Innovations in CBT for Treatment Resistant OCD and BDD

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Characteristics of Individuals with Treatment Resistant OCD and BDD

- Little or no response to standard treatment.
- Frequently described as having over-valued ideas or as delusional.
- Likely to refuse to engage in exposure based treatment.
- Their obsessions are generally seen as realistic and compulsions seen as reasonable efforts.

Over-Valued Ideas

- Generally seen as poor prognostic indicators
- Assumed to be more resistant to change
- Commonly seen in BDD and in OCD with poor insight or in forms of OCD seen as most treatment resistant such as hoarding

Definitions

- DSM defines an over-valued idea as
  - An unreasonable and sustained belief that is maintained with less than delusional intensity
  - The person is able to acknowledge the possibility that the belief may or may not be true
  - The belief is not one that is ordinarily accepted by other members of the persons subculture
  - Most sources use this as shorthand for poor insight and place it on a continuum with delusional certainty

Definitions

- DSM defines a delusion as a false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary.
- The difference between over-valued ideas and delusions is based on how firmly the belief is held

Delusions?

- Delusions are actually held with varying degrees of conviction which may fluctuate over time and are not “fixed”
- The definition from DSM does not accurately distinguish between delusions and over-valued ideas
- There is no qualitative distinction between beliefs we call delusions and other beliefs
- All differences are in degree

Quality vs Quantity

- The standard definitions and traditional thinking about delusions holds that there is a qualitative difference between the thinking of people who have delusions and those who don't
- This distinction does not stand up to closer examination

Normal Delusions?

- A survey of 60,000 British adults found
  - 50% believed in thought transference
  - 25% believed in ghosts
  - 25% believed in reincarnation
- Interview using the Peters Delusional Inventory
  - 272 healthy adults
  - 20 psychotic inpatients
  - 10% of the healthy population scored above the mean for the deluded patients

An Alternative Understanding

- The individual patient (and everyone else in the world) is attempting to make sense of their own experience. It is likely that they hear the voice and try to explain why they hear the voice. They may come up with an explanation that we think is strange but it makes sense to them.

Common beliefs

		Sex				Age			
All Adults	All Adults	Male	Female	18-12	25-29	30-39	40-49	50-64	65 & over
		%	%	%	%	%	%	%	%
God	90	86	93	84	82	91	90	91	95
Survival of Soul after death	84	78	89	85	88	81	86	82	84
Miracles	84	77	90	86	85	82	85	83	82
Heaven	82	75	89	83	71	83	84	80	85
Resurrection of Christ	80	73	86	76	68	81	82	81	84
The Virgin birth of Jesus	77	70	83	76	60	79	80	78	80
Hell	69	65	73	74	63	69	72	66	68
The Devil	68	64	73	68	62	72	72	68	62
Ghosts	51	45	58	58	65	55	57	48	27
Astrology	31	25	36	37	43	37	23	32	17
Reincarnation	27	23	30	30	40	30	25	26	14

Ideas of Reference

- Ideas of reference include the thought that others are talking about the individual and it is only a small step to the belief that they know what others are thinking about the them**
- Ideas of reference are typically described as a psychotic feature or a form of delusional belief
- They are extremely common in people with BDD

Schizotypy

- Schizotypal personality disorder is a predictor of poor treatment response (Jenike et al)
- This personality disorder or trait includes aberrant perceptions and beliefs
- Schizotypal patients may simply have what we would otherwise describe as delusions or over-valued ideas that impact compliance with treatment or interfere with belief change as a component of therapy**

Thought Action Fusion

- Thought action fusion can occur in moral or causal reasoning.
  - Moral thought action fusion is the belief that a thought is the moral equivalent of an action
    - If I think of doing something bad that is as bad as doing it
  - Causal thought action fusion is the belief that thinking about possible events changes their probability
    - If I think of something that can go wrong it is more likely to happen.
- Thought action fusion is seen as a key feature of OCD. How is it different from a delusion?

How Delusions Work

- Delusions are present in ¾ of people diagnosed with schizophrenia, ½ of people with BDD and an unknown percentage of people with OCD.
- They also appear in an estimated 5-10% of the general population.
- Individuals who develop such beliefs appear to jump to conclusions based on minimal evidence and ignore contradictory information.

Hallucinations

- Hallucinations are defined as a sensory experience that doesn't correspond to an external environmental event
- Hallucinations are not listed in the diagnostic criteria for OCD or BDD
- While there is no good data, a substantial number of people with BDD report hearing others commenting on their appearance.

