Current Targets in Obsessive-Compulsive Patients

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Riassunto

Scopo del presente articolo è fornire un contributo alla definizione degli scopi che effettivamente regolano l'attività ossessiva. A tal fine verranno presentati i dati emersi da una prima indagine clinica finalizzata a identificare gli obiettivi perseguiti con i comportamenti ossessivi da un gruppo di pazienti giunto alla nostra osservazione. Per ciascun paziente, al fine di identificarne le principali ossessioni e compulsioni, tre psicoterapeuti cognitivi hanno compilato uno schema diviso in 5 parti. Successivamente, a 18 giudici indipendenti, tutti psicologi e all'oscuro delle finalità dello studio, è stato chiesto di classificare la parte relativa alla prima valutazione dello schema secondo 4 categorie scelte sulla base della letteratura: Timore di colpa, Timore del giudizio altrui, Timore di contaminazione da sostanze disgustose, Timore di un danno ma senza colpa.
I risultati suggeriscono che l'attività ossessiva dei pazienti fosse finalizzata, principalmente, a due scopi: prevenire una colpa e la contaminazione da parte di sostanze disgustose.

Parole chiave: *Disturbo Ossessivo-Compulsivo, teorie di valutazione cognitiva, scopi, colpa, contaminazione.*

Summary

Current Targets in Obsessive-Compulsive Patients

This paper aims to contribute to a definition of the targets pursued by means of obsessive-compulsive behaviours. To this aim preliminary data from a study carried out on a group of obsessive patients will be presented for this purpose. In this study a five-part model (Mancini, 2005) for each patient's most important obsessions and compulsions was filled in by three trained psychotherapists. 18 judges were then asked to classify the first-evaluation part of these models according to 4 categories: Fear of harm, Fear of guilt, Fear of contamination, Fear of being ashamed. The results suggest that our patients' obsessive-compulsive behaviours were mainly directed towards two targets: preventing guilt and contamination by disgusting substances.

Keywords: *Obsessive-Compulsive Disorder, cognitive appraisal theories, targets, guilt, contamination.*

INTRODUCTION

Cognitive appraisal theories (e.g. Clark, 2004; Scherer, 1999) claim that normal and abnormal emotional states depend on the individual's subjective evaluations of internal and external events based on a number of criteria.

Although some criticisms have been levelled against the appraisal perspective in cognitive-clinical psychology (MacLeod, 1993), its validity has also been vigorously defended by citing various factors, not the least being its significant contribution to the improved understanding and treatment of Obsessive-Compulsive Disorder (OCD) (Clark, 2004).

Carr (1974) proposed one of the first cognitive appraisal theories of Obsessive-Compulsive Disorder. According to the author the targets pursued by Obsessive-Compulsive Disorder patients are those normally pursued by any person, such as health, physical integrity, the welfare of one's loved ones, one's own moral health. Patients would be characterised by an abnormal overestimation of the probability that unfavourable outcomes will occur. The development of anxiety and the occurrence of obsessive-compulsive symptoms in a specific situation should depend on the high value of the threats, on the person perceiving a high subjective cost (i.e. harm) and on the high subjective probability of an undesirable outcome.

