CHAPTER VI
DISCUSSION OF RESULTS

Not everything that is faced can be changed; but nothing can be changed until it is faced.

James Baldwin, Notes of a Native Son

The main objective of the present study was to investigate the relationship between insight and motivation for change in obsessive compulsive disorder.

Insight and motivation for change

It was hypothesized that Insight would be positively related to motivation for change in patients suffering from OCD. Results of the study do not support the hypothesis that insight would be predictive of overall motivation for change in OCD patients (Table 2). These results are contrary to the previous findings where a considerable amount of research has demonstrated that level of overall insight is a significant predictor of overall motivation for change; specifically evident
in the form of treatment compliance (Lin et al. 1979; Marder et al, 1983; Bartko et al, 1988; McEvoy et al, 1989b; Amador et al, 1993; MacPherson et al 1996; Mutsatsa et al, 2003). The results of the present study are surprising given the amount of emphasis in the literature placed on the role of insight especially in the treatment compliance (Christensen & Greist, 2001). This led these clinicians to advocate for assessing the level of insight at the outset of treatment. Poor insight and limited symptom recognition characterized most participants in clinical trials, along with low motivation and treatment compliance. Patients frequently had to be forced into treatment by significant others in their lives as the lack of will to change was marked in those who were poor on insight (Christensen & Greist, 2001).

The role that insight into mental illness might have in relation to compliance with treatments has been examined in several studies. Most such studies suggest that poorer insight into illness is associated with poorer compliance with treatments (Lin et al. 1979; Marder et al, 1983; Bartko et al, 1988; McEvoy et al, 1989b; Amador et al, 1993; MacPherson et al 1996; Mutsatsa et al, 2003). However, our study at the face of it failed to endorse this relationship.

Increasing, research has focused on determining possible factors which influence compliance and which could be used to find new ways of improving adherence to treatments (Buchanan, 1992; Kemp & David, 1996).

However, these findings should be interpreted with caution when drawing conclusions about the role of insight and motivation for change, keeping in view our results.

It is important to note that studies examining the relationship between insight regarding mental illness, and associated compliance to the treatment offered, are difficult to interpret. Some of the problems are related to the difficulty in evaluating the treatment adherence itself, but the main problem concerns the assessment of insight in these
circumstances and the consequent meaningfulness of the research results. Specifically, the problem consists of the circularity that results when insight is defined, in part at least, by acceptance of treatment. (Lin et al. 1979; Marder et al, 1983; Bartko et al, 1988; McEvoy et al, 1989b; Amador et al, 1993; MacPherson et al 1996; Mutsatsa et al, 2003). Rating insight then becomes tantamount to rating verbal compliance and difficulties arise in determining the individual’s aspects of the putative explored relationship. There are two issues: First, whether there are any theoretical grounds to consider verbal compliance with treatment as a component of insight (Markova & Berrios, 1995; McCabe et al 2000). Second, whether it is meaningful to treat verbal compliance qua insight as a variable against which actual treatment adherence is assessed (David, 1990).

Despite this assumption, some recent studies including the present study have failed to demonstrate that overall level of insight is a predictor of overall motivation for change in the patients suffering from OCD (Taylor & Perkins, 1991). The findings of the present investigation are consistent with the study conducted by Taylor & Perkins, (1991) who assessed 30 patients with psychotic disorder found that denial was associated with longer contact with services.

Results of the present study can be understood in terms of intellectual insight and emotional insight of the patients. As most of the insight assessment scales measure mainly intellectual insight in the absence of operational definition of emotional insight, which ideally should be the ultimate goal of any type of treatment modality. Even the present study has had to use Brown assessment of belief scale for the assessment of insight because it was the only measure found anywhere near to a robust functional definition of insight, after an intensive review of literature in the field of insight. Yet it was far from perfect because the fundamental questions about the presence of patient insight in psychotherapy or treatment as a whole, pertains to the relation of insight.
to action. But as it is a known fact especially about the patients suffering from OCD that their intellectual insight does not turn into the very action in spite of the intellectual knowledge about the senselessness and uselessness of the belief. Intellectual insight may be considered a cognitive process in which the patient grasps the cause-effect sequences in his or her conflicts. Emotional understanding, however, is thought to involve affect, such that the patient both grasps certain internal events intellectually, and also experiences feelings related to those events that previously had been unavailable or not experienced. For clinicians who make such a distinction, it is emotional insight that is considered the most effective in promoting behavior change. In regard to intellectual insight, Wachtel (1997) very aptly elaborated that:

