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Evaluation and Comparison of the Effects of Time Perspective Therapy, Acceptance and Commitment Therapy and Narrative Therapy on Severity of Symptoms of Obsessive-Compulsive Disorder

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Obsessive-compulsive disorder is a relatively common disorder and due to its debilitating nature, many studies have been conducted to reduce its symptoms. The purpose of this study was to evaluate and compare the effects of time perspective therapy, acceptance and commitment therapy, and narrative therapy on severity of symptoms of obsessive-compulsive disorder. The study sample consisted of 60 patients selected by accessibility method from all clients from Isfahan psychological and psychiatric services in 2013, and the Yale-Brown Obsessive-Compulsive Scale was administered on them. Results from multivariate analysis of covariance (MANCOVA) showed that differences between obsessive-compulsive severity symptoms in post-test and follow up stages in study groups were significant ($p<0.0001$). Also, there were significant differences in mean of obsessive-compulsive symptoms severity between therapy groups with control group, except for time perspective therapy.

Keywords: Obsessive-Compulsive Disorder, Time Perspective Therapy, Acceptance and Commitment Therapy, Narrative Therapy.

Obsessive-compulsive disorder (OCD) is a relatively common disorder and due to its debilitating nature, it causes serious problems for the patient, and his/her family. Some of its repercussions are loss of self-confidence, disappointment, reduction in educational and professional performance, personal failure in social relationships. According to Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5), OCD is classified as a separate class of psychological disorders; while it has been classified under anxiety disorders in the DSM-IV. According to DSM-5, observance of both or each one of obsession and compulsion symptoms is enough to diagnose OCD. Obsession refers to an uncontrollable frequent mental image, thought, unwanted desire that cause uncomfortable condition to the patients. The patient is not able to stop thoughts such as fear of air pollution, harming others or oneself, and expression of natural/sexual immoral desires. OCD is the fourth most common psychological disorder and is also a clinical challenge. In recent years, several medical and psychological treatments have been conducted to treat the disorder (Sadok & Sadok, 2007). Behavioral approach and other effective ways to encounter and prevent OCD responses are the first treatment options that help controlling the symptoms to a great extent. Nevertheless, the notable achievement regarding treatment of the disorder is undeniable, there are still cases that have no or negligible response to the treatment. However, there are patients who cannot approbate encountering methods and don't execute homework or the tasks (Sookman & Steketee, 2010). Although CBT is successful in treating OCD, many researches have been conducted to find out other methods with more efficiency (Rees & Vankoesveld, 2008). One of these approaches is time perspective therapy, that is rooted in social psychology and it is extending to clinical and psychological fields. It has to do with the way that people connect their behavior with the past, present and future and at the same time mirroring viewpoints, beliefs, and values pertinent to time. It also takes time as a quasi-trait structure constituted of several aspects including past positive, past negative, present fatalist, and present hedonist, and the

