Acceptance of being guilty in the treatment of obsessive-compulsive disorder

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Abstract

Results of different studies support the notion that obsessive activity is aimed at preventing misdeeds in the symptomatic domain and that OC patients judge the possibility of being guilty as unacceptable. These findings lead to the hypothesis that increasing acceptability of being guilty, even in non-symptomatic domains, reduces OC symptoms. This paper reports the outcomes of 4 patients with obsessive-compulsive disorder who were treated in a multiple-baseline across subjects design. The intervention was centred on acceptance of guilt in non-symptomatic domains. The dependent variable is the score recorded by the patients daily on a report that showed time occupied by obsessive activity and degree of interference with daily activities. Furthermore, each patient was administered the Y-BOCS, CORE-OM and QSC at the beginning and after twenty therapy sessions.
Results confirmed that intervention centred on accepting guilt in non-symptomatic domains is able to produce a significant reduction of OC symptoms.

Keywords: *Obsessive-compulsive disorder, Treatment of obsessive-compulsive disorder, Sensitivity to guilt, Acceptance of guilt, Self-forgiveness.*

Riassunto

L'accettazione del senso di colpa nel trattamento del disturbo ossessivo-compulsivo

Diverse ricerche supportano la tesi che l'attività ossessiva sia finalizzata a prevenire possibili colpe nel dominio sintomatico e che l'eventualità di essere colpevoli sia giudicata inaccettabile da tali pazienti. Da questa tesi deriva l'ipotesi che un trattamento finalizzato all'aumento della capacità di accettare la possibilità di essere colpevoli, anche in domini non sintomatici, dovrebbe tradursi in una sostanziale riduzione della sintomatologia ossessivo-compulsiva.
Il presente lavoro riporta gli esiti registrati in quattro pazienti con disturbo ossessivo-compulsivo, trattati seguendo un disegno a baseline multipla tra i soggetti. L'intervento è stato incentrato sull'accettazione delle colpe in domini non sintomatici. La variabile dipendente è il punteggio registrato dai pazienti quotidianamente su una scheda che rilevava il tempo occupato dall'attività ossessiva e il grado d'interferenza con le attività giornaliere. A ciascun paziente, inoltre, sono stati somministrati, a inizio e fine trattamento, la Y-BOCS, il CORE-OM e il QSC.

I risultati ottenuti hanno confermato l'ipotesi, dimostrando che un intervento incentrato sull'accettazione della colpa in domini non sintomatici è in grado di produrre una significativa riduzione dell'attività ossessiva.

Parole chiave: *Disturbo ossessivo-compulsivo, Trattamento del disturbo ossessivo-compulsivo, Sensibilità alla colpa, Accettazione della colpa, Perdono di sé.*

INTRODUCTION

The aim of this study was to attempt to answer the question: does greater tolerance of guilt in the non-symptomatic domain lead to fewer obsessions and compulsions? This question arises from a well-known background.

Research suggests that obsessive activity is aimed at preventing, reducing or neutralising the possibility of being guilty (see Shapiro and Stewart's review, 2011). Feelings of guilt seem to play a role in generating and maintaining checking symptoms as well as washing, order and symmetry symptoms. In fact, research in general psychology has demonstrated that guilt feelings make non-clinical people more sensitive to contamination (Zhong & Lilijenquist, 2007) and Not Just Right Experience (Mancini et al., 2008), which are considered, respectively, to be at the base of washing (Rachman, 2004), order and symmetry symptoms (Coles et al., 2003; 2005).

Other studies suggest that obsessive-compulsive (OC) patients are more sensitive to feelings of guilt and responsibility than other people, regardless of the domain (see Shapiro and Stewart review, 2011).

Self-structures in the aetiology and maintenance of OCD have also been investigated (Doron et al., 2008), for instance self-sensitivity (Harter, 1982). Doron, Moulding, Kyrios and Nedeljkovic (2008) investigated whether self-sensitivity is related to OCD symptoms and cognitions in individuals with OCD, and whether such self-sensitivity is specific to OCD versus other anxiety disorders. They classified individuals as «sensitive» if they reported «a domain as important for self definition but they did not consider themselves competent within that domain». These authors showed that sensitivity in moral domains, but not job competence or social acceptability, was associated with higher levels of OCD symptoms and OCD-related beliefs in OCD patients. Furthermore, individuals with other anxiety disorders did not show such sensitivity, suggesting some specificity of relationships to OCD.

OC patients consider the possibility of being guilty very serious: «Obsessionals regarded the possibility of causing harm as likely to result in other people making extreme negative and critical judgments of them… Thinking that others would loathe or despise them; the other groups expected the responses of others towards them to be more lenient» (Entholt, Salkovskis & Rimes, 1999).