“Intellectual and emotional insight appears as a distinction whose importance derives from whether, or how thoroughly, the patient is exposed to those cues that really make him anxious. Since in most instances, anxiety is most strongly attached to a complex configuration of cues in which verbal, affective, cognitive, and motoric elements are all prominent, verbalizing without the other cues being present is unlikely to have much therapeutic value. Thus, "intellectual insight" is ineffective,........... Some patients, in fact, particularly obsessional individuals, have learned discrimination such that verbalizing almost anything can occur without anxiety, so long as it is not in the context of emotional arousal and of an inclination to act on what is being said. Thus, for such a patient, verbalizing even seemingly "significant" things is likely to be therapeutically fruitless unless the other cues to which anxiety is attached are produced along with the verbal cues” (p. 94).

So these cues that make the patient anxious hinder his way to behaviour change and he avoids those cues that are related to emotional arousal. Avoidance is defined as difficulty facing disturbing emotions, thoughts, or circumstances. Avoidance often involves attempts to block or move away from disturbing experiences and can include drinking or using
other drugs to numb oneself, *discontinuing and avoiding therapeutic tasks*, shifting topics abruptly or maintaining a superficial focus, and isolating and withdrawing from external stimulation. A *way to disengage from recurrent insight-seeking and to decrease distress is to avoid the disturbing material*. This avoidance can take many forms, including distraction, denial, cognitive distortion, suppression, repression, substance abuse, self-harm, disengagement, dissociation, and even suicide (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Ottenbreit & Dobson, 2004). Ruminative processes can also serve the function of avoidance in that excessive thinking and emotionality can block deep experiencing (Borkovec, 2002). Those prone to intrusive thoughts, rumination, and worry might also avoid experiences that will trigger the recurrent thoughts because they are aware of this vulnerability (Borkovec, 2002; Segal, Williams, & Teasdale, 2002). There is evidence that *avoidance is not associated with productive insight, but rather with a rebound of the avoided material and perpetuation of an avoidance-intrusion-rumination cycle* (Beavers, Wenzlaff, Hayes, & Scott, 1999; Brewin et al, 1996; Wenzlaff & Luxton, 2003).

Hill and O’Brien (1999) made a further point about how action affects insight. They stated that Taking action is crucial for consolidating the new thinking patterns learned in the insight stage. *Action concretizes the abstract insights for clients into more permanent schemas*. Moreover, new understandings can be fleeting unless something is done to help the client consolidate them. Old thinking patterns and behaviors easily resurface unless new thinking and behaviors are practiced and incorporated, (p. 64).

Greenson (1978) commented wisely on this time dimension when he stated that: Repetition is necessary in order to overcome the patient’s tendency to ward off painful affects, impulses, and fantasies. Finally, the reiteration of an insight gives the patient a further opportunity for
mastery of anxiety and a chance to try out new modes of response. All these facts explain why working through takes a long time. The old was painful and yet familiar and safe; in this way it resembled an old love object. Repetition offers opportunities to part with the old, and to become acquainted with the new (p. 244).

The present study puts light on the fact that it is not the intellectual insight which is related to motivation for change rather it may be the emotional insight which is important for change.

It may be the case that type of insight plays a different role in obsessive compulsive disorder than it does in other psychotic illnesses e.g. Schizophrenia (McEvoy et al, 1989b; Amador et al, 1993; MacPherson et al 1996). There is significant impairment in cognitions of the schizophrenic patient as compared to OCD. Even most of the OCD patients have good awareness about the senselessness of the obsessions but due to the aversive and demanding nature of the OCD symptoms, the level of motivation may be fluctuating substantially over the course of the illness. OCD is no doubt a schizophrenia spectrum disorder but it certainly is a separate construct, a unique disorder with unique course and a unique relationship with insight; may well be related to much more with emotional insight which is well understood but is still deficient in its measuring tools.

No doubt the relationship of insight with motivation for change is a complex one.

Results of Table-2 indicate that significant positive relationship was found between insight and the locus of control internal which is one of the subscales of motivation for change. This implies that higher the insight, higher would be the intrinsic motivation for change- for efforts towards controlling of symptoms.

Literature is supportive of these findings that insight is a necessary precondition for a change, if not the sufficient one.
Researchers have postulated that it is not only the level of motivation that is important in treatment outcome, but also the specific quality or motivational orientation (i.e., intrinsic or extrinsic motivation) that may have distinct predictive power (Ryan & Deci, 2000; Harter & Jackson, 1992; Pelletier, Tuson, Haddad, 1997). In particular, in the realm of health-related research, intrinsic motivation for engaging in treatment has been shown to lead to better outcome for a variety of problems including diabetes (G.C. Williams, Freedman, & Deci, 2004), morbid obesity (Williams, Grow, Freedman, Ryan, & Deci, 1996), opiate addiction (Zeldman, Ryan, & Fiscella, 2004), alcohol dependence (Ryan, Plant, O’Mally, 1995), and cigarette smoking (Williams et al. 2002). More recently, Zuroff and colleagues (2007) extended this research from the health-related domain to the treatment of mental illness.

