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Cognitive-Behavior and Narrative Therapy in Obsessive-Compulsive Disorder

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1. Introduction

From its very beginning, behavior-cognitive therapy has been applied in the treatment of obsessive-compulsive disorder (OCD), particularly using the exposure with response prevention strategy.

This treatment has different components: one of them is the exposure to the situation that usually causes the compulsive behavior without completing the compulsive acts. The other is cognitive exposure to the secondary anxiety caused by the avoiding compulsory activity, with the confirmation that the feared situation doesn't come.

Cognitive Behavior Therapy (CBT) is as efficient as pharmacotherapy in the treatment of OCD and the effects last at least the same time. Some studies have found that the efficacy of the combination of CBT and medication is higher than that of each one separately. But the studies vary regarding the number of patients who achieved remission. Rodrigues et al [2011] revised published studies with CBT and pharmacotherapy and they found that the percentages of remission varied from 64% to 23%. But all the studies revised in their systematic review suggested the efficacy of CBT as a next-step strategy for treating patients who do not remit with pharmacological therapy only [1].

Almost 60% of patients with OCD do not respond adequately to medications and are considered to be refractory to pharmacotherapy [2]. Relapse rates are still high among OCD patients undergoing pharmacotherapy, from 24% to 89%, in part because of differences in study designs and definitions of relapse. CBT provides promise for OCD patients, with effectiveness rates ranging from 60% to 85%. Relapse rates three months after discontinuation of intensive CBT are up to 50%.

Desensitization, thought detention, flooding, implosion therapy, and aversive conditioning have been used in the treatment of OCD; all of them are based on the collaboration of the patient and the need of tolerating anxiety related to obsessive thoughts, avoiding acting the compulsions.

Following psychoanalytic view, OCD is related to aggressive impulses; so accepting them through introspective or cognitive therapy can produce positive results. Constructive psychotherapy can help some patients with good cognitive capacity. Cognitive component of therapy probably works emphasizing the creation of new representations and behaviors more than correcting distorted cognitions.

In some cases group therapy is useful; it has been proved in children and adolescent patients, populations that usually have problems to accept they are different to their peers. Group therapy enhances treatment adherence and facilitates the use of humor in therapy, particularly relevant for OCD patients because they live in a fearful and pessimistic world, and reveal a significant lower level of positive emotions, even compared with depressive population.

During cognitive therapy obsessions and compulsions are defined and relabeled as OCD symptoms, different from ordinary thoughts. Patients are encouraged to distance themselves from these obsessions and view these thoughts as strange to them. The exposure has to be planned, with a previous exposure hierarchy. Refocusing is a way of increasing tolerance for response prevention; refocusing on an alternative behavior facilitates response prevention and thought detention.

CBT procedures involve the selection and creation of alternative representations to restore more positive mood states. New directions in CBT try to modify a person's relationship to his/her negative thoughts rather than directly to challenge the content of the thoughts.

Mindfulness-based cognitive therapy is based on the application of Buddhist meditation techniques and it is beginning to be used in OCD as a complementary technique in treatment.

2. Obsessive-Compulsive Disorder — A brief explanation from cognitive approach

Obsessive-compulsive disorder (OCD) is considered a multifactorial disorder that can significantly impair functionality and quality of life [3]. Though obsessive thoughts are common in general population, in OCD the amount of time dedicated to them impairs the execution of normal functioning.

Patients with OCD selectively attend to fearful signs, but they generally present difficulties to inhibit irrelevant information as well. OCD is characterized for the preconscious deficit in the ability to process irrelevant information which is essential to symptoms formation and maintenance [4].

Compulsions can involve washing, ordering, cleaning, checking, seeking reassurance, repetitive actions as rituals, or mental compulsions, and their objective uses to be preventing some danger to oneself or to the loved ones, or avoiding anxiety provoked by the obsessions. Obsessions are found to be differentiated into five factors: contamination/cleaning, symmetry/ordering, aggressive/checking, pure obsessions, and hoarding [5]. Checking repetitions could be an altered function of memory of emotional events, a disability to distinguish what is the imaginary part of events or a deficient record without alterations of recent memory [4]. Repetitive checking behaviors are considered an example of the lack of certainty over the realization or not of an action. The patients cannot distinguish between “have done it” or “have imagined doing it”. This uncertainty could lead to obsessive doubts that provoked repetitive checking of doors, gas key, or others [4].

