“Inference-Based CBT: A New Hope for OCD”

by Rachel Strohl, Psy.D.

On Sunday February 25, 2024, Michael Heady, LCPC presented at the 24th annual conference of OCD New Jersey (OCD NJ). Mr. Heady is a full-time clinician and the Co-Owner/Director of the Anxiety and Stress Disorders Institute of Maryland (ASDI) where he has specialized in the treatment of OCD, anxiety disorders, and related conditions for the last 16 years. He is a faculty member of the International OCD Foundation (IOCDFs) Training Institute, a Clinical Fellow with the Anxiety and Depression Association of America (ADAA) and is on the Advisory Board for OCD Training School. He provides clinical consultation to therapists and has produced numerous professional webinars for organizations as well as group practices and clinics across the U.S. He has appeared on several podcasts discussing I-CBT, ERP, shame, intimacy, perfectionism and other OCD and anxiety related issues.

For over 50 years, behavioral models of treatment such as exposure and response prevention (ERP) have been the primary evidence-based treatments for obsessive-compulsive disorder. Meta-analyses consistently demonstrate these treatments to help approximately 50% of sufferers achieve clinically significant reductions in symptoms and only slightly more experience some reductions in symptoms (Ost et al., 2015 & Reid et al., 2021). Sufferers need more evidence-based treatment options. Inference-Based CBT (I-CBT) offers an evidence-based alternative to behavioral approaches that does not entail deliberate or distressing exposures (Aardema et al., 2022, Visser et al., 2015, and O’Connor et al., 2005).

Mr. Heady began the interactive multimedia presentation by explaining the difference between intrusions and inferences. Intrusions are normal, random, and not specific to OCD, and treatment focuses on acceptance or tolerance of intrusions. Inferences are active reasoning processes that lead to conclusions, e.g., I’m contaminated, and faulty inferences are not “normal” and treatable. I-CBT treats the faulty inference process without ERP or behavioral experiments.

In I-CBT, inferential confusion is what is being treated since it is the mechanism of change. Inferential confusion “lurks within stories” that feels real and can be compared to a magician creating an illusion with a slight of hand misdirection. Treatment includes a sequencing as follows: trigger – obsessional doubt – consequences and appraisals – emotions – compulsions. For example, driving over a pothole (then inferential confusion) – maybe that was a person – if so, then I could have killed them – anxiety and guilt – I better turn around and check.

One of the goals of I-CBT is to “slow you down” while OCD is trying to speed up. Mr. Heady differentiated between obsessional doubt vs. normal doubt. Normal doubt (what is) = relevant and objective sensory information or common sense in the hear and now. It doesn’t require justification and can be resolved with information. Obsessional doubt

(what if) = arises from within (feared possible self-narrative) and lacks objective sensory information. It is also "desperate for justifications," i.e., imagined or hypothetical stories.

Inferential confusion is a flawed reasoning process unique to OCD and leads one to conclude something about the "here and now" and "themselves" that is false but feels real. It is applied selectively to situations. Factors that create inferential confusion include 1) over-reliance on possibilities: what could be, what if's, could be's, and maybe's that are lacking any direct sense data. 2) Distrust of senses and self: the 5 senses, common sense, and inner sense data are dismissed by OCD. 3) Misuse of irrelevant associations: arbitrary information misused to justify conclusions and associations are not supported by relevant here and now sense data.

Reasoning is not arguing with OCD but setting up reality with common sense and the 5 senses. I-CBT identifies inferential confusion by 1) listening to the story 2) applying the sequence 3) finding the doubt 4) being curious how they got to the doubt 5) finding where did the doubt come from, and 6) what would another person need to agree with their doubt. The feared possible self (FPS) forms when there is an inferentially confused narrative about the self, which is the opposite of one's real self. I-CBT works to discover the FPS by asking, "what kind of person would think these were true…" and then not reconcile it (rituals). Mr. Heady outlined the treatment with the following modules: psychoeducation, intervention, and consolidation, as well as presenting empirically supported data to support I-CBT.

The Living with OCD panel was an emotional highlight of the conference, moderated by Dr. Marla Deibler. The panel consisted of individuals ranging in age from childhood, adolescence, and adulthood who have OCD or live with someone who does. Everyone on the panel briefly shared their personal struggles and triumphs with the disorder and its treatment. Instructional commentary was provided by Dr. Deibler who illustrated and expanded on the diagnosis, expression, and treatment of this disorder. Common questions were discussed utilizing these "real world" examples of life with OCD in the service of deepening the understanding of the disorder.

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