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CBT for a fear of morphing: a case illustration

Roz Shafran, Eva Zysk and Tim Williams

Joanne, in her late 30s, had suffered from symptoms of OCD since childhood. She recalled reading a Biology text book at about the age of 7 and having the sensation that she hadn't fully understood the passage. This sensation made her extremely anxious and she re-read the passage until she was sure she had fully understood it. Joanne's parents were not particularly academic but Joanne had excelled at school. She had won prizes for both achievement and effort, and these had been valued by her parents who had praised her for them. She considered that they were extremely proud of her and she felt she had let them down by failing to study at Oxford or Cambridge due to a poor exam grade. She had gone on to teacher training college and become a teacher, but had a strong sense that she had not lived up to her potential. Although she was functioning at work, she was working excessive hours, was exhausted due to lack of sleep and was constantly worried that she would make a mistake.

Joanne had been receiving therapy involving exposure and response prevention for obsessive compulsive disorder in a community setting but had not responded well to the intervention. She was referred to our programme for expert treatment of OCD and specific interest in targeting some of her primary OCD symptoms. In our first meeting with Joanne, she expressed concerns that she might lose her intelligence and become immoral. She feared that if she stood near someone undesirable, then she could become like them through a negative atmosphere. She feared that she would become like them both in terms of key aspects of herself (i.e., her intellect, morality, values and emotional wellbeing) and that she could become physically diminished in terms of both her height and attractiveness. She believed she had to take every possible opportunity to maximise her potential and ensure a

full understanding of whatever situation or conversation in which she participated. Joanne also had fears about a ‘reverse’ process through which she could infect other people with her mood and thoughts, and others could take away her positive traits. She reported a strong belief in her thoughts but had insight that they were irrational and they were not held with delusional intensity.

Joanne also experienced a range of other co-occurring difficulties including perfectionism (particularly focused on work), low mood and generalized anxiety. She was markedly disorganized and had irregular patterns of sleeping and eating which impacted her performance at work.

Joanne’s first experience of treatment was in adolescence and comprised a lengthy period of psychological treatment based on exposure and response prevention (ERP). Given that many patients report having received ERP but in fact have not received the key aspects of ERP or an adequate dose (Stobie, Taylor, Quigley, Ewing, & Salkovskis, 2007) or it has not been delivered optimally (Gillihan, Williams, Yadin & Foa, (2012), we asked Joanne detailed questions about her previous therapy. Her previous ERP had involved exposure hierarchies based solely on reducing repeated checking and washing. From her report, the treatment appeared to have been delivered well and in accordance with the key principles. Additional past therapies received had included face-to-face counselling support based on reducing perfectionism/anxiety about work, telephone support, and fluoxetine for depression and anxiety on two previous occasions. Joanne described all of these interventions as ‘very unhelpful’. She clearly, however, wanted help.

Introduction

Many people consider cognitive behavioural therapy (CBT) to be impersonal, stylised and unable to be tailored to an individual. One of us was horrified to recently hear a clinician say (rather proudly) that he had never had a client he could ‘make fit into those CBT boxes.’ However, a major appeal of CBT is being able to listen to what the client says and work together to see how the clinician’s knowledge base from theory and clinical practice can be married to the client’s personal experience and viewpoint. With obsessive-compulsive disorder, the challenge and rewards are multiple because it is such a heterogeneous disorder. One of its many forms has been the focus of recent growing and clinical interest and is known as ‘mental contamination’ (Rachman, 2006; Rachman, Coughtrey, Shafran & Radomsky, 2015).

Mental contamination is the experience of feeling dirty and polluted in the absence of physical contact with a contaminant. Unlike the traditional concept of contact contamination, where contamination fears are evoked by direct physical contact with an item or place associated with disease, dirt or harm, mental contamination evokes predominately internal feelings of dirtiness and pollution and thus will often appear elusive, obscure and intangible. Mental contamination and contact contamination regularly co-occur, due to a number of overlapping features. In both forms, clients report feelings of discomfort and dread that generate strong urges to wash, clean and avoid re-contamination. However, the key distinguishing feature is that mental contamination arises without physical contact with a contaminant. The primary source of mental contamination is human rather than an object or substance, and clients feel they are uniquely vulnerable to the polluting effects of the contaminant.

There are different forms of mental contamination described in the literature, one of which is known as ‘morphing fear’ (Rachman, 2006; Zysk, Shafran & Williams, in press).

This form of mental contamination has also been referred to as ‘transformation obsessions’ (Volz & Heyman, 2007; Monzani et al., 2015). It involves the worry that the person can be contaminated by or acquire unwanted mental, physical or social characteristics from others. In extreme cases, patients even fear being changed into this “undesirable” person (Rachman, 2006). The impact of exposure and response prevention on mental contamination in general, and morphing fears in particular, has yet to be established. Joanne’s previous treatment using exposure and response prevention had, understandably, focused on reducing the compulsions and avoidance associated with morphing fears. However, they had not directly addressed the fear of morphing and Joanne had not engaged well with ERP which led us to think a more cognitive intervention might be helpful.

