



Towards the DSM-6: The intersection of OCD and psychosis. Expert perspectives on insight in the diagnosis of OCD

Steffen Moritz^{a,*}, Stefan Leucht^{b,c}, Luca Hoyer^a, Stella Schmotz^a, Amitai Abramovitch^{d,1}, Lena Jelinek^{a,1}

^a Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf, Hamburg, Germany

^b Technische Universität München, TUM School of Medicine and Health, Department of Psychiatry and Psychotherapy, Klinikum rechts der Isar, Munich, Germany

^c German Center for Mental Health, partner site Munich-Augsburg, Munich, Germany

^d Department of Psychology, Texas State University, San Marcos, Texas, US

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ABSTRACT

In 1994, the DSM-IV added the specifier “with poor insight” to the diagnostic criteria of obsessive-compulsive disorder (OCD). The DSM-5 went one step further and now allows clinicians to diagnose OCD “with absent insight/delusional beliefs,” thereby blurring the long-standing distinction between OCD and psychosis. The present study surveyed OCD experts as to their opinions on the insight specifier and the future classification of OCD.

The final sample comprised 60 OCD experts, with a subgroup of 35 experts with verified identity and at least 6 years of clinical and/or research experience (“verified experts”).

While most experts supported the inclusion of the insight specifier for OCD, verified experts were split on the question of whether, in the case of full absence of insight, a diagnosis of OCD should be accompanied by an additional diagnosis (e.g., delusional disorder). A relative majority of the full sample (48.4 % yes vs. 36.7 % no) and an absolute majority of verified experts (51.4 % vs. 34.3 %) recommended removing the term “delusional beliefs” as a specifier; most were concerned that including delusional beliefs as a symptom of OCD might foster the prescription of antipsychotics and skepticism about the efficacy of psychotherapy for OCD. An absolute majority (56.7 % of full sample, 60.0 % of verified experts) agreed that at least some doubt or partial insight into the excessiveness of one’s obsessional beliefs should be present for a diagnosis of OCD. In addition, most experts opposed the reclassification of OCD as an anxiety disorder.

Looking ahead to the development of the DSM-6, we recommend that (1) the criteria should emphasize that full absence of insight is rare in OCD and that (2) the term “delusional beliefs” should be dropped.

1. Introduction

1.1. Classification of obsessive-compulsive disorder from the DSM-I to the DSM-5 and its association with insight

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), now in its fifth edition (American Psychiatric Association, 2013), was first published in 1952 to streamline and standardize psychiatric/psychological terminology (American Psychiatric Association, 1952).

Obsessive-compulsive disorder (OCD), then termed “obsessive compulsive reaction,” was already included in the DSM-I and has seen several changes across the different editions of the DSM. For example, hoarding was not explicitly mentioned in the context of OCD until the DSM-IV (American Psychiatric Association, 1994, p. 671); later it was recognized as a separate diagnostic entity (Hoarding Disorder)² in the DSM-5 (American Psychiatric Association, 2013). The focus of the present article is on the association of OCD with insight as level of insight is traditionally deemed of high relevance for the differential diagnosis of

* Correspondence author at: Department of Psychiatry and Psychotherapy, University Medical Center Hamburg-Eppendorf, Hamburg, Germany.

E-mail address: moritz@uke.de (S. Moritz).

¹ joint senior authors

² Of note, the DSM-5 clarifies that if hoarding arises from obsessions typical of OCD (e.g., not throwing away newspapers because they may contain information that could prevent harm), a diagnosis of OCD should be given instead.

OCD and psychosis/schizophrenia, outcome prognosis, and the treatment of OCD.

The DSM-I included “obsessive compulsive reaction” in the section “psychoneurotic disorders,” with anxiety as its key feature. The syndrome is described as marked “by unwanted ideas and (...) repetitive impulses,” with the individual being “compelled to carry out his rituals” (p. 33) even if they are acknowledged unreasonable by the patient. The DSM-II (American Psychiatric Association, 1968) renamed the syndrome “obsessive compulsive neurosis.” The criteria were essentially unchanged, although the central role of anxiety was somewhat de-emphasized. Insight was not further elaborated on other than the statement that obsessive ideas were often considered “nonsensical” (DSM-II; p. 40). The DSM-III (American Psychiatric Association, 1980) introduced the present syndromic label “obsessive compulsive disorder,” which it categorized as an anxiety disorder. Insight was briefly mentioned: “In Obsessive Compulsive Disorder, Hypochondriasis, and more rarely Phobic Disorder, in order to account for the symptoms, the individual may develop overvalued ideas that are difficult to distinguish from delusions. However, individuals with these disorders recognize, at least to some degree, that their symptoms and thinking are irrational, even if they are dominated by them” (p. 187). Criterion A stipulates that the obsessive ideas are experienced as “senseless or repugnant” (p. 235). A possible difference between children and adults, which we discuss below, was also mentioned: “The individual generally recognizes the senselessness of the behavior (this may not be true for young children)” (p. 235).

