CHAPTER-I

INTRODUCTION

*Learning is nothing but discovery that something is possible. To teach means to show a person that something is possible.*

—FRITZ PERLS, *Gestalt Therapy Verbatim*

What it is like to be an OCD patient? How he feels, perceives, reacts and thinks? How one can does the same repeated acts again and again in spite of having a good amount of awareness about the senselessness of the act? Why awareness alone does not give guarantee of change.

In the wake of so much advancement in research and theories we have certain answers to these questions. But still knowledge does not able to change the quality of life of these patients. And still OCD patients like alcoholics blamed for having poor insight or having poor motivation. There is dearth of research especially in the area of insight and motivation for change in OCD patients

Obsessive Compulsive Disorder is a chronic and disabling mental disorder. Affecting from 1 to 3% of the general population (Karno et al, 1988, Torres et al 2006). It runs a chronic course with waxing and waning severity of symptoms but rarely remits completely (American Psychiatric Association 1994, Rasmussen and Eisen 1998, Pine et al, 2004). Since 1970 research on OCD has increased exponentially. Serotonin reuptake inhibitors, and cognitive behaviour therapy has emerged as the mainstay of treatment in OCD. However, 40% to 60% of the patients still do not show satisfactory response to the treatment. Quality of life of OCD patients appeared very poor in many domains like
interference with socializing, family relations and ability to study and work. Many reported decrease in self esteem, and increase in suicidal ideation (Stein et al, 1996). Sometimes patients function at the level lower than a schizophrenic patient.

The efficacy of Exposure and response prevention (ERP) for OCD has been well established (e.g., Abramowitz, 1998), with response rates ranging from 63% (Stanley & Turner, 1995) to 90% (Abramowitz, 1997) for individuals who gets a full course of treatment. But, despite the effectiveness of ERP, many OCD sufferers have not benefited from ERP treatment. Studies estimate that among those who comply with ERP treatment 10% or more do not respond (Vogel, Bjarn, Stiles, & Gotestam, 2006). Moreover, because of the demanding and difficult nature of the treatment, many individuals refuse to participate in such an intervention. Refusal rates, in which OCD sufferers turn down available ERP treatment, are generally estimated at approximately 25-30% (Franklin & Foa, 1998; Kozak, Liebowitz, & Foa, 2000). In addition, among those individuals who begin ERP, many demonstrate poor compliance to the prescribed therapy, which is a predictor of overall poor response (Araujo, Ito, & Marks, 1996; Fama & Wilhelm, 2005). Furthermore, many patients drop out of treatment altogether, with estimates as high as 40% (Kozak et al., 2000).

More specifically, by investigating the role of motivation and insight in OCD treatment response we may uncover knowledge leading to more effective therapeutic techniques for treating individuals who do not respond to conventional OCD treatments.
**Obsessive-Compulsive Disorder**

Obsessive-Compulsive Disorder is classified in the *DSM-IV-TR* as an anxiety disorder characterized by the presence of obsessions and/or compulsions (American Psychiatric Association, 2000). Obsessive-compulsive disorder is characterized by recurrent intrusive thoughts, impulses or obsessions that cause distress and anxiety and become the driving mechanism for the compulsions, the overall aim of which is to neutralize the obsessions.

The diagnostic criteria from DSM-IV-TR (2000) describes these obsessions and compulsions:

**Obsessions are defined by:**

1. recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress.
2. the thoughts, impulses, or images are not simply excessive worries about real-life problems.
3. the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.
4. the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind.

**Compulsions are defined by:**

1. repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
2. the behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.
In addition to these criteria, at some point during the course of the disorder, the sufferer must realize that his/her obsessions or compulsions are unreasonable or excessive. Moreover, the obsessions or compulsions must be time consuming (taking up more than one hour per day), cause distress, or cause impairment in social, occupational, or school functioning.

The awareness of the groundlessness of the anxiety, the senselessness of the impulse, the impossibility of the belief and the accompanying struggle against obsessions has generally been considered fundamental components of OCD. However during the past century there have been numerous descriptions of the patients with OCD who are completely convinced with the reasonableness of their obsessions i.e. that there is fluidity between neurotic (i.e. associated with insight) and psychotic states (i.e. associated with lack of insight) corresponding to varying degree of insight and associated resistence. Studies have concluded that in OCD good insight is not necessarily present and that insight stands over a spectrum, from good to absent (i.e. delusional thinking) (Lelliott et al, 1988). Diagnostic & Statistical Manual of Mental Disorders-Text Revision (DSM- IV –TR) (APA, 2000) recognizes the separate entity of OCD with poor insight.

