Clinician's Handbook for

Obsessive Compulsive Disorder

Kieron O'Connor
and Frederick Aardema

WILEY-BLACKWELL

Clinician's Handbook for Obsessive-Compulsive Disorder

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*

Clinician's Handbook for Obsessive-Compulsive Disorder

Inference-Based Therapy

Kieron O'Connor
Frederick Aardema

WILEY-BLACKWELL
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Table of Contents

List of Cartoons

About the Authors

Dr Kieron O'Connor received his doctoral degree and clinical training at the Institute of Psychiatry, Maudsley Hospital in London. He is currently the Director of the Centre for Research on Tic and Obsessional Disorders at the Fernand-Seguin Research Centre, Hôpital Louis-H. Lafontaine, and full professor in the Department of Psychiatry at University of Montreal. He is also associated professor at the University of Quebec in Outaouais. His research focuses on improving understanding and treatment of people suffering from obsessive-compulsive spectrum and related disorders. The inference-based therapy (IBT) programme described in this handbook is a product of this research. He has created three multidisciplinary research teams working, respectively, on the treatment of three tic disorders: Gilles de la Tourette syndrome, delusional disorders and obsessional disorders. His approach combines clinical and psychophysiological methods. His recent research extends treatment programmes into eating disorders and body dysmorphic disorder and to children and adolescents. He is also involved with community education and workshops and has authored four treatment manuals. He has developed innovative treatment approaches to obsessions, tics and habit disorders including the inference-based approach. Dr O'Connor's publications include *Behavioural Management of Tic Disorders* (Wiley, 2005), and *Beyond Reasonable Doubt: Reasoning Process in Obsessive Compulsive Disorder* (with F. Aardema & M. C. Pélissier; Wiley, 2005).

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*

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

*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 and other publications', lists supporting literature.

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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

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.

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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 *When Doubt Begins* shows the client how doubt is responsible for most of his or her symptoms. This step is intended to ensure a proper adherence to the model, as well as increase the client's awareness on the origin of his or her symptoms.

The crucial first step is identifying the doubt behind the immediate manifestations of OCD behaviour. The identification then permits establishing the origin and sequence of the obsessional chain ending in the self-sabotage of compulsions and safety behavours. Only later when the everyday doubts are resolved is the underlying self-doubting theme addressed. Why? Because the theme becomes more visible to the client at this point. Self-repositioning towards the authentic 'real' self is then easier and more likely to succeed than at the start of therapy. A key exception to this treatment sequence is where the doubting inference may already be close to the self-theme. This may occur in overvalued narrow mono-symptomatic obsession, 'I could offend the devil', or in existential ruminations largely centred on the self, 'I doubt who I am', or in hoarding, 'I could be nothing without my objects'. So the self-doubt can be addressed initially or in tandem with immediate obsessional doubts, if it is already visible to the person.

The next step of Education and Foundation termed *The Logic behind OCD* focuses on the reasoning preceding the doubt and is intended to show the client that the doubt or obsession does not appear out of the blue. Exercises are intended to increase awareness that there is reasoning behind the doubt rather than that the doubt is just 'happening' to the person.

The third step of Education and Foundation termed *The Obsessional Story* expands upon the previous step by showing how obsessional doubt gains its strength and

reality value from a convincing narrative leading logically onto the doubt. This is the *narrative unit* giving credibility to the doubt and will be a primary focus in the course of therapy. The OCD narrative is constructed in collaboration with the client, utilizing the information on reasoning collected so far and filling in any gaps in the story. It is demonstrated to the client how the narrative leads to absorption into the obsession.

Finally, the fourth step of Education and Foundation *The Vulnerable-Self Theme* locates the OCD within a wider self-theme that makes the person vulnerable to create doubt in specific domains. The self-theme also throws light on the person's type and form of OCD. The vulnerability theme is the self the person fears becoming and is itself yet another OCD story. As noted earlier, the self-theme is derived from the obsessional doubts. This self-theme can be addressed right from the beginning of therapy, especially when the theme already forms a principal doubt in, for example, some ruminative doubts, or the theme can be introduced at a later stage when the person has already overcome doubts leading to more everyday compulsions. All of these four steps of Education and Foundation combine to form the fruitful ground for optimizing effectiveness of subsequent interventions.