Classically OCD patients are classified as “washers” or “checkers”, but classified with five factors seems to be more explanatory. Cognitive vulnerability dimensions may vary according to symptom subtype: harming-related fears due to the spread of contamination patients have higher scores in responsibility/thread estimation when compared with patients with pure contamination symptoms [5]. Inflated responsibility beliefs are related to harming/doubting/checking obsessive compulsive symptoms. Responsibility appraisals are less relevant for washers than for checkers or patients with aggressive/harming obsessions. Patients with contamination obsessive compulsive symptoms demonstrate cognitive bias to thematically related symptom stimuli, but patients with harming obsessions do not evidence greater cognitive bias to responsibility words than contamination patients [5]. Contamination patients have poorer response to cognitive therapy than checkers, which has to be kept in mind when a treatment is planned.

Memories do not preserve a literal representation of the world [6], and memory retrieval is constructive. In OCD it is frequent to observe illusory memories about previous danger that have been avoided thanks to rituals. Long-term memories are influenced by the emotion experienced during learning [7]. Mood-dependent memory is the enhance recollection of information previously recorded in a specific mood state. In patients with OCD, neutral information about cleanliness, sexuality, or order, is invested with a strong emotional correlate and becomes a fixed and obsessive idea. The internal representation of previously experienced emotional stimulus may elicit a transient emotional state [7]. This mechanism impairs the efficacy of cognitive therapy, because if the therapeutic work is to reconsolidate a new memory trace, an emotional stimulus is needed. Cognitive-behavior therapy acts on the premise that emotional memories are modified upon retrieval. In narrative approach, the retrieval is used, but the objective is not to reduce anxiety thanks to be exposed to the memory in a safe environment. The final objective is to re-explain the past experiences with a new look.

People with OCD tend to present deficit in tasks which imply cognitive bias and distortions, and they can be more sensitive in front of stimuli related to their fears [8], though contradictory data are found. Affective images are more capable to provoke cognitive bias than neutral ones. People with subclinical obsessive-compulsive symptoms evaluate neutral images

less amiable than control people do, and all type of images as less controllable. OCD people need to feel control over every aspect of their lives.

Obsessions are caused by catastrophic misinterpretations of the significance of one's thoughts or impulses, similar to normal negative intrusions but more severe, frequent and upsetting [9]. There are two stages in the model: first an intrusion and then the misinterpretation of it. The OCD problems surge with the combination of perceived high responsibility and expectation of a future catastrophe. Some authors view responsibility as central in OCD, but others suppose it's secondary to other processes.

The feared scenario appears more easily in OCD imagination than non-feared scenarios. The repetition and "practice" of the same obsession results in the relevant simulation becoming more coherent and elaborated and reinforced through ritualizing, fixing the symptomatology [10].

Thinking errors that lead to obsessions can be derived from "fusions", as moral thought-action fusion (thinking of an action is as bad as doing it), thought-event fusion (thinking about an event provokes it), thought-thought fusion (thinking about having a thought is the same that having it) [9].

Criticism was defined as "a negative reinforcement which produces feelings of failure and has been identified as a poor way to encourage better performance" (Neapolitan, cited in 3). Among the difficulties in definition, criticism can mean different things for different people, from "an act of analysis" to having quite negative connotations. Self-criticism has been investigated in relation to mental health, and depends on feedback from others and internal thoughts.

Central to the cognitive model of OCD is the role of responsibility. The distress experienced in OCD has relation with the cognition of the self-responsibility about causing danger to oneself or the others. People with OCD need feeling control over external circumstances, managing them through rituals and compulsions.

Beliefs related to inflated responsibility have been proposed as one of six cognitive variables that play a role in OCD (Obsessive Compulsive Cognitions Working Group). The other five ones are: overimportance of thoughts (Thought Action Fusion), excessive concern about the importance of controlling one's thoughts, overestimation of threat, intolerance of uncertainty, and perfectionism [3].

