CHAPTER 6
Summary and general discussion
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SUMMARY AND GENERAL DISCUSSION

The primary goal of this thesis was to contribute to development of the best possible treatment of the Obsessive Compulsive Disorder (OCD) by means of filling some of the gaps of knowledge that hamper such development and by examining the effectiveness of psychotherapy for the subgroup of patients with poor insight into OCD. In this chapter the main findings will be summarized and put into the context of the literature. Its theoretical and empirical implications will be discussed. After that, methodological limitations and recommendations for future research will be covered. The chapter ends with clinical implications.

SUMMARY OF MAIN FINDINGS

Aims set out in the introduction:

• To determine the magnitude of chronicity in OCD and to examine whether chronic OCD is different from non-chronic OCD in terms of severity, illness burden and socio-demographic variables, vulnerability factors and clinical characteristics.

• To better understand the relationship between Adverse Childhood Experiences (ACEs) and severity and chronicity of OCD, taking into account the role of comorbidity.

• To better understand the role of insight in OCD, that is: to establish the range of insight in a clinical sample of patients with OCD; characterize the clinical profile of OCD with poor insight; study the natural course of insight and its correlation with the natural course of OCD severity; and study the impact of poor insight on the natural two-year course of OCD.

• To compare the effectiveness of a relatively new psychotherapy that specifically targets insight in OCD, the Inference Based Approach (IBA), to the gold standard Cognitive Behaviour Therapy (CBT) in patients with OCD with poor insight.

The results of the Netherlands Obsessive Compulsive Disorder Association (NOCDA) study were used to explore the first 3 of these topics. The NOCDA study is an ongoing 6-year longitudinal naturalistic cohort study in which several psychological and social variables are measured repeatedly among 419 patients with OCD. To study the latter topic a randomized controlled multicentre trial in which 90 patients with OCD with poor insight participated was performed.

Chronicity in OCD

To study chronicity in OCD, participants with current OCD at the time of enrolment in the NOCDA study (N=382) were divided into a group of patients with chronic OCD and a group of patients with non-chronic OCD. These two groups were compared with respect to clinical and demographic characteristics.

The main findings (described in chapter 2) were that 62% of the patients with current OCD had a chronic course, defined as continuous presence of at least moderately severe OCD symptoms during two years before enrolment in the NOCDA study. Participants with a chronic course during the two years before enrolment in the NOCDA study, mostly also reported chronic symptoms during the third, fourth and fifth year before enrolment, whereas the participants with a non-chronic course during the two years before enrolment reported mostly symptom-free episodes during all the five years before enrolment.

There were no differences between patients in the chronic and the non-chronic group with respect to gender, years of education, living together with a partner. However patients with chronic OCD had less often a paid job. Further, among patients with chronic OCD more severe OCD symptoms, more subtypes of OCD, more symmetry and ordering symptoms and contamination and washing symptoms, more comorbid axis-I disorders, more severe depressive symptoms, less extraversion, an earlier age of onset, lower quality of life, more occupational disablement and more days of inpatient or day-care for mental problems were found than among patients with non-chronic OCD. Since all these factors might be mutually associated (in stead of solely associated with chronicity) independent relationships between these factors and chronicity were examined, revealing that more severe OCD symptoms, a higher number of subtypes of OCD, more contamination and washing symptoms and an earlier age of onset were independently associated with chronic OCD. Results of post-hoc analyses showed that the association between OCD symptom severity and chronicity was not driven by the severity of obsessions, but by the severity of compulsions.

Adverse Childhood Experiences (ACEs) and OCD Severity, Chronicity and Comorbidity

Data on ACEs and OCD symptom severity, chronicity and comorbidity of participants with current OCD at time of enrolment in the NOCDA study (N=382), were analysed to examine the relationships between ACEs on the one hand and OCD symptom severity, chronicity and comorbidity on the other hand.

