Indian Journal of Clinical Psychiatry
An Official Journal of **Association of Clinical Psychiatry**
(Indian Psychiatric Society- Uttar Pradesh State Branch (IPS-UPSB))

RESEARCH ARTICLE
doi: 10.54169/ijocp.v5i02.03

Exploring The Relationship of Symptom Dimensions with Insight and Functioning in Obsessive-Compulsive Disorder: A Cross-Sectional Study

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ARTICLE INFO

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Dates:
Received: 02-10-2025
Accepted: 18-10-2025
Published: 20-12-2025

Keywords:
Obsessive-compulsive disorder, Symptom dimensions, Insight, Functioning.

How to Cite:
Singh P, Kumar M, Bawankar N, Gupta S, Kour H. Exploring The Relationship of Symptom Dimensions with Insight and Functioning in Obsessive-Compulsive Disorder: A Cross-Sectional Study. Indian Journal of Clinical Psychiatry. 2025;5(2): 12-19.
doi: 10.54169/ijocp.v5i02.03

Abstract

Background: In patients with obsessive-compulsive disorder (OCD), insight is a reflection of their understanding that their symptoms are irrational. Variations in insight have been associated with differences in symptom dimensions, severity, and overall prognosis. Moreover, specific psychopathological dimensions may differentially impact social and occupational functioning in OCD patients.

Aim: To explore the association of symptom dimensions with insight levels and to examine their impact on social and occupational functioning in patients with obsessive-compulsive disorder (OCD).

Methods: This cross-sectional study included 100 patients diagnosed with OCD according to DSM-5 criteria, aged 18–60 years, at a tertiary care center. Based on the Y-BOCS Item-11, patients were categorized as having good or poor insight. For assessing symptom dimensions, the Dimensional Yale-Brown Obsessive-Compulsive Scale (DY-BOCS) was used, while the Social and Occupational Functioning Assessment Scale (SOFAS) was utilized to evaluate functioning.

Results: Of the 100 patients, 78% had good insight, while 22% exhibited poor insight. Overall, no statistically significant difference was found in the presence or severity of symptom dimensions between the two groups. A significant negative correlation was observed between the sexual/religious symptom dimension and SOFAS scores ($p<0.05$), indicating that greater severity in this domain was linked to poorer social and occupational functioning.

Conclusions: Poor insight was associated with higher symptom severity, divorce/separation and longer duration of untreated illness. Insight levels did not significantly differ across symptom dimensions. However, sexual-religious obsessions were strongly associated with poorer functioning, underscoring the need for domain-specific interventions beyond insight-based management.

Introduction

The concept of insight in the context of OCD refers to the extent to which an individual recognizes that their obsessions and compulsions are unreasonable,

excessive, and not based in reality. DSM-5 (American Psychiatric Association, 2013) provides three specifiers for the level of insight: with good or fair insight, with poor insight, and with absent insight/ delusional beliefs.[1]

Psychopathology is defined as the study of mental illness, behaviours, and experiences that are indicative of mental illness or psychological impairment. It encompasses the signs and symptoms associated with mental disorders. A common tool for assessing OCD symptom dimensions is the Dimensional Yale-Brown Obsessive–Compulsive Scale (DY-BOCS), which identifies six dimensions: [1] symmetry, 'just right' feelings, counting, and arranging; [2] contamination and cleaning; [3] harm-related content, including aggression, injury, violence, and accidents; [4] moral, sexual, and religious content; [5] hoarding; and [6] miscellaneous, including somatic concerns and superstitions.[2]

According to studies, insight varies across different OCD symptom dimensions.[3-6] Certain dimensions, such as hoarding,[3-5,7,8] have been consistently associated with poor insight. Some data also suggest that the need for symmetry may be linked to poor insight.[5,9] However, there is conflicting evidence regarding the relationship between contamination/washing symptoms and insight, as these symptoms have been associated with both good[4] and poor insight.[5] Thus, the association between specific symptom dimensions and insight remains inconsistent, highlighting the need for further research in this area.

