DEVELOPMENT OF A NOVEL INTEGRATIVE PSYCHOLOGICAL TREATMENT FOR OBSESSIVE COMPULSIVE DISORDER: COMBINATION OF NARRATIVE THERAPY, SOLUTION-FOCUSED THERAPY, ACCEPTANCE AND COMMITMENT THERAPY AND COGNITIVE BEHAVIORAL THERAPY WITH EXPOSURE AND RESPONSE PREVENTION

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Abstract
This paper represents a new comprehensive model of narrative therapy, solution-focused therapy, acceptance and commitment therapy (ACT) and cognitive behavioral therapy (CBT) combined with enhanced exposure and response prevention (ERP) for treatment of obsessive compulsive disorder (OCD). This integrative treatment highlights the particular strengths of the aforementioned treatment models and utilizes their components as complementary to each other. It may prevent the frustration of the limits of each approach and may also increase therapeutic outcomes. This integrative approach attempts to improve therapists’ capabilities in confronting with OCD patients who are resistant to treatment.

Keywords: Integrative psychological treatment; narrative therapy; solution-focused therapy; acceptance and commitment therapy (ACT); cognitive behavioral therapy (CBT); exposure and response prevention (ERP); Obsessive-Compulsive Disorder (OCD)

1. Introduction
Obsessive-Compulsive Disorder (OCD) is a complex heterogeneous disorder that has been identified by the World Health Organization as one of the world’s leading causes of illness-related disability (Koran 2000, Murray and Lopez 1996, Patel, Carmody, Simpson 2007, Skoog&Skoog, 1999). Therapeutic procedures for this illness is an example of the positive impact of modern researches on mental disorder. Psychological treatment for OCD can be historically viewed as consisting of three major approaches:

1- Traditional psychotherapy which is conceptualized OCD as a neurotic condition, with obsessive compulsive personality. When the defensive structure that maintains the personality breaks down, obsessive compulsive symptoms emerge. Although there is no evidence for an etiological explanation, suggestions include trauma during the anal phase, and conflict between a precocious ego and rigid superego (Breyman, 2002).

2- Behavior therapy and cognitive behavioral therapy (CBT) which are most effective psychological treatments for OCD. CBT involves exposing patients to anxiety-provoking stimuli while having patients resist from engaging in compulsive rituals or avoidant behaviors (Keeley, Storch, Merlo&Geffken, 2008). Through prolonged exposure, patients habituate to anxiety, and as a result,
they learn new objective information that is incongruous with previous distortions regarding perceived danger and responsibility (Foa & Kozak, 1986).

3- The relatively conceptualistic approaches such as Acceptance and Commitment Therapy (ACT; Hayes & Strosahl, 2004) and Mindfulness Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002). These therapies focus on symptom tolerance rather than reduction, and more flexible and adaptive ways of responding to unpleasant internal stimuli. Goals of these treatments focus on living in a meaningful manner, living according to one's values, focusing on the present moment and increased tolerance for negative emotions. These therapies have recently come to occupy a major place in the field of counseling and psychotherapy.

More recently, there has been an increased interest in the study of language processes in psychotherapy. Research and theoretical formulations of the therapeutic processes suggested that we must move from the microscopic study of verbal modes to a macroscopic approach in which these modes are organized into narratives (Gonçalves & Machado, 1999). In this approach narrative therapy and solution-focused therapy (SFT) are two increasingly used therapeutic modalities. Narrative therapy refers to a range of social constructionist and constructivist approaches to the process of therapeutic change. Change occurs by exploring how language is used to construct and maintain problems.

White and Epson (1990) believe that the base of narrative therapy is the idea that problems are manufactured in social, cultural, and political contexts. To deepen understanding, problems have to be viewed from the context in which they are situated. The core belief in solution-focused therapy is that the attempted solution would often perpetuate the problem, rather than solving it, and that an understanding of the origins of the problem is not always necessary. SFT offers the development of a solution that is not necessarily related to the problem; the client is the expert; if it is not broken, do not fix it; if something works, continue with it; if something does not work, do something else (Bennink, 2007). Only there are a few papers which utilize narrative therapy with cognitive behavior approach in OCD patients. In this paper the possibility of an integration of above mentioned approaches was considered and a new comprehensive approach was suggested. Almost all former approaches were included and utilized in the new approach. At first, Treatment gap of OCD was briefly reviewed, and then, theoretical framework of each approach, and the rationale of using them with OCD patients were explained. Finally, an integrated approach was introduced and the effectiveness of the method was discussed.