Relation of insight with intrinsic motivation, as it has been discussed earlier, should be interpreted with caution as the very operational definition for measuring insight and intrinsic motivation might have an overlap in their content. However, in OCD present study suggests that relationship between intrinsic motivation and the insight is high and may well be utilized while planning therapeutic interventions. If insight about illness can be increased then the internalized efforts towards changing the maladaptive thoughts and behaviors that are creating OCD will also exhibit enhancement, or the vice-versa. The widespread research that has gone into promoting intrinsic motivation can be utilized in the field of insight in OCD as implied by the findings of the current study.

**Insight and Coping Styles:**

It was hypothesized that Insight would be positively related to cognitive positive coping style in patients suffering from OCD. Results of Table 3 suggest that there were no significant correlations between insight and sub scales of coping styles.
Traditional explanations of awareness deficits in the mental illness (e.g. Psychoses) have advocated that poor insight results from psychological defenses or coping strategies employed to deflect the feeling of a loss of personal control, and to maintain a sense of well being (van Putten et al., 1976).

Rogers (1961) had proposed that when people encounter experiences, which are inconsistent with their self-concept, those experiences are temporarily rendered harmless by being distorted or denied in awareness. This may be a plausible response to the trauma of a psychotic episode. In everyday life mentally healthy people distort reality to enhance their self-esteem and maintain beliefs about their self-agency (Taylor & brown, 1988; 1994).

But most of these studies are related to schizophrenia or organic brain diseases where poor insight is a norm rather than exception, but most of the studies related to OCD suggest that most of the patients have good insight about the senselessness of the belief or ritual, so it does not appear like that they are denying their illness rather it gets them depressed in the long run.

In general, psychiatric disorders’ model / mechanism of insight tend to explain poor insight in terms of:

2. Psychological /Motivational responses to illness.
3. Symptomatic i.e. intrinsically related to a disease process and hence associated to a psychopathology (Collins et al., 1997; Smith et al., 2000).
4. Poor insight is a product of a combination of above mentioned mechanisms (Vaz et al., 2002; Startup, 1996).
5. In terms of personality factors, cultural and socially determined attitudes (Johnson & Orrell, 1995; David & Kemp, 1997; White et al, 2000; Clare, 2004).
The underlying explanations for poor insight have focused on the disease process itself either in terms of the psychopathology of the illness or in terms of neuro-cognitive dysfunctions. As Amador et al (1991) state, that some forms of unawareness may stem directly from the pathophysiology of the disorder and this view has been based on the principle that assumes the link between insight and disease and, hence takes insight as a symptom or indicator of the disease process rather than as a response to the condition e.g. psychological defense mechanism or coping factors.

Following the same school of thought, McEvoy et al (1996) employed a battery of neuro-psychological tests to find their interrelationship with insight in 32 patients with schizophrenia. They found that a global measure of insight, the Insight and Treatment Attitudes Questionnaire (ITAQ) was related to performance on a test of left parietal lobe function. In addition, the responses to one of the ITAQ items (the one that best reflected current awareness of mental illness in patients at the time of discharge) was related to performance on prefrontal lobe tests and right and left parietal lobe tests. They concluded that at least some of the deficits in awareness of illness in schizophrenia are related to neuro-psychological dysfunction.

Alternately, Startup (1996) proposes that the relationship between insight and cognitive deficits might more usefully be conceived as curvilinear on account of the contribution of psychological or motivational factors in the manifestation of insight.

In other words, existing neurological or psychological theories put forward to explain impairment of insight are not mutually exclusive and might contribute proportionately according to the level of cognitive impairment suffered by the individual.

