I. Introduction

- **A.** Treatment resistance comes in many forms, which all of us have been addressing over the years.
  - **1.** Using an alternative and less supported treatment is **not** the solution to those who refuse treatment or are resistant. E&RP is still the treatment of choice for OCD. Obtaining compliance from a patient is the clinical art.
  - **2.** Problem: Resistance can be either an acceptance issue or a failure of our case conceptualization or both.
  - **3.** 4 sources of resistance (there may be others):
    - **a.** Poor readiness preparation – does the client share our treatment goals and conceptualization?
    - **b.** Choosing the wrong feared consequences for exposure.
    - **c.** Over-Valued Ideation (OVI), e.g., Hypochondriasis, BDD.
    - **d.** Merged cases.
      - **1)** A problem is considered merged when the feared consequences (FCs) of their OCD problems overlap with the FCs of other issues, problems or diagnoses.
- **B.** Non-merged OCD.
  - **1.** Non-merged multiple problems – FCs unshared
  - **2.** treating their OCD first is the most efficacious approach, because the nature of OCD symptoms often makes it impossible to seriously address other issues.
- **C.** Merged – OCD and other problems share FCs
  - **1.** Non-OCD issues/FCs have two lives:
    - **a.** interferes with functioning outside of OCD symptomatology
    - **b.** comprises a part of the feared consequences of the sufferer's obsessions.
    - **c.** When this is true, these issues need to be incorporated into E&RP.

II. The Model

- **A.** The problem with a comprehensive models is that their flexibility may sound appealingly perfect, but there is the danger of applying the model without taking into account the complexity of the problems you are working with.
  - **1.** Hierarchy of information not unlike physics, chemistry, biochemistry ... physiology, etc.
  - **2.** A CBT model needs to focus on those specific areas – OCD, depression, PTSD are different problems.
    - **a.** Application of the model needs to be tailored to specific problems.
- **B.** Basic CBT
  - **1.** framework designed to capture uniqueness of individual's problems, including relevant historical data, learning, core beliefs about self, rules, assumptions and conditional beliefs, and compensatory strategies.
  - **2.** This framework assists us in comprehensively evaluating an individual's adaptation to life and provides a vehicle for examining the interplay of behavior and beliefs in the world.
  - **3.** Going back to that physics, chemistry, biochemistry – in real CBT, the B theory underlies the C theory. It has a utility for understanding and building upon.
    - **a.** Situation is the lowest level – the individual is confronted with something.
    - **b.** This will elicit:
      - **1)** an emotional CR that is uncomfortable that will form part of what shapes individual's response independent of interpretation.

2) automatic thoughts that in OCD may be experienced as intrusive or upsetting in some way, e.g., the table is dirty.

c. Next level is cognition of what is bad about being dirty.

1) This will be the Feared Consequence (FC)

d. Next the individual needs to make decisions about what to do.

4. Specific to OCD – ritual, compulsion, neutralizing – compensatory strategies.

a. Good case conceptualization requires further exploration of feared consequences to understand why neutralizing is necessary, eg. for contamination the FC's could be any or all of the below:

1) can't cope with anxious feelings from being dirty;

2) someone might die;

3) I might hurt someone;

b. This danger is idiosyncratic to the individual, what is most threatening and difficult for them to accept. From our cognitive theory language, we understand that some ritual decisions will be mediated by distortions. Our feared consequences may be further broken down

c. Again intolerance of uncertainty is the prime distortion of OCD – others may be present, but they are generally subordinate to intolerance of uncertainty.

1) FC's can obviously be complex, not only do I not want to hurt others, but if I somehow do hurt someone, the action may also mean something else about me – e.g., I'm a bad person. In this case, in the FC is a secondary distortion, e.g., all or none thinking and or labelling. Again, these are secondary distortions subordinate to intolerance of uncertainty.

2) From ACT. E&RP has always been an acceptance based treatment. ACT language can further inform us, but for present, uncertainty is a fact of life that needs to be accepted. Odds are attempts to reassure and is used by patients not as scientific evidence, but as ritual.

d. In any event, avoidance through ritual occurs. We know with E+RP that the focus will be upon contaminating and not washing, but how we present this and help the patient understand this we need to go back into the belief system

e. For many patients, we can simply do E+RP, because the FC is uncomplicated by other issues. You will be contaminated and have to learn to risk death.