Salkovskis (1985) and Rachman (1993; 2002) represent the tradition in which the root cause of Obsessive-Compulsive Disorder is exaggerated moral concerns. According to these theories, recent cognitive models assign a causal role to responsibility and guilt in the development and maintenance of this disorder. In these views it is held that people with Obsessive-Compulsive Disorder have an inflated sense of responsibility and are afraid to make mistakes for which they can be blamed. It is hypothesised that this makes them vulnerable to develop Obsessive-Compulsive Disorder and maintains the disorder (Arntz, Voncken and Goosen, 2007; Rachman, 1993; 2002; Salkovskis, 1985; Salkovskis and Forrester, 2002; van Oppen and Arntz, 1994). More specifically, elevated responsibility drives people with Obsessive-Compulsive Disorder to repeatedly check to avert being responsible for harm caused to other people or themselves (e.g. Rachman, 2002). Obsessions and compulsions could thus be considered as activities aimed at preventing the anticipated possibility of guilt for having acted irresponsibly. Compulsive perseveration may result from the obsessive patient's goal of avoiding the risk of not complying with his/her own perceived responsibilities. That is to say, these perseverations may derive from the fear of behaving irresponsibly and of causing unjustified harm to oneself or to others, and/or violating a moral norm (Freeman, Pretzer, Fleming, and Simon, 1990; Ladouceur et al., 1995; Mancini and Gangemi, 2004). There is empirical evidence to support this idea. When reassured that the experimenter will take all responsibility, patients report a reduced urge to perform their rituals (Lopatcka and Rachman, 1995; Shafran, 1997). Induction of responsibility in non-patients leads to an increase in OCD-like behaviour compared to the control conditions (Bouchard, Rhéaume, and Ladouceur, 1999; Ladouceur et al., 1995; Ladouceur, Rhéaume, and Aublet, 1997; Mancini, D'Olimpio and Cieri, 2004). Obsessive-Compulsive Disorder

patients, in situations in which they have a high personal responsibility to avert danger, feel more subjective responsibility and engage more in OCD-like behaviour compared to other people in situation in which way have a high personal responsability to avert danger (Arntz et al., 2007).

The prevention of contamination by disgusting substances seems to be another important target underlying Obsessive-Compulsive Disorder. Many symptoms may be aimed at preventing or to neutralising disgusting contamination even if it is not considered dangerous (Rachman and Hogdson, 1980; Tallis, 1996). Sensitivity to disgust is positively correlated with the washing subscale of the Maudsley Obsessive Compulsive Inventory (Ware, Jain, Burgess, and Davey, 1994). On the basis of behaviour and thought content Phillips and colleagues (Phillips, Senior, Fahy, and David, 1998) argued that cleaning disorders are strictly related to disgust, while Power and Dalgleish (1997) proposed that also checking disorders may also be linked to disgust. A lot of research in the years that followed, up to the recent book by Rachman (2006), a lot of research has shown that obsessive patients are particularly sensitive to disgust, not only washers but also checkers (e.g., Mancini, Gragnani, and D'Olimpio, 2001).

Dèttore and Melli (2004) recently suggested a fourth possibility on the basis of clinical observations, namely that people with Obsessive-Compulsive Disorder are concerned that they will make a bad impression, and feel ashamed. Their behaviours could thus be aimed at preventing this bad impression and, therefore, the need to be ashamed.

To summarise, cognitive appraisal theories consider four different types of evaluations central to Obsessive-Compulsive Disorder. According to these views, these perseverations may arise either out of the fear of harm, or the fear of guilt for behaving irresponsibly, or the fear of contamination, or the fear of being ashamed.

Our aim is to answer to the following question: what targets are pursued by means of obsessive-compulsive behaviours? Preliminary data from a study carried out on a group of obsessive patients will be presented fo this purpose. In this study a five-part model (Mancini, 2005) for each patient's most important obsessions and compulsions was filled in by three trained psychotherapists. 18 judges were then asked to classify the first-evaluation part of these models according to the 4 categories described above: Fear of harm, Fear of guilt, Fear of contamination, Fear of being ashamed.

METHOD

Participants

32 consecutive obsessive patients (15 women, 17 men) required a treatment for Obsessive-Compulsive Disorder at the Studio di Psicoterapia Cognitiva (SPC) in Rome. All of the patients were admitted to the treatment programme and partcipated in the study after their informed consent had been obtained.

