

Schema Therapy for Treatment-Resistant Obsessive-Compulsive Disorder with Childhood Trauma and Comorbid Personality Pathology: A Prospective Single-Group Repeated-Measures Study

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Abstract

This study examined whether schema therapy reduces symptom severity in treatment-resistant young adult patients with obsessive-compulsive disorder (OCD) with a history of childhood trauma and personality pathology. A prospective, single-group, repeated-measures design was used, without a control group. Of 26 eligible young adults who began treatment, 24 completed approximately one year of schema therapy and a three-month follow-up and were analyzed as completers. OCD severity, anxiety, disgust sensitivity, and guilt were assessed as outcomes at pre-treatment, mid-treatment, post-treatment, and three-month follow-up. Mal-adaptive personality domains were also tracked. One-way repeated-measures analyses of variance with Bonferroni-corrected comparisons tested change over time. OCD severity fell sharply from pre- to post-treatment, with a very large effect. Anxiety, disgust sensitivity, and state and trait guilt showed parallel reductions with large effects, while moral standards and the personality domains changed more modestly. Across measures, the largest shifts occurred during the active phases of therapy, with no significant change detected between post-treatment and follow-up. The reductions concentrated in the affective and guilt-related processes that schema therapy targets directly, whereas personality-domain change was smaller and appeared to follow symptom improvement. Within this uncontrolled completer sample, the findings provide preliminary evidence consistent with within-person improvement during schema therapy for complex, treatment-resistant OCD because there was no control group, the design cannot establish effectiveness, durability, or treatment-specific mechanisms, and the results require replication in controlled trials. However, schema therapy might be a promising treatment for complex, treatment-resistant OCD.

Keywords: Obsessive-compulsive disorder, personality disorders, schema therapy, childhood trauma, deontological guilt

Obsessive-compulsive disorder (OCD) is a chronic and debilitating disorder characterized by intrusive thoughts and repetitive behaviors or actions (American Psychiatric Association, 2022). It is one of the most common psychiatric causes of disability in the world (World Health Organization, 2019), with its prevalence around 1.8%. However, the prevalence of OCD in Pakistan is not known. Still, it seems to be relatively common,

with community estimates ranging between 3 and 4% and higher in some clinical and student samples (Butt & Azmat, 2024; Ashraf et al., 2017; Ayub & Ahmad, 2023; Jabeen & Kausar, 2020; Naveed et al., 2020). For decades, cognitive behavioral therapy with exposure and response prevention (ERP) has been the first-line treatment (Reid et al., 2021). However, it has a narrow scope of coverage. Even after sufficient trials of pharmacotherapy and CBT, nearly half of the patients continue to meet criteria for OCD and do not attain functional recovery (Sijercic et al., 2020; Van Roessel et al., 2022). This is a category of chronic non-responders, which is a persistent clinical problem. Standard ERP is based on the logic of habituation (García-Soriano et al., 2014). It is based on the assumption that repeated exposure to feared stimuli reduces the anxiety associated with

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them (Reid et al., 2021). The model has been criticized because it addresses the symptom but not the underlying affective component (Law & Boisseau, 2019).

It offers little insight into how some patients may have become obsessed in the first place, nor into the historical and relational factors that may have contributed to that sensitivity (Law & Boisseau, 2019; Mancini, 2018).

More recently, a cognitive account has suggested that the driver of OCD is deontological guilt, in addition to disgust (Semeniuc & Soponaru, 2023; Mancini, 2018). There are no differences between clinical and non-clinical populations on the theme of obsessions. They have a different heightened sense of responsibility and experiences of heightened guilt (Veale et al., 2015). An increase in perceived responsibility and fear of guilt causes OCD-like behavior in healthy people. The feeling of doing something wrong, which is the fear of breaking a moral law, seems to be the main component of this process (Gangemi & Mancini, 2017). Disgust is the second most important element. It is closely linked to concerns of contamination and is related to moral self-evaluation such that the patient who feels contaminated also feels morally debased (Rector et al., 2012). These affective processes resist the habituation logic of standard ERP, which may explain part of the treatment-resistance problem.

A further source of resistance lies in personality. Comorbid personality disorders are common in chronic anxiety and OCD, with rates around 40% for Cluster C alone. Such comorbidity has been linked to worse outcomes, weaker therapeutic alliances, and elevated dropout (Bulli et al., 2015; Thamby & Khanna, 2019). Borderline, obsessive-compulsive, and dependent personality features are frequently present in treatment-resistant cases. These structures are not addressed by symptom-focused CBT (Thamby & Khanna, 2019). Early maladaptive schemas (EMSs) offer a way to understand them. EMSs are enduring patterns of memory, emotion, and cognition formed when childhood emotional needs go unmet (Young et al., 2003). Higher levels of EMSs predict poorer CBT response in OCD (Atalay et al., 2008). These schemas link directly to a history of childhood trauma (Voderholzer et al., 2013; Baz & Karaguzel, 2022). Authoritarian, critical, and guilt-inducing parenting has long been associated with obsessive symptoms (Tenore et al., 2018), and childhood maltreatment is now known to predict greater OCD severity, with emotional abuse showing the strongest association (Boger et al., 2020).

Schema therapy (ST) was developed by Young for patients who did not respond to standard CBT (Young et al., 2003). It integrates cognitive, behavioral, experiential, and psychodynamic strategies, and it works through the concept of schema modes, the moment-to-moment emotional states that arise when schemas are

triggered. The integrated ST model of OCD conceptualize the disorder as an alternation between a guilty and fearful Vulnerable Child mode, a Demanding and Punitive Parent mode, and coping modes such as the Perfectionistic Over-Controller and the Detached Protector (Gross et al., 2012; Basile et al., 2017; Tenore et al., 2018). This is where ST departs sharply from CBT. Rather than seeking to extinguish anxiety, ST targets the historical guilt sensitivity, schemas, and schema modes that feed the symptom (Csigó et al., 2024; Dostal & Pilkington, 2023). It uses imagery rescripting and chair work to revisit the childhood scenes in which the patient learned to fear blame, and it aims for acceptance of the feared risk rather than reassurance (Basile et al., 2017, 2018; Baz & Karaguzel, 2022; Luppino et al., 2018). The central goal is to strengthen the Healthy Adult mode, which allows the patient to tolerate the possibility of being guilty or contaminated without resorting to compulsion (Basile et al., 2018). Preliminary trials support this approach in treatment-resistant cases (Peters et al., 2020, 2021).

In Pakistan's context, where religious and moral life influences the experience of OCD, this framework is particularly applicable (Ayoub et al., 2024). The ritual expectations around purity (*taharah*) and moral responsibility within Islam can heighten concerns about moral integrity and fear of contamination; internal voices within the ST model can be disciplinary and demanding, and family structures supporting honor and obedience can reinforce these internal voices (Akhtar et al., 2017; Ashraf et al., 2017; Jabeen & Kausar, 2020). Standard CBT may not completely capture these culturally based themes developed in the Western secular context. Although the potential of ST is high, evidence on the use of ST in OCD is limited and weak in design (Peeters et al., 2021). Existing studies rarely combine treatment resistance, documented childhood trauma, and personality pathology in one sample, and none has been conducted in a Pakistani population (Butt & Azmat, 2024). The present study addresses this gap. It examines whether schema therapy reduces symptom severity in treatment-resistant young adults with OCD, childhood trauma, and comorbid personality pathology, and tracks change across OCD severity, anxiety, disgust, guilt, and personality domains.