III. Treatment of Merged OCD

A. Nature of individual's belief system influence and compound or block treatment to OCD.

B. Nature of merged vs unmerged - consider two patients suffering from borderline personality disorder (BPD) and OCD.

1. Case 1, unmerged BPD and OCD, contamination issues and BPD relationship issues.

a. FC of OCD symptoms is fear of contamination and becoming ill.

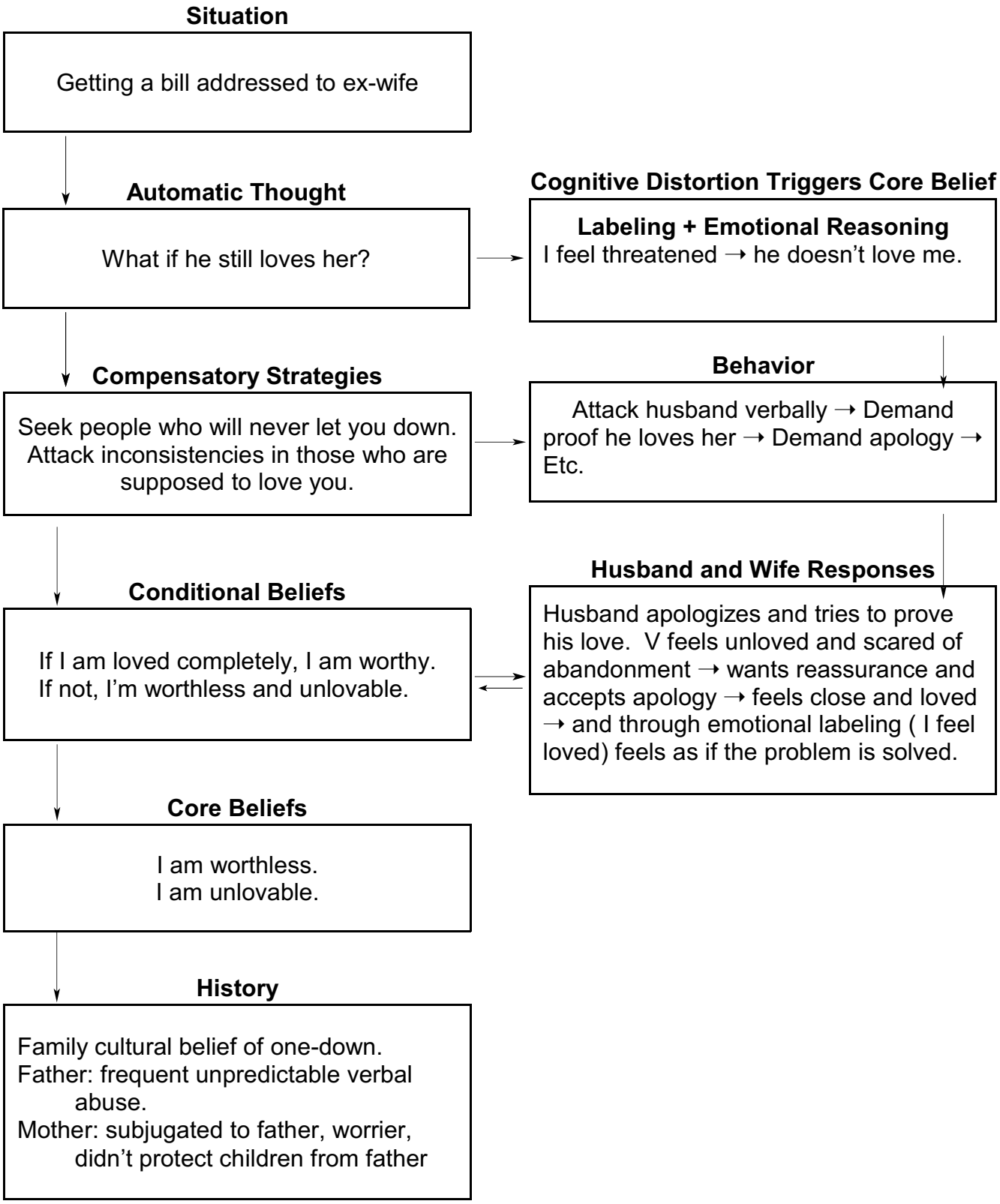
b. FC of borderline issues if feeling unloveable.

c. Treatment of the two issues can most likely proceed independently and choice of target can depend upon severity.