Joanne’s primary symptoms of OCD, her co-occurring problems with low mood and perfectionism, and the lack of benefit associated with prior ERP created a clinical challenge, but one that was familiar to us. We were committed to doing evidence-based practice (EBP), but there was no clear evidence to guide our practice. A particular challenge was whether to focus on the low mood, perfectionism or the mental contamination. Joanne was clear that she wished to address the contamination and felt that was the cause of her low mood, anxiety and perfectionism. We conducted our work with Joanne as part of a broader programme of research at our University that was specifically aimed at (i) developing a measure to assess the fear of morphing and (ii) evaluating cognitive behavioural therapy for the fear of morphing. Treatment with Joanne was provided by the first author, an experienced clinical psychologist and cognitive therapist, and a graduate student (second author). Each session was audiotaped. Therapy was conducted around large high table to facilitate shared reviewing of documents without the typical uncomfortable crouching around a low coffee table. In this chapter, we describe our work with Joanne to illustrate the ways in which we implement EBP, specifically using the 5-steps as articulated by Spring and colleagues (chapter 1). More

details about the case and treatment can be found elsewhere (Zysk, Williams & Shafran, submitted)¹.

The five steps of EBP in action with Joanne

Step 1: Asking clinically informative questions

Assessment comprised standard clinical interview questions about the reasons for referral, current difficulties, development of the difficulties, current functioning, past history of treatment, family situations and responses and treatment goals. Given Joanne's low mood, a risk assessment was also conducted in which she expressed occasional suicidal ideation but no plans to harm herself and an optimism that treatment would help her difficulties. In addition, a broad assessment of mental contamination was conducted. The assessment of mental contamination in a clinical interview seeks to elicit information about the extent to which the contamination arises in the absence of contact and is persistent, and seeks to establish the nature by which contamination is acquired and spread (Coughtrey, Shafran & Bennett, in press). Unlike contact contamination, the source of mental contamination is typically human, in that there is some aspect of 'unique vulnerability' in which the patient feels that they will become polluted/infected in the presence of the contaminant but that others would not be affected. For example, standing near a 'stupid' person made Joanne feel that she would be vulnerable to losing her intellect but that if the therapist was standing near the same person, the therapist's intellect would be unaffected. Mental contamination it is also often associated with moral violations which are discussed in the assessment (Rachman, 2006). Given the nature of mental contamination and previous treatment protocols which

¹ The case in that paper is referred to as 'James'. The same case is also described briefly in Zysk, Williams, Shafran & Melli, 2015.

outline key differences between standard CBT and CBT for mental contamination (cf. Coughtrey, Shafran, Lee, & Rachman, 2013), the following areas were assessed:

1. *Understanding the current problem and its impact in detail.* Joanne was asked for a specific and recent example of her morphing fear to elicit thoughts, feelings, and counterproductive behaviours (e.g., questions such as, “What do you do when you are near someone that you consider has the potential to make you a weak or inferior person?”). Joanne gave the recent example of being in a nightclub and standing near some women that were scantily and provocatively dressed. She said she felt they were immoral and she had become immoral by being in the same nightclub as such people. This indicated to the therapist Joanne found it difficult to distinguish between her fear of becoming immoral and her belief that she was immoral or had already become immoral by being near that person.
2. *The source(s) of contamination;* in particular human sources and hypervigilance to these sources. This included asking questions about how her vulnerability to morphing would operate. When Joanne described taking on the undesirable characteristics of others, she was asked “How would that happen?”. Some of the responses sounded reasonably rational on the surface (e.g., ‘If I am in a negative mood then that brings everyone down’), but had a large amount of magical thinking (e.g., “It is like their characteristics permeate my skin”). When asked by the therapist “What would happen if *I* were in conflict and contact with someone who was morally questionable?”, Joanne replied ‘nothing.’, but when the question was directed at herself, Joanne replied ‘I could become like them.’ When asked to explain this discrepancy, she responded ‘You don’t believe it could happen so it couldn’t but

because I believe it, then it makes it able to be so.’ This was a clear illustration of Joanne’s sense of unique vulnerability.

3. *History.* A detailed history of the development of the problem, such as time and speed of onset, and the client’s understanding of the issue is common in psychological treatment but it is particularly important for mental contamination. Specifically, she was asked “How do you make sense of the problem?”, “If that had happened to someone else, do you think they would become contaminated?”, “What was happening in your life when the problem first started?” and “What do you fear would be the worst outcome?” Trying to understand the relationship between Joanne’s checking behaviour, contamination fears and fear of morphing was difficult, but we hypothesized that Joanne was checking to ensure that she did not become another person, that she retained her morality, and that her intellect was fully intact.
4. *Psychological violations and betrayals.* Rachman (2010) has identified previous or current physical and psychological violations and betrayals as critical in the development of contamination fears. We began by asking Joanne “Can you tell me about anyone who has been particularly helpful to you? What were their characteristics?” before moving onto questions such as, “Can you tell me about anyone who has been particularly unhelpful to you? You don't have to identify them if you don't wish to. What were their characteristics?” In Joanne’s case, the therapist sought to understand the association between any betrayal and the current presenting issues around becoming a negative person. Joanne’s responses revealed her perception that her parents were highly critical with regard to failing to achieve high standards and, even more importantly, failing to live up to her potential.