The section on OCD in the DSM-III-R (American Psychiatric Association, 1987) did not explicitly use the term “insight” when highlighting differences between OCD versus schizophrenia/delusional disorder but wrote: “However, the person with Obsessive Compulsive Disorder who has an overvalued idea can usually, after considerable discussion, acknowledge the possibility that his or her belief may be unfounded. In contrast, the person with a true delusion usually has a fixed conviction that cannot be shaken” (p. 246). Criterion A also required that the individual experience the obsessive ideas as “intrusive and senseless” (p. 247). In 1994, the DSM-IV (American Psychiatric Association, 1994) introduced the specifier “with poor insight,” which was defined as follows: “if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable” (p. 423). Yet, criterion B required at least some insight into the excessive or unreasonable nature of obsessions or compulsions at some point in the course of the disorder. The DSM-IV stated that OCD features may escalate into delusional beliefs, but in such cases an additional diagnosis was suggested (“If the obsessions develop into sustained delusional beliefs that represent a major part of the clinical picture, an additional diagnosis of Delusional Disorder may be appropriate,” p. 301).

The DSM-5 (American Psychiatric Association, 2013) moved OCD from the anxiety disorder to the newly formed Obsessive-Compulsive and Related Disorders section and extends the insight specifier to OCD cases “with absent insight/delusional beliefs.” The DSM-5 states: “Individuals with obsessive-compulsive disorder and body dysmorphic disorder may present with poor or absent insight, and the pre-occupations may reach delusional proportions” (p. 104). Of note, unlike the DSM-IV, the DSM-5 does not encourage an additional diagnosis: “For individuals whose obsessive-compulsive and related disorder symptoms warrant the ‘with absent insight/delusional beliefs’ specifier, these symptoms should not be diagnosed as a psychotic disorder” (p. 236). The DSM-5 places emphasis on the term “delusion” by using it multiple times in the OCD section. While delusions (i.e., fixed false convictions; see above) are clearly not pathognomonic of schizophrenia, they are one of its hallmark features (Moritz, Borgmann, et al., 2024; Moritz, Gawęda, et al., 2024). As the DSM-5 removed the DSM-IV’s criterion B (i.e., that the person has recognized the excessive or unreasonable nature of the symptoms at some point in the course of the disorder), OCD can be diagnosed in cases with absent insight, thus facilitating a diagnosis of

OCD in individuals who would formerly have received a diagnosis of psychosis/schizophrenia.

The primary impetus for conducting the present study was our concern that the de-emphasis on insight for a diagnosis of OCD may somewhat blur the traditional distinction between OCD and psychosis/schizophrenia (Chiang & Purdon, 2023; Oulis et al., 2013), the latter of which is sometimes called a “disorder of conviction” (Moritz, Ramdani, et al., 2014); DSM-5 regards delusions and hallucinations as the “defining features” (p. 58) of schizophrenia, so that any diagnosis is doubtful unless core ideas, especially about persecution or the origin of voices, are held with delusional conviction.

The blurring of diagnostic categories may have a deleterious impact on both treatment and diagnosis, with a possible shift towards diagnosing cases as OCD that previously would have been considered on the psychosis spectrum.

1.2. Empirical basis of an association between OCD and psychotic features and delusions

OCD (symptoms) and a diagnosis on the psychosis spectrum may co-occur. A meta-analysis (Swets et al., 2014) of 3978 participants with schizophrenia estimated the mean OCD prevalence in psychosis as 13.6 % (adjusted), whereas the prevalence rate of any obsession or compulsion was as high as 30.3 % (adjusted), with regional differences and higher prevalence with a longer history of schizophrenia. A more recent review estimated the prevalence rates of OCD in schizophrenia to range between 12 % and 25 % (Pardossi et al., 2024). Some experts have suspected etiological commonalities (Balachander et al., 2022; Ghanbarzahi et al., 2023; O’Connell et al., 2018; Vellucci et al., 2023; West et al., 2024), but several other factors may artificially inflate comorbidity rates. For example, it has long been known that OCD symptoms may manifest as a side effect of clozapine (Hudak & Rasmussen, 2022; Kim et al., 2020; Schirmbeck & Zink, 2012). High comorbidity with schizotypal personality disorder (SPD; Hudak & Rasmussen, 2022) may also be exaggerated due to overlapping symptoms/criteria. For example, magical thinking is common in both disorders, as well as sensory irritations (e.g., obsessive thoughts in OCD often contain sensory properties, Moritz, Claussen, et al., 2014; Röhlinger et al., 2015). Moreover, SPD symptoms such as social anxiety and odd behavior or appearance may simply be epiphenomena of OCD, reflecting avoidance of others due to fear of contamination and aggressive thoughts as well as safety behaviors (e.g., wearing gloves, performing rituals). Since Bleuler (for a discussion, see Hudak & Rasmussen, 2022), obsessive-compulsive symptoms have been put forward as risk factors for later psychosis, but the evidence is ambiguous according to, for example, the DSM-III: “Obsessions and compulsions sometimes occur transiently during the prodromal phase of Schizophrenia. In such cases the diagnosis of Obsessive Compulsive Disorder is not made” (DSM-III, p. 235). It is important to keep in mind, however, that other syndromes, especially depression, are also common precursors of psychotic symptoms (Staines et al., 2022; Uher et al., 2024), challenging the alleged specificity of such longitudinal associations. As we argue in greater detail in the discussion, delusions in OCD are rare and, unlike psychosis, are usually not of an interpersonal or persecutory nature. According to re-analyses of studies using the insight item of the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) by Korkmaz (2023), only 1.2 % of patients show lack of insight to a delusional degree (poor insight: 10.8 %). In data collected at a clinic specializing in OCD at NIMHANS Bangalore (India) between 1997 and 2019, 1.5 % of patients showed no insight/delusional symptoms (poor: 8.2 %) (personal communication by Janardhan Reddy, July 1, 2024). The first author of the present article pooled data from prior studies of his unit (e.g., Moritz et al., 2002) and found a rate of 0.2 % for absent insight and 5.1 % for poor insight in 417 cases. The only study we found with a more sizable subgroup of patients without insight (17 %) was by De Berardis et al. (2005). A study on children (Lewin et al., 2010) lends support to the notion in the DSM-III, mentioned above: the percentage of

