CHAPTER III

A BRIEF REVIEW OF RELATED LITERATURE

Neither insight nor the motivation for change is a new concept to OCD. The brief review of related research however indicates that most of the insight research is related to schizophrenia or other psychotic disorders and the motivation for change is related to substance use disorder. There is good scope for research to understand the complex relationship of insight and motivation for change specially in obsessive compulsive disorder.

OCD and Motivation for change

Despite the evidence of treatment resistance and refractoriness for OCD, little research has been conducted to identify the correlates of treatment non-response and dropout. Sizable percentage of patients fails to comply with their therapeutic regimen, drop out of treatment prematurely, or encounter difficulty in maintaining therapeutic gains (Vogel et al., 2006). 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).

Due to demanding and difficult nature of the ERP therapy, many individuals refuse to participate in such an intervention. Refusal rates 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).

Christopher et al (2009) examined the role of motivation in the treatment of individuals hospitalized for severe OCD, specifically, the extent to which an individual’s motivation for treatment and motivational orientation (intrinsic or extrinsic motivation) predict OCD treatment response. The sample consisted of 142 individuals diagnosed with severe treatment-refractory OCD participating in an intensive treatment program. Results indicate that a high initial level of extrinsic motivation was associated with poorer treatment outcome when controlling for other variables. Furthermore, findings suggest intrinsic motivation appears to have an interactive effect with OCD symptom severity, such that a high level of intrinsic motivation at the outset of treatment may predict positive treatment outcome when OCD symptoms are more severe. Overall initial level of motivation was not found to be a significant predictor of OCD treatment outcome. Westra and Phoenix (2003) demonstrated the effectiveness of MI as an augmentation to conventional CBT treatment for anxiety.

Black et al. (1998) reported that only 18% of those with hoarding symptoms responded to treatment (medication and/or CBT) compared to 67% of OCD patients who did not hoard. Mataix-Cols, Rauch, Manzo, Jenike, & Baer (1999) reported similar findings among a sample treated with serotonergic reuptake inhibitors (SRIs). Poor insight and limited symptom recognition characterized most participants in these trials, along with low motivation and treatment compliance. Patients were frequently forced into treatment by significant others in their lives (Christensen & Greist, 2001).

More recent outcome studies indicate optimistic outcomes in terms of engagement in therapy (lower drop-out rates), decreased symptom
severity and disability (Freeston et al. 1997; Kyrios et al., 2001) and greater improvement in general coping (van Oppen & Arntz, 1994).

**OCD and Insight**

Traditional views concerning the notion that the presence of insight can be used as a criterion to differentiate between the psychosis and so called neurosis have begun to be challenged in practical as well as in theoretical ways. For example, in recognition of the increasingly 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 confirming that patients with OCD do show a range of insight resulted in a change made to the previous definitional criteria of DSM-III R and a new specifier of ‘OCD with poor insight’ was introduced into the DSM-IV (American Psychiatric Association, 1994).

Recognition of the observations that patients with delusions showed a range or continuum of insight and hence delusional beliefs, should not simply by definition, be associated with insightlessness. Using the same semi structured rating scale assessing insight into beliefs, Eisen et al. (2004) compared insight in patients with OCD and those body dismorphic disorders (BDD). The authors found that patients with (BDD) had significantly worse insight than patients with OCD even though severity of illness was comparable in the two groups.

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.

One study suggested that patients with poor insight into their obsessions /compulsions showed worse clinical outcome after exposure
treatment (Foa, 1979). On the other hand, a larger study by Lelliott et al (1988) found no difference in outcome following behaviour therapy between those patients with and without insight.

Aigner M, Zitterl W, Prayer D, Demal U, Bach M, et al.(2005) investigate the relative frequency of structural brain abnormalities in two subtypes of obsessive-compulsive disorder, namely OCD "with good insight" and OCD "with poor insight". 84 patients meeting DSM-IV as well as ICD-10 criteria for OCD underwent structural magnetic resonance imaging (MRI). Participants were subdivided (by two psychiatrists and one psychologist) in patients with insight and patients with poor insight as defined by DSM-IV. MRI examinations were performed by radiologists who were unaware of any subtype diagnoses. Most patients (83%) who had OCD with poor insight showed MRI abnormalities while such abnormalities were detected in only a minority of patients (21%) with good insight. The basal ganglia were the most often affected structure, followed by abnormalities in the parietal lobe, the occipital lobe and the frontal lobe, and abnormalities of the ventricular system.

