

EARLY LIFE EXPERIENCES IN OCD AND OTHER DISORDERS:  
A RETROSPECTIVE OBSERVATIONAL STUDY USING IMAGERY WITH RE-SCRIPTING<sup>1</sup>

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Abstract

*Objective:* The close link between obsessive symptomatology, guilt and inflated responsibility is well documented, although one might suppose that guilt sensitiveness and dysfunctional beliefs about responsibility are rooted further in time. Imagery with rescripting (IwR) is an emotion-focused technique that binds actual stressful emotions to past memories where similar feelings were activated. It is used to change the meaning of emotionally distressing memories, turning aversive mental images into positive ones, and achieving a healthier perspective on the event. The aim of this study was to compare the content of IwR exercises, collected during an on-going cognitive-behavioral psychotherapy, in OCD and non-OCD patients, in order to explore eventual differences in their early negative childhood memories. We expected guilt and blame-related childhood episodes to be more frequent in OCD, compared against non-OCD patients.

*Method:* Forty-one imagery exercises were collected and categorized according to their content, emotions, needs, type of re-scripting, and final cognitive re-attribution.

*Results:* OCD patients reported significantly more blame/reproach memories, expressing more guilt emotion and needs for acceptance. Within the re-scripting phase, all patients, regardless of their diagnosis, concluded the exercise protecting, reassuring and fostering emotional and needs expression, with no specific difference between groups.

*Conclusions:* This work has several limitations, including the subjective nature of the study, the small sample size and unbalanced gender distribution across samples. However, our findings are in line with cognitive models on OCD, supporting the role of guilt-related early experiences that seem to be specific to this disorder.

**Key words:** OCD, imagery with rescripting, guilt, early experiences, schema therapy

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**Declaration of interest:** none

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**Introduction**

The role of guilt emotion in obsessive-compulsive disorder (OCD) is well established. More specifically, according to some of the most influential cognitive models, inflated responsibility and guilt play a key role in the onset and maintenance of many obsessive symptoms (Arntz et al. 2007; Mancini 2001, 2016; Mancini and Gangemi 2004, 2011; Mancini et al. 2004; Rachman 1993; Rachman et al. 1995; Salkovskis et al. 1999, 2000; Shafran et al. 1997; Shapiro and Stewart 2011; Steketee et al. 1991). In this perspective, obsessions consist of mental contents that activate a hypertrophic sense of responsibility by signaling a perceived serious moral threat (e.g., doubts about wanting to kill one's own children and thus being a terrible person). In order to prevent or neutralize this threat, OCD patients activate some overt or covert behaviors, known as compulsions. Compulsions represent pathological solution attempts that activate paradoxical effects, for instance associated

to thought suppression (Abramowitz et al. 2001, 2009). Furthermore, because of the urgency of compulsions in response of obsessive thoughts or doubts, patients start blaming and criticizing their selves harshly. In long term, solutions attempts often foster new avoidance and compulsive responses, which in turn maintain obsessive symptoms.

Much is known about OCD onset and maintenance, while few studies investigated the role of early life experiences that might sensitize towards guilt feelings. In our clinical practice we observed many patients reporting childhood experiences characterized by guilt inducing parental style and severe reproach. Imagery with Rescripting (IwR) is an emotion-focused technique directed towards on negative early memories in order to change the meaning of distressing episodes, turning aversive mental images into positive ones and increasing the patient's sense of empowerment. Although IwR is an experiential technique, it is a rigorous approach where the therapist sticks to a precise protocol asking

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the patient to answer to specific questions. Also for this reason, it has gained increasing attention over the last years, being particularly used in Schema Therapy (ST, Young 2003), and its efficacy in reducing symptoms' severity have been proved in several studies applied to OCD and other psychological disorders (Arntz 2011, 2012; Veale et al. 2015; Arntz Weertman 1999). In a typical imagery exercise an image of one self as a child in a negative situation is identified and then improved by introducing a helping figure (i.e. the patient him/herself as an adult, the therapist or any other positive being) that fulfills the child's needs. Usually, patients treated with this technique experience positive feelings and develop compassion towards themselves as children, something they barely do that as adults. As well, they might understand that what has happened in their childhood was an (even if very sad and miserable) exception, that has nothing to do with loving and caring relationships, and that things did happen not because they were evil or bad, but because of others' troubles. IwR also help the patients to gain a different and healthier cognitive perspective on what has happened in their past and give them the chance to learn how fulfill their needs into their present.