absent insight was much higher in children than in adults, yet lack of insight still affected less than 10 % of patients (7 %; two thirds showed excellent (42 %) or good (24 %) insight). In summary, the prevalence of OCD in schizophrenia is elevated compared to the general population which may reflect genetic commonalities but also overlap in symptoms and is partly owing to medication effects and dysfunctional coping (e.g., compulsive rituals to ward off the influence of voices). In contrast, clear positive symptoms are rather rare in OCD, but they do exist

1.3. Study aims

In the present survey, we asked OCD experts for their views on the insight specifier in the DSM-5 criteria for OCD and whether they would recommend that the DSM-6 return to the criteria of the DSM-III-R and earlier editions, which had no specifier for insight, or the DSM-IV, in which cases with poor insight (but not absent insight/delusional beliefs) could be diagnosed as OCD.

2. Methods

2.1. Participants

From May 15, 2024, to June 6, 2024, we invited experts on OCD to take part in a survey. First, we emailed all editorial board members of the *Journal of Obsessive-Compulsive and Related Disorders*, the only scientific peer-reviewed journal that specializes in research on OCD and related disorders. We also advertised the study on the International OCD Research Listserv for experts on OCD and obsessive-compulsive related disorders, which has approximately 120 expert members from more than 18 countries. The listserv is moderated by one of the co-authors (AA). Further, we contacted OCD researchers who had actively published as first or senior authors in peer-reviewed journals on the disorder in the last 3 years (note that there was some overlap in the persons targeted by these various sources). The editor-in-chief of the *Journal of Anxiety Disorders*, Dr. Gordon Asmundson, also distributed the link to editorial board members.

As an incentive, each completer was offered free access to a 10h e-learning curriculum on body-focused repetitive behaviors (BFRBs; www.uke.de/e-bfrb-training). If participants already had access to this platform, we offered free access to an e-learning on metacognitive training for depression (www.uke.de/e-dmct) or psychosis (www.uke.de/e-mct).

A total of 185 individuals accessed the landing page of the survey (this number may, however, include multiple accesses by the same person); 65 experts completed at least one question on the core items of interest. Blind to the data, we discarded 5 individuals because they had less than 3 years of research or treatment experience for OCD ($n = 2$) or did not have an academic degree beyond a bachelor's degree ($n = 3$). Thus, the final sample encompassed 60 experts. We also formed a subsample of 35 “verified experts” who reported having at least 6 years of experience with research and/or treatment of OCD and whose identity is known because they provided their email address for verification (participants were sent a confirmation email for verification with the instruction to contact us if they had not entered the email address themselves). The study was approved by the local ethics committee of psychologists at the University Medical Center Hamburg (Germany; LPEK-0772).

2.2. Survey

This survey was created using Unipark®. The introductory paragraph of the survey informed participants that the survey was brief and directed only at mental health professionals with clinical and/or research experience with OCD. We then summarized whether and how the different editions of the DSM considered insight, noting that the DSM-III-R did not mention the term “insight” in the context of OCD, the DSM-IV introduced the specifier “with poor insight,” and, lastly, the

DSM-5 definition expanded the specifier to include cases “with absent insight/delusional beliefs.” We ended the introduction by expressing our hope that the experts’ opinions on the diagnostic importance of insight might impact the formulation of the diagnostic criteria for OCD in the DSM-6.

The survey first asked for demographic information (i.e., age, sex at birth, and racial/ethnic background (demographic items were optional). We proceeded with questions about the participant’s profession, highest academic degree, and clinical and research experience (see [Table 1](#)). We also asked whether the participant was a member of an organization related to obsessive-compulsive disorder or a member of an editorial board of a peer-reviewed journal on psychological disorders (optional response). We then posed the 12 questions shown in [Table 2](#) using a 5-point Likert scale (strongly disagree, somewhat disagree, neutral, somewhat agree, strongly agree) pertaining to the diagnostic criteria (especially related to insight) and classification of OCD.

3. Results

3.1. Background characteristics

Sample demographic characteristics are displayed in [Table 1](#). Of those who disclosed background information (82 %, $n = 49/60$), most were female and in their late 40s, with an average of 20 years of clinical and 19 years of research experience. Approximately two thirds identified as White. The majority were psychologists (60 %), and a minority were psychiatrists. Approximately 58 % held the title of professor, with full professors representing the largest subgroup (38.3 %).

3.2. Survey on insight

Results on the questionnaire pertaining to insight and classification are displayed in [Table 2](#) (also see the supplementary file). For our analyses, we contrast somewhat disagree/strongly disagree with somewhat agree/strongly agree. Results from the entire sample are displayed first, followed by the results from the subgroup of verified experts.

Experts had mixed opinions regarding the insight specifier introduced in the DSM-5. On the one hand, most regarded the inclusion of insight as a significant improvement (59.6 % vs. 8.8 %; 60.0 % vs. 8.6 %), and more individuals endorsed than opposed the DSM-5 option of rating insight from full insight to no insight/delusional beliefs (56.7 % vs. 30.0 %; 45.7 % vs. 31.4 %). While verified experts were split as to whether a diagnosis of OCD should be accompanied by an additional psychosis-spectrum diagnosis in cases with a complete lack of insight (e.