**OCD and Attribution styles**

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.

David Barlow (2000) suggests that there is a sense of uncontrollability related to possible future threats, danger, or impending aversive events, that underlies anxiety. Consistent with current models of
OCD phenomenology, he implicates the idea of individuals responding to “false alarms” or perceived threats as opposed to real threats. In this sense, he proposes that anxiety can be thought of as a state of helplessness due to a perceived inability to predict, control, or obtain desired outcomes in relation to anticipated events. In speaking to the third component of his tripartite vulnerability (or diathesis) model, Barlow describes a learned or conditioned vulnerability that predisposes a person to focus anxiety on certain objects or events. Regarding OCD in particular, he cites evidence that some individuals actually learn early on to equate dangerous thoughts with dangerous actions, thus leading to the notion of thought-action fusion (Zucker et al., 2002), where having an unwanted thought or intrusive image is experienced as synonymous with acting upon it.

So, active compulsions or avoidance rituals (“safety behaviors”) are carried out to “neutralize” the catastrophe and the accompanying distress. E.g. washing repeatedly to rid oneself of contamination, avoiding potentially contaminated objects, or distracting oneself, blocking out the aggressive thoughts/images (i.e. thought blocking), or purging the images through prayer rituals. The averting of disaster is misattributed to the compulsion. Thus, the “safety” behavior is strengthened via negative reinforcement i.e. the neutralization or removal of an aversive stimulus- in this case the anxiety and guilt experienced in relation to the contaminant or the unacceptable aggressive images respectively (Wolpe, 1969).

**OCD and Coping Styles**

Personality characteristics such a temperament (e.g. behavioral inhibition), poor insight, defensiveness, oppositionality, low self-esteem, social and emotional immaturity, avoidant coping style pose problems for youngsters, with or without OCD. The temperament quality of behavioral inhibition has been well-studied in developmental research (e.g. Kagan,
Defensiveness and oppositionality have been identified as treatment barriers (Swedo et al., 1989). Apathy has also been identified as a psychopathology risk factor, as have low self-esteem and social and emotional immaturity (Greenberg et al., 2001).

In their examination of “normal” childhood rituals, Leonard et al. (1990) found that while OCD children and controls did not differ in frequency and type of superstitions, parents of the OCD children reported significantly more remarkable patterns of early ritualistic behaviors than did parents of the control group of children.

Procrastination tendencies may not be strongly related to obsessive-compulsive tendencies as often as believed by practitioners, they definitely are associated with passive aggressive and anger-expressive tendencies (Ferrari, J. R. 1993; Ferrari, J. R., & McCown, W. 1994; Ferrari, J. R., & Olivette, M. 1994).

Application of the psychoanalytic ego psychology model results in viewing coping structurally as a style or trait rather than as a dynamic ego process. For example, a person may be classified as a conformist or conscientious, obsessive-compulsive, or as a suppressor, represser, or sublimator (cf. Loevinger, 1976; Shapiro, 1965; Vaillant, 1977).

Ruminations tend to occur in depression, and some depressed patients use the ruminative response as a coping style (Lybomirsky & Nolen-Hoeksema, 1995; Nolen-Hoeksema et al., 1994). The term is used to refer, not to the simple occurrence of negative thoughts, but specifically to the self-focused thinking engaged in by the person.

Classical descriptions refer to obsessional ruminations about the nature of the universe and other such metaphysical subjects. Scharfetter (1980) gives the examples: ‘Why is the tree just there?’ ‘Why does the world exist?’ and ‘Why do I exist?’ Slater & Roth (1969) cite the examples: ‘Why did God make the world?’ ‘Who created God?’
The obsessional rumination is a compulsion only in the sense that the person engages in it because of a strongly felt compulsive urge. The urge is to think through the question or theme that is raised in the obsession; the actual details of these thoughts, or the sequence, are not predetermined. Neither is there a fixed end-point at which the person feels some satisfaction or relief and so can stop.

Garber and Hollon (1980) the findings suggested that depressed and nondepressed individuals do not differ in their perception of skill tasks, but only in their belief about their own responses in the tasks. Depressed individuals view themselves as helpless in a skill situation, but do not view the situation itself as uncontrollable. Using Bandura's (1977) distinction between efficacy and outcome expectancies, these findings suggest that depressives and nondepressives do not differ in outcome expectancies, that is, the belief that a particular course of action will produce certain outcomes, but rather in 

efficacy expectancies.