2. OCD treatment gap: the need for improved interventions

OCD is distinct from other than anxiety disorders with respect to psychopathology and treatment requirements (Frost & Steketee, 2002). Various aspects and different issues have been considered in different OCD therapeutic models that have focused on different theoretical mechanisms of change. Diversity of theoretical models and clinical therapeutic procedures related to OCD indicates the complexity and multiplicity of the illness formation. Among the factors important in the development of OCD treatment models, are those that emphasized on biological factors, behavioral mechanisms, cognitive distortions and cognitive processes. Substantial treatments of OCD include pharmacotherapy with serotonin reuptake inhibitors (SRIs) and cognitive-behavioral therapy (CBT). CBT with the necessary procedures of exposure and response prevention (ERP) is now considered to be the gold standard of treatment for OCD (Abramowitz, 2006). Several controlled studies have found that CBT combined with pharmacological treatment is not more effective than CBT alone for this disorder (e.g., Foa, Liebowithz, Kozak, Davies, Campeas, Franklin & et al., 2005). Although following ERP an average symptom reduction between 50 to 60 percent may occur for responders (Abramowitz, 1998), complexity of the disorder causes poor response and no adherence which consequently reveals as unwillingness or inability to collaborate fully with ERP in sessions and home practice (Araujo, Ito, Marks, 1996; Whittal, Thordarson, & McLean, 2005). It is reported that approximately 50 percent of patients still do not respond optimally to CBT, even when combined with pharmacotherapy. These patients refuse treatment or drop out (20%), not improve, (25%), or have relapsed by follow-up (Baer & Minichiello, 1998; Cottraux, Bouvard, & Milliéry, 2005). Hence, mean symptom severity following treatment is within the mild range and residual symptoms may persist for a substantial number of
patients. A meta-analytic study showed that among intent-to-treat samples, about one half improve and only one quarter can expect to recover completely (Sookman & Steketee, 2007; Eddy, Dutra, Bradley, & Westen, 2004). Furthermore, OCD shares a relatively high comorbidity with a number of other mental disorder including other anxiety disorders, mood disorders and tic disorders. Among mental disorders which are comorbid with OCD, depression is one of the most investigated conditions in the treatment of OCD. In addition, findings are largely inconsistent in regard to the predictive value of comorbid depression on OCD treatment outcome. According to the findings there is a relation between higher rates of depression and poorer outcome (Abramowitz, Franklin, Street, Kozak, & Foa, 2000; Abramowitz & Foa, 2000). Researchers have postulated some explanation for this relationship such as delay in habituation process during exposure to anxiety-provoking situations due to over reactivity showed by some depressed patients, lack of the motivation to engage in a demanding treatment like exposure and response prevention, and higher tendency to misinterpret the significance of intrusive thoughts in these patients (Keeley, Storch, Merlo & Geffken, 2008). Depression can also influence the degree of adherence, therapeutic alliance, and motivation to change, and patients’ expectancies of treatment effectiveness. These factors were considered as most important of therapeutic effectiveness, which has proven as a powerful predictor of psychotherapy outcome. (Kirsch, 1999; Vogel, Hansenb, Stilesa & Gotestamb, 2006).

Considering the limitations of OCD treatment, finding alternative approaches to enhance effectiveness of established treatments merit further exploration. An interesting potential route to develop a more efficient and cost effective psychological treatment for OCD is to integrate the diverse therapy models to cover various aspects of OCD and reduce the frustration of the limits of each approach along its benefits. Such an approach may also increase therapeutic adherence and treatment response with reduction in likelihood of premature termination of treatment.

3. Integrative psychotherapy

Integrative psychotherapy is an effort to combine concepts and counseling interventions from more than one theoretical psychotherapy approach. It is not a particular combination of counseling theories, but rather it consists of a framework for developing an integration of theories that Clinicians find most appealing and useful for working with patients (Norcross & Goldfried, 2005). According to Norcross (2005) Psychotherapy integration is characterized by dissatisfaction with single-school approaches and a concomitant desire to look across school boundaries to see what can be learned from other ways of conducting psychotherapy. The ultimate outcome of doing so is to enhance the efficacy, efficiency, and applicability of psychotherapy (pp. 3–4).

Clinicians have used a number of ways to integrate the various counseling theories or psychotherapy, including technical eclecticism, theoretical integration, assimilative integration, common factors, multitheoretical psychotherapy, and helping skills integration (for review see Norcross & Goldfried, 2005).

Among these approaches Multitheoretical frameworks do not attempt to synthesize two or more theories at the theoretical level. Instead, there is an effort to bring some order to the chaotic diversity in the field of therapy. (Prochaska & DiClemente, 2005). The goal of multitheoretical approaches is to provide a framework that one can use for using two or more theories. Two examples of multitheoretical frameworks are (1) the transtheoretical approach by Prochaska and DiClemente (1984, 2005), and (2) multitheoretical model by Brooks-Harris (2008). Multitheoretical therapy presents five principles for psychotherapy integration, which include (1) intentional integration, (2) multidimensional integration, (3) multitheoretical integration, (4) strategy-based integration, and (5) relational integration. The first principle states that psychotherapy integration should be based on intentional choices. The therapist’s intentionality guides his or her focus, conceptualization, and intervention strategies. Principle two (multidimensional) proposes that therapists should recognize the rich interaction between multiple dimensions. The third principle emphasizes that therapists take into consideration diverse theories to understand their patients and guide their interventions. The fourth strategy-based principle says that therapists combine specific strategies from different theories. Strategy-based integration uses a pragmatic philosophy. Underlying theories do not have to be reconciled. The fifth or relational principle proposes that the first four principles must be enacted within an effective therapeutic relationship. In this paper, Inspired by Multitheoretical framework, the
possibility of integration of mentioned approaches without attempt to synthesize them at the theoretical level was considered.

4. Psychological treatment models

4.1. Exposure and Response Prevention (ERP).

The aim of ERP is to allow patients with OCD to experience repeated situations in which they are confronted with fearful stimuli that trigger obsessions and distress (exposure), while refraining from engaging in rituals or behaviors normally used to decrease this distress (response prevention). ERP treatment is based on basic behavioral learning principles of extinction and habituation, largely pioneered by Meyer (Meyer, 1966; Meyer & Levy, 1973), in which fears and anxiety tend to decrease and extinguish after repeated exposure to a stimulus. The exposure segment of ERP therapy can occur in one of two ways: The patient can be encouraged to confront the fearful stimuli in low-risk situations (in vivo exposure), or the patient can be encouraged to imagine situations that are aversive and frightened (imagine exposure).

The response prevention segment of ERP treatment is equally important to the success of OCD treatment due to the fact that, if patient is allowed to perform rituals during the exposure session, the learning experience would be circuited. More specifically, the goal of ERP is to help the patients to realize that feared situations in which they obsess over, are often not truly as dangerous as they believe, and the anxiety can reduce just on its own without the help of compulsive rituals or avoidance.