The cognitive model of OCD emphasizes the role of early experiences that could predispose an individual to develop an OCD. Rituals and compulsive behaviors can appear as a way to avoid external criticism, and gain paternal approval. So, OCD could be the result of social training. The parenting style in families with OCD people uses to be overprotective and critical what could increase the need of control and responsibility. The experiences of recurrent criticism may increase the "subjective cost of being responsible". Harm eventually is described by OCD patients as excessive parental criticism. Overprotective parents may result in fearful children. If overcritical style is added, the result could be children who attempt to control and do everything right and avoid errors, resulting in checking behaviors. OCD pa-

rents' relationships frequently are characterized by perfectionism, high level of criticism and risk-aversion. It is frequent to observe familiar antecedents of compulsive behaviors or obsessive thoughts in OCD. Though it may be related to genetic factors, cognitive and behavioral styles are usually learned at home.

Perfectionism and responsibility functions are to maintain a sense of self-worth, maintaining approval from others, specifically to gain approval from hypercritical parents. Individuals with OCD may feel unsure about their self-worth due to receiving contradictory messages from a dominant parent during childhood. Dysfunctional responsibility and responsibility beliefs were related to an ambivalent sense of self. The cognitive model of OCD proposes that an individual fears harm coming to self or being responsible and blamed for causing harm. Compulsive behaviors may emerge as a way to regain a positive self-image or to retain social approval.

Responsibility in OCD uses to be high, and they are told frequently "you will be to blame if anything happens". When responsibility decreases, also anticipated criticism does.

Compulsive behaviors increase when an expectation of failure is present as well. There is a relationship between criticism and checking behaviours. These are preventive, though the cleaning ones are restorative. Through interactions with parents children learn to regulate themselves, so excessive criticism for mistakes or punishment for irresponsibility incites a concern with safety and responsibility.

3. Cognitive behavior therapy

CBT procedures involve the selection and creation of alternative representations to modify irrational ways of thinking and dysfunctional ways of behaving [11]. Desensitization and exposure have been largely used in the treatment of OCD patients. CBT has become the psychological treatment of choice for OCD, reducing symptoms to a level similar to that seen with pharmacotherapy, with clinical improvement maintained during follow-up [12]. In many studies CBT associated to medication management has demonstrated to be superior to the two strategies separately, even in pediatric age [13], though it seems to be more efficient the addition to CBT to people with a partial response to medication.

An obsession is both meaningful and irrational, part of the self and yet alien and intrusive [9]. For this reason, obsessions are a problem for cognitive approaches.

But CBT does not always lead to clinical improvement. Sometimes even secondary effects can appear during CBT, as nausea and abdominal discomfort, which are related to the anxiety provoked by the exposition and response prevention along the treatment [12]. New directions in cognitive approach attempt to change the persons' relationships with their thoughts, not to directly intervene over the thought content. The cognitive models usually assume that previous adversity provokes vulnerability in the form of negative representations of the self and the world (negative schemas). Selves can be based on wishes or aspirations, and in OCD, as in other anxiety disorders, symptoms are associated with a perceived

failure to be the person oneself thinks he or she ought to be. Also, anxiety can be related to feeling too close to a feared or undesired self, and striving to avoid experiencing it [11], particularly relevant to OCD. Learning is a constructive process, constantly producing new representations which can collaborate or compete with the preexisting memories to control behavior, so the construction of new representations can be more efficient in the correction of distortions.

In OCD treatment can be focused in reduction of anxiety level, understanding OCD as an anxiety disorder; focused in response prevention, trying to reduce compulsions; focused in exposure to images, objects or situations that provoke obsessions; focused, finally, in changing old habits by new habits [14]. It is important to integrate symptomatology with patient's story: how the disorder appears, which factors are maintaining it, what kind of coping strategies the patient is using to fight with the obsessions and compulsions.

Third wave of CBT includes new themes: metacognition, cognitive fusion, emotions, acceptance, mindfulness, dialectics, spirituality, and therapeutic relationship [15]. Change in metacognitions is effective in treatment of OCD. Metacognition is the aspect of cognition that controls mental processes and thinking. To this model, the cognitive attentional syndrome, a psychopathological state consisting of repetitive cognitive processes such as worrying, rumination, dysfunctional threat monitoring, and dysfunctional cognitive and behavioral coping are at the core of depressive and anxiety disorders [15].