Each patient met the criteria for Obsessive-Compulsive Disorder as confirmed by a mental health professional who administered the *Structured Clinical Interview for DSM-IV* (SCID; Spitzer, Williams, Gibbon, and First, 1996). Of the sample, 13 (41%)

had no comorbid diagnosis, 5 (16%) had a comorbid diagnosis of a major depressive disorder, 4 (13%) had a comorbid anxiety disorder (e.g., panic disorder with or without agoraphobia, social phobia or generalised anxiety disorder). 1 individual (3%) had a comorbid bipolar disorder, 1 individual (3%) had a comorbid somatoform disorder and 8 (25%) had «another» mental disorder. In all cases, it was clear that Obsessive-Compulsive Disorder was the primary diagnosis in terms of severity, distress and functional impairment. All participants were given the interviewer-administered *Yale-Brown Obsessive Compulsive Scale* (Y-BOCS; Goodman et al., 1989; Goodman et al., 1989) as part of the assessment procedure. The mean total Y-BOCS score in this group was 29,3 (SD = 5,1), indicating that overall, the Obsessive-Compulsive Disorder symptoms of the sample were in the «severe» range. Only the obsessions and compulsions with higher ratings were taken into consideration. The types of obsessions and compulsions considered were classified in accordance with Leckman et al. (1997) and Summerfeldt, Richter, Antony, and Swinson (1999): 13 (40%) Obsessions and Checking, 16 (50%) Cleaning and Washing, 1 (3%) Accumulation, 2 (6%) Symmetry and Order.

Measures

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

The *Yale-Brown Obsessive-Compulsive Scale* (Y-BOCS) (Goodman et al., 1989a) is a 10-item semi-structured clinician-rated scale comprised of items which assess obsessions and compulsions. The measure has satisfactory psychometric properties and is sensitive to treatment effects (Goodman et al., 1989a; 1989b). The inter-rater reliability (r) based upon on a subset of ratings from the current sample was 0,89.

Procedure

Three cognitive psychotherapists, who did not know the purpose of our study filled out a five-part model (Mancini, 2005) for the obsessions and compulsions that the *Yale-Brown Obsessive-Compulsive Scale* indicated as the most important for each patient. That was part of a standard assessment procedure at the beginning of psychotherapy.

Five-part model. The *trigger event* is described in the first part. The event is a concrete fact (for example, having touched an object), an image (for instance, with a homosexual content), or a thought (for instance, the advantages that would derive from the death of a dear person). The patient's evaluation of the trigger event is described in the second part (*first evaluation*). The terapist asked three basic questions to investigate the first evaluation. The first question was referred to the internal dialogue of the patient when experiencing the trigger event (for instance, «What passed through your mind when you were experiencing the event and you felt upset?»). The second was referred explicitly to the evaluation of the trigger event (for example, «What do you think can happen after this event? What meaning does it have for you? Why is it so serious?»). The third question involved evaluation of the possible consequences for

not taking precautions against the trigger event (for example, «What would happen if, after brushing past someone in the street you did not take any precautions, touching everything as though nothing had happened? Why would this be so serious?»). In the third part a description is given of everything the patient does to prevent or neutralise the threat *(first order attempts to find a solution)*. In this box we find the avoidance behaviours, washing or checking behaviours, neutralisation rituals, requests for reassurance, ruminations. In the fourth part a description is given of any critical evaluation the patient makes of his/her concerns, of his obsessive–compulsive behaviours and of their consequences (*second evaluation*). The therapists asked questions to examine this evaluation (for instance, «What do you think about your obsessions and compulsions? We know suffering from such a disorder is tough, but what is the highest cost this disorder implies for you? What would the greatest benefits be if you did not suffer from this disorder?»). The fifth part contains a description of the strategies used by the patient to control his/her concerns and his/her obsessive–compulsive behaviours *(second order attempts to find a solution)*.

Once the model had been completed, it was shared by the patient, who modified it until it precisely matched his/her own experience. The patient's own words were used as far as possible, to construct the model. Let us make an example.

Maria was 40 years old, had been married for 12 years and had a 10 year old son. For about eight years she had suffered from a serious obsessive-compulsive disorder. She was obsessed with the idea of possibly catching AIDS. The fear of contagion had been triggered by banal stimuli, for instance, brushing up against someone in the street. She endeavoured to cope with the threat by means of washing, avoidance, requests for reassurance and ruminations. Maria was critical of her own fears, which she considered as exaggerated and also harmful. In her opinion her disorder seriously undermined the quality of her life, imprisoning her in an inextricable web of avoidance and washing; it also ruined the lives of her husband and her child. She was afraid in particular of making her son obsessive. She did her best to oppose the intrusive thoughts and to stop the ruminations and rituals, although with little success.

