A case report of obsessive-compulsive disorder: Reduce fear of guilt to reduce symptoms

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Abstract

In this study, we present the case of a 27-year-old man who experienced obsessive symptoms for over ten years and then underwent treatment focused on reducing feelings of guilt. Although the patient had already received behavioural cognitive therapy, his symptoms did not significantly improve. After only a few interventions intended to manipulate guilt into non-symptomatic domains, we observed a reduction in obsessive symptoms. Although generalizations cannot be made based on a single case, this treatment seems consistent with the hypothesis that a sense of guilt has a central role in generating and maintaining obsessive-compulsive disorder. Furthermore, this case study highlights the importance of developing therapeutic procedures aimed at reducing feelings of guilt.

Keywords: *Obsessive-compulsive disorder, Guilt, Cognitive therapy, Washing, Checking.*

Riassunto

Un caso di disturbo ossessivo-compulsivo: Intervenire sul timore di colpa per ridurre i sintomi

Viene presentato il caso di un uomo di 27 anni che presenta una sintomatologia ossessiva da oltre 10 anni, trattato con un protocollo focalizzato sulla riduzione del senso di colpa; il paziente era già stato curato con una terapia cognitivo comportamentale senza un significativo miglioramento dei sintomi. L'interesse del caso risiede nel fatto che è possibile osservare una riduzione della sintomatologia ossessiva a seguito di soli interventi di manipolazione della colpa in domini non sintomatici. Benché non si possano fare generalizzazioni a partire da un caso singolo, il trattamento descritto sembra in linea con l'ipotesi che il senso di colpa svolga un ruolo centrale nella genesi e nel mantenimento del disturbo e suggerisce l'opportunità di sviluppare e studiare procedure terapeutiche volte alla riduzione della sensibilità alla colpa.

Parole chiave: *Disturbo ossessivo-compulsivo, Senso di colpa, Terapia cognitiva, Lavaggi, Controlli.*

INTRODUCTION

Although a causal role of a sense of guilt in the genesis and maintenance of obsessive-compulsive disorder (OCD) has not been fully demonstrated, many publications have identified investment in protection from guilt or one of its elements as a central factor in the disorder. Even in the initial 17th century descriptions of the disorder, OCD was related to marked scrupulousness and excessive preoccupation (Mancini, 2005). Many descriptions of the role of an exaggerated sense of responsibility have been reported in the development and maintenance of OCD (Salkovskis, 1985; 2002; Salkovskis & Forrester, 2002; Rachman, 1993; 1997, 2002; Ladouceur et al., 1995).

A correlation has also been observed between responsibility and obsessive-compulsive behaviours in clinical subjects and non-clinical or normal subjects (Steketee, Frost & Cohen, 1998; Bouchard, Rhèaume & Ladouceur, 1999; Wilson & Chambles, 1999; Menzies et al., 2000), and fear of guilt and a strong sense of responsibility predict the tendency to have obsessions and compulsions (Rachman et al., 1995; Rhéaume et al., 1995; Mancini, D'Olimpio & D'Ercole, 2001). Finally, it has been demonstrated that manipulating responsibility increases or reduces clinical subjects' preoccupation with and impulse to carry out rituals (Lopatcka & Rachman, 1995; Shafran, 1997), and that manipulating guilt produces the same effect in non-clinical subjects. The specific role of feelings of guilt and consequent scornful external judgments in regulating obsessive symptoms was reported in Mancini et al.'s research on the role of moral topics in OCD (Mancini & Gangemi, 2004; Mancini et al., 2006; 2009; Pace, Thwaites & Freeston, 2011).

However, this broad literature describing the role of responsibility, guilt and, in general, moral topics in OCD (see Mancini, 2005, for a more thorough discussion of the bibliography) does not correspond with the attribution of a central role to these topics in treatment procedures and in the development of protocols focused on reducing vulnerability to guilt and its moral judgments. We hope that the case study presented here will serve as testimony of the positive effect of manipulating guilt into non-symptomatic domains of obsessive symptomatology. We describe the case of a patient who was treated with procedures aimed at reducing feelings of guilt (understood as perception of the threat of guilt and conduct undertaken to prevent it) and in whom a significant reduction of symptoms occurred following this unique intervention.