In this study (described in chapter 3) no evidence was found for a relationship between ACEs and severity of OCD and no evidence was found for a relationship between ACEs and chronicity of OCD. That is, none of the separate categories of
ACEs (sexual abuse, physical abuse, maternal dysfunction, paternal dysfunction, early separation and witnessing parental violence) were associated with symptom severity or chronicity, and no dose-response relationships between ACES and OCD symptom severity or chronicity were found. However, the number of ACES appeared to be significantly related to having 1 or more comorbid disorders. The Odds ratio (95% CI) for comorbidity was, respectively, 2.42(1.29-4.52), 2.07 (1.09-3.93), and 7.75 (2.56-23.46) higher for patients reporting 1, 2, or 3 or more categories of ACES than for participants with no ACES.

**Insight**

To study the role of insight in OCD, participants of the NOCDA study with OCD complaints at time of insight measurement (N=253), were divided into four groups, namely into participants with good-, fair-, poor- and absent insight. At the same measurement time clinical and demographic factors were assessed. The scores on these factors were compared among the insight groups. At follow-up (two years later), insight into OCD and severity of OCD were measured again. The correlation between changes in insight and changes in OCD was calculated. Finally, a linear mixed effects model was used to determine whether patients with poor insight at the first measurement had a different outcome at follow-up than patients who had good or fair insight at the first measurement, given the same OCD severity at the first measurement.

The study revealed that good insight (41.1%) and fair insight (44.7%) were common, that poor insight (12.6%) occurred relatively little and that absent insight (1.6%) was very scarce. Taking the latter two categories together, the whole range of insight (good, fair, poor) appeared to occur at every severity level of OCD ranging from subclinical OCD symptoms to extremely severe OCD symptoms. In other words: poor insight occurred even in patients with subclinical OCD.

With respect to the clinical profile of patients with OCD with poor insight was found that these patients reported more severe OCD symptoms, more chronicity and comorbidity, and a higher estimation of importance of thoughts than patients with good or fair insight. Further, both insight and OCD symptom severity were on average stable after two years follow-up, a small correlation was found between change of OCD severity and change of insight.

The principal finding of the study described in chapter 4 was that, given an equal severity at baseline, the two year course of patients with poor or absent insight was significantly worse than the course of patients with good insight and patients with fair insight. The course of patients with fair insight was not significantly worse than the course of patients with good insight. Poor insight appeared to predict a worse course independently of factors that were previously found to predict the natural course of OCD severity, namely OCD severity, age of onset, comorbidity, chronicity of OCD and severity of depressive symptoms.

**The effectiveness of the Inference Based Approach (IBA)**

To study the effectiveness of IBA, a parallel group randomized controlled multicentre trial was performed, in which 90 patients with OCD with poor insight received either 24 IBA sessions or 24 CBT sessions. The primary outcome measure was the Yale Brown Obsessive Compulsive Scale (YBOCS).

The IBA model is based on the assumption that patients with OCD feel the need to perform compulsive acts because they misjudge the actual state of affairs (for example fearing that an appliance is on when it is clearly visible that it is off). It is assumed that certain reasoning processes lead to these erroneous conclusions and distract the patients’ attention from observable reality. Examples of obsessive reasoning processes are: distrusting sensory information (‘the button of the appliance appears to be switched off, but perhaps I’m not seeing it properly’) or basing conclusions on purely imaginary sequences (‘if my cat jumped on the counter and walked over the ON switch of the coffeemaker, it might be on’). During IBA treatment patients get acquainted with these reasoning processes and thereby come to understand why their fears seem and feel so real (albeit these are in fact solely imaginary). The patients learn how to defend themselves against the absorbing and confusing effect of obsessive reasoning processes and how to stay in touch with reality by actively relying on the sensory information of the very moment. As a consequence the patient realizes that any compulsive act is superfluous and feels able to omit it. In the IBA treatment patients are encouraged not to resist compulsions as long as they are convinced that performing them is necessary. The rationale given for this is that resisting the urge to perform safety behaviour provokes anxiety, which in turn impedes reflection on the reasoning processes that lead to confusion of imagination and reality.