Mancini, Gangemi, Perdighe and Serrani (2007) found that obsessive patients, compared with patients who had other anxiety disturbances, evaluated the facial expressions

of anger, contempt and disgust they imagined were aimed at them as more severe than expressions of fear, sadness and joy, and felt they would more likely find themselves faced with anger, contempt and disgust expressions if their obsessive fears manifested. Furthermore, they remembered being the target of these expressions during childhood more than controls.

It is not rare for OC patients to remember harsh and scornful reproaches and the interruption of affective bonds as punishment without explicit forgiveness during childhood (Mariaskin, 2010; Pace, Thwaites & Freeston, 2011; Shapiro & Stewart, 2011).

Finally, different neuroimaging studies have revealed that the cerebral areas activated simultaneously with obsessive symptoms (i.e. the insulae, orbitofrontal cortex, and anterior cingulated cortex) are also the areas that seem to be involved in the elaboration of the emotion of guilt (Mataix-Cols, Conceição do Rosario-Campos & Leckman, 2004; Schienle et al., 2005; Nakao et al., 2005).

Taken together these data suggest two related conclusions. First, OC activity is aimed at preventing or neutralizing the possibility of being guilty in the symptomatic domain. Second, the possibility of being guilty is regarded as serious, likely, looming, and more importantly, as unacceptable and unforgivable. In other words, fear of guilt in the symptomatic domain derives from a more general, pervasive, and serious fear of being irremediably guilty. The experience of guilt is not evaluated as an experience that can be overcome, even if painful, but as definitively compromising one's dignity as a moral individual.

The following hypothesis derives from these conclusions: if patients change and consider the possibility of being guilty as negative, but acceptable, then OC symptoms should decrease. In other words, acceptance of being guilty, even in non-symptomatic domains, should be followed by a decrease in symptoms.

This hypothesis oriented the treatment of two obsessive patients (Cosentino & Mancini, 2012; Perdighe & Mancini, in press). In both cases, therapy was aimed at increasing patients' acceptance of the possibility of being guilty in the symptomatic and other domains and therapy did not intervene directly on obsessive symptoms. Furthermore, in both cases significant improvement was obtained and remained stable also at the one-year follow-up.

With respect to the hypothesis of this research, one limit of the procedure used in these two cases was that the patients were helped to accept feelings of guilt also regarding the symptomatic domain. Thus, we cannot exclude that direct intervention on the symptom occurred. By contrast, our current hypothesis is that the increase in the ability to accept being guilty, in non-symptomatic domains, leads to a decrease in symptoms.

METHOD

Participants

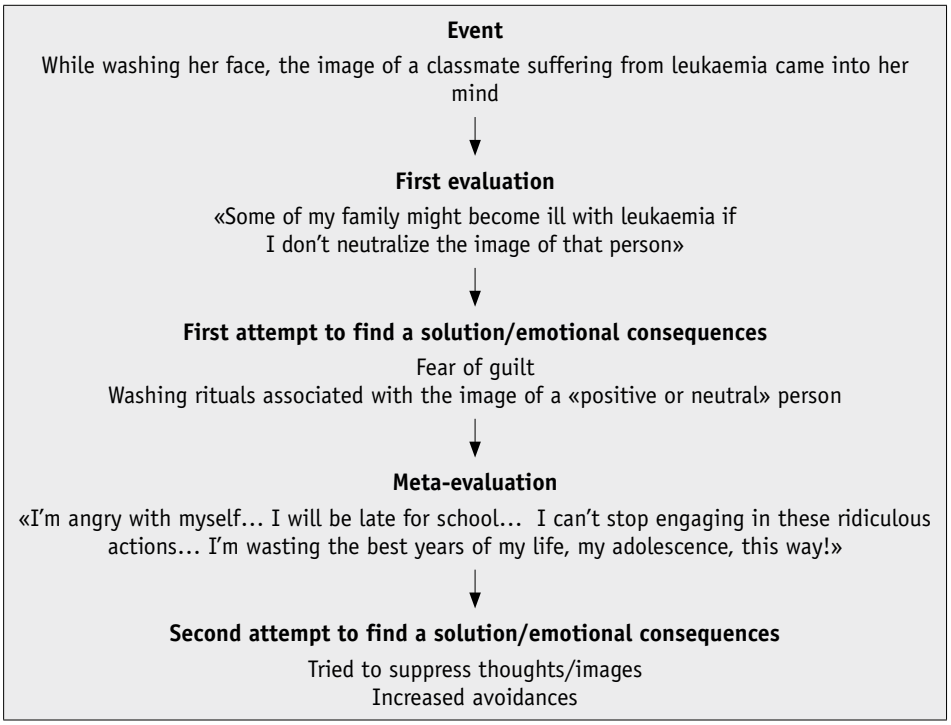
Participants were four patients treated at the Unit for treatment of anxiety and mood disorders of the School of Cognitive Psychotherapy (SPC) in Rome. They were affected

by an obsessive disorder that was diagnosed by an expert clinician according to the DSM-IV (American Psychiatric Association, 2002) and using the *Structured Clinical Interview for DSM* (SCID I). The first four patients who were diagnosed with OCD, agreed to participate and gave their written informed consent, were enrolled in the study. Participants were excluded if they had a history of psychotic disorders, bipolar disorder, or evidence of substance abuse within the past month.