5. *Spread of contamination.* As is standard, Joanne was asked about the nature of the spread of mental contamination. She was asked, “Do new items/persons/places ever become contaminated? How do they become contaminated?” Her responses painted a picture of places becoming contaminated if she had had a conflict there, or if immoral or underachieving people had been present in that place. She subsequently avoided those places.

6. *Mental imagery.* Joanne was asked, “Are there any pictures that cause you to feel contaminated?” This also included questions about protective images—“Are there any pictures in your mind that you use to protect yourself?” In response to these questions, Joanne revealed that she often ruminated after a perceived conflict or after being near someone immoral or who had failed to live up to their potential. Such rumination was mostly verbal and not in the form of pictures in her head and she would subsequently feel the need to engage in action (typically walking for hours at a time) in order to clear her head and ensure she had not lost any of her intellectual capacity. She did not have any protective imagery.

7. *Avoidance.* Joanne was asked questions about her avoidance of people, places and situations along with questions about cognitive avoidance e.g., ‘Is there anything that you avoid thinking about?’ For Joanne, a lack of contemplation of current affairs and deep philosophical questions such as the meaning of life and what happens when you die would indicate that she had lost her intellectual capacity. She therefore actively engaged in thinking about these issues, although paradoxically, they triggered questions about her intellectual capacity and whether she had lived up to her potential

thereby causing her further distress. Establishing the range of people, places and situations she avoided behaviourally was straightforward.

8. *Compulsive washing and checking and other behavioural responses.* Joanne was asked about the nature, frequency and intensity of her washing and checking behaviour in detail. As is typical with washing behaviour in mental contamination, any relief from washing was transient; she still felt dirty after conflict and she was articulate in describing how the washing of her skin did not alleviate the ‘dirtiness from my mind’. Her repetitive checking of her height and appearance in the mirror to establish whether she had physically changed was assessed in depth. She was asked ‘How often do you look in the mirror?’, ‘Where are the mirrors in your house?’, ‘What sizes are the mirrors?’, ‘Can you see all of yourself in the mirror?’, ‘What parts of yourself do you look at when you look in the mirror?’, ‘How long do you spend looking in the mirror?’, and ‘How do you feel when you look in the mirror?’ At first, the question of whether Joanne had comorbid body dysmorphic disorder was raised in the therapist’s mind but despite a resemblance to some features of BDD, the difficulties were considered to be better explained as related to her OCD, in part because they were not held with delusional intensity. Joanne was also asked about her walking behaviour as she had described solitary walking ‘to clear her head’. She walked for three to four hours a night, usually after midnight which was considered both risky to her safety and unhelpful to her daily routine and general wellbeing. This late-night walking resulted in her feeling chronically tired and impacted on her work; she would often miss work due to tiredness and sleep throughout the day.
9. *Other difficulties.* Joanne described difficulties with the following areas: perfectionism, chronic worry, depression, and anxiety in social situations.

To enhance the clinical interview component of our assessment process, a range of standardised measures were used. In selecting what measures to use, we were guided by the following principles and priorities.

1. *Morphing Fear Questionnaire* (MFQ; Zysk, Shafran, Williams & Melli, 2015). This measure assesses the presence and severity of morphing fears. Joanne's score of 29 indicated high morphing fear. Her responses to this measure also were consistent with responses of patients with OCD more so than patients with anxiety or depression only.

Vancouver Obsessional Compulsive Inventory - Mental Contamination Scale (VOCI-MC; Rachman, 2006). Joanne's score on this 20-item measure was 59 and she scored highly on items such as "Certain people or places that make me feel dirty or contaminated leave everyone else completely unaffected", Her scores were higher than the mean of patients with general contamination fears (Radomsky, Rachman, Shafran, Coughtrey & Barber, 2014).

Obsessional Compulsive Inventory - Short Version (OCI-R; Foa et al., 2002). Joanne scored 52 before treatment indicating high levels of general OCD symptoms including those relating to checking and washing compulsions (e.g. "I wash my hands more often and longer than necessary").

Beck Anxiety Inventory (BAI; Beck & Steer, 1990). Joanne's score of 24 was slightly lower than that the clinical mean of 25 in those with a primary anxiety disorder (Beck, Epstein, Brown, & Steer, 1988) but higher than non clinical norms (Gillis, Haaga & Ford, 1995; Creamer, Foran & Bell, 1995).

Beck Depression Inventory–II (BDI-II; Beck, Steer & Brown, 1996). Joanne was significantly depressed with a score of 43 – almost twice as high as the clinical mean for those with depression is 21.9 (Beck et al., 1996).

Yale–Brown Obsessive Compulsive Scale (Y–BOCS; Goodman et al., 1989a, b). Joanne’s score of 31 using this ‘gold standard’ assessment measure indicated that she had significant OCD (Tolin, Abramowitz, & Diefenbach, 2005).

