Correlates of insight among patients with obsessive compulsive disorder

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Abstract

INTRODUCTION: Obsessive-compulsive disorder (OCD) patients have been traditionally described as patients with real insight. However, in fact, the insight exists on a continuum, ranging from a good understanding of nonsensicality the obsessions and compulsions to lack of insight with considering them to be rational and appropriate.

METHOD: A computerized search of the literature published from 1966 to July 2013 was conducted on Medline and Web of Science using words “obsessive compulsive disorder” and “insight”. No language constraints were used. Lists of references of the articles identified by this computer database search were examined manually to find other studies.

RESULTS: Poor insight has been linked to a greater symptom severity, an increased risk of comorbid symptoms, worse adaptive functioning, and worse treatment outcomes for OCD. Reduced insight is related to longer duration of illness, early onset of symptoms, chronic course, and increased family history of OCD. Poor insight is also linked to comorbid diagnoses.

CONCLUSION: Impaired insight is prevalent in OCD and may contribute to both medical presentation and treatment outcome.

INTRODUCTION

Traditionally, obsessive-compulsive disorder (OCD) is described as a disorder in which subjects have quite good insight into their symptoms. Insight is a multidimensional concept (Eisen et al 1998; Kendler et al 1983; Kozak & Foa 1994), which includes components such as understanding that the belief has a psychological/psychiatric reason, and readiness to consider that the belief may be wrong (Eisen et al 1998; Kendler et al 1983). Numbers of investigators have proposed that there is a range of insight in OCD (Robinson et al 1976; Solyom et al 1985; Insel & Akiskal 1986; Lelliot et al 1988; Kozak & Foa 1994). Studies published poor insight in between 15% and 36% of patients with OCD (Eisen et al 2001; Tolin et al 2001; Marazziti et al 2002; Matsunaga et al 2002). Insel and Akiskal (1986) postulated that the insight in OCD exists on a continuum, ranging from a full understanding of the irrationality of obsessions and compulsions to viewing them as rational and appropriate.

Insight used to be defined as an understanding of the drive behind one’s thoughts or behaviors, as recognition of one’s emotional or psychological problems
or may even suggest an immediate understanding of a problem-based on various organizational strategies. Insight, however, is a somewhat vague defined, seems to be multi-dimensional and influenced by many internal and external factors (Neziroglu & Stevens 2002). Insight is, however, assessed more complexly by asking patients whether they believe they are ill, what possibly caused illness and whether they think that the treatment is needed. Insight into the occurrence of symptoms is just one aspect of a broader concept of insight (Cherian et al 2012). There is no clear definition what should be the object of insight in OCD, whether it should be symptoms, need for treatment or general understanding of illness (Markova et al 2009).

Insight is crucial not only for psychotic syndromes (Lincoln et al 2007; Kaplan et al 2006) but also in affective disorders (Keller et al 2007; Latarella 2012) and eating disorders (Steinglass et al 2007; Konstantakopoulou et al 2011), as well as OCD (Eisen et al 2001; Kozak & Foa 1994; Prasko et al 2009) and related disorders like body dysmorphic disorder (BDD). The term “insight” in a psychiatric context was perhaps first defined in 1934 as “a correct attitude to a morbid change in oneself” (Lewis 1934). More recent conceptualizations of insight have been expanded to include the presumed effects of disease awareness on the patient’s attitudes and behaviors in everyday life (such as medication adherence), as well as the ability to identify or “relabel” unusual mental events (Davis 1990). Furthermore, it has been realized that the previously used dichotomous conceptualization (“poor insight” or “good insight”) was insufficient to capture the nuanced variations observed in clinical practice. Lack of insight is one of the problems of integrated self-experience (Hoffman & McGlashan 2003).

In DSM-5, a wider “insight specifier” is prepared for inclusion in the diagnostic criteria for OCD (Phillips et al 2010; Leckman et al 2010; Mataix-Cols et al 2010).

METHOD

An electronic search of the works published from 1966 to July 2013 was conducted on Medline and Web of Science using words “obsessive compulsive disorder” and “insight”. No language constraints were used. Lists of references of the articles identified by this computer database search were examined manually to find other studies. In addition, we used other documents cited in these studies.

RESULTS

Although current diagnostic criteria for OCD require patient understanding that the obsessions and compulsions are disproportionate and unreasonable (APA 2000), specialists have noted that lack of insight into the curiousness or excessive nature of obsessive thoughts and compulsive behaviors in common in OCD patients. (Carmin et al 2008; Foa et al 1995; Kozak & Foa 1994). Studies have categorized 5% to 45% of patients with OCD as having poor insight (Foa et al 1995; Eisen et al 2001; Marazziti et al 2002; Matsunaga et al 2002; Kishore et al 2004; Storch et al 2008; Alonso et al 2008; Catapano et al 2010; Jakubovski et al 2011).