The model built by the cognitive psychotherapist together with the patient was as follows:

TRIGGER EVENT
Unwittingly brushing up against a passer-by

FIRST EVALUATION
I might have contracted the HIV virus, so I must do something

FIRST ORDER ATTEMPTS TO FIND A SOLUTION
Washing
Avoidance
Ruminations
Requests for reassurance

↓
SECOND EVALUATION
These worries of mine are exaggerated
I am ruining my life and that of my family
I could make my son obsessive
↓
SECOND ORDER ATTEMPTS TO FIND A SOLUTION
Attempts to stop the thought
(«Stop thinking about it!»)
Ruminations to convince herself that no possible mechanism exists that could put her at risk, and she searches for counterexamples to the danger
(«This worry is so absurd that I have to try to think straight, I will finally convince myself that there is no danger and stop tormenting myself»)

We then asked 18 psychologists (judges) in Rome to classify the first-evaluation part of the 32 models thus completed, according to 5 categories:
– Fear of guilt
– Fear of other people's judgment
– Fear of contamination from disgusting substances
– Fear of harm but without guilt
– Other

In particular, before reading out the models each judge was asked to carefully read the following instructions, which we have translated from the Italian.

> A description follows of a series of extracts from clinical interviews. Each one describes of a series of concerns caused by external events (e.g. contact with a given object) or internal events (e.g. a memory) that trigger a set of behaviours. You are asked to read the patient's assessments carefully and, for each patient, to answer the questions «what kind of concern worry does this patient have? What is the threat she/he fears most and that she/he is trying to avoid?» You are asked to choose from among five categories:
>
> *Fear of guilt*. The crucial concern of the patient is to avert feelings of guilt and of being guilty of having acted irresponsibly and thus of some behaviour for which she/he could be blamed; or else the patient is afraid that his/her own action/inaction can cause harm to other people or him/herself (for instance, «I fail to test the brakes and I am afraid that my carelessness of mine might lead to a pedestrian being knocked down»); or else the patient is concerned about breaking a moral or social rule (for instance, «I believe it is important to get to work on time otherwise I might be judged a shallow and sloppy person»).
>
> *Fear of being ashamed*. The patient's crucial concern is how to avoid making a bad impression (for instance, «I am afraid of having to address the meeting, as I might stammer, go red and be considered awkward») and being judged badly by others (for instance, «While I am talking to my doctor», «I realise I have made a serious grammatical error and wish the ground would swallow me up because I think he will think I am ignorant even though I know I'm not»).

Fear of contamination. The patient's crucial concern is that of coming into contact with some substance, not because it is dangerous, but because it induces feelings of disgust (for instance, «I have a feeling of disgust to think I am in bed reading a book borrowed from the library, as I have the impression that this might soil me, the pillow and the sheets», «It disgusts me to think of sitting down where someone else might have sat, perhaps dirty people who touched the seats with sweaty hands or even worse»).

Fear of harm. The patient's crucial concern is essentially the harm itself. His evaluations indicate that she/he is perceiving a threat, i.e. the risk of harm to himself/herself or to others.

Other. Any evaluation that cannot be included in the above categories may be included here.

The order of the 32 models referring to the patients was randomized within each presentation. The key question in the instructions was «What do you think is the patient's principal fear?». We then presented the five above mentioned categories to each judge in a different random order.

RESULTS

The mean number of choices for the 18 judges was 13,9 (SD = 3,3) for the Fear of guilt category, 9,2 (SD = 3,3) for the Fear of contamination category, 3 (SD = 2,1) for the Fear of being ashamed category, and 5,9 (SD = 2,7) for the Fear of harm category. The «Other» category was never selected.