In a study involving 26 patients with schizophrenia (DSM-IIIR), Startup (1996) administered a number of tests sensitive to frontal lobe dysfunction (Cognitive Estimates, Verbal Fluency, Trail (B)Making Test,
Stroop Test and Stylus Maze test), and used the ITAQ to assess the insight. He was able to demonstrate that a quadratic, rather than a linear model, could help explain the relationship between insight and cognitive deficits, accounting for 56% of the variance. Following on from this, Lyaskar et al (2003) carried out a cluster analysis on 64 patients with schizophrenia spectrum disorder and, using the PANSS (Positive and negative syndrome scale) insight item, they divided patients into those with good insight and those with poor insight. On administering tests of frontal lobe function (WCST), they obtained three groups of patients, namely, patients with good insight and average performance on WCST; patients with poor insight and average performance on the WCST, and patients with poor insight and poor performance on the WCST. They thus concurred with Startup (1996) that perhaps there are subgroups of patients who may show poor insight for different reasons: poor cognition on the one band might underlie problems in understanding reality in one group and a tendency to ignore or deny unpleasant things might contribute more to impairment of insight in another group.

Design of the present study was based on a new model that views insight as a dimensional construct rather than a dichotomous one. Startup (1996) has divided insight in different categories or in different types of insights. He differentiates between insight with no cognitive impairment, partial cognitive impairment and severe cognitive impairment. However, the model of insight on which the measurement of insight is based in the current study, is based on the following assumptions and studies:

- Insight differs in degree not in kind. Treatment can improve insight by a matter of degree (Hollander et al., 1999; Phillips et al., 2001a, b).
- Insight in Body dysmorphic disorder varies along a continuum, with many patients having overvalued ideas rather than either
the good or absent insight implied by a dichotomous model (McKenna, 1984).

- More recent clinical observations suggest that insight may fluctuate, even without treatment, and may change with the social environment or stress (Phillips and McElroy, 1993).
- It seems highly unlikely that a patient with fluctuating insight would have one disorder (delusional disorder) at one moment and another disorder at another. The more parsimonious explanation is that such a patient has a single disorder characterized by a spectrum of insight.

- The previous literature available in the field of insight that showed a wide range of insight, particularly as far as regarding their obsession / compulsions as senseless, is concerned (Insel & Akiskal 1996; Lelliot et al 1988) in OCD.

However, results of the present study suggest that insight might be different in kind or it may be related to the disease process itself rather than with the coping styles of the OCD patients.

Results of the present study suggest that like schizophrenia (WHO, 1973; Carroll et al, 1999; Pyne et al, 2001; Amador et al 1994) or neurological or organic brain syndrome (Clare, 2004), poor insight in OCD may be related to the disease mechanism/ processes itself rather than the denial or coping factors.

Literature has conclusively established that certain coping styles are specific to OCD (Clark, Ball, & Pape, 1991; Gold & Wegner, 1995; Wegner et al., 1987; Wegner et al., 1991) and may even be a determining factor for its psychopathology (Clark & Purdon, 1993; Wegner & Zanakos, 1994), but the findings of the current study very clearly show that these coping mechanisms are not related to the level of insight within OCD. Thus insight as measured here was not a coping mechanism but as explained earlier may have a more neuro-cognitive
nature. Thus management of coping styles may not help towards improvement of insight in OCD; and efforts towards enhancing insight of illness, which are one of the primary goals of intervention, will need to be planned independent of focus on patients coping mechanisms.

**Insight and Attributional Style:**

It was hypothesized that Insight would be positively related to optimistic attributional style in patients suffering from OCD. Findings of present study indicate that (Table 4) there were no significant correlations exist between insight and subscales of attributional styles.

Lack of insight may be viewed as *misattribution*, a form of cognitive error based on lack of information, systematic biases, or idiosyncratic beliefs regarding the symptoms. Misattribution implies there is a lack of agreement of patient with the correct attribution for symptoms and experiences that is given by common accord or, in doubtful cases, by medical authority. So misattribution is really an interpretation of experience that is due neither to a deficit nor to purely defensive functions, but that reflects a genuine alternative construction of reality. While it may not accord with the dominant view of psychiatry, this alternative reality makes sense within the patient’s personal world of meaning and, hence, confers the benefits of coherence, order, and intelligibility on unusual, chaotic, or disturbing experiences in the form of symptoms.

Amador and colleagues (1993) suggest that insight involves both awareness and attribution. Attribution depends on awareness, since we must notice something to make it the object of explanations. In addition, the way in which we become aware of deviant experience itself carries
information relevant to making causal attributions. Attributions or explanatory models also govern the deployment of attention and guide the search for sensations, experiences or events that fit a niche within the model or schema that may precede awareness. In practice, then, there can be no sharp distinction between awareness and attribution…….. Insight, like other forms of self-knowledge, must then be understood as a process of attribution or, more elaborately, as the construction of narratives about the self …….. Insight involves a series of attributions: symptoms are attributed to affliction and the affliction is labeled as a mental disorder with specific causes, course, and outcome. But attributions do not occur in isolation; they are part and parcel of more extended networks of meaning. Such networks influence the perception of what constitutes a symptom or a sign of illness within a given culture (Corin, Bibeau and Uchôa, 1993; Good and Good, 1980; Kirmayer, 1989)……… In some cases, psychotic experiences themselves provide their own interpretations and these are typically religious or supernatural, or in modern societies, involve magical applications of technology like radio waves, lasers, and microelectronics. In other cases, explanations are found after the fact from some sympathetic or authoritative source – but in every case they represent cultural conceptions (p.204).