  Is this a hallucinatory experience?

The Truth About Hallucinations

- Most people including most mental health professionals describe hallucinations as a sign of mental illness.
- Because of this belief and the typical reaction to talking about hallucinations, patients often deny they experience them.
- If hallucinations are acknowledged most mental health professionals believe discussion of them is contraindicated

Hallucinations in the General Population

- The incidence of psychotic symptoms in the general population is about 100 times greater than the incidence of psychotic disorders
- The experience of hallucinations at one point in time is not a good predictor of later hallucinations
- Hanssen et al 2005

You Heard What?

- In a survey of 375 college students 71% reported some brief, occasional experiences of voices while awake.
- In another study of 586 college students 30-40% reported hearing voices, and almost ½ reported it happened at least once a month
- Reports of hallucinations were not related to measures of psychopathology

Explanation of Hallucinations

- Functional brain imaging data shows speech areas of the brain are active when people are having auditory hallucinations.
- EMG data supports the conclusion that people are sub-vocalizing when they hear voices.
- The content is essentially the same as typical intrusive thoughts.
- Hallucinations may be explained as sub-vocalized intrusive thoughts which are misperceived as being from an external source.

Medical Model and Tradition

- The medical model and traditional way of understanding hallucinations and delusions include:
  - That they are the result of brain dysfunction or disease
  - That these experiences are qualitatively different from “ normal” experience
  - That it is futile or perhaps even harmful to engage in discussion of them
  - That it is best to explain that they are the result of the patients illness

Effects of Confrontation

- To some extent the caution about discussing delusions is supported by the fact that confronting them is most likely to lead to strengthening conviction.
- Arguing with the patient that their beliefs are false or that what they experience is not real will not only not convince them it will probably be experienced as invalidating and damage the therapy relationship.

The European Model of Over-Valued Ideas

- Most American sources seem to use intensity of conviction as the defining variable.
- The European model includes the idea that over valued ideas are characterized by: preoccupation, being more ego syntonic, development is comprehensible, and associated with a high degree of affect??

Application of these Distinctions

- If we view the distinctions suggested in the European model and allow for the fact that delusions are not held with absolute conviction it may suggest that we can understand beliefs as falling on several continua and that this more complex model can lead to implications for interventions.

Where do Delusions Come From?

- Beliefs arise from a search for meaning.
- Delusional beliefs may arise from attempts to explain experiences that are anomalous and which are emotionally important.
- They arise as a result of an attempt to find meaning and are influenced by both environment and preexisting beliefs.

Personal Importance Principle

- Obsessions attach to concerns that are of central importance to the individual. For example the patient who holds strong religious beliefs is most bothered by intrusive thoughts that conflict with religious values.
- Similarly?? delusions attach to central concepts about beliefs about the self and the world.

Why do Delusions Persist?

- Obsessions seem to persist because people avoid situations which could produce disconfirming information and compulsions produce negative reinforcement which strengthens the belief in the obsession.
- In delusional beliefs the same mechanisms are in place. Compulsions and other safety behaviors prevent disconfirmation

Why Treatment Resistance

- Over valued ideas and delusions are more resistant to treatment in part because they tend to be held with greater conviction but in addition they may have a stronger affective component.
- This stronger affective component means that addressing them at all is likely to be perceived as threatening.
- Due to being more ego syntonic conflicting arguments are more likely to be experienced as personal attacks.

Hallucinations and Treatment Resistance

- In effect the problem with hallucinations is not the presence but the reaction to them.
- In BDD the reported hallucinations are often confirming of the beliefs about appearance and others reaction to it.
- If the mental health professional is seen as not believing in the experience it is another event that can be interpreted as attacking or demeaning to the patient.

Discussion of Beliefs in Therapy

- Since most people with OCD will admit their beliefs or fears are exaggerated or irrational they are more likely to be willing to discuss or question them or consider a therapy task that would test them.
- More centrally held beliefs are more likely to be "OFF LIMITS" and an attempt to question or test them is likely to be threatening to the individual.

What does Cognitive Therapy Offer?

- The traditional view is that delusional patients need to be treated with medication.
- In fact approximately 60% of patients will still have psychotic symptoms when fully compliant with medication.
- A body of evidence has been accumulated that cognitive behavioral therapy produces a clinically important benefit in otherwise drug resistant psychotic patients.

Engagement in Therapy

- When the patient is able to question the beliefs or meaning of experiences it is easier to engage in a collaborative therapy approach.
- Both parties can engage in an effort to reduce dysfunction and distress beginning with a shared conceptualization of the problem.
- In working with a delusional patient this engagement is impeded.