Table 1
Demographic information ($N = 60$).

Variable	Mean, with standard deviation or frequency
Sex at birth (female/male) (optional)	31/29 (51.7 %/48.3 %)
Age in years ($n = 49$)*	48.56 (11.29)
Years of clinical experience	20.17 (11.13)
Race and ethnicity* (White/Other) ($n = 38$)	25/13 (65.8 %, 34.2 %)
Years of research experience	18.65 (11.04)
Profession	
Psychologist	36 (60.0 %)
Psychiatrist	17 (28.3 %)
Other (e.g., neuroscientist)	7 (11.7 %)
Highest academic degree/rank	
Master's	2 (3.3 %)
M.D./Ph.D.	23 (38.4 %)
Assistant professor	5 (8.3 %)
Associate professor	7 (11.7 %)
Full professor	23 (38.3 %)

* To ensure full anonymity, participants were not required to disclose their age or ethnic background (such information may have given hints to the identity of the participant).

Table 2

Responses of participants from the full sample ($N = 60$) and from verified experts with at least 6 years of experience ($n = 35$, in brackets). See also the supplementary material.

Item	strongly disagree	somewhat disagree	neutral	somewhat agree	strongly agree
If a patient with OCD shows complete lack of insight into his/her OCD symptoms, a diagnosis of OCD should be accompanied by an additional diagnosis (e.g., delusional disorder, schizophrenia), as in the DSM-III-R and DSM-IV.	28.3 % (22.9 %)	23.3 % (22.9 %)	8.3 % (8.6 %)	33.3 % (37.1 %)	6.7 % (8.6 %)
It is reasonable to distinguish OCD from psychotic disorders and delusions by the level of insight. To diagnose OCD, at least some doubt or partial insight into the excessiveness of the worries/beliefs should be present.	20.0 % (11.4 %)	18.3 % (25.7 %)	5.0 % (2.9 %)	25.0 % (22.9 %)	31.7 % (37.1 %)
I endorse the DSM-5 criteria for OCD with the possibility of rating insight from full insight to no insight/delusional beliefs.	10.0 % (11.4 %)	20.0 % (20.0 %)	13.3 % (22.9 %)	21.7 % (20.0 %)	35.0 % (25.7 %)
I endorse the DSM-5 criteria for OCD with the possibility of rating insight from full insight to no insight/delusional beliefs but believe that the term “delusional beliefs” should be dropped.	16.7 % (8.6 %)	20.0 % (25.7 %)	15.0 % (14.3 %)	31.7 % (37.1 %)	16.7 % (14.3 %)
I endorse the DSM-5 criteria for OCD with the possibility of rating insight from full insight to absent insight/delusional beliefs but think that “with absent insight” and “delusional beliefs” should be two separate options (the current specifier combines the two: “with absent insight/delusional beliefs”).	16.7 % (8.6 %)	20.0 % (20.0 %)	13.3 % (8.6 %)	26.7 % (31.4 %)	23.3 % (31.4 %)
The possibility of including delusional beliefs as a symptom of OCD in the DSM-5 blurs the distinction between OCD and a delusional or psychotic disorder. This may foster the prescription of antipsychotics for OCD.	10.0 % (2.9 %)	15.0 % (11.4 %)	11.7 % (11.4 %)	43.3 % (48.6 %)	20.0 % (25.7 %)
The possibility of including delusional beliefs as a symptom of OCD in the DSM-5 blurs the distinction between OCD and a delusional or psychotic disorder. This may foster skepticism about the efficacy of psychotherapy for OCD.*	17.5 % (5.7 %)	15.8 % (14.3 %)	8.8 % (8.6 %)	35.1 % (40.0 %)	22.8 % (31.4 %)
OCD patients are primarily characterized by the content of their symptoms (e.g., contamination, checking, (auto)aggressive thoughts), making a distinction based on insight unnecessary. All specifiers related to insight should be dropped.*	47.4 % (37.1 %)	40.4 % (48.6 %)	5.3 % (5.7 %)	1.8 % (0.0 %)	5.3 % (8.6 %)
The inclusion of insight in OCD diagnosis in the DSM-5 is a significant improvement.*	3.5 % (5.7 %)	5.3 % (2.9 %)	31.6 % (31.4 %)	36.8 % (42.9 %)	22.8 % (17.1 %)
The possibility of diagnosing delusional beliefs as part of OCD in the DSM-5 closes an important diagnostic gap.*	15.8 % (20.0 %)	26.3 % (28.6 %)	24.6 % (28.6 %)	22.8 % (20.0 %)	10.5 % (2.9 %)
Individuals with OCD sometimes exaggerate their conviction regarding the reasonableness of their OCD symptoms (i.e., their lack of insight) to enable them to continue to engage in compulsive behavior. Such behavior is not delusional.*	10.5 % (2.9 %)	7.0 % (8.6 %)	14.0 % (17.1 %)	54.4 % (51.4 %)	14.0 % (20.0 %)
The OCD diagnosis should be subsumed in the DSM section “anxiety disorders.”*	33.3 % (34.3 %)	21.1 % (22.9 %)	10.5 % (8.6 %)	19.3 % (20.0 %)	15.8 % (14.3 %)

* Notes. $n = 57$; due to rounding, values may not add up to 100 %.

g., delusional disorder, schizophrenia), as is suggested in the DSM-III-R and DSM-IV (45.7 % vs. 45.8 %), the full sample opposed the idea of a return to the former criteria (40.0 % agree vs. 51.6 % disagree). Less than 10 % of experts supported the idea of dropping all specifiers related to insight (7.1 % vs. 87.8 %; 8.6 % vs. 85.7 %).