IBA differs from CBT. Unlike CBT IBA focuses on what basis (i.e. imagination versus the observable reality of the very moment) the patient comes to the conclusion that the obsessional thought itself might be true. IBA leaves appraisals of the obsessions and compulsions (the primary foci of CBT) untouched. In IBA treatment, no cognitive restructuring takes place; instead, the patient learns to recognize and discard reasoning processes that prohibit the use of sensory information.
The main finding of the study on the effectiveness of IBA (described in chapter 5) was that OCD symptom severity of patients with poor insight significantly decreased after 24 IBA sessions (on average 10 points decrease on the YBOCS, mean percentage symptom reduction was 40%) as well as after 24 CBT sessions (on average 9 points decrease on the YBOCS, mean percentage symptom reduction was 35%). No significant difference between the treatment conditions was found. Post-hoc analyses in a small subgroup of patients with the worst insight (N=23), showed that patients treated with IBA reached significantly more OCD symptom reduction (on average 14 points on the YBOCS) than the patients treated with CBT (on average 6 points on the YBOCS).

**POSSIBLE EXPLANATIONS; MAIN FINDINGS IN THE CONTEXT OF THE LITERATURE**

**Chronicity OCD**
The findings on chronicity described in chapter 2 are in line with the literature, that is, in another recent study among treatment seeking patients with OCD, a strikingly similar proportion (61%) of the sample experienced no (partial) remission. This supports the assumption that chronicity is the rule rather than the exception in OCD. The finding that chronic OCD is associated with higher OCD symptom severity (that is severity of obsessions and compulsions) was, as described in chapter 2, found in several previous studies. More recently OCD severity appeared to be a predictor of chronic OCD in a prospective study.

The study described in chapter 2 was the first to further unravel the independent association between OCD symptom severity and chronicity and found that this association was not driven by severity of obsessions but only by the severity of compulsions. This finding needs replication. The finding suggests that severity of compulsions may be an important etiologic risk factor predicting chronic OCD. Compulsive-like safety behaviour seems to be a counterproductive strategy that contributes to the maintenance and chronicity of obsessive compulsive symptoms. However, since this relationship between severity of compulsions and chronicity in OCD was found in a cross-sectional design, another explanation of the finding might be that patients with chronic OCD no longer resist their compulsions whereas patients with non-chronic OCD keep on trying (with at least some success). Still another explanation might be that both severity of compulsions and chronicity of OCD are related to a third unknown factor.

The relationship between an early age of onset in OCD and chronicity described in chapter 2 was found in previous studies, as was the relationship between contamination and washing symptoms and chronicity. New was the finding of an independent association between the number of subtypes of OCD and chronicity. Prospective studies are needed to further examine whether a higher number of OCD subtypes, an earlier age of onset of OCD and presence of contamination and washing symptoms cause chronicity in OCD. Nonetheless, these factors appear to be independently associated with chronicity in OCD, which implies that they are empirically and clinically important when issues like aetiology or healthcare needs are addressed. Together the results of the study described in chapter 2 confirm the assumption that chronic OCD is critically different from non-chronic OCD.

**Adverse Childhood Experiences (ACE) and OCD Severity, Chronicity and Comorbidity**

As described in chapter 3, finding no relationship between ACEs and severity of OCD is consistent with findings of previous studies. This means that until now there is no evidence for a relationship between ACEs and OCD symptom severity in adult patients with OCD. The study described in chapter 3 was the first to examine the relationship between ACEs and chronicity in OCD. No relationship was found, which means that until now no empirical evidence is found for the idea that ACEs contribute to the maintenance of OCD. This contradicts findings about relationships between ACEs and symptom severity in other psychiatric disorders. For example in depression research was found that ACEs were associated with severity of depression and independently associated with chronicity of depression, after controlling for severity and comorbidity in a sample of patients with current depression. Furthermore, ACEs appeared to be a significant predictor of a lower likelihood of remission of depression and/or anxiety disorders in a recent study.