Hypotheses

H1. OCD symptom severity will decrease significantly across the four assessment points (pre, mid, post, and follow-up) in treatment-resistant young adults with OCD, childhood trauma, and comorbid personality pathology.

H2. Anxiety will decrease significantly across the four assessment points (pre, mid, post, and follow-up) in treatment-

resistant young adults with OCD, childhood trauma, and **H3.** Disgust sensitivity will decrease significantly across the four assessment points (pre, mid, post, and follow-up) in treatment-resistant young adults with OCD, childhood trauma, and comorbid personality pathology.

H4. Guilt will decrease significantly across the four assessment points (pre, mid, post, and follow-up) in treatment-resistant young adults with OCD, childhood trauma, and comorbid personality pathology.

H5. Maladaptive personality domains (Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism) will decrease significantly across the four assessment points (pre, mid, post, and follow-up) in treatment-resistant young adults with OCD, childhood trauma, and comorbid personality pathology.

H6. Improvements achieved at post-treatment will be stable across three-month follow-up in treatment-resistant young adults with OCD, childhood trauma, and comorbid personality pathology.

Method

Research Design

This study used a prospective, single-group, repeated-measures design to evaluate the within-person change during schema therapy for treatment-resistant obsessive-compulsive disorder (OCD) in young adults with histories of childhood trauma and comorbid personality pathology. Because the design was single-group, all participants received the intervention and no control or comparison condition was included. Outcomes were evaluated within subjects across the different assessment phases (pre, mid, post, and follow-up).

comorbid personality pathology.

Participants Recruitment

Participants were recruited through purposive sampling. Cases were identified through outpatient clinic intake, referrals from psychiatrists and clinical psychologists working in the field, and social media advertisements. Referring clinicians were asked to identify participants whose OCD had not responded to previous standard treatment. Recruitment ran in two intake waves to keep clinical caseloads manageable. The first wave opened in September 2024 and the second in January 2025. Because entry was rolling, participants began and finished therapy at different times. First-wave participants completed treatment by approximately September 2025, and the second-wave participants completed treatment by January 2026, with the final three-month follow-up assessments concluding in April 2026. Sample size was determined by the number of eligible participants available during the recruitment window rather than by a formal power calculation of 58 young adults assessed for eligibility, 32 were not enrolled in the treatment. Of those 32, nine did not meet inclusion criteria, 13 met one or more exclusion criteria, and 10 declined to participate. The remaining 26 met criteria and began treatment (see Figure 1). Of these, 24 finished the entire treatment and a 3-month after-treatment period, and were included in the analyses. Two participants discontinued early, after four and five sessions respectively, One because of difficulties traveling to sessions, and the other after relocating to another city for employment. Neither had begun the experiential phase of treatment, and neither was included in the final analysis. However, both of them were referred to other therapists working in their respective areas. Table 1 shows the baseline characteristics of the 24 participants.

Table 1

Demographic and Clinical Characteristics of Participants (N = 24)

Variables	F	%	M (SD)
Age of Participants (Years)			24.58 (2.06)
Gender			
Female	15	62.5	
Male	9	37.5	
Education			
Undergraduate	16	66.7	
Postgraduate	8	33.3	
Monthly Family Income (PKR)			218,958.33 (51,847.62)
Marital Status			
Single	17	70.8	

Married	7	29.2	
Employment Status			
Employed	9	37.5	
Unemployed	15	62.5	
Comorbid Personality Disorder (Predominant)			
Borderline (BPD)	11	45.8	
Obsessive-Compulsive (OCPD)	9	37.5	
Dependent (DPD)	4	16.7	
Personality Pathology Status			
Full Diagnosis	17	70.8	
Subthreshold Traits	7	29.2	
OCD Symptom Themes ^a			
Contamination and Cleaning	13	54.2	
Harm and Responsibility	12	50.0	
Symmetry, Ordering, and NJRE	10	41.7	
Scrupulosity (Moral/Religious)	8	33.3	
Aggressive OCD	8	33.3	
Health Anxiety/Illness	7	29.2	
Relationship OCD	6	25.0	
Sexual Orientation/Gender Identity OCD	5	20.8	
Number of OCD Themes per Participant			
Single Theme	4	16.7	
Multiple Themes	20	83.3	
Duration of Illness (Years)			6.04 (2.27)
History of Childhood Maltreatment ^a			
Emotional Abuse	18	75.0	
Emotional Neglect	16	66.7	
Physical Abuse	10	41.7	
Physical Neglect	8	33.3	
Sexual Abuse	10	41.7	
Self-Mutilating/Self-Harming Behaviors			
Present	16	66.7	
Absent	8	33.3	
Behavior Subtypes ^a			
Skin Picking	9	37.5	
Nail/Skin Digging	8	33.3	
Cutting	7	29.2	
Hair Pulling	6	25.0	
Scratching	6	25.0	
Hitting/Punching Self	5	20.8	
Burning	2	8.3	
Previous Treatment Modality			
Pharmacological Only	6	25.0	
Psychotherapy (CBT) Only	5	20.8	
Both Pharmacological and CBT	13	54.2	

Previous Psychiatric Hospitalization			
Yes	3	12.5	
No	21	87.5	
Duration of Previous Treatment (Years)			3.21 (1.58)
Current Pharmacological Treatment			
SSRI	13	54.2	
SSRI plus Augmentation	6	25.0	
None	5	20.8	
Family History of Psychiatric Illness			
Present	14	58.3	
Absent	10	41.7	

Note. *f*= Frequency; %= Percentage; *M*= Mean; *SD*= Standard Deviation; *PKR* = Pakistani Rupees; *NJRE* = Not Just Right Experiences; *OCD* = Obsessive-Compulsive Disorder; *CBT* = Cognitive Behavioral Therapy; *SSRI* = Selective Serotonin Reuptake Inhibitor.

Inclusion Criteria

Participants were eligible if they were 1) aged between 18 and 35 years. 2) They had to meet DSM-5 criteria for OCD as the primary diagnosis, confirmed by structured clinical interview. 3) They had to show documented treatment resistance. This was defined as an inadequate response to at least one adequate trial of an SSRI, given for a minimum of 12 weeks at an adequate dose, and/or with one prior course of evidence-based psychotherapy, typically cognitive behavioral therapy with or without exposure and response prevention. 4) A chronic course of illness, with a duration of at least two years. 5) A history of childhood trauma was required and had to be confirmed by both self-report and clinical interview. 6) Participants also had to meet criteria for at least one comorbid personality disorder, or show significant sub threshold personality traits. Sub threshold status was operationalized as meeting one fewer criterion than required for a full diagnosis on the SCID-5-PD. 7) Finally, participants had to be able to give informed consent and attend weekly sessions.