OCD is a disabling condition that adversely affects the quality of life of both patients and their families, and it significantly impairs social and occupational functioning.[10-12] Social functioning has been found to negatively correlate with sexual and religious symptom dimensions of OCD.[13] Additionally, another study reported specific associations between OCD symptom dimensions and various aspects of quality of life: symmetry/ordering symptoms were associated with poorer social quality of life; forbidden thought symptoms with diminished health-related quality of life; and contamination/ cleaning symptoms with reductions in leisure time, social interaction, and health-related quality of life. [14]Since insight is a modifiable and potentially treatable characteristic that may influence therapeutic outcomes in OCD, it is an important clinical variable that should be considered in the comprehensive evaluation and management of the disorder.[15] Although insight varies across symptom dimensions of OCD, the existing data are inconsistent, and there is a notable lack of research on this topic from India. Therefore, more research is needed to explore insight, psychopathology, and functioning in OCD patients. Hence, the current study was undertaken to investigate the relationship of symptom dimensions with insight and functioning in patients with OCD.

Materials And Methods

Ethical Considerations

Ethical approval for the study from the Institutional Ethical Committee (approval number: 187/ MC/EC/2023) was obtained before the start of the study (on April 05, 2023). The study was conducted in accordance with the ethical principles outlined in the World Medical Association's Declaration of Helsinki for research involving human participants.

Patient Consent

Written informed consent was taken from each participant in the study. They were assured of complete confidentiality of their identity, information, and the option of withdrawing from the study at any point in time.

Study Design

This observational study, employing a descriptive cross-sectional design, was conducted at a tertiary care centre in northwestern India over a period of one year, from June 2023 to May 2024. Participants were recruited using a convenience sampling method from outpatient and inpatient departments of the hospital. They were diagnosed with OCD as per DSM-5 criteria and confirmed by 2 independent interviewers.

Inclusion and Exclusion Criteria: Adults aged between 18 and 60 years who met DSM-5 diagnostic criteria for obsessive-compulsive disorder and had a Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

score of 8 or above were eligible for inclusion after obtaining written informed consent. Exclusion criteria comprised individuals with acute medical illnesses requiring immediate intervention, those with intellectual developmental disorder (IDD), comorbid psychiatric disorders (other than nicotine dependence), or refusal to consent.

Data collection tool

Patient Information Sheet and Informed Consent Form

Provided in both Hindi and English to ensure comprehension and voluntary participation.

Sociodemographic and Clinical Profile Proforma:

Developed for the study to record sociodemographic characteristics and clinical variables, including family history, age of onset, and illness duration.

Yale–Brown Obsessive Compulsive Scale (Y-BOCS II)

A validated instrument used to quantify the severity of obsessions and compulsions. The first 10 items contribute to a total score ranging from 0 to 40, with higher scores indicating greater symptom severity. Severity was classified as mild (8–15), moderate (16–23), severe (24–31), and extreme (32–40).[16]

Y-BOCS Item-11

This specific item is used to assess the extent of the individual's insight into their obsessive-compulsive symptoms. Insight is rated on a scale ranging from 0 to 4, where 0 indicates excellent insight, 1 denotes good insight, 2 reflects fair insight, 3 suggests poor insight, and 4 signifies a complete lack of insight.[17]

Dimensional Yale–Brown Obsessive–Compulsive Scale (DY-BOCS)

This clinician-administered (objective) tool was applied to identify and evaluate the severity of symptoms across various dimensions of OCD. The DY-BOCS organizes symptoms into six distinct domains: harm/aggression, sexual/religious obsessions, contamination/cleaning, symmetry/ordering/counting/arranging, hoarding/collecting, and a miscellaneous category. Each domain's clinical severity is assessed across three parameters—frequency, distress, and interference—each scored out of 5, allowing for a maximum score of 15 per dimension.[2]

Social and Occupational Functioning Assessment Scale (SOFAS)

This scale specifically focuses on the individual's performance in social and occupational settings. It is designed to assess functioning independently of the overall severity of psychological symptoms, ensuring that it reflects real-world functional ability rather than symptom burden. It is scored on a continuum from 0 to 100, with higher scores indicating better functioning.[18]

Statistical analysis

The data were first entered into Microsoft Excel and later transferred to IBM SPSS version 20.0.0 (IBM, New York, USA) for detailed statistical analysis. Descriptive statistics for quantitative variables are expressed as mean ± standard deviation (SD), while qualitative variables are summarized using frequency distributions. Pearson's correlation analysis was conducted to examine relationships between variables. A p-value of ≤ .05 was considered statistically significant for all analyses.

