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Efficacy of Group based Compassion Focused Therapy in Male Obsessive Compulsive Disorder: A Pilot Study

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Abstract

Introduction: Compassion Focused Therapy (CFT) engages Obsessive-Compulsive Disorder (OCD) patients in value-based action and changes the context of anxiety with self-kindness. The aim of the study was to explore the initial feasibility of CFT as a group therapy for OCD.
Method: This was a cross-sectional Pre, Post and follow up pilot study conducted in a group of five OCD patients based on purposive sampling. Patients were given group based CFT for 16 sessions. Assessment was done using Yale-Brown Obsessive Compulsive scale (Y-BOCS,1989), Beck Anxiety Inventory (BAI,1988), Beck Depression Inventory (BDI,1988), the Cognitive Intrusions Questionnaire (CIQ,1991), Obsessive Belief Questionnaire (OBQ 2005), Fears of Compassion Scale (FCS,2011), Other as Shamer Scale (OAS,1994), Subjective Well Being Scale (SWBS,1985) and Clinical Global Impression (CGI,1976). Data were analyzed using mean, standard deviation and repeated measure ANOVA with the help of SPSS version 25.
Results: Findings showed improvement in OC symptoms, anxiety, depression, avoidance behavior, on importance/ control of obsession thoughts, self-compassion, external shame and global symptom severity.
Conclusion: Findings suggests that group-based CFT is feasible and efficacious for testing on a large base of adult male OCD patients.

Keywords: Obsessive Compulsive Disorder, Depression, Group Therapy and Anxiety Disorders

Introduction

Obsessive-compulsive Disorder (OCD) is now one of the fourth most prevalent psychiatric disorders, with a lifetime prevalence of 2-3% [1]. However, despite the prevalence of this disorder, it is often underdiagnosed and treated which as a result imposes significant costs on both the patient and the health economy [2]. OCD is associated with functional disability and has debilitating effects on patient's day-to-day normal functioning to great extent. Cognitive-Behavioral Therapy (CBT), particularly exposure response prevention is one of the well-established psychological therapy for OCD [3]. Despite of its relative success, there are a significant number of patients who do not recover and there is relatively little data available on the long-term maintenance of gains (with that the dropouts and relapses remain high) [4]. Patients with OCD often feel responsible for indirectly harming others (e.g., accidentally causing harm by carelessness, contaminating an object) or directly (stabbing a loved one) which creates shame in them. These individuals start criticizing themselves for having such thoughts [5, 6]. Compassion Focused Therapy (CFT) is an emerging therapy, which is an integrative, scientific model based on evolutionary psychology, the neuroscience of affiliation, attachment theory, behaviorism, and cognitive behavioral therapy [7]. It also incorporates mindfulness and compassion [8]. CFT was developed for those with high

shame and self-critical individuals who cannot experience compassion; those who are most likely to have difficulties regulating fear with the use of affiliative systems. There is now increasing evidence that compassion-based approaches are associated with positive outcomes [8, 9]. Compassion is the way of helping individuals to train their minds, which can lead to a general improvement in well-being and ultimate enlightenment. CFT pose that individuals gradually learn to adopt compassion towards themselves and others which enables them to cope with challenging emotions with a greater degree of understanding, self-directed care, and support which further enables the most difficult change.

Mental health difficulties are understood as resulting, in part, from an imbalance among the three systems, typically an overactivation of the threat system and an under activation of the affiliative system [8]. The aim of the therapy is to develop the affiliative systems as a means of regulating the threat system. CFT seeks to de-shame and normalize emotional difficulties from the way our brains have evolved and the way we respond from our threat system, and the work on the role of social and emotional learning experiences have played to shape us over the course of our lives. Research has shown CFT to be effective in the treatment of specific mental health difficulties like psychosis [10], binge-eating disorder [11], acquired brain injury [12] depression and anxiety [13] and post-traumatic stress disorder [14].

