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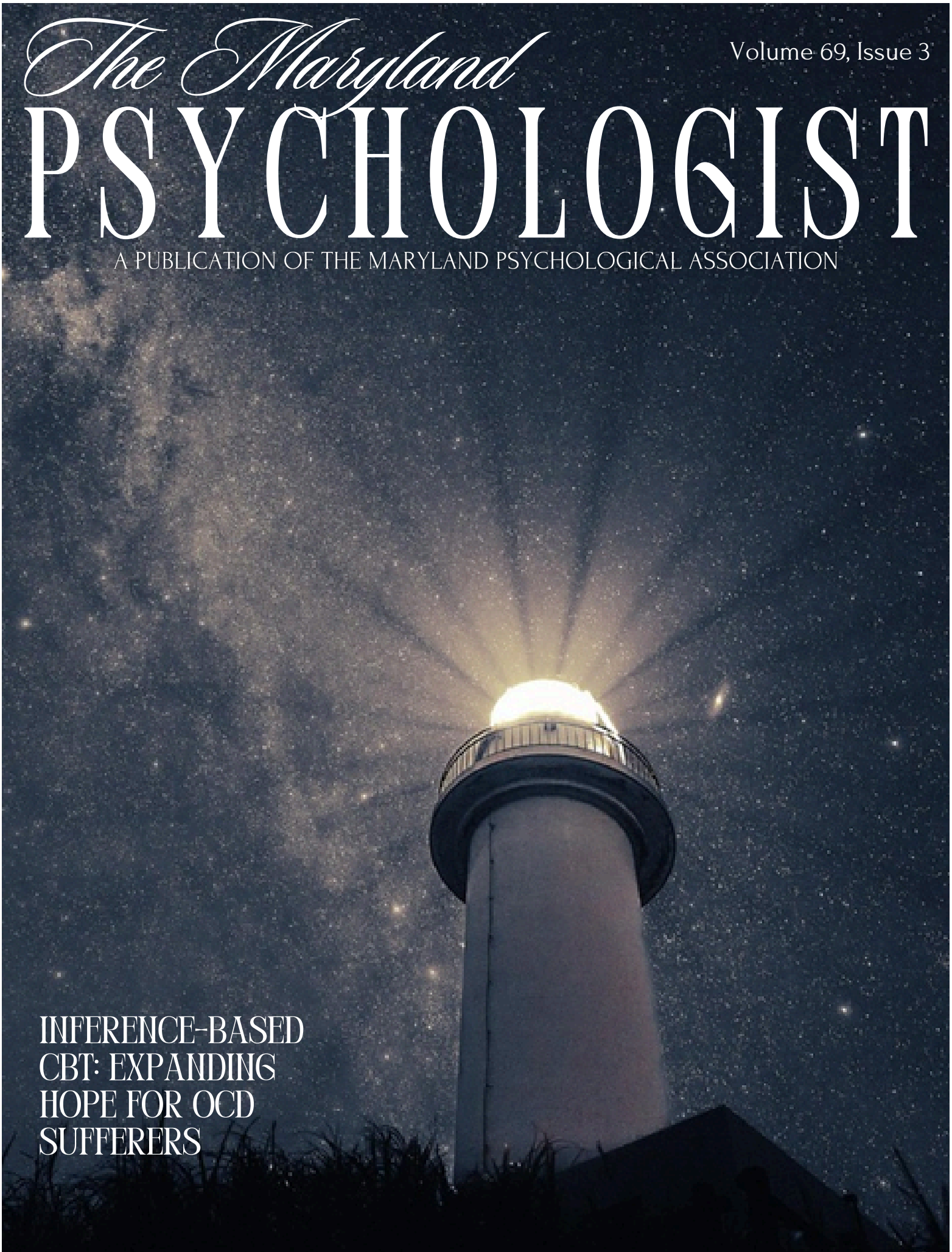

INFERENCE-BASED CBT: EXPANDING HOPE FOR OCD SUFFERERS

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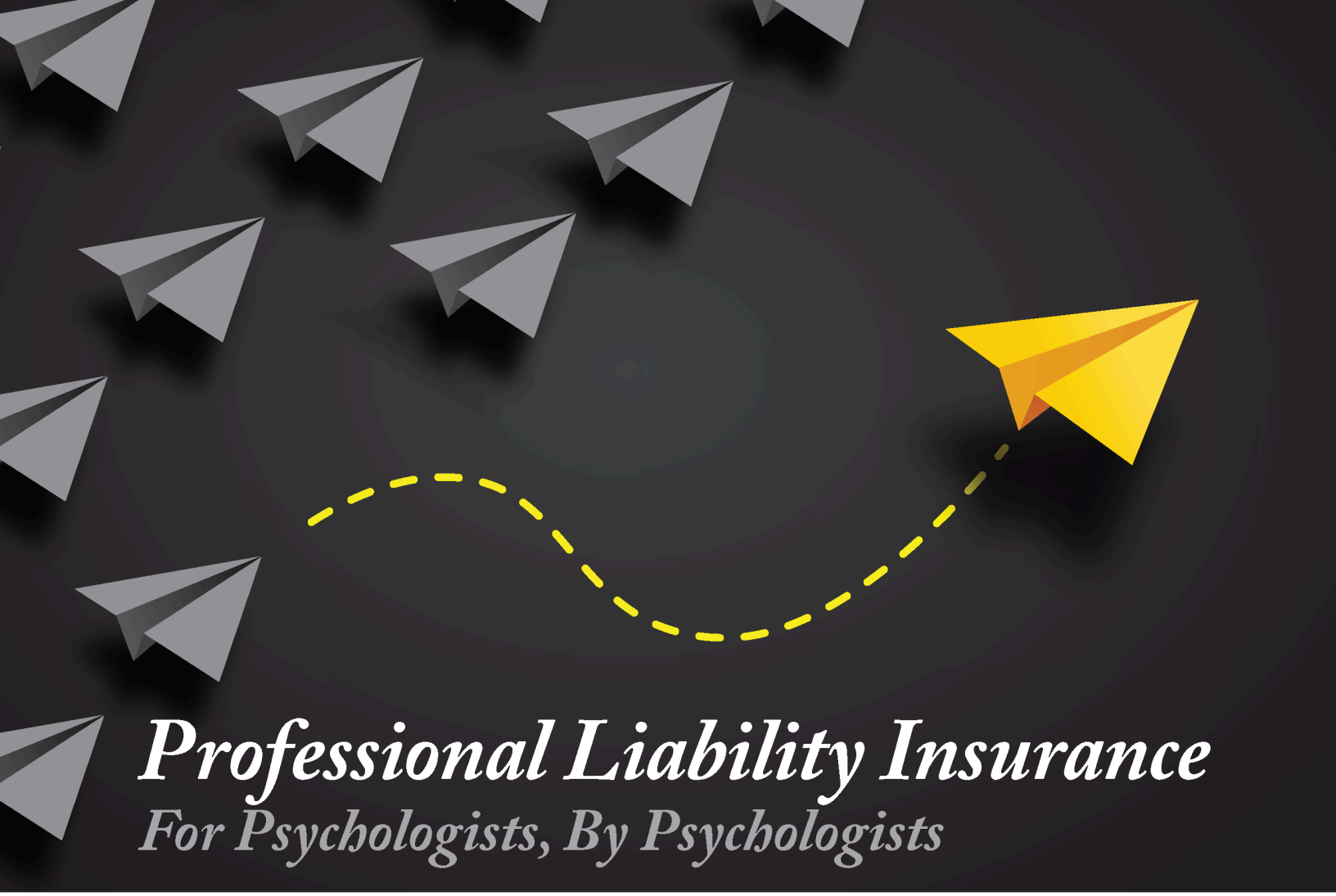
Letter from the *Editor*

Robyn P. Waxman, Ph.D.