**OCD With poor insight** : if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable. (Quick Reference from DSM-IV-TR, 2000).

**INSIGHT**

*Insight refers to the conscious awareness and understanding of one’s own psychodynamics and symptoms of maladaptive behavior.*
Recently, over the last 10-15 years, interest has been shown in the empirical exploration of insight in clinical psychology. These researches examine the relationship between patients’ insight and clinical variables, such as prognosis (McEvoy et al; 1989a; Amador et al; 1993), treatment compliance (Bartko et al; 1988, Buchanan, 1992; Mutsatsa et al., 2003) and severity of psychopathology, and have focused mainly on examining in patients with psychoses (Amador & David, 1998). There have been few systematic empirical studies exploring insight in conditions other than the various psychoses. Why the exploration of insight empirically should be limited to the psychoses is not clear, except that since loss of insight has long been intrinsic to the definitional criteria of certain psychotic symptom such as delusions (Berrios, 1994), examination of insight has been prompted by the condition where its loss is so dramatically apparent. However, as far as neurotic patients are concerned (Anxiety, Dissociative, and depressive disorder, etc.) much of empirical work has taken place in the psychodynamic field (Markova). Moreover, traditional views regarding that the presence of insight can be used as a criteria to differentiate between the psychoses and the so called neurosis have began to challenged in practical as well as in theoretical ways.

In the light of the observation that patients with OCD show a wide range of insight, especially regarding their obsessions/compulsions as senseless is concerned (e.g. Insel & Akiskal, 1986; Lelliott et al., 1988). Then the DSM-IV Field Trial, using a structured scale, explored the insight in 431 patients with OCD (Foa & Kozak, 1995) and conclude that patients with OCD do show a range of insight resulted in a change made to the previous definitional criteria of DSM-IIIR, and a new specifier of OCD with poor insight was introduced into DSM-IV (American Psychiatric Association, 1994). Yet there is not much work has been done on exploring the relationship between insight in the OCD patients and other clinical correlates.
Insight studied in general psychiatry has tended to be viewed in a more general sense of awareness of illness (Amador & et al., 1993) and/or with broader elaborations incorporated within the concept such as additional interpretations, attributions (Amador et al., 1991), re-labeling and self knowledge. Then there is the notion of insight viewed in terms of specific problem solving as in Gestalt cognitive psychology or, different again, is the deeper notion of insight as psychodynamic ‘comprehension’ (Markova, 2005).

In ancient Greek philosophy ‘Know Thyself’ is inscribed on the temple of Apollo at Delphi and self-knowledge was a dominant feature of Socrates’ teaching (Plato, Charmides, 164e). Descartes, (1648/1991, p. 335), assumed, as did Locke later, that every experience of the individual was accompanied by self-awareness. Indeed, Locke went further to say that the identity of the self was determined by consciousness (Locke, 1700/1979). In the eighteenth and nineteenth centuries self-awareness obtained the meaning of self-reflection and self-consciousness in a much wider sense. By being aware of others as reflexive beings, one is able to look at oneself through the eyes of others. One becomes the object of one’s own observation. As a result, introspection became a prevailing theme of that time. Another important psychological concept emerging in the nineteenth century, and influencing psychiatry and the conceptualization of insight was that of comprehension (Verstehen), as developed in different ways by Brentano (1874/1973), and eventually, Freud, Husserl and Jaspers, amongst others. This concept encompassed more than ‘understanding’ and more than ‘looking into one’s mind’ (as suggested by introspection). Instead, it aimed to capture the totality of one’s mental and existential state including non-conscious aspects. The conceptualization of insight caught within this frame thus demanded more than an intellectual awareness of being ill but called on deeper processes involving emotions and volitions, and that extended to a self that embraced a wider and richer concept (Markova, 2005).
In OCD insight is the patient’s degree of awareness and understanding about the senselessness or unreasonableness of obsessions.

Othmer et al, 2005 has given varying degrees or levels of Insight namely:

1. Complete denial of illness.
2. Slight awareness of being sick and needing help but denying it at the same time.
3. Awareness of being sick but blaming it on others, on external factors, or unknown organic factors.
4. Intellectual insight: Knowledge of the reality of a situation without the ability to use that knowledge successfully to effect an adaptive change in behavior or to master the situation. (Admission that the patient is ill and that symptoms or failures in social adjustment are due to the patient’s own particular irrational feelings or disturbances without applying that knowledge to future experiences).
5. True emotional insight: Understanding of the objective reality of the situation coupled with the motivational impetus to master the situation or change behaviour. (Emotional awareness of motives and feelings within the patient and the important people in his or her life, which lead to basic changes in the behavior).