Lipowski (1970-1971) coping strategies are directly related to the individual's personal meaning or an attitude towards his illness, injury or disability. . . . It [the given meaning] functions as a cognitive nucleus which influences emotional and motivational responses to illness and thus the coping strategies, (p. 98)

(1) Illness as challenge. This common view of illness inspires active and generally adaptive coping strategies. Disease or disability is seen as any other life situation which imposes specific demands and tasks to be mastered and which is accomplished by any means available. The related attitudes and coping patterns tend to be flexible and rational. . . . Timely seeking of medical advice, cooperation, information seeking . . . , rationally modulated activity and passivity, finding substitute gratifications—these are some of the related and desirable coping strategies.

(2) Illness as enemy. Disease is viewed as an invasion by inimical forces, internal or external. Our language clearly reflects this attitude when we
talk of "combating" illness or "conquest" or disease. The usual emotional concomitants of this meaning are anxiety, fear and/or anger. These feelings inspire the readiness to flight or fight or helpless surrender, depending on the current appraisal by the subject of his capacity to resist. In its extreme pathological form this attitude may be frankly paranoid and others may be blamed for having caused or aggravated the illness (Orback & Bieber, 1957). Free-floating anxiety or hostility may appear. Coping strategies reflect this attitude and take various forms of defense against danger and attack. Some degree of denial and projection are common, although regressive dependency and passivity may express a sense of helplessness and readiness to surrender (p. 98).

Relaxation techniques can help in minimizing the effects of high arousal levels on cognitive biases, and help patients maintain their exposure and increase their perceived coping capacity. Relaxation strategies are particularly useful for anticipatory and refractory anxiety.

**Motivation for change and Insight**

Poor compliance with treatment is a source of major problems in the management of patients with severe mental illness as it carries important implications for patients well being and prognoses (McEvoy, 1998). 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). 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).

With early treatment of first psychotic episodes, the likelihood of good recovery approaches 80% (Lieberman et al., 1992). However, half of
those patients treated for a first psychotic episode discontinue their prescribed treatment within 6 months (Weiden and Olfson, 1995). Failure to comply with prescribed drug schedules is the most common reason for hospital readmission (Caton, 1984).

Hoge et al. (1990) found that 103 (7.2%) of the 1434 psychiatric patients admitted to four acute inpatient units in state-operated mental health facilities in Massachusetts over a 6-month period refused treatment with antipsychotic medication. On admission, refusers had significantly higher psychosis ratings than compliant patients, and significantly less acknowledgement of illness and need for treatment.

MacPherson et al. (1996) assessed insight and compliance in 64 outpatients with schizophrenia, 15 of whom had “actively refused” antipsychotic treatment over the preceding two weeks. Patients who “actively refused” treatment had significantly lower insight scores than those who actively pursued treatment.

Kemp and David (1996) administered insight assessments to 74 patients during an index hospitalization. Better insight predicted better compliance after discharge, independently of whether compliance therapy was given.

Smith et al. (1999) assessed insight in 46 individuals with schizophrenia or schizoaffective disorder at the time of discharge from an inpatient unit. Patients who were insightless regarding the psychopathologic features that led to their recent hospitalizations showed poorer treatment compliance after discharge.

Buchanan (1992) measured insight in 61 patients with schizophrenia prior to their discharge from an index hospitalization by asking six questions:

1. Do you think that you have been unwell during this admission?
2. Do you think that you will become ill again?
3. Did treatment help?
4. Will you take treatment after you discharge?
5 Will you ever get back to your old self?

6 Why were you in the hospital?

Compliance over the ensuing two years of follow-up was assessed by inspection of records and by analysis of urine. Fifty-nine percent of patients were compliant at the end of one year, and 51% at the end of two years. Affirmative responses to question 3 (a belief that medication had helped during the admission) and question 4 (a stated willingness to take treatment after discharge) were significantly positively associated with compliance over the follow-up. A history of compliance with treatment prior to the index hospitalization, and voluntary status during the index hospitalization, were also significantly associated with compliance over follow-up.