Every once in a while, you learn something that causes you to take a step back and say, "Wow, how could I not have known that?" That's how I felt when I first heard about Inference-Based CBT for OCD. Having been in practice for almost thirty years, I often learn interesting techniques that I'm not familiar with but rarely do I hear about an approach that turns everything I thought I knew on its head. Yet that's how I felt. One of my colleagues told me about a workshop Michael Heady, MA, LCPC had given. She insisted that in his presentation Mr. Heady had shared that the obsessions people who have OCD have are meaningful. That flew in the face of everything I had been taught (and had been telling clients). I was immediately intrigued. He explained that these folks were the victims of a faulty reasoning process. In fact, their assumptions made perfect sense in a different context. I bought a book on I-CBT. I went through the I-CBT webpage. I watched all the training modules. And then I went right to the source. I called Mr. Heady to ask if he'd be willing to guest edit this issue of the TMP. I asked a few preliminary questions and everything he said resonated with my experiences. When working with clients who had OCD, there are plenty who responded well to traditional exposure response prevention (ERP) but there were many who didn't respond for whatever reason. Many couldn't tolerate being repeatedly exposed to the very things that triggered them without being able to engage in their compulsions. Many of them dropped out in frustration. And for me personally, those clients who were dealing primarily with obsessions (rather than compulsions) tended to be more difficult. How do you teach someone to resist their thoughts? As Mr. Heady described this alternative approach to treating OCD, I heard of a novel approach that looked at the cognitive processes clients engaged in. Intuitively, that sounded promising.

And I loved that Mr. Heady did not insist that we give up ERP. This was an approach that we could offer to supplement our current strategies. Alternatively, this was another way to work with clients, especially those who found that ERP failed to resolve their OCD. One of the most intriguing aspects was that many of the clinicians who embraced I-CBT had lived experience with OCD. They had been treated with ERP and reported improvement; however, it remained effortful to resist the compulsions. As you'll read, they finally found relief with I-CBT. I'm very grateful that several of these clinicians were willing to contribute to this issue of the TMP. Hearing personal stories from these clinicians brings it to life. Another surprise was that the I-CBT website (ICBT.online) offers all of the training modules that comprise I-CBT for free. That's pretty rare these days! I hope that you find this issue as exciting as I do and that you take the time to explore all of the resources they offer.



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A Note from the Guest Editor

Mike Heady, MA, LCPC

Mike Heady, LCPC is the co-owner and co-director of the Anxiety and Stress Disorders Institute of MD. He is a faculty member with the International OCD Foundation's Training Institute, co-chair of the IOCDF Inference-based CBT SIG, Clinical Fellow with the Anxiety and Depression Association of America, and is on the Advisory Board for OCD Training School. For over 15 years, he has utilized evidence-based treatments for anxiety disorders, OCD, and related conditions. As a regular presenter at regional and national conferences, Mike is committed to increasing understanding and access to evidence-based treatment options for both clinicians and consumers.

OCD affects approximately 1 in 40 adults and 1 in 100 children (IOCDF.org). Prior to the 1960s, it was widely considered untreatable until the development of exposure and response prevention (ERP). Victor Meyer, a psychologist at Middlesex Hospital in London, was the first to administer this experimental treatment to two patients with severe OCD in 1966. The success of ERP was exciting, and it indicated a significant addition in our understanding of OCD while increasing access to care for those suffering. In the 1980s, cognitive approaches to OCD emerged and focused on previously unexamined aspects of OCD; the cognitive processes that contribute to obsessions as well as cognitive interventions. This work added much needed specificity to our understanding of obsessions, allowing for more comprehensive targets for treatment (Rachman, 2009). The addition of cognitive explanations of obsessions marked another significant addition to our understanding of OCD and its treatment. Presently, most empirical investigations and clinical application of OCD treatment use a combination of cognitive and behavioral interventions. While CBT/ERP is widely considered the first-line treatment for OCD, not all sufferers get better. A comprehensive meta-analysis of 37 RCTs found that 60% of those who received ERP experienced some symptom reduction and 50% experienced clinically significant reductions (Öst et al., 2015). This finding was replicated in a mega-analysis of 8 treatment sites (Steketee et al., 2018). Aside from treatment efficacy, there are additional obstacles. ERP operates through repeated contact with distressing experiences while removing distress neutralizing responses and this process can be difficult to adhere to. A recent systematic review and meta-analysis on patient adherence reported that the dropout and refusal rates for ERP were both ~16% (Leeuwerik et al., 2019). Obstacles remain from the clinician side of treatment as well. In a survey of 230 clinicians, approximately 30% reported that they did not provide ERP for anxiety or OCD (Reid et al., 2017).

The combination of treatment dropout, treatment refusal, therapists not utilizing ERP, and the ~40% of sufferers who do not experience significant symptom reduction, underscores the need for diverse evidence-based treatment options. This series of articles will introduce a novel treatment for OCD. Developed by the late Dr. Kieron O'Connor and Dr. Frederick Aardema, Inference-Based CBT (I-CBT) is another significant addition in the understanding of OCD phenomenology and treatment. With a robust and growing body of evidence, I-CBT offers a vantage point on OCD that does not require ERP, nor does it aim to dispute the content of obsessions. It does not aim for acceptance or tolerance of intrusive thoughts or uncertainty related to OCD. Instead, it works to restore trust in oneself and their senses that were obscured by a unique form of faulty doubting (Aardema, 2024). The following articles will elaborate on the nature of this faulty doubting and the treatment model built to resolve it. You will learn about the treatment process and efficacy and be guided through how this treatment transformed the understanding of OCD specialists with lived experience. This series of articles are meant to intrigue and inspire further exploration, and it is my privilege to be the Guest Editor of this edition of The Maryland Psychologist.

Special thanks to the contributing authors Dr. Henny Visser, Bronwyn Shroyer, and Katie Marrotte, and editors, Dr. Kelvin (Shiu Fung) Wong, Dr. Stacy Shaup, and Jenn Caffey.

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INTRUSIONS or CONCLUSIONS

The Role of Reasoning in OCD Development and Recovery

BY MIKE HEADY, MA, LCPC

Imagine a person who has lived many years believing themselves prone to being a negligent person. The kind of person whose carelessness may bring harm to others. This self-narrative, while just under the surface of daily awareness, creates a vigilance for moments where they believe themselves to be most at risk. This person begins their day driving to work. They turn onto a winding backroad. As they navigate a sharp turn, they are suddenly jarred by an unexpected bump. Within seconds, they are flooded with the notion that the bump could have been a person. Panic and guilt wash over them as their mind justifies this with arguments like it's possible and hit and runs happen all the time and my eyes aren't always perfectly fixed on what's in front of me when I am checking my mirrors. As the possibility of the bump being a person begins to feel more credible, they frantically check their mirrors and their memory for any hint that someone was hit. When those actions fail, they stop and turn the car around to look for a person. They find nothing. Relief begins to set in, and they head back to work. Later that evening, at home, the wonder returns, and they check the news for any reported hit and runs or a missing person. Nothing. Unfortunately, this is not a new experience for this person and tomorrow will bring similar torments. This person is not negligent or careless and the bump was only a pothole. A pothole that was run over by dozens of other drivers that very morning, none of whom had any wonders outside the potential of a flat tire or a bent rim. So, what was different for this person? This article will discuss how a unique reasoning process not only constructs obsessions but when unraveled, will promote recovery from OCD.