The second part of treatment called *Intervention* attempts to directly change the obsession or doubt. It introduces the central tenet of IBT which is that obsessions are constructed and always occur without any direct evidence. Most crucially, in normal doubt there is always direct evidence or information that supports the doubt. No such direct evidence occurs in obsessional doubt. This concept is introduced from a number of angles in a series of distinct steps eventually resulting in an alternative non-obsessional narrative more in line with reality.

The first step of Intervention termed *OCD Is 100% Imaginary* establishes with the client that there is no direct evidence in the here and now, and so the OCD story is entirely subjectively generated. The client is shown that the doubt originates 100% from within the person rather than is fuelled from an immediate outside source. The purpose is not yet to invalidate the doubt. The main point to get across is that the doubt originates from the person as opposed to from reality in the here and now.

The second step of Intervention titled OCD is 100% irrelevant takes the point a little further and shows to the client that *if* the obsessional doubt originates solely from within the person rather than from the outside, *then* it is 100% irrelevant to the here and now. The crucial point here is that even though the doubt may very well be possible in the abstract, it is still irrelevant 'now'. Incomplete intellectual adherence to this idea should not prevent the therapist at this point from proceeding to the next step, but may negatively affect the effectiveness of future interventions. However, resolution of the obsessional doubt more likely in subsequent steps if the client intellectually grasps the idea that obsessions are irrelevant.

The third step of Intervention *The OCD Bubble* helps the client to identify the exact point where he or she crossed over to the imagination and left the world of senses. It is shown to the client that while inside of the OCD Bubble client contact with the physical senses and common sense is lost, and further compulsions only serve to fuel their imagination and rehearse the doubt, and so OCD makes them less secure.

The fourth step of Intervention termed *Reality Sensing* elaborates on how obsessional doubt is always a false doubt because it goes *against* reality. Reality sensing is simply trusting and going with the senses rather than doubting and going away from them. An alternative narrative is introduced that takes the senses into account leading to an entirely different conclusion than that which flows from the obsessional doubt. The client is encouraged to begin acting on alternative stories in combination with proper reality sensing. Potential problems with reality sensing are addressed, such as trying to do too much to 'get into' reality. The client may experience a void owing to a sense of not doing enough, and is taught how to sense reality without effort.

These four steps of the intervention form the basis for further consolidation of gains made so far in the course of treatment and to boost further progress.

The final part of treatment termed *Consolidation* attempts to further weaken the obsessional doubt by invaliding the obsessional story, strengthening the alternative story and encouraging the client to act upon this knowledge.

The first step of Consolidation is termed *A Different Story* where the client is encouraged to elaborate on the non-obsessional story in a natural and practical way. The person develops the art of story telling and how creating and telling stories about events and selves can transport emotions and perceptions and change beliefs.

The second step of Consolidation termed *Tricks and Cheats of the OCD Con Artist* familiarizes the client with the many tricks and cheats of the OCD that make it seem as if obsessional doubt has something to do with reality. Elements in the obsessional story of the client are addressed as specific devices used by the OCD to generate doubt. This is then followed up with teaching the client specific counter-strategies to trick the OCD con artist.

The third step of consolidation titled *The Real Self* highlights the selective nature of obsessional doubt as well as the vulnerable self-theme running through the doubt. The client is shown that the selectivity of the obsessional doubt only further invalidates the reality of obsessional doubt. A positive message is transmitted to the client to show that the OCD only affects a specific portion of the client's life, whereas functioning is often healthy in other spheres. Specific exercises are given to the client to strengthen awareness of this selectivity and in knowing the difference between their authentic and OCD selves.