Bartko et al. (1988) developed two 4-point scales for assessing “lack of feeling of illness (the patient denies being ill either spontaneously or when interviewed)”, and “lack of insight into illness (the patient fails to acknowledge his/her emotional state and behavior assessed as pathologic by the physician, and does not perceive the necessity of treatment)”. Fifty-eight patients with schizophrenia were rated on these scales at the time of their discharge from an index hospitalization. All of these patients were treated with long-acting depot antipsychotics, and followed over one year of aftercare. Thirty-two of the 58 patients (55%) became noncompliant over the follow-up, as evidenced by missed appointments or deliberate discontinuation of medications. Baseline ratings of “lack of feeling of illness” and “lack of insight into illness” were significantly higher in those patients who noncomplied than in compliant patients.

More complex pharmacologic treatments, both in terms of the number of drugs prescribed and the frequencies at which they must be taken, are associated with diminished compliance (Haynes, 1979a,b).

It is very likely that distressing extrapyramidal side effects contribute to noncompliance (Falloon et al., 1978; Hogan et al., 1983;

In the general medical literature, “there appears to be no relationship between patients’ knowledge of their disease or its therapy and their compliance with the associated treatment regimen” (Haynes, 1976), nor is there a correlation between patients’ intelligence or educational achievement and compliance (Haynes, 1976). Most authors (Soskis, 1978; Hogan et al., 1983; Irwin et al., 1985) report no relationship between schizophrenic patients’ abstract knowledge about the illness and compliance. Klein et al. (1974) and Boczkowski et al. (1985) reported no improvement in compliance among patients given education about the illness.

Kemp, Haywood et al., 1996 report a study of 74 patients with psychotic disorders randomly assigned to 4–6 sessions of compliance therapy or nonspecific counseling. Compliance therapy is based upon motivational interviewing, and is described by the authors as follows:

In the first two sessions of compliance therapy patients were invited to review their history of illness and conceptualize the problem. In the next two sessions, discussion became more specific, focusing on symptoms and the side effects of treatment. The benefits and drawbacks of drug treatment were considered, the patient’s ambivalence was explored, and the therapist highlighted discrepancy between the patient’s actions and beliefs, focusing on adaptive behaviors. In the last two sessions the stigma of drug treatment was tackled by considering that drugs are a freely chosen strategy to enhance the quality of life. Self efficacy was encouraged and the value of staying well and thus the need for prophylactic or maintenance treatment was emphasized. The therapist encouraged the use of metaphors such as “protective layer” and “insurance policy”. At 18 month follow-up, the patients who received
compliance therapy had greater insight and more favorable attitudes towards treatment. They were rated by clinicians as more compliant with treatment, and survived longer in the community without readmission.

Carroll and colleagues (1999) carried out a randomized controlled trial with 100 schizophrenia patients, of an educational package said to be designed to improve insight. It consisted of a video and booklet which, “explained the biomedical model of mental illness . . . and emphasized the value of maintenance medication”. The intervention had no effect.

Traditional psycho-educational methods do not necessarily improve illness awareness and adherence to medication (Streicker et al., 1986).

Two studies (Kemp et al., 1996; Lecompte and Pelc, 1996) have shown that insight and outcome can both be changed for the better in tandem with compliance. “Compliance Therapy” (CT) (Kemp et al., 1996, 1998) draws inspiration from a number of sources, e.g., the approaches of motivational interviewing (Miller and Rollnick, 1991) and cognitive–behavioural therapy of schizophrenia (Garety et al., 1994).

**Motivation for change and Attribution styles**

Weiner extended attributional model to provide a more general theory of motivation and emotion (Weiner, 1982, 1985, 1986). In his more general theory, Weiner (1985, 1986) suggested that the basic dimensions underlying causal attributions include internality (locus; where the cause is located), stability (the degree to which the cause is constant or fluctuates over time), and controllability (the extent to which the cause is perceived to be controllable). Reattribution techniques growing out of Weiner’s work typically target one or both dimensions of causality in attempting to alter a person’s attributions for successes and failures, encouraging them to make external, unstable attributions for failures and internal, stable attributions for successes.
Andrews and Debus (1978) used operant conditioning procedures to reinforce internal, specific (lack of effort) attributions in response to failures on a laboratory task. They were able to reverse subjects’ motivational and performance deficits by altering subjects’ attributions, obtaining an increase in internal, unstable (lack of effort) attributions on the same task at a 4-month follow-up. Similarly, Anderson (1983) found that subjects who were induced to attribute failure to internal, unstable causes (lack of effort) exhibited enhanced motivation and performance on an interpersonal persuasion task compared with subjects who were induced to attribute failure to internal, stable causes (lack of ability).

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).