All patients had previously received CBT and drug therapy without satisfactory results. None of them started drug therapy in the six months prior to beginning our treatment or during it. For all patients, interference of OC with daily life was considerable. None of them had a family history of OCD.

Case 1

The patient was a 17-year-old girl who was a student and lived with her family. OCD appeared when she was 12 years old. She was obsessed with the possibility that the mental image of a person who was the victim of misfortune or failure could damage her or her family. Neutralizing compulsions included washing and attempts to suppress the dangerous image. She had suffered from panic attacks. Following is an outline of the internal profile of her disorder (Mancini, 2005; Mancini & Perdighe, 2010):



Case 2

The patient was a 28-year-old man who was close to obtaining his university degree. Washer and checker-type symptoms had appeared about ten years before. At the beginning of therapy, he was obsessed by the fear that he might be homosexual and compulsively checked his sexual preferences. The internal profile of his OCD can be summarized as following:

Event

Photo of a man in boxer shorts in a magazine

↓

First evaluation

«Why do I linger over this image? It means that I like it... I could be homosexual... something immoral and disgusting that would damage me and my family»

↓

First attempt to find a solution/emotional consequences

Feeling disgust/Fear of guilt
Looked at pictures of naked men on the Internet/in magazines to experience feelings of disgust
Remembered episodes of sexual relations with women to try to re-experience the same feelings
Avoidances

↓

Meta-evaluation

«I spend my afternoons doing these stupid tests... I'm ruining my life... I feel stupid»

↓

Second attempt to find a solution/emotional consequences

Guilt feelings/Depression
Increased avoidances: he stopped going to the gym to avoid seeing naked bodies of other men

Case 3

The patient was a 22-year-old woman and only child who was a student and was living with her parents. Subclinical obsessive symptoms were present from the age of three. At elementary school, she worried too much about her grades. She was always isolated from her peers. OC had begun ten years before and was centred on religious topics. She was obsessed about moral contamination, and presented washing rituals, compulsive prayer, and avoidances. Her OCD internal profile:

Event

Entering into contact with persons, objects, words and images

↓

First evaluation

«They could be immoral and I could be contaminated by evil, become a sinner, deserving hell»

↓

First attempt to find a solution/emotional consequences

Feeling dirty
Purification rituals: prayer and washing; avoidances

↓

Meta-evaluation

«It's not rational; I'm strange… I can't stand it any more: I'm ruining my life and my parents' life»

↓

Second attempt to find a solution/emotional consequences

Guilt feelings; Depression
Avoidances so as not to have to perform even more rituals

Case 4

The patient was a 38-year-old man who was living with his parents. From 10 to 12 years of age he experienced obsessive doubts and ruminated about the existence of God and moral topics. In adolescence and young adulthood, he suffered from social phobias. Starting at age 27, he suffered panic attacks for two years. Five criteria of schizotypal personality disorder were satisfied (odd beliefs or magical thinking, odd thinking and speech, suspiciousness or paranoid ideation, lack of close friends or confidants other than first degree relatives, excessive social anxiety). From the age of eight he had been obsessed by doubts with disparate contents he defined as useless but, nonetheless, tried to resolve. A year before, his symptoms worsened following his mother's emergency hospitalization. He was unable to go to the hospital «because of symptoms». He felt very guilty:

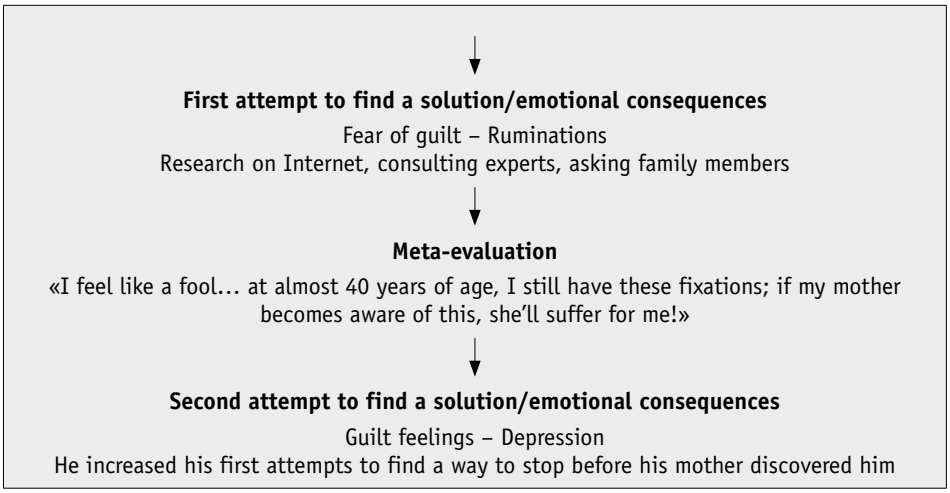
Event

«Why do all metals turn grey when they are rubbed?»