Considerable research has examined procedural variants related to outcome in ERP (for review see Abramowitz, 2006). Abramowitz (1997) reported that (a) therapist-supervised exposure was more effective in the short and long term compared to exposure performed only by the patient as homework assignments; (b) ERP that involved completely stopping rituals during treatment (complete RP) was more effective than partial RP; (c) prolonged (90-minute) exposure sessions held several times weekly with frequent homework resulted in larger symptom reduction; (d) combining in vivo and imagined exposure was superior to in vivo exposure alone in reducing anxiety symptoms (Foa& Franklin, 2003); and (e) reassurance seeking during ERP interfered with improvement (Abramowitz, Franklin,& Cahill, 2003).

4.2. Cognitive Behavior Therapy (CBT)

Accordingly, cognitive conceptualizations and treatment strategies have developed to focus on dysfunctional appraisals and assumptions that appear to give rise to obsessive-compulsive symptoms (Freeston, Rheume, & Ladouceur, 1996; Frost & Steketee, 1997; Obsessive Compulsive Cognitions Working Group, 1997, 2003, 2005; Salkovskis, 1985, 1989; Salkovskis & Westbrook, 1989). These models are invaluable in elucidating specific aspects of psychopathology in OCD that have been empirically examined. The Obsessive Compulsive Cognitions Working Group (OCCWG, 1997, 2003) identified several domains of dysfunctional beliefs related to obsessions and rituals in addition to responsibility beliefs; these include over importance and need to control intrusive thoughts, overestimation of threat, intolerance of uncertainty, and perfectionism.

Treatment requires modification of these beliefs involved in and leading to the misinterpretation of intrusive thoughts as indicating heightened responsibility, and of the associated behaviors involved in the maintenance of these beliefs. Patients are distressed because they have a particularly frightening perception of their obsessive experience; for example, that their thoughts mean that they are a child molester, or that they are in constant danger of passing disease on to other people. The core of treatment is helping patients to construct and test a new, less frightening model of their experience. The therapist apply discussion techniques and behavioral experiments to challenge negative appraisals and the basic assumptions on which these are based (e.g. by asking the patient to describe all contributing factors for a feared outcome and then dividing the contributions in a pie chart). Behavioral experiments are designed to directly test appraisals, assumptions and processes hypothesized to be involved in the patient’s obsessional problems (Salkovskis, 2007). Considerable research has examined procedural variants related to outcome in CBT and CT for obsessive-compulsive disorder (for review see Franklin, Abramowitz, Kozak, Levitt & Foa, (2000); McLean,

4.3. Acceptance and Commitment Therapy (ACT)

ACT, as developed by Steven Hayes and his colleagues, is theoretically rooted in relational frame theory (RFT), which is a behavioral approach to understand how individuals develop language and cognition. RFT is based on the assumption that the learning of language and cognition are not separate from the context and environment. Further, it is posited that the environment shapes internal states (such as language and cognition), and once internal states are shaped by the environment, these states act as cues that, in turn, shape one’s responses to the environment (Montgomery, Kim & Franklin, 2011).

This implies that learning is not separate from experiencing or doing. Most internal states that are developed by experiences from the environment may be unconscious, so that a person does not realize how the environment has influenced or triggered his or her internal states. ACT has six core processes or components (Hayes, Strosahl, Wilson, 1999): (1) acceptance; (2) cognitive defusion (emphasizing flexibility in place of rigidity in thinking); (3) being present; (4) self as context focusing on a transcendent sense of self; (5) values; and (6) committed action (in accordance with one’s values).

ACT does not attempt to have patients alter their thinking and feelings; instead its goal is to change their response to their own thinking and feelings. ACT therapists believe that emotion and behavior can exist together or independently of one another (Hayes, Luoma, Bond, Mastida & Ellis, 2006). Therefore, therapists direct patients toward acceptance of their emotions and experiences and to be present in the face of strong emotions that they might be avoiding. They also assess how patients struggle to resolve their problems and direct them to give up those struggles that might involuntarily be making their problems worse. Therapists also direct patients to see their emotions and thoughts as separate from the self. The ultimate aim of ACT is to help the patient in increased psychological flexibility. Psychological flexibility is defined as “the ability to fully contact the present moment and the psychological reactions it produces as a conscious person, and to persist or change behavior in the situation in service of chosen values” (Fletcher and Hayes, 2005; p. 319). It also encourages patients to clarify what their deepest values are in life and to act or live in accordance to their values in what is called “committed action”. There are many exercises, metaphors and techniques that an ACT therapist can use with patients to help them experience the six core processes of therapy (Montgomery, Kim & Franklin, 2011).

The empirical evidence supported the effectiveness of ACT for a wide range of psychological conditions. More recent outcome studies have been conducted on ACT for obsessive-compulsive disorder specifically to increase the willingness of participants to experience obsessions (Twohig, Hayes, & Masuda, 2006; Twohig, Hayes, Plumb, Pruitt, Collins, Hazlett-Stevens, 2010), however, more and better controlled outcome studies are still needed.

4.4. Narrative therapy

Narrative therapy indicates to a range of social constructionist and constructivist approaches to the process of therapeutic change. Change occurs by exploring how language is used to construct and maintain problems. Within a narrative frame, human problems are viewed as rising from and being maintained by oppressive stories which dominate the person's life. Human problems occur when the way in which peoples lives are storied by themselves and others does not significantly fit with their lived experience (Carr, 1998). Narrative therapy is goal directed. Monk, Winslade, Crocket, and Epson (1997) comment that the primary goal of narrative therapy is to form an alliance with patients that accesses, encourages, and promotes abilities to enhance relationships with one’s self and with others.

