Clinician's Handbook for

Obsessive Compulsive Disorder

Inference-Based Therapy

Kieron O'Connor
and Frederick Aardema

WILEY-BLACKWELL

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Praise for ***Clinician's Handbook for Obsessive-Compulsive Disorder***

The authors outline a fresh and creative perspective on cognitive therapy for OCD, derived from the development and testing of their Inference-Based Approach (IBA). This makes an important contribution by addressing components neglected or omitted in earlier approaches – a must read for anybody involved in the treatment of OCD.

Jan van Niekerk, *Clinical Psychologist, Fulbourn Hospital, Cambridge, UK*

The Inference-Based Approach (IBA) has transformed the treatment of OCD in my private practice. This finely detailed treatment manual will now give clinicians – and their clients–access to the most innovative horizons of OCD clinical research and practice.

Bob Safion, *LMHC Private Practitioner, Anxiety Treatments, Massachusetts, USA*

Building on a solid empirical and philosophical foundation, O'Connor and Aardema have written the definitive, practical guide to inference-based therapy for OCD for the practicing clinician that the field has been waiting for.

Gary Brown, *Research Director and Doctor in Clinical Psychology, Royal Holloway University of London, UK*

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List of Cartoons

About the Authors

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Dr Frederick Aardema studied clinical psychology at the University of Groningen and the University of Amsterdam in the Netherlands. Presently, he is a clinical researcher at the Fernand-Seguin Research Centre, Hôpital Louis-H.

Lafontaine, affiliated with the University of Montreal. He is also Co-director of the Centre for Research on Tic and Obsessional Disorders. Frederick Aardema has played a vital role in the development of an inference-based approach to the treatment of OCD, including the development of a new questionnaire that reliably measures a characteristic reasoning style in those with obsessive-compulsive and delusional disorder, the Inferential Confusion Questionnaire. In addition, his work in reasoning has led to the development of an innovative theoretical approach to pure obsessional ruminations. Dr Aardema has published widely in international journals in the field of obsessive-compulsive and related disorders, and is a frequent presenter at scientific conferences. In particular, his research interests include psychometric and experimental methods in the measurement of reasoning processes in OCD, as well as the application of inference- and narrative-based models to obsessions without overt compulsions. Other aspects of his research include dissociation, virtual reality, introspective ability, self-constructs and psychological assessment. Dr. Aardema's books include *Beyond Reasonable Doubt: Reasoning Process in Obsessive Compulsive Disorder* (with K. P. O'Connor & M. C. Pélissier, Wiley, 2005).

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Introduction

This clinician handbook provides the most comprehensive clinician guide so far for the application of inference-based therapy (IBT) to obsessive-compulsive disorder (OCD). It complements our previous book *Beyond Reasonable Doubt* which remains the base source text for the philosophical and reasoning theory underpinning of the inference-based approach (IBA) and the therapy programme (IBT) that derives from it. In the 5 intervening years since its publication, IBT has considerably expanded its reach in therapeutic work. This expansion largely stems from empirical research and replication of IBA principles in the literature, the clinical adaptation of IBT to diverse OCD and related populations and also from our own evolving conceptualization of OCD primarily as a reasoning disorder.

We do allude to this philosophical and research base in the text and provide support references for the curious and scientific minded. However, the target audience of this current handbook is the therapist–client dyad collaboratively engaged in IBT in clinical and non-clinical settings. It is hence a hands-on clinical how-to-do-it book. We have slow-motioned the course of therapy to hopefully permit an errorless and timely passage through all the steps of the programme. The text enables the therapist to identify key transition points in client thinking and behaviour, clear criteria for mapping client progress and sign posts for precisely locating the ‘Where am I now?’, ‘How did I get here?’ and ‘What happens next?’ for most eventualities arising in the therapeutic process.

IBT[1]

Since IBT is a distinct cognitive approach, we consider it worthwhile in this introduction to pinpoint some of its key original components as a way of priming the reader for what is to come. In our inference-based approach to understanding and treating OCD, an, the obsessional sequence begins with the initial inference of doubt. An inference is a conclusion about a state of affairs arrived at through prior reasoning. This doubt precedes the images of consequences, the appraisals and other downstream elements of the obsessional thought sequence. We acknowledge that these latter processes may be clinically relevant and may, therefore, also need to be addressed in therapy. However the target of IBT is the initial obsessional doubt and the reasoning processes which underpin this doubt.