Origins

The development of I-CBT is distinct from the current first-line treatments for OCD. I-CBT's origins are rooted in clinical observations and empirical investigations into the phenomenology of obsessions whereas current first-line approaches are adaptations of existing phobia and depression treatment models or general transdiagnostic treatments carried over to OCD (Rachman, 2009; O'Connor & Audet, 2019). Diverging from the predominant explanation that OCD operates within a phobic model where the problem is located in how one responds to intrusive thoughts, Dr. O'Connor, together with Sophie Robillard, observed individuals with OCD and noted that they were not focused on what was there in reality but what could be or might be there (O'Connor & Robillard, 1995). This meant that while obsessions are often experienced as intrusive, the form and context of how they operate could be explained as fictional narratives, constructed from faulty reasoning leading one to faulty conclusions (Aardema, 2024). This observation prompted exploration into specific reasoning errors that constructed these fictional narratives. At first the focus was primarily on the error of inverse inference where a person concludes something about reality (this object is contaminated) through possibilities and imagination (many people could have touched the object) rather than observations through the senses (O'Connor & Aardema, 2012). In collaboration with Dr. Aardema, the reasoning errors would later be expanded on and operationalized as Inferential Confusion (IC) (ICBT.online). Since then, numerous peer-reviewed studies across laboratories and from varied methodologies have explored IC in cross-sectional, longitudinal, psychometric, and experimental designs thus securing the unique and robust impact of this cognitive process in OCD, its ability to explain OC symptom development and maintenance, and its role as a cognitive mechanism of change within treatment.

Inferential Confusion (aka Obsessional Reasoning)

At present, research has supported three conceptually distinct cognitive processes that promote IC while also establishing a clear and meaningful distinction between normal everyday doubting and obsessional doubting. The three processes are, an overreliance on possibility or the imagination, distrust of the senses and self, and the use of irrelevant associations during reasoning (Baraby et al., 2023). Fundamentally, IC is the error in making what is irrelevant in the present moment be experienced as relevant and credible.

Each of these processes help to perpetuate one another, causing the person caught up in them to be absorbed into their imagination and detached from the normal and effortless trust in the self and senses which they possess in most other areas of their lives. The experience is not unlike being absorbed into a compelling and scary movie where, for a few moments,

you are immersed into a convincing but false reality. However, like all illusions, the details of its construction help to render it just another trick to be dismissed and, just like when the movie ends, one simply returns to genuine reality without effort.

This faulty yet captivating obsessional doubting narrative is distinct from normal doubting. To illustrate this, consider the following example. Imagine a physician discovering a concerning lump in a person's body. The physician orders a biopsy. While they await the results of this test, what might the patient be wondering? One possible conclusion based on the available information is that the lump might be cancerous. The patient might be worrying about what the results will state and what it will mean if they do have cancer. This would be based on a common and rather normal doubting process based on the reality of the unknowns in the present situation. Now, imagine that the biopsy results are back and the patient reads the report. It states their name, DOB, and all other relevant information about them. The results indicate that the lump is benign. However, instead of feeling relief imagine that they instead begin to wonder and doubt, what if the lab made a mistake and switched my results? What if they made an error interpreting the sample? After all, it's possible, and humans make human errors. In fact, I watched an exposé where it revealed some surgeons had accidentally operated on the wrong limbs of their patients. Therefore, this lump might be cancerous. This conclusion is meaningfully distinct from the patient's first conclusion of possibly having cancer because of how it was reasoned. While perhaps initially captivating, it is clear there is no relevant information that casts doubt on the results, yet the doubt was experienced and reacted to as relevant by the patient through the IC process.

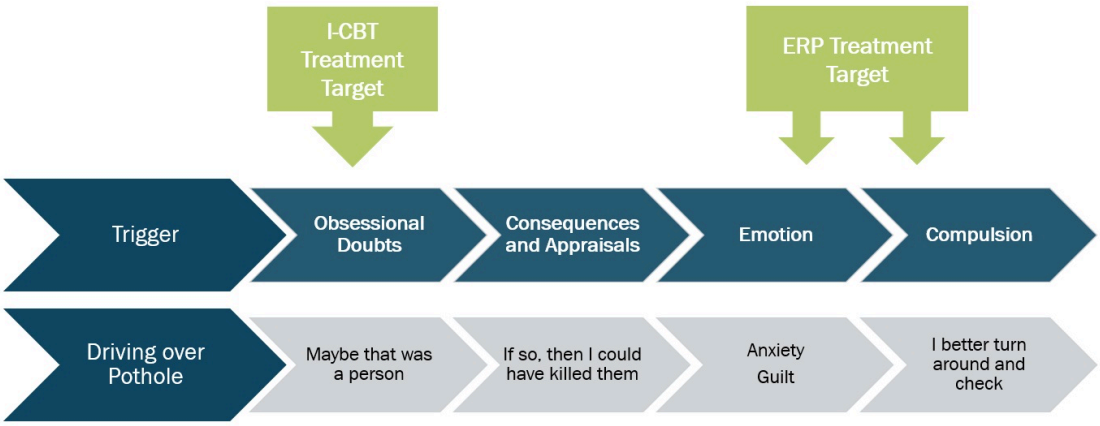
Why this Obsession?

It is widely accepted that obsessions are at odds with the sufferer's values and desires and seem to generate around areas the sufferer cares about. This dissonance or ego-dystonicity and the selectivity of obsessions can be explained by I-CBT. From this model, the IC process is not simply applied to external experiences haphazardly, rather IC is applied to the sense of self or identity prior to any present moment experiences. When this faulty reasoning is applied to the self, a faulty narrative about who one is or could become is formed, leading to a faulty conclusion about the self and not just the present moment experience. This process is referred to as the Feared Possible Self (FPS) and it explains the selectivity of obsessional themes. It creates a heightened alertness for these perceived vulnerabilities in the present moment and when one such circumstance arises, the individual carries forward the IC process that was already operating on the self, to the present experience.

FPS acts as the primary process that gives power and preference to selective present moment circumstances. In tandem, IC and FPS convince the individual to feel vulnerable to being or becoming someone they are not through faulty reasoning. This sets the stage for them to interact with specific present moment experiences obsessionally (Aardema, et al, 2024). As noted earlier, it is these cognitive processes that I-CBT was tailor-made to address. To quote Dr. Aardema, "If the doubts (IC and FPS) were resolved, what would be left of the OCD?"

Putting it Together

To provide clarity on these interrelated cognitive processes, let's explore how Inferential Confusion (IC) and Feared Possible Self (FPS) created the obsessional doubt in the case mentioned at the beginning of the article. To begin, let's consider the following schematic illustrating how I-CBT sequences OCD.



Frederick Aardema (2024). Retrieved from icbt.online. Used with Permission

The above diagram highlights the crossover point from reality (driving over the pothole) to obsessional doubting (maybe that was a person). The obsessional reasoning that occurs between these points is critical to why this person became convinced, scared, and ultimately performed compulsions. The person described a few reasons why this obsessional doubt was experienced as credible when they stated, it's possible (overreliance on possibility), hit and runs happen all the time (irrelevant information and association), and my eyes aren't always perfectly fixed on what's in front of me when I am checking my mirrors (irrelevant information and association). In addition to the stated reasons for experiencing the obsessional doubt as credible, prior to the pothole, this person was convinced that they are generally prone to being negligent or careless in a way that could harm others (their FPS). When we explore what kind of person might have hit someone when driving and would not have tried to figure out what happened the FPS can be revealed. In this case, the FPS was stated at the beginning of the example; they fear that they are a negligent person. All of these cognitive processes operate as a seamless and convincing narrative rather than separate and detached thoughts and this narrative process contributes to obscuring someone's insight into the irrelevancy of obsessional reasoning and absorbing them further into their imagination. It is easy to understand how the obsessional doubt could be confused for being reasonable and credible by this person when we consider these processes together. This person is convinced that they are negligent in a way that could harm others (despite this being false). They run over an unexpected bump while relying on reasoning that is rooted only in possibilities and out-of-context information, all of which is operating as an ongoing immersive narrative.