Results

The study included 100 patients with obsessive–compulsive disorder. The mean age was 31.9 years, and most participants were between 18 and 44 years of age as shown in Table 1. Males constituted 57% of the sample, and 55% were married. Nearly two-fifths were graduates or had higher education, while 84% were non-earning individuals. A majority of participants resided in rural areas (61%), were Hindu by religion (90%), and lived in nuclear families (59%). A family history of OCD was present in 22% of cases. The mean age of onset was 24.6 years, and the mean illness duration was 7.3 years. Most patients had severe (41%) to extreme (32%) symptom severity according to the Y-BOCS score.

The comparison of sociodemographic factors between the two OCD groups with good and poor insight is shown in Table 2. There was no statistically significant difference between the two insight groups, except for marital status. A higher percentage of married individuals were in the good insight

Table 1: Categorization of the sample into two groups of OCD with good and poor insight

Number of patients (n=100)	*Group*	
n (%)	OCD with Good Insight (Y-BOCS Item-11 Score 0, 1 & 2)	OCD with Poor Insight (Y-BOCS Item-11 Score 3 & 4)
	(78%)	22 (22%)

Table 2: Comparison of sociodemographic variables between good and poor insight groups

Variables	*Subgroups*	*OCD with Good Insight n (%)*	*OCD with Poor Insight n (%)*	*χ2/Fisher's exact/ t-test*	*p-value*
Age (Years)	Mean (SD)	32.49 (9.58)	30.0 (9.28)	1.103	0.278
Gender	Male	44 (56.4%)	13 (59.1%)	0.050	0.823
	Female	34 (43.6%)	9 (40.9%)		
Marital status	Married	47 (60.3%)	8 (36.4%)	6.274	0.034*
	Unmarried	29 (37.2%)	11 (50%)		
	Divorced/Separated	2 (2.6%)	3 (13.6%)		
Education	Up to Primary	6 (7.7%)	2 (9.1%)	1.370	0.873
	Middle class	14 (17.9%)	5 (22.7%)		
	Secondary	13 (16.7%)	2 (9.1%)		
	Higher secondary	14 (17.9%)	5 (22.7%)		
	Graduate and above	31 (39.7%)	8 (36.4%)		
Employment status	Nonearning	62 (79.5%)	22 (100%)	3.816	0.256
	Unskilled/Semi-skilled	8 (10.3%)	0 (0.0%)		
	Skilled	4 (5.1%)	0 (0.0%)		
	Semi-professional/Professional	4 (5.1%)	0 (0.0%)		
Locality	Urban	34 (43.6%)	5 (22.7%)	3.139	0.088
	Rural	44 (56.4%)	17 (77.3%)		
Religion	Hindu	69 (88.5%)	21 (95.5%)	1.091	0.452
	Muslim	9 (11.5%)	1 (4.5%)		
Type of family	Nuclear	45 (57.7%)	14 (63.6%)	1.196	0.596
	Joint	14 (17.9%)	5 (22.7%)		
	Others	19 (24.4%)	3 (13.6%)		
Monthly family income (in Rs)	≤ 10000	20 (25.6%)	7 (31.8%)	1.107	0.785
	10001-20000	24 (30.8%)	6 (27.3%)		
	20001-30000	17 (21.8%)	6 (27.3%)		
	>30000	17 (21.8%)	3 (13.6%)		
Family history	Present	16 (20.5%)	6 (27.3%)	0.441	0.563
	Absent	62 (79.5%)	16 (72.7%)		

*Significant p-value (≤0.05)

group, while a higher percentage of unmarried and Divorced/Separated individuals were in the poor insight group compared to the good insight group.

Table 3 compares various clinical variables between the groups. Patients with poor insight had a significantly longer period of untreated illness and a shorter duration of treatment compared to those with good insight. Also, the poor insight group had a significantly higher total Y-BOCS score and compulsion subscale score.