↓

First evaluation

«I have to remove all doubt or I continue to think about it all day. I would function badly at work and with others, ruin my life and it would be my fault»



Dependent variables

Each patient compiled a self-monitoring report daily that consisted of five items: time occupied by obsessive thoughts; their degree of interference with daily activities; time occupied by compulsions; their degree of interference with daily activities; control over compulsive behaviours. Each item was scored on a 5-point Likert scale. At the beginning and after 20 treatment sessions, each patient was administered a test battery that included:

– The Y-BOCS, *Yale-Brown Obsessive-Compulsive Scale* (Goodman et al., 1989) to assess severity of OCD symptoms. The Y-BOCS is a semi-structured interview that contains a symptom checklist and a severity scale. The symptom checklist includes a list of 40 obsessions and 29 compulsions each categorized according to content. The severity scale of the Y-BOCS contains 10 items: five for obsessions and five for compulsions. Goodman et al. (1989) have reported satisfactory reliability and validity of the Y-BOCS.
– The QSC, *Sensitivity to Guilt Feelings Questionnaire* (Perdighe et al., unpublished manuscript). It evaluates subjective sensitivity to guilt feelings by investigating: the tendency to avoid this feeling, its influence on the patient's life, and his capacity to tolerate it. The scale consists of 9 items; the response to each item is measured on a 7-point Likert scale ranging from 1 (never true) to 7 (always true). Examples of items include «I am not worried about being guilty or deserving admonition»; «It is painful to deserve being judged guilty by someone else». Adequate internal reliability (Spearman-Brown Split Half Coefficient = 0.80) and construct validity (examined with a contrasted groups approach, $t = -10.077$, $p < .01$; Cohen's $d = 0.7$) were found.
– CORE-OM, *Clinical Outcomes in Routine Evaluation-Outcome Measure* (Barkham et al., 1998; Evans et al., 2000). This questionnaire consists of 34 items that refer to four domains: subjective wellbeing, symptoms/problems, functioning (with reference to meaningful relationships and general and social functioning), risk, referring to self

and other injurious behaviours. Each item is measured on a 5-point Likert scale, ranging from 0 (not at all) to 4 (always); the interview the week before served as reference for the evaluation.

The Italian version of the CORE-OM showed good acceptability, internal consistency and convergent validity (Palmieri et al., 2009).

Therapists

Four therapists (TC, CP, GR and AS) participated to the study. They had CBT training and ten years of experience treating obsessive patients.

Experimental design

A multiple-baseline across subjects design was adopted; treatment was introduced 10-20 days later.

Treatment

Patients started monitoring at the beginning of the baseline and took tests at the beginning of the baseline and after twenty sessions. During the baseline period, patients had weekly sessions dedicated to case history. Treatment sessions were weekly and lasted one hour. Treatment strategy was divided into two parts: the first part lasted four sessions and was aimed at reconstructing and sharing the schema of the disorder, explaining the treatment rationale, monitoring guilt (but outside the symptomatic domain), monitoring internal self-accusing dialogue and identifying attempts to prevent, repair, justify or punish the self. The second part included 16 sessions and was aimed at increasing the acceptance of being guilty, but not in the symptomatic domain.

To reach the goals of the second phase, we adopted the techniques listed below:

1. Socratic dialogue, aimed at helping patients understand that, e.g., «preventing or neutralizing all guilt is impossible», «guilt is a normal part of everyone's life». For example, the patients were requested:
   – to imagine a new-born baby and the unfolding of its life, followed by the question: «do you think it is possible that this person will end his life without sins?»;
   – «Think of different cultures and religions… do any of them prescribe or consider a life without sin possible?»;
   – «Imagine the sins of omission we risk committing every day… what would happen if we wanted to eliminate this risk? How much would this complicate our existence? How expensive and counterproductive would it be?».
2. Two-chairs technique (Perls, Hefferkine & Goodman, 1971) aimed at evaluating and comparing the costs of preventing or neutralizing guilt and accepting being guilty.
   For patient 1, examples of costs of avoiding guilt included accepting to do something she did not want to do, such as attend a gymnastics program or go out with her brother

(who has Down Syndrome), forego doing things she would have liked doing, such as making friends with people her mother did not like, take a trip with her partner (boyfriend?) and have intimate relations with him. The patient synthesized the costs with the consideration that «behaving like this, in fact, I feel I am living a life that is not mine, and is not guided by what I really feel and want!». By contrast, the cost of behaving «guiltily» was to undergo her mother's reprimands and sulking, which was very painful for the patient.

