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Association of Depression with Phenomenology and Insight Among Patients with Obsessive-Compulsive Disorder

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Abstract

Background: The phenomenology of obsessive-compulsive disorder (OCD) is influenced by culture; its understanding can enhance case identification. Insight levels and depressive symptoms may vary with OCD phenomenology, affecting management and outcomes. This study assessed the association of depression with phenomenology and insight among patients with OCD and predictors of comorbid depression severity.
Methodology: This observational study enrolled 146 participants after receiving ethical approval and consent. Obsession and compulsion were assessed using the Yale-Brown Obsessive Compulsive Scale (YBOCS). Insight and depression were assessed with the Over Valued Ideas Scale (OVIS) and the Hamilton Depression Rating Scale (HDRS). Linear regression was employed to identify predictors of the severity of depression.
Results: The sample consisted of 68.5% males, with a mean age of 31.5 years. The mean duration of OCD was 63 months. Contamination was the most common obsession; while washing or cleaning was the most frequent compulsion. Aggressive, sexual, and religious obsessions were more prevalent in males. Notably, 73.2% of patients experienced depression. Those with depression exhibited longer and more severe OCD. The severity of depression had a significant positive correlation with the duration of OCD, the YBOCS score, and the OVIS score. Female gender and higher OVIS scores were significant predictors of the severity of depression, with gender being the most important predictor.
Conclusion: Depression is quite common among patients with OCD, particularly those experiencing longer and more severe illnesses. Being female and having lower insight significantly predict the severity of depression.

Keywords: Depression; Insight; Obsessive-Compulsive Disorder; OCD; Phenomenology; Predictors of Depression; Severity.

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Quick Response Code:

Introduction

Obsessive Compulsive Disorder (OCD) is a complex and varied condition that can significantly impair individuals, affecting an estimated 1% to 3% of the population at some point in their lives. [1] Phenomenology captures the experience of events directly, free from assumptions and theoretical frameworks, providing a straightforward account of mental occurrences without trying to pinpoint their causes or psychological roots. [2] It broadens the dimensional perspective of OCD by examining the unique characteristics of obsessive-compulsive symptoms. Six categories of obsessions have been recognized: doubt, fear, image, thought, impulse, and miscellaneous. Compulsions can be generally classified into two types: controlling and yielding. [3]

Although recognized as a single disorder, OCD presents as a clinically diverse condition, varying both in the types of symptoms experienced and the level of insight about these symptoms. [4] A study conducted in India found that men typically experienced an earlier onset and exhibited more frequent sexual and religious obsessions, along with pathological doubts and compulsions related to checking and repeating. In contrast, women tended to report a greater prevalence of contamination fears. [5] The earlier onset of OCD was specifically associated with a higher occurrence of sexual obsessions, as well as rituals involving repetition and hoarding, along with compulsions related to touching. [6]

Apart from the chronic course and slow treatment response, symptoms of OCD can be personally distressing and disabling. Therefore, it is not surprising to see an association between OCD and depression, and occasionally with suicidality. [5] A recent systematic review found that mood-related disorders accounted for 47.7% (major depressive disorder: 35.4%) of shared comorbidities, and a higher comorbidity with any psychiatric illness was observed in males.[7] This co-morbid depression steadily predicts poor treatment response to psychological therapies, mainly due to low engagement and early treatment dropout. [8]

In OCD, insight—recognizing the irrational nature of symptoms—is viewed as essential to understanding the disorder. This insight exists on a spectrum, ranging from full recognition of its absurdity to total unawareness. [9] Evaluating the level of insight is vital for effective OCD management.

Patients with diminished insight often exhibit more intense obsessive-compulsive symptoms, have a longer illness duration, follow a chronic trajectory, and respond less favourably to treatments. [10]

A phenomenological analysis of OCD is vital because individuals with mild or distinctive symptoms frequently go undiagnosed and untreated. The insight and severity of depressive symptoms can differ based on phenomenology, duration, and severity of OCD, affecting management, prognosis, and overall outcomes. Few earlier studies have explored this facet of OCD, and their findings have been inconsistent. However, there has been less focus on research examining the relationship between OCD phenomenology, insight, depression, and predictors of depression severity, particularly in the Indian context. Therefore, the current study investigates the association of depression with phenomenology and insight among patients with obsessive-compulsive disorders and predictors of comorbid depression severity.