Also new was the finding that ACEs are positively associated with comorbidity in OCD. A recent study found consistent results. These findings underscore the need to critically reconsider earlier findings on heightened trauma rates among patients with OCD compared to healthy controls, including the study that is cited in the DSM-5 to endorse that childhood physical and sexual abuse would be environmental factors associated with an increased risk for developing OCD, since this might not apply to the participants in those studies with pure OCD, but only to participants with other Axis I disorders comorbid to OCD. If this were the case, conclusions about possible (childhood) trauma relatedness of OCD might no longer be tenable.

Summarizing, the results of the study described in chapter 3 suggest that unlike in other psychiatric disorders, ACEs play no significant role in symptom severity and chronicity of OCD. An additional empirical implication of these findings is that
comorbidity is a factor that should be treated as an important potential confounder in future OCD studies.

Insight
The finding described in chapter 4 that fair insight was most common, slightly more common than good insight was also found in other studies\(^3\). The finding that absent insight did occur (albeit seldom) is consistent with recent literature\(^1\) and further confirms the changes from DSM-IV to DSM-5 with respect to abandoning the criterion that patients have to be able to recognize their symptoms as nonsensical and to add the specifier with absent insight\(^2\). The findings on the prevalence and the clinical picture of OCD with poor insight are in line with the literature, albeit the proportion of patients with poor insight was relatively low due to the fact that a part of the sample had largely remitted OCD. It is now generally estimated that patients with poor insight form over one-quarter of the population of OCD\(^2\). Likewise it is generally found that poor insight in OCD is associated with a worse clinical picture\(^1\), characterized by higher severity, more comorbidity and more chronic OCD.

The study described in chapter 4 was the first to examine the correlation between the course of insight and the course of OCD symptom severity in an observational cohort design. This finding of a small but significant correlation needs replication. If this finding appears to be a robust finding this means that changes in OCD severity play a small (possibly causal) role in changes in insight and vice versa. Possibly increased insight enables the patient to feel more secure and save when he or she considers to omit a compulsion, whereby compulsive behaviour might decrease, which in turn provides an opportunity to observe that nothing bad happens when no safety behaviour (that is no compulsion) was performed, which might further improve insight. It is unclear whether this hypothetical interaction starts with increased insight or decreased OCD severity. Given the small effect size of the correlation between the course of insight and the course of OCD symptom severity, still unknown other factors might be more important in these changes.

The question whether poor insight (as a category) independently predicts a worse natural course of OCD was also not studied previously. In two earlier studies\(^2\), the impact of insight as a continuous dimension on the natural course of OCD was studied (finding no significant relationship), but not the impact of poor insight (as a category). Trying to explain why in the previous studies no effect of insight as a continuous dimension was found on the natural course of OCD, whereas in the study described in chapter 4 poor insight appeared to predict a worse course, post-hoc the hypothesis was postulated that only poor insight might have a negative impact on the natural course of OCD and that there is no linear relationship between insight and the natural course of OCD. Indeed, patients with fair insight were not worse off at follow-up than patients with good insight. Moreover, a post-hoc analysis of the NOCDA data generated results that are in line with the two previous studies mentioned above; insight as a continuous variable did not predict a worse natural course of OCD. The finding that only poor insight predicts a worse course of OCD needs replication. However, so far we may assume that poor insight (and not limited insight) is a separate phenomenon that predicts an unfavourable course of OCD.

The new findings that poor insight occurs at every severity level of OCD, in stead of exclusively among patients with severe OC complaints, and that poor insight predicts a worse outcome independent of OCD symptom severity, independent of severity of depressive symptoms, and independent of chronicity of OCD symptoms, allow to reject the ideas that poor insight is merely a proxy of symptom severity or a concomitant of a depressive state or an indicator of chronicity. Poor insight in stead appears to be a separate phenomenon. This is important because it underscores the relevance of further studying the topic and (also facing the results of the last study described in this thesis) it might imply the need for treatment that specifically targets insight in OCD.