Exclusion Criteria

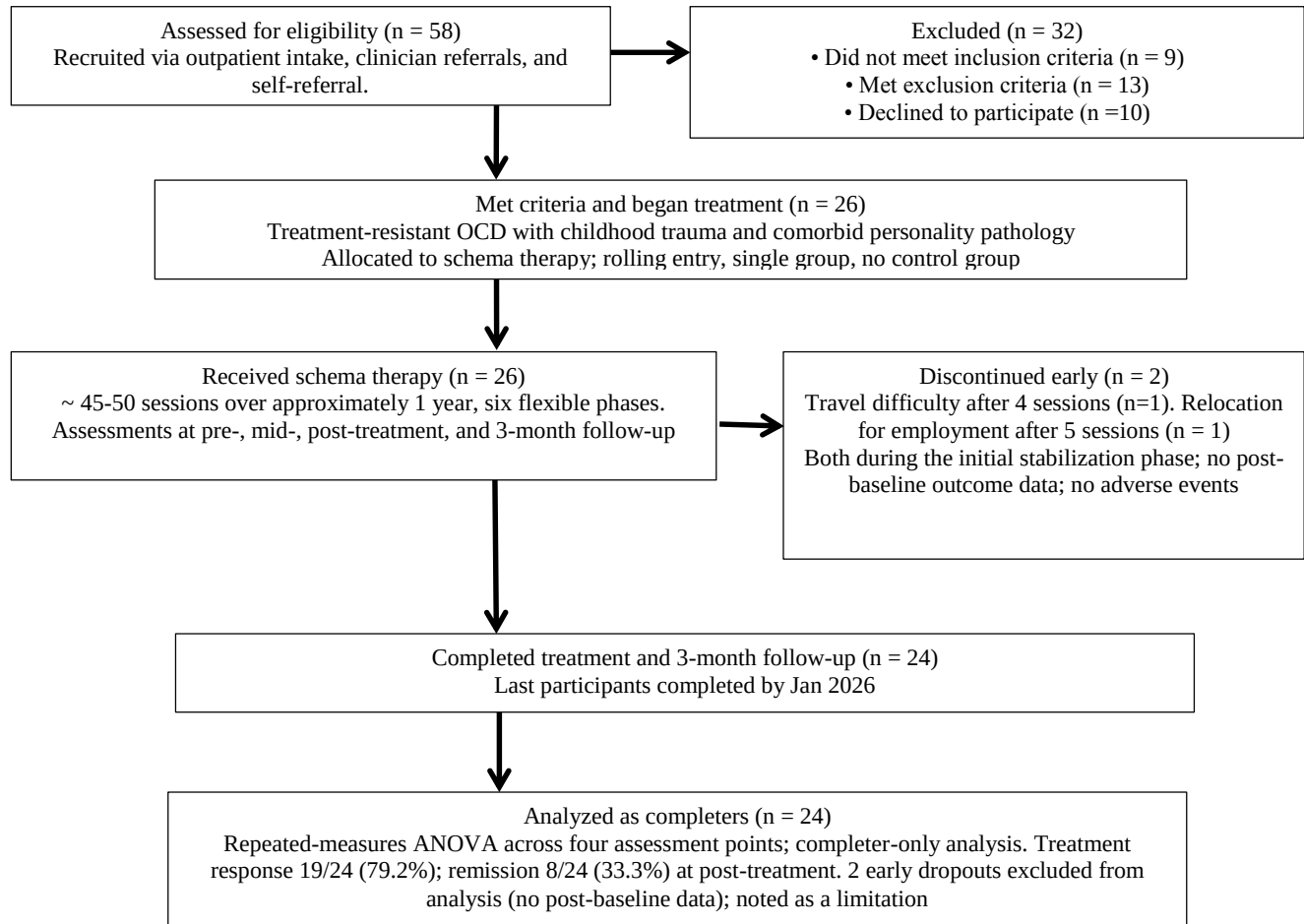
Participants were excluded if they 1) presented with active psychosis, a current manic episode, or a primary psychotic or bipolar disorder. 2) They were excluded for current substance dependence requiring detoxification. 3) They were also excluded for acute and high suicide risk

requiring inpatient care at intake. 4) Participants with intellectual disability or cognitive impairment were also excluded. 5) Participants already enrolled in another structured psychotherapy were excluded to avoid confounding treatment effects.

Prior and Concurrent Treatment

The treatment-resistance criterion is defined in the inclusion criteria above of the 24 completers, six had received pharmacotherapy only, five had received cognitive behavioral therapy (CBT) only, and 13 had received both. Reported medication regimens included fluoxetine (40-80 mg/day), sertraline (150-200 mg/day), fluvoxamine (200-300 mg/day), and paroxetine (40-60 mg/day), each taken at an adequate dose for at least 12 weeks. Six participants had also received antipsychotic augmentation (risperidone 1-2 mg/day or aripiprazole 5-10 mg/day) added to an SSRI. Among those with prior CBT, most had received structured exposure and response prevention. Pharmacological history was verified through past prescriptions issued by authorized psychiatrists. CBT and ERP history was obtained directly from referring therapists rather than by self-report. Participants on stable pharmacotherapy could continue if their regimen had been unchanged for at least eight weeks before enrolment, and no participant changed SSRI regimen during schema therapy.

Figure 1
Participant Flow through the Study



Note. OCD = obsessive-compulsive disorder. The study used a single-group, uncontrolled, prospective repeated-measures design; the absence of a control group precludes causal inference

Instruments

A set of structured interviews and self-report questionnaires was used. Diagnostic and trauma measures were administered at intake to establish eligibility and characterize the sample. Outcome measures were administered at all four assessment points.

Diagnostic Measures

Diagnosis was confirmed by trained clinical psychologists using two structured clinical interviews. The following tools were used to diagnose the participants.

Structured Clinical Interview for DSM-5 Disorders, Clinician Version

The SCID-5-CV (First et al., 2016) is a widely used semi-structured interview protocol. It was used to formulate the diagnosis of obsessive-compulsive disorder and to rule out other psychiatric conditions.

Structured Clinical Interview for DSM-5 Personality Disorders Version

The SCID-5-PD (First et al., 2015) is a widely used semi-structured interview protocol. It was used to evaluate the 10 DSM-5 personality disorders and sub threshold traits.

The Childhood Trauma Questionnaire, Short Form

It is a 28-item self-report measure used to assess experiences of childhood maltreatment (Bernstein & Fink, 1997). It includes 25 items that evaluate five domains including emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. A trauma informed clinical interview was conducted alongside the questionnaire to corroborate self-reported histories.

Primary Outcome Measure

The primary outcome was OCD severity. The following tool was used to assess OCD severity over time.

