First meeting of the EABCT Special Interest Group on OCD
Assisi 2011

The first meeting of the EABCT SIG on Obsessive Compulsive Disorder has taken place in Assisi, Italy. It has been the first initiative of an EABCT SIG all over Europe, and the participants were all very excited to be part of this new project.

It is of common knowledge that OCD is one of the most disabling psychiatric disorders, generally very resistant to change. The price people pay if they are affected by OCD, or even if they are family members of an OC patient, are enormous. Scholars and researchers need to join their efforts in order to deepen their understanding of Obsessive Compulsive Disorder, and to find more effective ways of helping patients who are affected by it. The Assisi’s meeting has been organised in order to allow scholars and researchers a less formal and more interactive chance of meeting than international traditional congresses generally are.

This meeting has been made possible by the collaboration of various persons, who have believed in the importance of such an initiative: Rod Holland, president of the EABCT, who from the very start gave his support, Antonio Pinto as a member of the EABCT Board, and Francesco Mancini, director of the Specialisation School in Cognitive-Behavioural psychotherapy APC (Associazione di Psicologia Cognitiva).

The goal of this meeting was to foster the debate among experts on Obsessive Compulsive Disorder, to deepen knowledge on OCD’s mechanisms of functioning, maintenance of symptoms and treatment. The potential strengths of CBT has been deepened, thanks to the contributions of many different experts, studying the same disorder, but from different perspectives.

Moreover we wanted it to be an occasion of exchanging ideas among researchers and scholars on how to disseminate effective, sound, well-grounded Cognitive-Behavioural Therapy. We hope that, considering the reverberation that this event will have, both among professionals, and among the public, this goal will start to be reached.

The program of the meeting has been as follows:

Friday 20th May 2011-MORNING
9.30 Welcome to the participants Antonio Pinto, EABCT Board member

9.45-10.45 Presentation and discussion
Drawing together the cognitive model of OCD to improve its explanatory and therapeutic power, PAUL SALKOVSKIS (UNITED KINGDOM)

10.45 Coffee-break offered by EABCT

11.15-12.15 Presentation and discussion
Core fears, values and OCD, JONATHAN HUPPERT (ISRAEL)

12.15-13.15 Presentation and discussion
OCD and illusions of thinking, DAVIDE DETTORE (ITALY)

13.15 Lunch
Friday 20th May 2011-AFTERNOON
15.00-16.00 Presentation and discussion
The interconnectedness of low self-esteem and a sense of insecurity in OCD patients, GISELA RÖPER (GERMANY)

16.00-17.00 Presentation and discussion
The Nordic Long-term OCD Treatment Study (NordLOTS): The effectiveness of CBT treatment for pediatric obsessive-compulsive disorder, NOR CHRISTIAN TORP¹, KITTY DAHL¹, PER HOVE THOMSEN² and TORD IVARSSON¹ (¹NORWAY AND ²DENMARK)

17.00 Coffee-break offered by EABCT

17.30-18.30 Presentation and discussion
Why subtypes of OCD?, MICHAEL ZAUDIG (GERMANY)

20.30 Social dinner at “La locanda del cardinale”, offered by SITCC¹ and APC²

Saturday 21st May 2011-MORNING
10.00-11.00 Presentation and discussion
Fear of deontological guilt and fear of contamination in OCD, FRANCESCO MANCINI and AMELIA GANGEMI (ITALY)

11.00 Coffee-break offered by EABCT

11.30-12.30 Presentation and discussion
Obsessive-compulsive symptoms as proxies for inaccessible internal states, REUVEN DAR (ISRAEL)

12.30-13.30 Presentation and discussion
How compulsive perseveration undermines trust in cognitive operations, MARCEL van den HOUT (NETHERLANDS)

13.30 Lunch

Saturday 21st May 2011-AFTERNOON
15.00-16.00 Presentation and discussion
Potential benefits of using Acceptance and Commitment Therapy for different types of OCD, IFTAH YOVEL (ISRAEL)