Enhancing Engagement

- Early establishment of goals
- Sharing of the cognitive model
- Therapist presentation:
  Knowledgeable, Trustworthy, Likable, Confident

- Expectations for therapy
  Therapists work hard and patients get better vs.
  Patients work hard and therapists get better
- Patience

Can You Tell Me About Them?

- If we inquire in an empathetic way the patient may be able to describe the experience with voices.
- This includes many characteristics
  - Number, Identity, Social position, Gender, Volume, Power, Knowledge, Occurrence, Content, Beliefs about origin and mechanism

An Alternative Understanding

- The individual patient (and everyone else in the world) is attempting to make sense of their own experience. It is likely that they hear the voice and try to explain why they hear the voice. They may come up with an explanation that we think is strange but it makes sense to them.

What is it Like

- If given a chance and an accepting response many people with voices will describe their experience. We tend to shut this down when we respond to the presence as a symptom of an illness and an indication that more medication is all that is needed to take it away. Consider how you would feel if you reported an experience and others said that is just a sign you are sick. ??

The Message to Give Patients

- You are not crazy, the problems you have are understandable.
- Either your concerns are real or you believe them to be real. (Both explain how you feel)
- How you interpret events affects how you feel.
- It is important to evaluate beliefs by testing them and this involves changing your behavior.
- What you pay attention to and how you pay attention can affect how you feel and what you believe.

Normalization

- Engaging the patient in the collaborative production of an explanatory normalizing rationale /model of symptom emergence is the first crucial step in developing a relationship with the patient (Kingdon and Turkington)

How Can We Engage the Delusional Patient?

- Empathy warmth and genuineness are central to building any therapeutic relationship but are especially critical with individuals with psychotic symptoms.
- Word perfect accuracy contributes to avoiding invalidating experiences.
- Instead of invalidating or denying delusional beliefs engage in evaluating them collaboratively by gathering evidence and developing alternative explanations.

More on Engagement

- Be willing to agree to disagree.
- When the patient is distressed it may be useful to engage in tactical withdrawal.
- Allow the illogical or psychotic logic to flow over you. Eventually it becomes comprehensible
- Teach a cognitive model, emotional responses are the result of interpretation of events, not the events themselves. Events can include intrusive thoughts, images, obsessions or hallucinations.

Examining Antecedents

- It is important to look at events leading to development of symptoms in the context of how they could be interpreted to support the conclusions embedded in delusions or lead to experiences such as hallucinations in context so they may lead to development of alternative explanations.

Anna's Belief that She is Ugly

- When asked about evidence that she was ugly a BDD patient reported that her father had told her she was when she was a child.
- This was seen as irrefutable evidence of a fact.
- A cognitive restructured alternative was that this was evidence only that her father said this not that it was a fact.
- This alternative “clicked” and led to a dramatic shift in the patients self image.

What Can We Do?

- If we begin by simply listening to the patient and trying to understand their experience we can begin to build a helping relationship. This alone may have considerable impact on their mental status.
- We can work toward an open dialogue about the experience of the voice and how to deal with it.

What is the Real Problem with "Psychotic" Symptoms

- The actual beliefs and explanations of experience are not a problem in and of themselves.
- The problem is the distress associated with the experience or belief or the interference with function that follows from the beliefs.
- With this in mind the goal of therapy is not necessarily to change the belief but rather to change the effects of the belief, reduce distress and interference.

What are safety behaviors and why are they a problem?

- Safety behaviors are things someone does to get relief where they believe that if they did not do them some disastrous consequence would follow. A classic example is the panic patient who takes a Xanax and believes it saves his life. The problem is that such behaviors actually reinforce the belief in the danger of the symptom and the magical belief that the coping response was all important in preventing a disaster. This perpetuates the disorder and distress associated with the symptom

Joining in the patients conceptualization

- In order to work with patients who have delusional beliefs we need to first join with them in conceptualization.
- This includes accepting that they are reporting their experience as they understand it and their beliefs represent their efforts to make sense of those experiences.

Working with Delusions

- Begin with an individual formulation that accounts for the patients beliefs and associated distress.
  - What evidence is the person using as the basis for their beliefs?
  - How do these ideas build on the persons ideas about self, others and the world?
  - How do these thoughts make sense of previous life experiences?