The Research Data

The treatment model of I-CBT was built upon rigorously researched cognitive principles.

I will summarize the cross sectional, psychometric, experimental, and longitudinal data and the next article will discuss the clinical trials data. Presently, the body of evidence for I-CBT only applies to adults. A relatively large number of studies have shown IC to be a consistent, unique, and significant predictor of OC symptoms across all dimensions, independent of the six belief domains (importance/control of thoughts, perfectionism/intolerance for uncertainty, and overestimation of threat/inflated sense of responsibility) put forward by the Obsessive-Compulsive Cognitions Working Group (Aminaee et al., 2024; Baraby et al., 2023; OCCWG, 2005; Emmelkamp & Aardema, 1999; Wu et al., 2009). IC has been shown to account for the relationship between the belief domains and OC symptoms (Aardema et al., 2006), and preliminary evidence has linked IC in a causal relationship to the development of OCD (Wong & Grisham, 2017). A few studies have also supported changes in level of IC as a predictor of treatment outcome (Aardema et al., 2005, 2010, 2017; Baraby et al., 2023; Ouellet-Courtois, in preparation).

FPS as a concept has also been evaluated in peer-reviewed studies across laboratories and designs (cross-sectional, psychometric, and experimental) as relevant to OC symptom development and treatment outcome (Aardema et al., 2013, 2021; Baraby et al., 2021, 2023; Nikodijevic et al., 2015; Sauvageau et al., 2020; Yang et al., 2021). I-CBT considers the interaction between IC and FPS as central to the development of OCD. It also acknowledges that obsessive beliefs play a role in the prediction of OC symptom severity. Presently, the data suggests that IC and FPS are central to OCD and that they may precede obsessive beliefs in the developmental sequence (Baraby et al., 2021; Aminaee et al., 2024). A complete list of publications cab be found at https://icbt.online/publications/

What this Means

I-CBT is a flexible 12-module process typically delivered between 16 and 24 sessions. Each module is designed to address IC and FPS with the outcome being a reorientation of normal effortless trust in the self and senses that existed prior to obsessional reasoning. Understanding obsessions as faulty conclusions arrived at from earlier faulty reasoning has significant implications for our understanding of the phenomenology of OCD and for those suffering from it. The establishment of cognitive processes that can be resolved generates new treatment targets and the opportunity to offer those suffering something different. I-CBT is specifically developed to resolve IC and FPS, and it does this without requiring prolonged in vivo or imaginal exposures, thus expanding access to care to those who do not respond to exposure-based treatments, experience them as too challenging or refuse them altogether. This alternative evidence-based approach may also attract more clinicians who were otherwise ambivalent about exposure-based methods to treat those with OCD. More detailed information regarding treatment theory and process can be found in The Clinician's OCD Manual: Inference Based Therapy (O'Connor & Aardema, 2012), Resolving OCD: Understanding Your Obsessional Experience (Aardema, 2024), or you can visit ICBT.online.

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HOW I-CBT OUTCOMES COMPARE TO CBT FOR OCD

BY HENNY VISSER, PH.D.

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Henny combines clinical work, research and educational activities. In 2016 she obtained her PhD in psychiatry with a thesis on 'Obsessive-Compulsive Disorder: Unresolved issues, poor insight and psychological treatment'. In the past years she has kept a special interest in the diagnostics and innovative psychotherapy for Obsessive Compulsive Disorder (OCD). Her recent research focuses on the effectiveness and neurobiological mechanisms of Inference-Based Cognitive Behavioral Therapy (I-CBT) for OCD. She wrote a book on the treatment of OCD in collaboration with someone with lived in experience with OCD.

In addition to her research, Henny is psychotherapist at the department for patients with anxiety- and obsessive compulsive disorders of the Amsterdam Medical Center.

How I-CBT Outcomes Compare to CBT for OCD

Obsessive-Compulsive Disorder (OCD) is a debilitating condition, often treated effectively with Cognitive Behavioral Therapy (CBT). However, a significant subset of patients does not respond sufficiently to CBT or struggles with its more challenging aspects. I-CBT emerges as an innovative approach addressing the reasoning processes underpinning obsessive doubt. This article reviews evidence comparing I-CBT and CBT, discussing I-CBT's effectiveness and tolerability.

Introduction

OCD affects millions worldwide, characterized by intrusive thoughts (obsessions) and repetitive behaviors (compulsions). CBT, particularly with ERP, is the gold-standard treatment, demonstrating high effectiveness in reducing symptoms and improving quality of life. Nevertheless, approximately 25-40% of patients experience insufficient symptom relief. Furthermore, many people find the ERP component of CBT to be frightening and burdensome.

I-CBT might offer a complementary alternative, focusing on the reasoning processes that sustain obsessive doubt. Rather than exposure-based interventions, in I-CBT patients observe their reasoning and discover that they are stuck because they are constantly trying to solve an imagined problem in reality. They find out that at the moment they feel the urge to perform a compulsive action, they doubt that everything is fine, even though there is no relevant context to start doubting and even though it is clearly observable that everything is indeed okay. They start to recognize their over-reliance on the imagination and their active dismissing of sensory and inner information in obsessive situations. In I-CBT, individuals learn to actively redirect their attention to the observable reality of the present moment, just as they do in situations where they have no obsessions. Only when people recognize that, fundamentally, everything is fine and there is nothing to fear at that moment, they do refrain from performing their compulsive actions.

This approach differs fundamentally from standard CBT. It targets a different aspect of OCD, namely the reasoning process that gives rise to obsessive doubt. While standard CBT focuses on teaching people to resist their compulsions despite obsessive doubt, to tolerate uncertainty, and to no longer overestimate danger and responsibility associated with the doubted situation. This article explores the evidence for I-CBT and its role in expanding OCD treatment options.

Evidence of Effectiveness

Four randomized controlled trials (RCT's) evaluated I-CBT's efficacy compared to CBT. All conducted in representative samples of patients with OCD formally diagnosed using validated structured interviews consistent with DSM criteria. These samples consisted of patients referred to specialist OCD centers, exhibiting moderate-to-severe symptoms as measured by the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), the gold standard for assessing OCD severity. Primary outcome of these RCTs was OCD symptom severity as measured with the YBOCS, however other aspects e.g. quality of live were also measured.

The first RCT was performed in 2005 in Montreal, Canada (O'Connor et al., 2005). Forty-five patients with OCD were randomized to 24 sessions of I-CBT, cognitive therapy, or ERP. All groups demonstrated significant reductions in OCD symptom severity, with large effect sizes observed across conditions. No significant differences were found between the treatment modalities. Follow-up at 6 months revealed sustained improvements in all groups.

The next study involved 90 Dutch participants with poor insight OCD, comparing 24 sessions of I-CBT and CBT (Visser et al., 2015). Both treatments yielded significant symptom reductions, with large effect sizes in overall OCD symptom severity, as well as marked improvements in secondary outcomes such as quality of life, anxiety, mood, and insight in OCD. No significant differences were observed between the conditions. Follow-up at 3 months indicated maintenance of gains in both groups.