The presence of symptom dimensions in OCD patients with good and poor insight is compared in Table 4. Overall, no statistically significant differences were observed across various symptom dimensions between the two groups as shown in Table 5.

Sexual/religious symptoms showed a statistically significant negative correlation with functioning, as shown in Table 6.

Discussion

The present study was conducted on 100 OCD patients to evaluate the relationship of symptom dimensions with insight and functioning. 78% of the study sample had good insight, while 22% had poor insight, which is consistent with earlier studies reporting that 9–45% of OCD patients have poor insight.[3-7,19-25]

Patients with poor insight also had longer untreated illness and shorter treatment duration, which highlights the impact of insight on treatment-seeking behavior and adherence. Poor insight could result in delay, including recognizing the need for help and therefore delay in the initiation of effective treatment. This is consistent with the finding in the previous study[22] which also reported that poor insight patients had a long span of untreated illness. Symptom severity was significantly higher in poor insight patients, as evidenced by higher Y-BOCS total scores and compulsion subscale scores, as patients with poor insight have reduced resistance to compulsions, which leads to increased symptom severity. These findings are in harmony with previous studies.[4,6,7,12]

In this study, no significant differences were observed in symptom dimensions between good and poor insight groups, suggesting that insight level does not meaningfully influence the type of OCD symptoms. Although contamination and cleaning symptoms were somewhat more frequent in the poor-insight group, and aggression, symmetry, and sexual/religious obsessions appeared more common in the good-insight group, none reached statistical significance. Cherian *et al.* (2012)[6] similarly reported higher rates of contamination fears and washing compulsions in poor-insight patients ($p < 0.001$) and more aggressive obsessions in those with good insight ($p < 0.001$). Jakubovski *et al.* (2011)[5], in a larger sample (n = 824), also found no significant correlation between insight and DY-BOCS dimension scores, except for a link between poor insight and hoarding. While several studies noted greater hoarding symptoms among poor-insight patients,[3,6,12,26] however, no participant in the present study exhibited hoarding features. Alonso *et al.* (2008)[4] observed more contamination and cleaning symptoms in good-insight patients, but no significant differences across other dimensions. Overall, the relationship between insight and OCD symptom dimensions still remains inconclusive.

In the current study, among the symptom dimensions, sexual and religious obsessions had the most substantial negative impact on functioning. A possible explanation for this could be that such obsessions- particularly those involving fears of blasphemy or inappropriate sexual thoughts- can cause intense distress. This may lead patients to avoid situations where they fear these thoughts might be triggered. Additionally, these obsessions are often accompanied by feelings of deep shame or guilt, making it difficult for individuals to seek help or engage in social interactions. Other symptoms, such as aggression-related obsessions, showed a moderate trend toward impairing functioning, although this was not statistically significant in the present study. This may be because aggressive thoughts often result in avoidant behaviors. In contrast, contamination, symmetry, and miscellaneous symptoms showed only minimal effects on functioning in this study. This suggests that individuals with these symptoms may still be able to maintain some level of social and occupational functioning, possibly because these symptom types may attract less societal stigma

Table 3: Comparison of clinical variables between groups

Clinical variable (in Years)	*Group*		*Independent t test*	
	OCD with Good Insight Mean (SD)	*OCD with Poor Insight Mean (SD)*	*t*	*p-value*
Age of onset	25.24 (8.619)	22.36 (7.480)	1.540	0.132
Duration of illness	7.15 (6.302)	7.64 (5.242)	-0.364	0.718
Duration of untreated illness	2.22 (1.877)	6.36 (4.124)	-6.782	0.000*
Duration of treatment	4.94 (5.560)	1.27 (1.804)	3.036	0.003*
Y-BOCS Total score (Range: 0-40)	26.72 (7.599)	30.09 (3.490)	-2.017	0.046*
Y-BOCS Obsession subscale score (Range: 0-20)	14.14 (3.702)	13.50 (2.198)	0.773	0.441
Y-BOCS Compulsion subscale score (Range: 0-20)	12.58 (4.232)	16.59 (1.764)	-4.331	0.000*

Table 4: Comparison of the presence of different symptom dimensions of DY-BOCS between groups