Material and Methods

Following approval from the Institutional Ethics Committee, this cross-sectional observational study was conducted in the psychiatry department of a tertiary care hospital in northwestern India. All procedures followed were in accordance with the ethical standards of the Institutional Ethics Committee, including informed consent, confidentiality, and privacy. As the obsession and compulsion phenomena of OCD are quite distressing, appropriate supportive and therapy sessions were provided to them as part of comprehensive management.

This study enrolled patients through convenience sampling over one and a half years, from July 1, 2021, to December 31, 2022, who met the selection criteria (n=146). The study included patients diagnosed with OCD according to the International Classification of Diseases, Eleventh Revision (ICD-11) [11], aged between 18 and 60 years. Patients with a history of depression before the onset of OCD, comorbid psychiatric illnesses (excluding depression), intellectual disabilities, substance use disorders (excluding tobacco), chronic medical conditions, organic brain syndromes, and neurological disorders were excluded.

Participants meeting the selection criteria were recruited after providing written informed consent. We recorded socio-demographic details, including age, gender, religion, marital status, residential status (urban or rural), educational level, employment status, and socio-economic status. We also noted clinical profiles, such as the age of onset of OCD, total duration of illness, obsession and compulsion content, insight, and family history of psychiatric conditions, including OCD and depression. The form, content, and severity of the obsession and compulsion were evaluated using the Yale-Brown Obsessive Compulsive Scale (YBOCS). Subsequently, we assessed insight levels in patients with OCD and severity of depression using the Over Valued Ideas Scale (OVIS) and the Hamilton Depression Rating Scale (HDRS), respectively.

Y-BOCS, a 10-item scale, assesses OCD severity. Items 1-5 address obsessions, while 6-10 cover compulsions, scoring from 0 to 4, with 4 indicating the highest severity. Y-BOCS categorizes symptoms as mild (0-13), moderate (14-25), moderate to severe (26-34), and severe (35-40). The checklist outlines various obsessions (e.g., contamination, hoarding, aggression) and compulsions (e.g., arranging, counting, checking). Symptoms may refer to past or current experiences, highlighting major obsessions and compulsions. The checklist and scale demonstrate high test-retest reliability, good to high internal consistency, and high validity.[12]

The OVIS scale quantifies overvalued ideations and insight in OCD patients. It consists of 11 items, with 10 items scored from 0 to 10 on a Likert scale, and the last item scored separately. Each item includes three questions to assess the patient's beliefs. Each item of the OVIS is rated from 0 to 10, with higher scores indicating poorer insight. The scores are summed and divided by 10 to generate a total score. OVIS scores range from low (indicating minimal impact of overvalued ideas) to moderate to high (indicating a greater degree of impact and potentially poorer insight). Good insight is indicated by a low OVIS score of ≤ 3.9, fair insight is reflected by an OVIS score of ≥ 4 and ≤ 5.9, and poor insight is indicated by an OVIS score of ≥ 6 (moderate to high OVIS score). Internal consistency ($\alpha = 0.88–0.95$) and inter-rater reliability ($r = 0.86$) are adequate.[13]

The HDRS, a 17-item clinician-rated scale, assesses the severity of depression. Participants are evaluated using a 5-point Likert scale. Scores range from 0 to 7 for normal, 8 to 13 for mild, 14 to 18 for moderate, 19 to 22 for severe, and 23 or higher for very severe depression (Cronbach's alpha = 0.85).[14]

Data was analyzed using SPSS Version 21. Means and standard deviations were calculated for continuous variables, while frequencies for nominal or ordinal variables were determined. The Shapiro–Wilk test assessed data normality. Continuous variables were compared using the Mann-Whitney U test, considering the non-normal nature of the data. Categorical variables were compared with the Chi-square test. Bivariate correlation analysis employed Spearman's coefficient to examine associations between continuous variables. Linear regression analysis was used to identify predictors of depression severity. A p-value of less than 0.05 was considered significant.