1. Intrusion or Inference?

It is important to note that the primary obsessional doubt is an inference, not an intrusion. The word ‘intrusion’ is frequently used by therapist and client alike to denote the obsessional thought. But obsessional doubts do not intrude, or simply jump spontaneously into the head. Of course the thoughts are often unwanted, are alien to the client and can feel invasive but they do not in fact intrude into thinking. The obsessional doubts are rather created and maintained by the client's way of reasoning. The obsessional thoughts may be noisy residents but they are not intruders. We think it misleading also to consider that obsessions can develop from reactions to otherwise normal ‘pop up’ thoughts, that is, random thoughts triggered by spurious observation in the course of the day. Examples include ‘Oh, there's a green hat with a propeller. How funny’, ‘Wow, those women's shoes are huge. They could trip up’ and ‘Who's *that* guy shouting at? Not me, I hope’. In other words, for IBA the reactions to

so-called ‘intrusions’ do not create obsession, rather the client inferring doubt unnecessarily leads on to the chain of obsessional thinking and behaviour. Eliminate the doubt and logically all other components of the OCD sequence are eliminated. Appraisals certainly induce distress. But cognitive models emphasizing the exclusive role of appraisals *may* offer a satisfactory account of how thoughts hang around in people without OCD since, here, the doubting inference is not in the way.

2. Inferential Confusion

In the inferential approach to therapy there is only one principal process responsible for obsessional doubt : inferential confusion. Admittedly, inferential confusion has complex inputs and effects, but our clinical research shows that this singular process accounts well for most aspects of obsessional thinking and behaviour: the ego-dystonicity, the repetitive behaviour, the dissociation and the lack of confidence. Inferential confusion is a robust and identifiable construct and consists of two processes: (1) distrust of the senses or of self and of common sense, and (2) over-investment in remote possibilities. These two processes are part and parcel of the same construct. We've tried all sorts of statistical and clinical ways to separate them, but the two processes work in tandem and go hand in hand. Our research indicates that distrust of the senses or self fuels a reliance on subjective narrative, and the obsessional narrative justifies the distrust in the senses. The important clinical implication is that both must be addressed *together* since addressing one without the other goes only halfway. This caveat may seem like a catch 22: you can't do this before that, or that before this. But the metaphor to use here is of two revolving pistons where one piston represents trust in self and senses, and the other piston is investment

in remote possibilities. As one piston goes up, the other goes down in tandem. So working on both at the same time moves us along faster.

Our research indicates that where there is successful resolution of inferential confusion, the obsessional thinking and behaviour reduces to zero, together with all associated obsessional emotions.

3. Thinking Before Acting

The focus in IBT is on cognitive change as a first priority with behavioural change following seamlessly behind. Behavioural experiments, exposure, or reality testing may not be necessary to eliminate compulsive behaviour. In IBT the aim is to reorient the client to reality through cognitive education and insight, so that the client relates to reality as reality by performing what we term ‘reality sensing’ which entails relating to reality in a normal non-effortful way. This cognition-behaviour sequence does not detract from the proven efficacy of behaviour therapy nor its power to impact on thoughts. IBT can be combined with exposure-based treatments. There is still debate over the exact processes operating in exposure, and there is evidence (though not causal) that where traditional behaviour therapy is successful, inferential confusion also changes, so reduction in inferential confusion is related to successful exposure.

The location of the source problem of OCD lies for IBT within a reasoning about possibilities. It is not located within an anxiety disorder or a phobic reaction to a real sitmulus event. The goal of IBT in the *first instance* is not to change a client's behaviour but to modify obsessions. IBT does not expose the client to do what they don't wish to do in the guise of eliciting anxiety to better tolerate it. Rather IBT addresses a confused way of reasoning about possibility. For example, a woman may believe she has contaminated her

hand through touching a handrail, or a man may be convinced he has inadvertently left his oven turned on. According to IBT, these clients do not initially require exposure to handrails or ovens but rather insight into the inferentially confused nature of their obsessional doubts . . . confusing real probability with an imagined possibility which convinces them they may have done acts they did not. A major principle of IBT is that clients already possess within otheir repertoire the ability to vercome obsessions. They require a shift from OCD reasoning to non-OCD reasoning and reality sensing as already performed in non-OCD situations.

4. A Constructionist Approach

IBT implicitly adopts the constructionist principle of information processing that views perceived personal reality as a construction. The pragmatic therapist need not be too worried here since, firstly, the constructionist model is implicit in IBT and not laboriously elaborated; and, secondly, the constructionist approach offers a more obvious and direct fit with the creative way we all interact with the world. There is no need for explanations involving hypothetical black boxes mediated by arrows to-ing and fro-ing in between. Reality feels no less ‘real’ by being constructed, and we appeal frequently in the programme for a return to an authentic personal reality and real self.