Narrative therapy aims to refuse to see people as problems and help them to see themselves separate from the problems. White and Epson (1990) state that once a person sees a problem as separate from the person’s identity, the opportunity for change has been created. This change can take in the form of behaving differently, resisting or protesting the problem, and negotiating the relationship with the problem in other ways. Narrative therapy’s goals uniquely affect the therapeutic process. Techniques in narrative therapy includes externalization (speaking of the problem as separate from the individual), relative influence questioning (exploring the influence of the problem on the individual and the individual on the problem), identifying unique outcomes and unique accounts (identifying
times when there were exceptions to the problem), bringing forth unique re descriptions (attaching new meaning to behavior), and assigning between-session tasks (continuing work begun in session between sessions) (Etchison & Kleist, 2000).

Few clinical trial and case studies indicate that narrative therapy can successfully treat most types of OCD especially in those cases where there is a high level of confidence in the likelihood of the obsessional doubt. Narrative therapy may also offer a clinical advantage in children and young adolescents with OCD. (O'Connor, Aardema & Pélissier, 2005; Julien, O'Connor, & Aardema, 2009; Pélissier & O'Connor, 2002; Pélissier, O'Connor & Dupuis, 2009; Griffin, 2003).

4.5. Solution-focused Therapy
The clinical theory of solution-focused therapy is informed by a social constructionist position that holds that there are no clinical problems independent of the social interchange that occurs between clinicians and clients (de Shazer, 1991). Accordingly, clinical problems are co-created in language between therapists and clients. De Shazer (1991) has noted, however, that the notion of problem necessarily implies the existence of “non-problem” or exception, that is, times when the problem does not happen even though the client has reason to expect it to happen, and, of course, the space between problem and non-problem or the areas of life in which the problem/non-problem is not an issue and is not of concern to the client. (p. 83). Therefore, a clinical problem is conceptualized as problem/ exception. The change process results from identifying and amplifying exceptions. Clinicians apply interventional questions to help clients identify exceptions; and encourage them to do more of the behaviors that have directed them to solve the problem in the past. Problem resolution criterion’s in solution-focused therapy is the time that the problem was sufficiently improved, or sufficient progress has been obtained according to the Specified goal. The process of solution-focused therapy usually involves five stages: (1) constructing a problem and goal, (2) identifying and amplifying exceptions, (3) interventions or tasks designed to identify and amplify exceptions, (4) evaluating the effectiveness of interventions, and (5) re-evaluating the problem and goal. In solution-focused therapy, the client and therapist collaborate to define a problem and goal. The problem definition is then subsumed by the problem/exception conceptualization. In many cases, problem resolution is attributed to the client’s own view that he is no longer experiencing the problem. This might be related to an increase in exceptions or an increase in the client’s awareness of exceptions. In each case, however, change is facilitated by the client’s attributing significant meaning to the exceptions (Guterman & Rudes, 2005).

As de Shazer (1991) has suggested, “for the client, the problem is seen as primary (and the exceptions, if seen at all, are seen as secondary), while for therapists the exceptions are seen as primary; the interventions are meant to help clients make a similar inversion, which will lead to the development of a solution” (p. 58).

Guterman & Rudes (2005) provided a theoretical integration of rational emotive behavior therapy (REBT) and solution-focused therapy to integrate REBT and solution-focused conceptualizations and interventions, which can bring effective change, but this approach was not utilized specially for OCD patient.

5. The Rationale for Using Components in Proposed Integrative Treatment

Proposed integrative model suggested in this study initiates with postmodern orientation. It employs a constructionist, narrative approach and solution-focused approach to organize the clinical work. It then moves to the modern orientation consist of ACT, CBT and ERP in OCD treatment. Using the narrative metaphor guides the therapist to think about people's lives as stories and to work with them to experience their life stories in ways that are meaningful. Using the metaphor of social construction leads the therapist to consider the ways in which every person's social, interpersonal reality had been constructed through interaction with other human beings and to focus on the influence of social realities on the meaning of people's lives (McQuaide, 1999). The different ways a person constructs the story of his life can be a source of strength and resilience or a source of weakness and vulnerability. The goal of the narrative therapy is to help patients broaden their life stories. This entails having a broader perspective on the impact of social-political-economical-cultural forces impacting on one's narrative as well as having a deepened understanding of forces from the past and present, that impact on one's future (McQuaide, 1999). Proposing the problem as an enemy in externalizing method in narrative therapy reduces problem’s power and increases the hope and
embraces the possibility of the change. Externalization of the problem also appeared to be helpful in limiting the negative effects of criticism, blaming, and the assumption of guilt on the patient (Tomm, 1989). Emphasizing on unique occurrence and alternative story beside non-judgmental listening and not blaming patient for the problem builds supportive and caring relationship aid to promote compliance and willingness of the patient to involve emotionally in therapy. Good therapeutic relationship is necessary for tolerating the considerable anxiety and discomfort resultant of exposures. It can help the patient to commit substantial time and energy to a highly structured and demanding treatment. Hence, constructing the suitable rapport means commitment to treatment procedures and participating more fully in EX/RP.

Building an audience for change enables patient to replace the dominant story of problem-saturation with the alternate story of problem resolution. This process supports patient in maintaining and improving positive changes when others notice that he is managing problems more effectively. Certainly, patient needs to notice and recognize changes in his own behavior in order to be motivated to continue therapy efforts (O'Connor, Meakes, Pickering & Schuman, 1997). Through precise listening, especially to solutions drowned out by the patient's problem, solution focused interventions help patient envision more empowered lives. Solution-focused skills help the patient in developing a vision of a more satisfying future and direct him and therapist towards a deeper awareness of the strengths and resources that the patient can use in turning vision into reality. These skills are based on the belief that it is essential to work within each patient's frame of reference (DeJong & Berg, 1998). With this model therapists do not focus on categories of pathology or problems, believing that this will only lead to discouragement or self-stigmatization. It is believed that all environments contain resources, that the discovery of patient strengths is a process of cooperative exploration between client and helper who are not seen as experts but as consultant, and that focusing on strengths increases patient motivation (DeJong & Berg, 1998). Looking for exceptions helps patient to realize there are times when the patient controls the problem and the problem does not control the patient.