To draft this manuscript, we used the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline. [15]

Results

Out of the 146 participants, approximately two-thirds were male. Most were married, lived in urban areas, practiced Hinduism, and came from nuclear families. The average age was about 31.5 years, and the average education level was 12 years. The mean duration of OCD was 63 months, with an onset age of 26 years. A small percentage of patients had a family history of OCD (12%) and depression (20%). The mean YBOCS scores (25.20) indicated moderate to severe OCD, while the mean HDRS scores (15.20) pointed to moderate depression in the study sample. The average score on the OVIS scale was 2.75, suggesting that most patients exhibit low OVIS, which corresponds to good insight.

Table 1: Socio-demographic and Clinical details of study participants (n = 146)

Socio-demographic variables	Frequency (%)
Gender	
Male	100 (68.5)
Female	46 (31.5)
Marital Status	
Single	58 (39.7)
Married	88 (60.3)
Divorced	0 (0)
Locality	
Urban	81 (55.5)
Rural	65 (44.5)
Occupation	
Professional	22 (15.1)
Skill worker	21 (14.4)
Semi-skilled/unskilled worker	29 (19.9)
Unemployed	11 (7.5)
Housewife/household	29 (19.9)
Retired	4 (2.7)
Student	30 (20.5)
Family type	
Nuclear	85 (58.2)
Extended	5 (3.4)
Joint	56 (38.4)
Religion	
Hindu	134 (91.8)
Muslim	12 (8.2)
	Mean (SD)
Age (Years)	31.5 (11.343)
Education (Years)	12.14 (3.76)
Family Income (Rupees per month)	62712 (77554.871)
Duration of Illness of OCD(Months)	63.15 (59.34)
Age of Onset of OCD(Years)	26.335 (12.47)
YBOCS score	25.219 (3.97)

OVIS score	2.75 (1.26)
HDRS score	15.205 (8.19)

n=number of participants; %=percentage; SD=Standard Deviation; OCD=Obsessive Compulsive Disorder, YBOCS=Yale-Brown Obsessive-Compulsive Scale, OVIS=Over Valued Ideas Scale, HDRS=Hamilton Depression rating scale

The obsession index showed that contamination obsession was the most prevalent (52.1%), followed by aggressive (32.2%) and sexual obsession (29.5%). Within the contamination obsession, concern with household items was most common, and among aggressive obsession, the most common obsession was "fear might harm others". Among sexual obsession, sexual thoughts, images, or impulses scored highest, and few reported contents involving sexual themes related to children and homosexuality. Around 21% of study participants reported religious obsessions, the most common being concerned with blasphemy. Obsessions related to symmetry were reported in 25% of study participants, and the majority were accompanied by magical thinking. Somatic obsessions were present in 12% of study participants, with most of them having obsessions with concerns related to illness or disease. Miscellaneous obsessions, like fear of not saying just the right thing and the need to know, were present in 8% of study participants. Four study participants (2.7%) reported hoarding obsessions. Aggressive, sexual, and religious obsessions were seen more often in males.

Regarding compulsions, washing and cleaning behaviors were the most common at 50.7%, followed by repeating rituals at 36.3%, miscellaneous compulsions at 30%, and checking behaviors at 29.5%. Among washing and cleaning behaviors, ritualized handwashing and excessive bathing were the most prevalent. Among repeating rituals, the most common was the need to repeat routine activities and to reread or write. Among miscellaneous compulsions, the most frequent included mental rituals and the urge to touch, tap, or rub. Among checking behaviors, most are related to verifying locks and appliances, followed by ensuring that no mistakes are made. Each of the counting and ordering compulsions was noted in around 16% of participants.

Table 2: Phenomenology of Obsessions and Compulsions

Phenomenon of Obsession and Compulsions	OCD with Depression (n=107)	OCD without Depression (n=39)	Total (n=146)
Phenomenology of Obsessions			
Contamination obsession			
Contamination obsession	56	20	76
Concern with bodily waste or secretions	11	2	13
Concern with environmental contaminants	39	17	56
Concern with household items	46	18	64
Excessive concern with animals	2	0	2
Bothered by a sticky substance or residues	0	0	0
Concerned will get ill because of contaminant	6	3	9