Amador and colleagues (1993) found that insight about past and current episodes of psychosis was poorly correlated. Insight about past illness episodes involves the narrative reconstructions of memory; current insight may be more dependent on feedback from control mechanisms (intra-psychic and social feedback loops) that give evidence of dysfunction or lack of match of action with intention. But both forms of insight are highly context-dependent: past reconstruction and current self-perception.
It may be one feature of some forms of illness that individuals’ capacity to respond to shifting contexts is impaired and hence, their self-presentation shows greater stereotypy than that of healthy individuals. The notion of insight as a narrative construction has special significance for psychosis, because there is evidence that the ability to organize discourse at the level of narrative is impaired in schizophrenia (Hoffman, 1986). Narrative is particularly important in the construction of a coherent sense of self against which events are evaluated through the process of self-awareness (Bruner, 1990; Kirby, 1991; Ricoeur, 1992). If the stability and coherence of this narrative is interfered with, then the capacity for insight may be correspondingly impaired. Further, since the form of narratives varies cross-culturally (Ewing, 1990; Howard, 1991), culture may interact with psychotic impairment of insight at the level of what narratives of the self are available, socially coherent and credible. Research on attribution and insight suggest that attributional style of the individual is highly context dependent i.e. past reconstruction and current self perception. It might be possible that due to mental illness individual’s capacity to respond to these mechanisms gets impaired. The relation of insight and attribution as suggested by Amador et al (1993) is difficult to comprehend as no sharp distinction lies between insight and attribution. In ‘Brown assessment of belief scale’ when we assess whether the person recognizes that the belief have a psychiatric/psychological cause in real terms we are assessing what insight or attribution? So it is quite difficult to differentiate insight from attribution in operational terms. However research has demonstrated about insight that insight is dynamic in nature i.e. it may fluctuate (Phillips and McElroy, 1993) and it has wide range especially in OCD (Insel & Akiskal1996; Lelliot et al 1988).

On the contrary research literature about attributional style suggests that when researchers use the term beliefs, or cognate
expressions such as the sense of control over one's life, they make certain attributions about control not in one context but many. It is often not easy to tell from the term itself; thus, belief about control could be a belief in a specific context or a general belief. The former is a cognitive appraisal, the latter a disposition carried to the situation by the person. This distinction is a variant of the larger state-trait distinction, which has long been of interest to personality and social psychologists (e.g., Allen & Potkay, 1981; Averill, & Opton, 1968).

**Motivation for change and coping styles:**

It was hypothesized that Motivation for change would be positively related to adaptive coping styles in patients suffering from OCD. Table 5 indicated that the Composite score of motivation for change found to be positively and significantly correlated with adaptive coping style specifically problem solving. However non adaptive coping styles, specifically cognitive negative, magical thinking and external attribution are significantly negatively related to overall motivation for change.

The psychological construct of motivation for change and coping styles appeared to be bipolar in nature having significant positive and negative affinities with each other’s constructs.

Skinner and Wellborn (1994) have argued for a motivational approach to stress and coping. From this perspective, stress arises from threats to basic psychological needs, such as relatedness, autonomy, and competence. Coping is thus “an organizational construct that describes how people regulate their own behavior, emotion, and motivational orientation under conditions of psychological distress . . . [and] encompasses peoples’ struggles to maintain, restore, replenish, and repair the fulfillment of these needs” (p. 112).
Results are supportive to the hypothesis as adaptive coping style of problem solving is significantly correlated to overall motivation for change.

Kahn et al. (1964), spoke of two major groups of problem-oriented strategies—those directed at the environment and those directed at the self. Included in the former are strategies for altering environmental pressures, barriers, resources, procedures, and the like. The latter includes strategies that are directed at motivational or cognitive changes such as shifting the level of aspiration, reducing ego involvement, finding alternative channels of gratification, developing new standards of behavior, or learning new skills and procedures. Coping efforts include both problem and emotion-focused strategies that are directed at the problem and at the emotions, respectively.