Similar results were found by Aardema and colleagues (Aardema et al., 2022). In this RCT, which was conducted in Canada, I-CBT was compared to mindfulness-based therapy and CBT in 111 participants with moderate-to-severe OCD over 20 sessions. All treatments demonstrated large within-group effect sizes on primary outcomes, including OCD symptom severity and quality of life measures, with no significant differences observed between the two methods. Improvements were sustained at a 6-month follow-up.

Most recently a study in the Netherlands was completed. This multicenter non-inferiority trial randomized 197 participants to either I-CBT or CBT, each receiving 20 sessions (Wolf et al., 2024). Both treatments showed large significant reductions in OCD symptoms, large improvement and quality of life, functioning and insight in OCD and reductions in anxiety and depressive symptoms. These improvements maintained at 6- and 12-months follow-up. Non-inferiority trials test whether a new treatment is not unacceptably worse than an established treatment within predefined margins. In this study, non-inferiority of I-CBT to CBT could neither be confirmed nor refuted.

An open trial with a sample of 125 participants was conducted in 2017 in Canada. An additional group of 22 participants acted as a natural wait-list control group. Results suggest effectiveness in terms of OCD symptom reduction and improvement of quality of live and I-CBT's broad applicability across OCD subtypes, including treatment-resistant cases (Aardema et al., 2017). Follow-up at 6 months indicated durable effects. No improvements were observed in the control group.

Drop-out and Treatment Tolerability

I-CBT versus CBT drop-out percentages were registered in the latest three of the above-mentioned RCT's and were respectively 12% vs 21%; 18% vs 26%; 22% vs 28%. The proportion of dropouts in these studies did not differ significantly between the conditions.

Among the described RCTs, treatment tolerability was only examined in the most recent RCT performed in the Netherlands (Wolf et al., 2024). In this study the Treatment Acceptability/Adherence Scale (TAAS) was used to assess treatment tolerability (Milosevic et al., 2015). This 10-item questionnaire evaluates the acceptability of, and adherence to, psychological treatment for anxiety and related disorders. Participants rate their agreement with statement (e.g., "I would find this treatment exhausting," "It was distressing to me to participate in this treatment") on a 7-point scale (1 = "strongly disagree" to 7 = "strongly agree"). Assessment after 10 sessions and after 20 sessions revealed significant better tolerability of I-CBT compared to CBT, at both measurement moments with a medium to large effect size. The higher treatment tolerability during and after I-CBT treatment was mainly reflected in the perception that I-CBT was less exhausting, less distressing, and less intrusive than CBT, and that participants in the CBT group more frequently expressed a preference to try another type of psychological treatment instead of CBT.

Discussion

I-CBT targets a different aspect of OCD compared to CBT. It aims to resolve obsessive doubt by helping individuals to stop relying on imagination and instead rely on the observable reality. Research using the most appropriate method for assessing the effectiveness of a treatment—randomized controlled trials—has not demonstrated the superiority of CBT over I-CBT or vice versa. The same holds true for the dropout rates of both methods. However, it cannot yet be stated with certainty that I-CBT is non-inferior to CBT. I-CBT does appear to be better tolerated than CBT, but this finding requires replication.

All of this raises the question of when the relatively young I-CBT, in terms of the number of studies conducted, should be offered to someone with OCD instead of CBT. This question is particularly difficult to answer because there is still no clear understanding of the exact mechanisms of action of both methods. Furthermore, it remains unknown which patient variables determine whether someone benefits more from CBT or I-CBT. There may be a group of patients with persistent symptoms who do not improve with any form of psychotherapy. However, it is not yet established that non-responders to CBT would also fail to respond to I-CBT, and vice versa. It is possible that more people will benefit now that both methods are available.

Conclusion

Inference-Based Cognitive Behavioral Therapy (I-CBT) represents a promising addition to the OCD treatment landscape. Offering comparable efficacy to CBT and enhanced tolerability, I-CBT can broaden access to effective care.

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BREAKING THE CHAINS OF OCD:

Two Journeys to Healing

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BRONWYN'S STORY

When I became a mental health clinician, specializing in OCD was low on my interest list. Like many of us in the mental health field, my undergraduate and graduate education regarding OCD could easily fit on a brief fact sheet. From other clinicians, I learned that OCD was notoriously difficult to treat and often with limited success. Colleagues stated their own dislike of working with those with OCD, finding it onerous work. My take-aways from hearing other clinicians discuss OCD were that they found people with OCD to be difficult, that the condition is a bit hopeless, and that they felt ill-equipped to adequately address it.

But these were not my reasons for staying away from OCD as a specialty. My reasons were much more personal.

At fifteen, an event took place in my life that caused OCD to enter into my world with a bang. My mother was facing a health scare, and there was a chance that she was not going to survive. Gratefully, the doctors' worst-case scenarios were not the reality of the situation, and my mother fully recovered. But the psychological toll was already set in motion for me. My mind responded to the news of my mother's potential early death with a journey into OCD that would stay with me for the next 29 years.

I vividly remember my first compulsion. I would leave a note for my mom each day. It had to be written the same way and placed in the same spot each and every morning. My OCD process had me thinking that if I could just leave a perfectly written note nothing bad would happen to my mother. That compulsion, fully based in magical thinking, was a snapshot into what was about to become a severe case of OCD that would touch every aspect of my life as well as morph and expand over time.

I started with accidental harm themes ("If I do/don't do x, y, or z, then something bad might happen to my loved ones or me"). This moved into scrupulosity and contamination themes. At my worst, I was washing my hands or repeating prayers or checking to make sure doors were locked for hours each day. The skin on the backs of my hands was dry, red, chapped, and cracked from so much time spent in soap and hot water. The palms of my hands were blistered and peeling from the friction of turning a door knob over and over. My mind was exhausted with mental compulsions involving neutralization and repetition. My OCD likes to follow the pattern of having an obsessive thought, needing to perform the compulsion, but then doubting whether the compulsion was done correctly. This pattern was on repeat for hours at a time.

All of the major milestones of my life were impacted by OCD. Relationships, friendships, jobs, school - OCD was always there. It tagged along at graduations and other big moments in a young person's life. It was a constant companion through the everyday tasks of grocery shopping, going to work, or interacting with family. For three decades, it wasn't me living my life. It was me living my life through an OCD lens. It was my unwanted tormentor.

I am blessed with parents who wanted me to get help. My mom identified my OCD almost immediately. I entered therapy and attempted medication management. I never responded to medication, although I have certainly seen other OCD sufferer's benefit. A few years into my OCD journey, I enrolled in a research trial using Exposure and Response Prevention (ERP). My therapist was amazing. Now, as an OCD specialist myself, I can look back and see just how good my therapist was at taking me through the steps of ERP; checking in with me throughout the week on homework; and not forcing me into exposures I wasn't willing to do. ERP helped me get better at ritual prevention, but I never habituated to my triggers, tolerated the distress, or learned to feel safe in those situations. Once treatment was over, all of the OCD came back. In hindsight, I can see that the need to please my therapist and not fail treatment was what made resisting compulsions doable. I didn't want to neglect treatment. I didn't want to be a failure. So, I complied with my treatment goals the best I could in order to be the model patient. ERP can be a life-changing treatment modality. I've seen it work wonders with others, but I didn't have the buy-in necessary to keep myself going. And it's possible even with buy-in, ERP and I would not have been a good fit. This can happen with any modality for any condition.

