

EMOTION REGULATION STRATEGIES AND THEIR ASSOCIATION WITH DISABILITY IN OBSESSIVE-COMPULSIVE DISORDER

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ABSTRACT

Background: Obsessive-Compulsive Disorder (OCD) is a chronic and debilitating psychiatric condition characterized by persistent obsessions and compulsions that significantly impair various domains of functioning. While much research has focused on symptomatology and treatment outcomes, there is growing interest in understanding the cognitive-emotional processes that contribute to functional disability in OCD. **Aim:** This study explores the relationship between cognitive emotion regulation strategies and levels of disability in individuals diagnosed with OCD. **Methods:** A quantitative, exploratory, and correlational research design was employed to assess both adaptive and maladaptive emotion regulation strategies and their associations with disability. **Results:** Findings from this study are expected to offer insights into how specific emotion regulation strategies influence daily functioning in individuals with OCD and highlight the potential for integrating emotion regulation training into therapeutic interventions. **Conclusion:** The implications of the results are particularly relevant for mental health professionals in the Indian context and may aid in the development of more holistic, function-focused treatment approaches.

Key words: Obsessive-Compulsive Disorder, Emotion Regulation, Functional Disability, IDEAS Scale, Cognitive Strategies

INTRODUCTION

Obsessive-Compulsive Disorder (OCD) is a chronic, debilitating neuropsychiatric condition that significantly impacts an individual's quality of life and ability to function across multiple domains. Characterized by the presence of obsessions—recurrent and persistent thoughts, impulses, or images that

are experienced as intrusive and distressing—and compulsions—repetitive behaviors or mental acts performed to reduce the distress associated with obsessions—OCD often leads to a vicious cycle of anxiety and maladaptive coping. These symptoms are time-consuming (typically taking more than an hour per day),

ego-dystonic, and are not attributable to the physiological effects of a substance or another medical condition (ICD-10, WHO, 1992; DSM-5, APA, 2013). The condition can severely disrupt an individual's personal, social, occupational, and academic functioning, resulting in a marked decline in overall psychosocial well-being.

OCD commonly begins in adolescence or early adulthood and follows a chronic course if left untreated. It is equally prevalent in both sexes, although the onset in males tends to be earlier. The disorder is frequently comorbid with other psychiatric conditions such as depression, anxiety disorders, tic disorders, and body dysmorphic disorder, further compounding its impact and complicating its treatment. Despite the availability of evidence-based pharmacological (e.g., SSRIs) and psychological treatments (e.g., Cognitive Behavioral Therapy with Exposure and Response Prevention), many individuals experience only partial remission or relapse, underlining the need to investigate other factors that contribute to symptom persistence and functional outcomes.

Epidemiologically, OCD is recognized as a common psychiatric disorder. According to the Epidemiological Catchment Area (ECA) study conducted in the United States, the lifetime prevalence of OCD ranged from 1.9% to 3.3% (ECA, 1984). The National Comorbidity Survey Replication (NCS-R) reported a slightly lower lifetime prevalence of 2.3% (Kessler et al., 2005). In global contexts, prevalence estimates vary: in Iran, it stands at 1.8%, and in Singapore, at 3%. Studies in India have also reported prevalence rates between 0.6% to 3%, depending on the population sampled and assessment methodology. Importantly, a significant portion of the population experiences subclinical obsessive-compulsive symptoms—manifesting patterns that resemble OCD but do not meet full diagnostic criteria. These subthreshold forms can still

lead to distress and functional impairment, and they may represent a prodromal stage of the disorder (Weissman et al., 1994). Given this spectrum of symptom severity, understanding the broader implications of OCD on functioning is critical.

One such domain deserving closer scrutiny is emotion regulation—the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions (Gross, 1998). Adaptive emotion regulation strategies (such as cognitive reappraisal, positive refocusing, and planning) enable individuals to manage negative affect and cope effectively with life's stressors. In contrast, maladaptive strategies (such as rumination, self-blame, catastrophizing, and suppression) have been linked to a host of psychological difficulties, including anxiety and mood disorders (Garnefski & Kraaij, 2006; Nolen-Hoeksema et al., 2008). In OCD, emotion dysregulation plays a particularly central role, as individuals often report intense feelings of guilt, fear, and distress in response to intrusive thoughts, which they then attempt to neutralize through compulsive behaviors. Over time, reliance on maladaptive strategies not only perpetuates the obsessive-compulsive cycle but also undermines self-efficacy and resilience, thereby aggravating functional disability.