Symptom dimensions of DY-BOCS	*Group*		*Chi square/Fisher's Exact test*	
	OCD with Good Insight n (%)	*OCD with Poor Insight n (%)*	*X2*	*p value*
Contamination and cleaning	52 (66.7%)	19(86.4%)	3.233	0.109
Hoarding and collecting	0 (0%)	0(0%)	-	-
Symmetry and ordering	22 (28.2%)	3 (13.6%)	1.943	0.264
Aggression	25 (32.1%)	3 (13.6%)	2.886	0.111
Sexual and religious	19 (24.4%)	3 (13.6%)	1.248	0.388
Miscellaneous	6 (7.7%)	2 (9.1%)	0.044	1.000

Table 5: Correlation among the severity of symptom dimensions of DY-BOCS and Y-BOCS Item-11 (Insight) in patients of OCD

Symptom dimensions of DY-BOCS	Y-BOCS Item-11 (Insight)	
	Pearson Correlation Coefficient (r)	p-value
Contamination and cleaning	0.037	0.712
Hoarding and collecting	-	-
Symmetry and ordering	-0.143	0.157
Aggression	-0.078	0.440
Sexual and religious	-0.091	0.368
Miscellaneous	0.068	0.502

None: of the symptom dimensions demonstrated a statistically significant correlation with insight, as shown in Table 5.

or cause fewer direct disruptions in work-related activities. These findings are comparable to a study done by Rosa *et al.* (2012), who reported that sexual/religious and hoarding symptoms had the strongest negative effects on social functioning.[13]The study's cross-sectional design precludes causal inference between insight, symptom profile, and functioning. The modest sample size and absence of hoarding cases may limit generalizability. Self-reported avoidance behaviors and treatment adherence were not quantified, which might have clarified mediating pathways. Future longitudinal research with larger

Table 6: Correlation among symptom dimensions of DY-BOCS and functioning (SOFAS score) in patients with OCD

Symptom dimensions of DY-BOCS	*SOFAS score*	
	Pearson Correlation Coefficient (r)	*p-value*
Contamination and cleaning	-0.128	0.203
Hoarding and collecting	-	-
Symmetry and ordering	-0.060	0.552
Aggression	-0.183	0.068
Sexual and religious	-0.343	0.000*
Miscellaneous	-0.043	0.674

*Correlation is significant (at p-value ≤0.05)

and more diverse samples should examine neurocognitive and cultural moderators of insight and functioning in OCD.

Conclusion

In this study, poor insight was associated with higher symptom severity and compulsions, divorce/separation, longer duration of untreated illness and shorter duration of treatment. Level of insight is not significantly associated with either the presence or severity of specific symptom dimensions, reinforcing the inconclusive nature of the relationship between insight and OCD symptomatology. Notably, the study found that certain symptom dimensions, particularly sexual-religious obsessions, were significantly associated with poorer functioning. This underscores the functional burden imposed by specific types of obsessive-compulsive symptoms, independent of overall illness severity or level of insight. These findings highlight the importance of comprehensive symptom assessment in routine clinical practice to more effectively address functional outcomes in the management of OCD.

Ethical Considerations

Ethical approval for the study from the Institutional Ethical Committee (approval number: 187/MC/EC/2023) was obtained before the start of the study (on April 05, 2023). Participants were informed about the purpose of the study, and written informed consent was obtained from all participants prior to the study. The study was conducted in accordance with the ethical principles outlined in the World Medical Association's Declaration of Helsinki for research involving human participants.

Patient Consent

Written informed consent was taken from each participant in the study. They were assured of the complete confidentiality of their identity, information, and the option of withdrawing from the study at any point in time.

Acknowledgment

The author would like to thank the participants who volunteered for the study.

Author Approval Statement

All authors have read and approved the final manuscript. Each author meets the authorship criteria, and the manuscript represents honest and original work.

Conflict of Interest

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Sources of Funding

The authors received no financial support for the research, authorship, and publication of this article.

Data Availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Author's Contributions

Concept, design, literature search: Singh P, Kumar M; Data acquisition: Kumar M, Bawankar N, Kour H; Data analysis: Gupta S; Manuscript preparation: Kumar M, Bawankar N; Manuscript editing and manuscript review: Singh P; Guarantor: Kumar M

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