The effectiveness of the Inference Based Approach
The study described in chapter 5 was the first to examine the effectiveness of any treatment specifically for patients with OCD with poor insight. However, it turned out that, after using DSM-IV criteria of poor insight to select participants (lacking cut-off scores for poor insight on the insight measure at the outset of the study), also patients with rather limited in stead of poor insight (conform cut-off scores that were available at a later stage) participated in the study (about which more below under the heading methodological considerations). Nevertheless, both patients treated with IBA and patients treated with CBT reached statistically and clinically significant symptom reduction. As described in chapter 5 it is very unlikely that non-specific factors or spontaneous recovery explain this progression. This means that, albeit in previous studies was found that (DSM-IV defined) poor insight predicted poor outcome of CBT\(^1\), there is some evidence now that this group of patients does benefit from psychological treatment, i.e. CBT or IBA. With respect to CBT, taking previous findings into account, it seems justified to conclude that patients with OCD with good and fair insight generally reach more symptom reduction after treatment with CBT than patients with poor insight, but that there is no need for treatment pessimism, because the latter group on average may benefit from CBT.
The finding described in chapter 5 that patients who were treated with IBA reached significant symptom reduction, is in line with the results of a previous study among patients with OCD (with or without poor insight)\(^5\). This suggests that IBA might be a fruitful approach of treating patients with OCD (with or without poor insight) and might be an alternative for CBT.

The (post-hoc) finding that the patients with the worst insight reached more symptom reduction after treatment with IBA than after treatment with CBT is in line with findings of an earlier study on the effectiveness of IBA, in which post-hoc a trend was found that IBA was superior to CBT for OCD patients with poor insight\(^5\). This means that there are some indications that IBA is superior to CBT in treating patients with OCD with poor insight. However, these findings need to be replicated.

Theoretically an explanation of why patients with poor insight do respond better to IBA than to CBT might be that for these patients, more understanding of why their fears seem and feel so real might be a prerequisite to be able to structurally distance themselves from their obsessive convictions. In IBA treatment, patients learn to recognize how they get absorbed in imagination and how they do ignore the sensory information which proves that here and now everything is safe. In other words they learn to understand why their fears seem so real even though these are purely imaginative.

Interestingly, the findings of the study described in chapter 4 and the post-hoc analysis performed in the study described in chapter 5 mentioned here above, come together in that patients with poor insight* show a different pattern of reaction to therapy and a different natural course of OCD than patients with limited insight. This corresponding finding underscores the assumption that poor insight is a separate phenomenon and that patients with OCD with poor insight form a distinguishable subgroup. Furthermore this underscores the need for the use of uniform validated cut-off scores for poor insight in future studies.

*The cut-off score (=6) on the insight measurement (the Overvalued Ideas Scale (OVIS))\(^5\) that was used to select the subgroup of patients with the worst insight for the post-hoc analysis in the study on the effectiveness of IBA, was the same cut-off score for poor insight that was used in the study on the impact of insight on the natural course of OCD.

Methodological considerations and implications for future research

Limitations due to the samples that were recruited

For the studies described in chapter 2 and 3 baseline data of the NOCDA study were used and for the study described in chapter 4, wave 3 (2 years after baseline) and 4 (4 years after baseline) data of the NOCDA study were used. Methodological strengths of the NOCDA study include the use of a large, well diagnosed, representative clinical sample of OCD patients and the examination of many risk factors in concert\(^1\). However, the use of this sample also implied limitations for the studies on chronicity in OCD and on poor insight into OCD. Participants were patients with OCD who were referred for treatment in mental health (outpatient) clinics that were specialized in OCD. This means that at baseline patients with severe symptoms and a longer duration of OCD might be overrepresented in the sample, implying the possibility of overrepresentation of patients with chronic OCD in the sample. Further, it stands to reason that individuals with poor insight are less likely to seek treatment due to poor awareness of their disorder. Therefore, and because a part of the sample reached significant symptom reduction by the time of wave 3, patients with poor insight into OCD might have been underrepresented in the sample. Results of the study on poor insight may not be generalizable to all adults with OCD, but just to treatment seekers with OCD.