I gave up on attempting treatment after a period of time, which ultimately meant I was choosing to live my life marred by OCD. I lived this way for decades. There wasn't a day of freedom from OCD during those years. I white-knuckled my way through each 24-hour period, avoiding triggering situations when I could so that I didn't have to engage in compulsions.

With this personal side of OCD ever-present in my life, I stayed away from treating OCD as a professional. I didn't want to hear the stories of how it was affecting others. I didn't want to help carry their burden when my own was already so heavy. I didn't agree with my colleagues that people with OCD were difficult to work with or that treatment was hopeless or that it was difficult work to do. I just wanted to be able to push pause on OCD and focus on a client's non-OCD-related goals for their life. I loved (and still love) treating PTSD, and as I continued in that work as a specialty area, I consistently saw OCD as a co-occurring condition in my clients. My thoughts around professionally avoiding OCD were naive, and due to limited access to OCD specialists, there was only one path forward. I had to change my mindset about treating OCD because there was no way I was going to let my clients suffer the way I had.

I got trained in Exposure and Response Prevention treatment, engaged in consultation, read up on research, studied Acceptance and Commitment Therapy, learned more about medication management, and joined professional groups related to OCD treatment. In one of those professional communities, I was introduced to Inference-based CBT (I-CBT). That moment was a catalyst that changed not only my professional life, but also my personal life.

At that time, I-CBT wasn't well-known as an OCD treatment. There wasn't a list of providers I could click on and find someone knowledgeable in working through an I-CBT lens. There wasn't any training I could attend to learn it. But there was a manual, and I had a small group of colleagues who also had lived experience of OCD learning alongside me. My goal was to understand I-CBT so that my clients would have treatment options. I did not expect that after four months of learning I-CBT that I would be sub-clinical for the first time in 29 years.

All of a sudden, my mind was much quieter. My compulsions weren't necessary. I didn't buy-in to the obsessional thinking. I hadn't habituated or learned to tolerate distress. There wasn't anything to tolerate or habituate to. I no longer believed what OCD was telling me.

So, why did I-CBT work for me when nothing else had? I think there are three main reasons:

1. Inferential Confusion: Through I-CBT, I had the answer for why my mind would get caught up in obsessional doubts. I could see how information that I knew to be true on paper was getting hijacked and used out of context. I got to see the blueprint behind what my mind was doing to cause me to get pulled away from normal reasoning and placed into a reliance on imagined hypotheticals. I learned just how much I was discounting or ignoring my sense data in the moment. I-CBT unveiled OCD's process to me. Once I saw the faulty reasoning process I was using in those OCD moments, I could safely ignore anything that came as a result of my mind shifting into inferential confusion.

2. Feared Possible Self Doubt: I-CBT also gave me an answer as to why my OCD played out the way it did, and why my client's each have a unique presentation and mix of obsessional doubts. There is an underlying doubt about the self that inferential confusion creates. This doubt, called the Feared Possible Self Doubt, is the theme that runs through all of an OCD sufferer's doubts. I was never going to have obsessive thinking in regard to purposefully harming someone or about my identity, but we see those types of doubts occurring often in some people with OCD. Why not me? All of my OCD linked back to an underlying fear that somehow I was going to be negligent in some way which would bring harm to me or my loved ones. All of my contamination, accidental harm, and scrupulosity fears came back to this overarching theme. This discovery gave me insight into why my OCD looks the way it does. It gave me another piece of the puzzle. Once I had that piece, I felt more in control. Insight into an internal process is one of the greatest gifts we can give our clients. It demystifies what is happening within their suffering and gives them tools to stop it.

3. The Senses Are the Gatekeepers of the Relevancy of Possibility: Possibility is around us all of the time, but OCD is able to use that to its advantage. If you can imagine something happening, OCD says that you better act as if it will happen. Realizing that I don't normally live my life based on possibility was life-changing. It allowed me to see that when not triggered by OCD, I use my senses to tell me whether or not a possibility is relevant to my life at that moment. When triggered by inferential confusion, I stop paying attention to what my senses (physical senses, intentions, desires, Real Self, common sense) tell me and give more weight to imagined possibilities. Understanding the mechanism for when a possibility is relevant or not was another piece of the puzzle in understanding my OCD process.

Now in recovery from OCD, I can see just how much time and space inferential confusion took up in my life. We have good treatments for OCD. Medication management, ERP, and ACT can all benefit OCD sufferers. But they don't work for everyone, so it is important that we continue to add treatment options that also have an evidence base such as I-CBT and Metacognitive Therapy (MCT). In my own treatment journey, one of the biggest and most humbling lessons I have learned is that no treatment modality will be the answer for everyone, but everyone deserves to have access to a treatment option that will help them.

In my practice today, I specialize in treating clients suffering from OCD or co-occurring OCD+PTSD. In a twist that I didn't see coming, I have centered OCD treatment as the core of my professional work. It is most definitely my passion to spend my day thinking about OCD and how to help each individual client. While OCD is on my mind many hours a day as I help others heal from OCD or provide consultation/training to other clinicians, it no longer controls my mind. Because of I-CBT, I can now see OCD for what it is. It can no longer pull me in. It is an absolute pleasure to help my kind, wonderful clients engage in treatments that work for them.

There are several positive changes that I-CBT has brought to my practice:

1. I-CBT is well tolerated. This is also supported in recent research (Wolf et al., 2024). I-CBT is completed through teaching core concepts and through a co-exploration of the client's inferential confusion process. While ERP is a solid and beneficial treatment, not all OCD sufferers respond to exposure-based treatment or want to engage in it. Since I-CBT does not include exposure, it fills an important spot in the menu of OCD treatment options.

2. We are treating the formation of obsessions. For clients who want to understand why they do not need to worry about their obsessive thoughts, I-CBT is a game changer. There is no tolerating uncertainty because there is a return to trusting sense data in the moment that can resolve the doubt.

3. We are treating one specific process. By targeting inferential confusion, clients generalize the treatment across all of their obsessional doubts. Once an OCD sufferer understands inferential confusion and how they are getting tricked, the content of the doubt doesn't matter even if it changes over time. The client now understands how that obsessional doubt came to be and can ignore it as meaningless because they know why it is irrelevant based on its construction.

4. I-CBT is fun. Helping a client put pieces of a puzzle together so they can see the whole picture of what is happening in their mind is such an honor. Once the picture is complete, they have agency. They have freedom from inferential confusion.

5. Options. As a clinician, I feel competent when I have evidence-based tools that may benefit my clients. I-CBT is an incredibly powerful part of my practice. I haven't thrown out my other evidence-based tools but adding I-CBT to my practice is one of the best decisions I've made professionally.

As an OCD specialist, I get to see hope, a return of trust in the self, and resolution of obsessive thinking (and therefore compulsions) through my work with I-CBT. After nearly three decades of suffering with OCD myself, it's a true gift to watch my clients end their suffering with OCD much earlier in their own OCD journeys. I'm incredibly grateful that we have this treatment option available to us.

Katie Marrotte, MSW, LSCW

Katie is a licensed clinical social worker who specializes in the treatment of OCD. Katie has a Master's degree in Social Work with a concentration in Health and Mental Health from the University of St. Joseph in West Hartford, Connecticut. Social work focuses not just on pathology but also looks at human development through a lens of policy, social justice, and social welfare to give a more complete look at factors affecting people on a grander scale. This background in social justice contributes to her passion for pursuing a more robust set of skills for treating OCD, as well as advocating for multifaceted treatment approaches and competency for OCD specialists.

Katie also runs a private practice offering Inference-Based CBT and Exposure Response Prevention for OCD. Katie believes that the most effective approach for treating OCD should be evidence based, multifaceted, and most importantly, informed by the needs of the client.