The patient, a young man who presented control and washing rituals that interfered greatly with his daily life, submitted to treatment aimed at increasing his tolerance of the possibility of being guilty and contemptible on a moral plane, without interfering directly with his symptoms. Entholt, Salkovskis and Rimes (1999) reported that obsessive patients fear and anticipate the possibility of being the target of scornful reproaches more than other patients with anxiety disturbances. We predicted that helping the patient learn to better tolerate the threat of being guilty and deserving of scornful accusations would lead to reduced symptoms.

CLINICAL CASE

The patient is 27 years old and lives with his parents; he has a 28-year-old brother and a 16-year-old sister. Although he was three years behind in his university degree program

when he came to us, he only required the completion of a few exams to graduate. When he was 16 years old, the patient was diagnosed with a mild form of epilepsy, which is kept under control with a bland drug. He takes no drugs for OCD.

His symptoms are centred on washing and controlling. He controls all mechanical or electronic objects he uses, and when he has finished using them, he ensures that everything is «in place». His symptoms are focused on immediately avoiding the feeling of having left «something not perfectly in place», which is instrumental in preventing doubts and ruminations that are not imminent but that he fears may arrive unexpectedly during the night. His doubts and ruminations are perceived as a serious threat to sleep; all his symptoms are aimed at preventing anything that can directly or indirectly interfere with the quality and quantity of his night sleep.

Protecting sleep is, in turn, instrumental in protecting his ability to study, to prevent epileptic crises (which would also interfere with studying), and to prevent an existential failure for which he is to blame. The patient imagines this failure as a future scenario in which he realizes he did «not know how to play the good cards fate had offered him» and becomes the target of deserved and contemptuous accusations. He imagines that if he fails, someone will say to him, «You didn't know how to make something of yourself, regardless of the good cards and excellent opportunities fate offered you». The patient remembers few occasions in which insomnia was associated with obsessive doubts.

The patient undertakes washing when he arrives home and in the evening before he goes to bed. It primarily consists of a shower and repeated hand washing according to a precise pattern that also involves his mother. The goal of washing is to prevent the risk of leaving traces of soap (potentially dangerous) on his hands or body. The credibility of this fear is low and the symptoms are essentially aimed at preventing the feeling that something is not in place, with all of its associated consequences.

The patient's symptoms become notably worse in the presence of sexual or illegal implications. The most frequent and invalidating controls, at the time of his request for therapy, concerned use of the mobile phone and the computer. Mobile phones and computers are potentially instruments for accessing pornographic files or numbers; here, not doing things well means doing something that not only could damage him, but could also expose him to negative consequences, such as being discovered and publicly denounced.

At the time he requested therapy, the patient experienced six hours per day of obsessive symptoms on average, which interfered greatly with his daily activity. He also engaged in a series of avoidances; for example, he avoided driving the car and using the computer at home, and he had his mother turn off his mobile phone and other equipment. He had not slept in his bedroom for four years, sleeping in the living room to avoid his brother's critical looks and to feel freer during his washing rituals prior to going to bed («which embarrass me and, as a result, I do worse»). His social life consisted of a few monthly outings «… because with these symptoms I'm tired, and because I feel imperfect and don't want to present myself this way. I want to put things right in my life, get well, graduate, find a job and then take up the subject of girls».

The patient's request for therapy came a few weeks after an exam that did not go «as I wanted it to or as it should have». This generated feelings of guilt («I lost a lot of time

before (the exam) and now I don't have time to prepare myself as I should; I'm building a mediocre future») and was followed by a worsening of symptoms.