The aim of this study was to investigate emotional content of early life stressful experiences in a sample of patients diagnosed with OCD and in a comparison group of patients with other than OCD diagnoses. We hypothesized that patients suffering from OCD would report more past episodes being characterized by blaming experiences and feelings of guilt, than what patients with other diagnosis would do. In line with our goal, we used Imagery with Rescripting technique to investigate adverse childhood memories and core emotions that might be linked with actual suffering. We collected IwR exercises that were categorized according to their content, emotions, and core needs, type of re-scripting and consequent cognitive re-attribution. We expected OCD patients' early life experiences to be more frequently characterized by guilt, compared to patients with other diagnoses. As well, we hypothesized more frequent responsibility and guilt-inducing parental styles and more frequent unmet core needs related to acceptance and forgiveness, in the OCD vs non-OCD patients' memories. Finally, we also expected different cognitive re-attributions in the re-scripting phase, with OCD patients moving from attributions such as: *"I'm guilty... I'm wrong... It's my fault... It is my responsibility"* to healthier ones like: *"It's not my fault... I'm ok... I have the right to make mistakes... I do not have to feel guilty because I did nothing wrong, I am just a child"*. Such attributions would not be present in the clinical control group.

## Materials and methods

Forty-one IwR exercises were collected in a sample of outpatients undergoing traditional cognitive-behavioral therapy (CBT) at the Scuola di Psicoterapia Cognitiva, in Rome (Italy). Inclusion criteria for the study were a diagnosis of OCD, for the experimental group, and an Axis I (excluding OCD) diagnosis for the clinical control group. Patients younger than 18 years old were excluded from the study. Additional exclusion criteria were mental retardation or evident cognitive deficits, psychosis and high levels of dissociative symptoms. Within the OCD group only, patients with any comorbidity were excluded from the study. The Axis I Structured Clinical Interview for DSM-IV Disorders (SCID-I; First et al. 1995) and Axis II (SCID-II; First et

al. 1997) were administered by trained and experienced clinicians to assess for specific psychopathology, at the beginning of each psychological treatment. Self-report measures specific to patients' primary Axis I diagnosis were also administered before therapy, but due to the different questionnaires used across groups we do not refer to such assessments. During an on-going CBT treatment, patients underwent one single session where their therapist applied IwR technique. In order to explore the actual and early emotional content of the episodes and the associated unmet core needs, the re-scripting intervention, and the cognitive re-attribution after the imagery exercise, we selected imagery exercises of forty-eight patients. Twenty-eight had a diagnosis of pure OCD (mean-age (SD)=33.0 (9.1) years; 14 males), while twenty patients were diagnosed with other Axis I or II disorders (mean-age (SD)=32.0 (8.4) years; 2 males).

## Procedure

IwR started with patients closing their eyes and imaging a recent stressful event (usually experienced in the two weeks before the session). Therapist request was very generic and patients were free to report any kind of episode where they had experienced a negative feeling, with no specific association to their actual symptomatology. The therapists, then, asked the patient to describe the selected event in detail, speaking at the present tense and in first person. Particular focus was driven on the emotions and on their associated bodily sensation. When the emotion was clear and strong enough, the therapist asked the patient to wipe the image of the current situation away, stay with the emotion (bridge affect) and to go back to his/her own childhood trying to catch an image that was associated to that emotion. The childhood image was then again explored with emphasis on emotions and needs. In the final re-scripting phase the therapist helped the patient as a child to fulfill his/her needs. By entering him/herself into the image (healthy adult) or by asking some aid to the therapist, or to any significant other. The main goal of this phase was to help the child to fulfill all his/her needs in order to feel safe, protected, loved, accepted, and so on. Afterwards, again, the child had to describe the scene from his/her own perspective with a specific focus on his/her feelings and thought after the re-scripting intervention made by the adult (i.e., him/herself, the therapist or others). If some new needs arose during this phase, again the adult intervened to fulfill them. When all child needs were fulfilled the exercise was concluded. In a final debriefing phase, with their eyes opened, patients gave their feedback about the exercise and together with the therapist a new perspective on the past event was given. All imagery exercises were recorded and patients had to listen to them as homework, in the week after the session.