KATIE'S STORY

For me, there was no before and after OCD. There was no new baby to thank, no waning estrogen, no traumatic event that prompted some chemical cascade which ended tragically in a brain forever changed. It was simply there, it was simply me - and without a before and after, there was no insight that something was wrong.

For decades, OCD was my baseline. My first real obsessions surrounded the safety and wellbeing of my mother, whom I was constantly worried would come to some harm unless I did a magical ritual. For years I kept everything she ever gave me, afraid that if I threw it away, some harm would come to her. I remember going to the nurse's office daily, nauseated with fear that something bad would happen to her while I was gone because she wasn't safe within my dome of protection.

As I matured, the subject of my obsessions grew to encompass even more hypothetical ways myself and those I loved could be hurt, maimed, or killed. When I watched movies that had scenes depicting a character's suffering, I would lay awake at night trying not to imagine my loved ones succumbing to the same fate. Naturally, these scenes would play on repeat, starring someone I loved in a nightly Theater of Suffering. Now showing: horrible things happening to your friends and family, and you're powerless to stop it. I'd do what I could to neutralize these thoughts, but they came intruding anyway.

In the background of a dysfunctional family, the OCD was left to flourish in secret. There was not much room for additional pathology in a family that wished to keep alcoholism, recidivism, and domestic violence under wraps. We were, after all, a polished, solidly middle-class white family and there was no room to waiver from the performance that all was well in suburban Connecticut. Adhering to my role as a child who was doing perfectly well, thank you very much, I developed compulsive rituals that were invisible, which only led to delaying diagnosis by another two decades.

In my clinical practice, I rarely see a simple case of OCD. I like to say that it's the carbon molecule of disorders and often comes along with fellow travelers. The same was true for me. By the age of 13, I was experimenting with substances and by 14 I had developed self-injurious behaviors, body dysmorphia, and anorexia. Come my early 20's, I was in the throes of full-blown addiction while two family members fought cancer. OCD roiled in the background, making me doubt my safety, sexuality, and the safety of those around me. I couldn't grieve my grandfather because the disorder was telling me I could have caused his death with my thoughts. Doubts plagued me that maybe I wanted him dead. My life was shrinking rapidly. Safe nowhere, least of all my own mind, I barely left the house.

Worry not, dear reader, things do indeed start improving for our protagonist.

At 23, sobriety came less like a flotilla of angels trumpeting on a soft white cloud and more like Kathy Bates in Misery, hobbling me. I heaved into the porcelain bowl of a local nonprofit detox center, my body enduring withdrawals that medications would not relieve. Suboxone was not yet widely available. The diagnostic intake missed the OCD and only focused on the amount and types of substance used to maintain distance between myself and my life. It was the right course of action to attend to the most life threatening of disorders first, and though the OCD was the source of tremendous suffering, it certainly was not fatal.

With no awareness that the thoughts I was experiencing were abnormal, a second and third diagnostic intake at a residential treatment program and partial hospital program respectively, also missed the OCD. It would be missed again in two years of therapy, where it was labeled trauma, and again with an anxiety specialist who stated with confidence that I watched too many horror movies - this is, to her credit, a certainty - but failed to adequately explain or treat the OCD.

I harbor no resentment towards the professionals who missed a glaring diagnosis. After all, I missed it too. A four-year degree in social work, plus a masters in social work with a concentration in mental health, followed by two years of clinical work in a substance use outpatient, and I still could not identify what was going on in my own mind. Thoughts of harm were constant, and there were many days I could not make it to work because I was plagued with unwanted thoughts of gruesome accidents, being assaulted by clients, as well as scrupulosity both in session and in session notes. At home, I'd lay awake mentally tallying the ways home invaders might be able to get in, imagine graphic harm coming to my dog, and worry that I might actually be homosexual.

At 31, as I lay on the couch ruminating, I come to an epiphany. I must be homosexual. Why else would I be doubting my sexuality for so long? This seems like the only possible answer. I confess to my husband, sobbing, he gently comforted me and promises we will remain friends. Yet shortly after the words leave my mouth, I begin to feel that this is somehow wrong. A quick search leads me to information that would fundamentally alter the course of my life and career. I have obsessive compulsive disorder.

It seemed immediate, I stopped obsessing over my sexuality. Having an explanatory model helped me realize there was nothing to worry about. After many phone calls and unanswered emails, I finally get in touch with a wonderful, compassionate specialist who takes me on as a client. I buy every book I can get my hands on, and after some psychoeducation, we get to work on an exposure hierarchy. For months, we work together. She is my cheerleader, my teacher and my guide. I wrote exposure scripts, stopped avoiding situations that would trigger unwanted thoughts, and practiced not ruminating. “Maybe it will, and maybe it won't” became my life's motto.

I make immense progress and return mostly to life as normal, easing part-time into my own practice offering Exposure and Response Prevention. Yet, the unwanted thoughts of harm follow me wherever I go. In treatment, I identify my values and make space for uncomfortable thoughts. I buy a mindfulness workbook, listen to podcasts, try self-help books, and work meditation into my daily practice. Ever the stubborn patient, I refuse medication but try nootropics, which after some encouraging results, stop working. After months of treatment, I am still troubled by unwanted thoughts and my own compulsive need to figure out what they are and why I am having them. I eventually conclude that this is what my life will be like forever, and since it's a far cry from where I was when I started treatment. I settle.

Around this time, I am embraced by a wonderful community of clinicians with lived experience. During daily conversations, we compare notes and nearly all of us report the same thing: standard course of treatment did not get us to remission. We were still experiencing obsessions. Some of us, myself included, reported feeling like frauds as we were trying to help others heal while still experiencing symptomatic obsessive compulsive disorder ourselves. We had all failed to reach subclinical YBOCS scores through the gold standard of treatment.

Rumblings of a different type of treatment for OCD hit our circle, and all at once, we were our own first patients for Inference Based CBT (I-CBT). We reasoned that if this treatment was worth bringing to clients and eventually a larger audience, we wanted to try it on ourselves first. This was well before I-CBT was more widely accessible. There was something about this treatment that made it feel as though it was written about the way my mind worked. It made perfect sense. In group consultation we discuss I-CBT, I jot down, “it’s like walking into your house, smelling no smoke, seeing no flames, and reasoning, ‘maybe my house is on fire.’” I feel the scales fall from my eyes. I probably turned my camera off to hide my jaw dropping. I realize that this is exactly what I have been doing: reasoning my way into imagined possibilities, catastrophic events that simply did not exist in reality. Not only did they not exist in my current reality, they never existed at all. There was never anything to worry about.

It was never enough to be assured that my obsessions were false, I had to understand why. It was this sticking point that kept me from getting better with Exposure and Response Prevention. The model did not feel like an adequate explanation for my disorder, I felt that there had to be more. The idea that intrusive thoughts were random simply felt untrue. They never felt random to me. Further, my mind outright rejected the idea that everyone experienced intrusive thoughts and that OCD was a result of appraising these thoughts as dangerous or unwanted. I remember asking friends and my husband if they experienced thoughts like mine and their response was unilateral befuddlement, with a tinge of pity and undercurrents of abject horror. “God no,” one of my friends responded, “is that what it’s like for you?” I could accept that some intrusions were a universal experience, like imagining oneself driving off a bridge or other ‘call of the void’ thoughts. However, I doubted, very reasonably, that many people imagined their dog ingesting sewing needles, or entertained the possibility of causing the Universe itself to collapse with their thoughts. And while I found the maxim of “maybe it will, maybe it won’t” a useful mnemonic to remind myself to stop trying to figure out the validity of an obsession and move on, I grappled with the idea that not only could I really not know if an obsession was true, but that people without OCD tolerated the possibility that they were negligent, clueless, immoral, harmful people. Were we really all just Schrodinger’s monsters? It simply didn’t make sense to me.