CFT focuses on shame and self-critical thoughts in OCD which results from immoral obsessive thoughts, leaving behind a feeling of embarrassment for having such thoughts. CFT helps people with OCD to engage in value-based action and change the context in which they experience anxiety. It also increases the capacity to observe these experiences with self-kindness and from an observer perspective, it increases the psychological flexibility which can help them to better cope with their shaming thoughts. This increased interest in compassion is evidenced by numerous papers [15]. People who are affected by OCD are among those who have difficulty in regulating their emotions [16]. CFT attributes that anxiety arises due to overactive or oversensitive threat system and subsequent appraisals, but, in many cases underdeveloped regulation of the soothing system in particular that of endorphin-oxytocin link creates difficulty in using intervention of exposure and cognitive therapy as the person doesn't possess the emotional system necessary to experience alternatives, especially those of a verbal nature, as calming, soothing, and reassuring [17].

CBT has been proven to be a gold standard therapy for any kind of neurotic spectrum disorder including OCD [18]. Considering novel findings in existing research, application of CFT is challenging to authors, especially in India where the prevalence of male OCD are less than females [19, 20] and developing compassion can be difficult for males [21]. Unlike CBT, CFT not only targets symptom reduction but it also focuses on self-growth by reducing shame, self-criticism and improving compassion. CFT teaches the client to cultivate skills to develop compassion, which helps to regulate emotion and provide a feeling of safety, self-acceptance and comfort. There is a dearth of published research articles regarding the efficacy of CFT in male OCD. CFT in a group context highlights the significance of the relational aspects, common human conditions, and the importance of being able to give and receive compassion [22, 23]. The CFT group creates the contexts where they can share, help each other and explore what compassion is, as well as learn how to cultivate and share compassion to de-shame, validate, soothe and encourage them to face their fear. Henceforth, this pilot trial may contribute to novel research findings and also help in exploring future research in OCD.

Method

This pilot study aimed to explore the primary feasibility of group-based intervention (CFT) of male with OCD. A single group pre, post with follow up hospital-based cross- sectional pilot study had been conducted based on purposive sampling in the Central Institute of Psychiatry, Ranchi, India in 2018. The study was approved by the Institutional Ethics Committee in the same year. Assessments were conducted at pre-intervention, post-intervention and one month follow-up. The sample of this study included five male OCD patients according to the inclusion and exclusion criteria. The study had been conducted at the indoor, outdoor and psycho-social unit of the Central Institute of Psychiatry, Ranchi, India. Patients who had met the inclusion criteria were chosen. The inclusion criteria included the diagnosis of OCD (F42) as per ICD-10 criteria, Y-BOCS scores equal to or greater than 16, male gender, age group of 18 to 50 with a minimum education of primary education and those giving the informed consent for the study. Patients who were having severe depression or suicidal intent, mild severity in Y-BOCS (score lower than 15), current or past schizophrenia, bipolar disorder or organic disorder, mental retardation, lack of motivation for the treatment or lack of time available to attend the sessions and those who were not giving informed consent or refusal of the group setting were excluded from the study.

Participants in the age group of 18 to 50 years diagnosed as OCD as per ICD 10 criteria were selected from the inpatient male ward, outpatient and psychosocial unit of CIP as per the inclusion and exclusion criteria of the study. An informed consent was obtained from the participants. The socio-demographic details and necessary clinical information was obtained. Initial baseline assessment was done for participants. The CFT group was given 16 sessions; two sessions a week; two hours per session. At the end of the intervention, the second assessment was done with the same scales. Similarly, the follow-up assessment was done after a month.

Initially, eight participants were selected based on diagnosis and case record history using a purposive sampling method. Among the participants two did not fulfil the inclusion and exclusion criteria due to a Y-BOCS score less than 16 and having mental retardation, and one participant had dropped out. Finally, five participants were selected for the present study.

The assessment tools used in this study were as follows:

Socio-demographic and clinical data sheet: The socio-demographic and clinical data sheet includes the patient's name, address, age, sex, religion, educational qualification, family income, family type, habitat and clinical variables such as age of onset, duration of illness, treatment history, family history of medical and psychiatric illness, past history of medical and psychiatric illness, substance use, mental status examination and diagnosis.