Concept of insight includes various judgments relating to the following:

- An attribution of the change to pathology (Jaspers, 1948; David, 1990; Amador et al., 1991).
- Social consequence of illness (Amador et al., 1991)
- Aetiology and likely recurrence (Greenfeld et al., 1989)
• Perception of changes in the self and one’s interaction with the world. (Markova & Berrios, 1992)
• Need for medical treatment (McEvoy et al., 1989; David, 1990; Amador et al., 1991).
• Attitudes towards experiences (Soskis & Bowers, 1969; Cutting, 1978; Marks et al., 2000)
• Comparisons with previous function (Sherer et al., 1998)

Insight related parameters include fixity of beliefs, conviction, perception of others view of the belief, bizarreness, resistance and degree of control. (Eisen et al, 1998). The reliable and valid Scale to Assess Unawareness of Mental Disorder, which includes 17 items that measure insight and two ratings of delusions, also supports the notion that insight, like delusionality, has multiple components. Impaired insight might reflect a psychological process of denial as a way of coping with the negative consequences of illness (Johnson et al, 1996).

MOTIVATION FOR CHANGE

Motivation can be understood not as something that one has but rather as something one does. It involves recognizing a problem, searching for a way to change, and then beginning and sticking with that change strategy. There are, it turns out, many ways to help people move toward such recognition and action. Miller, 1995

The study of motivation is an area of psychology that has particular relevance to the issues of dropout, compliance, and maintenance of change. In fact, lack of motivation is one of the most frequently cited reasons for patient dropout, failure to comply, frequency of relapse, and other negative treatment outcomes for a variety of
psychotherapeutic interventions (Pelletier, Tuson, Haddad, 1997; Ryan, Plant, & O’Malley, 1995).

‘Patient motivation’ is defined as the set of all variables, which arise, sustain and direct behavior towards attendance and participation in the treatment. In clinical writing motivation is often used as an antonym for terms such as denial and resistance and a synonym for constructs such as acceptance and surrender. Poor motivation fosters the expectancy of poor prognosis.

Nature of motivation include

- Motivation is a key to change.
- Motivation is multidimensional.
- Motivation is dynamic and fluctuating.
- Motivation is influenced by social interactions.
- Motivation can be modified.
- Motivation is influenced by the clinician’s style.
- The clinician’s task is to elicit and enhance motivation.

In this context, motivation is redefined as purposeful, intentional, and positive—directed toward the best interests of the self. More specifically, motivation is the probability that a person will enter into, continue, and adhere to a specific change strategy (Miller & Rollnick, 1991).

The change process has been conceptualized as a sequence of stages through which people typically progress as they think about, initiate, and maintain new behaviors (Prochaska and DiClemente, 1984). This model emerged from an examination of 18 psychological and behavioral theories about how change occurs, including components that compose a biopsychosocial framework for understanding addiction. In
this sense, the model is "transtheoretical" (IOM, 1990). They observed that people who make behavioral changes on their own or under professional guidance first "move from being unaware or unwilling to do anything about the problem to considering the possibility of change, then to becoming determined and prepared to make the change, and finally to taking action and sustaining or maintaining that change over time" (DiClemente, 1991, p. 191).

- **Precontemplation:** Entry point to the process of change. Person is not yet considering the possibility of change. Does not see themselves as having a problem. *Therapeutic tasks:* Provide information and feedback to raise awareness of the problem and the possibility of change; raise doubt; increase perception of risks and problems.

- **Contemplation:** Characterized by ambivalence; both considers and rejects change. Seesaws between reasons to change and reasons to stay the same. *Therapeutic tasks:* Tip the balance in favor of change; evoke reasons to change; risks of not changing; strengthen client’s belief that change is possible.

- **Preparation:** Characterized by accepting the need to change; to do something about the problem. At this point, either enters into action or slips back into contemplation. *Therapeutic tasks:* Help the client determine the best course of action to take in seeking change. Help find a change strategy that is acceptable, accessible, appropriate and effective.

- **Action:** The person is engaging in particular actions to bring about change (e.g., treatment). The goal is to produce change in the problem areas. *Therapeutic tasks:* Help the client take steps toward change.