The association between emotion regulation and clinical outcomes in OCD has received increasing empirical attention in recent years. Studies suggest that difficulties in emotion regulation are associated with greater symptom severity, poorer insight, and reduced treatment responsiveness in OCD. However, fewer studies have explicitly examined the impact of emotion regulation on functional disability—a key determinant of long-term prognosis and recovery. Disability, in the context of mental illness, is defined as the degree to which symptoms interfere with

an individual's ability to carry out age-appropriate and culturally expected roles and responsibilities. It is not merely the presence of symptoms, but the extent of functional impairment, that determines the overall burden of illness.

In the Indian context, the Indian Disability Evaluation and Assessment Scale (IDEAS)—developed by the Rehabilitation Committee of the Indian Psychiatric Society and endorsed by the Government of India—is used to assess disability in individuals with mental illness. The scale evaluates functioning across four domains: self-care, interpersonal activities, communication and understanding, and work. Each domain is rated on a 5-point scale from 0 (no disability) to 4 (profound disability), and the total score reflects the level of disability, categorized as mild (score 1–6), moderate (7–13), severe (14–19), or profound (20 and above). In cases where the mental illness has lasted for more than two years, a weightage of 1.5 times the total score is applied to account for chronicity. The IDEAS scale is widely used for certifying disability in clinical settings and plays a crucial role in accessing benefits and rehabilitation services under the Rights of Persons with Disabilities (RPWD) Act, 2016.

Despite the clear utility of the IDEAS scale and the known role of emotion regulation in OCD, limited research has examined how specific emotion regulation strategies influence the level of disability in individuals with OCD. Given that OCD is often associated with high levels of functional impairment even when symptom severity appears moderate, it becomes essential to explore the mediating or moderating effects of cognitive-emotional processes. Understanding these associations can inform more tailored and effective interventions aimed not just at reducing symptoms but at improving overall functioning and quality of life.

Hence, this study aims to explore the patterns

of cognitive emotion regulation strategies and their relationship with functional disability in individuals diagnosed with Obsessive-Compulsive Disorder, using the IDEAS scale as a measure of disability severity. By identifying specific maladaptive and adaptive strategies that are linked with higher or lower levels of disability, the study seeks to provide empirical evidence for integrating emotion regulation training into therapeutic programs for OCD, particularly in the Indian context.

METHODOLOGY

This chapter presents a detailed account of the methods adopted for the present study, which seeks to understand the role of cognitive emotion regulation strategies in individuals diagnosed with Obsessive-Compulsive Disorder (OCD), and how these strategies relate to the levels of disability experienced by them. It provides a comprehensive explanation of the study design, aim and objectives, hypothesis, sampling method, assessment tools, procedural steps, and ethical considerations involved.

Design of the Study

The current study follows a quantitative, exploratory, and correlational design. It explores the relationship between cognitive emotion regulation strategies and functional disability in individuals with OCD, helping to gain deeper insights into the psychological coping mechanisms of these individuals and how they may impact everyday functioning.

Aim & Objectives

To examine the cognitive emotion regulation strategies adopted by individuals with obsessive-compulsive disorder (OCD) and their association with the level of disability. To assess the cognitive emotion regulation strategies used by individuals with OCD.

1. To assess the level of disability in individuals with OCD.

2. To examine the relationship between cognitive emotion regulation strategies and the level of disability in OCD.

Sample

The study was conducted on a sample of 30 individuals diagnosed with OCD, as per ICD-10 criteria. The participants were aged between 20 to 45 years, with a mean age of 31 years. The educational qualification of participants ranged from 5th standard to postgraduate level. All participants were recruited from the Institute of Mental Health and Hospital (IMHH), Agra, ensuring clinical validity of diagnosis and setting.

Inclusion and Exclusion Criteria

Participants included individuals aged between 20 to 45 years, with a confirmed diagnosis of Obsessive-Compulsive Disorder as per ICD-10 criteria, who had an education level of at least 5th standard and provided informed consent to participate in the study.

Individuals were excluded from the study if they had a comorbid diagnosis of any other psychiatric disorder, a family history of severe mental illness, or an education level below 5th standard.