The Yale–Brown Obsessive–Compulsive Scale (Y_BOCS): The scale was developed by Goodman et al. in 1989. The Y-BOCS measures the severity of obsessive-compulsive symptoms and is divided into two subscales, one for compulsions and the other for obsessions. Each one has five items and can be used independently. The total score varies from 0 to 40. Correlations between each item and the total Y-BOCS score ranged from r=.36 to .77. All rater pairs demonstrated significant correlations (r=.72 to .98; P<.05). It showed a high level of internal consistency with Cronbach α=0.83 [24].

The Beck Anxiety Inventory (BAI): This tool is a 21-item anxiety symptom checklist developed by Beck et al. in 1988. It covers core anxiety symptoms commonly experienced by clinically anxious patients across anxiety disorders from the Diagnostic and Statistical Manual of Mental Disorders. Patients rate symptom intensity for the previous week on a scale ranging from 0 to 3.The BAI has highly internally consistent, alpha = .92. and test-retest reliability over a week, r(81) = .75 [25].

The Beck Depression Inventory (BDI): This tool is a 21-item self-report measure that assesses symptoms of depression over the previous week. It was developed by Beck et al. in 1961, one of the most widely implemented measures of depression and is often utilized in treatment studies. The psychometric properties of the BDI are well established with internal consistency and found a mean α coefficient of 0.86 for psychiatric patients and 0.81 for non-psychiatric individuals [26].

The Cognitive Intrusions Questionnaire (CIQ): Freeston et al. developed this questionnaire in 1991 to assesses content, form, and appraisal of obsessions as well as neutralization strategies used with the target of obsession. It has three domains i.e., positive appraisal scale, negative appraisal scale and avoidance strategies scale**.** Its Cronbach's alpha ranged from .72-.92 for the three subscales across thought types [27].

Obsessive Belief Questionnaire-44 (OBQ-44): The Obsessive Beliefs Questionnaire-44 OBQ-44 was developed by the Obsessive-Compulsive Cognitions Working Group in 2005 to measure beliefs considered important in the development and maintenance of OCD. The questionnaire has three domains i.e., perfectionism and intolerance of uncertainty (PC), importance and control of thoughts (ICT), and responsibility and threat estimation (RT). The internal consistency coefficients (Cronbach a) for all three OBQ subscales were high and comparable to those reported for the rationally derived subscales (OCCWG, 2003). The internal consistency for the OCD sample were .93 for responsibility/threat estimation and perfectionism/certainty; and .89 for importance/control of thoughts; .95. The internal consistency for the three total scores was also high .94 [28].

Fear of Compassion Scale (FCS): This scale has been developed by Gilbert et al. in 2011 to measure fear of compassion for self (compassion we have for ourselves when we make mistakes or things go wrong in our lives), fear of compassion from others (the compassion that we experience from others and flowing into the self) and fear of compassion for others (the compassion we feel for others, related to our sensitivity to other people's thoughts and feelings). The Cronbach's alphas for this scale were 0.85 for fear of compassion for self; 0.87 for fear of compassion from others and 0.78 for fear of compassion for others [29].

Other as Shamer Scale (OAS): The OAS was adapted from Cook's 1988 [30] Internalized Shame Scale to measure 'external shame' [31, 32]. The scale consists of 18 items rated on a five-point scale according to the frequency of evaluations about how others judge the self, (0 = never to 4 = almost always). In the original study, the scale showed high internal consistency with a Cronbach's alpha of .92. The scale has been shown to have a high alpha level of .96.

Subjective Well-Being Scale (SWBS): This scale is a self-reported questionnaire developed by Nagpal and Sell in 1985. It consist of 40 items designed to measure an individual's mental status regarding overall feeling about life. There are 40 items divided into 11 factorial dimensions. The sum of all 40 items gives an overall subjective well-being score. Higher scores indicate a better subjective well-being and vice versa. The reliability of the SUBI inventory is 0.79, and the validity is 0.86 [33].