Problem solving coping style that was found to be related to the motivation for change includes some changes in strategies or actions to resolve the problem. Therefore, it includes the strategies in which action is oriented towards the problem that increase self-esteem and self efficacy. So, problem solving coping style indicate that patient has a readiness, willingness and motivation for behaviour change. These results are supported by various studies in literature problem-solving (Claiborn et al 1981; Greenberg 1993).

In the current results emotion focusing coping style, specifically cognitive negative, magical thinking and external attribution are significantly negatively related to overall motivation for change (Table 5). Cognitive negative coping styles include rumination of the problem, self blaming, hopelessness and negative comparisons with others. This emotion focusing coping style is opposite of what is needed in the motivation for change- in the will to make persistent efforts towards changing ones maladaptive ways of thinking and behaving which are presenting as psychopathology here as OCD. These results are also in
line with the motivational research theories e.g. hopelessness and helplessness model—which states when a negative outcome is thought to be a product of the person’s effort (internality), there will be a loss of self-esteem and a greater likelihood of depression than if the outcome is seen as the result of external factors. If such attribution is viewed as the result of stable person factors, the costs of uncontrollability will be chronic as well. There is, moreover, an added attributional factor of "globality," that is, a generalization of helplessness from a specific context to the overall life context (Abramson, Garber, & Seligman, 1980).

*These appraisals refer to the extent* to which a person believes that he or she can shape or influence a particular stressful person-environment relationship. They are products of the individual’s evaluations of the demands of the situation, as well as his or her coping resources and options and ability to implement the needed coping strategies. In the latter respects, situational appraisals of control parallel Bandura’s concept of self-efficacy. Bandura (1977a) distinguishes between an efficacy expectancy, which is the conviction that one can successfully execute the behavior required to produce an outcome, and an outcome expectancy, which is defined as a person’s estimate that a given behavior will lead to certain outcomes. Bandura makes this distinction because . . . individuals can believe that a particular course of action will produce certain outcomes, but if they entertain serious doubts about whether they can perform the necessary activities such information does not influence their behavior, (p. 193).

Magical thinking actually includes the pattern of wishful thinking and super natural beliefs which are far from reality. Wishful Thinking involves efforts to think that a stressful situation simply will resolve itself (e.g., “I hoped a miracle would happen”).

Magical thinking is a kind of Problem Avoidance associated with efforts to not deal with the problem situation at hand (e.g., “I wished that
the situation would go away or somehow be over with"). Rather this is a kind of strategies used to regulate emotion include seeking comforting information from the environment that was consistent with the attitudes and hopes of the person. As these wishful patterns for day dreaming satisfied the individual temporarily, the actions may be getting inhibited, or behaviour may not be directed towards resolving the real problems of one’s life. (Folkman & Lazarus, 1980; Aldwin, Folkman, Schaefer, Coyne, & Lazarus, 1980)

External attribution was negatively correlated with overall motivation for change suggest that external attribution for successes form a pessimistic attributional style causing OCD patients to believe that they are incompetent to manage their thoughts and compulsions which leads to lose of confidence and the experience of learned helplessness that decreases motivation to change.

**Motivation for change and attribution styles:**

It was hypothesized that Motivation for change would be positively related to optimistic attributional style in patients suffering from OCD. Results of Table-6 indicate that internal attribution for good events is positively related to overall motivation for change. Bandura (1977) suggested that a person would experience an enhanced sense of self-efficacy if, when successes occurred, he or she made attributions to his or her own ability rather than to task difficulty, to luck, or to his or her effort in that particular situation. More research has been done linking self-efficacy expectancies to behavior (Bandura, Reese, & Adams, 1982) and affective states (Kanfer & Zeiss, 1983). Other studies have consistently found a strong association between self-efficacy expectations and approach behavior in a variety of other phobias (Bandura, 1982; Bandura, Adams, Hardy, & Howells, 1980; Williams, Dooseman, & Kleinfeld, 1984). Self-efficacy measures have also been used successfully in predicting outcome and relapse rates in a variety of other clinical
groups, including smokers (Coehlo, 1984), alcohol abusers (Marlatt & Gordon, 1985), and obese subjects (Weinberg, Hughes, Critelli, England, & Jackson, 1984).

Result of the present study indicate that depressive attributional styles like stable and global attributions for bad events is negatively related to overall motivation for change.

These results can be explained according to the Weiner theory (1979) that links between the type of attribution made and the emotional and motivational state resulting from that attribution, as well as expectancies for future performance. He suggested that internal, stable attributions for failures led to reductions in a person’s self-esteem, motivation, and level of expectancy, whereas external, unstable attributions for failures did not result in a decrement in self-esteem, motivation, or expectancies.