16.00-17.00 Presentation and discussion
Treatment of OCD: state of the art, PAUL SALKOVSKIS (UNITED KINGDOM)

17.00 Coffee-break offered by EABCT

17.30-19.00 Working group

¹ Società Italiana di Terapia Comportamentale e Cognitiva, SITCC. www.sitcc.it
² Associazione di Psicologia Cognitiva, APC. www.apc.it
In order for those who were not present to get an idea of how interesting all the presentations have been, here are the abstracts:

**Obsessive-compulsive symptoms as proxies for inaccessible internal states**

*Reuven Dar*

Department of Psychology, Tel Aviv University (Israel)

One of the principal symptoms in patients with Obsessive-compulsive disorder (OCD) is persistent doubt, which can invade many domains of actions and feelings and can lead to a variety of pathological behaviors typical of OCD, including excessive self-monitoring, repeated checking, mental reconstruction, repeated questions and demands for external validation or reassurance. Following both classic and modern models of OCD, we have recently advanced the hypothesis that obsessive-compulsive (OC) symptoms, in particular doubting and checking, are related to a deficient sense of subjective conviction. We suggested that this deficit leads people with OC tendencies to monitor and question their own subjective experiences, thereby further undermining confidence in these experiences. Finally, we suggested that OC individuals develop and rely on "proxies" — objectively verifiable indicators of internal states — to compensate for their deficient subjective conviction. In contrast to the models of OCD cited above, we proposed that the deficit in subjective conviction is general, rather than limited to OC concerns such as safety and cleanliness.

A series of studies in our lab has provided preliminary evidence for our proposal, which we named the SPIS (Seeking Proxies for Internal States) hypothesis. In these studies, we compared the performance of students who were previously classified as high vs. low in OC tendencies on a variety of tasks that examined the extent of seeking and relying on objectively verifiable proxies in judging one's own preferences, perceptions, level of understanding and other subjective states. The results of these studies indicate that the hypothesized deficit in subjective conviction and the resultant seeking and reliance on external proxies in OCD are a general characteristic that is not restricted to OC concerns such as safety or cleanliness. If this is the case, then what might be the source of this general deficit in subjective conviction? There are at least two distinct possibilities: one is that OC individuals have intact access to their subjective states, but meta-cognitive processes such as excessive self-monitoring and self-questioning lead to doubts in regard to these states. This possibility is consistent with studies that show that excessive checking, whether behavioral or mental, can lead to increased distrust of one’s own memory and perception. The second possibility, on which my discussion will focus, is that inputs from internal states in OCD are attenuated, so that checking and self-questioning only serve to increase doubts that are grounded in a real deficiency in perceiving internal states.
OCD and illusions of thinking

Davide Dèttore

Department of Psychology, University of Florence (Italy)

A growing number of evidences suggests that obsessive-compulsive disorder (OCD) could be associated with cognitive deficits. OCD patients show mnestic and executive dysfunctions, as pointed out by several neuropsychological tests, and it is a common opinion that cognitive dysfunctions can play a relevant role in mnestic alterations of OCD patients by means of the mediation of ineffective organization strategies.

According to some authors, these cognitive deficits are considered central in the development of OCD symptoms. For example, OCD patients can’t use a global organization of their memories, but, on the contrary, their mnestic structures are localized and fragmented, leading to organization failure and consequently to abnormal levels of doubting and uncertainty in life events (Greisberg and McKay, 2003).

Other authors evidenced different cognitive alterations in OC subjects, such as inferential confusion (O’Connor, 2002; Aardema, O’Connor, Emmelkamp, Marchand & Todorov, 2005), in consequence of which they confuse an imagined possibility with a real probability, or cognitive flexibility deficits in problem-solving (Chamberlain, Fineberg, Blackwel, Robbins & Sahakian, 2006; Chamberlain, Fineberg, Menzies, Blackwel, Bullmore, Robbins & Sahakian, 2007).

