The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 3, Issue 4, No. 67, DIP: 18.01.191/20160304
ISBN: 978-1-365-39397-6
http://www.ijip.in | July-September, 2016

Symptom Dimensions and Insight in Obsessive Compulsive Disorder

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ABSTRACT

The present study was carried out with the intent of systematically examining insight and its relationship with specific clinical characteristics including symptom dimensions in Obsessive compulsive disorder (OCD). Study was conducted at the symptoms Central Institute of Psychiatry, Ranchi, with a 40 OCD patients, who were rated on YBOCS, D, YBOCS and BABS and were divided and analyzed in six symptom dimensions in OCD. Results revealed that the most common dimension was contamination (32.6%) whereas hoarding was least common (3.4%). Better insight correlated significantly with severity across all OCD dimensions except hoarding and sexual/religious dimensions. Significant difference in insight among the symptom dimensions in OCD was seen. Better insight for sexual and aggressive dimensions than for hoarding, symmetry, miscellaneous was observed.

Keywords: *OCD, Hoarding, Symmetry*

Obsessive compulsive disorder is an anxiety disorder characterized by recurrent, persistent and intrusive thoughts, images or impulses that are difficult to control and cause considerable distress or anxiety (obsessions) and repetitive ritualistic behaviors or mental acts performed excessively to relieve distress or anxiety caused by obsessions (compulsions). In obsessive compulsive disorder, insight in to senselessness of symptoms is treated equivalent to insight into illness. In the DSM-IV field trial subjects were interviewed to assess their insight into the senselessness of their obsessive fears. Data showed that individuals with OCD exhibit a range of insight. It is now recognized that insight may lie on a continuum of full awareness of senselessness or absurdity at one end to a total lack of any such awareness at the other end (Exner et al, 2009). Since the diagnostic qualifier “with poor insight” was included in the DSM-IV in 1994, between 5% and

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45% of patients with OCD have been found to have poor insight (Foaet al, 1995; Eisen et al, 2001; Catapano et al, 2010).

Insight is associated with other clinical variables such as severity, duration, age of onset of OCD (Turksoy et al, 2002; Ferrao et al, 2006; Lewin et al, 2010), comorbid depression, anxiety (Turksoy et al, 2002;Bellino et al, 2005;Storch et al, 2007; Lewin et al, 2010), genetic polymorphism (Samuels et al, 2007),quality of life, disability, intellect (Bellino et al, 2005; Alonso et al, 2008;Lewin et al, 2010) and symptom subtype (Turksoy et al, 2002; Bellinoet al, 2005; Ferrao et al, 2006; Jakubovski et al, 2011). Despite this recognition, the relationship between insight as a clinical construct and other clinical characteristics is not well studied.

Moreover symptom presentation is very diverse in OCD, and there is conflicting data on dimension-specific correlations between symptoms and insight as a clinical construct. Additionally, few studies so far have analyzed how insight would associate with specific OCD symptom patterns (Jakubovski et al, 2011) and have shown conflicting data on the relation between symptom dimensions and insight (Cherian et al, 2012).

The present Study Aimed tofind the relationship of insight with severity of obsessive compulsive disorder in obsessive compulsive disorder group and to compare insight among symptom dimensions (contamination, hoarding, symmetry, aggressive, sexual, miscellaneous) in obsessive compulsive disorder group.

METHOD

The present study was conducted at the Central Institute of Psychiatry, Ranchi, with a modest sample size of 40 OCD patients according to the ICD-10 DCR (WHO, 1992) and 40 matched controls for age, sex, education. The subjects were recruited after fulfilling the specified inclusion and exclusion criteria. The subjects were rated on YBOCS, BABS, D-YBOCS. For the analysis of data, the subjects were divided into six groups, based on six symptom dimensions in OCD: contamination, hoarding, symmetry, aggressive, sexual/religious and miscellaneous. BABS into each OCD symptom dimension present in a case of OCD was assessed separately. Statistical analysis was done using Statistical Package for Social Sciences version 22.