Among obsessive-compulsive and related disorders, “insight” – also often referred to as a degree of “delusional” – usually means a person’s belief that his/her disorder-relevant belief is right (Phillips et al 2012). Amongst adults with OCD, poor insight has linked to a greater symptom severity, an increased risk of comorbid symptoms, lower adaptive functioning, and worse treatment outcomes.

The extent to which a patient possesses insight into the unreasonable character of the obsessional beliefs and compulsions may contribute to both clinical appearance and treatment outcome (Kozak & Foa 1994; Catapano et al 2001; Vogel et al 2006).

Insight and severity of the disorder

Poor insight into OCD has been associated with a severe form of illness (O’Dwyer & Marks 2000; Solomy et al 1985; Turksoy et al 2002; Bellino et al 2005; Catapano et al 2001; Ravi Kishore et al 2004; Jakubovski et al 2011), greater symptoms of depression and anxiety, higher probability of comorbid depressive disorder and lower resistance to obsessive and compulsive symptoms (Turksoy et al 2002; Alonso et al 2008), specific OCD indicators (washing and checking compulsions) (Matsunaga et al 2002) and chronic course of disorder (Bellino et al 2005). Explanation may be that the lack of insight might be directly associated with a lower number of attempts to resist obsessions and compulsions.

Eisen et al (2004), however, did not find significant correlates of OCD insight and severity. Other studies examining the relationship between insight and OCD symptom severity have yielded mixed results (Poyurovsky et al 2007; Alonso et al 2008; Catapano et al 2010; Shimshoni et al 2011). Reasons for these discrepant findings remain unclear.

Children with little insight had higher levels of symptom and more repeating compulsions (Storch et al 2008b). Parents valued children with little insight as having other internalizing symptoms and described higher levels of family accommodation compared to parents of youth with good insight.

Lewin et al (2010) examined relations between insight and various factors – cognitive, developmental, clinical, demographic features, and comorbidity in a treatment-seeking sample of 71 youth with OCD. Youth with poor insight was more likely to have lower levels of cognitive functioning and global functioning compared to youth with high insight. In addition, low-insight youngsters were more likely to present with higher levels of depression and poorer levels of perceived control compared to their equals with high insight. In this particular research, insight was not correlated with...
any other demographic or clinical feature including symptom severity, OCD age of onset, illness duration, family history of OCD, parental OCD, the presence of Anxiety/Tic/ADHD disorders, or gender. Nevertheless, there were identified two possible cognitive factors that predispose youth with OCD to poor insight. Youngsters with poor insight demonstrated lesser levels of cognitive functioning. It could be that children who have less verbal and more concrete thinking are more likely to believe that the “danger” factual or rational, and in turn, more likely to adhere rigidly to the OC beliefs. Youth with poor insight reported lower levels of perceived control over their surroundings. It could be the case that the less a child can control symptoms, the most prone he or she may continue to consider them as real. Thus decreased of cognitive functioning, increased rigidity in thought, and decreased perceptions of environmental control, might play a role in poor insight.

Despite being classified as a single disorder, OCD is a clinically heterogeneous disorder, both in relations to symptom content (Bloch et al 2008) and insight into symptoms (Fontenelle et al 2010).

While various obsessions have not been previously associated with poor insight, hoarding has been related to poor insight compared to other OCD symptoms (Black et al 1998; Frost & Gross 1993; Christensen & Greist 2001; Matsunaga et al 2002; De Berardis et al 2005; Samuels et al 2007; Jakubovski et al 2011). There are some data to suggesting that need for symmetry also could be associated with poor insight (Elvish et al 2010; Jakubovski et al 2011).

Jakubovski et al (2011) made a comprehensive clinical assessment in 824 outpatients with OCD. Increased severity of present and worst-ever hoarding symptoms and a higher rate of joblessness were associated with limited insight in OCD after calculating for current severity of OCD, age, and gender. Reduced insight was also related to bigger scores in further symptom dimensions (contamination/washing and symmetry/ordering/counting) but these associations lost significance when overall symptom severity was adjusted.