Yale-Brown Obsessive Compulsive Scale

Y-BOCS was used to assess the severity and types of Obsessive-Compulsive Disorder symptoms in the participants (Goodman, 1989). It has two sections: Symptom Checklist (list used to identify the specific types of obsessions and compulsions), and Severity Scale (10 items that rate symptoms) over the prior week. It has a 5-point Likert scale ranging from 0 (none) to 4 (extreme).

Secondary Outcome Measures

The secondary outcomes were anxiety severity, disgust sensitivity, guilt, and personality domains. The following measures were used to assess them.

The Beck Anxiety Inventory

BAI was used to measure the severity of clinical anxiety in the participants (Beck et al., 1988). It focuses on physical and somatic symptoms of anxiety.

The Disgust Scale

It was used to measure disgust sensitivity because disgust is often associated with contamination-related symptoms (Haidt et al., 1994). It contains 32 items covering several domains of disgust, including food, animals, body products, sex, body-envelope violations, death, hygiene, and magical thinking.

The Guilt Inventory

It was used to assess guilt-related experiences in patients with OCD because guilt is often associated with OCD symptoms (Jones et al., 2000). It has three domains including state guilt, trait guilt, and moral standards.

The Personality Inventory for DSM-5-Short Form (PID-5-SF)

It is a 100-item self-report measure designed to assess maladaptive personality traits (Maples et al., 2015). It measures 25 personality facets. It uses a 4-point Likert scale ranging from 0 to 3. Higher average scores indicate elevated levels of specific personality traits.

Process Measures

Schemas and modes were treated as process measures rather than primary outcomes. The following tools were used to build the formulation and guide therapy.

The Young Schema Questionnaire, Long Form 3

It was used to assess early maladaptive schemas (Young et al., 2003). This 232-item questionnaire measures 18 schemas. It uses a 6-point Likert scale, ranging from 1 to 6. Higher mean scores indicate stronger endorsement of a given schema.

Young Schema Mode Inventory

It was used to assess schema modes (Young et al., 2007). This 124-item measure evaluates 14 schema modes across four broad domains: child modes, dysfunctional coping modes, dysfunctional parent modes, and the healthy adult mode. Higher scores indicate stronger activation of the relevant mode.

All measures were administered in Urdu. Each scale was translated and culturally adapted through a standard forward-back translation procedure. Two bilingual clinical psychologists independently translated each measure into Urdu, a third back-translated it into English, and discrepancies were resolved by consensus. Internal consistency in the present sample was acceptable to good: Y-BOCS ($\alpha = .89$), BAI ($\alpha = .87$), Disgust Scale ($\alpha = .82$), state guilt ($\alpha = .85$), trait guilt ($\alpha = .88$), and moral standards ($\alpha = .79$).

Procedure

Interested individuals were screened using Y-BOCS. Individuals who were eligible based on inclusion and exclusion criteria underwent a full diagnostic assessment across two to three sessions, using the structured interviews and the self-report battery described above. Eligible participants were informed about the research. Written informed consent was obtained. Participants then received the intervention based on the schema therapy model. Therapy was provided by clinical psychologists who had completed formal training in schema therapy. The average duration of treatment was one year including 45-50 sessions approximately. Outcome measures were administered at pre-treatment, mid-treatment, post-treatment, and 3 month's follow-up phases. Participants who were taking pharmacotherapy (N=19) were allowed to continue their medication, and keep consulting their psychiatrists. Assessments were conducted by a clinician who was not the treating therapist wherever possible, to reduce bias in outcome ratings. Throughout the study, confidentiality and ethical standards were strictly maintained.

Intervention

The intervention followed the integrated schema therapy model for OCD developed by Luppino et al. (2018), Tenore et al. (2018), and Basile et al. (2018), which links Mancini's (2018) cognitive account of obsessive functioning to the schema and mode framework of schema therapy (Young et al., 2003). In this model, obsessive symptoms arise from an alternation between a frightened, guilty Vulnerable Child mode, a Demanding and Punitive Parent mode, and the coping modes used to survive that pressure, the Perfectionistic Over-Controller and the Detached Protector or Self-Soother (Basile et al., 2017; Tenore et al., 2018). Given the participants' chronic and treatment-resistant OCD, comorbid personality pathology (full or sub threshold borderline, obsessive-compulsive, or dependent traits), and childhood trauma, the protocol was adapted to include a longer stabilization phase, sustained attention to personality-level schemas, and trauma-informed pacing (van der Kolk, 2015). Treatment took place across six overlapping, flexibly delivered phases, with those who became destabilized during the experiential work returning to earlier stabilization strategies before further experiential work was commenced.

Phase I: Assessment & Case Conceptualization (Sessions 1-6)

In phase I, symptoms, personality patterns, and early history were mapped onto an individualized mode formulation, as OCD treatment requires an understanding of the maintaining processes as well as early history as the roots of guilt sensitivity (Luppino

et al., 2018; Tenore et al., 2018). This work was informed by diagnostic imagery (Arntz, 2011) that connected charged situations in childhood to current challenges, and by the Young et al. (2003, 2007) YSQ/SMI. The main techniques in this phase were the life-history review, schema and mode assessment, and an initial functional analysis of the symptom cycle.

Phase II: Bonding, Safety, and Emotional Regulation (Session 7-12)

Phase II built the therapeutic bond through limited reparenting (Young et al., 2003) and developed affect tolerance using safe-place imagery (Arntz, 2011) and DBT-informed distress-tolerance and self-soothing skills (Linehan, 2014). This expanded stabilization reflected the trauma principle that safety must precede memory processing (van der Kolk, 2015) and the fragility of the alliance in borderline presentations (Arntz, 2011).

Phase III: Schema and Mode Identification with Cognitive Work on Guilt and Disgust (Sessions 13-22)

Phase III combined mode identification with cognitive work on guilt and disgust. The chair work mode interview helped participants voice, name, and dis-identify from their modes (Young et al., 2003), while Socratic dialogue and the reduction ad absurdum argument (Mancini, 2018) loosened the belief that certainty could, and must, be achieved; reassurance being useless or harmful with obsessive patients. The costs of compulsions were also mapped (Mancini, 2018), with attention to the character logical perfectionism of obsessive-compulsive presentations.

Phase IV: Experiential Change Through Imagery Rescripting and Chair work (Sessions 23-38)

Phase IV was the experiential core. Imagery with rescripting revisited childhood scenes, which the therapist and the adult self re-entered to protect the child and challenge caregivers (Arntz, 2011; Mancini, 2018), drawing on imagery's power over verbal methods. Chair work confronted and limited the demanding and Punitive Parent, met the needs of the Vulnerable and Angry Child, and addressed coping modes through empathic confrontation (Young et al., 2003; Tenore et al., 2018). For traumatized participants, rescripting doubled as trauma processing while stabilization skills remained available (van der Kolk, 2015).