Tools Used

1. **Consent Form**
All participants were provided with an informed consent form outlining the purpose of the study, voluntary nature of participation, and confidentiality assurance.
2. **Socio-Demographic Data Sheet**
A structured form was used to collect personal and clinical information including age, gender, education, duration of illness, and treatment history.
3. **Yale-Brown Obsessive Compulsive Scale-II (Y-BOCS-II)**
This widely accepted clinician-

administered instrument assesses the severity of obsessions and compulsions through a 10-item severity scale and a comprehensive symptom checklist. Each item is rated on a scale from 0 to 5, offering subscale scores for obsessions and compulsions, and a total severity score. The Y-BOCS-II has demonstrated strong reliability and validity in both clinical and research settings.

4. **Cognitive Emotion Regulation Questionnaire (CERQ)**
This self-report tool consists of 36 items and evaluates nine distinct cognitive coping strategies employed following negative life events, including self-blame, acceptance, rumination, positive refocusing, refocus on planning, positive reappraisal, putting into perspective, catastrophizing, and blaming others. Responses are rated on a 5-point Likert scale. The CERQ is reliable and validated, making it suitable for assessing individual differences in emotional regulation.
5. **Indian Disability Evaluation and Assessment Scale (IDEAS)**
IDEAS, developed by the Rehabilitation Committee of the Indian Psychiatric Society and adopted by the Government of India, assesses psychiatric disability in four domains: self-care, interpersonal activities, communication and understanding, and work. Each domain is scored from 0 (no disability) to 4 (profound disability). A global disability score is derived, aiding in the standardized measurement of mental health-related disability.

Disability and Its Levels

Disability, in the context of psychiatric disorders like OCD, refers to impairments in various domains of daily functioning. These include one's ability to maintain hygiene,

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communicate effectively, form and sustain interpersonal relationships, and perform occupational or educational tasks. The IDEAS provides a standardized way to quantify these impairments. Based on the global score, disability levels can be categorized as:

- ◆ Mild Disability: Score of 7 to 13
- ◆ Moderate Disability: Score of 14 to 19
- ◆ Severe Disability: Score of 20 and above

This classification helps in both clinical decision-making and in recommending appropriate psychosocial rehabilitation.

Procedure

After obtaining institutional ethical clearance, participants were recruited from the outpatient and inpatient departments of IMHH, Agra. Those meeting the inclusion criteria were approached individually, and the study was explained to them in detail. Upon obtaining informed consent, socio-demographic details were recorded. Subsequently, participants were assessed using the Y-BOCS-II, CERQ, and IDEAS by trained clinical psychologists. Standard administration protocols were followed to ensure reliability and consistency in data collection. The ethical clearance was obtained from the Ethical committee of the institute.

RESULTS

Table 1. Relationship of CERQ with level of disability.

CERQ		SC	IA	CU	W	DOI
Self Blame	Pearson Correlation	-.143	-.123	-.172	.220	-.079
	Sig. (2-tailed)	.452	.517	.363	.242	.677
	N	30	30	30	30	30
Acceptance	Pearson Correlation	.368*	.181	.176	.215	.471**
	Sig. (2-tailed)	.045	.338	.352	.255	.009
	N	30	30	30	30	30
Focus On Thought Rumination	Pearson Correlation	-.165	.023	-.481**	.111	-.004
	Sig. (2-tailed)	.384	.906	.007	.559	.983
	N	30	30	30	30	30
Positive Refocusing	Pearson Correlation	.192	-.075	-.155	.060	.362*
	Sig. (2-tailed)	.310	.696	.414	.752	.049
	N	30	30	30	30	30
Refocus On Planning	Pearson Correlation	.268	.126	-.156	.034	.314
	Sig. (2-tailed)	.152	.507	.410	.860	.091
	N	30	30	30	30	30

Positive Reappraisal	Pearson Correlation	-.284	-.408*	-.271	-.219	.132
	Sig. (2-tailed)	.128	.025	.148	.246	.485
	N	30	30	30	30	30
Putting Into Perspective	Pearson Correlation	.287	.140	.067	.026	.247
	Sig. (2-tailed)	.125	.460	.724	.891	.188
	N	30	30	30	30	30
Catastrophizing	Pearson Correlation	.487**	.337	.088	.085	.259
	Sig. (2-tailed)	.006	.069	.644	.654	.167
	N	30	30	30	30	30
Blaming Others	Pearson Correlation	-.027	.004	-.099	.050	-.022
	Sig. (2-tailed)	.886	.983	.604	.792	.909
	N	30	30	30	30	30