3. Modified double standard (van Oppen & Arntz, 1994; Mancini, 2005), aimed at fostering self-forgiveness. For example, patient 4 was asked to evaluate several of his misdeeds, such as failing to do his volunteer work or responding nastily to his mother, or imagining that his brother (for whom he felt great esteem and affection) had the same guilty behaviour he did and evaluating its seriousness. Then he was asked to imagine how three other people, so-called external judges, would judge his and his brother's behaviour. Finally, the patient was asked to reconsider his initial misdeeds. During the exercise, he realized how much he blamed himself («You abandoned the dogs you say you love», «now they won't go out for three days just because you didn't feel like taking them») and how, instead, it would easier to show himself the dimension of benevolence and pardon, imagining his brother («it can happen that you don't feel like doing your volunteer work; it's something extra you do, it's not an obligation and it's not right for you to feel all the responsibility», «If you've made a mistake, what can you do? Everybody makes a mistake sometime»). Also in imagining the evaluation of the three «external judges», he realized how much more benevolence and capacity to pardon he attributed to others, even when they judged him, and how he was incapable of pardoning himself. It was suggested that he adopt a benevolent and forgiving attitude toward himself, such as he would have had toward his brother and the three external judges would have had toward both of them.
4. Experiential exercises aimed at exposing patients to feelings of guilt, keeping attention on guilt-producing internal dialogue, giving up any attempts to reduce guilt.
   For example, we identified situations in which patient 4 felt guilty, such as responding too quickly to a request for information on the street, bumping carelessly into a person on the subway and not immediately excusing himself. He was asked not to prevent the guilt, but to expose himself to it and focus his attention on self-accusing thoughts («Now this elderly woman will take the wrong turn because of my hurry in giving her directions; I'll make her lose a lot of time and cause her fatigue») and connected feelings and emotions. He was told to observe his thoughts and emotions without doing anything to change or prevent them, and to note their intensity, duration and tolerability, and wait for their spontaneous decrease.

Treatment integrity

All sessions were audio-recorded. Two independent judges listened to five sessions (extracted randomly) for each of the four treatments. The judges were expert therapists

who were unaware of the goals of the study and had the task of detecting any interventions carried out in the symptomatic domain or aimed at reducing guilt (our goal was to increase acceptance of guilt, not reduce it). No interventions in this direction were found from either of the two judges.

Data analysis

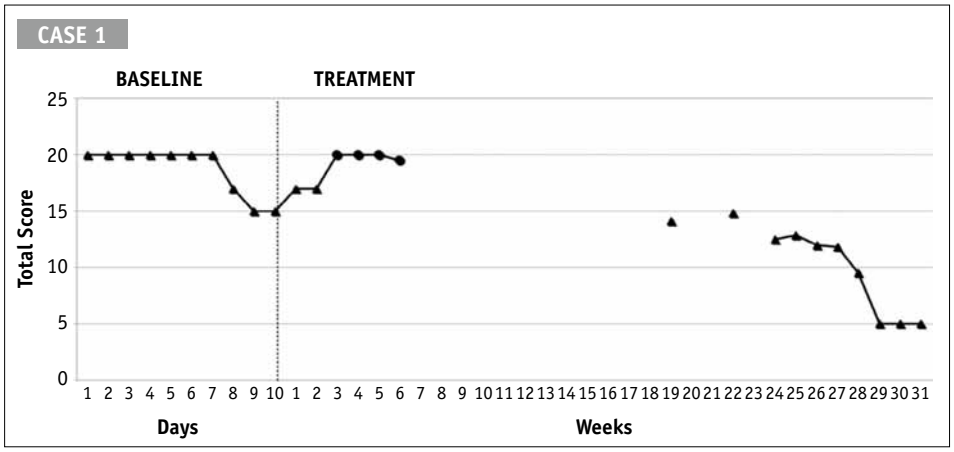
A preliminary screening of data showed few data missing for each instrument (less than 2% for each instrument). Missing data were corrected according to each test norms or by inserting the scale average for the participant with missing data.

As regard to the self-monitoring report, only patient 1 had a great number of missing values in daily monitoring. We obtained a total score in monitoring by summing the scores obtained daily in the five items (obsessive thoughts: time involved in and interference with daily activities; compulsions: time involved in and interference with daily activities; control over compulsive behaviours, reversed score). The total scores by each patient were plotted (figure 1) during the assessment (baseline) and the 20-week treatment sessions. A t-test analysis was conducted on the total score to highlight the differences before and after the treatment.