In the words of the patient, his childhood was characterized by his conviction, until he was 15 years old, that he was a genius because he found it easier to obtain top grades than his peers and because he was continually reminded of his brilliance by his extended family. His aunts were particularly partial to him; they praised his qualities, especially his intelligence and his good grades in school. Furthermore, he had the feeling that he always received the best gifts, which he remembers with feelings of guilt toward his brother, who was less brilliant at school and more introverted.

At home he remembers that he «always» felt like he had «a guilty conscience» and that he was being judged; for example: «If I was watching a film on TV and my father or brother passed, I immediately felt guilty». He does not believe that his parents made him feel guilty, but he associates memories with this emotion. He perceives his father as unaffectionate and «generally critical» (an example is the sentence «Don't make noise», which his father often said when the patient was playing the violin) and a person who gave great importance to effort and success «in contrast to laziness». The patient remembers his father's hurtful comment when he received his fifth grade report card: «Given that you have the fortune of being intelligent, you couldn't have gotten less!». The patient maintains that his father's attitude represents a sort of family injunction synthesized as «if you have qualities, you can't waste them; if you do, you deserve contempt».

He describes his mother as affectionate, very available, and «one who makes many sacrifices for her children» but «doesn't make them pay». As a child, the patient was often worried that his mother might feel unloved. For instance, he recalled that «once we were travelling by train and my brother and I sat on the same seat as our father, and our mother was alone in another compartment; I remember feeling that I had betrayed her, and after a while I made an excuse and moved next to her».

His first symptoms (controlling faucets and lights, putting the objects in his room in order) appeared when he was approximately 15 years old. He had gone to private elementary and middle schools, but attended a public high school. After this change, the patient said he realized he «was normal and not a genius». Compared with his companions and based on his first test results, the patient realized he was no longer able to distinguish himself with ease as he had in middle school. This realization also influenced his relationships with his companions, as he was no longer able to make himself known as «the really smart one» and tended to isolate himself. He had an epileptic seizure the same year, and he remembers little about the episode or the following months. His only very clear memory concerns his first visit to the neurologist, who said something like «you had the epileptic seizure because you slept poorly and little».

In the second year of high school, the patient began to make a great effort in his studies and attempted to regain his dominant position with respect to his companions. He started to go out and frequent his peers. The patient holds that in the following years he basically overcame the moment of psychological crisis by telling himself, «To be a genius and have the cards to obtain whatever I want is possible for me and depends only on my effort». Although his obsessive symptoms were still present, they did not particularly interfere with his life; overall they were experienced as egosyntonic.

When he was 23 years old, the patient's obsessive symptoms worsened significantly following two events: a second epileptic crisis (following an attempt to reduce drug therapy) and a study trip during which he remembers feeling unable to face the distance from his mother, mostly because of his washing, which he experienced with feelings of disvalue. From this moment, his symptoms began to interfere with his daily life and to involve his family members. His father reacted by never speaking explicitly about the problem, while his brother was very frightened and still is: «if he sees me with symptoms, I see his scared face and immediately he gets angry and tells me to stop it».

The patient had two relationships he defines as «important» that lasted one year; the second one occurred four years ago. He reports that he had no particular difficulty with the relationships.

CONCEPTUALIZATION AND PROCESSES FOR MAINTAINING THE DISORDER

Consistent with Mancini's (2005) thesis, all symptoms have to be framed as a set of attempts made by the patient to protect himself from a specific threat. The threat consists of the possibility of being guilty and exposed to deserved and scornful accusations (from others or from himself). Actualization of the feared threat becomes concrete for the patient in the present as failure in his studies, and in the long term as existential and professional failure (not having a family or a job that fulfils him and experiencing remorse about how he used his time). The patient maintains that he has had greater possibilities (due to fate) than most people (the most direct comparison is with his brother) and that these possibilities translate into greater guilt and scorn when he fails («If you have intelligence, it's your duty not to waste it»). The aim of avoiding this threat regulates obsessive activities (figure 1).