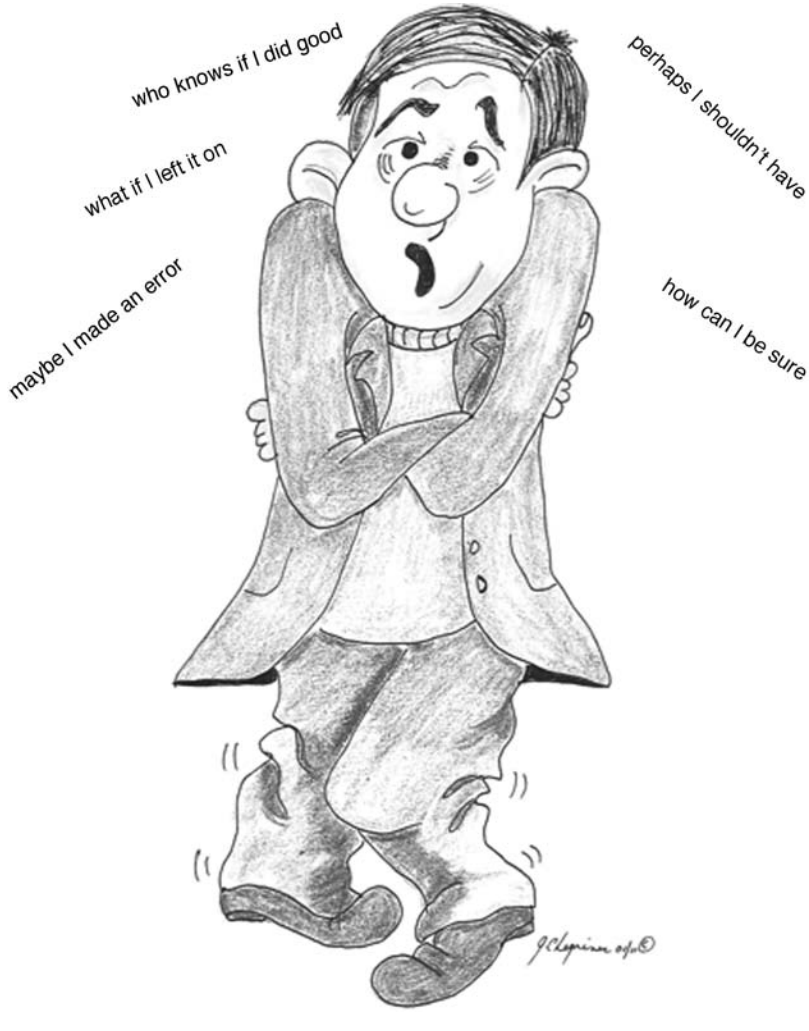
The vulnerable self-theme underlying the OCD is also explored since this theme renders the person vulnerable to doubt in certain areas and not others. This OCD self is also a false self in the same way that the obsessional doubt is false. An important part of overcoming OCD is to find and recognize who the client really is ... the authentic self. The authentic self, since it is based in reality, is usually the opposite to the OCD self. The authentic self is the self which achieves constructive accomplishments in the world and was always there, albeit masked by the OCD.

The fourth step of consolidation termed *Knowing and Doing: Relapse Prevention* focuses on the translation of knowledge into action. The client is encouraged to act upon the knowledge that the doubt is false and to identify and correct any thoughts that keep him or her from acting 'sensibly'. This section addresses the split between

knowing how to act and acting on it. Knowing implies behaving. It is not a leap in the dark but a natural progression of the same attitude. Every single thought and belief that still prevent the person from behaving in a noncompulsive way have to be specifically addressed as invalid *given* the lack of sense of information in the here and now.

Relapse prevention also addresses strategies to maintain gains, foresee difficulties and if necessary strengthen contact with reality with the authentic self and the senses and dispel imaginary doubts.