On the other hand, only a minority found that the delusional beliefs specifier in the DSM-5 closed an important diagnostic gap (33.3 % vs. 42.1 %; 22.9 % vs. 48.6 %). A relative majority (i.e., the largest subgroup but not exceeding 50 %) of the full sample (48.4 % vs. 36.7 %) and an absolute majority (i.e., more than 50 %; 51.4 % vs. 34.3 %) of the verified experts recommended dropping the term “delusional beliefs.” Somewhat more participants endorsed separating absent insight and delusional beliefs as two distinct options (50.0 % vs. 36.7 %; 62.8 % vs. 28.6 %). Of note, an absolute majority of the participants agreed that to diagnose OCD, at least some doubt or partial insight into the excessiveness of the worries/beliefs should be present (56.7 % vs. 38.3 %; 60.0 % vs. 37.1 %).

Most experts saw a risk in including delusional beliefs as a symptom of OCD as it could blur the distinction between OCD and a delusional or psychotic disorder, thus fostering the prescription of antipsychotics for OCD (63.3 % vs. 25.0 %; 74.3 % vs. 14.3 %) and skepticism about the efficacy of psychotherapy for OCD (57.9 % vs. 33.3 %; 71.4 % vs. 20.0 %).

We also asked about pseudo-delusions. According to most of the experts, individuals with OCD sometimes exaggerate their conviction regarding the reasonableness of their OCD symptoms as a pretext for continuing to engage in compulsive behavior, so this should not be regarded as delusional (68.4 % vs. 17.5 %; 71.4 % vs. 11.5 %). Most participants opposed the return of OCD to the DSM section on anxiety disorder (35.1 % vs. 54.4; 34.3 % vs. 57.2 %).

Finally, we correlated years of experience in research and treatment

and each of the survey items. While experience in research was not found to be significantly correlated with any individual item ($r < 0.2, p > .1$), treatment experience correlated negatively with the endorsement that “absent insight” and “delusional beliefs” should be two separate options ($r = -.307, p = .018$) and agreement for re-entering the OCD diagnosis into the DSM section anxiety disorders ($r = 0.306, p = .022$).

4. Discussion

Obsessive-compulsive disorder (OCD) and psychosis/schizophrenia are traditionally distinguished using lack of insight versus intact insight and the ego-dystonic nature versus ego-syntonic nature of the individual's beliefs and ideas. In short, OCD is regarded as a disorder of doubt and schizophrenia is regarded as a disorder of conviction (Moritz, Ramdani, et al., 2014). While this distinction may have heuristic value, it is not exhaustive. Perhaps most importantly, OCD symptoms are usually related to worrying about significant others or about being harmed by agents or diseases (e.g., bacteria) but not other persons. This is in stark contrast to psychosis, where the patient feels compromised or persecuted by others. There are also important exceptions related to insight. As mentioned above, many OCD patients show less than optimal insight (see introduction). In turn, while delusions are defined as “a false belief based on incorrect inference about external reality that is firmly held despite what almost everyone else believes” (DSM-5, p. 819), many patients with psychosis show partial insight or “double book keeping” (Bleuler, 1950) in that the door to reality is not fully closed and the delusional ideas are contemplated as possibilities among other interpretations (Lopez-Morinigo & David, 2024). Hence, psychosis scales such as the Psychosis Rating Scale (Haddock et al., 1999) usually rate the degree of conviction in a *delusional belief* on a continuum that can range from full insight to partial insight to delusional conviction.

Our results show that most of the OCD experts endorsed the shift of OCD from the category of anxiety disorders to the newly formed Obsessive-Compulsive and Related Disorders section in the DSM-5; interestingly, clinicians with more experience were more open to returning OCD to the anxiety disorder section. Experts also viewed the inclusion of insight as a significant improvement to the diagnostic algorithm. Relatedly, most experts were against dropping all specifiers related to insight from the DSM-6. At the same time, most reported that to diagnose OCD, at least some doubt about or partial insight into the idea that the worries/beliefs are at least excessive should be present (56.7 % vs. 38.3 %; 60.0 % vs. 37.1 %), which is more in line with the position held by the DSM-IV than that of the DSM-5. The “delusional beliefs” aspect of the specifier, in particular, raised concerns, and a relative majority in the case of the full sample (48.4 % vs. 36.7 %) and an absolute majority (51.4 % vs. 34.3 %) in the case of the verified experts supported the deletion of the term “delusional beliefs.” The inclusion of this term, which suggests a link between OCD and the psychosis spectrum, raised concerns among the experts surveyed. Their primary concern was that this could lead to increased prescription of antipsychotic medications for OCD and potentially increase skepticism about the effectiveness of psychotherapy for OCD. Interestingly, more than two thirds of the experts thought that individuals with OCD sometimes exaggerate their conviction regarding the reasonableness of their OCD symptoms in order to continue their compulsive behavior, which should not be regarded as delusional.