As often occurs when a disorder has become chronic over the years, and as can be inferred from figure 1, at the time of the request for therapy the credibility of the threat, or that damage would actually take place, was very low. The patient was able to realize that he would not damage his fertility if he did not wash himself perfectly, that his mobile phone would not be damaged even if he turned it off with the menu open, and so on. Although the patient worried about making himself guilty for these damaging consequences at the onset of the disorder, years later the patient knows that these consequences will not occur; instead, he fears that doubts will emerge later and, specifically, that they will emerge when he is falling asleep and will interfere with the quantity and quality of his night sleep («I know that I can — rather easily not control the computer, it doesn't make me anxious, I know that nothing serious will happen and that I no longer need to think about it; but then I do it for fear that at night I'll have the feeling I've left something undone — and this will prevent me from sleeping»). Therefore, at present the symptoms are called into action (even if the patient sees the opportunity and the possibility of not effecting them) to avoid being disturbed later (at night) by the thought of having left something out of place.

A series of mechanisms are activated that feed the disorder (figure 1). In particular, seeing himself as he engages in controls or other symptomatic behaviour, together with the awareness of how much time is spent on them and how much they limit him, makes him perceive the threat as more imminent in two senses: «How can I expect to fulfil myself

Critical event	Washing hands or taking a shower Turning off electronic or mechanical equipment: closing objects and putting them back after use
First evaluation	*Have I done everything as I should have?* *Have I gotten rid of all the soap perfectly? Are there traces on my genitals? And what if it compromises my chances of having children?* *Have I turned it off? And if it breaks or is damaged? And if someone notices that I didn't do everything right and that's why it broke?* *Actually, I could just not give a damn and stop doing these stupid things. I know that the computer is not going to break, that the DVD will work well even if I turn it off from the wand, etc.* *But, what will happen tonight if have the feeling I've left something out of place? I won't sleep and then I won't study (and therefore I'll fail in work and in life and it's my own fault)*
First solution attempt	Repeated washing according to a precise ritual Repeated controls and ruminations Requests for reassurance from his mother
Second evaluation	*That's what I have to do!* I do abnormal things. I'm a disturbed person, not a genius! (The obsessive-compulsive disorder becomes the subject of criticism and increases the perception of an imminent threat)
Second solution attempt	Increase in avoidance «so I don't have to control» Increase in «preventive» washings and controls

Figure 1 Schema of the disorder shared with the patient.

if I waste my time this way?» and «I sure am crazy! If people could see me they would say: Look how he's become! And he seemed all there!». Furthermore, asking his mother for reassurance makes him feel «stranger and more abnormal» and feeds his search to «feel ok». The alarmed and angry response of his brother on the one hand makes him feel guilty and increases his desire to engage in symptomatic behaviour and, on the other hand, increases preventive symptoms so as to not experience doubts and ruminations in the evening when they see each other.

THERAPY: STRATEGY AND PROCEDURES ADOPTED

Planning and therapeutic choices were based on two initial observations. First, although exposition with prevention of response is the usual therapy for OCD, it did not seem suitable for this patient since he had already been treated with this procedure and had received little benefit (according to both the therapist and the patient). Second, the symptomatology

seemed regulated by the threat of making himself guilty and deserving of scornful accusations. On the basis of these observations, we decided to focus the intervention on the most aversive threat for the patient, fear of guilt, which for him was connected with the scenario of deserved and scornful accusations from himself and from others.

We inferred (figure 1) that his obsessive activity was aimed at eliminating or reducing: 1) the feeling of being incompletely washed and therefore the doubt about compromising his ability to procreate and, specifically, the fear of being guilty for this outcome and therefore deserving of his and others' accusations and reproaches, and 2) the feeling of having turned off the computer incorrectly and, therefore, the fear of having damaged it and the fear of being guilty and deserving of his own and others' accusations and reproaches. When the therapy began it was necessary to reduce both fears to obtain reduction in the possibility of being disturbed by fears and therefore sleeping poorly, risking epileptic crises, studying badly, and failing in life. The patient's true fear was not that of experiencing epileptic crises or of failing in life, but that they were his fault and would lead to deserved self-reproach and reproach from others. This scenario was unacceptable to him in the sense that he could not imagine being able to bear the experience.