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) also propose a stage model, based in part on Brehm’s (1966) concept of reactance, in an effort to explain why people do not necessarily give up when they discover that they are helpless, as the learned helplessness model originally argued (Seligman, Maier, & Solomon, 1971). Reactance means that when behavior is restricted, people respond with anger and increased motivation to overcome the resistance to their freedom of action. Wortman and Brehm propose that such 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. 

Wortman and Dintzer (1978), too, write:

We believe that many of the behaviors associated with helplessness (giving up, losing interest in the outcome, and/or motivation to pursue it) are maladaptive only when the outcome in question is controllable or modifiable. If the outcome is truly uncontrollable, these behaviors may be highly functional (cf. Weiss, 1971). (p. 87)

**Motivation for change and coping styles**

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). This theory is explicitly developmental in nature in that it differentiates between long-term and short-term outcomes. In the short term, coping serves to manage the individual’s engagement with the situation (as opposed to simply withdrawing from it), while the long-term outcomes refer to development in the personality, social, and cognitive domains. Not surprisingly, the notion of coping as emotion regulation has become more dominant in the child psychology literature (Eisenberg, Fabes, & Guthrie, 1997).

Eisenberg and Zhou (2000) state that emotion regulation is defined as the process of initiating, maintaining, modulating, or changing the occurrence, intensity, or duration of internal feeling states and emotion-related physiological processes, often in the service of accomplishing one’s goals. . . . In our view, emotion regulation often is accomplished through effortful management of attention (e.g., attention shifting and
focusing, cognitive distraction) and cognitions that affect the interpretation of situations (e.g., positive cognitive restructuring), as well as through neurophysiological processes. In contrast, emotion-related behavioral regulation is the process of initiating, maintaining, inhibiting, modulating, or changing the occurrence, form, and duration of behavioral concomitants of emotion. Inclusion of the control and modulation of facial and gestural reactions and other overt behaviors. Misregulation is the lack of behavioral regulation or ineffective coping (regulation) attempts. (p. 167)

The important point is that whether general or specific, illusory or realistic, one's belief in one's ability to control an event influences how that event is appraised and, through appraisal, subsequent coping activity.

Kahn et al. (1964), who speak 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. The strategies named by Kahn et al. as directed toward the self would not be called typical problem-solving techniques, yet they are indeed directed at helping the person manage or solve the problem. With the exception of developing new behavior or learning new skills and procedures, we would call the inward-directed strategies named by Kahn et al. cognitive reappraisals that are problem-focused.

The shift in psychological thought toward cognition has forced motivation, once a central theme in psychological theory, to take a back seat. Little is now being written about the role of motivation in treatment. Earlier accounts took the view, which is still relevant, that the most
important decision of a patient precedes treatment, and that is to seek professional help. It has long been assumed that only a person willing to undergo the struggle to change will begin treatment and stay with it. From this standpoint, commitment, in the sense that a deliberate decision is made, grows out of the recognition that things are going badly and that treatment might help.

The therapist attempts to generate and sustain motivation. Psychoanalysts point to the transference relationship, the reduction of distress (through catharsis or abreaction), and the patient's hope that things will improve by following the treatment regimen as motivating features of therapy.

For relatively minor problems such as smoking—minor not in the sense of health consequences but in how it is usually perceived one gets the decided impression that self-initiated (i.e., self-motivated) quitting is statistically more common than quitting that is brought about in formal treatment (Pechacek & Danaher, 1979). People who do a certain amount of externalizing of responsibility for the decision to quit may need a therapeutic regimen with its social support in order to sustain the struggle; these people may have a poorer prognosis than those who see clearly that successful quitting depends largely on their own level of commitment. Yet so far has the "cognitive revolution" gone that in Pechacek and Danaher's analysis of successful quitting, they never once mention motivation or commitment (Prochaska & DiClemente, 1983). Instead, many of the conclusions they draw about successful quitting suggest that feedback from quitting that is, positive changes, increased self-efficacy, credibility of the treatment, and gaining new skills—helps sustain the person in the difficult task of self-control. From this standpoint, Pechacek and Danaher's cognitively based conclusion that successful quitting is produced when "the treatment produces rapid enhancement of self-efficacy by performance accomplishments, vicarious learning, and/or by persuasive communications" (p. 411) seems wrong to
us, at least for many clients. A sharp increase in self-efficacy could actually weaken commitment by producing a false sense of security about their ability to sustain the initial success (e.g., "I can handle a puff or two without having to smoke the whole pack").