4.1. Delusional beliefs—an imprecise term

The DSM-5's OCD specifier “absent insight/delusional beliefs” gives the impression that these two aspects are largely overlapping or have essentially the same meaning. However, the term *delusional* is ambiguous as it is commonly understood as a delusion-like idea, which can also cover non-delusional ideas such as intrusive thoughts and beliefs held with little conviction where insight is retained or is at least partially present (for a discussion, see [Moritz et al., 2024](#)). Perhaps more importantly, in clinical jargon, ‘delusions’ are often equated with paranoia/persecutory delusions, and even many schizophrenia researchers speak of delusions when in fact they are referring specifically to paranoid delusions ([Dudley et al., 2016](#); [Freeman, 2011](#); [Ward & Garety, 2019](#)). The difference is important since persecutory delusions refer to convictions regarding a malevolent person or institution that is inflicting harm *purposefully*. This is not the case in OCD, where patients usually do not attribute events to the bad intentions of others but instead blame bad luck/unfortunate circumstances (e.g., catching a life-threatening infection). According to our results, OCD experts are concerned that the DSM-5 specifier may increase psychiatrists’ willingness to prescribe antipsychotic (neuroleptic) medications for OCD. Although these medications are effective in treating positive symptoms and delusions in schizophrenia, they have many side effects and their efficacy is far less established in OCD. The guidelines of the National Institute for Health and Care Excellence (NICE), for example, recommend that antipsychotics as a monotherapy should not normally be used for treating OCD and should only be used, among other options such as additional cognitive behavioral therapy, when standard treatment fails (section 1.5.4.7). The consensus guidelines of the European College of Neuropsychopharmacology (ECNP) also stipulate in the abstract that antipsychotic medications should be confined to treatment-refractory cases and that even for OCD with poor insight/with “psychotic features,” the “treatment of choice should be medium to high dose of SSRI” ([Goodwin et al., 2009](#), p. 520). Yet, later these guidelines say that the combination of antipsychotic medications with SSRIs might be considered in those with poor insight, although “it has not been thoroughly examined for OCD with poor insight” (p. 528). While one study estimated that one in two OCD patients benefited from antipsychotics ([Conti et al., 2024](#)), a more recent review found efficacy in only one in three patients ([Thamby & Jaisooriya, 2019](#)). Indeed, a recent Cochrane review ([Komossa et al.,](#)

[2010](#)) found no effect of olanzapine augmentation on OCD and only some (not fully conclusive) evidence that adding quetiapine or risperidone to antidepressants increases efficacy. This approach, however, must be weighed against adverse effects.

4.2. Recommendations for the DSM-6

The results of this expert survey can be distilled into several recommendations for the DSM-6.

1. The insight specifier should be retained, covering full to absent insight. We recommend four additions:

- 1a. The term insight should be more clearly defined as insight pertaining to the pathology of the symptoms.
- 1b. The term delusional beliefs should be dropped as it is imprecise.
- 1c. The text should emphasize that OCD without insight is a rare condition.
- 1d. Clinicians should be advised to explore whether poor insight reflects strategic motivation (lack of insight as a pretext for continuing with compulsive behaviors) rather than a primary lack of insight.

2. OCD should be retained in its own section and should not be located in the anxiety disorders section, as it was in the DSM-IV.

For future research, we may also need to learn more about the course over time of various aspects of insight in light of findings showing considerable fluctuation in insight even across short periods of time ([Landmann et al., 2019](#)). The different dimensions of insight also deserve more research as some patients may acknowledge that their symptoms need treatment but reject the diagnosis or certain forms of therapy. Or, they may have insight into their compulsions as pathological responses to their obsessive thoughts but lack insight regarding the excessiveness of these thoughts.

Ethical standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

CRediT authorship contribution statement

Steffen Moritz: Writing – review & editing, Validation, Supervision, Project administration, Methodology, Investigation, Formal analysis, Conceptualization. **Stefan Leucht:** Writing – review & editing, Writing – original draft, Conceptualization. **Luca Hoyer:** Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Conceptualization. **Stella Schmotz:** Writing – review & editing, Methodology, Investigation, Conceptualization. **Amitai Abramovitch:** Writing – review & editing, Writing – original draft, Formal analysis, Conceptualization. **Lena Jelinek:** Writing – review & editing, Writing – original draft, Methodology, Investigation, Conceptualization.