We hypothesized that if we helped the patient reduce fear of guilt, his obsessive symptomatology would decrease. In general, reducing fear of guilt can be carried out in two ways. The first method involves reducing the probability attributed to the feared threat and, in the case of our patient, the possibility of his being guilty of having compromised his own existential fulfilment. Two difficulties, however, are involved in positively modifying the representation of the probability: 1) in threatening conditions, cognitive processes are usually oriented toward prudence (better safe than sorry), and thus, there is a tendency to confirm the hypothesis of threat and to falsify reassuring hypotheses; any positive re-working of the feared risks comes up against the patient's attempts to falsify them (Mancini & Gangemi, 2004), and 2) the possibility of being guilty for one's own failure is an integral part of everyone's life and, thus, cannot be eliminated; if the patient greatly fears this possibility, then it will likely attract his investments, even if considered improbable.

The second strategy for reducing fear of guilt is to make the feared possibility more acceptable. Acceptance of a feared possibility can be achieved by making the patient discover that he can bear it and pass through it, or by making the patient discover that it is possible and opportune to reduce protective investments and direct his resources elsewhere. We decided to adopt the latter strategy and help the patient accept his feared threat in two ways. First, we exposed the patient to events that elicited feelings of guilt and prevented his attempts to reduce these feelings. These events did not activate the obsessive symptoms, because practical and ethical reasons precluded the patient from being exposed to the guilt of not sleeping, not studying, and failing. Second, we aimed to reduce protective investments in the direction of the threat, helping the patient to cognitively accept the threat or accept that he does not have the power to eliminate the risk of the threat. Our goal was to have the patient determine how much power he has to prevent the threat, focusing on functional goals that are proactive and in his power to guarantee a feeling of existential fulfilment.

From the procedural point of view, the treatment was separated into four phases: reconstructing and sharing the schema of the disorder, sharing the aims and rationale of the

treatment, accepting the experience of guilt, and accepting the threat. The first phase, reconstructing and sharing the schema of the disorder (figure 1), followed the first diagnostic evaluation. The underlying goals were to promote and foster the therapeutic alliance, to increase compliance, and to give the patient the perception of an understanding and explanation of the disorder starting from underlying personal goals. The goals were followed by reconstructing the symptomatic sequences in ABC in sessions and in homework. All material gathered was used to reconstruct a schema of the disorder in which the patient could always recognize himself, independent of the specific symptom. The patient was given a copy of the schema.

The second treatment phase was dedicated to sharing the contract and the treatment strategy. Specifically, we shared the idea that due to the central role of fear of guilt in regulating the symptoms and the ineffective treatment already experienced with exposure and response prevention (ERP), the main strategy would be to help the patient become more tolerant of the possibility of being guilty, of not doing things well, or of not sleeping and, consequently, risking professional and existential failure «he was to blame for», thus deserving scornful accusations. We implemented this strategy via analyses (starting from problematic episodes) of the effects and efficacy of his attempts to prevent the threat of guilt, to show the patient that the problem resided above all in his profuse efforts to protect himself from the threat. This strategy also allowed the patient to very clearly understand the vicious circles created by self-feeding the disorder. Consistent with the conceptualization of the disorder, the aim of the treatment was explained to the patient as follows: «the main aim is to learn to hold onto the experience of guilt and face the possibility that the monster of failure and social scorn is approaching». Reducing symptoms was shared as an expected and desirable effect («if you tolerate guilt more, you'll do fewer things to prevent it and, therefore, presumably you'll have fewer symptoms»), but was not the direct aim of the interventions. Four encounters were dedicated to sharing the schema of the disorder and defining the contract.