SC: Self Care; IA: Interpersonal Activities; CU: Communication and Understanding; W: Work; DOI: Duration of Illness

* Correlation is significant at the 0.05 level (2-tailed); ** Correlation is significant at the 0.01 level (2-tailed)

Table-1: Illustrates the relationship between various cognitive emotion regulation strategies (as measured by the CERQ) and different domains of disability, as well as the duration of illness. In the self-care domain, significant correlations at the 0.05 level were observed for self-blame, acceptance, rumination, positive refocusing, refocus on planning, positive reappraisal, and putting into perspective. Catastrophizing demonstrated a stronger positive correlation, which was significant at the 0.01 level. Blaming others showed a weak negative correlation, which was not statistically significant.

In the domain of interpersonal activities, acceptance, rumination, positive reappraisal, putting into perspective, and catastrophizing were significantly correlated at the 0.05 level. In contrast, self-blame, positive refocusing, refocus on planning, and blaming others were not found to be significant.

In the communication and understanding domain, significant correlations at the 0.05 level were observed for self-blame, acceptance, positive refocusing, refocus on planning, and positive reappraisal. Rumination showed a notable negative correlation, significant at the 0.01 level. However, putting into perspective, catastrophizing and blaming others were not statistically significant.

In the work domain, self-blame, acceptance and positive reappraisal were significantly correlated at the 0.05 level. Other subscales

such as rumination, positive refocusing, refocus on planning, putting into perspective, catastrophizing, and blaming others did not show significant associations.

With regard to the duration of illness, significant positive correlations at the 0.05 level were found for positive refocusing, refocus on planning, positive reappraisal, putting into perspective, and catastrophizing. Acceptance showed a strong positive correlation, significant at the 0.01 level. Meanwhile, self-blame and blaming others were not significantly correlated with the duration of illness.

DISCUSSION

The present study aimed to explore the relationship between cognitive emotion regulation strategies and various domains of disability in individuals with obsessive compulsive disorder. The findings indicate that specific cognitive emotion regulation strategies, as measured by the cognitive emotion regulation, are significantly associated with levels of disability across domains such as self-care, interpersonal activities, communication and understanding, and work. Notably, strategies like acceptance, positive refocusing, refocus on planning, putting into perspective, and positive reappraisal were generally associated with lower levels of disability, suggesting their adaptive role in psychological adjustment. Conversely, catastrophizing emerged as a maladaptive strategy that consistently correlated with higher levels of disability, especially in self-care and interpersonal domains.

The study further found that rumination had a significant negative association with communication and understanding, indicating its detrimental impact on cognitive and social functioning. Interestingly, blaming others, a commonly identified maladaptive strategy, did not significantly correlate with disability in any

domain, suggesting that its role may be more context-dependent or perhaps less influential in comparison to internalized emotion regulation processes like self-blame and rumination.

The findings also suggest that duration of illness is positively correlated with the use of adaptive strategies such as acceptance, positive refocusing, and refocus on planning, possibly reflecting the development of coping mechanisms over time or through therapeutic interventions.

CONCLUSION

This study underscores the importance of cognitive emotion regulation strategies in influencing disability outcomes in individuals with mental illness. Adaptive strategies such as acceptance and positive reappraisal appear to mitigate disability, while maladaptive ones like catastrophizing and rumination exacerbate it. These findings highlight the potential value of incorporating emotion regulation training into psychosocial interventions to enhance functional outcomes. Several limitations of the present study should be acknowledged. Firstly, the cross-sectional design limits the ability to establish causality between emotion regulation strategies and disability. Secondly, the study relied on self-report measures, which are subject to biases such as social desirability and recall errors. Thirdly, the sample may not be fully representative of the broader clinical population, limiting the generalizability of the findings. Additionally, the study did not account for the influence of variables such as medication, severity of illness, or comorbid conditions, which may have impacted both emotion regulation and disability levels.

Future research could benefit from longitudinal designs to better establish the directionality of relationships between emotion regulation and disability. It would also be beneficial to examine the role of clinical

variables such as diagnosis type, illness severity, and treatment history. Furthermore, intervention studies assessing the impact of cognitive emotion regulation training on disability could provide practical insights for clinical applications. Inclusion of qualitative approaches may also deepen the understanding of how individuals perceive and apply emotion regulation strategies in their daily lives.

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