Tools Used

Socio-demographic and clinical data sheet: A semi-structured socio-demographic and clinical data sheet specially developed for the study. It included socio-demographic variables like name, age sex, religion, marital status, years of formal education, occupation, annual family income, family type and residence and clinical variables including diagnosis (ICD-10), clinical details as onset, course, duration of illness, history of present illness, drug status, treatment history, past history of psychiatric illness, family history of psychiatric illness, premorbid personality and Mental Status Examination.

Yale-brown obsessive-compulsive scale (y-bocs): This scale, designed by Wayne Goodman and his colleagues (Goodman et al, 1989), is used extensively in research and clinical practice to determine both severity of OCD and to monitor improvement during treatment. This scale measures obsessions separately from compulsions and specifically measures the severity of symptoms of obsessive-compulsive disorder.

Dimensional YBOCS (D-YBOCS): The D-YBOCS (Rosario-Campos et al, 2006), consists of a symptom checklist divided into six different dimensions. The scale is completed by the patient, who endorses the symptom as present, and in the second part of the D-YBOCS a clinician rates the severity of each symptom and overall impairment on a scale from 0 (no symptoms) to 10 (symptoms are extremely troublesome). Patients are also asked the degree of avoidance related to each specific symptom on a scale from 0 (never) to 5 (extreme, very extensive avoidance).

Brown assessment of beliefs scale (BABS): The Brown Assessment of Beliefs Scale (Jane et al, 1998) is a seven-item clinician administered semi-structured scale designed to assess delusionality of beliefs in a broad range of psychiatric disorders, developed to rate the degree of conviction and insight patients have concerning their beliefs. The BABS is based on this premise-that insight exists on a continuum and itself consists of a number of dimensions. These dimensions are conviction, perception of others' views of beliefs, explanation of differing views, fixity of ideas, attempt to disprove beliefs, insight, and ideas/delusions of reference.

RESULTS

TABLE 1: Presence of Various Symptom Dimensions in Obsessive Compulsive Disorder patient (OCD) group: (N=40)

Total no. of symptom dimensions	89
Average no. of symptom dimensions	2.2
Sub-Groups on the basis of dimensions:	
Contamination	29
Aggressive	18
Miscellaneous	17
Sexual/Religious	12
Symmetry and Arranging	10
Hoarding	3

TABLE 1 shows various symptom dimensions present in a case of OCD. An average of 2.2 symptom dimensions was seen to be present in a patient of OCD and a total of 89 symptom dimensions in subgroups of six dimensions were found in 40 OCD patients. The most common dimension was contamination (32.6%) whereas hoarding was least common dimension (3.4%)

TABLE: 2 Correlation between Insight (BABS) and Severity on DYBOCS on various Symptom Dimensions of OCD: (N= 89)

	Contamination And Cleaning (N=29)	**Hoarding And Collecting (N=3)**	**Symmetry, Ordering, Counting And Arranging (N=10)**	**Aggressive Obsessions And Related Compulsion (N=18)**	**Sexual And Religious Obsessions And Compulsion (N=12)**	**Miscellaneous (N=17)**
Pearson correlation	-.590	-.866	-.722	-.816	-.462	-.752
p value	**.001****	.333	**.018***	**<.001*****	.130	**<.001*****

***** p<.05; ** p<.01; *** p<.001

TABLE 2 shows correlation between insight on BABS and dimensional severity on DYBOCS on various symptom dimensions of OCD patient group (N=89) using Pearson correlation analysis. Insight scores on BABS had significant negative correlations with severity across all OCD dimensions except hoarding and sexual/religious dimensions.