There were several points of I-CBT that I needed to understand in order to get better. The model confirmed several suspicions that I had about OCD through observing my own experience. First, an obsession - or an obsessional doubt - is the result of a reasoning process called inferential confusion. This is where I-CBT differs from other models of the disorder. Through the I-CBT lens, all obsessional doubts are inferences, or conclusions based on logic and reasoning. What this means is that since all obsessional doubts are the result of a reasoning process, there is logic behind every single obsession, regardless of how far-fetched or bizarre. There is no such thing as a random obsession. This felt intuitively true to me, as someone who lived with the disorder for 25 years. I knew that none of my obsessions were random and was happy to justify every one of them with a mountain of data; abstract facts, rules, hearsay, personal experience and possibility.

Second, I was confusing imagined thoughts with real thoughts through a fusion process called thought-thought fusion, or as I like to teach it, doubt-thought confusion. With obsessional doubts that are taboo in nature, harm thoughts for instance, one might imagine that they could have a thought, and confuse this with a real thought, a thought that has intention and desire. Certainly there is a difference between an imagined thought, or obsessional doubt, "I might think of harming my dog," versus a real thought, "I can't wait for dinner later." The former never happened. I did not sit and merrily fantasize of harming my dog, I imagined that I might think of harming my dog and made frantic attempts to neutralize said imagined thought. What this meant for me is that I did not have to be the hapless victim of, or watchful guard against intrusive thoughts if they were not real to begin with. I did not have to be afraid of them, or the situations that triggered them, meaning I could happily watch my shih tzu romp across a field without imagining him dropping dead of a heart attack in front of me, when previously I would compulsively avoid looking at him.

Lastly, because all obsessional doubts lack direct evidence, they exist entirely within the imagination. Words like, "might", "could have" and "maybe," smack of imagined possibilities rather than concrete realities. Why tolerate uncertainty about an imagined possibility when I could instead stay with my known reality and common sense, like I do in the situations of my life that the OCD didn't touch? If obsessional doubts are imaginary, it doesn't matter if they are possible in the abstract.

Knowing OCD's inner workings completely demystified the experience for me. ERP had me walking through a haunted house and pointing my flashlight at props until I felt less frightened, while committing to not check, research, or assure myself that the props were indeed fake. I-CBT gave me the opportunity to turn on the overhead lights. With everything illuminated, I could see the props, my obsessional doubts, were simply convincing fakes. No matter how convincing, plausible, or gruesome, they were still not real. I never imagined I could have such relief or such certainty.

I was only able to make limited progress with the gold standard (ERP), and felt as though I had failed because I didn't do my exposures well enough, or practice response prevention with enough rigidity, though I truly felt that I lived the ERP lifestyle. After all, I really liked ERP. I found it empowering and rebellious to put myself in situations that aggravated my disorder, and learned I could see myself through to the end. Yet, I was only a partial responder. I kept getting stuck on 'why,' and as someone who is terminally curious, I needed to understand the 'why' of my disorder. I needed it to be stripped to parts and laid before me so I could see exactly how it worked. I believe that had I had access to I-CBT as a first line treatment, ERP would have been unnecessary for me.

We as clinicians are instruments of healing, and as such we should endeavor to not be too attached to whether the healing occurs through one evidence-based method or another. We must consider that we will have clients for whom one or two treatments fail. We must also consider that others won't engage in certain treatments at all. For these clients, it is important to consider having multiple options for OCD in our treatment repertoire.

MPA'S LEADERSHIP DEVELOPMENT ACADEMY (LDA)

MPA's Leadership Development Academy (LDA) graduated its second group of psychologist scholars in June 2024, with a cohort of 10 leadership fellows from across the state of Maryland. Beginning in September 2023, scholars attended MPA's board retreat. Subsequently, each month they attended various workshops led by experts in their fields, and met with individual mentors. Participants were also coached in career advancement, and gained skills in team building, coaching and supervision, workplace communication, and media presentations. Furthermore, these scholars not only navigated a rigorous and carefully designed program, but also delivered on three ambitious action projects, summarized below:

1. Managing and Responding to Burnout Among Psychologists: Scholars consolidated research on burnout and offered resources and recommendations for clinical psychologists to use to prevent and/or manage burnout more effectively.
2. Advocacy Through MPA's Legislative Committee: In collaboration with MPA's Legislative Committee, scholars developed an online survey for MPA members to complete. This survey was designed to assess members' opinions regarding issues MPA could address through formal advocacy efforts. Results of this survey culminated in identifying potential advocacy initiatives, including issues regarding insurance companies and fair pay, accessibility, and expansion of psychologist's prescriptive authority.
3. Developing a Repository for Clinical Supervision: A third group of scholars addressed a growing need for accessible and high-quality clinical supervision resources by creating an online repository for licensed providers who provide supervision across the state.

These projects not only showcased the fellows' leadership and teamwork, but also left a lasting impact on the MPA community. By addressing real-world challenges and delivering actionable solutions, this cohort exemplified tangible benefits of formal leadership training.

Gearing up for its third year, MPA's Leadership Development Academy will commence in September 2025. MPA is seeking the next generation of psychologist leaders who are interested in nurturing their talents and leadership potential. The academy is designed to broaden and deepen leadership skills to enable psychologists to grow as leaders in their respective field, communities, and at MPA.

The LDA is open to psychologists with 10 or fewer years of leadership experience. It is an opportunity for participants to identify and strengthen leadership styles, values, and to learn alternate approaches to reach personal leadership potential.

The LDA will run for 10 months from September 2025 to June 2026. The program begins with a leadership assessment with individual administration and feedback to allow fellows to identify strengths and challenges. Fellows will then meet monthly with personally matched mentors to accompany them on their leadership journey. Scholars will also attend Annapolis Day in January (2026). Public advocacy is a strong component of the academy. MPA's lobbyists and members of MPA's Legislative Committee will offer instruction on statewide legislative advocacy. Fellows will accompany seasoned MPA members to Annapolis during the 2026 legislative session to meet with state representatives to discuss MPA's policy initiatives.

In efforts to include fellows from Maryland counties near and far, didactic workshops will be held virtually. Topics will include: Leading with a Diversity Lens and Understanding Implicit Bias, Effective Team Building, Managing Conflict and Building Trust, Media Training, Supervising and Coaching, and Leading in Diverse Workplaces where Psychologists Practice.

There is no charge to participate in the program. Continuing education credits will be awarded where appropriate. Applications will be released this spring with a submission deadline of May 30, 2025. Anyone interested in learning about the LDA can get more information by contacting Esther Finglass at efinglass@gmail.com or visiting our website at www.marylandpsychology.org/leadership-development-academy.

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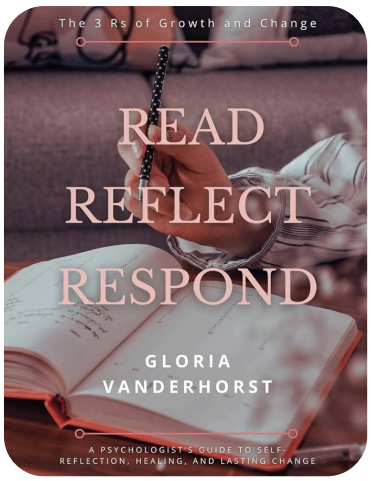

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