In decision-making and in Bayesian probabilistic several researches (Milner, Beech & Walker, 1971; Volans, 1976; Fear & Healy, 1997) demonstrated in OC subjects a “data-gathering excess”: they required much more evidence to make a decision than normal controls.

Other researches in inductive and deductive reasoning (Péllissier & O’Connor, 2002; Simpson, Cove, Fineberg, Msetfi & Ball, 2007; Péllissier, O’Connor & Dupuis, 2009) showed that OC patients need more information and postpone the final decision.

In summary, many authors noticed the probable presence of specific cognitive distortions in OCD patients. In the present contribute we wish to underline the existence of some cognitive illusions that are normal and generalized in the population. Such illusions are able to facilitate the origin and the maintenance of OCD. We consequently will analyze, following the classification of Pohl (2004), illusions of thinking (conjunction fallacy, confirmation bias, illusory correlation, illusion of control, biases in deductive and causal reasoning), illusions of judgement (availability and representativeness, anchoring effect, validity effect), and memory illusions (associative memory illusions, effects of labelling and misinformation effect) and their relationships with OCD. In conclusion, we’ll draw some clinical implications and suggestions.
Core Fears, Values, and OCD

Jonathan D. Huppert

The Hebrew University of Jerusalem (Israel)

When providing psychoeducation to patients who have OCD, they sometimes respond by asking “But why specifically this type?” Over time, I have developed my answer to be that OCD “glums on” to the things that are most important to the person’s life- to their values. It knows how to “push one’s buttons” by focusing specifically on the areas, beliefs that the individual holds most dear, and uses the vulnerability of ambiguity or uncertainty to activate the fears that perhaps the person will act or not act in a way that will violate their basic beliefs. Values are defined as an idiosyncratic set of ideals he wants to achieve (Schwartz, 1992). I will discuss the concept of core fears and how these may map on to one’s values. I will describe some support for this notion from the literature on how religion impacts the presentation of OCD and from some case examples. I will propose that consideration of values in the treatment of OCD may account for alternative models including responsibility and guilt as the core determinants of OCD. In addition, I will show how such considerations may be in direct opposition to classical Freudian and some more modern psychodynamic models of OCD. Finally, I will present some ideas for future research to consider core fears and values beyond the symptom subtypes of OCD.
The interconnectedness of low self-esteem and a sense of insecurity in OCD patients.

Gisela Röper

Munich (Germany)

Self-esteem is generally low – at times extremely so – in people suffering from OCD. Their low self-esteem is closely linked to a chronic sense of insecurity. OCD-symptoms are seen as a way of striving to gain some sense of inner hold on managing daily tasks, which have become a major challenge. Since rituals usually have to be conducted despite knowing that they are unnecessary or exaggerated, OCD patients suffer from the well-known shame or guilt of not being able to resist the urge to ritualise. This means a permanent undermining of self-esteem.

From a clinical-developmental perspective, trajectories of different themes of insecurity will be described and how they combine into a sense of insecurity that is characteristic for this group of patients. A developmental stance is proposed as leverage to underpin cognitive-behavioural treatment methods. Attention must also be given to general self-esteem as an ongoing focus throughout treatment to provide a base for a lasting treatment effect. Here, the new approaches of the so-called “3rd wave” of behaviour therapy like ACT and MBCT amplified by a resource orientation add greatly to the treatment packages now available to OCD patients.
The Nordic Long-term OCD Treatment Study (NordLOTS): The effectiveness of CBT treatment for pediatric obsessive-compulsive disorder.

Nor Christian Torp¹, Kitty Dahl¹, Per Hove Thomsen² and Tord Ivarsson¹

¹ The Centre for Child and Adolescent Mental Health, Eastern and Southern Norway (Norway)

² University Hospital in Aarhus (Denmark)

Introduction:

NordLOTS is a Nordic long term, multisite stepped-care treatment study in Norway, Sweden and Denmark for patients between 7 - 18 years with a primary OCD diagnosis. The main goal of the study are 1) to identify and treat children and adolescents with moderate to severe OCD in local clinics, and 2) to evaluate treatment response.

