# Guilt-related early life experiences characterize OCD: An observational study using ImRs

**Barbara Basile***,
Brunetto De Sanctis*, Stefania Fadda*, Olga Ines Luppino*,
Claudia Perdighe*, Angelo Maria Saliani*, Katia Tenore*
Francesco Mancini*°

* Associazione di Psicologia Cognitiva (APC) &
Scuola di Psicoterapia Cognitiva (SPC), Rome Italy
° Marconi University, Rome, Italy

## Background


- Guilt and Inflated responsibility play a role in OCD onset and maintenance*
- Little is known about **early life experiences** that sensitize towards **guilty feelings in OCD**

*Arntz et al. 2007; Mancini 2001, 2016; Mancini & Gangemi 2004, 2011; Rachman 1993; Rachman et al. 1995; Salkovskis et al. 1999, 2000; Shafran et al. 1997; Ladoucer et al 1996

# OCD



**Obsessions** are intrusive and unwanted thoughts, images or ideas, as well as doubts about actions. Obsessions are typically in areas such as horrific images (such as blasphemy, sexual ideas or violent images), thoughts of contamination, or doubts relating to whether some action was completed, or not.

**Compulsions** are specific behavioral actions, including covert mental rituals, intended to neutralize the obsessions, or to verify behaviors that are the subject of doubts.

# The developmental origins of responsibility

Salkovskis (1999) described several kinds of experiences that can lead to inflated responsibility:

1. Parents fostering and encouraging the child's sense of responsibility
2. Rigid codes of conduct are applied within the family
3. Child was not confronted with any responsibility
4. Having caused real harm or having had the feeling of having caused harm through an action/ thought/ desire

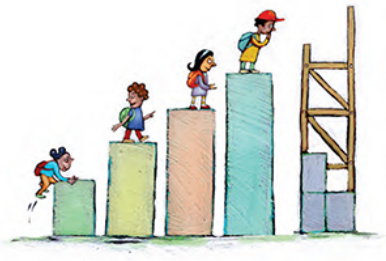
## Family environment

- Demanding and critical
- Threat to relationship

Leonard, Swedo, Lenane et al, 1993; Tynes, Salins, Winstead, 1990, Pace et al., 2011; Mariaskin, 2009

## Aim

- Explore early memories in OCD patients
- Through ImRs, identify core aspects of such episodes: episodes' content, emotions, thoughts, unmet needs, meaning of memory, re-scripting interventions
- Compare memories, and their core contents, across OCD and non OCD



## Hyotheses

1. **OCD** patients would report more memories characterized by **blaming** and **guilt** feelings, than non-OCD
2. **OCD** patients express more frequently unmet **core needs** related to acceptance and forgiveness, vs non-OCD
3. Different **cognitive re-attributions** between groups, with OCD patients moving from meanings such as:

*"I'm guilty … I am bad…"* → to → *"It's not my fault … I'm ok …"*

## Methods

**Inclusion criteria:**

Age > 18 years old

**Experimental group**

- OCD diagnosis, no comorbidity

**Clinical control group**

- Axis I diagnoses

**Exclusion criteria:**

- Mental retardation
- Evident cognitive deficits
- Psychosis
- High levels of dissociative symptoms
- Dysfunctional Personality

**Assessment:**

- Structured Clinical Interview for Axis I and II (SCID-IV)
- Y-BOCS in OCD and specific symptomatic scales in control group

## Sample

| | Pure OCD N=19 | Non-OCD* N=18 | P value |
|---|---|---|---|
| **Mean age(SD)** | 33.0 (9.9) | 32.0 (8.4) | ns |
| **M/F** | 10 M/9F | 2 M/16F | 0.00 |
| **Undergoing medication** | N=7 | N=1 | 0.05 |

- Patients undergoing CBT therapy (between 6 months and 2 years of treatment)
- ImRS being their first emotion-focused experiential exercise
- Age range: 18-55 years old

* Mainly Depressive and Anxious symptoms

## ImRS Procedures

1. With eyes closed, a **recent stressful event** (usually experienced in the two weeks before the session) was described. Particular focus was driven on the emotions and on their associated bodily sensation.
2. Bridge affect to the past: getting an **image from childhood** that was associated to that emotion. Thoughts, emotions and needs were explored with emphasis.
3. **Re-scripting** phase (**adult perspective**): the therapist helped the patient as a child to fulfill his/her needs (i.e., patient entering into the image or by asking some aid to the therapist, or to any significant other).
4. Re-scripting phase (**child perspective**): intervention by the adult-patient experienced by the patient as a child. If needed, child asked for and received further interventions from the adult.
5. **Debriefing** phase: eventual changes in meanings/attributions about oneself and what had happened in the image are discussed.

Arntz & Weeterman, 1999

## ImRs categorization

- Emotions of the current stressful situation
- Main content of the childhood memory
- Age of the child
- Significant others involved (parents or others)
- Emotional content (one or more emotions were labeled)
- Unmet core needs associated to the episode
- Re-scripting intervention made by the healthy-adult (or the therapist or any significant other) to fulfill unmet core needs
- Cognitive re-attribution/new meaning about the event.