Concerned will get others ill by spreading the contaminant	2	1	3
No concern with consequences	2	0	2
Aggressive obsessions			
Aggressive obsessions	39	8	47
Fear might harm self	11	1	12
Fear might harm others	14	3	17
Violent or horrific images	7	2	9
Fear of blurting out insults	1	0	1
Fear of doing something else embarrassing	7	2	9
Fear will act on an unwanted impulse	2	0	2
Fear will steal things	0	0	0
Fear will harm others because of not careful enough	5	2	7
Fear will be responsible for something else terrible happening	3	1	4
Sexual obsessions			
Sexual obsessions	31	12	43
Forbidden or perverse sexual thoughts, images, or impulses	30	11	41
Content involves children or incest	4	2	6
Content involves homosexuality	1	0	1
Sexual behavior toward others	0	0	0
Other obsessions			
Hoarding obsessions	4	0	4
Religious obsessions	21	10	31
Need for symmetry	28	8	36
Miscellaneous obsessions	29	5	34
Somatic obsessions	13	4	17
Phenomenology of Compulsions			
Cleaning/washing compulsion			
Cleaning/washing compulsion	54	20	74
Excessive/ritualized handwashing	52	17	69
Excessive showering/bathing, toothbrushing	33	13	46
Other measures to prevent contamination	5	1	6
Repeating rituals			

Repeating rituals	42	11	53
Rereading or writing	13	2	15
Need to repeat routine activities	29	8	37
Checking compulsion			
Checking compulsion	33	10	43
Checking locks, stoves, and appliances	27	7	34
Checking that did not/will not harm self	2	0	2
Checking that nothing terrible did/will happen	3	3	6
Checking that did not make a mistake	11	5	16
Checking tied to a somatic obsession	0	0	0
Other compulsions			
Miscellaneous compulsion	33	10	43
Counting compulsion	15	9	24
Ordering compulsion	17	6	23
Hoarding compulsion	2	0	2

Notably, 73.2% of patients with OCD had depression (HDRS score >7). Based on the presence of depression, the sample has been divided into two groups: OCD with Depression and OCD without Depression. Those with depression had significantly longer OCD duration and a higher YBOCS score. No significant differences were found in other demographic and clinical variables and OVIS scores between the two groups.

Table 3: Comparison of Demographic and clinical variables among the two groups with the Mann-Whitney U test

Variables	OCD without depression (Mean Rank)	OCD with Depression (Mean Rank)	Mann-Whitney U value	Sig
Age (Years)	73.38	73.54	2091.000	0.984
Education (Years)	72.50	73.86	2125.5000	.857
Family income (in rupees per month)	74.51	73.13	2047	.861
Age of onset of Depression	80.42	70.98	1816.500	.232
Duration of OCD (months)	58.06	79.13	2688.500	.007

Duration of untreated illness (Years)	70.31	74.66	2211	.579
Total YBOCS score	68.22	75.43	2292.500	.04
Total OVIS score	67.31	75.76	2328.000	.285

OCD = Obsessive Compulsive Disorder, YBOCS = Yale-Brown Obsessive Compulsive Scale, OVIS = Over Valued Ideas Scale

No associations were discovered between specific obsessions and compulsions' phenomenology and depression or insight levels. (Supplementary Table 1,2)

On Spearman correlation, the severity of depression on HDRS had a significantly positive correlation with the duration of OCD, the YBOCS score, and the OVIS score. This suggests that the longer the duration and the greater the severity of OCD and overvalued ideas (poorer insight), the more severe the depression will be. The OVIS score correlated significantly positively with YBOCS. This indicates that the higher the severity of OCD, the worse the insight will be. The OCD severity was positively correlated with the patient's age and the duration of OCD. (Table 4)

Table 4: Spearman Correlation of sociodemographic and clinical variables

	Age	**Education Years**	**Family Income**	**Age of onset of OCD (Years**	**Duration of OCD**	**YBOCS Score**	**OVIS Score**
	Spearman's rho (*p*)						
Education Years	0.080 (0.340)						
Family Income	0.025 (0.762)	0.029 (0.731)					
Age of onset of OCD (Years)	0.875 (0.000)	-0.001 (0.991)	0.042 (0.614)				
Duration of OCD	0.219 (0.008)	0.109 (0.192)	-0.045 (0.590)	-0.208 (0.012)			
YBOCS Score	0.216 (0.009)	-0.110 (0.186)	-0.051 (0.537)	0.122 (0.142)	0.237 (0.004)		
OVIS Score	0.104 (0.211)	-0.003 (0.969)	-0.112 (0.177)	0.069 (0.407)	0.117 (0.159)	0.281 (0.001)	
HDRS Score	0.054 (0.515)	-0.079 (0.341)	-0.006 (0.946)	-0.027 (0.742)	0.218 (0.008)	0.165 (0.047)	0.182