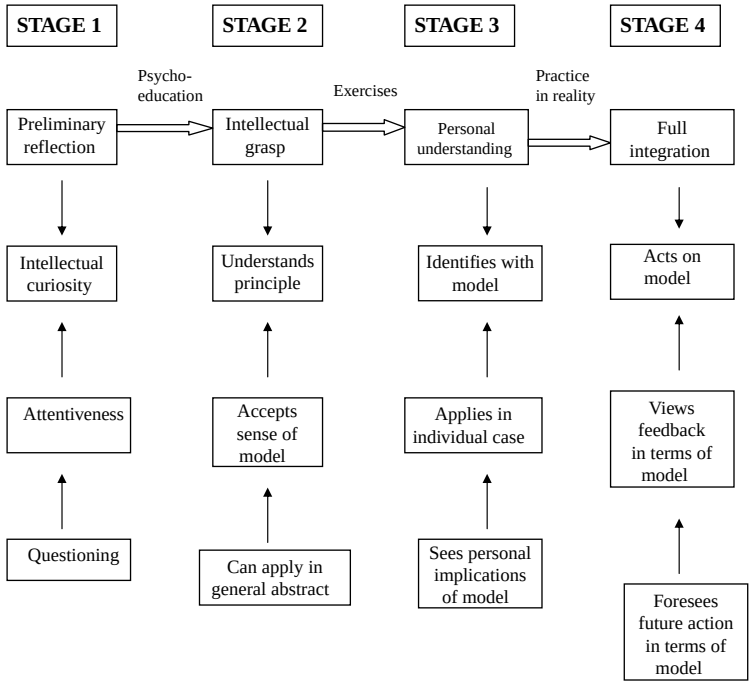
Finally, a trouble shooting and problem solving section covers technical problems in applying IBT, plus more general or conceptual queries from client and therapist.



Cartoon 1. The doubting dance.

Process Towards Integration

Emphasis is placed within the IBT model on the integration of the model into thought and action, and we illustrate the process by which contact with the IBT model can lead to full integration through a natural progression of accompanying steps.



This cognitive schema, inspired by the well-known Prochasky and DiClemente's transtheoretical behavioural model of change, charts the progression from a preliminary reflection on the IBT model through intellectual and personal understanding to a full integration of the model. The therapist acts as guide through the stages combined with interventions designed to prompt insight and advance.

In stage 1, the person needs initially to show an openness and interest in the model. So, for example, psycho-education in the model and its account of aspects of OCD helps move the person along from a preliminary reflection to intellectual grasp. If the person does not show this initial interest, one might question readiness to undertake IBT.

In stage 2, intellectually, the person sees the utility and relevance of the model to OCD and how it can be applied generally. So the person may be able to describe how the model may apply to other people's OCD. In stage 3, in personal understanding the person is comfortable discussing their own obsession in IBT terms. The person begins describing their own symptoms in IBT terms, for example 'Here I realize I went over the bridge into imagination', or 'Yes, this doubt I experienced was

definitely obsessional'. Finally, when integrated, the person uses IBT vocabulary to discuss all experiences. The person begins resolving their OCD experiences entirely in IBT terms. 'I see now how I need to catch the obsession before I cross over the bridge', 'I see that OCD was an illusion, making me imagine I needed to doubt and to check'. Ideally the person should be in between stages 2 and 3 for each of the specific IBT components when practicing this step. Typically the person arrives at stage 4 towards the end of the programme.

Treatment 'Resistance'

A word on treatment resistance. The term 'Resistance' is an unhelpful metaphor since it implies clients are actively fighting against getting better for all sorts of hidden reasons. In IBT, there is no treatment resistance, just different stages in an errorless learning process. The question becomes where and when the person is ready to take the next step. In following the programme, the person is always achieving and always somewhere on the map of progress, even if stuck for a while. The person can be succeeding even when standing still since they are doing the necessary reflections bit by bit to further progress. It is important throughout also to acknowledge and encourage even small steps since the person or family may consider them negligible. In fact, small steps are often the most important ones. A client not ready to progress to the next step may be still in reflection, may require more understanding or more answers, may be fearful or reluctant to progress or may have decided the programme is not for them.