Phase V: Behavioral Change, Response Prevention in the Service of Risk Acceptance (Sessions 39-48)

Phase V translated these shifts into behavior through response prevention in the service of risk acceptance rather than habituation (Mancini, 2018). From a strengthening Healthy Adult, participants abstained from neutralizing while tolerating discomfort, since suppression paradoxically increases intrusions and urges (Thiel et al., 2016). A non-judgmental acceptance

stance, behavioral experiments, and de-fusion decatastrophized guilt, and freed time was invested in valued goals.

Phase VI: Consolidation and Relapse Prevention (Sessions 49-50)

Phase VI consolidated gains through Healthy Adult imagery (Arntz, 2011) and strengthened its three functions; dis-identification, perspective change, and pattern-breaking (Young et al., 2003), alongside values clarification and relapse-prevention planning. A session-by-session summary of the treatment protocol is presented in Table 2.

Treatment Fidelity

The intervention was delivered by two trained clinical psychologists with approximately five years of experience treating OCD. Both therapists followed the six-phase protocol described above, and treatment was delivered on a weekly basis. Of the planned 50 sessions, completers attended a mean of 47.3 sessions ($SD = 2.1$; range = 43-50). The attendance rate was above 94%, missed sessions were rescheduled, and no participant fell below the minimum dose required to complete all six phases. Treatment fidelity was supported through monthly clinical supervision with a senior clinical psychologist, in which case formulations, mode work, and adherence to the phase structure were reviewed. No major protocol deviations occurred; minor deviations were limited to the flexible pacing of phases according to individual clinical need, consistent with the model.

Table 2*Phase-by-Phase Schema Therapy Intervention Plan*

Phase	Techniques Used	Description of Technique	Rationale
1. Assess ment & Case Conceptualization (Sessions 1-6)	Life-history review; schema & mode assessment (YSQ, SMI); functional analysis of symptom cycle; diagnostic imagery	Symptoms, personality patterns, and early history are mapped onto a schema therapy formulation. The YSQ and SMI (Young et al., 2003, 2007) are used as clinical tools, not only measures. Diagnostic imagery (Arntz, 2011; Young et al., 2003) links a charged childhood scene with a caregiver to current difficulties.	OCD cannot be treated without grasping both the maintaining processes and the historical roots of guilt sensitivity (Luppino et al., 2018; Tenore et al., 2018). Comorbid personality pathology requires a schema- level, not symptom-only, formulation (Young et al., 2003).
2. Bonding , Safety & Emotional Regulation (Sessions 7-12)	Limited reparenting; safe- place imagery; grounding & distress-tolerance / self- soothing skills (DBT- informed)	The therapeutic bond is built through limited reparenting (Young et al., 2003). Safe-place imagery (Arntz, 2011) gives a portable image of security. Distress-tolerance and self- soothing skills (Linehan, 2014) scaffold affect regulation for detached or dysregulated participants.	Trauma treatment requires safety and affect regulation before memory processing (van der Kolk, 2015). The bond cannot be assumed with borderline features (Arntz, 2011). Pushing past the Detached Protector too early provokes shutdown or compulsions (Tenore et al., 2018).
3. Schema/ Mode Identification & Cognitive Work on Guilt and Disgust (Sessions 13-22)	Chair work mode interview; disidentification; Socratic dialogue & reductio ad absurdum; cost-benefit analysis of compulsions; acceptance-building	The mode interview voices each mode from a separate chair to explore its origin, function, and costs, enabling disidentification. Socratic dialogue and reductio ad absurdum (Mancini, 2018) expose the futility of pursuing certainty; costs of compulsions are mapped (Mancini, 2018).	Modes and obsessive appraisals describe the same machinery (Mancini, 2018; Tenore et al., 2018). Reassurance is useless or harmful with obsessive patients. Perfectionism is character logical in OCPD presentations.
4. Experie ntial Change: Imagery Rescripting & Chairwork (Sessions 23-38)	Imagery with rescripting (ImRS); multi-chair work with the Demanding/Punitive Parent; work with Vulnerable & Angry Child; empathic confrontation of coping modes	ImRS bridges a present distress to a childhood scene, which the therapist and the adult self-re-enter to protect the child and challenge caregivers (Arntz, 2011; Mancini, 2018). Chair work confronts and limits the parental mode; empathic confrontation addresses the Detached Protector (Young et al., 2003).	Guilt tied to parental blame and fear of being disgusting are best healed experientially (Tenore et al., 2018; Basile et al., 2018); imagery exceeds verbal methods. ImRS doubles as trauma processing and meets unmet needs in borderline features.

5.	Behavioral Change: Response Prevention in Service of Risk Acceptance (Sessions 39-48)	Planned abstinence from neutralizing (response prevention); acceptance stance; behavioral experiments; distancing & defusion; continued chairwork / empathic confrontation; valued-goal setting	From a strengthening Healthy Adult, participants tolerate urges to wash, check, reassure, or ruminate without neutralizing, forgoing short-term relief (Mancini, 2018). A non-judgmental acceptance stance, behavioral experiments and defusion decatastrophize guilt; freed time is invested in valued goals.	Suppression increases intrusions and urges; the cycle breaks only when neutralization is abandoned (Mancini, 2018). The aim is acceptance of risk, not reassurance. Pacing respects OCPD rigidity and dependent reassurance needs.
6.	Consolidation & Relapse Prevention (Sessions 49-50)	Healthy Adult imagery; strengthening the three Healthy-Adult functions; values clarification; relapse-prevention planning	Healthy Adult imagery (Arntz, 2011; Young et al., 2003) rehearses coping with future stressors using recalled successful experiences. The three functions of disidentification, perspective change, and pattern-breaking are strengthened (Young et al., 2003); personal values and goals are clarified.	Gains are fragile without a plan for schema reactivation, especially in chronic, characterological presentations (Young et al., 2003). Rehearsing the Healthy Adult lengthens time in the adaptive mode and shortens recovery after slips (Young et al., 2003).

Note. YSQ = Young Schema Questionnaire; SMI = Schema Mode Inventory; *ImRS* = imagery with rescripting; *DBT* = dialectical behavior therapy; *OCPD* = obsessive-compulsive personality disorder.

Ethical Considerations

The study followed the ethical standards of the American Psychological Association. Institutional Review Board approval (IRB Ref: IRB-572/07-2024) was obtained before recruitment, and written permission to use each copyrighted measure was secured from its authors. All participants gave written informed consent after a full explanation of the study’s purpose, procedures, duration, and their right to withdraw without affecting their care. Because the sample was severely and chronically distressed, a no-treatment control group was judged ethically indefensible, informing the single-group design. Given the trauma histories, experiential techniques were paced to minimize destabilization, with stabilization established before memory-focused work (van der Kolk, 2015). Data were anonymized and stored securely with identifying information kept separate, and outcome assessments were conducted, wherever possible, by a clinician other than the treating therapist to reduce bias.