In a following phase, only for research purpose, each therapist provided a summary of each IwR exercise labeling the emotion(s) of the current situation (used as bridge on the past), the main content of the memory, the age of the patient at that time, any significant others that were involved in the event, its emotional content, the unmet core need(s), and the intervention made by the healthy adult (or the therapist or any significant other) to fulfill such needs, and a final cognitive re-attribution about the event made by the patient after the exercise. IwR exercises were anonymized and categorized by four diagnosis-blind clinicians (B. B., C. P., O. I. L., B. D. S.) according to their contents. A second rating

**Table 1.** Main characteristics of the OCD and non-OCD group are reported

T-independent test, for age, and X<sup>2</sup> statistics, for the remaining variables, were performed to test for groups' differences; p values are ported in the last column.

Abbreviations: SD=standard deviation; ns=not significant.

	OCD group N=19	Non-OCD group N=18	P value
Age Mean (SD)	33.0 (9.9)	32.0 (8.4)	ns
Gender M/F	10 M/9F	2 M/16F	0.00
Undergoing Pharmacotherapy	N=7	N=1	0.05

by another blind judge was also performed, showing a good inter-rater reliability. Descriptive and X<sup>2</sup> statistics were used to compare all selected categories across the OCD and non-OCD groups.

## Results

Nine patients with primary OCD diagnosis were excluded from the study because of an additional psychopathological condition. Three patients satisfied DSM-IV-TR criteria for depression, four displayed a comorbid PD and other two presented an anxiety disorder. The remaining 19 cases received a pure OCD diagnosis. Descriptive statistics of the remaining patients included in the study are shown in **table 1**.

Patients did not differ in terms of age (total range 18-55 years old), but there were significantly more males within the OCD group. Primary diagnosis in the non-OCD clinical control group included depression (n=10), anxiety (n=7) and bulimic disorders (n=1). All patients participating in the study were undergoing a CBT protocol for their disease. One third of OCD patients underwent pharmacological treatment, while only one patient within the clinical group was taking drugs.

Overall data are reported in **table 2**, showing the most frequent answers given by patients within the different phases of the IwR exercise and reporting statistically significant differences between the two groups. In detail, OCD patients reported more frequently emotions of guilt within the recent distressing episode. Floating back to their childhood they described blame, reproach and guilt inducing memories, being mainly characterized by guilt and fear emotions. Mean age of the child within the past episode was around 8 years old. Both parents, separately or together, were involved in the stressful memory. Unmet core needs included acceptance, reassurance, care/love and, consistently, the re-scripting phase included protection and reassurance about their mistake or misbehavior. In the final debriefing phase OCD patients changed their perspective on the past event concluding that what had happened was associated to the others' problems/troubles (usually their parents), that it was not their responsibility and, thus, that they had not to feel guilty for what had occurred.

When considering the IwR exercises in the non-OCD group, patients reported feelings of anger and loneliness during the actual stressful episode, floating back to neglect, hyper-responsibilization, abuse or failure memories that involved only one parent (mother or father). The most frequent emotions characterizing their memory were loneliness, fear and sadness, with an associated unmet core need of attention, safety, care/

love and reassurance. Mean age within the negative memory was 8.8 years old. The re-scripting phase involved interventions of protection and reassurance, while within the cognitive re-attribution phase non-OCD patients concluded that what had happened in the past was related to "the others personal troubles", that they were a "lovable child" and that "it is ok to express feelings and needs".

The re-scripting phase generally involved the healthy adult of the patient, equally in both groups, although within the OCD group only, the re-scripting involved direct interventions by the caregiver who adapted his/her behavior to the patient's request, repairing and reassuring the child (i.e., "Mum hugs me and says it is ok and it was not my fault", "Parents comfort me and promise me that the day after they will help me at school").