When the patient was emotionally involved enough in the therapy that he would be motivated to practice homework, cognitive behavioral approaches is privileged. Cognitive behavioral interventions start with ACT practices and continue with exposure and response prevention exercises and cognitive distortions modification in narrative background and solution focused mode.

The main mechanisms of ACT is altering patients' tendency to treat thoughts as literal and to avoid them, and increasing the experience of meaningful, value-based actions (Tolin, 2009). ACT seeks to give the patient an understanding of our attachment to our internal experiences and offers alternatives in letting go of the struggle with unpleasant internal experiences and learning more flexible ways of responding to these events. Many symptoms and defining features of OCD can be targeted and managed with ACT, specifically those aspects tied to patient resistance to engage in treatment (Tolin, 2009). According to ACT, core processes of in this approach seeks to teach a patient how to abandon the idea of thought suppression, how to "defuse" from intrusive thoughts, and may allow a person more tolerance of unpleasant emotions. It also teaches the patient to contact the context and presents way of defining valued life direction and constructing patterns of committed actions. Additionally ACT may increase the willingness of anxiety disordered patients, as in OCD to engage in exposures leading to a higher likelihood of successful treatment. In ACT, the patient is taught frequently using metaphors and experiential exercises, rather than direct didactic instruction. In the other words, many ACT strategies are deliberately metaphorical. Metaphors have several advantages: First of all, metaphors are not specific and proscriptive; it is more difficult for patient to show resistance to them. Metaphors are just stories. The patient senses this as well and knows that there is no obvious way to "be good" or "be bad" when responding to metaphors. Second, metaphors are not simply logical, linear forms of verbal behavior; they are more similar to pictures. The point of the ACT metaphors is often hard to capture in a simple moral or verbal conclusion. Carefully presented metaphors can be a kind of experiential exercise- as if one had really experienced the described event or story. Third, metaphors are simply remembered and can be used in many settings other than the specific setting in which they are learned. This makes metaphors useful if one is looking for broad-based behavior change (Hayes, stroshahl & Wilson, 1999).

Considering the above advantages, ACT is proven to be more effective than a didactic discussion. It can provide a tale and potentially more
persuasive way to convey patient to the key point that his reactions (be they overt or covert) are contributing to the maintenance of the problem. Although many psychotherapeutic approaches emphasize on accepting unwanted and disturbing feeling, however, ACT explicitly link willingness to values and specific behavioral goals. ACT blends experiential openness and acceptance on the one hand with work toward specific valued goals on the other (Orsillo, Roemener, Block –Lener, LeJuene& Herbert, 2011); it is one of the greatest strengths of ACT. Values clarification enables the therapist to instruct the patient becomes more active in his life and target avoidances and compulsive behaviors. As a result, patient can accept ERP exercises and easily challenge with cognitive distortions.

The main mechanisms contribute in ERP have been summarized as extinction or habituation resulting from systematic exposure to fear-related stimuli and prevention of avoidance or neutralizing behaviors, and, alterations of fear-related beliefs and memory structures resulting from exposure to corrective information. To these, could also add, increased sense of self-efficacy or mastery over one's environment, increased fear tolerance, and the development of inhibitory stimulus-stimulus associations ((Tolin, 2009). In ERP the patient is directly instructed to refrain from engaging in compulsive behaviors. The patient learns that it is impossible to control obsessive thoughts and emotional distress directly, and that it is unhelpful to attempt to do so. Instead, the patient is encouraged to focus his efforts on changing his overt behavior (compulsions and avoidance) using a graded plan for confrontation of avoided activities, situations, and thoughts. After the patient is exposed to fearful situation, the therapist encourages the patient to think realistically about the probability of negative outcomes during exposure exercises. In CT the therapist assists the patient in generating “rational responses” or more helpful or realistic self-statements. This is done through encouraging the patient to think realistically about the probability of negative outcomes, inflated responsibility, and other obsessive beliefs using a variety of strategies such as probability calculation, pie charts, and taking another perspective. The therapist also helps the patient identify core beliefs about his identity using downward arrow and other techniques. (Tolin, 2009). Driven techniques from above mentioned three models (ERP, CBT and ACT), are organized in a narrative context and are utilized using a solution focused frame. This procedure is explained in the next section.

6. Process of Integration
6.1. Phase 1: postmodern approach to treatment

Process of integration includes three phases and five stages. The process starts with postmodern approaches that employ narrative therapy and solution focused therapy to organize the clinical work in a narrative context. During the whole of the process; homework and tasks are designed to help the patient to practice and fully engage in treatment plan.

6.1.1. Stage 1: construction and building patient’s story

This phase starts by simply asking the patient “please describe your life story from the beginning” with OCD dominant theme. The purpose of this question is to direct the patient to construct his life story with details in a coherent set of events across time. The aim of this stage is building a collaborative coauthoring consultative position.