Visual Analogue Scales (VAS): We constructed a series of 10cm VASs to measure self-report ratings of anxiety, feelings of general contamination, feelings of internal contamination, and washing & neutralising urges/behaviours, ranging from “Not at all” to “Extremely”. The VAS comprised 8 scales, 4 of which asked the patient to rate current symptoms, and 4 which asked about symptoms over the previous week. VASs are sensitive to clinical change (cf. McCormack, Horne, & Sheather, 1988), and data collected using VASs have been shown to be reliable and valid (Reips & Funke, 2008). These VASs were used each session due to the importance of monitoring treatment progress and improving outcome (Lambert et al., 2001; Egan & Hine, 2008).

Step 2: Acquiring best available research evidence

The National Institute for Health and Care Excellence (www.nice.org) is a UK government body that provides evidence-based guidance for a range of health and social care issues. Its website additionally provides a range of evidence services including a search for evidence and access to journals and databases. While we would like to think that it is the first port-of-call for the majority of practising clinicians in the UK, our own research indicates that research evidence is not the primary source of information when it comes to decision-making

(Gyani, Shafran, Myles, & Rose, 2014) and NICE guidelines for the treatment of OCD are largely ignored in primary care (Gyani, Shafran & Rose, 2012).

Nevertheless, the guidelines produced on the treatment of OCD (CG31, published in 2005 <https://www.nice.org.uk/Guidance/CG31> and updated in 2015) state that adults such as Joanne, who have a moderate functional impairment and who have not responded to a less intensive (fewer than 10 therapist sessions) of CBT (including ERP), should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP) because these treatments appear to be comparably efficacious.

These guidelines are clear; however, our dilemma was that an adequate dose of both of these treatments had been tried previously without success. Furthermore, we questioned the extent to which the clinical trials on which the research evidence was based were designed to inform the care of people like Joanne with mental contamination. Thus, while Joanne clearly met criteria for OCD, it was unclear to what extent the evidence generalises to this particular type of OCD, let alone to morphing fears.

We decided to consult the primary literature by searching journals using search terms such as ‘transformation obsessions’, ‘morphing’, ‘mental contamination’ and ‘treatment-refractory OCD’. We also searched using US terms such as ‘empirically supported treatments for OCD’. We used Google Scholar for these searches rather than Science Direct or any journals that require a University subscription/pass. The reasons for using Google Scholar first were (i) ease of searching, (ii) ease of obtaining the paper, (iii) ease of communicating with our clinical colleagues. We then also searched PubMed and Science Direct. Given the rarity of the problem, we also looked at UK Charity websites for OCD such as ‘OCD-UK’ and ‘Obsessive Action’. The reason for this is that we felt there may be people with similar issues who were sharing their personal stories of treatment. It was from that search that the term ‘emotional obsessions’ was identified as being used in the same way as morphing fears

or transformation obsessions (Hevia, 2009). We therefore re-ran our literature searches adding this new term. Although we did not discover much more than we had identified previously, it was helpful to understand the different ways in which the same construct was being labelled and identified.

As a final additional step, we contacted our colleagues working in this field (there aren't many of us!) to seek additional advice and information as to other sources of evidence including their personal experience of treating such cases. The conversation took the form of an informal supervision in which we presented the problem and the clinical dilemmas and the asked for guidance about how to conduct an evidence-informed intervention. This was a helpful process in that it necessitated synthesising and summarising a complex case and to formulate a clear question to guide treatment. After receiving useful advice and formulating a treatment plan, we then stopped our thorough search.

Step 3: Appraising the evidence critically

It is hard to objectively and critically appraise the evidence having been working in the field for so long and being so close to the topic. It is also challenging to objectively reconcile the presenting issues with the research literature. For this reason, decisions about the treatment plan and approach based on the available literature were made in discussion first between the first and second authors, and then in supervision with the third author. This may by some be labelled as reassurance seeking but perhaps it can be considered best clinical practice (!). The third author was able to bring in a different angle from the viewpoint of a practitioner who treated younger people with OCD and who brought a developmental perspective to treatment. Such a perspective draws attention to the both the strengths and weaknesses of the existing literature.

We reviewed the main large clinical trials to establish whether it was likely that they included or excluded people with morphing fears, but were left unsure. It is possible that someone with Joanne's difficulties of mental contamination and morphing could have been misunderstood as having delusions (in particular the belief that she could physically change in stature) and therefore be excluded from the majority of trials. Certainly, there was no mention of Joanne's problem in the large RCTs, and even if people like her were included, we had no information about the extent to which the treatments were helpful, specifically, in addressing the nature of her concerns.

The literature that appeared most relevant was the description of treatment from Rachman (2006), existing case series with younger people on transformation obsessions (Volz & Heyman, 2007), our own case series on mental contamination (Coughtrey et al., 2013) and the case study of Hevia (2009). These sources emphasised that there is much about standard (unadapted) CBT that could and should be used to treat Joanne, but that some specific additional interventions might be warranted if Joanne failed to respond to the existing interventions.