The constructionist view of the world is that attitudes, beliefs and reality are continually reconstructed depending on our doings. The office cabinet metaphor of mind which reifies beliefs as memos filed away in the brain is replaced by a creative process which generates feelings, stories and experiences in the ‘here and now’ through individual interactions with environments in the ‘here and now’ launched by my intentions in the ‘here and now’. The past is

constructed in the present according to planned doings in the future, and it's always ‘now’ somehow. This focus on the person's ‘now’ and all he or she is doing ‘now’ as the key to understanding suffering ‘now’ is in one sense a modern development of basic behaviourism, where behaviour is viewed as entirely maintained by current contingencies. However, cognitive constructionism adds the ‘creating’ to the ‘maintaining’.

Constructionist approaches emphasize narrative construction and active immersion as a way to access beliefs. Beliefs are stories we tell ourselves and keep on telling ourselves, not some deep down, hard-to-get-at ‘node’ necessarily requiring heavy-duty psychological drilling and excavation! The stories we construct give our lives meaning. This is why we place a lot of emphasis in IBT on narrative immersion and the role of language in implanting and transporting ideas effectively. A bonus by-product of using IBT is that the therapist as well as the client learn the art of effective self-story telling.

5. Doubt Creation

Doubt in OCD is ‘created’ by the client and then actively rehearsed and maintained by the client's neutralizing thinking and behaviour. Of course, to the inferentially confused client, it seems the uncertainty is out there, a fact of life difficult to tolerate. ‘How can I or you know for sure it's really safe?’ the client asks. ‘I really just don't know how to clean my teeth’, another client pleads. ‘Please tell me how can I know when they're clean?’ Such pleas imply that a genuine uncertainty or incompleteness in knowledge exists when in reality such interrogations are themselves usually the sequel to an inferentially confused obsessional doubt. The client knows when other people's teeth are clean, and he knows the teeth he sees in his mirror are

clean. So certainty is not at issue; the dilemma is rather a distrust of sense information and doubt of given perceptual knowledge.

Finally, the IBT programme in this is designed to be interactive and user friendly with quizzes, exercises worksheets and training cards. We have also introduced humour through cartoons and illustrations, partly in recognition of the constructive impact of humour on the creation of a successful therapeutic alliance, but also because in clients with OCD and in therapy generally vivid visualization can be as captivating as words. One last point . . . our view is that all therapy programmes are works in progress and we welcome feedback from users, both therapists and clients.

Kieron O'Connor and Frederick Aardema
Montreal

Note

1. In order not to encumber the text, we have not followed the standard textbook procedure of citing references in the text. However, the bibliography, entitled ‘Key IBA publications’, exhaustively lists supporting literature.

Chapter One

Overview of the IBT Programme

Overview of the IBT Evaluation and Treatment

The present inference-based therapy (IBT) has been developed over the course of the last 15 years utilizing information building upon clinical case studies as well as numerous psychometric, experimental and treatment outcome studies. The approach is a reasoning therapy that focuses on the resolution of the reasons for the initial doubt or obsession responsible for the client's symptoms. The therapy program is highly cognitive in nature often requiring a lot of attention from the therapist in correctly using the model taking fully into account the specific needs of the client. At the same time, there is also a great deal of structure in the current approach, and the accompanying materials are intended to benefit both the therapist and client in their collaborative work.

Step by Step

The idea of the stepped manual is that both client and therapist progress in small steps which simply follow on naturally from each other. The client moves from reflection on a point to intellectual acceptance, to personal and emotional engagement, to enactment. Along the way, metaphors are used to convey the natural nature of the progress and avoid the implication that major leaps out of

the ordinary need to be made. In keeping with this ‘natural flow’ metaphor, the therapist should be careful to always locate him or herself and the client on the map of recovery. In particular the conditions to be met before transition from stage to stage are spelt out clearly. We have tried to pinpoint the signs that reveal progress and of course how to deal with no progress.

Broadly speaking, the current stepped programme can be subdivided in three main parts– (1) Education and Foundation, (2) Intervention and (3) Consolidation, each of which consists of a series of different steps. Duration of treatment may vary from client to client, but in most cases, all steps can be provided to the clients in the course of 12 to 20 treatment sessions but number of sessions can be flexible. This allows the therapist to sometimes spend two treatment sessions on one particular step in treatment if the client experiences difficulty, or if further practice reinforcement is necessary before proceeding to the next step.

Each step in treatment includes accompanying worksheets that form the basis for the sessions covering the specific step in treatment. The worksheets are provided to the client after the session to ensure proper integration of the material. In addition, the client is provided with an exercise sheet and a training card as it pertains to each step in treatment. The exercise sheets and training card are intended to ensure the practical application of the material learned during the therapy, and form an essential part of the treatment. In addition, quizzes and cartoons are provided for further consolidation of learning, enhance understanding, and increase the overall complicity of the client and effectiveness of the treatment delivery.

The first part of treatment termed *Education and Foundation* primarily revolves around education and foundation and lays the foundation for IBT. Step one called