Overvalued ideation in adolescents with obsessive-compulsive disorder

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ABSTRACT

In Obsessive Compulsive Disorder (OCD), overvalued ideas (OVI) are considered poor prognostic indicators in adults. To date, OVI has not been studied in an adolescent population with OCD, nor has it been examined in relation to obsessive-compulsive beliefs. To investigate the relationship between OVI and specific cognitions, fifty-five adolescents with OCD (35 male; 20 female; age range 13–17 years; $M = 14.05$ years, $SD = 1.75$ years) participated. It was predicted that OVI would be associated with symptom severity and would moderate obsessive-compulsive beliefs and functional disability. Results showed that OVI was associated with symptom severity, but did not moderate the relationship with any OC beliefs or functional domains. To evaluate the role of OVI in treatment outcome, thirteen adolescents completed a cognitive-behavioral treatment program. Severity of their OCD symptoms, OVI, degree of functional impairment and quality of life were assessed. It was expected that all variables would change in response to treatment. Further, it was expected that OVI would mediate treatment outcome for all measures of obsessive-compulsive symptom and belief assessments. Results indicated that there was clinically significant change in symptom severity and functional disability, as well as beliefs regarding responsibility/overestimation of threat. Treatment, assessment, and methodological recommendations for this population are offered.

1. Introduction

Obsessive Compulsive Disorder (OCD) is principally characterized by obsessions, negative feelings, and compulsions. Obsessions are thoughts, images, or impulses that are repetitive, intrusive, and difficult to suppress. The five core features of obsessions are discussed in greater detail in Clark (2004) and are based on the criteria for diagnosing OCD in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013). A compulsion, ritual, or neutralizing strategy has four main characteristics: the response is intentional, repetitive, excessive, and the person feels an urge to perform it. The prevalence of OCD has been well studied in population-wide surveys across the globe. These studies show that OCD occurs in 1 – 3% of adults (Fireman et al., 2001; Weissman et al., 1994) and 1.9 – 4% in children (Douglass et al., 1995; Karno et al., 1988; Zohar, 1999). OCD is considered responsive to treatment, with two approaches shown to be efficacious: cognitive-behavioral therapy (CBT) with exposure and response prevention (ERP) and psychopharmacologic interventions, including selective serotonin reuptake inhibitors (SSRIs) (Franklin et al. (2015); Pediatric OCD Treatment Study (POTS) Team, 2004).

As OCD continues to be studied by researchers, cognitive-behavioral etiology models are becoming promising approaches to conceptualizing OCD (Clark, 2004; Frost and Steketee, 2002; Salkovskis, 1999). These models propose that OCD develops from a certain set of dysfunctional beliefs, leading the person to misinterpret or overestimate the significance of their unwanted and intrusive thoughts. When an individual attributes unwarranted significance to such thoughts, mental events can become transformed into obsessions and lead to compulsions.

A diagnosis of OCD presumes that, at some point, the patient has recognized the obsessions as excessive or unreasonable. However, some OCD patients believe their obsessions are logical and are unable to perceive their obsessions as being irrational. Thus, their obsessions are said to be overvalued. An overvalued idea (OVI) is "an unreasonable and sustained belief that is maintained with less than delusional intensity," (5th ed.; DSM-V; American Psychiatric Association, 2013). A number of authors (Hollander, 1993; Kozak and Foa, 1994; Neziroglu et al., 1999) consider the strength of a belief as one of the prominent features characterizing overvalued ideas. Overvalued ideas are irrational, unreasonable beliefs that are held with strong conviction, and the person lacks insight or the ability to attribute the belief to the disorder (i.e. OCD; Neziroglu and Stevens, 2002). Conceptually, over-

valued ideas interfere with disconfirmatory learning and habituation processes in ERP (Kozak and Foa, 1994).

Some scales have been created for the measurement of overvalued ideas. Eisen et al. (1998) developed the *Brown Assessment of Beliefs Scale* (BABS), which measures different dimensions of insight in a variety of disorders including schizophrenia. Foa et al. (1995) developed the "Fixity of Beliefs" questionnaire, which evaluates the strength to which OCD patients recognize that their obsessions and compulsions are unreasonable or irrational. Lastly, Neziroglu et al. (1999) developed the *Overvalued Ideas Scale* (OVIS), assessing the main beliefs associated with OCD. It measures the following components of an overvalued belief: strength, reasonableness, accuracy, perception of others' views, acknowledgement of differing views, general fixity of belief, and insight. In this case, the concept of belief is related to the degree a concept is held as accurate, as opposed to beliefs in the cognitive model of OCD, whereby broad errors in thinking (i.e., inflated responsibility, intolerance of uncertainty) are considered functional in the etiology of the condition.