future. Time perspective therapy (TPT) is a novel treatment method based on time perspective theory (Zimbardo & Boyd, 1999). In general, psychological engagement with any time frames or loss of attention to a time framework appears to have to do with abnormal performance. As the theory implies, over past negative orientation, psychological engagement with negative experience, present fatalist orientation, or future negative are the strong indicators of psychological problems (Beek, Berghuis, Kerkhof & Beekman, 2011). Boyd and Zimbardo (2005) made it clear that treatment or a healthy psychological performance is achieved by maintaining balance between the past, present, and the future. This balance might be a reflection of an individual's capabilities to learn from the past, compatibility with the present, and preparing to encounter with orientated behaviors for the future. There is a pool of information of using time perspective theory in many heath facilities; while there is paucity of clinical psychology and psychotherapy studies. The first work on the role of time perspective on committing suicide was carried out by Laghi, Baiocco, D'Alessio & Gurrieri (2009). Beek, Berghuis, Kerkhof and Beekman (2011) examined the relationship between time perspective, personality, and psychological pathology and concluded that subjects with higher past negative scores were more vulnerable to stress and psychological symptoms such as anxiety and depression. In addition, they found a relationship between lack of orientation to future in time perspective and depression/suicide thoughts. Furthermore, positive relationship was found between neurosis and past negative perspective. Zimbardo, Sword and Sword (2012) codified a 6-session treatment protocol based on TPT to reduce PTSD symptoms. Given psychological engagement and compulsory behaviors of OPD patients, a sort of imbalance in time perspective can be spotted among the patients and the symptoms can be controlled by dealing with the imbalance. Following the recent surge of attention to limitation and shortcomings of the 2nd wave of behavior therapies, new approaches known as 3rd wave of behavior therapies emerged around two decades ago, which are based on mindfulness and field based interventions such as dialectic therapy, performance analytical psychological therapy, mindfulness cognitive therapy, metacognitive therapy, acceptance and commitment therapy (ACT). Comparing with the approaches in which clinical improvement entails with change in content of thoughts, emotions, and change of physical expression and form, the new treatments focus on frequency or positional susceptibility of cognitions and emotions (Hayes & Strosahl, 2010; Hayes, 2004). One of the appealing treatments of this kind is ACT, which was introduced by Hayes in 1986. The treatment, theoretically, is rooted in the communication system theory, and functional contextualism. The main purpose of ACT treatment is to create psychological flexibility, which means capability to make practical choice among variety of items, rather than doing something to distract oneself from disturbing thoughts, emotions, memories, or desires (Forman & Herbert, 2008). In fact, instead of form, content, or frequency, ACT emphasizes on change of function of thoughts and emotions. The patient, under ACT program is trained to accept their negative experiences, thoughts, and emotions, rather than changing them; therefore, they need to change their usual response (i.e. deletion or avoidance). ACT is featured with six key processes including psychological acceptance, psychological awareness, cognitive diffusion, the patient's background, determining values, and committed action (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Forman and Herbert, 2008). With regards to OCD, the ACT tries to teach the patients to find a new relation with obsessive and anxious thought, rather than controlling the thoughts, avoiding, seeding assurance, and so on. An obsessive thought is experienced as a thought, anxiety is felt only as an emotion, and therefore instead of taking time on controlling thought, obsession, and anxiety, the patient can focus on more important and fruitful jobs. The few studies on ACT and its effect on OCD have confirmed capacity and effectiveness of this method in improving psychological flexibility of the patients (Twohing, Hayes, and Masuda, 2006).

In addition to the non-encountering treatments mentioned above, novel treatment methods based on post modernism have drawn

attention of psychologists. Post modernists believe that knowledge and cognition are relative matters and depend on the context so that the system of beliefs only pictures social mental structures (i.e. different ideas) not the reality that people create about their world (Liotar, 2003). Studies on these novel theoretical methods suggest, regarding treatment procedures, that therapists should shift from detailed examination of problems toward holistic approaches in speech and speaking style of patients. People tend to organize their problems through holistic approaches, narratives, and the stories they share about their life. Among the holistic approaches, narrative therapy and solution-based treatment are two key popular approaches among psychologists and therapists. Under the former, the narrations expressed by people are used to delve into their emotions, feelings, and perspectives. People tend to act and react based on the narrations they have built and this process helps them to feel the capability of predicting and controlling their life. In fact, by narration people try to put their experience into a structure (Linehan, 2008). Narrative therapy, indeed, is based on the perception of the fact that the language people use to perceive their life is narrative. Instead of dealing with humans as, for instance, male, depressed [obsessive], narrative therapy takes the patients as unique history and helps them to review and reform these narrations and stories and rebuild more unique narrations that appreciate internal strength and responsiveness of the patients (Polkinghorne, 2004). Problem, under narrative therapy method, is not considered as a functional disorder, but rather as a narration that needs reediting, which is done through treatment. The procedure of treatment includes manipulating interpretations and beliefs (that may limit and disturb the normal way of life) of the referrals regarding the past events. Externalizing, unique outcomes, documents, an outsider witness are all the elements of this method. For instance, it is emphasized under externalizing that problems are not part of personality and existence of an individual, but they are rather imposed from the outside world and the therapist helps the patient to detach them from their character. The problems can be examined more accurately under this method. Under narration therapy, for example, instead of "you are obsessive", it is said "obsession is controlling your life." In fact, building a new narration needs new mental images and meanings. When we adopt stronger language, we enjoy a richer experience. In addition, there are no preset changes of mind to be imposed on the patients' personal experiences neither the patient is diagnosed with obsession, schizophrenia, or so on. Here, the patient is provided with special therapeutic dialogue in which the references, with some privileges, are both with the reader and the author of their tales (Prochasca & Norcross, 2013). Although, studies on narrative therapy approaches have started three decades before, many authors have emphasized on effectiveness of narrative therapy for psychological disorder patients (Shapiro & Ross, 2002). Among the studies done in this field, researches on using narrative approach for treating alcoholism (Kaminsky, Rabiowitz, & Kasan, 1996), sexual abuse victims (Drauker, 1998), and for helping the juvenile to find their identity (Murphy & Shigematsu, 2000) are notable. Griffin (2003) surveyed effectiveness of narrative therapy on an 8year old girl with OCD. The results indicated that the method was effective on reducing obsession symptoms among children and the juvenile.