At the time of the design of the study on the effectiveness of IBA (described in chapter 5) only 1 study was available in which a cut off score on the OVIS for poor insight was used\(^5\). The project group of the study was unfortunately at that stage not aware of this cut-off score. The study (described in chapter 4) on the impact of insight on the natural course of OCD in which cut-off scores for fair, poor and absent insight are described, was designed years after the start of the IBA study. As described in detail in chapter 5, in the IBA study, instead of a cut-off score on the OVIS, DSM-IV criteria of poor insight were applied to select patients with poor insight at intake and at screening for participation in the study, alongside a second step in which patients had to score above pre-set cut-off scores on the first 2 items of the OVIS. In hindsight a consequence of this procedure was that only a part of the sample had poor insight conform the cut-off score for this used in chapter 4 and that the rest of the sample appeared to consist of patients with rather limited insight. These latter patients scored in the worst half of the fair insight range described in chapter 4. This means that the question about the effectiveness of IBA vs CBT was studied in a sample consisting of patients with rather limited insight and patients with poor insight. Only the post-hoc analysis was performed in a subsample with only patients with poor insight. The results of the post-hoc analyses need replication.
In future studies on the effectiveness of IBA for patients with OCD with poor insight, the cut-off score for poor insight on an insight measurement should be used to select patients with poor insight. The results of the study in this sample of patients with rather limited and poor insight suggest that IBA might also be effective for patients with OCD without poor insight (which is, as mentioned above, consistent with a previous study). In future studies on the effectiveness of IBA, the questions should be answered whether IBA is non-inferior to CBT in treating patients with OCD without poor insight and superior to CBT in treating patients with OCD with poor insight. Furthermore, it is important to find out whether patients with OCD who do not respond to CBT reach more symptom reduction after subsequent treatment with IBA than after continuation of CBT. Altogether this might answer the question whether more patients with OCD can be cured when psychotherapeutic treatment options for OCD would be extended with IBA.

**Limitations due to the study designs that were used**

In the studies on chronicity and ACEs cross-sectional designs were used, whereby specific pathways by which OCD severity, contamination and washing symptoms and the number of OCD subtypes are related to chronicity in OCD are unknown. The same holds for the specific pathways by which ACEs are related to comorbidity in OCD patients. Data from the NOCDA study will give the opportunity to repeat these studies using prospective methods.

Further, with respect to the study on ACEs no control group consisting of patients with other mood- and anxiety disorders and no control group consisting of healthy controls were included in the study. This was not necessary because the research questions concerned the relationship between ACEs and OCD severity, -chronicity and –comorbidity. However, to draw firm conclusions about the (non-existence of) relatedness between ACEs and OCD, comparison with control groups would be necessary. Combining data from the NOCDA study and the Netherlands Study of Depression and Anxiety (NESDA) (in which data of healthy controls are available) will give the opportunity to further study this topic. A potential hypothesis for a study like that is that patients with pure OCD do not have more ACEs than healthy controls and do have less ACEs than patients with OCD and comorbid Axis-I disorders, and patients with primary mood- or anxiety disorders.

**Limitations due to definitions, measurements and cut-off scores**

In the study described in chapter 2, because of the lack of an existing validated definition of chronic OCD, a chronicity criterion was used analogous to the criteria of chronicity in depression. The application of this criterion actually resulted in two groups with a highly distinguishable long-term course: by definition the two groups differed with respect to their 2-year course, but, they also appeared to differ critically during an additional 3 years (i.e. during a five-year course). However, although these results provide support for the correctness of this definition of chronicity in OCD that was used in the study, it needs further validation. In future research, using longitudinal data, the definition of chronic OCD should be tested and compared to other classifications of course subtypes to find out what criteria separate those with persisting disabling symptoms best.