Objectives:

The aim of the presenting paper is to assess the effectiveness of a family-based cognitive-behaviour therapy (CBT) in form of exposure and response prevention using the Children’s Yale Brown Obsessive Compulsive Scale (CY-BOCS) as the main outcome measure.

Method:

Approximately 250 and 300 children and adolescent with primary OCD were asked to participate in a clinical trial were all patients receive CBT with exposure and response prevention (E/RP) for14 treatment sessions as a first step in a stepped-care treatment approach. Assessment are done by an independent evaluator, at baseline and repeated at week 7 and 13. Patients are classified as CBT responder or non-responder based on CY-BOCS scores of 15 or below at post treatment. None responders will be randomized to either continued CBT or medication with SSRI in step 2. All patients will be evaluated and followed for every 6 month for three years in order to describe short and long term treatment benefits.

Hypotheses:

We expect that 30-40% of patients included in step 1 will be non- or partial responders and continue to step 2.

Inclusion and exclusion criteria:

The primary entry criteria for the study are as following:

(1) DSM-IV criteria for OCD as their primary diagnosis,
(2) OCD symptoms score as 16 or above on the CY-BOCS.
Exclusion criteria are few in order to receive as good representation for pediatric OCD as possible.
Measures:

Children Yale-Brown Obsessive Compulsive Scale (CY-BOCS).
Children’s Global Assessment Scale (CGAS).
Child Behavior Checklist (CBCL).
Clinical Global Impression – Severity.
Clinical Global Improvement.

Data management and analysis:

A within-subjects, repeated-measures analysis of variance was employed to examine change in CY-BOCS Total Score, CY-BOCS Obsession Severity, and CY-BOCS Compulsion Severity from baseline to post-treatment.

Results:

Some preliminary outcome data will be presented. Good treatment response from Step 1 is obtained in all participating countries. Our data indicate that the E/RP treatment produces a reduction in CY-BOCS total score. At present 649 children have been screened for participation in the study, in which 213 patients have been included. As many as 79% of the 125 patients who finished step 1 are responders with CY-BOCS score less than 15.
Why subtypes of OCD?

Michael Zaudig

Psychosomatische Klinik Windach, Windach (Germany)

Research on the phenomenology of OCD suggests that the DSM-IV-TR definition and ICD-10 definition of OCD have several limitations.

DSM-IV-TR definition implies that obsessions and compulsions are independent phenomena – that one or the other is necessary and sufficient for a diagnosis of OCD. Some experts argued that OCD ought to be defined by the presence of obsessions and compulsions. In DSM-IV field trials data showed that 96 % of OCD-patients exhibited both obsessions and compulsions. Only 2,1 % evidenced obsessions and only 1,7 % demonstrate compulsions without obsessions.

It has become increasingly apparent that OCD is heterogeneous and possibly composed of many different subtypes, for example hoarding, early age of onset, washing, checking, symmetry, ordering and arranging; pure obsessions, pure compulsions; compulsive hoarding; tic related obsessive-compulsive disorder; OCD with insight or without insight. Also these subtypes may share overlapping etiologic mechanisms and may respond to similar treatments, there also appear to be some important differences especially in therapeutic outcome.

Beside the subtypes of OCD, OCD appears to share characteristics with other disorders labelled as obsessive-compulsive spectrum disorders – OCS. OCS is considered to encompass between 10 or 20 conditions such as trichotillomania, body dismorphic disorder and tourette syndrome. Also the concept of an OCS remains highly controversial, especially as work begins on the next iteration of the DSM it is felt that advances in understanding and treating these putative OCS disorders can arise from a more critical examination of how they are similar to and different from OCD.

