INSIGHT IN THE PATIENTS OF OBSESSIVE-COMPULSIVE DISORDER, A CROSS SECTIONAL STUDY

Corresponding Author:
Dr. Tanuj Verma,
Email: tanujverma524@gmail.com
ORCID: 0000-0002-8927-7406

Tanuj Verma¹, Vaibhav Kumar Srivastava², Shrutika Srivastava³, Pritika Srivastava⁴

¹Assistant Professor, Department of Psychiatry, UIMS, Prayagraj, Uttar Pradesh, India.
²Junior Resident, Department of Pharmacology, Narayan Medical College, Jamuhar, Sasaram, Bihar, India
³Department of Pathology, Narayan Medical College, Jamuhar, Sasaram, Bihar, India
⁴Department of Obst & Gynae, Eras' Lucknow Medical college & Hospital, Lucknow, Uttar Pradesh, India

Abstract

Background: Obsessive Compulsive Disorder (OCD) is characterized by recurring, intrusive, anxiety-provoking thoughts or images (obsessions) associated with repetitive, physical or mental rituals (compulsions) aimed at relieving the anxiety. It is a chronic disorder with marked morbidity in all age groups. Insight refers to the awareness of one's emotional and psychological problems. In OCD, Insight refers to the recognition of senselessness of the symptoms. It can vary from full awareness of the senselessness or absurdity of the thoughts to a total lack of awareness. There have been a few studies that have found good Insight to be associated with better prognosis of Illness. However, the data regarding the same is scarce, with only a few studies reported from our region. Hence, this study is being conducted with the Aim of Evaluating Insight in patients of OCD and to try and fulfill this lacuna of information. **Materials and Methods:** The study was conducted over a period of 1 year (Jan21-Jan22). It was a cross sectional observational study. Patients attending Psychiatry OPD at UIMS and IPD patients were taken into consideration for the study and those fulfilling the Inclusion criteria were eventually taken up for study. **Result:** Majority of the subjects were females, age 21-30 and employed. Most of the subjects had good Insight. It was best in those having obsessions of dirt and contamination and worst for those having sexual obsessions. Those with poor Insight had a greater mean illness duration and greater no of comorbid illnesses while severity of illness was more in patients having good insight. **Conclusion:** Poor Insight was found to be directly coorelated with a poorer prognosis of illness, greater severity and greater mean duration of illness.

INTRODUCTION

Obsessive Compulsive Disorder (OCD) is characterized by recurring, intrusive, anxiety-provoking thoughts or images (obsessions) associated with repetitive, physical or mental rituals (compulsions) aimed at relieving the anxiety. It is a chronic disorder with marked morbidity in all age groups. It is the fourth most common mental disorder in adults after Depression, Substance abuse and Phobias.[1] It has got a prevalence of 2-3% in general population. The average age of onset is 20 years (earlier in males-19 years, later in females-22years).[2] Insight refers to the awareness of one's emotional and psychological problems. It tends to effect a person's understanding of his /her illness which has a significant impact on a person's

behavior in terms of –Adherence to medication and proper compliance. It also leads to various lifestyle modifications.[3] In OCD, Insight refers to the recognition of senselessness of the symptoms. It can vary from full awareness of the senselessness or absurdity of the thoughts to a total lack of awareness. Since the Inclusion of diagnostic qualifier "with poor Insight" in DSM-IV in 1994, between 5-45% of OCD patients have been found to have poor Insight.[4] Poor Insight has been found to be associated with an earlier age of onset of illness, longer duration with greater severity of Illness, poor Adaptive functioning and a higher number of comorbid illnesses. It has also been found to be linked with a poor response to treatment; psychotherapy as well as pharmacotherapy. It tends to have a significant impact on the compliance of

pharmacological treatment as well as the follow up in psychotherapeutic sessions.[5,6] A few studies have also compared grades of Insight with varying symptom profiles with varying results.[4]

MATERIALS AND METHODS

The study was conducted over a period of 1 year (Jan 21- Jan 22). It was a cross sectional observational study. Patients attending Psychiatry OPD at UIMS and IPD patients were taken into consideration for the study and those fulfilling the Inclusion criteria were eventually taken up for study.

The Inclusion criteria set for the study was- Age: 16-60 years, patients confirming to obsessive compulsive disorder according to guidelines laid down by ICD-10, those giving the informed consent and having a reliable informant.

While, patients having some other psychiatric illness prior to the onset of obsessive compulsive disorder, those diagnosed with medical and surgical illness requiring immediate intervention, those diagnosed with mental retardation and those not willing to give informed consent were Excluded from the study.

A total of 80 patients were seen out of which 70 were taken up for study.

Sociodemographic data- Name, Age, Sex, Marital status, Occupational status etc, was collected on a semi structured proforma.

Y –BOCS scale was applied to assess symptomatology and the level of Insight.[5]

We also assessed the coorelation of Insight with various clinical variables such as- Severity of Illness, Duration of Illness, Co- morbid illnesses, Symptomatology, etc.

MINI International Neuropsychiatric scale version 6.0 was applied to assess for presence of comorbid psychiatric disorders.[6]

RESULTS

[Table 1] showing the overall distribution of patients.

[Table 2] showing the Gender wise Distribution of Subjects.

[Table 3] showing the Age wise Distribution of Subjects Coming for Consultation.