Phillips et al (2012) using BABS (Brown assessment of beliefs scale), examined insight/delusionality of OCD – or body dysmorphic disorder – associated with attitudes in 211 subjects with primary OCD versus 68 subjects with body dysmorphic disorder (BDD). In both disorders, levels of insight vaulted the full range, from good to absent. Nevertheless, the distribution of BABS scores across insight categories differed considerably by the disorder, with the majority of OCD patients presenting excellent or good insight and the greater part of BDD patients showing limited or absent insight. BABS score was significantly associated with the severity of BDD and OCD, but in regressions it counted for only 21% of the variation in OCD and 28% in BDD.

However, there are conflicting data on the relation between contamination/washing symptoms and insight. Fear of contamination/washing has been associated with both good (Alonso et al 2008) and poor insight (Jakubovski et al 2011). Cherian et al (2012) studied 545 consecutive patients with a primary diagnosis of DSM-IV OCD. They had been evaluated by Y-BOCS and the item 11 for insight, the MINI (Mini International Neuropsychiatric Interview) and the CGI (Clinical Global Impression scale). The sample had 498 (91%) patients with good insight (score≤2) and 47 (9%) patients with decreased insight (score>2) as per the Y-BOCS item 11. Poor insight subgroup had a significantly higher score on the Y-BOCS compulsions and total score, the CGI-Severity and a greater rate of contamination fears and washed compulsions. Good insight group had a significantly higher occurrence of aggressive obsessions. In linear regression, contamination dimension and Y-BOCS total score predicted poorer insight and presence of forbidden thoughts predicted better insight.

Early onset OCD
Early-onset OCD (i.e., prepubertal onset) has certain characteristics that differentiate it from late-onset OCD, including male preponderance, a distinct pattern of comorbidity, an increased familial loading for OCD, and frequent lack of insight (Geller et al 1998). Diminished insight is associated with early onset of symptoms and longer duration of the disorder (Kishore et al 2004).

Youth with poor insight had inferior intellectual functioning and reported decreased perception of control over surroundings (Lewin et al 2010). In addition, patients in poor insight group were younger, reported higher levels of depression, and lower levels of adaptive functioning.

Complete insight into OCD symptoms is not essential for the diagnosis of OCD in children (APA 2000); however, adolescents can be diagnosed with the qualifier, “with poor insight” if needed. However, the development of insight across different age groups is not documented to date. It is reasonable that the insight progresses with age with the development of the higher cognitive processes such as abstract thinking (Indelker & Piaget 1958). While clinical observation indicates that most children and adolescents have a realistic level of cognizance that the symptoms are unusual and excessive, there are subsets of youth with OCD who deny that symptoms are problematic or unreasonable (Geller 2006; Lewin et al 2006). This youth often experiences problems with CBT (Storch et al 2008a, 2008b).

Insight and comorbidity
Poor insight has been associated with psychiatric comorbidity (Bellino et al 2005; Kishore et al 2004). Matsunaga et al (2002) pointed out that improvement in depressive status in patients with OCD after successful treatment is accompanied by improved insight, suggesting that affective status may influence insight in OCD. Bulter and Mathews (1983) have even hypothesized that severe depression may contribute to the
transformation of obsessions into delusional beliefs. The results of Alonso et al (2008) support the idea that emotional disturbances may interfere with the person’s ability to deal with obsessions, reducing the perception of the absurdity and nonsense of the obsessive phenomena.

Poor insight has been found to be associated with comorbid depression (Catapano et al 2001; Foa 1979; Kishore et al 2004), body dysmorphic disorder and with a family history of schizophrenia (Eisen et al 2004; Catapano et al 2001; Catapano et al 2010), OCD, and anxiety disorders (Bellino et al 2005).

There may also be a connection between comorbid personality disorders and insight in OCD. Poor insight OCD has been associated with schizotypal (Jenike et al 1986; Fear et al 2000; Matsunaga et al 2002) and obsessive-compulsive personality disorders (OCPDs) (Rodrigues-Torres et al 1995). However, a recent Italian study failed to find any correlation between degrees of insight and clinical aspects, apart from for an adverse trend in the occurrence of somatic obsessions (Marazziti et al 2002).

Insight and treatment outcome

There is little data related to the correlation between a treatment response and insight and findings are conflicting.

Several studies did not discover any relationship between baseline insight and response to drug (Eisen et al 2001; Matsunaga et al 2002; Ferrao et al 2006; Alonso et al 2008) but other studies found reduced drug response (Hantouche et al 2000; Catapano et al 2001; Erzegovesi et al 2001; Catapano et al 2010; Kishore et al 2004; Shetti et al 2005) and response to behavioral therapy (Solyom et al 1985; Foa 1979; Foa et al 1999; Hantouche et al 2000; Mataix-Cols et al 2002; Himle et al 2006; Prasko et al 2009) in those with poor insight. Another studies, however, reported that poor insight OCD patients responded as well to behavior therapy as those with good insight (Lelliott et al 1988, Ito et al 1995). Consequently, it remains unclear whether insight is a predictor of reduced treatment response or whether this association is due to other confounding clinical factors. Steketee and Shapiro (1995) reported inconsistent findings with regard to the relation between insight and treatment outcome, and they suggested that such inconsistencies may be partially due to limitations with regard to standard measures of insight and the instability of the construct. Since their review, a standardized measure of insight has been developed, namely the Brown Assessment of Beliefs Scale (Eisen et al 1998).