This collaborative approach is highly effective in helping the patient to describe his story about difficulties in managing disorder effects in his life. Therapist also should be open-minded about the working context, intentions, values, and biases and let the story to be expressed with patient's language rather than the therapist's language. Therapist should adjust the therapy with the patient's pace and regularly summarizes the story and checks if the patient is comfortable with the pace. All therapeutic conversations aim to explore multiple constructions of OCD related realities in the same way that the patient is experiencing them. This requires the therapist to privilege listening over questioning, and to question in a way that helps patient to see that the stories of his life is actively constructed, rather than passively narrated and presented. One of the most important exercises in this stage is asking the patient to remember the best and the worst memories with OCD, and his experience and reaction on the past time to these memories. This exercise can aid therapist to estimate the patient's motivation to change his story.
6.1.2. Stage 2: deconstruction and building an alternative story

6.1.2.1. Stage 2 - step 1: Externalizing the problem

Process of deconstruction and building an alternative story initiates with the externalizing the problem (Carr, 1998). Externalizing the problem is the central therapeutic technique used to help patient begin to define his problem as separate from his identity. A particular style of questioning for externalizing OCD is to ask about how the problem has been affecting the person's life and relationships for example

“How does your OCD disturb you? “ For this purpose the patient can be asked to call (name) his OCD story. An externalizing personification of OCD might be similar to following questions” what your OCD is similar to?” For example one patient may name his OCD “monster”. Then can be asked “What feeds your OCD monster?” “Who helps your OCD monster to attack your life?”

This kind of questions (that assumes the problem and the person quite separate) helps the patient to begin to externalize the problem and to internalize personal agency. It may also break off the habitual enactment of the dominant problem-saturated story of the person's identity (Carr, 1998). Therapist can also use relative influence questioning which allows the patient to think of himself not as problem-person but as an individual who has a relationship with a problem. Some examples of relative influence questions are:

“In that situation are you stronger than OCD or is OCD stronger than you?
“To what extent are you controlling your life at that point and to what extent is the OCD controlling your life?

This type of questioning also opens up the possibility that patient may report that on some situations the problem influences him to the point of oppression, but he can resist the problem. These questions help the therapist to reach to the second step of stage 2.

6.1.2.2. Stage 2- step2: Identifying and Amplifying Exceptions

In this stage therapist starts to utilize solution focused therapy in a narrative context. At first, therapist should ask patient to rename his OCD story. The following questions are relevant examples:

“If you could imagine that your story has changed how will you recall that?”
“If you wanted to rewrite your OCD story what title you would select for that?”

Then therapist should attempt to guide patient’s conversion into the exploring exceptions. Exceptions are situations and events or experiences that would not be predicted by the problem-saturated plot or narrative that has dominated the patient’s life and identity. Therapist can ask about particular instances in which the patient avoided being oppressed by obsessions and compulsions. An example of such questioning might be:

“Would you talk about the time when you could prevent OCD not to oppress you?
Or “How did you make that happen?”

Exception questions may also recognize the situations in the past when the obsessions, anxiety and compulsions occur in a more tolerable degree:

“Have there been times in the past when the OCD symptoms did not exist, or at least was less severe?”

If the patient identifies exceptions, then proceed to amplify them. If the patient states that there have been no exceptions, however, encourage him to consider small differences. Patients can frequently remember exceptions when are asked to consider small changes that have occurred. It has also been found that small changes often lead to bigger changes. After the exceptions are identified, the patient is helped through various questions to amplify these exceptions. One of the main functions of amplifying exceptions is to help patients to identify the differences between the times when they have the problem and the times when they do not (Guterman & Rudes, 2005). Another purpose of the amplification process is to empower patient with a sense of self-efficacy. Questions aimed toward this end include, “What does this exception say about you and your ability to deal with the OCD?” and “What are the possibilities?

“How did you manage to resist the influence of the OCD on that situation?”
“What is the power helping you to resist obsessions or compulsions in this occurrence?”

Verbalizing differences produces clearness both for therapist and for his patient. If at one point the patient identifies how he/she got good things to happen, he will realize how to repeat this at future.

In this stage therapist also involves miracles questioning to encourage patient to imagine himself in a future situation in which he is living without OCD and functioning satisfactory. Understanding of how patient was able to short-circuit the negative influence of the disorder over him and his life helps him to break the cycle of hopelessness. This also heightens the patient's awareness of his capability as problem-solver, and can reduce degree of depression which is identified as being concordant with OCD. Therapeutic focus on the development of an alternate story with emphasis on exceptions facilitates identifying patient’s strengths in dealing with OCD. It empowers the personal agency of patient which is necessary for engaging exposure and response prevention exercises and tasks being in CBT approach.

6.1.2.3. Stage 2-Step 3: presentation of alternative story

When the patient learns that the story he lives by, is full of gaps and incongruities which are usually little noticed because of the apparent overwhelming dominance of the OCD saturated story, alternative story can be propounded. The creation of alternative story anchors therapeutic process. The essential theme in the alternative story would be selected judiciously between various dysfunctional beliefs in cognitive approach of OCD treatment. For example therapist can say:

“It seems that the life story which you told has gaps and incongruities. Don’t you think it’s better to call it “fears of anxiety”? Or “inflated responsibility”? At the end of this stage therapist starts to utilize the ACT metaphors and exercises to get closer the proposed alternative story in patient’s mind.

6.2. Phase 2: ACT as a mediator between postmodern and modern approaches

At this stage therapist enters ACT components in treatment plan by using metaphors and experiential exercises. The main goal in this stage is to make the patient more flexible and activate him to move on his own value path. At this point special tactics should apply to facilitate acceptance, ease defusion of thoughts, cheering contact with the present moment, clarifying values, and behavioral commitment.

Greatest metaphors which serve to treatment are visualizing the patient's problem through the stories with different main characters than the patient. As a result, patient get connected to the story characters faster and the primary intent of the metaphor is quickly internalized by him.

6.2.1. Stage 3: reconstruction

6.2.1.1. Stage 3-step 1: altering patients’ tendency to control thoughts

At first, patient is being asked to review the efficacy of the past and present efforts to control obsessions and anxiety related thoughts. Then, therapist may use the metaphors to concrete the results of patient’s attempts. This step indicates how does control agenda might create suffering and fail in long term. This phase of the treatment is an essential step to prepare the patient to accept and tolerate the anxiety and disturbing thoughts. Metaphors are useful demonstrative tools that can show the patient that his goal (to live free of obsessions and anxiety) will pull him away from living the kind of life that he really valued and likes to have. For example “the man in hole”, “feeding OCD tiger “ or “polygraph” as metaphors, can provide potentially more persuasive way to convey patient of who previous attempts to solve the problem have not worked.