							(0.028)

Linear regression identified predictors of depression severity. Automatic linear modeling was employed. Gender, total OVIS score, severity of OCD on YBOCS, and illness duration were included as predictors for analysis. The best subset method selected the model, using the Corrected Akaike Information Criterion (AICC) as the inclusion criterion. The final model excluded the Severity of OCD. Female gender and higher OVIS scores significantly predicted depression severity in the final model, with gender being the most important predictor.

Table 5: Predictors of Severity of Depression among patients with OCD

Variables	Coefficient	Std. error	t	Sig.	95% Confidence Interval		Importance
					Lower	Upper	
Female Gender	4.348	1.388	3.132	0.002	1.604	7.092	0.583
OVIS Score	1.053	0.516	2.039	0.043	0.032	2.073	0.247
Duration of OCD	0.020	0.012	1.692	0.093	-0.003	0.043	0.170

Discussion

In exploring the phenomenology of obsessions, the index study identified contamination obsession and cleaning or washing compulsions as the most prevalent. An Indian study [16] also found contamination obsession to be the most common, closely followed by aggressive obsession and obsession with symmetry. However, checking compulsion emerged as the most common in that study, followed by cleaning compulsion and repeating rituals. The differences in phenomenology may stem from cultural variations, as emphasized by a study showing that religiosity can influence both the nature and severity of obsessions and compulsions.[17] Similarly, a study indicates that symmetry obsessions and ordering compulsions are the only presentations with frequencies that did not significantly differ across cultures.[18]

Additionally, around 92% of our study participants exhibited multiple obsessions and compulsions. Earlier studies indicated that multiple obsessions were found more frequently than specific obsessions. In a study conducted in Sri Lanka, around 50% of participants had more than one type of obsession and compulsion.[19] One possible reason for this higher frequency of multiple phenomena could be the thorough application of the YBOCS checklist in our study, unlike the assessment by a semi-structured questionnaire in the cited research, as many obsessions or compulsions evident in an individual were not apparent during the initial clinical interview, since patients often revealed only the most distressing ones. Those causing less subjective distress are usually overlooked, highlighting the importance of this evaluation. It becomes crucial to address each obsession and compulsion during psychotherapy to achieve remission.

In the index study, males commonly presented with aggressive, sexual, and religious obsessions compared to females, who typically had multiple types of obsessions and compulsions. A multicentric study from northern India also found that males exhibited a higher rate of sexual obsession, while females showed a greater prevalence of hoarding obsession.[20]Similar findings were echoed in earlier studies where men had a higher frequency of sexual and religious obsessions, and women had a higher frequency of fear of contamination.[5,21]One study concluded that no symptom presentation of OCD covaried with gender except for sexual obsessions, which were more commonly endorsed in samples with a greater number of male patients.[18] A possible reason for the high prevalence of aggressive or sexual obsessions seen in males could be attributed to the different social roles and expectations within our society. The mean age of onset of OCD for males was lower compared to females, consistent with another study.[22]

In the index study, 82% of participants showed good insight. Likewise, a study conducted in northern India indicated that around 81% of patients exhibited good insight, though this evaluation used the Brown Assessment of Beliefs Scale (BABS).[23]

Furthermore, research found a positive link between hoarding, a fixation on symmetry, and insight levels.[24] This connection was not observed in our study, presumably due to most of our patients demonstrating good insight and the limited number of individuals with hoarding obsessions in our sample.

Like our findings, another study observed that patients with limited insight displayed more severe obsessive-compulsive symptoms. [10,25] Another study found that metacognitive aspects, OCD severity, and related disability emerged as key predictors of insight among individuals with OCD.[26] These findings highlight the crucial need to evaluate insight and its impact on predicting treatment outcomes. This also suggests implementing cognitive restructuring and mindfulness techniques in the management plan to improve insight.