The classic pattern of depressive attributional style involves an individual explaining their negative outcomes (failure) as internal (one’s own fault) versus external (the environment’s fault); as stable (unchanging) versus unstable (variable); and as global (happening all the time across all situations) versus specific (happening one time in a specific situation) (Schulman, Seligman, & Amsterdam, 1987). Conversely, an individual with an optimistic attributional style will tend to interpret negative outcomes (i.e., failure) as due to external, unstable, and specific factors (Peterson & Seligman, 1984).

Arkin, Appleman, and Burger (1980) found a greater tendency in socially anxious subjects to make internal, stable attributions for failures and external, unstable attributions for successes, compared with socially nonanxious subjects. Peplau et al. (1979) found that internal, stable attributions for loneliness in college was associated with higher levels of depressive symptoms, compared with students who made unstable attributions for loneliness.
Depressive attribution style is related to prolonged exposure to uncontrollable aversive events, which result in motivational, cognitive, and behavioral deficits (Schill and Marcus, 1998).

Wortman and Brehm (1975) propose that increased motivations, and efforts to regain control, are apt to be the initial reaction to uncontrollable outcomes, but that continued unsuccessful efforts will lead ultimately to lowered motivation, increased passivity, and depression.

Thus the current study endorses a similar relationship in patients suffering from OCD. This has marked implications for psychological interventions planned for OCD patients wherein while motivating them for changing their symptomatic behaviors’ a therapist can schedule a reattribution training for patients in which they could be trained in attributing optimistically.

**Contribution of insight, motivation for change, coping style and attributional style to OCD**

It is expected that insight, motivation for change, coping style and attributional style will contribute significantly to OCD.

Table 7 suggests that most of the variation in OCD was due to Self esteem, religious attitude and insight.

**Self esteem** emerged as a major source of variation almost 20% variation in OCD was due to the self esteem which was the subscale of motivation for change. Lack of motivation can be described as motivation-stems from a lack of perceived competence (Deci & Ryan, 1985) or positive efficacy beliefs (Bandura, 1996). Lowered self-esteem is a deficit of hopelessness when a failure is attributed to an internal, stable and global cause (Crocker, Alloy, & Kayne, 1988; Dweck & Licht, 1980).

**Religious attitude** is positively associated with severity of OCD symptoms and especially with compulsive symptoms and contributing significant change in OCD.
This phenomenon could be understood from the fact that religious blasphemy is one of the types in OCD symptoms checklist. The act of religious blasphemy creates a feeling of intense guilt and it interferes with the patient’s fears and anxieties. As the severity of symptoms increases patient performs the religious rituals more compulsively. Freud’s theory of religious ritual (1907) is that it is a kind of obsessional neurosis, with similar compulsions to carry out certain acts, guilt if this is not done, and that the rituals are distorted symbolic versions of repressed instinctive desires. The main basis of this theory is the observation that religious rituals often do have a compulsive character, to carry out ritual acts with great precision.

Corin’s (2004) work also shows way valued by the Hindu philosophy of life, through prayers, meditation and singing; the performance of rituals and prayers as a way to sustain hope; and a resort to karma theory, which relates current problems to events during past lives.

Kirov and colleagues (1998) found that 61.2% of their sample of 52 schizophrenic patients actively used their religion for coping with their illness. They found that religious practice was helpful to some subjects as a way to re-establish personal equilibrium following a psychotic episode or to find meaning for otherwise difficult-to-explain experiences. Many of those most likely to use religion as a coping style were also able to recognize that they had a mental health problem. Indeed, those using religion to cope were rated as having higher insight into their illness and were more likely to be compliant with antipsychotic medication than were the other sample subjects.

For family members in India, the evocation of causes involving evil spirits and black magic went on in parallel with diagnoses given by astrologists who explained the patient’s problems by the position of auspicious and inauspicious planets.
For both patient and family, the evocation of evil spirits and black magic served to name a feeling of strangeness and alienation. The relative importance of a general quest for meaning and of astrological explanations among patients and family members may reflect their respective positions towards psychosis: for the patients’, a desire to name strangeness and recover meaning; and for the families, a desire to reintegrate the patient within a shared socio-cultural framework.

Pargament et al. (2000) found that there was a negative aspect to religious coping. In particular, feeling as if God had abandoned them, was punishing them, or that they were being judged by others in the congregation not only led to worse outcomes but actually seemed to hasten death among seriously ill patients (Pargament, Koenig, Tarakeshwar, & Hahn, 2001).

Some studies suggest that religion has negative consequences for mental health, or has no effect at all on mental health (e.g. Bergin, 1983; Levin & venderpool, 1987).