It was not a difficult decision to decide to use CBT including some exposure and response prevention based on the literature. What *was* difficult was planning how best to use the exposure tasks. Their traditional use involves creating a graded hierarchy based the view that patients' anxiety habituates with repeated exposure and therefore decreases over time. We were not inclined to use this model because it had been unsuccessful with Joanne previously and did not capture the nature of her presenting issues. Moreover, the habituation model is based on an outdated learning model rather than an empirically based one of inhibitory learning (Craske et al., 2014), the latter of which provides multiple ways of optimising exposure (for example by focusing on expectancy violation). Thus, in considering

the cognitive nature of the presenting problem, the lack of cognitive input into previous treatments, the clinical guidance from NICE, the case series emphasising behavioural experiments in the treatment of mental contamination (Coughtrey et al., 2013), and the literature showing equivalence between CBT and ERP (see Öst, 2014 for a review), we decided to offer a cognitively-focused CBT with an emphasis on behavioural experiments incorporating some exposure to test beliefs. Our treatment manual served as a starting point and overall guide (Rachman et al., 2015).

Our use of CBT with an emphasis on behavioural experiments would specifically address Joanne's fear of morphing. However, Joanne was also experiencing a wide range of related co-occurring difficulties including low mood, perfectionism and disorganisation/lack of structure, all of which were impacting her work and daily functioning. We faced what is perhaps the most common clinical dilemma in practice – how to address comorbidity. It is truly baffling (and scandalous) that psychological treatments, trials and guidance almost invariably focus on one specific diagnosis yet estimates indicate that 45% of those with mental health problems have multiple disorders (Kessler, Chiu, Demler & Walters, 2005) and this figure rises to 62% among people with OCD (Torres et al., 2006).

The comorbidity of mental disorders and the lack of literature on how to address them presents a critical dilemma about implementing evidence-based treatment. It is the problem of comorbidity that is partially responsible for the surge of interest in 'transdiagnostic' treatments for anxiety disorders such as those of developed by David Barlow (Farchione et al., 2012), Peter Norton and others (McEvoy et al., 2009). However, this research is in its infancy. Two alternatives to the transdiagnostic approach are to sequence interventions or to apply multiple different evidence-based protocols simultaneously. There is little literature to

guide such clinical decision making, and nothing existed that was specifically relevant to Joanne's case.

We expanded our search to consider relevant studies that addressed anxiety problems broadly. Two studies related to the treatment of comorbidity seemed to be potentially informative for Joanne's treatment plan. The first indicated that, for panic disorder, remaining focused on CBT may be more beneficial for both principal and comorbid diagnoses than combining CBT for panic disorder with 'straying' to CBT for comorbid disorders (Craske et al., 2007). The second was a subanalysis from an RCT on depression which found that more time and effort spent addressing anxiety in session predicted less improvement in both depression and anxiety over the course of treatment (Gibbons and deRubeis, 2008). Taken together, we concluded from this research that it is better to focus on one problem than to become distracted by providing multiple interventions or drifting from the main focus of therapy.

In summary, it was clear that there was a need to synthesise the key information in the literature with the realities of Joanne's experience. Joanne had not responded to ERP or psychopharmacology previously. She had an unusual form of OCD that had not been well-researched, and it was unclear if this form had been included in trials. Furthermore, there was a great deal of comorbidity on which the literature fails to provide adequate guidance in the treatment of such a case. It was also notable that the Joanne's current behaviour was exhausting her; not only was such exhaustion leading to practical problems with regard to her work, but also we recognised that it could be an issue for implementing treatment strategies. A final consideration was the need to balance the potential benefit of the intervention and harm and, as with our other patients, we considered it essential to keep a record of any potential adverse events resulting from therapy. After consideration of the available evidence

with regard to the treatment of OCD in general, mental contamination, non-responsiveness to interventions and addressing comorbidity, and the urgent need to help Joanne improve her functioning at work for both psychological and practical reasons, we opted to:

- (1) Focus on addressing morphing fears rather than adopting a transdiagnostic approach, but to briefly and regularly monitor other concerns (in particular mood, perfectionism and worry).
- (2) Use CBT with a heavily cognitive focus in which Joanne's key maladaptive cognitions would be challenged, alongside behavioural experiments incorporating exposure to help challenge fears, as with other cases of mental contamination.
- (3) Use session-by-session measurement to evaluate specific, measurable goals such as reduction of compulsive acts and having a better routine to help reduce number of days off work.

Step 4: Applying the evidence

We met with Joanne twice weekly for the first two weeks in order to maximise momentum, and then moved to a weekly then fortnightly schedule for the majority of treatment and towards the end as part of relapse prevention work. Fifteen sessions were provided in total over a 24 week period. The sessions did not start with setting an agenda as is often the case but instead began by reviewing homework before setting the agenda as has been done in the treatment of eating disorders for many years (Wilson, Fairburn & Agras, 1997). This is a personal choice but is used so that items arising from the homework can be easily incorporated into the agenda and the homework is the very first thing asked about in treatment which helps convey its importance. Below, we describe the major treatment strategies that were used with Joanne. Some interventions took place in a single session (such

as formulation) whereas others, particularly behavioural experiments, were conducted across multiple sessions.