OVIs are considered poor prognostic indicators across much of the literature, suggesting that these patients are more resistant to treatment than those who do not have OVIs (Foa, 1979; Foa et al., 1999; Neziroglu et al., 2001, 2004). OVIs, as measured by the OVIS, have been shown to predict treatment response to both fluvoxamine (Neziroglu et al., 2004) and behavioral therapy (Neziroglu et al., 2001). Further, Bellino et al. (2005) found that poor insight was associated with more compulsions, illness chronicity, and a positive family history of OCD. Recent work by Catapano et al. (2001) and Turksoy et al. (2002) indicated that lack of insight was associated with less resistance to obsessions and compulsions which contributed to poorer treatment outcomes. Finally, Ravi Kishore et al. (2004) revealed that poor insight was associated with an earlier onset of symptoms, longer duration of illness, increased symptom severity, and higher comorbidity. Although OCD with poor insight has been examined in adult patients, few investigations into the presence of insight in adolescents with OCD have been conducted. The diagnosis of OCD in pediatric populations does not require awareness that the obsessions or compulsions are excessive or unreasonable.

Clinical lore suggests that insight is a significant prognostic sign in the treatment of adult OCD. However, to date there is limited data regarding how clinical characteristics and treatment outcome vary as a function of insight level in pediatric patients (Storch et al., 2008, 2013). The present study aims to better understand the presence of overvalued ideas in adolescents. Based on the limited studies of OCD within pediatric populations, poor outcome has been related to more severe obsessions, greater baseline academic impairment, and poor peer relationships (Borda et al., 2013). In light of the available research in adult samples examining overvalued ideas (used as a proxy for insight), it was expected that it would be associated with greater symptom severity and disability, and greater endorsement of obsessive-compulsive beliefs in a pediatric sample. As a result, it was anticipated that OVI would be associated with greater symptom severity, and that OVI would moderate the relationship with obsessive-compulsive beliefs and with functional assessments.

2. Method

2.1. Participants

The present study included 55 (35 male; 20 female) participants between the ages of 13–17 years ($M = 14.05$ years, $SD = 1.75$ years) who were being treated in Buenos Aires during 2010–2014. Inclusion criteria were (a) principal diagnosis of OCD derived from the Anxiety Disorders Interview Schedule for DSM-IV: Children's Version (ADIS-IV-C; Silverman and Albano, 1996); (b) Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS; Storch et al., 2004) clinical rating of moderate or more severe, and Child Sheehan Disability Scale (CSDS; Whiteside, 2009) of moderate to high functional impairment; and (c)

Table 1
Participant demographics.

Baseline	N = 55
Mean Age (in years)	14.35 (0.89)
Female	24 (43.6%)
Male	31 (56.4%)
Treatment Completers	N = 13
Mean Age (in years)	14.00 (1.00)
Female	3 (23.1%)
Male	10 (76.9%)

Table 2
Obsessions and compulsions in full sample (N = 55).

Obsessions	*N (%)*
Aggression	36 (65)
Somatic	31 (56)
Symmetry	17 (31)
Sexual/Religious	15 (27)
Miscellaneous	15 (27)
Compulsions	
Checking	36 (65)
Repeating	35 (64)
Ordering	26 (47)
Washing	23 (42)
Mental Rituals	20 (36)
Miscellaneous Compulsions	13 (24)
Hoarding	11 (20)

Note. Symptoms listed based on broad domains from the checklist portion of the Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS). Hoarding is included here as the checklist and data were collected prior to the development of the DSM-5 and the separation of hoarding into a separate diagnosis.

ability to participate in the assessment process. Parents gave consent to participate in the study. All conducted interviews and measures were administered in Spanish. A subset of the sample completed a cognitive-behavioral treatment program ($n = 13$, boys = 10, girls = 3) (see Treatment section below for details of the intervention protocol, Tables 1, 2 for sample descriptive information, and Table 3 for baseline descriptive data).

Adolescents were excluded if they met any of the following criteria: (a) history and/or current diagnoses of psychosis, autism, bipolar disorder, or current suicidality, as measured by the ADIS-IV-P and determined through all available clinical and school information; (b) principal diagnosis other than OCD; or (c) a positive diagnosis in the caregiver of mental retardation, psychosis, or other psychiatric disorders or conditions that would limit his or her ability to understand questionnaires.

Participants met criteria for additional diagnoses as follows: separation anxiety ($n = 10$), social anxiety disorder ($n = 3$), specific phobia

Table 3
Baseline measure descriptive statistics.

	Mean	*SD*
YBOCS Obsession	14.95	3.11
YBOCS Compulsions	15.38	2.92
OVIS	5.65	2.75
CSDS School	6.64	1.11
CSDS Social	7.55	1.10
CSDS Family	6.29	0.76
OBQ Factor 1	59.25	4.03
OBQ Factor 2	62.89	8.47
OBQ Factor 3	43.71	7.80

Note. OBQ Factor 1 = responsibility/threat estimation; OBQ Factor 2 = perfectionism/certainty; OBQ Factor 3 = control/importance of thoughts.