OCD patients reveal a significant lower proportion of positive emotions in dreams than other people, and their dreams tend to be shorter, less complex and less emotional. These characteristics are not modified after CBT treatment, except the trend to show less negative emotions during dreams. Exposure does not seem to have traumatizing effect [16].

In patients with anxiety there is a preferential encoding of information that is consistent with the treat-related concerns [5]. The objective of cognitive therapy is to correct dysfunctional beliefs and information processes biases.

4. Treatment of OCD from a cognitive constructive perspective

Usually cognitive behavioral treatment of OCD is directed to develop a less threatening explanation of world and to prevent compulsive responses to obsessive thoughts in order to neutralizing those behaviors.

During cognitive behavioural treatment some patients present an impairment of depressive symptoms, specifically during exposure, but This group presents a higher level of improvement after treatment. It must be due to the integration of new knowledge and experiences, which initially could lead to a bigger "chaos" [17]. Changes are associated to system destabilization, old patterns are less viable, and new patterns emerge, what provokes fluctuations.

Beliefs and behaviors are supposed to be related one to each other in OCD, and this relation can be bidirectional. During treatment, changes in beliefs can be followed by changes in conducts, but also changes in beliefs can be preceded by the behavioral changes [17].

Higher levels of predicted criticism are related to poorer treatment outcome, because negative feedback is found to be less effective if the individual feels he has no influence over his performance.

Attributional style involves communicating a causal belief about an event, and high levels of relatives' hostility is related to high levels of responsibility attributions. Cognitive treatment of OCD tries to develop a less threatening explanation for the world. From a constructive perspective, it's important to develop a less dangerous perceived world, in which personal control does not determine all the life circumstances.

Memory distortions may reflect the influence of adaptative processes that are beneficial for cognitive functions, but also result in memory errors [18]. These distortions are based on the operation of a schema that is useful to organize and interpret information. Episodic memory supports the construction of future events by extracting and recombining stored information into a simulation of a novel event. Brain activity is highly similar during remembering the past and imagining the future [18]. This similarity could explain the link between thought and act that is observed in some patients with OCD.

The elevated expressed emotions act as stressors for OCD patients and enhance symptomatology, so an objective of the treatment must be coping with those and / or family therapy to reduce them.

Neutralizing behaviors such as compulsions have as an objective to prevent some danger that would produce blame from significant ones. The OCD behaviors are maintained to avoid criticism but are converted to stereotypical behaviors that no longer function in terms of the original reasons. And OCD behavior itself provokes further criticism and acts as a stressor to maintain behaviors.

When criticism is a focus in OCD treatment, Some previous questions must be answered: who delivers criticism, how, where it is delivered, how does the recipient perceive the feedback, if it is followed by punishment, and if it is overlapped with blame. The therapy focus could be accepting or managing actual criticism when it is accurate and directed toward appropriate targets. If patient is in an unsupportive environment, therapeutic work must involve family or significant others who are the source of criticism [3].

Other cognitive mechanisms implicated in OCD are heightened responsibility, thought-action fusion (TAF), self-doubt, overimportance of thoughts, cognitive control, perfectionism, overestimation of threat, and intolerance of uncertainty [10]. Obsessions are viewed as interferences about reality, arrived at on the basis of an inductive narrative: the reality is perceived initially adaptively, but as a result of reasoning errors, that vision derives in obsessional interferences: he or she is influenced by self-generated narratives that lead them to doubt their perception of external experience in favor of a hypothetical, internally generated version. These errors produce inferential confusion when a remote possibility is conflated with a fictional narrative, so the previously imagined becomes a real possibility. Then the individual acts as if this imagined supposition is potentially real and is drive to try to modify it, albeit unsuccessfully [10].

OCD is related to “inflated responsibility”, because responsibility is extended beyond its “normal” range [9]. A person with OCD acts “as if” personally responsible of the object of him or her obsession. They do not believe to have acted the obsession, but they feel as if it has happened. Some styles of information processing do not lend themselves to rational revision of beliefs, but the integration of these aspects of experience when integrating alternative narratives to the OCD narrative may change cognition in the process of therapy.