Formulation

An individualised formulation of the maintenance of Joanne's problem was devised based on the theory of mental contamination (Rachman, 2006) and appraisal based cognitive-behavioural model of OCD. The formulation focused on triggers of mental contamination, beliefs relating to contamination and maintaining behaviours (e.g., compulsive washing and avoidance). A historical formulation was also constructed to help the client make sense of the problem (Beck, 1976). This historical formulation focused on her early experiences, any critical incidents and beliefs that arose from those. Joanne reiterated the key memory of failing to understand a Biology textbook at aged 7 was a pivotal moment in the development of her difficulties, and that her early experiences revolved around school work and performance at school. She said she had 'always' considered that her self-worth was contingent on academic achievement and that doing well was 'who I am'. Joanne's maintenance formulation is shown in Figure 1.

Please insert Figure 1 here

Psychoeducation

Psychoeducation was provided in the first session about mental contamination in general and morphing fears in particular, for example about the stability of characteristics and possibility or otherwise of transference of qualities. The distinction between mental and contact

contamination was made with particular emphasis on the human source of contamination and personal vulnerability. An illustration of the Psychoeducation is as follows:

Therapist: Most work has been done on understanding and treating the feelings of dirtiness that come from touching something that is considered contaminated or dirty – for example touching dog mess. Everyone would agree that if one touches dog mess, then it is important to wash one’s hands to stop it from spreading and get rid of any germs. Mental contamination has only recently been identified as a type of OCD in which the same feelings of dirtiness are experienced but not from touching something that is considered dirty but instead from one’s own thoughts, from being near particular types of people or even from seeing something, similar to the symptoms you report. In mental contamination, the source of the dirtiness is often a person rather than a particular object/thing. Also, in mental contamination people often feel it is only them that can become contaminated from the thoughts or being near certain types of people or seeing things and that other people are unaffected. People with OCD who have mental contamination very often have contact contamination too – there is a lot of overlap between the two forms.

Some psychoeducation was provided about: the mislabelling of mood states (i.e., feeling ‘dirty’ or ‘diminished’ rather than ‘anxious’); differentiating between thoughts, feelings and facts; the connection between mood and visual perception based on work in eating disorders; and biases such as thought-action fusion and ex-consequencia reasoning. The role of hypervigilance and selective attention was also discussed with regard to seeking internal evidence of retention of intellect. More general psychoeducation about the importance of sleep and relationship between sleep, mood and intrusions was provided.

Monitoring

Joanne was asked to keep a record in real-time of her triggers, intrusions, appraisals, and behaviour and to reflect on these at the end of each day. An example is below.

Situation	Trigger	Intrusion	Appraisal	Behaviour	Reflection
With a friend	Argument	Need to drop the argument	Need to understand where the argument went wrong to ensure I understand	Needing to bridge the argument in head and recall sentences as otherwise I will be diminished	Angry at myself as I knew it wouldn't make a difference

Behavioural experiments

A range of behavioural experiments were conducted to test Joanne’s beliefs that she ‘lost intellect’ or became shorter as a result of being near people she perceived as immoral or being in conflict with them. Joanne was asked to take a photograph of herself next to a height chart before and after such interactions. Together in session we showed these photos to colleagues and asked them to ‘spot the difference’ in terms of her physical appearance, with Joanne predicting that people would see her as shorter and less intelligent in the ‘after’ picture. This was not the case. We did behavioural experiments to see what would happen if Joanne had a relaxing bath instead of walking after fearing that she had lost her intellect. We

operationalised ‘losing intellect’ and ‘losing potential’ by using time to complete a crossword as a proxy for intellectual performance.

Addressing the meaning of morphing

The meaning of morphing into an ‘unintelligent’ person who, for example, could not produce a coherent argument based on logic was addressed by a discussion of the relationship between diminished intellect, reduced stature and quality of life. Joanne was asked to construct a pie chart of the multi-faceted nature of her personality and to help broaden her sense of self-identity (based on Fairburn’s 1995 self-evaluation pie-chart for treatment of eating disorders). The role of self-perceptions is of increasing interest and relevance to contamination fears (Doron, Sar-El & Mikulincer, 2012) and addressing them via information gathering and consideration of self-identity can be helpful; such interventions are not considered ‘reassurance seeking’ as it is not providing repeated assurances but rather is about an exploration of the construct of self-identity. The permanent nature of Joanne’s personality in terms of a dislike for Marmite and country music was reviewed to help strengthen her identity, and asking people close to her who have known her many years such as her parents to list her immutable characteristics. Asking her parents to help with treatment also assisted in decreasing Joanne’s secrecy and encouraging confiding in others. She had been reluctant to confide in her parents for fear that her parents would be critical and confirm her view that she was less successful than her siblings. In fact, her parents revealed they had suspected Joanne was struggling for many years but did not know what the struggle was about or how to help her. They assured her that her job was worthwhile and they were proud of her for being a teacher.

Imagery

Imagery was a not a significant issue for Joanne and was not a central focus on treatment.