Taking into account the absence of experimental study on effectiveness of time perspective therapy, ACT, and narrative therapy on the severity symptoms of OCD, the present study is an attempt to compare effectiveness of the three treatments. So, here are four hypothesis:

Hypothesis 1: There is a significant difference between the mean points of severity of obsessive-compulsive disorder among time perspective therapy, ACT, narrative therapy group, and control group.

Hypothesis 2: There is a significant difference between the mean points of total severity of obsessive-compulsive disorder of time perspective group and control group at the post-test and follow up stages.

Hypothesis 3: There is a significant difference between the mean points of total severity of obsessive-compulsive disorder of ACT group and control group at the post-test and follow up stages.

Hypothesis 4: There is a significant difference between the mean points of total severity of obsessive-compulsive disorder of narrative group and control group at the post-test and follow up stages.

Method

The study was conducted as applied and semi-experimental work using pretest-post test and follow up design. There were three experimental groups and a control group (n = 60). The participants were selected through convenience method among the study population, and comprised of all OCD patients referred to clinics, health facilities, and psychological and psychiatric centers located in Isfahan city (2013). The participation criteria included diagnosis of OCD, age range of 6-20 years, adequate education and intelligence to participate in treatment sessions, taking no psychiatric medicine or not changing the medication program in the past six months. Exclusion criteria for the sample was diagnosis of psychotic/bipolar disorder/drug abuse disorder, reluctance to take part in the study, and failing to attend the program for more than two sessions.

The study design included one independent variable of treatment framework at four levels: 1- time perspective treatment; 2-ACT; 3-narrative therapy; and 4-waiting list. Dependent variables included the participants' scores on the Yale-brown obsessive, compulsive scale (YBOCS). Once the participants were selected, YBOCS was used as pretest and then the participants were randomly classified in four groups. The experimental group 1, as time perspective therapy group, received time perspective therapy protocol based on Zymbardo, Sword & Sword (2012) during six 1hr weekly sessions. The experimental group 2, as ACT group, received ACT protocol during ten 1hr weekly sessions (Hayes, & Strosahl, 2010). Regarding the experimental group 3, as narrative therapy group, the participants received narrative therapy intervention during eight 1hr sessions. Finally, the control group was placed in the waiting list and in observance of moral codes and to remove irrelevant effects of the intervention, a 5hr workshop was held and preliminary information regarding OCD was provided without any therapeutic approach. Therefore, YBOCS was used as post test immediately after the end of therapy, and follow up was conducted two months after the end of therapy sessions.

Research tool

For data gathering, demographical information checklist including age, gender, marital status, education, occupation, record of the disease and previous treatment was used. In addition, DSM-based clinical interviews were performed by clinical psychologist and psychiatrists to confirm OCD and checking inclusion/exclusion criteria. Furthermore, Y-BOCS was used as standard tool to record and assess obsession symptoms, measure severity of symptoms, and the response to the treatment. Questions 1 to 5 were on obsession and 6 to 10 on compulsion, which measured five features of the symptoms including 1- spent time; 2 - extent of performance interruption; 3 - extent of hardship; 4 - resistance; and 5 - control. In addition, the obsessive and compulsive thoughts were ranked from 0 (no symptom) to 4 (maximum expression). The minimum and maximum points were 10 and 40 respectively (Abramowitz, 2006). The scale is a reliable and valid scale and it is widely used to measure severity of OCD. Dadfar, Bolhari, Malakuti, Malakuti, & Bayanzad (2002) obtained reliability (r = 0.98) and internal correlation (α= 0.89) of the scale, while the reliability of the scale was sought through retest method in two weeks period where a score of 0.84 was obtained. Rajeziesfahani, Motaghipur, Kamkari, Zahiredin, & Janbozorgi (2012) examined reliability and validity of Farsi version of (YBOCS) and the internal stability of two sections of the checklist (SC) and severity scale (SS) were obtained (0.97 and 0.95 respectively) and two-half reliability for SC and SS was obtained (0.93 and 0.98 respectively). In addition, retest validity was 0.99. In short, reliability and validity of the