In reality, the resistant person is often feeling lost, stranded, overwhelmed or misunderstood within the therapy-scape and needs guidance. In following the path of therapy, one foot step comes logically and naturally after the other, and if it doesn't, then for the client the passage from step to step no longer seems natural.

Chapter Two

IBT: Evaluation Tools

The following case provides an example of case conceptualization using the IBA model.

Mary

Mary (46) is obsessed about the possibility of being contaminated by blood, particularly other people's blood. She grows hostile and frustrated every time she sees a stain on a garment or a painting which is red – any shade of red – because she immediately imagines it could be blood, and if it is blood, then she will be contaminated. She gets angry at the people who would put this red in her way even if she doesn't touch it. She cannot use a multicolour carwash since she considers the red foam could be blood. She will not drive by a red slogan on the wall because it could be blood, or an advertisement in red for the same reason. If by chance she comes into contact with red, she is likely to throw out her clothes and insist her husband does likewise if he was near her. There is a seat in her car she has been unable to sit in for four years since a friend in a red dress who was menstruating sat there, and a room in her house is out of bounds to her and her husband since she once watched red ants on the television in the room and in her mind the red signalled blood and the blood could have seeped out of the television onto and into the furniture.

Halloween is her worst nightmare – red hands, masks, gloves, teeth. She curses the shops and children displaying these items. When asked whether she considers there is really blood on the Halloween items or in the carwash, she admits probably not . . . but there's a possibility. She read about a French artist who used real blood on his canvas. A guy put poison in the meat cans, so someone in a factory could put in real blood out of spite. How does she know it's not real blood? How can she or any one or even I, the

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therapist, be sure it's not real blood? She gets very angry that the shops would prominently display these items. 'Have they no sense! These things are dangerous'.

Occasionally she will make enquiries to manufacturers or Google search to try to establish the content of red products, but far from reassuring her, these enquiries leave her even less sure. She has dismissed their reassurances in a couple of days with more doubt about the source. Once a doubt is implanted, then the story quickly chains off to a series of dire consequences in which Mary rapidly becomes emotionally engaged. Often she ends up neutralizing just to escape the emotional distress as much as the contamination consequences she is sure will follow.

Some of Mary's stories involve items contaminating other items and, for example, furniture, cushions and clothes have been in quarantine for years because they were in her car when she drove past some red. Ultimately now she cannot drive her car because the front seat was contaminated by driving too close to another red car. All this, of course, creates major obstacles to her family and her functioning.

When Mary came to the clinic for IBT she had already received exposure-based therapy and cognitive-behavioural therapy (CBT) based on re-evaluating her appraisals of the consequences of her obsessions. What she reported was that she was unable to get the initial stories about red contamination out of her mind and no matter how much she worked on minimizing the consequences by, for example probability calculations, the thoughts persisted. For example, although she knew that even if it were blood, her body defences would protect her, she couldn't get the potential doubt to go away. Whilst she accepted that some consequences were exaggerated, they were quickly replaced by new ones.

When her IBT therapist asked what she imagines will happen if she is infected, she is very vague about realistic consequences. But what she is particularly concerned with is the possibility of inadvertently, for no fault of her own, become infected.

Mary's case captures well the main points in IBT case conceptualization.

- Her problem begins with a doubt.
- The doubt is always about whether something which appears OK could be something else, in this case whether a red object is blood.
- The doubt goes against what her senses tell her that the redness is not blood.
- She becomes immersed in her obsessional story and acts on it, so giving it a reality value.
- The doubt is the problem and not her perception or her coping in reality with real blood.
- Mary already possesses the skills to deal with blood and is able to cope normally when encountering real blood. Interestingly, when faced, for example, with a sister's nosebleed, she rapidly helped her sister stem the flow.

In the following section discusses how to evaluate obsessions from an IBT perspective: the key dimensions to evaluate, how to use the clinical scales and in what way the scales inform the treatment plan. Evaluation forms an essential part