Greater severity of current and worst-ever hoarding symptoms was associated with poor insight in OCD after controlling for current OCD severity, age, and gender.[25] Another study found a correlation between insight and compulsions, particularly of the checking type, indicating that worse insight is associated with greater compulsion severity.[27] This suggests that individuals who do not recognize their behaviors as excessive or irrational tend to have more intense and disruptive compulsive symptoms. This relationship was not identified in the index study.

Unlike our findings, poor insight has been associated with a longer duration of illness. [28,29] However, similar to our findings, poor insight has also been found to be associated with comorbid diagnoses such as depression. [10,29]

In the index study, approximately 73% of participants had depression. Additionally, an association was observed between the duration of OCD and the YBOCS severity score, as well as the presence and severity of depression. Compared to our study, research conducted in Turkey found that 45% of OCD patients had depression. However, similar to our findings, the group with depression had higher scores on the YBOCS severity rating.[30] Studies from the United States report that the lifetime prevalence rates of comorbid major depressive disorder (MDD) are 19%, which is relatively low compared to our results.[31] Apart from the differences in study design, sampling strategies, and demographic and cultural factors, one possible explanation for the high comorbidity of depression in our study might be the influence of conducting research in a tertiary care center, where most cases were referred from various other facilities.

Our findings were comparable to a study conducted in Australia, which indicated that a group of patients with OCD and depression had a longer duration of OCD.[32] Similar to our findings, some earlier research also suggests that a chronic course of OCD is associated with an increased risk of a comorbid depressive disorder.[33,34] This may be due to the extended illness duration being associated with greater impairment of functioning. In contrast to our findings, an extensive community-based study found no relationship between depression and OCD symptom duration.[35]

A study in Taiwan found that somatic obsessions were particularly associated with depression. [36] Another study reported that the OCD contamination subtype and perfectionism were linked to depressive symptoms.[37] Studies found that higher scores on the unacceptable thoughts subtype, which typically features obsessions related to morality, aggression, and sex, are connected to depression in OCD [38], and these types of obsessions further predict a depression diagnosis. [39] However, our study showed no significant link between the type of obsession or compulsion and the presence of depression.

Our study identified only female gender and higher OVIS scores as significant predictors of depression severity, after automatically excluding OCD severity from the final regression model. This may be due to poor insight leading to increased obsession and compulsion symptoms and a longer duration of untreated illness. In contrast, another study indicates that the severity of obsession and compulsion can predict depressive symptoms, and the logistic regression analysis revealed that hoarding compulsion, stressful life events, anxiety scores, and YBOCS scores were positively associated with depression severity in OCD.[40] Additionally, another study's logistic regression model suggested a link between obsession severity and the occurrence of MDD in OCD.[39]

Our study found that being female is the strongest predictor of depression severity. Our results aligned with some studies, suggesting that females are more prone to depression than males. [41,42] However, other research shows no such relationship. [43] Besides hormonal changes and variations in coping mechanisms, socio-cultural influences such as gender roles, bias, and restricted opportunities can greatly affect women's mental health, potentially accounting for the gender differences observed in depression. In the social environments of our study participants, women frequently encounter heightened societal expectations and pressures concerning family, work, and relationships, along with diminished social support.

This study offers valuable insights into the detailed phenomenology and predictors of depression severity, utilizing clinician-rated scales to minimize biases and errors related to patients. Nonetheless, it has limitations, such as being cross-sectional and conducted at a single tertiary care hospital. Consequently, it's essential to recognize that these findings cannot be generalized. Additionally, the research did not consider other co-morbidities, including anxiety disorder or any other affective disorder, which could influence the severity rating for OCD and its progression.

Conclusion

Clinicians need to assess phenomenology to identify hidden obsessions and compulsions. Each phenomenon plays a crucial role in personalized treatment planning, particularly within cognitive behavioral therapy (CBT). Additionally, individuals experiencing long-term OCD and elevated YBOCS scores tend to have a higher prevalence of depression, highlighting the importance of early and timely intervention. Being female and exhibiting poorer insight are significant indicators of depression severity. Implementing therapy techniques designed to improve insight could be beneficial for those with OCD. Future studies should emphasize community-based research with larger, diverse samples across various age groups, especially longitudinal studies to monitor recovery over time.

Conflict of interest: The authors declare no conflict of interest

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