.4 (12.079)	94.10 (11.804)	t = 11.692 , p=<0.001
Rosenberg SES	34.08 (6.263)	19.33 (4.253)	t = -16.130 , p=<0.001

OCD: Obsessive compulsive disorder. JF Scale: Janis and Field Social Adequacy Scale. Rosenberg SES: Rosenberg Self-Esteem Scale.

Mean scores on the JF scale indicated that the patients had low social adequacy and social adjustment (51.4±12.07) compared to the controls (94.10±11.80). Rosenberg SES scores also indicated a lower level of global self-esteem in the OCD group (34.08±6.26) in comparison with the controls (19.33±4.25).

Independent Samples t tests indicated that the reported differences were statistically significant, both for the JF scale (t = 11.692; p<0.001) and the Rosenberg SES (t = 16.130; p<0.001).

Discussion

The present study aimed at replicating previous findings from high-income populations indicating a link between self-esteem and OCD in a sample from a low-income country. Although the study design was relatively simple, the main value of the present study is to eliminate the possibility of potentially confounding cultural factors and to raise questions for further cross-cultural research into the role of self-esteem in OCD. To the best of our knowledge, this is the first study investigating the relationship between self-esteem and any anxiety disorder in a sample from a low-income country.

Results indicated that in terms of generalised self-esteem, as measured by the Rosenberg scale, the clinical group differed significantly from the non-clinical controls. Similarly, self-esteem in relation to social adequacy as measured by the JF scale²⁷ also differed significantly between groups. These findings are consistent with previous studies, which have demonstrated lower self-esteem and social adequacy in OCD patients than the controls.^{10,11}

In a review of the cross-cultural epidemiological literature, Staley & Wand¹⁷ concluded that the prevalence and clinical characteristics of OCD are similar across cultures, though the phenomenology and expression of the disorder may be influenced by cultural beliefs and concerns. While the present study provides preliminary evidence for a similar relationship between OCD and self-esteem as that found in studies conducted in high-income countries, the design of the study does not give scope to comment accurately on the nature of this relationship. Several previous studies have demonstrated that cultural and religious beliefs influence the content of obsessions in OCD.^{28,29} It would, therefore, be interesting to note whether incorporating a distinction between culturally related and specific symptoms would have impact on the relationship with self-esteem. For example, research with a larger clinical

sample could examine whether differences in levels of self-esteem exist between individuals classified as having obsessions/compulsions identified as related to religious or cultural themes and those who are not.

Related research in high-income countries is currently focussing on the role of the self-concept in cognitive-behavioural theories of OCD which emphasise that the self is a multi-dimensional construct in which some domains are valued more than others.³⁰ It is also suggested that an individual's perceived competence in these valued domains is strongly related to his/her self-worth and self-esteem. Doron and Kyrios³¹ reported that individuals with OCD may possess 'sensitive' domains of self, described as domains deemed as important by the patient but in which the patient feels incompetent. It is argued that this feeling of incompetence leads to low social adequacy which in turn may lead to dysfunctional responses, such as catastrophic interpretations of the significance of intrusive thoughts^{13,14} and an overinflated personal responsibility for harm.^{15,16} This self-sensitivity may result in the misappraisal of intrusive thoughts and ineffective strategies to manage the intrusions.¹² The present research is not inconsistent with the view that low self-esteem and social adequacy in OCD may be due to feelings of incompetence and demoralisation in relation to 'sensitive' domains of self. Several limitations of the present study should be kept in mind. It used a cross-sectional design and it is, therefore, difficult to ascertain whether low self-esteem and social adequacy can be described as a consequence of the anxiety disorder or as a general vulnerability factor. Several studies in high-income countries have indicated that the relationship between self-esteem and OCD may be a general vulnerability factor attributable to all anxiety disorders rather than specifically to OCD.¹¹ However, there is also evidence suggesting that patients suffering with OCD understand the irrational nature of their symptoms which may lead to feelings of embarrassment and guilt and a subsequent reluctance to seek help.³² This, in addition to feelings of shame and powerlessness associated with the obsessive-compulsive cycle could potentially be causal of a reduced level of self-esteem.³³ It is, therefore, clear that future research would benefit from including a clinical control group consisting of patients diagnosed with other anxiety disorders in addition to a longitudinal design to elicit a clearer understanding of causation.

Another limitation of this study was the small sample size. Despite this limitation, the study provides preliminary evidence which can support further research. A further limitation relates to the sampling method used to recruit the control group. Relatives of the patients diagnosed with OCD were approached to act as a non-clinical control group and it is recognised that this sample may not be fully representative of a general population, particularly when investigating measures of self-esteem. Furthermore, this resulted in a significant difference in the mean age of the clinical and control groups, a potentially confounding factor, and the size of the control group was small in comparison to the OCD group. Additionally, the findings from this study should be interpreted with caution as the sample was recruited from one hospital in a large urban setting.

Conclusion

The study replicated findings from high-income populations and provided preliminary evidence to suggest that the relationship between low self-esteem, social adequacy and OCD is not culture-specific. Further investigation into the nature of this relationship would be beneficial and an increased understanding of the relationship between low self-esteem, social adequacy and OCD would be complemented by research incorporating a distinction between culturally related and specific symptoms.

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