scale is acceptable and it suits diagnostic and therapeutic applications.

Results

Mean points of severity of obsessive-compulsive disorder of the four groups throughout the three stages of the study are listed in Table 1.

Table 1. Mean and Standard deviation of four groups in three stages

Stage	Group	Mean	SD
Pretest	Control	27.86	5.34
	TPT	31.73	2.96
	ACT	28.53	3.70
	NT	23.93	3.59
Post test	Control	27.73	4.96
	TPT	28.13	3.92
	ACT	13.73	1.43
	NT	18.26	3.63
Follow up	Control	27.6	4.71
	TPT	31.2	3.21
	ACT	15.86	2.29
	NT	18.66	3.57

Hypothesis 1: There is a significant difference between mean points of severity of obsessive-compulsive symptoms among the time perspective therapy, ACT, narrative therapy group, and control group.

MANCOVA by control of pretest was used to examine this hypothesis. Results indicated significant relationship between pretest with post-tests and follow up (p = 0.0001). Furthermore, differences between total mean of severity of obsessive-compulsive symptoms in post-test and follow up were significant and values of the differences were varied from 0.53 to 0.82. Moreover, there were significant differences between the groups in post-test and follow up (p=0.0001). Therefore, hypothesis 1 was confirmed.

Hypothesis 2: There is a significant difference between the mean of severity of obsessive-compulsive symptoms in time perspective therapy group and control group at the post-test and follow up stages.

As shown in Table 3 and 4 there is no significant difference between the mean points of total severity of obsessive-compulsive symptoms of time perspective therapy group and control group at post-test and follow up stages. In fact, time perspective therapy failed to significantly reduce the mean point of severity of obsessive-compulsive symptoms when it was compared with that of the control group, therefore hypothesis 2 is rejected.

Hypothesis 3: There is a significant difference between the mean points of total severity of obsessive-compulsive symptoms in ACT group and control group at the post-test and follow up stages.

As listed in Table 3 and 4, there is a significant difference between mean points of total severity of obsessive-compulsive symptoms in ACT group and control group at the post-test and follow up stages. In fact, ACT led to a significant reduction of mean point of severity of obsessive-compulsive symptoms as compared to the control group; therefore hypothesis 3 is supported.

Hypothesis 4: There is a significant difference between the mean points of total severity of

Table 2. Test of between subject effects

Source	Dep. variable	Df	F	Sig.	Eta^2	Observed power
Pretest	Post test	1	40.52	0.0001	0.42	1
	Follow up	1	19.64	0.0001	0.26	0.99
Group	Post test	3	75.19	0.0001	0.8	1
	Follow up	3	60.14	0.0001	0.76	1
Error	Post test	55				
	Follow up	55				

Table 3. Total point of obsessive-compulsive symptoms at post-test stage

Dep. Variable	Group	Group	Mean dif.	Standard error	sig
Obsessive-compulsive severity in post test	Control	TPT	1.94	1.10	0/08
		ACT	14.40	1.04	0/0001
		NT	7.08	1.10	0/0001
	TPT	ACT	12.46	1.08	0/0001
		NT	5.14	1.27	0/0001
	ACT	NT	-7.32	1.12	0/0001

Table 4. Total point of obsessive-compulsive symptoms at follow up stage

Dep. Variable	Group	Group	Mean dif.	Standard error	sig
Obsessive-compulsive severity in follow up	Control	TPT	-1.83	1.19	0/13
		ACT	12.03	1.12	0/0001
		NT	7.13	1.19	0/0001
	TPT	ACT	13.87	1.17	0/0001
		NT	8.97	1.38	0/0001
	ACT	NT	-4.90	1.22	0/0001

obsessive-compulsive symptoms in narrative group and control group at the post-test and follow up stages.

