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A study of poor insight in social anxiety disorder

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ABSTRACT

We investigated levels of insight among patients with Social Anxiety Disorder (SAD) as compared to patients with Obsessive–Compulsive Disorder (OCD) and evaluated whether levels of insight in SAD were related to specific sociodemographic and/or clinical features. Thirty-seven SAD patients and 51 OCD patients attending a tertiary obsessive–compulsive and anxiety disorders clinic were assessed with a sociodemographic and clinical questionnaire, a structured diagnostic interview, the Brown Assessment of Beliefs Scale (BABS), the Social Phobia Inventory (SPIN), the Beck Depression Inventory (BDI), the Sheehan Disability Scale (SDS), and the Treatment Adherence Survey-patient version (TAS-P). According to the BABS, SAD patients exhibited insight levels that were as low as those exhibited by OCD patients, with up to 29.7% of them being described as "poor insight" SAD. Although poor insight SAD patients were more frequently married, less depressed and displayed a statistical trend towards greater rates of early drop-out from cognitive-behavioral therapy, their insight levels were not associated with other variables of interest, including sex, age, employment, age at onset, duration of illness, associated psychiatric disorders, SPIN and SDS scores. Patients with poor insight SAD might perceive their symptoms as being less distressful and thus report fewer depressive symptoms and high rates of treatment non-adherence.

1. Introduction

Insight is the human ability to critically appraise one's own mind state "from inside" (Oyebode, 2008). Poor levels of insight have been well documented in psychotic disorders (e.g. schizophrenia) and severe mood disorders (e.g. bipolar disorder), but have also been identified in patients with obsessive-compulsive disorder (OCD) (Fontenelle et al., 2010), body dysmorphic disorder (BDD) (Phillips et al., 2012), hoarding disorder (HD) (Dimauro et al., 2013), as well as other neuropsychiatric conditions (Konstantakopoulos et al., 2012; Hartmann et al., 2013). Regardless of the primary syndrome, poor insight is generally associated with a more severe clinical presentation. In OCD, for instance, poor insight has been associated with an earlier age of onset (Ravi Kishore et al., 2004; Catapano et al., 2010), higher rates of comorbid mood (Turksoy et al., 2002; Ravi Kishore et al., 2004; Alonso et al., 2008, Catapano et al., 2010), anxiety (Turksoy et al., 2002), and personality disorders (Turksoy et al., 2002; Alonso et al., 2008; Catapano et al., 2010); family history of psychosis (Catapano et al., 2010), poorer quality of life (Eisen et al., 2006) and functioning (Storch et al., 2008), and worse treatment response (Hantouche et al., 2000; Catapano et al., 2001; Erzegovesi et al., 2001; Ravi Kishore et al., 2004; Himle et al., 2006).

As patients with OCD and other OC-related disorders such as BDD and HD differ in their awareness of symptoms, developers of the DSM-5 added specifiers regarding levels of insight for each disorder (APA, 2013). These specifiers are intended to alert clinicians that patients with OC-related disorders should not be classified and treated as patients with other psychotic disorders generally managed with an antipsychotic monotherapy. Although there is evidence that antipsychotic augmentation therapy is beneficial in SRI-resistant OCD cases (Bloch et al., 2006), this strategy has been linked with potentially severe side effects (Meyer, 2007) and may not be effective when employed as a monotherapy in OCD-related disorders (Keuneman et al., 2005). Probably, a similar strategy can be adopted to prevent antipsychotic

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treatments being administered to poor insight patients with other disorders that are frequently comorbid with OCD, such as anxiety disorders.

Social anxiety disorder (SAD) indeed has substantial overlap with several conditions that may present with poor insight, including OC-related disorders and eating disorders. Each of these conditions has an early age of onset, is highly comorbid with each other, and tend to respond to similar pharmacological treatments (e.g. serotonin reuptake inhibitors) (Schneier et al., 2002). In fact, when SAD is comorbid with other disorders, it tends to emerge first (McEvoy et al., 2011). The characteristic feature of SAD (i.e., fear of being negatively evaluated by others) is also evident in the clinical picture of these comorbid disorders – for example, in relation to sexual-religious obsessions in OCD (Assuncao et al., 2012), dysmorphic concerns in BDD (Fang and Hofmann, 2010), bizarre possessions in HD (Frost et al., 2011), and weight and shape in ED (Hinrichsen et al., 2003).

Until DSM-IV-TR, only those patients who displayed insight into their social anxiety symptoms were qualified for a diagnosis of SAD (APA, 2000). However, a relevant change that has taken place with the DSM-5 conceptualization of SAD is that patients no longer need to recognize their symptoms as irrational (Bogels et al., 2010). Although in one study it was reported that less than 1% of patients with SAD failed to recognize that their fears as excessive or unreasonable (Zimmerman et al., 2010), we are not aware of any previous attempts to investigate levels of insight in SAD patients using standardized instruments to measure insight as a dimensional construct. Also, if some patients with poor insight SAD do exist, it is not clear whether they demonstrate specific sociodemographic or clinical features. Based on the findings described in other disorders, we hypothesized that poor insight SAD would likely be associated with an earlier age of onset, more severe SAD and depressive symptoms, greater rates of comorbid major depression, and a poorer adherence to treatment.

In this study, we investigated the levels of insight among patients with SAD compared to OCD patients, and evaluated whether poorer insight was related to distinct sociodemographic features, comorbidity patterns, or clinical characteristics, including treatment adherence with particular focus on pharmacotherapy and cognitive-behavioral therapy.