Further, OCD course was measured retrospectively, implying the possibility of over- or underestimation of persistence and severity of symptoms due to a state-dependent bias or a general recall bias or.

With respect to the study on ACEs, data on ACEs were collected retrospectively. Patient reports might represent recollections of childhood trauma or absence of childhood trauma that are influenced by their condition, or be subject to rater bias, therefore cautious interpretation of the results is necessary. A broad range of ACEs were assessed, however, a history of being bullied by peers, which is an ACE that is related to adult psychopathology was not examined. Although being bullied often co-occurs with family dysfunction and maltreatment, theoretically responders in the ACE study with a low number of ACEs might in fact have been bullied.

With respect to the study on the impact of poor insight a methodological limitation concerns the rationale for setting the cut-off scores on the measurement used to determine the level of insight (the OVIS) for good, fair, poor and absent insight. Although the cut-off for poor insight is the one previously employed in the adult OCD literature, its validity still remains to be definitively established. The cut-off scores for fair and absent insight were based on personal communication with the author of the OVIS. Until now no insight measures with validated cut-off scores for different insight levels are available. This is, as discussed above, also the most important limitation of the study on the effectiveness of IBA in the treatment of patients with poor insight. Lacking a validated OVIS cut-off score to determine poor insight after selection of patients on the basis of the DSM-IV criteria for poor insight, it was chosen to use a combination of scores on the first 2 items of the OVIS. Although the sample had poorer insight (i.e. a significantly higher mean OVIS score than the grouped mean OVIS score that was found in other OCD samples), in hindsight it would have been better to use a OVIS total score cut-off to select the sample.
CLINICAL IMPLICATIONS OF THE FINDINGS

Since it was found that chronic OCD was associated with more severe OCD symptoms, an early onset age of OCD, the presence of contamination and washing symptoms and multiple subtypes of OCD, clinicians should be aware that presence of these characteristics in a patient with OCD might imply a more chronic course of OCD, which in turn might justify faster allocation to specialized treatment centres. Findings like these may be incorporated in a decision tool, i.e. an evidence based staging-profiling instrument for OCD.

As there was (in line with the literature) no evidence for a relationship between ACEs and severity of OCD and chronicity of OCD, it seems, pending more research on this topic, generally advisable to first start treating OCD just by means of evidence-based treatment, when adult patients with a primary diagnosis of OCD do report ACEs.

Because the findings of the study on insight into OCD suggest that poor insight has a negative impact on the prognosis of OCD (independent of the severity of that disorder and other factors that predict poor outcome in OCD) and that poor insight occurs at every severity level of OCD (that is, contrary to what is generally assumed, also among patients with subclinical or mild symptoms), the clinician treating patients with OCD should measure insight using a validated structured interview like the OVIS or the Brown Assessment of Beliefs Scale (BABS). Pending robust evidence for the superiority of IBA to CBT in treating patients with OCD with poor insight, the clinician should, when the patient with poor insight does not respond to (intensive) treatment with evidence based interventions like CBT and pharmacotherapy, consider treatment with IBA as a step to be taken before considering more invasive next treatment options.

CONCLUDING REMARKS

Chronic OCD is the rule rather than the exception and is critically different from non-chronic OCD in the sense that it is associated with higher OCD severity, a higher number of OCD subtypes, presence of contamination and washing symptoms and an earlier age of onset of OCD. Until now there is no evidence for adverse childhood experiences to be related to severity or chronicity of OCD, but there is some for it to be related to comorbidity in OCD. Poor insight is a separate phenomenon that does occur at every severity level of OCD and has a negative impact on the prognosis of OCD. Nevertheless, on average patients with OCD with poor insight do benefit from psychotherapy. IBA specifically targets insight and might be more promising than CBT for patients with OCD with poor insight.
REFERENCES