The aim of subtyping should result in more specific treatment strategies.
Potential Benefits of Using Acceptance and Commitment Therapy for Different Types of OCD

Iftah Yovel

Department of Psychology, The Hebrew University of Jerusalem (Israel)

Acceptance and Commitment Therapy (ACT) is a broad behavioral clinical approach which encourages values-committed action and fosters acceptance and mindfulness in areas where pain is inevitable. This discussion will focus on the potential benefits of integrating ACT theoretical perspective and clinical interventions into cognitive behavioral treatments of obsessive-compulsive disorders. The theory underlying ACT suggests that verbal representations, which are normally generated by the human mind, inevitably increase the psychological presence of pain and often lead to the dominance of language products over other sources of information. Furthermore, the adequacy of problem-solving strategies that are used to achieve desired goals and decrease suffering is substantially decreased when applied to private experience. Acknowledging the inevitability of psychological pain, ACT aims at replacing experiential avoidance and similar harmful processes which lead to psychological inflexibility with more adaptive strategies, with the general goal of pursuing broad life objectives. Thus, rather than emphasizing symptom reduction, ACT encourages mindful acceptance of unwanted experiences and fosters committed action which is consistent with one’s chosen values. Identifying and highlighting these values during the course of treatment is not often emphasized in other types of CBT for OCD. Also, certain broad types of traditional CBT interventions seem to be incompatible with ACT theory and practice (e.g., cognitive restructuring vs. acceptance or cognitive defusion). Others (e.g., exposure, behavioral analysis) are consistent with ACT, but ACT’s theoretical framework and the metaphors it uses in treatment may facilitate their administration.
How compulsive perseveration undermines trust in cognitive operations

Marcel van den Hout

Utrecht University (The Netherlands)

OCD patients are doubtful and try to reduce doubt by perseveration: continuing behavior beyond the point where the goal of the behavior is reasonably reached. OCD research on doubt/perseveration largely concentrated on memory doubt and perseverative checking. Data accumulated to show that perseverative checking has the ironical effect of increasing doubt about checked events.

Still, many OCD patients are uncertain about other cognitive functions like perception, text comprehension, reasoning et cetera. Ordinarily, such functions are carried automatically and the positive outcome of the ‘automatised’ functions is taken for granted, just like the outcome of one or two routine checks.

Interestingly, these non-memory uncertainties too are attended by perseveration: uncertainty about visual perception may be followed by staring, uncertainty about text comprehension gives rise to repetition of phrases or re-reading over and over again, uncertainty about reasoning stimulates step-by-step piecemeal reasoning. Experimental studies gave strong evidence that not only does perseverative checking breeds doubt about memory, but that perseverative perception, text repetition and reasoning have a similarly paradoxical effect of increasing uncertainty.

Thus, the “perseverative checking → memory distrust” phenomenon seems a special case of a more general phenomenon:

“perseveration → distrust of the cognitive function involved”

Obviously, then, we need an encompassing theory on how various types of compulsive perseveration fuel obsessive doubt. Such theory will be presented and illustrated with (preliminary) data.
Drawing together the cognitive model of OCD to improve its explanatory and therapeutic power.

Paul Salkovskis

University of Bath (United Kingdom)

The cognitive theory of OCD described in 1985 proposed that appraisal of responsibility for danger to self or others was not only central to the experience of distress in OCD, but also accounted for the motivation to engage in checking and neutralizing behavior. In this presentation, the further development of the cognitive-behavioural theory will be outlined.