2. Methods

Thirty-seven SAD patients and 51 OCD patients attending our University (tertiary) Anxiety and Obsessive–Compulsive Disorders Clinic were recruited for this study. To be included, patients had to (i) have a diagnosis of SAD or OCD according to DSM-IV-TR criteria – if other psychiatric disorders were present, they had to be less severe (according to the interviewing psychiatrist's clinical judgment) and associated with a later age of onset than SAD and OCD – (ii) be aged between 18 and 65 years, and (iii) have the ability to read, comprehend and complete written forms. Patients with a comorbid diagnosis of both OCD and SAD, schizophrenia, acute mania or delusional depression were excluded from our sample. All recruited patients signed an informed consent and agreed with the objectives and procedures of this study, which was approved by the local Institutional Review Board and in accordance with the Declaration of Helsinki.

Part of the OCD sample included here was described in a previous paper (Santana et al., 2013). Subjects were assessed with a sociodemographic and clinical questionnaire, scales to measure the severity of SAD or OCD symptoms [Social Phobia Inventory (SPIN) (Vilete et al., 2004), and the Dimensional Yale–Brown Obsessive–Compulsive Scale (DY–BOCS) (Rosario-Campos et al., 2006)], an instrument to evaluate associated depression [Beck Depression Inventory (BDI) (Cunha, 2001)], and a scale focusing on disability levels [Sheehan Disability Scale (SDS)] (Sheehan et al., 1996).

Insight was evaluated using the Brown Assessment of Beliefs Scale (BABS), a seven-item semi-structured clinician-administered scale with specific probes and anchors designed to assess insight into a dominant belief that has preoccupied the patient during the past week (Eisen et al., 1998). The dimensions covered by the scale include conviction; perception of others' view of beliefs; explanation of differing views; fixity of ideas; attempt to disprove beliefs; and insight and ideas of reference. For each item, there are specific probes with five anchors ranging from 0 (nondelusional/least pathologic) to 4 (delusional/most pathologic). The seventh item is not included in the total score. Ratings represent an average score for the past week.

The BABS was employed to rate insight into (i) core SAD beliefs, which are generally described as the fear of being criticized or negatively evaluated by others, but expressed in more specific forms and assessed in greater detail in each patient (e.g. fear of looking "silly", "like an idiot", "not intelligent", "crazy", "unprepared", or "disturbing", among others) and (ii) core OCD beliefs in different OCD dimensions, identified as relevant by means of a score ≥ 3 on the Dimensional Yale–Brown Obsessive–Compulsive Scale-Short Version. Given the multisymptomatic nature of OCD, two methods of using BABS in OCD samples were employed, as described previously (Santana et al., 2013): (i) a dimension-specific strategy, which assess insight into all clinically significant OCD symptoms separately, thus allowing the identification of the beliefs associated with lower insight levels and (ii) a traditional approach, recommended by developers of the scale, which rates insight into OCD symptoms as a composite of the general average insight level.

Adherence to CBT and pharmacotherapy was assessed with the Treatment adherence survey-patient version (TAS-P), a rater-administered questionnaire originally developed by Mancebo et al. (2008). We felt the TAS-P would be the most appropriate instrument to assess treatment adherence across SAD and OCD samples due to its simplicity and ease of administration although, to date, its use has been restricted to OCD patients. For instance, the TAS-P assesses if CBT and/or pharmacotherapy were previously recommended, started, interrupted or declined; the approximate number of CBT sessions attended and/or of weeks of medication use; and the reasons, if any, for non-adherence to these forms of treatment. In our study, we investigated lifetime treatment adherence, including adherence to treatment recommendations made while in our clinic.

2.1. Statistical analyses

Categorical variables were summarized in terms of frequencies and percentages and continuous variables were summarized in terms of means ($\pm$ standard deviations). Two types of comparisons were made: (i) SAD patients vs. patients OCD patients and (ii) poor insight SAD patients (BABS ≥ 13) vs. good insight SAD patients (BABS < 13). The cut-off score for BABS was empirically defined through the observation of a zone of rarity in the histogram depicting the distribution of conventional BABS scores over the entire studied sample (data not shown). Chi-square or Fisher's exact test categorical variables and Student's t test or Mann–Whitney test for continuous variables were used.

3. Results

SAD patients were compared to OCD patients in terms of sociodemographic and clinical features (see Table 1). SAD patients were predominantly female, belonged to a higher socioeconomic stratum, displayed increased rates of alcohol dependence, had more unproductive days at school or work, and reported an earlier onset of symptoms. In contrast, OCD patients displayed higher rates of unemployment, greater religiosity, and a trend towards more frequent prescription of drug treatments.

As emphasized in Table 1 and described above, insight levels assessed using the BABS were analyzed according to two approaches. When compared to insight levels in OCD patients rated against their primary symptom domain, SAD patients demonstrated equivalent (low) insight levels. However, when compared to insight levels in OCD patients rated across all symptom domains, SAD patients demonstrated significantly lower insight levels. A comparison between SAD and OCD in terms of treatment adherence is depicted in Table 2.

In relation to SAD, up to 29.7% of the sample (11 patients) exhibited poor insight, defined as a score of 13 or more on the BABS. Poor insight SAD patients were more frequently married and had lower BDI scores than good insight SAD patients (Table 3). There were no other distinct differences between the groups, although poor insight SAD patients displayed a statistical trend towards higher rates of CBT non-adherence (Table 4).

4. Discussion

In this study, patients with SAD were characterized by levels of insight that were as low as those exhibited by OCD patients – a