6.2.1.2. Stage 3-step 2: clarifying values and commitment to action

Emphases in this step are on clarifying values. At the beginning, therapist describes values assessment homework and asks patient to complete it. Then therapist emphasizes the importance of adaptive (or value-directed) functioning despite having intrusive thoughts and feelings. Then therapist is engaging with patient in writing assignment about his deepest thoughts and feeling including past failed attempts at commitment. “The garden metaphor” highlights the importance of choosing the valued direction and the need to recommit to that direction even in facing with obstacles. ACT ask the patient to experience distress only in a line of being able to preace to valued life ends (Orsillo, Roemener, Block –Lener, LeJeune& Herbert, 2011). In OCD patients, valued work provides adequate exposure because the systematic exposure is a center of the treatment. Willingness as an alternative is very important in acceptance of tasks and homework. The success of any exercise is regarded as a new exception and the patient is encouraged to exercise to create more exceptions.
6.3. Phase 3: the modern approach to treatment
At this phase therapist focuses on proven psychological model exposure and response prevention and cognitive therapy on treatment of OCD accompanying with narrative background and solution focused perspective. Using the behavioral commitment exercises, enable therapist to bridge the gap between ACT and ERP which rise from duration and extent of the activity, because each kind of treatment for OCD that would be affected, must encourage direct behavioral change.

6.3.1. Stage 4: building a new story
6.3.1.1. Stage 4- step 1: planning ERP
This step starts with determining situations and stimuli related to anxiety and compulsive behaviors. Then the patient is directly instructed to abstain from engaging in compulsive behaviors. Therapist should design ERP given, according to the patient desire, motivation and ability, and encourage deliberately confrontation of frightful situations, and thoughts. Finally doing ERP exercises is highlighted as a committed action that patient had committed in order to achieve the goals and values in the previous step.

6.3.1.2. Stage 4- step 2: amplifying patient actual ability to build new story
At this step, therapist should emphasize the importance of exposures as obvious exceptions and encourages the patient to move towards amplifying the exceptions as the ultimate goal of the therapy. Then therapist enhances the patient's ability to create further exceptions to change his life story.

6.3.2. Stage 5: Consolidation of new story using the cognitive modifications
Whereas behavioral changes often facilitate cognitive change, after each exposure task, one of the dysfunctional beliefs which are important in cognitive behavioral approach should be introduced by the therapist. After defining the problem in terms of the cognitive theory, patient is instructed to use the disputation method, which entails identifying and challenging cognitive distortions. The aim of the disputation method is to help patient internalize a new, rational belief system.

6.3.2.1. Stage 5- step 1: psycho - education
For the purpose described above, therapist must teach the patient about common cognitive distortions or errors in thinking (e.g. inflated responsibility, over importance and need to control intrusive thoughts, overestimation of threat, intolerance of uncertainty, and perfectionism).

6.3.2.2. Stage 5- step 2: conceptualizing dysfunctional beliefs in solution focused frame
At this step therapist should utilize solution focused therapy framework to put the cognitive distortions and dysfunctional beliefs in the form of solution-focused perspective. When the problem was conceptualized as “inflated responsibility/not inflated responsibility” then the patient is encouraged to seek exceptions of inflated responsibility. In other words, patient is encouraged to seek the times when he was not behaving according to inflated responsibility belief.

6.3.2.3. Stage 5- step 3: amplifying exceptions
The purpose of this stage is amplifying exceptions using Socratic questioning and disputation method. When the patient identifies exceptions, he is encouraged to carry on amplifying them. Patient is instructed to use the disputation method and assisted at the same time to generate “rational responses” or more helpful or realistic self-statements. The therapist encourages the patient to think realistically about the probability of negative outcomes, responsibility, and other obsessive beliefs using a variety of strategies such as probability calculation, pie charts, and taking another perspective. Since in previous step, patient has been noticed to his realistic ideas by the therapist, creation of doubts about the accuracy and efficiency of these beliefs requires less effort and former convictions will be replaced with the right beliefs more rapidly. Finally, the therapist emphasizes on ERP as the most useful method to generate more exceptions and create new story with new different theme from the previous dominant story.

7. Case Example
Mrs. F is a 35 year’s old married woman who had graduated from university with a degree in history. She was married fifteen years ago and lives with her husband and three children: 12 years, 9 years and 5 years old. She was born in a religious middle class family and raised with her three sisters and her only brother. She had a kind but strict parents. She visited the outpatient psychological service center for the first time because the distress related to her obsessions and compulsions got worse. She reported that her OCD symptoms began when she was 17 years old with no known antecedent. Her
primary obsessions focused on fears of losing something, her parents’ death and intrusive thoughts of a sexual nature (e.g., she would have thoughts and images of closed relatives having sex). At the time, she struggled with religious scrupulosity and obsessions related to fears of contamination from dirt, fears of losing her husband and children. Her compulsive behaviors included praying, reassurance seeking from her husband and her parents, and other people who were aware of her problem, extreme hand-washing and repetitive questioning. She was used to replay and analyze situations in her mind, and engaged in avoidant behaviors to lessen any exposure to situations that might evoke intrusive thoughts. She had also moderate depression at the time of referring. She reported spending between 4 to 7 hours per day performing repetitive rituals that interfered substantially with her marital, maternal and social functioning.

Mrs. F was appearing to feel guilty because her husband and her children had to repeat her rituals in her way. Her husband complained about repetitive and time-consuming behaviors and commands on cleaning and taking care of their children. She called her life story “cruel”. She thought her problem was linked to “A monster” that was a result of losing her freedom many years ago, trapping her in a prison full of suffering and pain.