The explanation of association between insight and treatment response may be that those patients who exhibit difficulty in recognizing that their obsessive and compulsive symptoms are excessive and unreasonable may require additional cognitive interventions and behavioral experiments aimed at reducing the patients’ fixity of beliefs (Keeley et al 2008).

Insight is linked with other clinical variables that are also markers of decreased treatment response. These variable are severity of OCD (in some but not all studies – Solyom et al 1985; Turkson et al 2002; Kishore et al 2004; Catapano et al 2010), comorbid illnesses (especially depression, personality disorders, and other anxiety disorders – Turkson et al 2002; Kishore et al 2004; Bellino et al 2005; Alonso et al 2008; Catapano et al 2010), and symptom subtype (Bellino et al 2005; Samuels et al 2007; Saxena 2007).

There seems to be also connection between compulsive and treatment response. Short-term trials determine worse responses in OCD patients with hoarding symptoms when treated with either cognitive–behavioral therapy or pharmacotherapy (Abramowitz 1997; Mataix-Cols et al 1999; Mataix-Cols et al 2002; Rufer et al 2006; Saxena 2007; Stein et al 2007).

Patients with poor insight may be less able to involve in cognitive therapies (e.g., challenging irrational thoughts) and consequently have poorer prognoses (O’Dwyer & Marks 2000; Storch et al 2008). Others propose that patients with poor insight may have increased trouble incorporating information that is inconsistent with their obsessive beliefs (Foa et al 1999; Tolin et al 2001). Other experts suggest that reduced insight may increase anxiety and consequently impede habituation, potentially indicating SRI augmentation (Abel 1993; Foa et al 1999).

Role of psychotropic drugs and insight remains unclear. Shimshoni et al (2011) in their study found out, that OCD patients who were presently taking psychotropic medication had better insight on the BABS than those who were not medicated. It is uncertain whether better insight in treated subjects reflects the greater readiness of patients with better insight to search for and participate in mental health treatment, improvement in insight into treatment, neither or both. Treatment by SRI improves insight in OCD after treatment with serotonin reuptake inhibitors (Alonso et al 2008; Eisen et al 2001). The association of poor insight with SRI treatment non-response reported by some authors (Erzegovesi et al 2001; Shetti et al 2005) underlies the hypothesis that poor insight OCD constitutes a distinct subtype of the disorder with underlying biologic differences involving neurotransmission pathways other than the serotonergic one, mainly a dopaminergic dysregulation (Sobin et al 2000). This neurobiological hypothesis is supported by recent observations reporting that obsessive patients with poor insight show significantly more magnetic resonance imaging abnormalities than subjects with good insight (Aigner et al 2005). While it has not been proved that the adding of antipsychotics to SSRI improves the treatment response of poor insight patients with OCD (Bloch et al 2006) is a pharmacologic strategy that is often used by clinicians. OCD patients who do not respond to selective serotonin reuptake inhibitor but show a significant improvement with the addition of an atypical antipsychotic have recently been
reported to exhibit a significantly lower N-acetyl aspartate concentration in the anterior cingulate (Sumitani et al. 2007).

CONCLUSIONS

Studying clinical correlates of insight has important clinical implications. Poor insight is widespread in OCD patients and may contribute to both clinical picture and treatment outcome. Clinicians must be aware that insight may be weak or even entirely absent in OCD in order not to misdiagnose obsessive patients of psychotic disorders with the consequent adverse therapeutic effects. Improving insight may be useful for improving therapeutic efficacy. Insight should not be considered a static phenomenon but a rather dynamic one because the treatment that helps to reduce obsessive symptoms appears to lead to significant improvement in insight. This process is also influenced by clinical conditions such as personality or affective status. However, the relation between specific symptom dimensions and insight is rather inconsistent. Further research is required to explain the relationship between insight and controversial clinical issues such as a response to pharmacologic and behavioral treatment or symptom dimensions. Such studies are also needed to increase understanding of the relationship between obsessions and delusions and to refine treatment strategies for patients who have poor insight.

REFERENCES