Declaration of competing interest

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References

- American Psychiatric Association, 1952. *Diagnostic and Statistical Manual of Mental Disorders*. First Edition (DSM-I) American Psychiatric Association.
- American Psychiatric Association. (1968). *Diagnostic and Statistical Manual of Mental Disorders*. Second Edition (DSM-II). American Psychiatric Association.
- American Psychiatric Association, 1980. *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition. DSM-III. American Psychiatric Association.
- American Psychiatric Association, 1987. *Diagnostic and Statistical Manual of Mental Disorders*. Third Revised Edition (DSM-III-R). American Psychiatric Association.
- American Psychiatric Association, 1994. *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition (DSM-IV). American Psychiatric Association.
- American Psychiatric Association, 2013. *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5). American Psychiatric Publishing.
- Balachander, S., Thatikonda, N.S., Kannampuzha, A.J., Bhattacharya, M., Sheth, S., Ramesh, V., Chandy Alexander, A., Muthukumar, M., Joseph, M.S., Selvaraj, S., Ithal, D., Sreeraj, V.S., John, J.P., Venkatasubramanian, G., Viswanath, B., Reddy, Y. C.J., Jain, S., 2022. Familial risk of psychosis in obsessive-compulsive disorder: Impact on clinical characteristics, comorbidity and treatment response. *J. Psych. Res* 156, 557–563. <https://doi.org/10.1016/j.jpsychires.2022.10.001>.
- Bleuler, E. (1950). *Dementia Praecox Or the Group of Schizophrenias*. Published in 1911. G. Aschaffenburg, Ed.. Deuticke.
- Chiang, B., Purdon, C., 2023. A study of doubt in obsessive-compulsive disorder. *J. Beh. Ther. Exp. Psych* 80, 101753. <https://doi.org/10.1016/j.jbtep.2022.101753>.
- Conti, D., Gironè, N., Boscacci, M., Casati, L., Cassina, N., Cerolini, L., Giacobelli, L., Viganò, C., Conde, M.M., Cremaschi, L., Dell'Osso, B.M., 2024. The use of antipsychotics in obsessive compulsive disorder. *Human Psychopharmacol: Clin. Exp* 39 (3), e2893. <https://doi.org/10.1002/hup.2893>.
- De Berardis, D., Campanella, D., Gambi, F., Sepede, G., Salini, G., Carano, A., La Rovere, R., Pelusi, L., Penna, L., Cicconetti, A., Cotellessa, C., Salerno, R.M., Ferro, F. M., 2005. Insight and alexithymia in adult outpatients with obsessive-compulsive disorder. *Eur. Arch. Psych. Clin. Neurosci.* 255 (5), 350–358. <https://doi.org/10.1007/s00406-005-0573-y>.
- Dudley, R., Taylor, P., Wickham, S., Hutton, P., 2016. Psychosis, delusions and the “jumping to conclusions” reasoning bias: a systematic review and meta-analysis. *Schizophrenia Bull.* 42 (3), 652–665. <https://doi.org/10.1093/schbul/sbv150>.
- Freeman, D., 2011. Improving cognitive treatments for delusions. *Schizophrenia Res* 132 (2–3), 135–139. <https://doi.org/10.1016/j.schres.2011.08.012>.
- Ghanbarzahi, A., Seprehnezhad, A., Hashemi, N., Karimi, M., Shahbazi, A., 2023. Disclosing common biological signatures and predicting new therapeutic targets in schizophrenia and obsessive-compulsive disorder by integrated bioinformatics analysis. *BMC Psych* 23, 40. <https://doi.org/10.1186/s12888-023-04543-z>.
- Goodwin, G., Fleischhacker, W., Arango, C., Baumann, P., Davidson, M., de Hert, M., Falkai, P., Kapur, S., Leucht, S., Licht, R., Naber, D., O'Keane, V., Papakostas, G., Vieta, E., Zohar, J., 2009. Advantages and disadvantages of combination treatment with antipsychotics. *Eur. Neuropsychopharmacol* 19 (7), 520–532. <https://doi.org/10.1016/j.euroneuro.2009.04.003>.
- Haddock, G., McCarron, J., Tarrier, N., Faragher, E.B., 1999. Scales to measure dimensions of hallucinations and delusions: the psychotic symptom rating scales (PSYRATS). *Psychol. Med* 29 (4), 879–889. <https://doi.org/10.1017/S0033291799008661>.
- Hudak, R., Rasmussen, A., 2022. Obsessive-compulsive disorder and schizophrenia: conceptualization, assessment and cognitive behavioral treatment. *J. Cognit. Psychother* 36 (3), 247–267. <https://doi.org/10.1891/JCP-2021-0008>.
- Kim, D.D., Barr, A.M., Lu, C., Stewart, S.E., White, R.F., Honer, W.G., Procyshyn, R.M., 2020. Clozapine-associated obsessive-compulsive symptoms and their management: a systematic review and analysis of 107 reported cases. *Psychother. Psychosom* 89 (3), 151–160. <https://doi.org/10.1159/000505876>.
- Komossa, K., Depping, A.M., Meyer, M., Kissling, W., Leucht, S., 2010. Second-generation antipsychotics for obsessive compulsive disorder. *Cochrane Datab. System. Rev* 12, CD008141. <https://doi.org/10.1002/14651858.CD008141.pub2>.
- Korkmaz, U., Şahin, A.R., Böke, Ö., Sarısoy, G., Karabekiroğlu, A., Özdin, S., Güz, H.Ö., 2023. Psychotic-like experiences in obsessive compulsive disorder. *Eur. J. Psych.* 37 (4), 100215. <https://doi.org/10.1016/j.ejpsy.2023.06.001>.
- Landmann, S., Cludius, B., Tuschen-caffer, B., Moritz, S., Külz, A.K., 2019. Mindfulness predicts insight in obsessive-compulsive disorder over and above OC symptoms: an experience-sampling study. *Behav. Res. Ther* 121, 103449. <https://doi.org/10.1016/j.brat.2019.103449>.