Clinical Global Impression (CGI): The CGI rating scales are commonly used as clinician-rated measures of global symptom severity and treatment response for patients with mental disorders [34]. It was developed by W. Guy in 1976, the validity of the CGI ranged between 0.52 and 0.74 reflecting moderate to strong associations between scores [35]. The reliability of CGI for the CGI severity is 0.66 and CGI changes is 0.51 [36].

The present study seeks to test this hypothesis that whether CFT is feasible and effective in male OCD symptoms and related variables.

CFT was applied to adults with OCD as a therapeutic module for eight weeks (16 sessions) adapted from Gilbert et al.'s Compassion Focused Therapy Module [8]. The module has been adapted for the current study. However, few therapeutic techniques had been tailored made to meet their need and a better understanding of the patient in order to meet the treatment efficacy. This tailored made culturally relevant therapeutic module had been approved by the institutional ethics committee. The details of the compassion focused therapy sessions are presented in Table 1.

Table 1. Compassion Focused Therapy Sessions

Sessions	Details
Session 1	Psychoeducation is about the nature of OCD and orienting the patient about CFT based therapeutic model as part of developing a compassionate understanding of onset of symptoms.
Session 2-4	Baseline assessment was completed along with soothing rhythm breathing and simple body scan and relaxation. Soothing rhythm breathing was taught, which involves learning how to pay attention on breathing in a gentle and kind way. Simple body scan and relaxation is an exercise that entails when trying to relax, just notice and return back when your mind wanders from focusing and relaxing. Allowing to focus on your breathing and becoming more relaxed as you become more familiar with your body with having more awareness of where tension sits on your body. A group discussion where participants were introduced and they were made comfortable with each other to share their experiences.
Sessions5-7	Compassion imagery focuses on creating a safe place where the person feels comfortable, safe and calm. It starts with a soothing breathing rhyme followed by mindfulness. Exercises like creating compassionate color and creating inner compassion are taught where the patient imagines a color in association with compassion and practices soothing breathing rhythm with compassion color entering the body. Patients develop the inner compassionate self through imagining kindness and compassion flowing out from you to others, compassion flowing into oneself and compassion to yourself followed by group discussion.
Session-8-12	Compassionate reasoning and thinking: Compassion focused thought balancing was taught where thoughts that have triggered difficult emotions were analyzed and tries to come up with an alternative thought by imagining one's compassionate self/image that help to cope with difficult feelings and thoughts. Patients were taught diffusion where they try to stop over identifying with their thoughts and feelings while imagining themselves as a compassionate and wise person that bring kindness and balance to their thoughts. A session of group discussion was conducted where patients discussed about their thoughts and feelings, and how they utilized the approach they learned in the therapy. Compassion feeling and behavior: The patients developed this skill through a compassionate letter writing exercise which helped them to learn how to stand back and reflect empathically.
Session-13-14	Sessions which focus on fear of and block to compassion are addressed to develop courage in order to confront and work with things which were avoided previously. Group discussion addresses an individual block to compassion and how other group members use strategies to overcome the block.
Session15-16	In the last two sessions, the therapy was summarized.

Results

The SPSS version 25 was used for statistical analysis. Descriptive statistics were used to describe socio-demographic and clinical variables repeated measure ANOVA was used to calculate the effectiveness of therapy over various time points in the participants. The level of significance was kept at 0.05.

Patients had a mean age of 31.20 years (SD 9.14) and the mean years of education for all participants was 13.60 (SD 2.51) along with the mean years of illness of 8.40 (3.05).

Mean score on Y-BOCS, anxiety, depression, avoidance strategies, importance/control of thought, other as shamer and CGI from pre-test to post-test and then in follow up had significantly decreased, which indicates a significant improvement. On the domain of compassion towards oneself, the score indicates a significant improvement of compassion from within over time.