**Insight** is causing significant variation in obsessions and this is negative in direction i.e. more the insight less the obsessions would be, and vice versa.

Common observations that patients with OCD show a wide range of insight, particularly as far as regarding their obsessions/compulsions as senseless is concerned (Insel & Akiskal, 1986; Lelliott et al, 1988) then the DSM-IV Field Trial, using a structure scale, specifically explored insight in 431 patients with OCD (Foa & Kozak, 1995). Their conclusions confirm that patients with OCD do show a range of insight.

Using a semi-structured rating scale the Brown Assessment of Beliefs Scale (BABS) assessing insight in 71 patients with OCD, Eisen et al, (2001) found that insight improved as symptoms of OCD improved though insight itself was not found to be a predictor of a clinical response to pharmacotherapy.
Relationship between insight and depression in terms of self esteem factors, have also been proposed though empirical results have not been conclusive (Iqbal et al., 2000; Drake et al. 2004). Patient with depressive disorders show better insight into their illness than patients with schizophrenic/schizoaffective/other psychotic disorders Cassidy et al. (2001).

Poor insight (or aspects of insight) associated with worse depression (O’Connor & Herrman, 1993; Collins et al. 1997; Buckley et al., 2001; Sevy et al., 2004). An interesting study, explicitly testing a hypothesis of psychological mechanisms underlying insight (specifically invoking mechanisms of self-deception), was reported by Dixon et al. (1998). Using a discrepancy method of assessing insight (i.e differences between patients’ and relatives’ evaluations) in 41 schizophrenic patients, they found that subjective ratings (i.e. those made by patients) of worse depression were associated with increased insight. In contrast, objective ratings (i.e. those made by relatives) of worse depression were associated with poorer insight. Subjective increased depression was also associated with greater insight into psychotic illness in the study by Sanz et al. (1998).

Recent longitudinal studies of patients with schizophrenia spectrum disorders found that patients with good insight had experienced more suicidal attempts than those with poor insight (Bourgeois et al. 2004; Mintz et al., 2004).

Role of insight appears adaptive in nature as it cushioned the patient from depression and stigma and it also appears that it is related to the disease process itself because insight varies with symptom severity specially in OCD (Eisen et al, 2001).

**Contribution of Insight, coping style and attributional style to motivation for change in OCD**
It is expected that insight, coping style and attributional style will contribute significantly to motivation for change in OCD.

**Table-8** indicate that the major source of variation in motivation for change was due to the external attribution coping style that was contributing 23% of total variance.

External attribution includes blaming the luck or other people for what has happened. Results of the present study show that external attribution is negatively associated with motivation for change.

Arkin, Appleman, and Burger (1980) found a greater tendency in socially anxious subjects to make internal, stable attributions for failures and external, unstable attributions for successes, compared with socially nonanxious subjects.

McGinn and Sanderson (1999) found that individuals who are able to attribute their improvement to themselves are more apt to do better than those patients who make external attributions for their treatment gains. As the therapist decreases his or her involvement in the exposure process, patients are encouraged to make internal attributions for their success at ERP. Hopefully, this results in an increase in patients’ self-confidence, willingness to continue on to greater challenges, and generalization of their successes to day-to-day experiences.

The other source of variance was problem solving coping style of the patients which was contributing 9% out of total variance. Problem solving was positively related to the motivation for change.

Problem solving coping style include some change in strategies or actions to resolve the problem. Therefore, it includes the strategies in which action is oriented towards the problem that increase self-esteem and self efficacy. So, problem solving coping style indicate that patient has a readiness, willingness and motivation for behaviour change. These results are supported by various studies in literature problem-solving (Claiborn et al 1981; Greenberg 1993).
Cognitive negative coping style was responsible for other 8% out of total variance. Cognitive negative coping style was negatively contributing to motivation for change.

Internal attributional style for good events was the other significant source of variance which was contributing 5.5% change towards motivation for change. Internal attributional style for good events was positively associated with motivation for change.

Bandura (1977) suggested that a person would experience an enhanced sense of self-efficacy if, when successes occurred, he or she made attributions to his or her own ability rather than to task difficulty, to luck, or to his or her effort in that particular situation. More research has been done linking self-efficacy expectancies to behavior (Bandura, Reese, & Adams, 1982).

Thus, in the context of current study we can conclude that in OCD to enhance the will to change a therapist may focus on patient’s attributional style specifically internal and external attributional style for good events. Secondly therapist may alter patient’s way of coping e.g. teaching a problem solving coping styles would be good strategies in combating OCD rather than emotion focusing coping styles.