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Schema Therapy and Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder (OCD) is characterized by recurrent intrusive thoughts, images or urges (obsessions) with or without repetitive mental or behavioural acts (compulsions).[1] OCD is a relatively common disorder. The Epidemiologic Catchment Area study estimates its lifetime prevalence at the 2,5%,[2] with an early onset and a chronic course. The National Comorbidity Survey Replication estimates an annual prevalence of 1.2% and a lifetime prevalence at 2.3%. In Europe, the economic burden of OCD among adults was estimated (2012) to be 2272 euro on average.[3] The Schema-focused Cognitive Therapy, developed by Young and co-workers in the years 1990-1999,[4] is an integrated psychotherapeutic approach combining various Cognitive behavioral therapy (CBT) techniques such as Exposure Response Prevention, of proven effectiveness, with elements of Attachment Theory, Gestalt, Interpersonal and psychodynamic theory.[5] The CBT component of Schema Therapy (ST) is strong; however, in ST there is a greater emphasis on the therapeutic relationship, as compared with the classical CBT, and more emphasis, as well, on affect and mood states. Characteristically, there is a greater attention to childhood origin and developmental process. Finally, there is more emphasis on lifelong coping styles.

Basic concepts of ST are:

- Early Maladaptive Schemas (EMS)

They are assumed to be stable constructs, developed in infancy and adolescence, made of memories, emotions, thoughts and somatic perceptions, contributing to the shaping of self-perception, identity, theory of relations with others and expectations.

- Modes

A Mode is an operational schema, adaptive or not adaptive, present in an individual in a given moment. One of the main objectives of ST is that of helping the patient to move from a maladaptive mode to an adaptive one. Ten modes grouped in four categories can be identified.

The therapist challenges and helps the patient challenging the validity of his/her schema. Experiential techniques and behavioural homework (with cognitive implications) contribute to the task. Imaginative procedures and role-playing are characteristic components of ST, with particular reference to Imagery with rescripting and chair work. The therapeutic relationship in ST is as essential as in any other psychotherapy approach, empathy and partial reparenting being here of paramount importance. It is evident that ST incorporates and integrates various components from different psychotherapy theories and approaches, mostly from CBT, which is the most established evidence-based treatment for Anxiety Disorders and OCD, although it has a 26.2% drop-out rate[6] and a 50% unsatisfactory outcome.[7] ST was originally developed to treat severe patients, such as Personality Disorders, not helped by CBT, supposedly those with greater difficulties in having access to and/or in changing their cognitions and emotions, ST focusing on the origin and development of disorders in the early periods of life. A novel approach such as ST, incorporating and integrating components of proven efficacy from previously established psychotherapies, is supposedly effective. However, in science, including clinical science, supposing is the beginning of the game, not the end of it. Reproducible and valid observations, measurements, comparisons are needed, as well as

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appropriate study design (RCT) and adequate sample size. A recent Systematic Review of ST effectiveness in patients affected by anxiety, OCD or Post Traumatic Stress Disorder (PTSD), out of the initially identified 41 studies, included only 6 of them in the final analysis, according to previously established criteria.[8] The results of these studies are certainly not incompatible with the hypothesis that ST can be beneficial in Anxiety disorders, OCD and PTSD, but, unfortunately, serious methodological weaknesses and substantial probability of Type B error, do not allow firm, definitive statements about the effectiveness of ST. The study by Baz and Özkorumak[9] published in this issue of the journal is an exceptionally important contribution. There have been previous studies on this topic,[10,11] but as the authors noted, their results regarding the "soft" signs in the healthy siblings of OCD patients can account for the variety and variability among the OCD spectrum disorders. There is much to be learned from the work of Baz and Özkorumak, particularly regarding the discussion of their results. In fact, they highlighted the relevance to determine the cause and effect of the association of EMSs and OCD. This could be a crucial point for the treatment of OCD. Studies on the association on EMSs and the severity of OCD are also needed. Admittedly, this is not an easy task but of paraomount importance for the proper treatment. Properly designed, conducted and analyses Randomized Clinical Trials are needed in this important area. They should ideally be large enough to allow the evaluation of ST effectiveness at different levels of OCD severity, comorbidity, metacognition. Outcome measures, times and numbers of assessments should receive due attention, but is needed given the great potential of ST.

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