## Discussion

In this retrospective observational study we explored significant negative early memories in patients with OCD and with other Axis I psychopathological conditions. Using IwR experiential technique we detected and compared emotions, unmet core needs, re-scripting intervention and cognitive re-attribution of an evocative past event in patients suffering from OCD and in others with a different disorder. Imagery technique allows connecting a stressful present event with a significant memory of the past, fulfilling its associated unmet emotional core needs and favoring a new perspective on what has happened in the past. In line with our hypothesis, OCD patient reported significantly more frequent actual and past emotions of guilt, referring stressful memories being characterized by parental blame/reproach and guilt inducing contents. Conversely, non-OCD patients (i.e., mainly diagnosed with depression or an anxiety disorder) reported emotions of loneliness and anger, typically associated with childhood neglect experiences. All patients, regardless of their diagnoses, reported unmet childhood needs of safety, love/care and reassurance, but only OCD clients indicated a more frequent need of acceptance and not being rejected by significant others. Whereas, non-OCD patients revealed more frequent needs of attention and "being seen" (i.e., emotional deprivation schema) by their caregivers. Conversely to our hypothesis, re-scripting interventions, made by the patient's healthy adult or by the therapist (or by both together), were similar across the two groups. Overall, re-scripting included protection (from the abuser or within the fearful situation), reassurance about the child's behavior or his/her deep/true self, and encouragement in expressing needs and emotions.

**Table 2.** Frequencies of each label within the IwR exercises are reported for both groups. Only the most frequent answers described by patients have been reported. P significances for Chi square or T-test are reported in the last column indicating significant differences across groups

Phase of IwR Exercise		OCD	Non-OCD	p value
<b>Emotion in the current event</b>				
	<b>Guilt</b>	<b>13</b>	<b>0</b>	<b>0.00</b>
	Anger	2	7	0.09
	Loneliness	0	2	0.08
<b>Main content of the memory</b>				
	<b>Reproach/Blame</b>	<b>7</b>	<b>1</b>	<b>0.03</b>
	Guilt inducing	3	0	0.08
	<b>Neglect</b>	<b>0</b>	<b>4</b>	<b>0.05</b>
	Hyper- responsabilization	2	3	0.6
<b>Age of the child In the memory</b>				
	Mean (SD)	8.0 (2.5)	8.8 (2.9)	0.8
<b>Figures involved in the image</b>				
	<b>Both parents</b>	<b>4</b>	<b>0</b>	<b>0.05</b>
	Father	6	4	0.5
	Mother	5	6	0.7
<b>Emotion in the memory</b>				
	<b>Guilt</b>	<b>11</b>	<b>3</b>	<b>0.03</b>
	<b>Loneliness</b>	<b>0</b>	<b>4</b>	<b>0.05</b>
	Fear	8	7	0.8
	Sadness	2	7	0.1
<b>Unmet Core need</b>				
	Acceptance	6	1	0.06
	<b>Attention</b>	<b>0</b>	<b>4</b>	<b>0.05</b>
	Safety	5	6	0.7
	Care/Love	5	4	0.7
	Reassurance	6	5	0.7
<b>Re-scripting</b>				
	Protection	8	8	1
	Reassurance	5	4	0.7
	Expressing emotions and needs	3	2	0.6
<b>Cognitive re-attribution</b>				
	Others' troubles	9	11	0.6
	<b>De-responsibilization/ "I am not guilty"</b>	<b>4</b>	<b>0</b>	<b>0.05</b>
	"I am lovable"	0	3	0.08
	"It is ok to express my feelings and needs"	4	1	0.1

Abbreviations: SD=standard deviation.



In the final debriefing phase, after the IwR exercise, the therapist and the patient gave a cognitive re-attribution about the event. Both OCD and non-OCD patients changed their perspective about the past event attributing what has happened to the other's (mainly the parents) faults or personal troubles. Additionally, while non-OCD patients, having reported more neglect experiences, changed their new perspective moving to attributions such as "*I am lovable, I deserve to be loved*", OCD patients moved from "*I am guilty, it is my fault*" to "*I am not guilty, it is not my responsibility*" attributions. We suggest this difference relies on the specific self-concept OCD patients develop about themselves compared to that of other patients. While the former perceive themselves as responsible for eventual mistakes or flaws, feeling deeply wrong and evil, and thus deserving to be punished, blamed or chased away, non-OCD early memories were characterized by feelings of loneliness and emptiness, based on the beliefs of being unlovable and thus condemned not to be seen or loved by their caregivers.