Relapse prevention

In the final two sessions, with the aid of the therapist, Joanne devised a relapse prevention plan reviewing what was done in treatment, what she found to be useful, distinguishing between a lapse and relapse and how to spot the early signs of a relapse. She was asked to consider the main message of therapy and to summarise this in a format akin to a ‘tweet’. Joanne’s tweet was ‘Not everything you do is a statement’ which wasn’t exactly what the therapist had in mind (!) but, on talking it through, Joanne explained it meant that she needed to remember that she could just be herself. Given the broad emphasis of the intervention that had included work on depression and perfectionism in the latter stages of treatment, Joanne’s explanation and tweet made sense. The impact of reducing the compulsive walking on her exhaustion and increasing her attendance at work was a key aspect of the relapse prevention work.

Step 5: Analysing the effects and adjusting practice

We measured the effects of our interventions throughout our work with Joanne. Her outcome using standardised measures (Table 1) and her session-by-session visual analogue scale scores (Figure 2) indicated that the intervention had been highly successful at addressing her fear of morphing and scores on the other measures including depression and anxiety had significantly reduced. However, she was still experiencing some symptoms of mental contamination, OCD and anxiety more broadly.

Please insert Table 1 and Figure 2 here

Reflecting on our work with Joanne and her progress over time highlights some intriguing questions about the intervention process. It might have been helpful to have given the Obsessive Beliefs Questionnaire (Obsessive Compulsive Cognitions Working Group) to

assess perfectionist beliefs within the context of OCD. Understanding perfectionism would have helped guide the treatment intervention. It might have been helpful to incorporate some of the burgeoning work on self-identify in OCD (Doron et al., 2012) and possibly self-compassion (Gilbert, 2009). However, even as we are thinking of that, we know that our enthusiasm for such methods should not go too far ahead of the empirical support for these interventions (both generally and in the context of mental contamination). We also want to keep an eye on the great risk of therapist drift (Waller, 2009). By trying to do too much, it is possible that we would have risked achieving very little. We believe that the behavioural experiments were essential ingredients of her care, allowing us to address the cognitive and behavioural components of Joanne’s difficulties without getting caught up in prolonged and ultimately futile philosophical debates with her. It is also striking how more mundane aspects of work, such as ensuring Joanne got sleep, are so often neglected in case presentations and research outcomes. Without such fundamentals, it is hard to see how therapy can get off the ground.

Summary

One of the joys (and challenges) of working with OCD is the heterogeneity of the disorder. It requires drawing on wide ranging expertise and information. We had a ‘head-start’ in working previously with patients with fear of morphing and with OCD generally; also, some of our previous expertise on the treatment of eating disorders and mirror-checking proved particularly helpful for Joanne. At the same time, having knowledge of the treatment of perfectionism made it tempting to ‘drift’ from the focus on morphing and try to address multiple problems simultaneously—even though there is no empirical support for doing this, and even some data to indicate it may be unhelpful.

The reality of clinical practice is that time is very pressured and clinicians are required to make decisions about how to proceed in the face of great complexity and partial evidence. There often is a lack of time to gather the research evidence and reflect on your clinical practice, then incorporate patient values and preferences and revise the plan. It is challenging to create time to for deliberation and reflection. Without this, however, CBT can become impersonal, rote and rigid. Also, even when you have made sound decisions in collaboration with the client and guided by the literature, it is easy to get off track. Recognizing this challenging context, our key pieces of advice are:

- (1) 'Flexibility with Fidelity'. Kendall's description of how to apply evidence-based treatment flexibly but within fidelity to a protocol is unsurpassed (e.g., Kendall & Beidas, 2007). Take those principles with you and enjoy the creativity that such an approach gives within the safety of an empirically supported approach.
- (2) Keep it simple. Maintain your focus on the main presenting problem but also monitor symptoms that are not the immediate focus of the intervention.
- (3) If you are recording your sessions, take a couple of minutes at the end to reflect on the session and plan for the next one. It really is worth it. Play that small section back at the beginning of your next session. Chris Fairburn taught us this and it has been an invaluable tool. We used it in each session of our work with Joanne.
- (4) Use supervision well – prepare for it properly by scheduling preparation time in your diary, keeping meaningful notes about the issues arising from supervision and thinking through your chosen supervision question. Discussing the research literature with one another, particularly when the supervisor has a different perspective, was also key in our work with Joanne.

(5) Collaboration and curiosity are key. Humour helps if it is used appropriately, and genuine curiosity of the client's experience is essential. If you feel you are losing that curiosity, it is time to step back and reflect on reasons why.

There will never be an evidence base for each individual variant of OCD and so knowing how to acquire and extrapolate from the existing data are essential skills, as we have illustrated in this chapter. Also, knowing how to apply interventions in flexible and personalized ways is critical. In fact, in our view, the most pressing research priority is providing an evidence-base on how to address multiple co-occurring difficulties. Given the high proportion of comorbidities between disorders, the lack of data is truly appalling. Such information would be of benefit to the large proportion of clients who currently do not receive evidence-based treatments (Lilienfeld et al., 2013) or who fail to respond to existing interventions (e.g., Loerinc et al., 2015). It would also enable clinicians to bring evidence-based practice to the clinical coal-face.