Data Analysis

Data were analyzed in IBM SPSS Statistics on the 24 participants who completed treatment and the three-month follow-up. Descriptive statistics summarized demographic and baseline clinical characteristics. Distributional assumptions were

checked before inferential testing, including normality and, for the repeated-measures models, sphericity (Mauchly’s test), with the Greenhouse-Geisser correction applied where it was violated. One-way repeated-measures analyses of variance, with assessment phase (pre-treatment, mid-treatment, post-treatment, and three-month follow-up) as the within-subjects factor, tested change in the primary outcome of OCD severity (Y-BOCS) and the secondary outcomes of anxiety (BAI), disgust sensitivity (Disgust Scale), and guilt (Guilt Inventory). The Y-BOCS was designated a priori as the single confirmatory primary outcome; all other measures were treated as exploratory and interpreted descriptively. Because eleven separate repeated-measures ANOVAs were conducted, the exploratory analyses carry an increased risk of Type I error. Bonferroni correction was applied to the pairwise comparisons within each measure, but no correction was applied across the family of outcomes. The exploratory results should therefore be read as hypothesis-generating. Significant omnibus tests were followed by Bonferroni-corrected pairwise comparisons to locate reliable change and to test maintenance at follow-up. Early maladaptive schemas (YSQ) and schema modes (SMI), treated as process variables, were not analyzed due to the large number of subscales. Effect sizes (partial eta-squared) were reported alongside significance tests, with alpha set at .05, and the clinical

significance of change on the Y-BOCS was examined through the proportion of participants reaching accepted response thresholds. Treatment response was defined as $\geq 35\%$ reduction from baseline Y-BOCS, and remission as a post-treatment Y-BOCS total score ≤ 12 (Mataix-Cols et al., 2016).

Results

The analysis proceeded in three steps. First, descriptive statistics were computed for all outcome measures at each assessment point. Second, the assumptions underlying repeated-measures analysis of variance were tested. Third, a one-way repeated-measures ANOVA was conducted for each measure, followed by Bonferroni-corrected post-hoc comparisons to identify the significant differences between time points.

Prior to the repeated-measures ANOVA, the assumptions of normality and sphericity were examined. Normality was evaluated with the Shapiro-Wilk test, which was non-significant across the four assessment points for OCD severity (W range = .938 to .971, $p > .05$), anxiety (W range = .945 to .979, $p > .05$), disgust sensitivity (W range = .932 to .968, $p > .05$), state guilt (W range = .941 to .974, $p > .05$), trait guilt (W range = .936 to .977, $p > .05$), and moral standards (W range = .949 to .982, $p > .05$). For the personality domains, scores were normally distributed at all time points for Negative Affectivity (W range =

.944 to .976, $p > .05$), Detachment (W range = .951 to .980, $p > .05$), Antagonism (W range = .947 to .978, $p > .05$), and Psychoticism (W range = .939 to .972, $p > .05$), with the single exception of Disinhibition at mid-treatment ($W = .911$, $p = .039$). Because nearly all distributions were normal and only one of 44 distributions (Disinhibition at mid-treatment) departed significantly, the repeated-measures ANOVA was retained as the primary analysis. As a sensitivity check, the non-parametric Friedman test (Field, 2017) was run for any outcome with a non-normal distribution, and it yielded the same conclusion as the parametric test.

Sphericity was assessed with Mauchly's test, which was non-significant for OCD severity ($W = .831$, $\chi^2(5) = 4.02$, $p = .547$), anxiety ($W = .840$, $\chi^2(5) = 3.78$, $p = .582$), disgust sensitivity ($W = .902$, $\chi^2(5) = 2.25$, $p = .814$), state guilt ($W = .896$, $\chi^2(5) = 2.40$, $p = .792$), trait guilt ($W = .764$, $\chi^2(5) = 5.84$, $p = .322$), moral standards ($W = .727$, $\chi^2(5) = 6.92$, $p = .227$), Negative Affectivity ($W = .648$, $\chi^2(5) = 9.43$, $p = .093$), Detachment ($W = .829$, $\chi^2(5) = 4.07$, $p = .539$), Antagonism ($W = .679$, $\chi^2(5) = 8.43$, $p = .134$), Disinhibition ($W = .880$, $\chi^2(5) = 2.78$, $p = .734$), and Psychoticism ($W = .840$, $\chi^2(5) = 3.79$, $p = .581$). As sphericity was met for all measures, the untransformed degrees of freedom were retained for the F tests. Partial eta squared (η^2p) was computed to estimate effect sizes. All statistical tests were two-tailed, with the significance level set at $p < .05$.

Table 3

Descriptive Statistics for Outcome Measures Across the Four Assessment Points ($N = 24$)

Measures	Pre-treatment M (SD)	Mid-treatment M (SD)	Post-treatment M (SD)	3-Month follow-up M (SD)
Y-BOCS severity	28.21 (3.45)	22.04 (3.88)	15.83 (4.12)	16.71 (4.35)
Beck Anxiety Inventory	31.46 (7.21)	25.13 (6.84)	18.29 (6.52)	19.04 (6.79)
Disgust Scale	4.38 (0.71)	3.71 (0.68)	2.94 (0.74)	3.08 (0.69)
Guilt Inventory				
State guilt	38.63 (5.21)	31.79 (5.58)	24.33 (5.94)	25.71 (5.67)
Trait guilt	78.42 (9.83)	68.21 (10.34)	56.71 (11.08)	58.92 (10.61)
Moral standards	61.29 (7.42)	57.83 (7.61)	53.21 (8.07)	54.13 (7.88)
PID-5-SF domains				
Negative Affectivity	2.31 (0.38)	2.08 (0.40)	1.79 (0.43)	1.84 (0.41)
Detachment	1.92 (0.44)	1.74 (0.45)	1.53 (0.47)	1.58 (0.46)

Antagonism	1.18 (0.41)	1.11 (0.40)	1.02 (0.42)	1.05 (0.41)
Disinhibition	1.64 (0.46)	1.52 (0.45)	1.38 (0.47)	1.43 (0.46)
Psychoticism	1.07 (0.43)	0.98 (0.42)	0.86 (0.44)	0.89 (0.43)

Note. *M*= Mean; *SD*= Standard Deviation; *Y-BOCS*= Yale-Brown Obsessive Compulsive Scale; *PID-5-SF*= Personality Inventory for DSM-5-Short Form.

The means and standard deviations for all outcome measures across the four assessment points are reported in Table 3. On the primary outcome, mean OCD severity decreased from 28.21 (SD = 3.45) at pre-treatment to 15.83 (SD = 4.12) at post-treatment, with a closely comparable score of 16.71 (SD = 4.35) at follow-up. The secondary outcomes followed the same downward course. Anxiety (BAI) declined from 31.46 (SD = 7.21) to 18.29 (SD = 6.52) at post-treatment, and 19.04 (SD = 6.79) at follow-up, and disgust sensitivity dropped from 4.38 (SD = 0.71) to 2.94 (SD = 0.74) and 3.08 (SD = 0.69), respectively. The guilt subscales showed a similar reduction, state guilt decreased from 38.63 (SD = 5.21) at pre-treatment to 24.33 (SD = 5.94) at post-treatment and 25.71 (SD = 5.67) at follow-up; trait guilt from 78.42 (SD = 9.83) to 56.71 (SD = 11.08) and 58.92 (SD = 10.61);

and moral standards, which shifted least, from 61.29 (SD = 7.42) to 53.21 (SD = 8.07) and 54.13 (SD = 7.88). The PID-5-SF personality domains moved in the same direction but more modestly, with the clearest reductions in Negative Affectivity, from 2.31 (SD = 0.38) at pre-treatment to 1.79 (SD = 0.43) at post-treatment and 1.84 (SD = 0.41) at follow-up, and Detachment, from 1.92 (SD = 0.44) to 1.53 (SD = 0.47) and 1.58 (SD = 0.46); Antagonism, Disinhibition, and Psychoticism each changed only slightly.