Our data are in line with previous literature (Barcaccia et al. 2015, Tenore 2016, Mariaskin 2009, Leonard et al. 1993, Tynes, et al. 1990, Salkovskis et al. 1999) highlighting historical vulnerability in OCD, suggesting that patients' early life experiences are characterized by high rates of parental criticism, blame and reproach, and by guilt induction. Conversely, our non-OCD patients did not report guilt-related stressful memories, corroborating the peculiar role of this emotion in OCD. While memories of OCD patients were characterized by reproach and criticism, non-OCD past episodes were characterized by emotional neglect. Contrary to previous cognitive models of OCD (Mancini 2016, Salkovskis 1999), hyper-responsibilization was present across all patients, regardless of their diagnosis. This might indicate that this kind of childhood experience might be common to different diagnoses and is not exclusive to OCD. For instance, parental-child or other hyper-responsibilization experiences have been reported in OCD, but also in other conditions (Salkovskis et al. 1999, O'Connor et al. 2002). Previous studies have shown that parental education style of OCD clients is particularly strict (Timpano et al. 2010) concerning morality, performance and unrelenting standards (Alonso et al. 2004). Blame and reproach represent the consequence of having accidentally violated parental rules and standards, "becoming morally bad or wrong". Another study (Van Noppen and Steketee 2009) revealed that patients with more severe OCD symptoms retrospectively rated their family members as more critical and hostile than those with less severe OCD symptoms. A construct from parenting literature, defined as "psychological control" (Barber 1996), includes manipulative parenting behaviors that impede a child's psychological and emotional development as an autonomous person. Psychological control can be expressed through a variety of parental tactics, including guilt-inducing strategies, in order to pressure children to comply with a parental request, contingent love or love withdrawal, where parents make their attention and care contingent upon the children's attainment of parental standards, and invalidation of the child's spontaneous expression of thoughts and feelings. Chiang (2013) proposes that psychological control in childhood might predispose towards the development of elevated trait levels of fear of guilt, leaving the child more vulnerable to developing OCD. Children of parents who frequently use guilt induction as a psychological control strategy may grow to fear feeling guilty, because it seems unpredictably (i.e., caregivers

pressure to feel guilt may arise both in situations for which children are culpable and when children have no responsibility at all) and might indicate imminent punishment or love withdrawal.

Commonly, OCD patients reported both parents to be involved in the stressful childhood experience, while control patients described the presence of only one caregiver. We think that having both parents, instead of just one, being critical/punitive might further boost the harshness of parental message and punishment. Additionally excluding the chance of having another caregiver who might repair and heal for the other's behavior. Previous literature on parental style of OCD patients report that it might be characterized by high negative expressed emotion, with high levels of intrusiveness and exaggerated emotional responses, interchanged with hostile and critical educational manners (Van Noppen and Steketee 2009, Pace et al. 2011, Salianni et al. 2016, Hibbs et al. 1991, Shanmugiah et al. 2002). In a recent study Chiang and Purdon (2018) investigated OCD clients inner dialogue associated with doubtful thoughts. Patients reported that their inner voices clearly revoked parental past messages and were characterized by an authoritarian, punitive and scornful tone of voice.

No differences have been detected between the two groups in terms of rescripting interventions. All patients, independently of their specific emotions or unmet core needs, seemed to benefit from increased protection, reassurance and needs and emotions' expression interventions. Types of re-scripting included protection from the abusive figure and safety interventions in the fearful situations, stopping the critical/blaming messages and reassurance about being a lovable, good, caring, or morally correct child. Normalization and reduction of the importance given to eventual mistakes or distractions carried out by the child were also applied. Other interventions also included validation and encouragement of needs and emotions' expression, as being part of a healthy and natural practice. All re-scripting were aimed at fulfilling the child unmet core needs and at helping the patient to gain a new and more functional insight on what had happened in his/her past, and was linked to more recent negative events.