A *Reliable Change Index* (RCI; Jacobsen & Truax, 1991) was then carried out on the Y-Bocs, on the QSC and on the Core-om scores of the 4 patients before and after 20 weeks of treatment.

RESULTS

A comparison between baseline and treatment monitoring shows less time spent ruminating about obsessions and compulsions, decreased interference of obsessions and compulsions, and increased control over obsessions and compulsions. Difference between



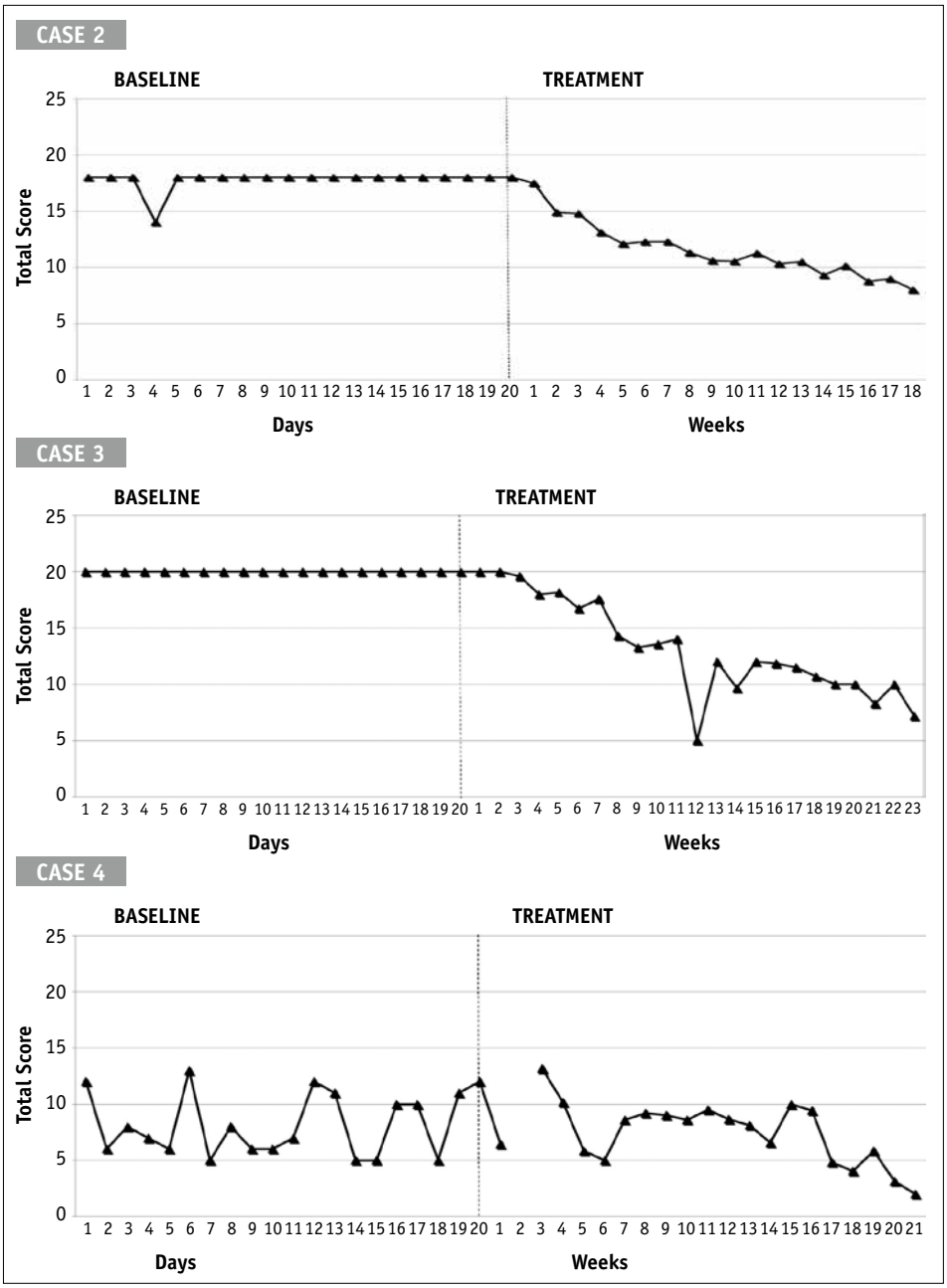


Figure 1 Monitoring patients' total score. The round gauges in Case 1 (weeks 3-6) indicate treatment suspension for summer vacation; missing dots indicate absence of monitoring.

initial and final score is statistically significant for patient 1 ($t(13) = -5.3$; $p < 0.01$), 2 ($t(18) = -11.05$; $p < 0.001$) and 3 ($t(22) = -7.67$; $p < 0.001$). No significant difference emerged for patient 4 ($t(19) = -1.78$; $p = 0.09$). However, patient 4 shows changes in the same positive direction and, after 20 sessions, his scores seem more stable than at the baseline.