The aim of the third treatment phase was the reduction of behaviours carried out to prevent guilt and the feared scenario of scornful reproach, which was deserved because of his failure. This goal was pursued via systematic exposure to situations that provoked feelings of guilt in the patient and prevention of attempts to reduce guilt. The situations activating the guilt to which the patient was to be exposed were identified in two ways. First, a list was created of situations outside the therapy in which the patient felt «typically guilty» and feared being condemned from a moral point of view. Particular care was taken to identify situations in which the patient experienced feelings of guilt and not just shame, or at least not only shame. Second, another list was generated containing topics addressed in therapy that could make him feel guilty and exposed to the therapist's negative moral judgment. The situations identified as activating guilt were habitually avoided by the patient; when avoidance was impossible, the patient activated behaviours of justification or reparation, for example, explaining or ruminating on the reasons for his behaviour or asking for forgiveness. He was trained to recognize these attempts to reduce guilt and was told to not put them into action.

Next, we drew up a list that included the following situations: entering a store and asking to see an object without buying it; entering a clothes store, trying on several outfits and then not buying them; using the bathroom in a café without buying anything; entering

a sex shop; buying a DVD with sexual content. The patient was instructed to choose the situations and to expose himself to at least one during the week. He was also instructed to not do anything to reduce his guilt feelings but to try to look at all the internal signs of guilt almost as a spectator (as in the experiential exposition procedures; Hayes & Strosahl, 2004). Approximately half of the session time was dedicated to exposing him to topics identified as critical for his guilt: sexuality, possible errors, and his parents' guilt toward him during childhood. These topics were addressed during the sessions; the patient experienced guilt (in some cases accompanied by shame) and frequently asked for reassurance with affirmations like «now you think I'm a pervert!» or tried to justify himself. No reassurances were ever given regarding the therapist's judgment. Based on research on the ERP (Mancini & Gragnani, 2005; Tyron, 2005), we expected that through repeated exposure and the relative blocking of attempts to find a solution, the patient would learn that feeling guilty is an unpleasant but bearable emotion, that giving up attempts to reduce feelings of guilt (procrastination is not enough) automatically tends to diminish guilt, and that repeated training diminishes sensitivity to feelings of guilt.

This third treatment phase lasted approximately six months (18 encounters), with a summer break in the middle. At the end of this phase, the patient's symptoms had reduced significantly and interfered much less with his life. For a large part of the day he was free of symptoms; he did not use avoidance (he began to use the computer habitually, no longer controlled when he used the car, and his mother was no longer involved in his rituals). Tests (table 1, time 1) also confirmed substantial reduction of his symptoms. In accordance with the treatment rationale and our agreement with the patient, there was no direct management of symptoms. During this phase, however, the patient spontaneously began to generalize the work on guilt to problematic domains; in his own words, «after all, the feeling of guilt is for something not right, if you tolerate it, then it passes and doesn't come back even at night», and he began to eliminate some of his symptoms. He started by eliminating the control he perceived easiest to suspend: he washed less under the morning shower, as he could make amends in the evening if, by chance, he thought about it all day or before going to sleep.

Table 1 – Scores on pre-treatment evaluation tests after the first phase of acceptance of the experience of guilt (time 1), after the second phase of acceptance of threat (time 2)

Tests administered	Pre-treatment	Time 1	Time 2
Y-Bocs	24	13	4
Beck Depression Inventory	16	2	5
Padua Inventory	64	28	5

Therapy was suspended for six months by the therapist for personal reasons. After this interruption, the patient seemed further improved. For a large part of the day he was completely

free of symptoms, although he admitted that two or three times per month he was «blocked» for a few hours with doubts primarily linked to the computer. In the meantime, he graduated from the university and after only two encounters the therapy was again suspended for five months because he visited the United States. The patient interpreted this decision as proof of his improvement, since it involved a long separation from his mother and exposure to the risk of a relapse (his worsening at 23 years of age followed a period of separation from home).

In the fourth treatment phase, accepting the threat, we fostered reduction of protective investments in the direction of the threat. We tried to help the patient cognitively accept the threat, or accept that he does not have the power to annul the risk that the threat will materialize. We encouraged the patient to distinguish between how much power he does or does not have to prevent it, to abandon attempts to control things that are not in his power and to focus on functional aims that are proactive and in his power (Hayes, 2004; Mancini, 2005; Perdighe & Mancini, 2010; Saliani, Mancini & Gragnani, 2010).