Therapists cannot depend solely on the commitment the client brings to therapy. An initial commitment is apt to wax and wane during treatment. It is crucial at each stage for the client to decide to do what the therapist is asking in the therapy setting and to further decide to use what is learned outside that setting. It is motivation that leads to these decisions.

**Insight and Attribution styles**

Amador et al (1991) conceive insight as comprising of

1. Awareness of the signs, symptoms and consequences of illness.
2. General attribution about illness and specific attribution about symptoms and their consequences.
4. Psychological defensiveness.
5. Clearly, this represents a wider and more detailed structure of insight which incorporates comprehensively views on individual experiences and being ill.

Recognizing the practical difficulties in translating from such a wide and complex construct to an empirical measure of insight, Amador and Strauss(1993) narrowed this concept further to one comprising two salient components:

1. Awareness of illness.
2. Attribution regarding the illness.

Amador et al. (1991) take the multidimensional view further by distinguishing two main component dimensions of insight: awareness of illness and attribution regarding illness. Unawareness of illness
reflects an individual’s failure to acknowledge the presence of a specific deficit or sign of illness even when confronted with it by an examiner. Incorrect attribution reflects the individual’s expressed belief that the specific deficit, sign, or consequence of illness does not stem from mental dysfunction. For example: a patient with severe flat affect who does not recognize the presence of this negative symptom illustrates unawareness of flat affect; a patient who is aware that her or his expressions of emotion were flattened, but is certain that this was due to a recent course of antibiotics, would be said to be aware but would display incorrect attribution regarding this sign of illness.

Evidence suggests that depressed college students and psychiatric outpatients may be more accurate than normal controls in some aspects of self evaluation, such as in judging social competency and evaluating contingencies between their own behaviors and certain outcomes (Alloy and Abramson, 1979; Lewinsohn, Mischel, Chaplain and Barton, 1980). Similarly, in a study contrasting depressed with nondepressed college students, Sackeim and Wegner (1986) found that depressed subjects were more accurate in their self-evaluations (i.e., did not utilize the same self-serving biases) than non depressed subjects. In a second study, they contrasted depressed inpatients and outpatients with inpatients with schizophrenia and of normal controls. Sackeim and Wegner found that the latter two groups utilized “self-serving biases” in their appraisals of their behaviors and their outcomes, the depressed patients did not. The self-serving biases were characterized as follows: “If an outcome is positive, I controlled it, I should be praised, and the outcome ‘good’. If an outcome is negative, I did not control it (as much), I should not be blamed and it was not so bad anyway.” The authors go on to say that the cognitive distortions displayed by normal controls and patients with schizophrenia represent a “normal” pattern of functioning. In
fact, there is an abundance of work with nonpsychiatric samples that supports this position (Taylor and Brown, 1988).

Freudreich et al, (2004) who, on the basis of using the Scale to Assess Unawareness of Mental Disorder (SUMD) in their study, suggest that, in schizophrenia, symptom unawareness is most likely to reflect illness pathology compared with other components of insight as determined by the SUMD, namely, the judgments made around attribution of symptoms or willingness to accept treatment. Similarly, recognition that social and cultural factors are important to the views held by the individuals concerning beliefs around mental disorders (Johnson & Orrell, 1995; Lam et al, 1996; Chung et al, 1997) i.e. representing another perspective or dimension of insight, is much more indicative of reflecting a mental state rather than being a part of a disease process. Thus, the wider notion of insight as knowledge and judgments or attributions concerning what is happening to the individual cannot easily fit into a symptomatic picture of the concept.

**Insight and Coping styles**

Traditional explanations of awareness deficits in the 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 (Mayer-Gross, 1920; Searles, 1965; Semrad, 1966; Levy et al., 1975; McGlashan & Carpenter 1976; Van Putten et al.1976). A person might respond to the onset of psychosis by rejecting the reality of their situation in an attempt to preserve their ‘pre-morbid’ self-image. Rogers (1961) has 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 when one considers that in everyday life mentally healthy people distort reality to enhance their self-esteem and
maintain beliefs about their self-agency (Taylor & Brown, 1988; 1994). In an extensive review of the clinical and psychological literature, Taylor & Brown (1988) concluded that when faced with negative, ambiguous or unsupportive feedback, healthy individuals often respond with exaggerated perceptions of control and unrealistic optimism. This type of response to anomalous and stressful mental events may also occur in psychiatric patients.