TABLE: 3 Comparison of Insight between Various Symptom Dimensions of Obsessive Compulsive Disorder patient (OCD) group: (N=89)

Insight (BABS)	**Symptom Dimensions of Obsessive Compulsive Disorder**						**F (df=83)**	**p**	**Post hoc (Bonferroni)**
	Contamination and cleaning (N=29)	**Hoarding and collecting (N=3)**	**Symmetry and arranging (N=10)**	**Aggressive (N=18)**	**Sexual and Religious (N=12)**	**Miscellaneous (N=17)**			
Total Insight	13.17 ± 3.96	22.00 ± 1.00	19.30 ± 1.64	9.33 ± 2.50	9.92 ± 2.50	16.06 ± 2.01	26.66	**<.001****	4,5<1<2,3,6
Estimated Insight for Dimensional Severity	13.28 ± 0.43	20.91 ± 1.34	17.85 ± 0.76	10.20 ± 0.56	9.28 ± 0.67	16.92 ± 0.56	35.25	**<.001****	4,5<1<2,3,6

***** p<.05; ** p<.01; *** p<.001

TABLE 3 shows comparison of insight among groups based on symptom dimensions (N=89) in OCD patient group using one way ANOVA and ANCOVA applied on insight scores (BABS) for each symptom dimensions corrected for DYBOCS severity. Post hoc –Tukey (Bonferroni) was

also performed. The means for insight scores on BABS was highest for hoarding dimension (22.00 ± 1.00), followed by symmetry (19.30 ± 1.64), miscellaneous (16.06 ± 2.01), contamination (13.17 ± 3.96), sexual and religious (9.92 ± 2.50) and lowest for aggressive dimension (9.33 ± 2.50), which indicated best insight for aggressive dimension and worst for hoarding. There was a significant difference in insight scores on BABS among the dimensions and the difference remained statistically significant even on correction for severity on DYBOCS. The results showed better insight for sexual and aggressive dimensions than for hoarding, symmetry, miscellaneous and for contamination insight lied in between that for other dimensions.

Figure 1: Means Plot of insight in six symptom dimensions in Obsessive Compulsive Disorder patient (OCD) Group: (N=89)

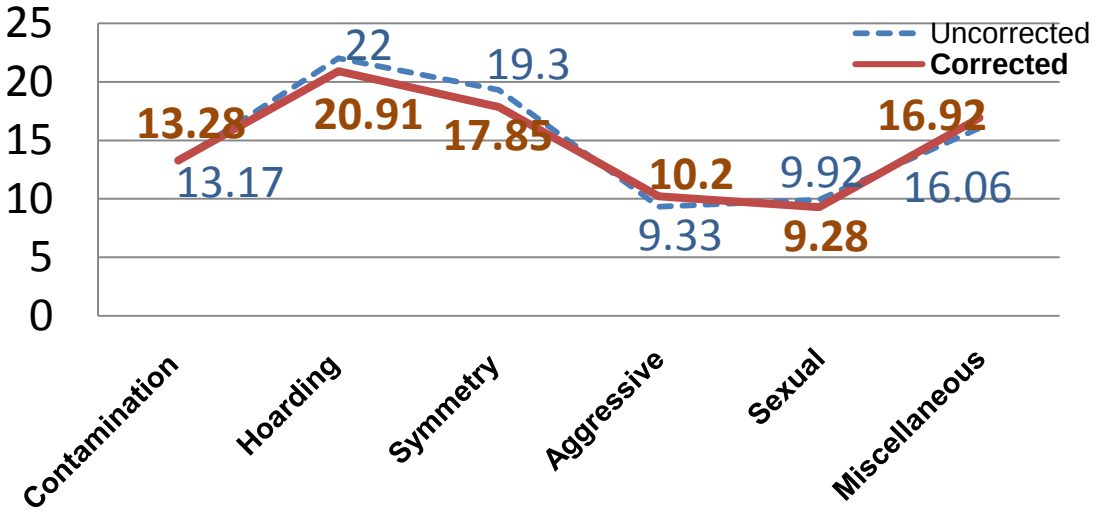

Figure 1 shows better insight for aggressive and sexual dimensions which are represented at one pole of the means plot than for hoarding, symmetry and miscellaneous dimensions at the other pole with poorer insight for these dimensions. For contamination dimension insight lied in between the other dimensions representing fair insight for this dimension. Also, even after correction for severity of the dimensions similar plot for dimensions was found as seen in the figure.