As showed in figure 2, the Y-BOCS score decreased by more than 30% in all patients and was at the cut-off or below. The decrease was statistically significant in all four patients (RCI > ±1.96; $p < .05$).

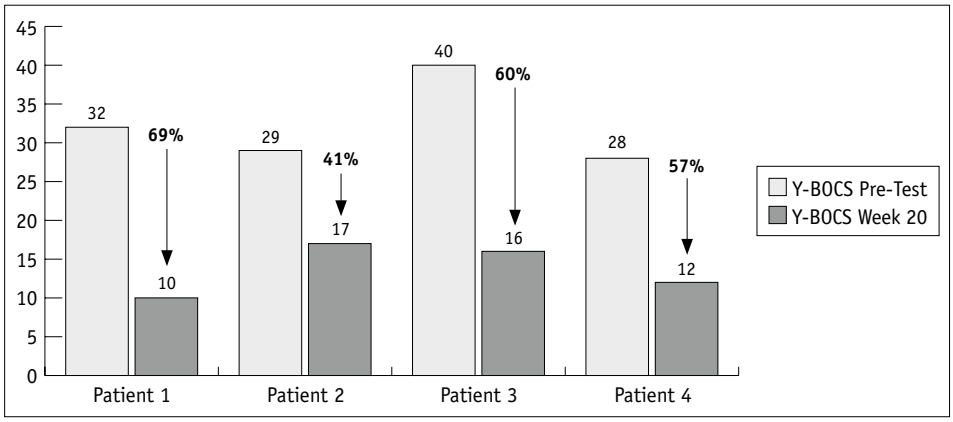


Figure 2 Y-Bocs score of the 4 patients before and after 20 weeks of treatment.

Furthermore, three patients showed a statistically significant decrease (RCI > ±1.96; $p <$ .05 for patients 1, 2 and 4) in sensitivity to guilt (figure 3) and in Core-om (figure 4) scores.

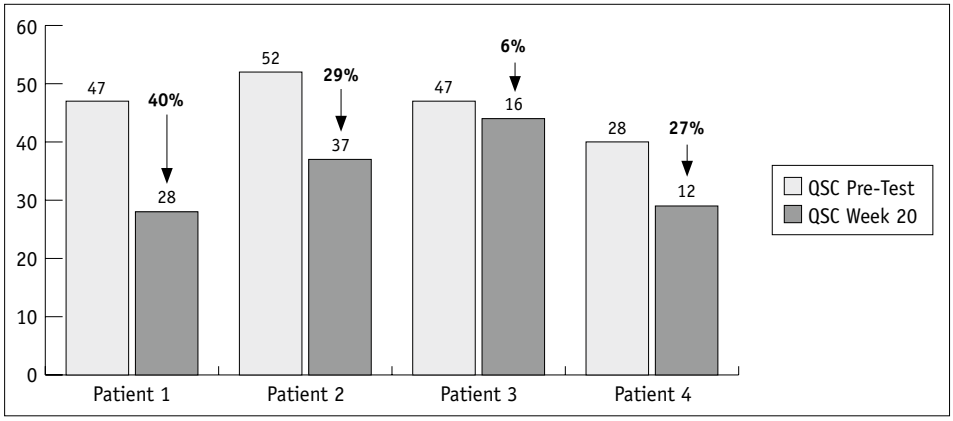


Figure 3 QSC score of the 4 patients before and after 20 weeks of treatment.

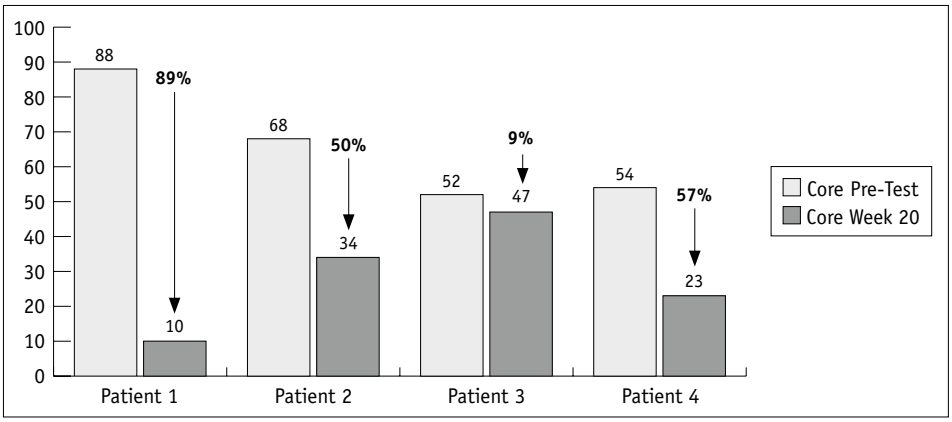


Figure 4 Core-Om score of the 4 patients before and after 20 weeks of treatment.