Weinstein and Kahn (1955) who argued that anosognosia, or denial of illness, was an adaptive response to avoid distress or a catastrophic reaction to the recognition of disability. The authors were less concerned with the actual mechanism of this process and referred, instead, to the dynamic approaches of Schilder, Goldstein and Sandifer. They concentrated on providing a descriptive account of patients’ behaviours which, they argued, could be interpreted as symbolic representations of their ‘adaptation’ to disability. Weinstein and Kahn (1955) did stress the point that such interpretations of behaviours (particularly in relation to implicit denial) were very much dependent on the perspective of the observer and his/her theoretical preconceptions. Basing their ideas on comprehensive observations of 104 patients with various forms of brain damage and anosognosia, they distinguished between two kinds of behavior indicative of denial. First, they referred to explicit verbal denial which involved complete denial of illness, denial of major disability, minimization or attribution to some benign cause, projection of disability outside of the self and temporal displacement of the disability. Second, they described implicit denial which was suggested by behaviour such as withdrawl, in attention, pain asymbolia alteration in sexual behaviour, hallucinations and mood changes. In both categories of denial, the authors contended, that it was the symbolism behind either the words (explicit) or the behaviours (implicit) that signified the adaptational nature of the behaviours and made simple unawareness of the disability less likely.
Lyaskar et al (2002) examined the relationship between patients’ insight and coping style (using avoidance and positive reappraisal scales of the Ways of Coping scale). They reported that, in their sample of 132 patients with schizophrenia or schizoaffective disorders, patients unaware of their symptoms showed a greater preference for positive reappraisal than partially aware or unaware patients (SUMD). In addition, they found that patients unaware of the consequences of their illness endorsed a greater preference for escape –avoidance as a coping style. Within the acknowledged limitations of the study design, the researchers suggest that, perhaps, different types of coping strategies might be differentially related to deficits in different aspects of insight and raise the importance of exploring this further particularly in terms of developing and enhancing rehabilitation strategies. Indeed, in another study, Lyasker et al, (2003) found that a sub group of patients (schizophrenia spectrum disorders) with poor insight and average executive function (WCST) scored significantly more on the distancing (passive dismissal) coping strategies than patients with poor insight and impaired executive function.

Moore et al, (1999) explored levels of self-deception or denial in schizophrenic patients using the Balanced Inventory of desirable Responding. They found that patients with poorer insight had fewer depressive symptoms and had higher scores on the self –deception measure, and suggested that the mechanism of impaired insight in these patients might relate to the psychological process of denial. Weinstein and Kahn proposed that it was not the localisation of the lesion or the type of disability itself that were specifically related to the presence or the type of denial shown by the patient although they did stipulate that deeper brain structures had to be affected. Rather, it was the individual’s

Personality and previous experience that determined the type of denial manifested, i.e. the symbolic modalities in which he habitually
expressed his motivations’ (p.97). The non specificity of the brain lesion in this regard also helped to explain why such a range of disabilities or dysfunctions might be denied, not just hemiplegia or blindness but he fact of having an operation or some distressing family or social event. Anosognosia or denial using the model is thus conceived as developing within a dynamic interplay of brain and personality motivational factors though the specific mechanisms remain unclear. On the basis of questionnaires and interviews exploring individual/personality factors with relatives of patients showing denial, Weinstein and Kahn (1955) suggested that a particular personality type predisposed to the development of denial. Such patients, they claimed, premorbidly considered illness as a weakness or failure and were strongly concerned about the opinions of others and had strong drives to do well and to succeed. Subsequently, Weinstein et al, (1994) attempted to capture such personality traits empirically by means of their Denial Personality ratings in their research on denial or anosognosia in dementia.

**Coping and Attribution styles**

Heider (1958), proposed that the concepts people have about causality affect their social behavior. Weiner et al (1978) has extended attribution theory to emotion, reasoning that how people explain their successes and failures affects, not only their behavioral commitment to achievement, but the feelings they experience in the wake of their efforts. One can, for example, attribute success to external factors such as luck or the nature of the task, or to internal factors such as one’s own effort or ability; these diverse attributions then influence the emotional reaction e.g., controllable vs. uncontrollable and stable vs. unstable causes in the interpretation of emotional response. Sweeney, Shaeffer, and Golin (1982) found that depressed subjects made different attributions for negative outcomes when these occurred to others than when they themselves were the target of negative outcomes.
Glass (1977a, b) has provided us with one of the most influential theories about the nature of Type A and how it works to increase cardiovascular risk. He characterizes Type A persons as having a strong commitment to control situations, which makes them particularly vulnerable to the loss or absence of control. When control is threatened or frustrated, Type A's are said to become highly emotional, perhaps alternating between excessive striving to strengthen control and despair over their lack of control. According to Glass, this leads to surges of catecholamine secretion, and possibly other psychophysiological changes relevant to cardiovascular functioning such as increased lipids or changes in blood clotting time. Other research gives some qualified support to this concept (e.g., Pittner, Houston, & Spiridigliozi, 1983; Rhodewalt & Davison, 1983).