The score on YBOCS ($F= 6.08$, $p =.025$) with an effect size of .60 indicated a significant improvement in OCD symptoms. The score on anxiety ($F = 11.43$, $p =.005$) with an effect size of .741 and on depression ($F=10.57$, $p =.006$) with an effect size of .72 showed significant improvement in anxiety and depressive symptoms. Further score on avoidance strategies scale ($F=8.63$, $p =.010$) with an effect size of .683 revealed that patients had started showing improvement over time in avoidance behavior in OCD.

On the importance/control of thought score of ($F=7.22$, $p =.016$) with an effect size of .64 indicated significant reduction in obsessive thought, i.e., giving importance to obsessive thoughts / trying to control the obsessive thoughts. With respect to compassion towards oneself, the domain score of ($F=15.8$, $p = .002$) with an effect size of .79 indicated a significant improvement in compassion domain of oneself. The others as shamer domain with the score of ($F=24.18$, $p =.0001$) and a high effect size of .858 showed a significant improvement in the feeling of external shame. Also, the score of ($F=45.23$, $p = .0001$) with a high effect size of .919, implies a significant improvement in global functioning.

Table 2. Descriptive Data of the Socio-demographic Variables

Variables	Mean	SD
Age (in years)	31.20	9.14
Education (in years)	13.60	2.51
Illness (in years)	8.40	3.05

**p ≤ 0.05; ***p ≤ 0.01; ****p ≤ 0.001

Table 3. Descriptive Data and Repeated Measure of Analysis of Variance of Clinical Variables

Mean and SD				Variance in Group over time		Effect size
Variable	Pre-test Mean ± SD	Post-test, Mean ± SD	Follow up Mean ± SD	F	P	
Y-BOCS	20.40 ± 4.67	17.40 ± 3.84	12.40 ± 4.82	6.08	.025**	.60
Anxiety	15.60 ± 7.64	11.00 ± 6.51	7.00 ± 6.63	11.43	.005***	.74
Depression	17.60 ± 6.47	13.40 ± 8.18	11.40 ± 6.58	10.57	.006***	.72
Avoidance Strategies Scale	105.60 ± 23.45	83.20 ± 14.97	66.20 ± 24.55	8.63	.010***	.68
Importance/Control of thought	37.40 ± 14.57	33.80 ± 14.30	30.20 ± 13.86	7.22	.016**	.64
Compassion toward oneself	16.00 ± 10.55	20.20 ± 11.30	22.00 ± 11.14	15.89	.002***	.79
Others as shamer	33.60 ± 13.16	27.40 ± 13.57	23.60 ± 13.73	24.18	.0001****	.85
CGI	5.00 ± 0.70	2.80 ± 0.44	2.4 ± 0.54	45.23	.0001****	.91

Discussion

In this current pilot study, CFT had been delivered in group settings. A total of 16 group therapy sessions had been given to five male OCD patients. In line with our hypothesis, results revealed that CFT has a positive effect on OCD symptoms along with anxiety, depression, avoidance behavior and importance/control of thought along with clinical global improvement. There is a significant change in the score of post assessment which increased at one month follow up. These results not only suggest that CFT is a promising therapeutic intervention to help individuals with OCD symptoms but also suggests improvement in compassion (compassion towards self).

Among the groups, participants reported that knowing others who had experienced similar psychological disorders helped participants to feel less isolated and inadequate. They also reported less shame in discussing about the psychological problems with others. This is supported by research on group CFT which indicates that discussing their experiences with one another helps the patients to develop affiliative experiences and reduce shame [8, 37].

We found that there is a significant improvement in OC symptoms. It is possible that compassion behavior helps patients to develop the courage to confront and tolerate OCD related thoughts. Additionally, when this thought is confronted with a compassionate feeling, it helps to cope better with obsessive thoughts. So, for example, when the individual has to engage in a difficult or frightening behavior, they will try to create an encouraging, warm tone in their minds associated with the supportive thoughts. All the time the client is taught to use warmth, compassion and gentleness as a reference point to move towards more threatening situations. Hence, it improves OC symptoms.