In patient 3, sensitivity to guilt (measured with the QSC questionnaire) decreased only by 6%; nevertheless, the patient said she felt much less conditioned by feelings of guilt and gave several examples of the change in her sensitivity to guilt: more than once, she made decisions that went against her parents' will, aware that this would result in reproaches from her mother. By contrast, before the intervention she avoided provoking reprimands from her parents, particularly her mother, at all costs. She took initiatives that had previously made her feel guilty, such as going to the beautician, smoking a cigarette occasionally, or going out to eat on Sunday, a day she should have dedicated only to the Lord.

Below, we provide some examples of symptomatic changes that were either reported by the patients or directly observable.

Case 1

After the 20 sessions, the patient reported changes regarding management of fear of guilt in obsessive symptomatic domains: «Sometimes when I face situations that activate my fear of guilt, for example, if a thought/intrusive image crosses my mind, I say to myself: "Even if the worst should happen, it would be a small black dot along my lifeline, which is still white regarding the future!", or I imagine a street with several lines drawn on the ground and have to accept stepping on them if I do not want to remain blocked!».

Other changes were observed in obsessive domains; for example, she moved freely in the classroom and in other areas of the school, with no fear of contact with objects or places contaminated by people she considered «negative». She serenely tolerated nearness as well as physical contact with «negative» people. For example, she accepted to fly sitting next to one of these people and went to the birthday party of a «negative» friend.

Case 2

In the symptomatic domain, changes were observed such as returning to activities he had previously avoided, for example, the gym and football. He took trips with friends he knew he would have to share a bedroom and bathroom with.

Case 3

At the beginning, she was often blocked and took a few seconds to repeat ritual prayers. In the final sessions, however, she was rarely distracted by rituals. In fact, the decrease in rituals allowed her to attend university and take exams. In earlier years, she had abandoned courses twice after a few weeks of lessons. In fact, her rituals were incompatible with studying and going to lessons.

Case 4

The reduced interference of symptoms permitted the patient to carry out activities he considered important, such as sports and volunteer work with dogs, which, in the past, his symptoms had often forced him to forego.

DISCUSSION

Results are coherent with our hypothesis: treatment aimed at increasing acceptance of being guilty in non-symptomatic domains leads to a decrease in OC symptoms.

These findings are also coherent with our thesis that:

1. there is a general fear of being guilty at the basis of OCD;
2. being guilty tends to be regarded, by OC patients, not only as a negative possibility but also as unacceptable and undeserving of forgiveness.

Considering our results from the view of clinical usefulness we have to admit at least two limits. First, the small number of subjects and, second, the lack of a follow-up demonstrating stability over time of the results obtained. But what can this treatment add to what is already available in cognitive and behavioural psychotherapy?

Some studies in the literature have demonstrated the effectiveness of strictly cognitive treatment aimed at reducing the sense of responsibility (Ladouceur et al., 1996) and sense of guilt in the symptomatic domain (Vos, Huibers & Arntz, 2012). Our intervention was different because it was centred on increasing the capacity to accept the sense of guilt or the risk of being guilty in non-symptomatic domains, rather than reassessing the sense of responsibility for the feared catastrophe. It should be noted that in two of our patients no sense of responsibility was involved in the obsessive symptomatology. In case 2, the patient was afraid of being homosexual, which for him was the same as being morally disreputable. In case 3, the patient was afraid of becoming a morally disreputable person.

Recent studies (Twohig, Hayes & Masuda, 2006; Twohig et al., 2010; Saliani et al., 2011) demonstrate the effectiveness of procedures aimed at increasing acceptance of ob-

sessive thoughts. The intervention described here also differs substantially from these procedures because it is not aimed at accepting obsessive thoughts but, specifically, at accepting guilt or the risk of guilt in non-symptomatic domains.

The importance of this study for therapy lies in the fact that it demonstrates the usefulness of intervening in non-symptomatic domains. This can be useful in cases that present very different, numerous, and pervasive obsessive symptoms. It may also be useful when interventions directed towards symptoms provoke the patient's resistance. It is known (Foa et al., 2005; Clark, 2005; Abramowitz, Lackey & Wheaton, 2009) that a high percentage of patients refuse ERP or that ERP is not effective enough, as we also found in the patients who participated in this study.

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