Goldfried and Robins (1982) suggested four general clinical applications of Bandura's self-efficacy model that involve reattribution training. A person initially can be helped to make internal (e.g., effort) rather than external (e.g., luck or task difficulty) attributions when he or she achieves a desired outcome. The person can then, after repeated success experiences, come to attribute the pattern of success to dispositional factors (e.g., ability). This internal, stable, global attribution should thereby result in enhanced self-efficacy expectancies. In addition, when acquiring a new set of coping or instrumental behaviors, a person can be encouraged to make external, situational rather than internal, dispositional attributions for outcome failures. Finally, Goldfried and Robins suggested that a person be taught to cope with high levels of internal physiological arousal by noting other causal factors implicated in achieving successful outcomes. By developing more complex causal attributions e.g., “I did not perform well, in part, because of my level of arousal; however, there are other causal pathways through which I can obtain my desired goal, in spite of being overly aroused.
In study related to cancer children Frank et al (1996) found that a depressive attributional style characterized by internal, stable, and global attributions significantly predicted poorer adjustment and avoidant coping was associated with children's depression and anxiety. Social support factors may help to strengthen a child's ability to cope (Varni, Katz, Colegrove, & Dolgin, 1994).

Some researchers have suggested that making meaning may be most often used in coping with extreme stressors, such as trauma (Mikulincer & Florian, 1996) or major losses (Wortman, Battle, & Lemkau, 1997). Cognitive reframing may include a reorganization of existing cognitive-motivational structures or a reappraisal or reinterpretation of the event. For example, a pre-med student who has done poorly on an examination may interpret this as a “wake-up call” and redouble his or her efforts; others may decide that medical school wasn’t really what they wanted to do and be secretly relieved that now they can switch to a major in something they would much prefer to do.

Explanatory style has emerged from its connection to helplessness as a personality characteristic in its own right, one that is broadly associated with coping, adaptation, and well-being (Buchanan & Seligman, 1995).

Demographical variables and insight

Empirical studies showing no correlation between insight and socio demographic variables like age, gender, socio-economic status, age of onset, education, chronicity, duration of illness.(Heinrichs et al 1985; Greenfeld et al 1989; David et al 1992; Takai et al 1992; McEvoy et al 1993b; Young et al 1993; Amador et al 1994; Dickerson et al 1997;). However, some studies showing at least some correlation between insight and socio - demographic variables. Increased duration of illness is associated with reduced insight. (Linn, 1965; Caracci et al 1990 ;). Marks et al, 2000; found that increased duration of illness is associated with
impaired insight. Kim et al, 1997; found that impaired insight is associated with later age of onset of illness. Pyne et al, 2001; found out that duration of illness and younger age correlated with reduced insight in outpatients. Fenning et al, 1996; tells that being married was associated with better insight. Lelliott et al, 1988; find out that there is no difference in outcome between patients with poor and good insight. Number of studies shows no association at all between the degree of patients insight into mental disorder and severity of their mental disorder (McGlashan & Carpenter, 1981; McEvoy et al, 1993a,b; Cuesta & Peralta, 1994; Lyasker & Bell, 1994; David et al, 1995; Lyasker & Bell, 1995; McEvoy et al, 1996; Flashman et al, 2000; Eisen et al, 2001;) . Secondly, a number of studies report a direct relationship between poor insight and global severity of mental disorder, i.e. the poorer the patient’s insight the more severe his /her mental illness (David et al, 1992; Takai et al, 1992; Young et al, 1993; Kemp & Lambert, 1995; Fenning et al, 1996; Young et al, 1998; Rossell et al, 2003; Eisen et al, 2004;) Eisen et al (2001) found no correlation between Insight and severity of OCD. Eisen et al (2004) found that poor Insight associated with more severe symptoms only in BDD (not OCD).