- **Maintenance:** Maintaining the changed behavior; avoiding the problem behavior. The challenge is to sustain the change
accomplished by previous action and to prevent relapse. 
*Therapeutic tasks:* Help the client to identify and use strategies to prevent relapse.

- **Relapse/Recycle:** A reversion back to problem behavior. Normal, expected occurrences as a person seeks to change any long-standing pattern. *Therapeutic tasks:* Help the client to renew the process of contemplation, determination, and action without becoming stuck or demoralized because of relapse.

Motivational interviewing has been *practical* in focus. The strategies of motivational interviewing are more persuasive than coercive, more supportive than argumentative. The motivational interviewer must proceed with a strong sense of purpose, clear strategies and skills for pursuing that purpose, and a sense of timing to intervene in particular ways at incisive moments ([Miller and Rollnick, 1991, pp. 51-52]).

The clinician practices motivational interviewing with five general principles in mind:

- Express empathy through reflective listening.
- Develop discrepancy between clients' goals or values and their current behavior.
- Avoid argument and direct confrontation.
- Adjust to client resistance rather than opposing it directly.
- Support self-efficacy and optimism.

Research has shown that motivation-enhancing approaches are associated with greater participation in treatment and positive treatment outcomes. Such outcomes include reductions in consumption, increased abstinence rates, social adjustment, and successful referrals to treatment ([Miller et al, 1995]). A positive attitude toward change and a
commitment to change are also associated with positive treatment outcomes (Miller and Tonigan 1996; Prochaska and DiClemente, 1992)

**COPING STYLES**

Coping is an individual’s cognitive and behavioral efforts to manage (reduce, minimize, master and / or tolerate) specific internal as well as external demands that are appraised as taxing or exceeding the person’s resources (Folkman and Lazarus, 1984).

Individual’s coping styles and strategies have become important targets of investigation in as much as coping plays a critical role in how individual respond in the face of a stressor. Coping has been eloquently defined in the transactional tradition by Lazarus and Folkman (1984) as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). This definition emphasizes the unique qualities of each situation that will determine, in conjunction with the individual’s appraisal of the stressor, the individual’s particular response. A study by Compas, Malcarne, and Fondacaro (1988) found that problem-focused coping (coping efforts aimed at changing the circumstances of the situation) was negatively related to emotional and behavioral problems, while emotion-focused coping strategies (efforts aimed at reducing emotional distress) were positively related to these difficulties. Another study (Ebata & Moos, 1991), focusing on coping strategies in response to the problem each child in the study perceived as the most important of the past year, found that adolescents exhibiting depressive and conduct disordered symptomatology reported more avoidance coping (efforts to avoid thinking about the stressor or to manage emotional distress) than adolescents without these symptoms. Avoidance coping strategies have
also been shown to be negatively related to psychological adjustment (Stern & Alvarez, 1992).

**ATTRIBUTIONS**

Attributions are inferences that people make about the causes of events and behavior. People make attributions in order to understand their experiences. According to Kelly (1973) “*attribution is a complex process in which we observe other’s behavior and then attempt to infer the causes behind it from various clues*” Researchers classify attributions along the dimensions: internal (behavior is due to personal factors such as traits, abilities, or feelings) vs. external (person’s behavior is due to situational factors), stable (unchanging factors e.g. bad luck) vs. unstable (temporary factors), controllable (efforts) vs uncontrollable (ability) and global (I am dull) vs specific (situation or time specific).

Individuals with a positive attributional style explain negative life-events in terms of external ("It was their fault"), unstable ("That won’t happen again"), and specific ("That situation was difficult") causes, and positive life-events in terms of internal, stable, and global causes & had an indirect positive influence on self-esteem via expectancies. Abramson et al. (1978)

According to Abramson et al. (1978), individuals with a negative attributional style will attribute negative life-events to internal ("It’s my fault"), stable ("It will happen again"), and global ("It’s in everything I try to do") causes. The hopelessness theory of depression (Abramson et al., 1988) has suggested that when negative life-events are attributed to internal and also stable, global causes, the resultant depressive reaction may negatively influence self-esteem.
Objective of the study

1. To study the relationship between insight and the motivation for change in OCD.
2. To study the relationship between insight and coping styles in OCD.
3. To study the relationship between insight and attributional style in OCD.
4. To study the relationship between motivation for change and coping style in OCD.
5. To study the relationship between motivation for change and attributional style in OCD.
6. To study the relative contribution of insight, motivation for change, coping style and attributional style on OCD.
7. To study the relative contribution of insight, coping style and attributional style on, motivation for change in OCD.