Since 1985, the theory has been refined to clarify the role of OCD relevant and OCD specific factors. In the light of research carried out over the past few years, cognitive factors involving responsibility (specifically defined) can still be held to be central to the experience of OCD. The presentation will consider ways in which the theory has been elaborated and empirically evaluated to incorporate issues of sensitivity to harm arising from omission, the use of “just right” feelings in the decision to stop obsessional behaviours. Other research indicates the importance of “mental contamination” as a further type of OCD particularly related to past experience, and the way in which repeated action serve to increase perceived threat. These advances clarify the need for transdiagnostic and disorder specific treatment strategies and how these can best be linked together. It is still maintained that some form of appraisal in terms of responsibility for threat is necessary in forming the bridge between intrusions and compulsions in clinical OCD.
In this presentation we will argue the existence of two different guilt emotions: Altruistic guilt and Deontological guilt. According to appraisal theories of emotion, the two senses of guilt differ not in the activating event, but only by virtue of its interpretation in the context of individual goals, beliefs, or desires. In this perspective, deontological and altruistic guilt differ in the goals that could be threatened: the altruistic goal of benefitting another or the deontological goal of the “Do not play God” principle.

Evidence of these two distinct senses of guilt comes from a recent study by Basile and colleagues (Basile et al., 2011). Using an fMRI paradigm the authors found the existence of two different brain networks involved in deontological and altruistic guilt, which seem to involve the insula in deontological guilt, and the superior temporal sulcus and medial prefrontal areas in altruistic guilt. Further evidence in support of the existence of the two senses of guilt comes from a number of studies (Mancini & Gangemi, in press), demonstrating the different influences of the two emotions on individual moral preferences. Using the well-known switch version of the trolley problem, we found that altruistic guilt lead participants faced with trolley dilemmas to choose action (consistent with the altruistic goal of minimizing suffering), while deontological guilt lead them to choose inaction (consistent with the “Do not play God” principle).

We will then argue that obsessive-compulsive patients are more sensitive to deontological guilt than to altruistic guilt. Experimental data consistent with this hypothesis come again form a number of studies. In a first study, we demonstrated that obsessive patients expected to be faced with expressions of anger or disgust, more frequently than other anxious patients, when asked to imagine their fears to become real (Mancini, Perdighe, Serrani & Gangemi, 2010). Moreover, fMRI studies showed that there is an overlap between brain activity in deontological guilt and the brain of an obsessive patient during symptom activation. Finally, in a recent study we found that OCD patients solve problems like trolley dilemma by preferring inactions more than both other clinical and non-clinical individuals (Mancini & Gangemi, in press).

We will finally argue the existence of a special relationship between deontological guilt and disgust. Empirical evidence of the existence of this relationship will be presented.
Moreover, in addition to the very interesting position papers that were presented and discussed, we had the chance of talking, in the course of a working group, of several topics regarding the future of our SIG:

- How could we get funds?
- Which purposes could we fix, as a group?
- Can we do any multi-centric research?
- Can we do something in order for the psychological research on OCD to be more easily disseminated among the clinicians and the public (as opposed to the research on medication)?
- What could the next steps be?
- When and where shall we meet again as a group?
- Is there someone else we should include and invite to participate?

All the participants contributed with their thoughts and ideas to enrich the discussion. It has been agreed that a reachable purpose to reach jointly could be the development of a toolkit for the assessment of OCD.

We talked a lot about the problem of the poor dissemination both among the public and the professionals, of psychological research on OCD and of evidence-based treatments and how to let people know that effective psychological therapies are available. In the UK a lot of improvement in this field has been reached by the dissemination of reliable guidelines for treatment, such as the NICE guidelines. Thus many of the participants agreed on the idea of contributing to insert guidelines for effective treatments into various websites.

The working group allowed us as well to add new names of colleagues potentially willing to be part of the special interest group on OCD.

Our next meeting has already been fixed: we shall meet in May 2012, in Italy.

Participants came from Italy, Israel, Germany, Norway, Netherlands, United Kingdom

PARTICIPANTS:

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Grazia Spitoni (ITALY)
Iftah Yovel (ISRAEL)
Jonathan Huppert (ISRAEL)
Katia Tenore (ITALY)
Kitty Dahl (NORWAY)
Luca Cieri (ITALY)
The success of this meeting has really been beyond expectation. I must thank all the participants and all the colleagues who supported this project, and I hope to see all of them, and many more, in the next year’s meeting.

Barbara Barcaeccia