At post-treatment, 19 of 24 participants (79.2%) met criteria for treatment response ($\geq 35\%$ Y-BOCS reduction), and 8 (33.3%) achieved remission (Y-BOCS ≤ 12), with both rates largely stable across three-month follow-up (75.0% and 29.2%, respectively).

Table 4

Repeated-Measures ANOVA for Outcome Measures Across the Four Assessment Points (N=24)

Measure	Source	SS	df	MS	F	p	η^2p
Y-BOCS Severity	Time	2347.98	3	782.66	198.55	< .001	.896
	Error	271.99	69	3.94			
Beck Anxiety Inventory	Time	2713.26	3	904.42	43.57	< .001	.655
	Error	1432.14	69	20.76			
Disgust Scale	Time	31.33	3	10.44	61.00	< .001	.726
	Error	11.81	69	0.17			
State Guilt	Time	3076.35	3	1025.45	107.59	< .001	.824
	Error	657.67	69	9.53			
Trait Guilt	Time	7075.54	3	2358.51	48.02	< .001	.676
	Error	3388.80	69	49.11			

Moral Standards	Time	986.43	3	328.81	14.90	< .001	.393
	Error	1522.72	69	22.07			
Negative Affectivity	Time	4.13	3	1.38	33.50	< .001	.593
	Error	2.84	69	0.04			
Detachment	Time	2.23	3	0.74	11.99	< .001	.343
	Error	4.29	69	0.06			
Antagonism	Time	0.36	3	0.12	4.27	.008	.156
	Error	1.94	69	0.03			
Disinhibition	Time	0.94	3	0.31	5.21	.003	.185
	Error	4.14	69	0.06			
Psychoticism	Time	0.65	3	0.22	4.39	.007	.160
	Error	3.40	69	0.05			

Note. $p < .05$; η^2p = Partial eta Squared; *MS*=Mean Square; *SS* = Sum of Squares; *Y-BOCS*= Yale-Brown Obsessive Compulsive Scale

The repeated-measures ANOVA results are presented in Table 4. The analysis revealed a significant effect of time on every outcome measure. OCD severity showed a marked reduction across the four assessment points, $F(3, 69) = 198.55$, $p < .001$, $\eta^2p = .90$. Significant effects of time were likewise found for anxiety, $F(3, 69) = 43.57$, $p < .001$, $\eta^2p = .66$, and disgust sensitivity, $F(3, 69) = 61.00$, $p < .001$, $\eta^2p = .73$. Among the guilt subscales, time had a significant effect on state guilt, $F(3, 69) = 107.59$, $p < .001$, $\eta^2p = .82$, trait guilt, $F(3, 69) = 48.02$, $p < .001$, $\eta^2p = .68$, and moral standards, $F(3, 69) = 14.90$, $p < .001$, $\eta^2p =$

.39. The personality domains also changed significantly over time, most strongly for Negative Affectivity, $F(3, 69) = 33.50$, $p < .001$, $\eta^2p = .59$, and Detachment, $F(3, 69) = 11.99$, $p < .001$, $\eta^2p = .34$, and more modestly for Antagonism, $F(3, 69) = 4.27$, $p = .008$, $\eta^2p = .16$, Disinhibition, $F(3, 69) = 5.21$, $p = .003$, $\eta^2p = .19$, and Psychoticism, $F(3, 69) = 4.39$, $p = .007$, $\eta^2p = .16$. The partial eta squared values indicate large effects for the symptom and guilt measures, with the strongest effect observed for OCD severity, and moderate-to-small effects for the personality domains.

Table 5
Bonferroni-Corrected Pairwise Comparisons Between Assessment Points

Measure	Comparison	<i>MD</i>	<i>SE</i>	<i>p</i>
Y-BOCS Severity	Pre-Mid	6.17	0.53	< .001
	Mid-Post	6.21	0.50	< .001
	Post-Follow-up	-0.88	0.65	.932

Beck Anxiety Inventory	Pre-Post	12.38	0.46	< .001
	Pre-Follow-up	11.50	0.62	< .001
	Pre-Mid	6.33	1.47	.001
	Mid-Post	6.84	1.33	< .001
	Post-Follow-up	-0.75	1.19	1.000
	Pre-Post	13.17	1.51	< .001
Disgust Scale	Pre-Follow-up	12.42	1.22	< .001
	Pre-Mid	0.67	0.11	< .001
	Mid-Post	0.77	0.11	< .001
	Post-Follow-up	-0.14	0.13	1.000
	Pre-Post	1.44	0.14	< .001
	Pre-Follow-up	1.30	0.12	< .001
State Guilt	Pre-Mid	6.84	0.77	< .001
	Mid-Post	7.46	0.96	< .001
	Post-Follow-up	-1.38	0.85	.601
	Pre-Post	14.30	0.87	< .001
	Pre-Follow-up	12.92	0.90	< .001
	Pre-Mid	10.21	1.90	< .001
Trait Guilt	Mid-Post	11.50	2.56	< .001
	Post-Follow-up	-2.21	1.99	1.000
	Pre-Post	21.71	2.09	< .001
	Pre-Follow-up	19.50	1.72	< .001
	Pre-Mid	3.46	1.25	.054
	Mid-Post	4.62	1.52	.029
Moral Standards	Post-Follow-up	-0.92	1.57	1.000
	Pre-Post	8.08	1.43	< .001
	Pre-Follow-up	7.16	0.95	< .001
	Pre-Mid	3.46	1.25	.054
	Mid-Post	4.62	1.52	.029

Negative Affectivity

Pre-Mid	0.23	0.04	< .001
Mid-Post	0.29	0.07	.002
Post-Follow-up	-0.05	0.07	1.000
Pre-Post	0.52	0.06	< .001
Pre-Follow-up	0.47	0.06	< .001

Detachment

Pre-Mid	0.18	0.07	.067
Mid-Post	0.21	0.07	.041
Post-Follow-up	-0.05	0.06	1.000
Pre-Post	0.39	0.08	< .001
Pre-Follow-up	0.34	0.07	< .001

Antagonism

Pre-Mid	0.07	0.03	.220
Mid-Post	0.09	0.05	.356
Post-Follow-up	-0.03	0.05	1.000
Pre-Post	0.16	0.05	.036
Pre-Follow-up	0.13	0.05	.058