Imagination has a core role in OCD, as is demonstrated by the efficacy of imaginary exposure with response prevention. Imagining a future event increases the subjective likelihood that the event is going to occur, being more important when the event is easy to be thought. The concerns of OCD people are almost always about imagined events that have never occurred before, at least to them [10].

Treatment uses to be similar in children and adults, due to clinical similitude [19], but in younger there’s more evidence in behavior psychotherapy and pharmacological than in a cognitive approach. In the cognitive therapy one of the components is relabeling obsessions as symptoms, not ordinary thoughts. Patients are encouraged to distance themselves from obsessions and view them as bizarre messages. Refocusing on an alternative behavior is important, too, as a way to tolerate response prevention. Group treatment for OCD can be useful due to the sense of “being in it together”, that reduces anxiety [19].

Treatment of dysfunctional schemas is useful too in OCD, assuming these are in the origin of negative intrusions and its misinterpretations. Sometimes OCD is the result of the inability to cope with early experiences as abuse and emotional rejection. The assumption of a unitary and rational self underlies in cognitive view, though it has no restraining influence on the practice of cognitive therapy [9].

Narrative approach does not treat cognitions as stand-alone thought units, compared with veridical perception nor reduce them to schemas, but narrative theory considers thoughts in the experience and adaptative context of the person [9]. The narrative engages the person in his/her own problem and positions on it, so obsessions fit into a complete scene.

First stage in narrative therapy is to elicit narratives, asking people to present the problem in their own words, so it is easier to understand the relations among obsessional thoughts, personal relationships, beliefs... obsessions are not isolated items, empty of content. Thinking emerges as a part of a script, so responsibility can be origin of obsessions from “me” or from “others”, as a way to understand oneself or something that affects relationships with other people through the possible errors.

In dialogical approach, the inner world is studied in the form of interpersonal relationships: the concept of one self is expanded to a multiplicity of relatively autonomous “I” positions, each one with one voice. The voices of separate selves are validated socially, are heard, silenced or modified through dialogue [9]. Obsessions have an alien nature, that could be understood as a thought or behavior designed as “not me”, belonging to the unfamiliar self, revealed when people do not understand their own reactions. A dialogical approach sees the issue of designating and obsessional thought, image, or impulse as consistent or inconsistent with the “self” in a contextual and dialogical manner [9]. Some patients report that

they feel like another person when they are performing an obsessional ritual, they feel that the ritual is stronger than themselves. Self-generated narratives can modify confidence in alternative possibilities as well as actual perceptions.

The dialogical approach to obsessions interprets the specificity of obsessions in terms of an unresolved dialogue [9], that can be completed, rephrased or answered to move it to resolution. Many times the second voice is not present, so people with OCD are not able to answer it. But sometimes OCD people explain their obsessions as “voices”, different from the reason voice. In any case, obsessional neutralizing behavior would be dictated by the power of narrative, exposing and identifying with the person the processes by which narratives are constructed.

With the schema theory, OCD emerges when a conflict appears between contradictory schemas. Development of a unitary self is not possible in presence of incompatible attachment schemas. An excessive sense of personal vulnerability threatens identity. But OCD patients can have a high functioning in many contexts, with the problem centered in a specific situation, where the obsession emerges.

Many obsessions are consistent with the two-stage model of intrusions, in the way “If I think about it, I will become very anxious”, but some times there is a common framework, as to feel one is a sinner if a blasphemous thought (intrusion) appears. The themes of all obsessions fall into three categories, following Rachman (cited in 9): aggression, sexuality and blasphemy. Intrusive thoughts become more frequent, persistent and unpleasant when the threat is bigger. It is not clear if the theme of an obsession is related to developmental experiences and prior beliefs. However, from narrative framework it is possible to link it to earlier development, so the content of the obsession can be traced to children-parents’ previous experiences. The final aim of the treatment is to generate alternative accounts of the OCD experience which would modify the meaning of thoughts and behavior.