[Table 4] showing the Educational, Occupational and Residential Status of the Subjects

[Table 5] showing the Distribution of Grades of Insight among the Subjects

[Table 6] showing the comparison between Insight Grades and Clinical Symptomatology of OCD

[Table 7] showing the correlation of Insight Grade with Mean Y-BOCS Score, Mean Duration of Illness and the number of Co-morbid Illnesses Respectively

Socio Demographic Data

Table 1: Overall Distribution of Patients

S. No.		No. of Patients
(1)	Total number of patients	80
(2)	No. Included in study	70
(3)	No.Excluded from study	10
	Reasons for exclusion	
	Not meeting criteria for age group (<18 yrs/>60 yrs)	7
	Not willing to give consent	3

Table 2: Gender wise distribution of population

Gender	No. of subjects	Percentage
Female	43	61.5%
Male	27	39.5%

Table 3: Age of Presentation

Age Group	No of patients	Percentage
<20	15	21.11%
21-30	34	48.50%
31-40	12	17.11%
41-50	7	10.00%
>50	2	2.81%

Table 4: Other Socio Demographic Details

Category	Variables	Number	Percentage
Educational Status	Illiterate	11	15.70%
	Primary	17	24.28%
	Middle	14	20.00%
	High school	12	17.10%
	Intermediate	8	11.13%
	Graduate	5	7.11%
	Postgraduate	3	4.28%
Occupational	Farmer/Unskilled labour	13	18.50%

status	Homemaker/Housewife	35	50.00%
	Employed	18	25.70%
	Unemployed	4	5.71 %
Habitat	Rural	36	51.50%
	Urban	34	49.50%

Clinical Data

Table 5: Grading of Insight

Insight grades	Number of Patients	
	Number	Percentage
1 (Good)	51	72.85%
2(Fair)	9	12.85%
3 &4 (Poor & Delusional)	10	14.28%

Table 6: Coorelation Between Insight and Clinical Sympatomatology

Insight	Dirt & Contamination with cleaning	Symmetry and arranging	Pathological doubting and checking	Sexual obessions	Other*	
1	25	12	2	1	1	
2	4	1	8	1	1	
3&4	2			9	5	

*Fear of harming others, religious obsessions and other miscellaneous obsessions with their respective compulsions.

Table 7: Other Coorelates of Insight

Insight grades	Mean YBOCS Score	Mean Duration of Illness (in yrs)	No of comorbid Illnesses (as per MINI)
1	32.5	9.6 yrs	-
2	25.5	11.3 yrs	2
3 and 4	22.5	13.2 yrs	3 -4

DISCUSSION

(A) Sociodemographic Data

In our study, females (n=43,61.5%), formed a greater portion of the overall sample, as compared to males (n=27,39.5%) [Table 2]. Anxiety disorders have been seen to be more common in females. Our result was comparable to another study conducted by Chandrashekhar et al, in the year 1996,which found a greater prevalence in females (32%, as compared to males 10%).[7] Various other studies also found similar results.[8,9] The most common age of presentation was in the age group of 21-30 yrs, amounting upto 48.50% of the subjects(n=34) [Table 3] .This result was also similar to that found in various other studies.[7,8] Majority of the subjects were found to be studied upto primary grade school (n=17,24.28%), followed by middle grade school. [Table 4]. As per the occupational status, majority of the patients were found to be engaged in some sort of occupation, with only (n=4,5.71%) of the subjects being unemployed [Table 4]. There was no significant difference in the residential status of the subjects with near equal distribution between Urban (n=34) and Rural (n=36) [Table 4]. These results were similar to other previous studies.[1,7,8]

(B) Clinical Data

Majority of the subjects (n=51,72.85%), were found to have an Insight grade of 1 on the YBOCS Scale, indicative of Good Insight [Table 5]. This was similar to the results seen in various other previous studies.[10] OCD being a neurotic disorder, usually presents with good Insight, with patients coming by themselves for seeking treatment, owing to the distressing nature of the symptoms. On corelating the grades of Insight with clinical symptomatology, those having the obsession of dirt and contamination with the associated compulsion of checking and cleaning, were mostly found to be having good Insight (n=25), while those having Sexual obsessions were mostly found to be having Poor and Delusional Insight (n=9) [Table 6]. This was similar to the results seen in another study conducted by Jakubowski et al.[11] We also assessed the Coorelation of Insight with the severity of Illness as per the YBOCS Score. Those with good Insight were found to have the greatest severity of Illness followed by those with fair Insight and then those with poor and delusional Insight Respectively. This was in concordance with results seen in various other previous studies.[11,12] We conclude that those with good Insight were fully aware of their symptoms and their absurd nature, and were hence more distressed by the same, which reflected in form of a greater severity of Illness. We also assessed the coorelation of Insight with the mean duration of Ilness. It was seen that those with poor/Delusional Insight had a greater mean duration of Illness as compared to those having good/fair Insight. The same relationship was found between Insight grades and Number of Co-morbid Illness, wherein there was a positive coorelation between poorer Insight and Number of Co-morbid Illnesses [Table 7]. All these results were similar to those seen in a few previous studies.[11,12]

CONCLUSION

Majority of the subjects were females, age 21-30 and employed. Most of the subjects had good Insight. It was best in those having obsessions of dirt and contamination and worst for those having sexual obsessions. Those with poor Insight had a greater mean illness duration and greater no of comorbid illnesses while severity of illness was more in patients having good insight.

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