Disinhibition

Pre-Mid	0.12	0.07	.436
Mid-Post	0.14	0.06	.193
Post-Follow-up	-0.05	0.08	1.000
Pre-Post	0.26	0.08	.022
Pre-Follow-up	0.21	0.07	.026

Psychoticism

Pre-Mid	0.09	0.07	1.000
Mid-Post	0.12	0.06	.201
Post-Follow-up	-0.03	0.06	1.000
Pre-Post	0.21	0.06	.007
Pre-Follow-up	0.18	0.07	.074

Note. MD= Mean Difference; SE= Standard Error; Y-BOCS= Yale-Brown Obsessive Compulsive Scale

Bonferroni-corrected post-hoc comparisons were conducted to locate differences between assessment points (Table 5). Pre- to post-treatment differences were significant for all measures. The pre- to mid-treatment contrast, however, was significant only for the symptom and guilt measures, and not for moral standards ($p = .054$) or the personality domains of Detachment ($p = .067$), Antagonism ($p = .220$), Disinhibition ($p = .436$), and Psychoticism ($p = 1.000$), which changed significantly only by post-treatment. The largest changes thus occurred between pre- and post-treatment. The post-treatment to follow-up difference was non-significant for all measures, indicating only that no further significant change was detected; given the small sample and limited power, follow-up stability was interpreted cautiously. For guilt and personality measures, positive mean differences reflect declining severity over time.

Discussion

This study examined whether schema therapy reduces symptom severity in treatment-resistant young adults with OCD, childhood trauma, and personality pathology. The findings show within-person improvement over the course of treatment. OCD severity declined significantly from pre- to post-treatment and produced a very large effect. This means participants who had not responded to traditional mental health services, including pharmacotherapy and/or CBT, moved from severe to mild-moderate symptom ranges within a year after schema therapy. The change herein indicates that targeting the in-depth affective roots of OCD functioning, not just the symptoms, might lead to change in resistant cases (Remmerswaal et al., 2023). This fits with the integrated schema model that sees OCD within cycles of mode (guilt) rather than faulty cognition (Tenore et al., 2018).

The anxiety and disgust sensitivity scores showed a significant decrease with a large effect size. Notable here is that disgust reduction was found, given that disgust is a non-drug-susceptible affect and is poorly affected by exposure (Rector et al., 2012). This decrease in disgust sensitivity suggests experiential imagery rescripting may be able to access contamination-linked affect, which behavioral methods cannot (Basile et al., 2018). Cleanliness in Pakistan has deep-rooted religious and moral significance, and the issue of contamination can be further aggravated by the norms of cleanliness associated with prayer and ritual washing (Akhtar et al., 2017; Ashraf et al., 2017). These were loosened by schema work, which focused on the underlying self-defectiveness, instead of the behavior. The differences in state and trait guilt were greatest, and the differences in moral standards were least. It implies that the therapy decreased pathological blaming of self without affecting the participants' moral system, a desired therapeutic effect. Moral

standards remain consistent with the idea behind the model of differentiating healthy values and punitive self-judgment (Gangemi & Mancini, 2017; Mancini & Gangemi, 2004). This distinction is relevant in Pakistan, where the sense of guilt is tightly intertwined with family honor and religious responsibilities. Participants were probably able to keep the culturally valued conscientiousness and discard the punitive parent voice that pathologized it (Akhtar et al., 2017).

Change across the personality domains was uneven, with the clearest reductions in Negative Affectivity and Detachment and minimal change in Antagonism, Disinhibition, and Psychoticism. This suggests that the personality domains most sensitive to current distress responded first, while the domains reflecting more enduring structure remained largely unchanged. This is consistent with the view that personality shifts happen after symptom reduction, and not before (Peeters et al., 2020; Thamby & Khanna, 2019). It is also applicable to the longer stabilization phase that was adopted here, which focused on affect regulation instead of characterological restructuring (Zhang et al., 2023). The greatest improvements were seen in the therapeutic phases for all measures. At follow-up, scores did not improve any further. It indicates improvements were sustained over the three-month follow-up rather than continuing to change, as seen in this maintenance pattern. It indicates that there is a possibility that schema therapy might lead to long-term changes in the inner structure, rather than symptom alleviation (Peeters et al., 2021). The absence of significant change between post-treatment and follow-up is consistent with the relapse-prevention literature, indicating that gains might level off after the strengthening of the Healthy Adult mode (Mataix-Cols et al., 2016).

The findings, taken as a whole, indicate that the model focuses directly on aspects of change in the affective and guilt-related processes. The personality-level change seemed minor and was secondary. The sequencing aligns with a pattern consistent with the model's premise that obsessive symptoms are sustained through emotion-driven processes linked to early experience, though the schema and mode constructs themselves were not assessed as outcomes in this study (Semeniuc & Soponaru, 2023).

Conclusion

This study provides preliminary evidence that within this single sample, schema therapy was associated with within-person improvement over time in young adults with complex, treatment-resistant OCD. Reductions in OCD severity, anxiety, disgust, and guilt were large and scores at the three-month follow-up did not differ significantly from post-treatment. Change concentrated in the affective processes the model targets directly, while

personality-level change was smaller and appeared to follow symptom improvement. Because the design included no control group, these findings are preliminary and require replication in controlled trials.

Limitations and Suggestions

There are some limitations that should be noted. First, because it was only a single group and there was no control group, it was not possible to make a causal claim. Natural change or nonspecific therapy factors are not easily separated from improvements. Second, the sample size was small, and the sample was obtained through purposive sampling, thus reducing generalizability. Third, the duration of the follow-up was short (three months). Fourth, multiple outcomes were self-reported and could have been biased. Randomized controlled trials with active comparison groups are needed to test schema therapy as a treatment for treatment-resistant OCD in the future. More extensive and multi-site samples would enhance generalizability. Extended follow-up periods would clarify whether these gains persist. Dismantling studies might clarify the factors that contribute to change, such as imagery rescripting and chairwork. Testing mechanisms directly would be accomplished by investigating mediators like schema mode shifts. In particular, although EMS and schema modes were used to guide case formulation, they were not analyzed as outcomes. Their role as

mechanisms of change therefore remains untested and is a priority for future work.

Implications

The findings of the study have several useful implications. This research offers a possible treatment direction for a group that often exhausts standard options and is left with few alternatives. The results suggest that clinicians facing treatment-resistant OCD need not view non-response to SSRIs and conventional CBT as an endpoint. Instead, a model that targets the emotional and historical roots of obsessive functioning may reopen the possibility of change. The study lends support to the integrated schema model of OCD by showing that symptom relief concentrated in the guilt and affect-related processes the model holds responsible for maintenance. This supports the idea that resistant OCD may be driven by more than cognitive or behavioral factors alone. The research also has practical applications: participants' pathological self-blame decreased while their endorsement of moral standards remained largely intact. This should reassure patients and therapists concerned that treatment might erode conscientiousness. Results also indicate that trauma-informed and personality-focused work should be integrated into OCD treatment rather than treated as separate concerns.

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