Viewing over-responsibility, exaggerated danger, improbable consequences and magical thinking within a narrative context helps to understand the development of them and explain the individual response pattern [9]. The therapy tries to empower the patient to modify his or her own obsessional narrative, not to ignore it or fight with it.

5. Obsessive-Compulsive Spectrum Disorders (OCSD)

Some disorders present clinical similarities with OCD, with the urge to execute a behavior though it is unwanted or lived as desadaptative followed by relief when it is done or anxiety if it could be done. These disorders are conceptualized as Obsessive-Compulsive Spectrum Disorders (OCSD). Some authors understand these as an addictive behavior. These disorders at the compulsive end respond better to SSRIs and those at the impulsive end (dysmorphic disorder, hypochondriasis, onychophagia, and psychogenic excoriation) appear to benefit from a wider range of thymoleptics [20]. But also all of them respond, at least partially, to CBT. Among Obsessive Compulsive Spectrum Disorders are described the following:

- **Body Dysmorphic Disorder:** associated to preoccupation with an imagined or overemphasized defect in appearance appear repetitive and often ritualistic behaviours (such as mirrorchecking and request for reassurance). Exposure to social situations avoiding camouflage, resist to compulsive behaviors and cognitive restructuring have shown to be beneficial. CBT plus psychopharmacologic treatment with Serotonin Reuptake Inhibitors (SRI) have demonstrated the higher response.
- **Hypochondriasis:** is the persistent fear or belief that one has a serious illness based of one's misinterpretation of body signs, which leads to hypervigilance. Treatment is based in restructuring faulty assumptions about physical symptoms and modifying maladaptive patterns of behavior that maintain symptomatology. Individual psychotherapy focusing on illness and symptom perception can be useful, too.
- **Trichotillomania:** recurrent pulling of one's hair with noticeable hair loss. There is an increased stress immediately before the behavior with posterior relief. Habit reversal therapy (selfmonitoring, competing response, thought stopping) is the more efficient CBT, also associated to acceptance and commitment therapy.
- **Pathological gambling:** uncontrollable urge or impulse to gamble that progressively increases in intensity until generating social and / or economic difficulties. Imaginary desensitization is more efficient than aversion relief or other behavioral treatments.
- **Compulsive buying:** implies shopping preoccupations or behaviors. The possible benefit of cognitive restructuring techniques to enable patients to develop more appropriated responses to their impulses has been suggested as efficient.
- **Kleptomania:** is characterized by the recurrent failure to resist impulse to steal items that are not needed for personal use or for its monetary value. Patients experience increased sense of tension prior to the act and a sense of pleasure, relief, or gratification when committing theft. There are no studies published about CBT in kleptomania.
- **Onychophagia and psychogenic excoriation:** chronic nail biting and compulsive skin picking are considered impulse control disorders, because the self-injurious behaviors are habitual, ritualistic, tension-reducing, and ego-dystonic. Competing response therapy is significantly superior to aversion therapy, and aversion therapy is superior to self-monitoring alone.

6. Conclusions

OCD is a chronic, severe, and sometimes incapacitating disorder which needs to be treated in a multifactorial way. Psychopharmacological treatment has demonstrated its utility in this illness, but the best results are obtained when it is associated to psychotherapy. This efficacy is more evident in patients who are resistant to pharmacotherapy alone.

One of the most proved therapies is cognitive behavioral therapy. CBT has many strategies to treat OCD. The most used strategies are exposure with response prevention, but these are

not applicable in all the patients, because they can provoke an increase of anxiety which could be unbearable.

We propose in this revision to work with a narrative approach, putting the disorder in the frame of the patients' lives, understanding how and when it has emerged, trying to find the sense of it, to give a new look to the disorder and constructing a new way to cope with the irrational or overemphasized ideas.

There are not many evidences of constructive or narrative approach in treatment of OCD, but we think constructivism has an important role in OCD treatment. Understanding the beginning of the disorder and the role of it into patients' lives improve the way the patients can face the symptomatology. This perspective helps the patients to re-explain the symptoms as a way to cope with a fearsome world which could be adaptative in a moment but these symptoms have lost their coping function when they have transformed themselves in a rigid way.

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