Imagery exercises were anonymized and categorized by 4 diagnosis-blind clinicians
A second rating by another blind judge was performed (good inter-rater reliability)

## Results

- Descriptive analyses
- Chi square and t-Test analyses to compare frequencies of selected categories across the OCD and non-OCD groups

| Phase of Imagery Exercise | | OCD | Non-OCD |
|---|---|---|---|
| **Emotion current event** | | Frequency of reported item | |
| | **Guilt** | **13*** | 0 |
| | Anger | 2 | 7 |
| | Loneliness | 0 | 2 |
| **Content of the memory** | | | |
| | **Reproach/Blame** | **7*** | 1 |
| | Guilt inducing | 3 | 0 |
| | **Neglect** | 0 | **7*** |
| | Hyper-responsibilization | 2 | 3 |
| **Age of the child** | | | |
| | Mean (SD) years old | 8.0 (2.5) | 8.8 (2.9) |
| **Others involved** | | | |
| | **Both parents** | **4*** | 0 |
| | Father | 6 | 4 |
| | Mother | 5 | 6 |
| | Others | 4 | 6 |

* Statistically significant for p > .05
Chi square analysis for frequencies
T-test analysis for continuous variables

| Phase of Imagery Exercise | | OCD | Non-OCD |
|---|---|---|---|
| **Emotion in the memory** | | Frequency of reported item | |
| | **Guilt** | **11*** | 3 |
| | **Loneliness** | 0 | **4*** |
| | Fear | 8 | 7 |
| | Sadness | 2 | 7 |
| **Unmet Core need** | | | |
| | **Acceptance** | **6*** | 1 |
| | **Attention** | 0 | **4*** |
| | Safety | 5 | 6 |
| | Care/Love | 5 | 4 |
| | Reassurance | 6 | 5 |
| **Re-scripting** | | | |
| | Protection | 8 | 8 |
| | Reassurance | 5 | 4 |
| | Expressing emotions/needs | 3 | 2 |
| **Re-attribution/meaning** | | | |
| | Others' troubles | 9 | 11 |
| | ***"I am not guilty"* de-respon** | **4*** | 0 |
| | *"I am lovable"* | 0 | 3 |
| | *"It is ok to express feelings/needs"* | 4 | 1 |

## Conclusion


## Conclusion


| | OCD | Non-OCD |
|---|---|---|
| **Content of the memory** | **Blame/reproach** | Neglect |
| **Emotion in the memory** | **Guilt** and Fear | Loneliness, Fear and Sadness |
| **Unmet Core need** | **Acceptance**<br>Safety, Care/love, Reassurance | Attention<br>Safety, Care/love, Reassurance |
| **Re-scripting** | Protection and Reassurance | Protection and Reassurance |
| **Re-attribution/meaning** | Others' troubles<br>***"I am not guilty" , "I have the right to make mistakes", "I am just a child""*** | Others' troubles |

## Conclusion


1. Early memories in OCD are characterized by **blame/ reproach** by **both parents**
2. OCD patients' episodes are characterized by **guilt**
3. The associated unmet need is **acceptance**
4. OCD patients move to new **self-attributions** (" *I am not guilty*") and, similarly to non-OCD, to "others' fault/ problems" attributions

**OCD patients tipically perceive themselves as responsible for potential damages or mistakes, feeling deeply wrong and Thus deserving punishment and even rejection**

**OCD patients typically perceive themselves as responsible for potential damages or mistakes, feeling deeply wrong and thus deserving punishment and even rejection**

Our observational findings might help to unveil the roots of patients' sensitivity towards guilty feelings (Mancini 2016, Salkovskis 1999)

- Previous studies identified specific **maladaptive schemas and modes** to characterize OCD populations.
- Schemas and modes pervasiveness was also found to be associated with OC symptoms' severity.

| Study | Maladaptive Schemas | Modes |
|---|---|---|
| **Basile et al 2017** | All schemas being higher in OCD vs healthy controls; Correlations: association between OCD severity and **Failure**, **Punitiveness**, Subjugation, Social Isolation | Positive association between OCD severity and the **Punitive parent** |
| **Kwak et al 2015** | **Failure**, **Defectiveness/shame**, Enmeshment, Social Isolation (vs HC , PAD) | Not explored |
| **Voderholzer et al 2014** | **Failure**, **Punitiveness**, Subjugation, Abandonment, **Defectiveness/shame**, Dependence, vulnerability to harm (vs ED, CPD) | Vulnerable and Angry child mode **Punitive and Demanding parent** |
| **Kim et al 2014** | All schemas being higher in OCD than in healthy controls | Not explored |
| **Atalay et al 2008** | **Failure**, **Punitiveness**, **defectiveness/shame, unrelenting standard,** Subjugation, Social Isolation, vulnerability to harm, emotional deprivation, enmeshment, entitlement, approval-seeking | Not explored |
| **Lochner et al 2005** | **Defectiveness/shame,** Social Isolation, Subjugation, Mistrust/abuse, Emotional inhibition | Not explored |

## Caveats

- Small sample size
- Different gender distribution across samples
- Clinical control group mixed diagnoses

## Clinical implications and future directions


Apply imagery in OCD treatment focusing on blaming/reproach and guilt-related episodes in order to:

- Fulfil unmet core needs related to acceptance, care and protection and to promote mistakes' normalization
- Modify OCD patient's self-representation about the self being deeply bad/wrong and deserving punishment, to move to more healthy and realistic representations
- Use Acceptance techniques to encourage guilt tolerance

See,
**Poster presentation by Tenore et al.**,
Veale et al. 2012, Mancini 2018, Basile et al. in press

## Thanks


**basile@apc.it**