

Phenomenology and correlates of insight in pediatric obsessive–compulsive disorder

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Abstract

Obsessive–compulsive disorder (OCD) is marked by the presence of obsessions and/or compulsions that cause significant interference in an individual's life. Insight regarding symptoms in youth with OCD may affect accurate assessment, acceptance and motivation for treatment, tolerance of negative valence states (i.e., fear) and treatment outcome, so assessment of this construct and associated clinical characteristics is important. Accordingly, the current study sought to expand the literature on symptom insight by examining multi-informant ratings of insight from children, parents, and clinicians simultaneously and its relationship to varied clinical characteristics. One-hundred and ten treatment-seeking youth with a primary diagnosis of OCD, aged 6–17, participated in the study along with a parent/guardian. The nature of symptom conviction, fixity of ideas, and perceptions about the cause of the problems were important indicators in assessing child insight and resulted in a comprehensive, psychometrically-sound measure of insight. Insight was generally not strongly associated with clinical characteristics. Poor insight was moderately associated with less resistance of obsessive–compulsive symptoms, increased externalizing symptoms, and ordering symptoms. Overall, this study contributes further information into the nature and correlates of insight in youth with OCD, and provides a psychometrically sound approach for its assessment.

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Obsessive–compulsive disorder (OCD) is characterized by the presence of obsessions and/or compulsions that are disabling and/or distressing to the affected individual [1]. The clinical presentation of OCD in both adults and children is marked by considerable heterogeneity in symptom typology, course, and associated clinical characteristics. Regarding symptom typology, factor analytic studies have demonstrated the presence of several unique symptom dimensions including symmetry/ordering, contamination/cleaning, sexual/religious obsessions, aggressive obsessions/checking, and hoarding dimensions [2]. Among the

associated clinical features (e.g., comorbidity, cognitive features, etc.), one factor that has received considerable attention in the adult literature – and preliminary investigation among children – is insight into the degree to which obsessive–compulsive symptoms are recognized as absurd, excessive and senseless, independent of efforts to resist symptoms [3]. There is considerable evidence that insight falls on a continuum with many affected adults not recognizing the excessive and unreasonable nature of their obsessive or compulsive symptoms [4].

Until recently, the literature on insight in OCD has primarily involved adults. Insight has been inversely related to a number of clinical characteristics including symptom severity, preponderance of compulsions, illness chronicity, limited patient resistance against and presumably control of symptoms, early symptom onset, positive family history of OCD, and higher rates of comorbidity [4–6]. Such findings

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collectively suggest that OCD with poor insight represents a distinct clinical subtype primarily characterized by ego-syntonic symptoms that might extend to delusions, paranoia, and even psychosis [7–10], or in children may overlap with autism spectrum disorders, and is associated with attenuated outcome to cognitive-behavioral therapy [11,12] and pharmacotherapy [13].

Less is known about the phenomenology and psychosocial correlates of insight among children with OCD. However, youth with OCD frequently exhibit poor insight [14,15], which can complicate the nature of assessment, treatment provision, and treatment outcome. Regarding treatment course, many youth with poor insight will not recognize their symptoms as problematic and thus, resist engaging in the treatment process vis-à-vis limited motivation or disruptiveness contributing to negative treatment outcomes [16]. In extreme cases, youth with strikingly poor insight may appear to have overvalued ideation or psychosis, resulting in inappropriate diagnostic and treatment decisions [17].

There have been two studies that have directly examined insight in youth with OCD. Storch et al. [15] investigated the relation between insight, as measured by item 11 on the Children's Yale–Brown Obsessive–Compulsive Scale (CY-BOCS), which assesses insight [18], and clinical characteristics among 78 children and adolescents with OCD. Only 55% of the sample was considered to have good or better insight into their symptoms. Insight was inversely related to OCD symptom severity, OCD-related functional impairment, and family accommodation [15]. Lewin et al. [14] found an inverse relationship between age and insight; 48% of youth below age 10 years had good insight compared to 72% of preadolescents (age 11–13 years) and 79% of older adolescents (age 14–17 years). Insight was inversely associated with depressive symptoms but not significantly related to comorbidity patterns, obsessive–compulsive symptom severity, externalizing or internalizing symptoms, family accommodation, or OCD-related impairment. Statistical trends were found in the relationships between insight and the symptom dimensions of superstitious and somatic obsessions, and ordering compulsions [14]. Besides these direct reports, poor insight in youth with OCD has been related to the presence of hoarding symptoms [19] and attenuated cognitive–behavioral therapy outcome [16,20].

Despite the importance of insight in the presentation and treatment of OCD in youth, investigations have been limited by the absence of a comprehensive assessment measure. Among adults, the clinician-administered Brown Assessment of Beliefs Scale [21] was developed to assess this phenomenon across seven items (i.e., conviction, perception of others' views, explanation of differing views, fixity of beliefs, insight, delusions of reference, attempt to disprove beliefs). The BABS is widely used and demonstrates strong psychometric properties in adults with OCD [21,22] and schizophrenia [23]. However, there is no parallel instrument for assessing insight into the nature of obsessive–compulsive

symptoms in youth. To date, research has utilized only single item ratings of insight (e.g., Storch et al. [15] using CY-BOCS item 11; Lewin et al. [14] using a semi-structured unvalidated interview).

Given the importance of insight in the clinical understanding of OCD, our central aim is to provide a preliminary evaluation of descriptive and clinical correlates of child insight. In order to achieve this end, we first present psychometric data (including internal consistency, construct validity, and convergence and divergence with theory relevant constructs) for a semi-structured interview that assesses insight in youth with OCD, the Child Assessment of Beliefs Scale (CABS). Then, we use this measure to assess relative rates of insight and examine correlates of insight utilizing cutting edge methods provided by Kraemer et al. [24]. Through this approach, we inform this understudied area and provide a brief and useful tool for future investigation.

1. Method

1.1. Participants

Participants included 110 youth (68 male [62%]; 6–17 years of age [$M = 13.04$, $SD = 2.83$]) with a primary diagnosis of OCD and their parent(s) who were presenting for treatment at one of two university-based pediatric OCD specialty clinics. Most participants were Caucasian (90.0%; $n = 99$) with small numbers of children belonging to the following ethno-racial groups: Hispanic (3.6%; $n = 4$), African–American (1.8%; $n = 2$), Asian (0.9%; $n = 1$) or other (2.7%; $n = 3$). One participant (0.9%) did not report information regarding race.

Primary and comorbid diagnoses were determined through best-estimate procedures [25] by an experienced psychiatrist or psychologist through a semi-structured clinical interview involving the participant and his/her caregiver(s). Other clinical information (e.g., responses to study measures) was reviewed following the interview to assist with diagnostic decisions. If necessary, the interviewing clinician reviewed clinical data with a second clinician to determine consensus diagnoses. There were no instances of disagreement for the primary diagnosis of OCD. Disagreements about comorbid diagnoses were rare in frequency and resolved via discussion. Exclusion criteria included the following: (a) history of and/or current psychosis, autism, bipolar disorder, or current suicidality; (b) any caregiver factor (e.g., mental retardation, psychiatric disorders or conditions (i.e., dementia) that would limit their ability to provide consent for their child.

1.2. Measures

1.2.1. Child Assessment of Beliefs Scale (CABS)

The CABS, based on the Brown Assessment of Beliefs Scale, was modified by making the wording appropriate for children to understand and removing the item that pertains to explaining differing views as our piloting of the item

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