Problematic Beliefs Supported by Mental Health Professionals

- There are some beliefs about symptoms which may contribute to treatment resistance and which are supported by popular conceptualizations or other mental health professionals who have interacted with the patient.
  - Depression is anger turned inward and expressed only by a compulsion. If not expressed the anger would lead to aggressive behavior

Continuing Work with Delusions

Is the individual reacting to puzzling, confusing or otherwise ambiguous experiences?

How is the person reasoning about experiences?

- Recognize known biases
  - Bias for confirmatory information
  - Tendency to jump to conclusions
  - All or nothing thinking

Feed back this formulation to the patient

In effect the reasoning of the client is “unpacked” and treated as understandable in a normalizing and empathetic manner.

Therapy Process

- Develop alternative interpretations of anomalous or other distressing experiences.
- Review evidence supporting interpretation and alternative explanations of experience
- Develop the ability to become an observer and evaluate thoughts rather than simply accepting them.

Working from the Outside In

- The effect of confrontation of delusions is typically to lead to greater entrenchment.
- Therapeutic efforts may be more acceptable if you begin with less central beliefs.
- Using the approach of working with more peripheral beliefs first and working with toward more central ones is less likely to be met with resistance and may lead to acceptance of the process of developing alternatives.

Peripheral Questions

- In discussing any delusional or overvalued idea it is best to explore the belief beginning with more peripheral elements and by examining details and possible inconsistencies. With the use of Socratic questioning and with the understanding that beliefs are rarely held with absolute conviction an approach that is both accepting and mildly skeptical is likely to lead to reevaluation of the belief.

No Safety Behavior Please!

- There are a number of techniques that have been found helpful in dealing with hallucinations but they must be used in context.
- Both Therapist and patients need to understand that the use of these methods is a way to be more comfortable as the voices can be unpleasant or annoying but that it is not "necessary" to get rid of the voices.

Behavioral Experiments

- Often confused with exposure exercises.
- Determine a specific thought or belief to be tested.
- Determine what information is needed to conduct this test.
- Set up an experiment to gather this data.
- Establish in advance what a particular outcome will mean.

Outcome of Behavioral Experiment

- How does the outcome relate to the automatic thought?
- How much do you believe the thought now?
- To what extent were predictions confirmed or disconfirmed?
- What is a realistic view given the results of the experiment?
- What next?

Use of Classic Cognitive Interventions

- Becoming aware of automatic thoughts
- Which thoughts to address
- Identifying when they are occurring and learning to catch them
  - Worst case scenario
  - Recounting events
  - Affect shifts
- Use of a DTR

Critical Role of Therapist Acceptance

- In any effort to use cognitive restructuring or other cognitive approaches to belief change the attitude of the therapist plays a critical role.
- Because the beliefs we describe as over valued or delusional are typically held with strong affect any indication of a non accepting attitude by the therapist is likely to be damaging to the already fragile working alliance.

Work on Values

- If overvalued ideas are more of a problem because of firmly held values than because of their content then work focused on those values has the potential to lead to important change.
  Example A person who values perfection may be treatment resistant since the goal of treatment seems to be to accept imperfection. The effect and desirability of seeking perfection can be examined and the reconsidered.

The Role of Mindfulness

- Mindfulness as a special kind of attention without judgment or evaluation
- Since it is not the intrusive thought but the evaluation or judgment that is the source of distress a mindful response to the intrusions leads to reduction of distress
- Mindfulness can be viewed as a skill which can be developed with practice. This may begin with practice of mindful attention to non distressing stimuli

Wells and Attention Training

- Based in Wells SREF model
- Successfully used in case studies with panic and hallucinations
- Attention Training Technique
- Application to excess attention to detail in OCD or BDD

Schema Focused Therapy

- Based in the work of J. Young
- Early maladaptive schema serve as prototypes for automatic thoughts
- Delusions may emerge as a result of invalidation of personal schema and may serve to protect against loss of self-esteem or other threat
- Schema are responded to in one of 3 fundamental ways. Overcompensation, Confirmation/ Surrender, or Avoidance

Steps in Schema Work

- Rationale: Use of prejudice model
- Identification of schema using Socratic questioning and downward arrow
- Use of historical testing
- Use of responsibility pie
- Use of continua to evaluate schema
- Review of advantages/disadvantages of a schema or belief
- Development and testing of alternative schema

Motivational Interviewing

- First developed for work with substance abuse clients where treatment resistance is often extreme
- Therapists are taught to roll with the resistance and enhance ambivalence
- Adopted for treatment of hoarding (a particularly difficult form of OCD) by Frost and Steketee