Within the final cognitive re-attribution phase, patients discussed together with the therapist what had happened in the imagery exercise. Overall, all patients, regardless to their diagnosis, reappraised the past event shifting the focus from themselves to an external causal agent, centered on others' (mainly their parents) personal difficulties (i.e., mother had psychological problems, parents did not know how to deal with their current life problems, and so on). But, in a further clarification of parental difficulties, while non-OCD patients associated parental problems to their belief of being unlovable, OCD clients attributed the cause of their parents' troubles to their own mistakes or misbehavior. More in detail, before the imagery exercise, OCD patients interpreted what had happened in the past as being their fault, confirming their sense of inflated responsibility and their intense guilt feeling, derived from the belief of having caused others' suffering. Thus, gaining a new and healthier perspective on the past event allowed OCD patients to perceive themselves as "not guilty and not evil" anymore. Equally, non-OCD individuals changed their initial belief into that of themselves "being a lovable child". Our data are in line with the hypothesis that guilt plays a central role in the development and maintenance of OCD, as described in many cognitive models of OCD (Mancini 2016, Salkovskis 1999). Surprisingly, OCD patients' early memories were not

specifically characterized by emotional inhibition, as this pattern seemed to occur also in the control group.

Beyond its therapeutic role, imagery allows to get a better understanding of symptoms' onset and maintenance. In line with our observational data and with previous clinical evidence, we suggest that blame, reproach and guilt inducing negative experiences might shape child sensitivity toward specific cognitive and emotional contents related to forthcoming obsessive symptoms. These early experiences might have contributed to cultivate patients' sensitivity towards making mistakes, an overall sense of failure, unrelenting standards and perfectionisms, fear of punishment, and most of all, towards an inflated responsibility and sensitivity to guilt emotion. In line with the Schema Therapy model (ST, Young et al. 2003) our findings strengthen the role of specific childhood negative experiences in the development of early maladaptive schemas in OC pathology. Previous studies exploring the ST model in OCD revealed the role of specific maladaptive schemas in OCD. These include social isolation, punitiveness, failure, unrelenting standards, negativism/pessimism, and vulnerability to harm (Basile et al. 2017, Atalay 2008, Voderholzer et al. 2014). On the other hand, emotional neglect and feelings of being unlovable detected in our non-OCD patients, mostly diagnosed with depression, might refer to the emotional deprivation, abandonment and emotional inhibition schemas. These constructs have been previously detected in patients with depressive symptoms (Renner et al. 2013), where early aversive experiences such as abusive, neglecting and over controlling behaviors might have contributed to the development of chronic depression in adulthood.

Our study has many important limitations. The subjective nature of our research and the lack of reported validity represent an important pitfall, small samples' sizes, different gender distribution across groups, and diverse diagnoses in the control group. Another caveat refers to the lack of any outcome measure to detect symptoms' severity and change across time, although this was beyond the aim of this study. Finally, imagery exercises are, by their nature, retrospective and thus vulnerable to personal distortions. This might lead to false memories or biases, also related to the child's age and cognitive stage of development at the time of the memory.

## Conclusions

We think this study has the merit to shed a light on the specificity of peculiar childhood experiences that might sensitize towards future OCD development. Specifically, our data support the role of blame/reproach and guilt inducing early experiences in OCD patients, but not in individuals with other Axis I diagnoses. These episodes might sensitize patients suffering from OCD towards core aspects of the disorder such as guilt sensitivity, inflated responsibility, perfectionism and fear of making mistakes. The focus on the cognitive historical vulnerability is a central point of clinical intervention, and might facilitate symptoms' reduction (beyond and in combination with traditional Exposure and Relapse Prevention), promoting relapse prevention interventions and helping patients to get a deeper understanding of the development of their emotional/psychological problems. Using IwR specifically focusing on past experiences characterized by blame/reproach and guilt emotion might thus represent an eligible technique to use with patients with OCD in

order to access and heal their stressful emotions, and to enable cognitive re-constructing of beliefs about being evil and guilty.

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