As listed in Table 3 and 4, there is a significant difference between the mean points of total severity of obsessive-compulsive symptoms in the narrative group as well as the control group at the post-test and follow up stages. In fact, narrative therapy leads to significant reduction of mean point of severity of obsessive-compulsive symptoms in comparison with that of the control group; therefore hypothesis 4 is supported.

Discussion

Considering the lack of experimental studies on comparing effectiveness of time perspective therapy, ACT, and narrative therapy (as three non-exposure therapy) on severity of OCD, the present study compared effectiveness of these three methods and surveyed feasibility of employing these treatments as an alternative, novel treatments for OCD. The results showed that hypothesis one was supported, but hypothesis 2 wasn't supported. To the best of our knowledge, there is no similar study on effectiveness of time perspective therapy on severity of obsessive-compulsive symptoms. TPT failed to impose a significant reduction in severity of obsessive compulsive symptoms. Therefore, this therapy can be taken as complementary solution to be used along with other techniques and treatments. However, effectiveness of time perspective therapy on suicide (Laghi, Baiocco, D'Alessio & Gurrieri, 2009), anxiety and depression (Beek, Berghuis, Kerkhof & Beekman, 2011) and PTSD (Zymbardo, Sword & Sword, 2012) was reported. ACT significantly reduced mean points of obsessive-compulsive symptoms when compared with the control group. Instead of emphasizing on exposure, ACT emphasizes on experiencing internal events as they take place. The aim is to help the patient to experience an obsessive thought only as an experience and instead of responding to it, engage in doing what is in line with its values. The mere presence of the obsessive thought is not a problem, but the main issue is the patient's reaction to such a thought; which is known as psychological flexibility. Indeed, with regards to OCD, the ACT is aimed to find a new relationship with obsessive and compulsive thoughts instead of spending a great deal of energy and time to control, avoid, and ensure such thoughts. Obsessive thought is encountered as an experience and anxiety as

an emotion so that rather than spending a great deal of energy and time to cut such thoughts and anxiety, the patients can concentrate on valuable and important tasks (Lezadi, Asgari, Neshatdust, & Abedi, 2012). The processes of creating gap, acceptance, values, and committed action help OCD patients to undertake responsibility of behavior changes and cope with them when needed. Therefore, ACT maintains a balance between these methods. In flexible fields (e.g. evident behavior) the treatment focuses on changes and in inflexible fields it focuses on accepting and mindfulness. In practice, ACT trains OCD patients to take themselves as host of these thoughts and stop fighting them. The patients are asked to stop fighting and trying to control such thoughts. The findings are consistent with Lezadi, Asgari, Neshatdust, & Abedi (2012) results; they compared effectiveness of ACT and CBT and showed that ACT leads to a significant reduction in points of severity of obsessive-compulsive symptoms, although no significant difference was found between ACT and CBT.

Narrative therapy resulted in significant reduction between the mean points of obsessive-compulsive symptoms when compared with that of the control group, therefore, hypothesis four was supported. The patients under narrative therapy are considered as experts of their lives and their problems were separated parts of their lives. It is believed that the patients possessed many skills, beliefs, and values that enabled them to reduce effects of the problems in their lives. To this end, narrations of the patient's life are rewritten with assistance of the therapist. Critical points of life, key points, important relationships and memories that are still clear over the years are identified; the motto of the therapists is that "the person is not the problem; but the problem is the problem." According to narrative therapy, OCD are parts of life story, which have lost their track and psychological treatment is a practice to rebuild the story. In this way, the patients are helped to change their narration of their lives in a more constructive, realistic, and profitable way. Probably, the change of viewpoint also helps the patients to change their viewpoint regarding their lives, which leads to considerable reduction in severity of OCD symptoms. The results are consistent with Oconnor, Aardema, & Pelissier (2009) and Griffin (2003).

Conclusion

Given the results, ACT and narrative therapy were effective in reducing the symptoms of OCD patients, especially for patients that resisted to exposure treatment. Time perspective therapy also helped in reducing severity of obsession, but it can be used as a complementary treatment for OCD.

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