She believed that her cruel life history not only affected her, but also has caught her family in trouble. This has caused Mrs. F’s family to suffer a lot. She did not like her story but felt that she was forced to accept that “cruelty” without objection. She really loved her husband and hated to insult or annoy him. Also she was a kind and considerate mother that really wanted her children be healthy and happy; however, her problem spoiled their happiness and made their family life joyless. This paradox was very painful for Mrs. F and made her feel extremely guilty and depressed. She was willing to change her life, but felt that she is unable to do it.

She had previously been treated with CBT and was slightly improved for a while (about eight months); however, her obsessive symptoms had come back after her husband got sick. It can be concluded that Mrs. F became absolutely frustrated from recovery. She was told that changing her story requires slow and steady movement and therapist will accompany her in this job. After she told her story, therapist asked Mrs. F to rename it. She renamed it as “freedom”. In the next step she was asked to look back to her life story in the past, but this time instead of focusing on darkness and cruelty, she had to seek times when the OCD monster was asleep or failed to afflict her. In fact, therapist has searched Mrs. F’s story exceptions. After some efforts, patient could remember the time when her third child was born. She and her husband were very happy and she was not obsessed for a short time. She also recalled three years ago when the family had traveled to the north of the country, she has really enjoyed spending time with her family and her obsession did not hurt her. She recalled when her husband and children were very sad and upset because of her problem, but she had controlled her obsessive behaviors, while she was anxious and upset about them. She recognized several other times, in which she had controlled the symptoms. For example, at the time of having a spiritual relationship with God, when she was too tired, when she has been working in her favorite fields, and when she has been treating with CBT. Then she was asked to review and find what cause those exceptions to occur.

She stated that being in a good mood, loving her husband and her children, belief in God and an expert’s assistance and guidance are some instances which encourage her to resist that cruel story. By remembering the exceptions and imagining the miracle occurrence she was able to see the situation better and became hopeful to be capable of changing the story. She was encouraged to repeat exceptions in her real life, and she was pleased to report that a week has passed well. Mrs. F. was surprised that she could control her obsession after a long time, for a while. The obsessions decreased without any serious effort. She felt that the reason was her assurance about the fact of her power to deal with the problem in past and her story has been heard by a therapist, and the therapist was fully aware of the details of her illness and her "inner sense of the problem". In this stage, the therapist propounded alternative story which can explain Mrs. F’s dilemma better because there were contradictions in that story. She described her life as if she was a caring mother and a loving wife. Yet she has spoiled their time and freedom. She felt that she was unable to understand such a paradox and suffered severely from it. What was the subjigated story about why she was wrong? She was told that caring and kind mothers do not bear things in oppressive ways. If there were no other story, than her
problematic one, she would be kind hearting. Hence there must be an alternative story helping her stay there.

The therapist suggested an alternative to the Mrs. F’s life story in which the dominant theme was intense fear and anxiety about facing unpredictable risks. This new story was more acceptable for Mrs. F and was closer to her understanding from her own identity; therefore, she accepted it without resistance and agreed to work on it. The therapist told her that the cause of her anxiety was stiffness and rigidity of Mrs. F. If she wanted to change the story, more flexibility would be required. To be more flexible, she should begin to accept and tolerate anxiety. The therapist began to apply experiential exercises and metaphors to clear consequences of the refusal of anxiety. Mrs. F acknowledged that the “Tiger” and “The man in a hole” metaphors are very similar to her situation. She was inspired by considering her personal values, on top of them, the happiness and tranquility of her families, to outline a specific program and follow that program through the planed committed behaviors. When she was quite excited to engage in home assignments, therapist designed exposures and response prevention program for dealing with situations related to her obsessions and compulsions. After eleven sessions her husband reported that she has been able to stop the reassurance-seeking behavior and frequent and repeated questioning. Her hand washing and cleaning procedures were also somewhat reduced although she was still worried about her husband and children getting sick. At this stage her cognitive distortions and dysfunctional beliefs were considered (e.g. inflated responsibility, overestimation of threat, intolerance of uncertainty, over importance and need to control intrusive thoughts). Mrs. F was encouraged to seek exceptions to her cognitive distortions using the problem/exception framework, which has made the challenge to her cognitive distortions easier, because she realized there were times in the past when she has a realistic behavior and has not acted on these beliefs. At the end of her treatment she stated that she feels the story of her anxiety was changing and she has greatly succeeded in writing a new story. She knew that the key to achieve this triumph was the hope of change, help and support of an expert, exposure to anxiety provoking situations and the acceptance of anxiety. She feels her freedom has been returned.

8. Conclusion
In this paper the integration of narrative therapy and solution focused therapy with acceptance and commitment therapy and cognitive behavioral approaches in working with OCD patients was illustrated. The narrative approach of externalizing the problem can relieve the patient as quickly as possible, the problem with which he enters to therapy, and which has limited his power and willfulness. Narrative approach and solution focused therapy help the patient find well established relationships with the therapist, clarify goals, embrace possibility of change and increase motivations to control disorder. ACT instructs patient to decrease avoidance, stop attempting to control internal events and encourage new ways of thinking about internal stimuli. ERP similar to ACT in instruction, decrease the avoidance and compulsive behavior, and furthermore emphasizes on directly doing things which were frightful and were being avoided. Finally, cognitive therapy emphasizes on modifying dysfunctional beliefs and encourages new ways of thinking about external stimuli and situations. We believe that the integrative approach covers the various aspects of OCD better than either of approaches alone, and as a result it may be even more effective in management and reduction of OCD symptoms, but better understanding of the effectiveness of integrative approach necessitate more controlled researches and clinical trials.
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