- Lewin, A.B., Bergman, R.L., Peris, T.S., Chang, S., McCracken, J.T., Piacentini, J., 2010. Correlates of insight among youth with obsessive-compulsive disorder. *J. Child Psychol. Psychiatry* 51 (5), 603–611. <https://doi.org/10.1111/j.1469-7610.2009.02181.x>.
- Lopez-Morinigo, J.-D., David, A., 2024. Is too much insight bad for you? *Br. J. Psych.*
- Moritz, S., Borgmann, L., Heinz, A., Fuchs, T., Gallinat, J., 2024a. Towards the DSM-6: Results of a survey of experts on the reintroduction of first-rank symptoms as core criteria of schizophrenia and on redefining hallucinations. *Schizophrenia Bull* 50 (5), 1050–1054. <https://doi.org/10.1093/schbul/sbae061>.
- Moritz, S., Claussen, M., Hauschildt, M., Kellner, M., 2014a. Perceptual properties of obsessive thoughts are associated with low insight in obsessive-compulsive disorder. *J. Nerv. Mental Dis* 202 (7), 562–565. <https://doi.org/10.1097/NMD.000000000000156>.
- Moritz, S., Gawęda, Ł., Carpenter, W.T., Aleksandrowicz, A., Borgmann, L., Gallinat, J., Fuchs, T., 2024b. What Kurt Schneider really said and what the DSM has made of it in its different editions: a plea to redefine hallucinations in Schizophrenia. *Schizophrenia Bull* 50 (1), 22–31. <https://doi.org/10.1093/schbul/sbad131>.
- Moritz, S., Meier, B., Kloss, M., Jacobsen, D., Wein, C., Fricke, S., Hand, I., 2002. Dimensional structure of the Yale-Brown obsessive-compulsive scale (Y-BOCS). *Psych. Res* 109 (2), 193–199. [https://doi.org/10.1016/S0165-1781\(02\)00012-4](https://doi.org/10.1016/S0165-1781(02)00012-4).
- Moritz, S., Ramdani, N., Klass, H., Andreou, C., Jungclaussen, D., Eifler, S., Englisch, S., Schirmbeck, F., Zink, M., 2014b. Overconfidence in incorrect perceptual judgments in patients with schizophrenia. *Schizophrenia Res: Cognit* 1 (4). <https://doi.org/10.1016/j.scog.2014.09.003>.
- O'Connell, K.S., McGregor, N.W., Lochner, C., Emsley, R., Warnick, L., 2018. The genetic architecture of schizophrenia, bipolar disorder, obsessive-compulsive disorder and autism spectrum disorder. *Mol. Cell. Neurosci* 88, 300–307. <https://doi.org/10.1016/j.mcn.2018.02.010>.
- Oulis, P., Konstantakopoulos, G., Lykouras, L., Michalopoulou, P.G., 2013. Differential diagnosis of obsessive-compulsive symptoms from delusions in schizophrenia: a phenomenological approach. *World J. Psych* 3 (3), 50–56. <https://doi.org/10.5498/wjpv.v3.i3.50>.
- Pardossi, S., Cuomo, A., Fagiolini, A., 2024. Unraveling the boundaries, overlaps, and connections between schizophrenia and obsessive-compulsive disorder (OCD). *J. Clin. Med* 13 (16), 4739. <https://doi.org/10.3390/jcm13164739>.
- Röhliger, J., Wulf, F., Fieker, M., Moritz, S., 2015. Sensory properties of obsessive thoughts in OCD and the relationship to psychopathology. *Psych. Res* 230 (2), 592–596. <https://doi.org/10.1016/j.psychres.2015.10.009>.
- Schirmbeck, F., Zink, M., 2012. Clozapine-induced obsessive-compulsive symptoms in schizophrenia: a critical review. *Current Neuropharmacol* 10 (1), 88–95. <https://doi.org/10.2174/157015912799362724>.
- Staines, L., Healy, C., Coughlan, H., Clarke, M., Kelleher, I., Cotter, D., Cannon, M., 2022. Psychotic experiences in the general population, a review, definition, risk factors, outcomes and interventions. *Psychol. Med* 52 (15), 3297–3308. <https://doi.org/10.1017/S0033291722002550>.
- Swets, M., Dekker, J., van Emmerik-van Oortmerssen, K., Smid, G.E., Smit, F., de Haan, L., Schoevers, R.A., 2014. The obsessive compulsive spectrum in schizophrenia, a meta-analysis and meta-regression exploring prevalence rates. *Schizophrenia Res* 152 (2–3), 458–468. <https://doi.org/10.1016/j.schres.2013.10.033>.
- Thamby, A., Jaisooray, T., 2019. Antipsychotic augmentation in the treatment of obsessive-compulsive disorder. *Indian J. Psych* 61 (7), 51. <https://doi.org/10.4103/psychiatry.IndianJPsychiatry.519.18>.
- Uher, R., Pavlova, B., Najafi, S., Adepalli, N., Ross, B., Howes Vallis, E., Freeman, K., Parker, R., Propper, L., Palaniyappan, L., 2024. Antecedents of major depressive, bipolar, and psychotic disorders: a systematic review and meta-analysis of prospective studies. *Neurosci. Biobehav. Rev* 160, 105625. <https://doi.org/10.1016/j.neubiorev.2024.105625>.
- Vellucci, L., Ciccarelli, M., Buonaguro, E.F., Fornaro, M., Durso, G., De Simone, G., Iasevoli, F., Barone, A., De Bartolomeis, A., 2023. The neurobiological underpinnings of obsessive-compulsive symptoms in psychosis, translational issues for treatment-resistant schizophrenia. *Biomolecules* 13 (8), 1220. <https://doi.org/10.3390/biom13081220>.
- Ward, T., Garety, P.A., 2019. Fast and slow thinking in distressing delusions: a review of the literature and implications for targeted therapy. *Schizophrenia Res* 203, 80–87. <https://doi.org/10.1016/j.schres.2017.08.045>.
- West, M.L., Green, J., Barber, M.E., Sharif, S., Lisowski, V., Friedman-Yakoobian, M., 2024. Overlap of obsessive compulsive and psychosis risk symptoms in a specialized clinic. *Early Interven. Psych* 1–10. <https://doi.org/10.1111/eip.13596>.