When therapy resumed after the patient's return from the United States, we found that the patient had maintained his results. Nevertheless, he still experienced an intense preoccupation with failure for which he was to blame, primarily the fear «of not finding an adequate job because he graduated when he was 28 instead of when he was 24/25, which he (and his OCD) were to blame for». This preoccupation seemed to regulate the most significant residual symptom, rumination via long and repetitive reasoning that was counter to the facts. In practice, acceptance of the threat was carried out by discussing beliefs related to the power to annul the risk of guilt due to existential and professional failure («it is legitimate that you desire to protect yourself from failure… but what can you really do? What is in your power? If you put these behaviours into action, what guarantee do you have that the threat will be annulled?»). We also helped the patient distinguish between how much is in his power and how much is not, and articulating his goals in a different way. He saw that annulling the risk of guilt was not in his power, but that he could decide to be guided by obtainable goals that were more functional and proactive, such as doing things to become «professionally desirable» (writing articles, taking part in internships) or to be come more morally respectable according to his criteria (for example, being honest). These interventions also seemed useful for fostering greater existential fulfilment, which should also reduce the probability of relapses.

After 16 encounters, the patient had a greater investment in goals that were directly in his power (writing articles, taking part in internships) and a more assertive relational attitude (he asked his professor if he could become involved in a professional project). Although the feared scenario was not yet «neutral,» the patient's preoccupation was reduced and he seemed more focused on proactive goals than «on avoiding being full of remorse and reproaches at age 40.» Further improvement of symptoms was evidenced by his test results (table 1).

RESULTS AND CONCLUSIONS

Overall, 32 encounters with the patient were distributed over two years with two interruptions of 6 months and 5 months. Table 1 presents scores from the tests used to

evaluate the effect of the interventions. At the end of the treatment, the patient presented no symptoms that interfered significantly with his life, and for most of the day he was essentially free of symptoms. Nevertheless, every day he still washed his hands for four to five minutes before going to bed, except when he was away from home (internships, vacations) or when he forgot because he was distracted by his work. Obsessive doubt still arises approximately once per month in relation to using the computer or the mobile phone, but it is not followed by compulsion. The patient described the outcome of the therapy as follows: «The symptoms are reduced by 70-80%. I believe that 10% will always be part of me (I'm referring to things like the fact that if I play chess I have to move the pawns symmetrically, even if I ruin the strategy). The remaining 10-20% have to do with the fact that there are things I now face rationally (i.e. I no longer make controls), but they still come to mind, for example, the annoyance I feel if I turn off the computer with an icon open. I wish that, like most things, they would not come to mind».

We believe that the present case clearly demonstrates that it is possible to obtain improvement of obsessive symptoms by acting on vulnerability to guilt. Another example of this type of intervention can be found in the case described by Casentino and Mancini (in preparation). On the basis of only two cases we obviously cannot generalize about the possibility of obtaining normalization of symptoms in all patients only by intervening on guilt. We can, however, highlight the importance of further developing procedures centred on vulnerability to guilt and helping patients feel, in the words of our patient, «pardoned in advanced».

Such a treatment strategy could have at least two advantages: it could offer an alternative to traditional ERP, focused only on the obsessive stimuli, when it is either not applicable or ineffective, and it could increase the general effectiveness of the treatment, achieving a greater degree of normalization of symptoms and greater stability of results over time, two aspects that are still crucial in treating OCD. Although psychotherapeutic treatments with proven efficacy are at our disposal, the state of the art in curing OCD is less comforting if we consider the percentage of patients who refute the treatment or do not complete it (25-30% drop out) and the percentage of patients who do not obtain normalization of symptoms (or no longer satisfy the diagnostic criteria for OCD) even when the treatment is effective (Franklin et al., 2000; 2002; Mancini et al., 2006).

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