It has been found that individuals with OCD with high levels of self-compassion are less avoidant and are more psychologically flexible [38]. Significant improvement was noticed in an observational study in OCD patients [22].

There is a significant improvement in anxiety symptoms which can be attributed to the exercises i.e. soothing rhythm breathing, simple body scan and relaxation which helps the patients to tone down their anxiety as these exercises keep our mind concentrate on breathing while redirect the anxious thought as well as gentle breathing helps to feel relax. This is corroborated with research studies where CFT is found to be effective in reducing anxiety [9, 22].

Patients also reported a significant improvement in depressive symptoms. Compassion attention and thinking are the effective ways in reducing depressive symptoms through the use of technique i.e. mindfulness, compassion focused thought balancing and letter writing. It helps to regulate difficult emotion and learn to stop over identifying with negative thoughts and feelings.

Letter writing also helps to reflect on unhealthy thinking style and enable them to think in a compassionate way which reduces depressive thinking. Research on Practicing compassion-based exercises such as letter writing to oneself had found to reduce symptoms of depression [39]. Observational studies have demonstrated that the experience and development of compassion has been found to reduce depression in people [9, 22, 23].

The current finding of CFT's effect in reducing the avoidance behavior may be attributed to compassion thinking as patients with OCD have a tendency to cognitively avoid obsessive thoughts by distracting, replacing it with more pleasant and unpleasant thoughts, even reprimanded, planned to avoid anxiety threatening situations and dwelled about the consequences of the situation described by the thought. CFT improves information processing (decision making) through techniques like distancing and wise observing, breaking identification with one's thought and experiments that allow them to stand back and refocus with their compassion mind to bring more balance to their thinking.

Additionally, it improves compassion towards oneself as patients learned to become less critical for their condition and accept themselves for the person they are with feeling of warmth, support and kindness where the patients had approach to their distress through compassion focused imagery. Existing literature provides no such findings where compassion exercises have improved self-compassion. However, the current finding reveals that compassion feeling for other people and responding to the expression of compassion from others does not show any improvement as they find difficulties in imagining as obsessive thought intrude during the exercise. Improvement in self-compassion is noted in CFT [9, 10, 14, 23].

There is an improvement in external shame as with group compassion focused therapy. Patients felt less shameful in

discussing about their problems. CFT also significantly reduced external shame as measured by the OAS scale [22].

There is a significant improvement in clinical global functioning. Actually, CFT does not focus on symptom reduction rather, it focuses on global functioning as it helps to learn to tolerate, accept and work with difficult emotions. CFT shows improvement in the clinical global improvement. Increase in compassion in CFT group is associated with decrease in anxiety, depression and OC symptoms [8].

This study faced some limitations. As the sample size was small, it may have limited the generalizability of the current study. Since the participants were all male, it would have been interesting to see the impact of CFT on a female suffering from OCD. However, some participants suggested that the CFT approach may be less acceptable among individuals who prefer more goal-oriented and symptom-focused methods. The study is not a RCT study or has no control group for comparison. The study has shown some promising results which if replicated on a larger sample and when compared with other standard therapies may prove to be effective. These initial findings will contribute to future development of CFT for other disorders as well.

Conclusion

The findings corroborate that this study, as a pilot study, was effective and showed some interesting results, which can lead to future research. CFT showed promising effects in improving OCD symptoms, along with anxiety, depression, avoidance behavior, importance/control of obsessive thoughts and self-compassion. It also reduced shame and global symptom severity related to OCD. Taken together, CFT helps in symptoms reduction as well as self-growth. It is also the first Indian study on compassion focused therapy on OCD. However more randomized control trial researches are required to conclude whether CFT is used as a stand-alone therapy or adjunct to other therapies.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Ethical Approval

This study was approved by the ethics committee of the Central Institute of Psychiatry, Ranchi, India.

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