The repeated-measures ANOVA on the number of times each of the four categories was preferred revealed a significant difference among the four categories, $F(3,51) = 35,55$, $p < 0,001$, $c^2 = 0,67$. As shown in Figure 1, the Fear of guilt category choice was significantly

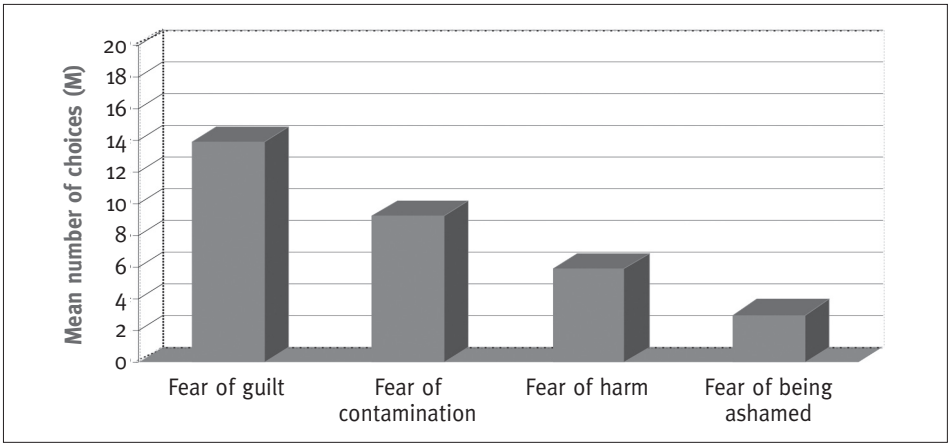


Figure 1 Mean number of choices for the 18 judges, for the four categories.

more prevalent compared to the other categories (Fear of contamination: $t(17) = 4{,}03$, $p < 0{,}005$; Fear of being ashamed: $t(17) = 10{,}16$, $p < 0{,}001$; Fear of harm: $t(17) = 6{,}17$, $p < 0{,}001$). The Fear of contamination category choice was significantly higher than both the Fear of being ashamed category choice ($t(17) = 5{,}22$, $p < 0{,}001$) and the Fear of harm category choice ($t(17) = 2{,}7$, $p < 0{,}02$). Finally, the Fear of harm category was chosen a significantly greater number of times compared to the Fear of being ashamed category, $t(17) = 5{,}27$, $p < 0{,}001$.

DISCUSSION

The results suggest the obsessive-compulsive behaviours of the patients in our group were mainly directed towards two targets: preventing guilt and contamination by disgusting substances. Both targets were much more frequent compared to those of preventing harm without any moral implications or any adverse judgment. Our results are thus in line with what Salkovskis (1985), Salkovskis and Forrester (2002), and Rachman (1993; 2002; 2006) suggest in their theories, and consistent with the results by Sica, Novara and Sanavio (2002).

As regards the fear of being ashamed, it may be of interest to add one further observation: the feared judgment did not have the characteristics of derision but rather of irritation, reproach or disgusted exclusion. For instance:

> ... it would be awful if I do not remember this! I am an idiot! I might have forgotten something fundamental and caused myself a lot of problems. I might be criticized and reproached by someone just because I don't remember something properly! I should remember all the important things!

Likewise, the theme of the guilt also emerged through other assessments classified as fear of harm, for instance:

> ... if I don't do anything to get rid of this feeling, I might actually even get a tumour. After all it doesn't cost me anything to make certain gestures to undo the feeling; the stakes are very high. If I don't do anything what will happen then? Not only will I die but my parents will suffer tremendously, as was the case when my uncle died. Even if I don't believe it, it suits me to behave as if I did.

Our research has several limitations. First, the number of patients and the fact that only Italians were involved, makes it difficult to generalize from the results. Second, the models were reconstructed by means of a clinical interview that may have been influenced by the cognitive behavioural training of the interviewers, who were also the patients' psychotherapists. Nevertheless it must be borne in mind that the interviewers reconstructed the model as part of the usual assessment phase, preceding therapeutic intervention and therefore, at the time of the interview, they did not know that the model would be used in this study. Moreover, the models were completed as far as possible using phrases uttered by the patients themselves. Finally, the models were corrected several times by the patients themselves until they considered them to reflect their actual experience.

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