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Figure 1

A formulation of the maintenance of Joanne's difficulties

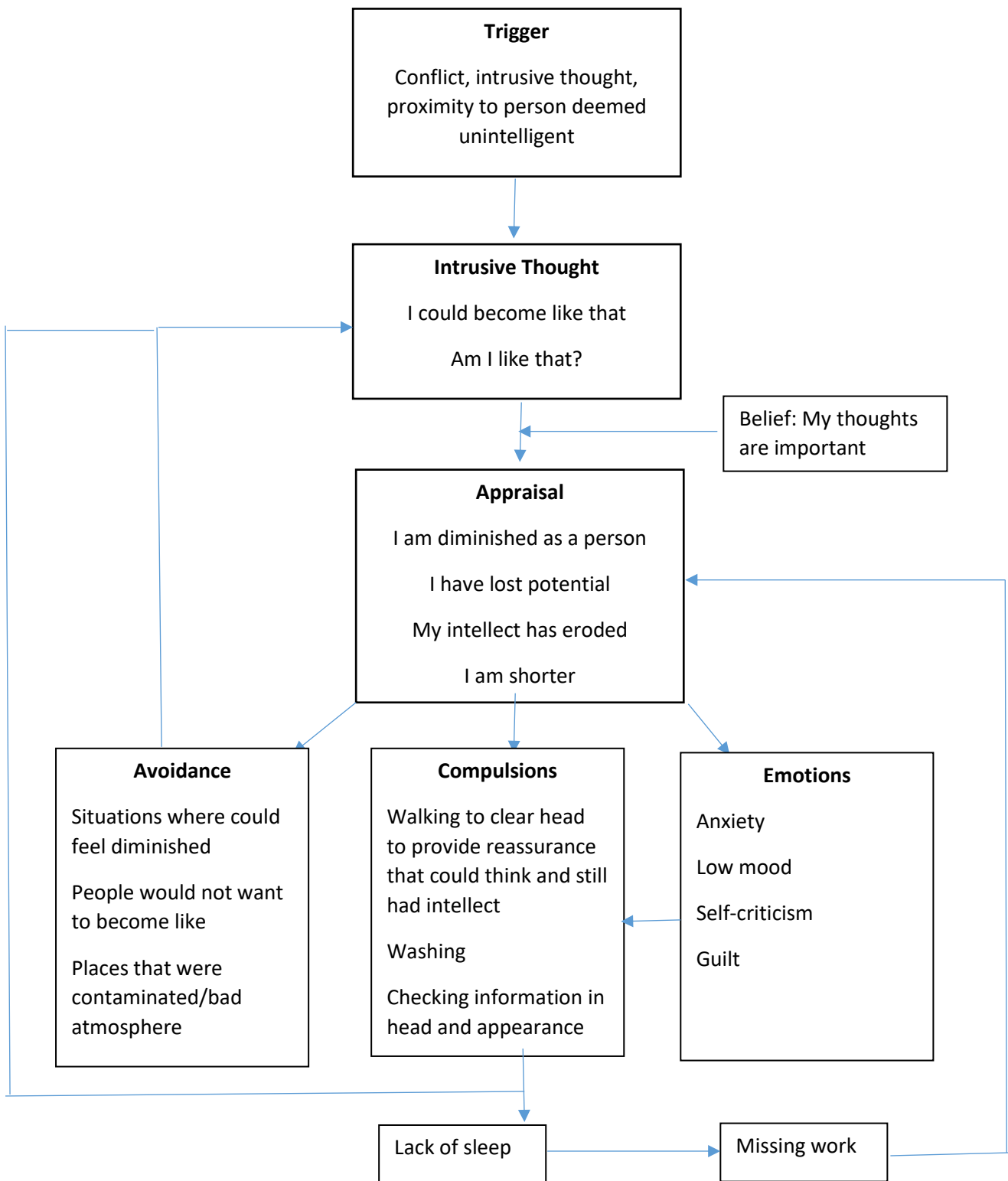


Table 1 Outcomes of standardised measures collected over 5 assessments

Wee k #	Treatment Stage	ADIS-IV Diagnoses	<i>Y-</i> <i>BOCS</i>	<i>MF</i> <i>Q</i>	<i>VOCI-</i> <i>MC</i>	<i>OCI</i> <i>-R</i>	<i>BAI</i>	<i>BDI-</i> <i>II</i>
0	Assessment	OCD, depression, mild social phobia, mild GAD	31	29	59	52	24	42
9	Start treatment	OCD, depression, mild social phobia, GAD	27	28	56	37	12	43
20	Mid treatment (session 10)	OCD, depression, mild social phobia, GAD	27	10	N/A	N/A	N/A	N/A
28	Mid treatment (session 13)	Mild OCD, mild social phobia, mild GAD	20	3	13	12	4	18
36	End of treatment (session 15)	Mild OCD, mild GAD	14	1	37	15	4	2

Figure 1: Session by session VAS measures for treatment targets