DISCUSSION

The most common dimension in this study was contamination (32.6%) whereas hoarding was least common dimension (3.4%). This is in accordance with findings in various Indian studies (Khanna and Reddy, 2004). Better insight correlated significantly with severity across all OCD dimensions except hoarding and sexual/religious dimensions which were too less to find significant correlation in our sample of 12 for sexual/religious dimension and only 3 for hoarding dimension. This study is the only one to report dimension specific correlation with severity of

various symptom dimension using a meticulously designed methodology to tap the dimensional correlates of insight which gives strength to the current study.

There was a significant difference in insight among the symptom dimensions in OCD and the difference remained significant even on correction for severity of dimensions in OCD. Results showed better insight for sexual and aggressive dimensions than for hoarding, symmetry, miscellaneous. In contamination dimension insight lied in between that for other dimensions.

Poor insight has been associated mainly with hoarding obsessions and related collecting compulsions (De Berardis et al, 2005; Jakubovski et al, 2011; Matsunaga et al, 2002; Kishore et al, 2004; Samuels et al, 2002; Storch et al, 2007) and with miscellaneous obsessions- somatic obsessions (De Berardis et al, 2005; Marazziti et al, 2002); dysmorphophobic worries (Solyom et al, 1985) and need for symmetry and exactness in studies by Elvish et al. (2010) and Matsunaga et al. (2002). These findings are similar to our findings.

Alonso et al. (2008) linked good insight with fear of contamination and washing compulsions while study by Jakubovski et al. (2011) reported association between poor insight and contamination dimension but the significance disappeared after controlling for overall severity of illness in this study. Another study, conducted by Matgunga et al. (2002), found that poor insight was linked to washing and checking compulsions. Our study reported fair insight neither good nor poor for contamination dimension which is a novel finding from our study. Individuals who reported fear of harming self or others via overwhelming impulse and those with religious obsessions had poorer insight in a previous study (Tolin et al, 2001). In contrast, good insight for aggressive obsessions was found in the present study.

These results further supports the dimensional nature of insight ranging from poor insight for hoarding and symmetry dimensions, which can be well explained on the basis of ego-syntonicity associated and good for aggressive and sexual dimensions. Insight for contamination dimension lied in between that for hoarding and symmetry at one end to aggressive, sexual/religious and miscellaneous dimensions at the other pole and this can be explained on the fact that contamination fears are often understandable even if excessive, resulting in less ego-dystonicity and hense has fair insight with insight into symptoms improving with increasing severity unlike that for forbidden thoughts of sexual, aggressive and religious nature which are often perceived as alien to one's nature and therefore more ego-dystonic and less acceptable. In the traditional Indian society, there is special significance to purity and cleanliness (Underwood and Rhodes, 2008) and considering the primacy of cleanliness, hygiene and purity in Indian culture, it is perhaps not unusual that concerns with contamination are considered reasonable while sex is still a taboo in Indian society and religion still occupies a central role in the society. Considering this, it is perhaps understandable that obsessions related to religion, god, sex and harm are perceived as egodystonic and hence have well-preserved insight.

That degree of insight has specific correlation with certain symptom dimensions also adds to the growing interest in the dimensional aspect of OCD. The strength of this study is that each dimensional component of OCD has been given individual importance. It is possible that good insight is typical of certain dimensions (aggressive, sexual/religious thoughts) but not others (hoarding, symmetry).

Acknowledgments

The author appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interests

The author declared no conflict of interests.

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How to cite this article: H Kumar, I Ali, Anamika, B Devi (2016), Symptom Dimensions and Insight in Obsessive Compulsive Disorder, International Journal of Indian Psychology, Volume 3, Issue 4, No. 67, ISSN:2348-5396 (e), ISSN:2349-3429 (p), DIP:18.01.191/20160304, ISBN:978-1-365-39397-6