2. Case 2

3. OCD can be attached to any of the following: core beliefs, conditional assumptions, rule, etc. See attached case examples
4. Not every patient is going to need or will benefit from simultaneously attacking every problem at once. It is a clinical decision where your initial efforts need to be focused and the CBT framework provides some guidance.
5. For OCD, E+RP will probably always be a part, but when it is done is the question.
6. Not a manualized treatment.
   a. Discovery of merged issues may not be evident in initial evaluation.
7. Case conceptualization needs to be explained to patient.
   a. Patient can't agree to a treatment that s/he doesn't understand.
   b. Your explanation contains a framework for when and why you focus on E&RP vs the non-OCD aspect of the merged Fcs.

Case 2-A: V as "Simple" Borderline Without Merged OCD



Case 2-B: V as Borderline With Merged OCD

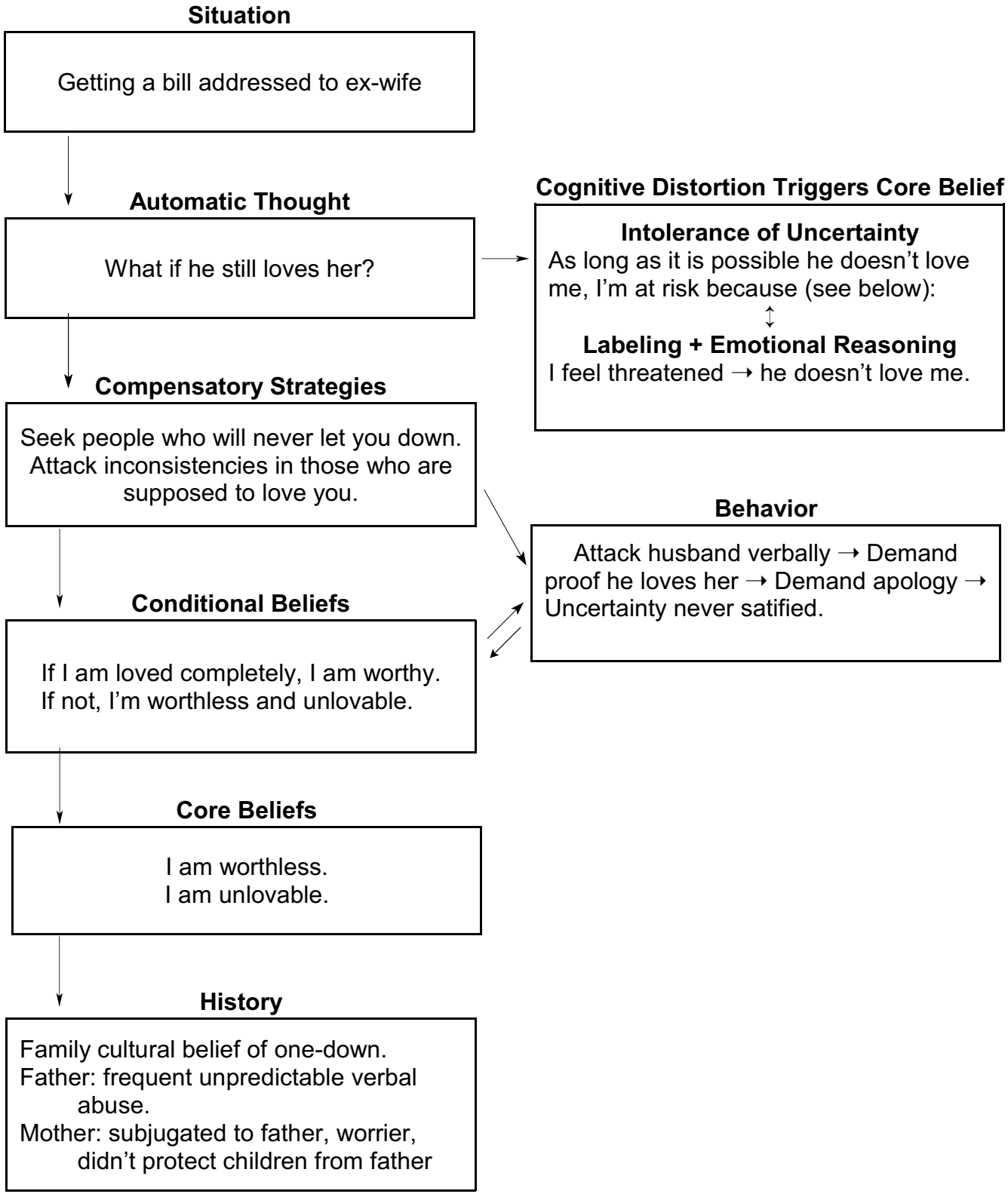
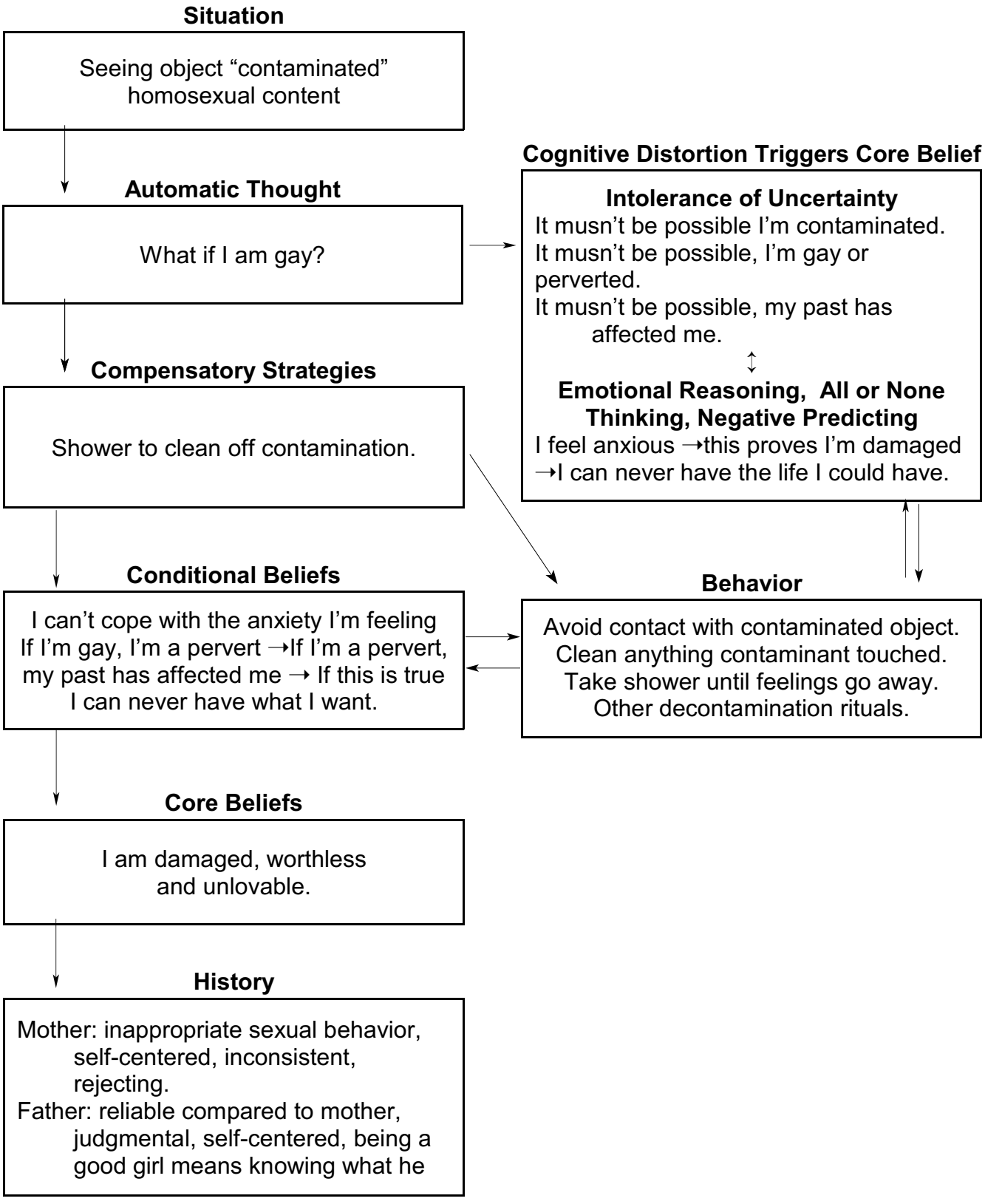


Figure 3 : OCD Symptoms Merged with PTSD



Problem Presentation: OCD & Other Problems Without Significant Overlap

CBT Case Conceptualization

Complete evaluation of individual's problems

Other Significant Diagnoses/Issues

Situation →Automatic Thoughts →Compensatory Strategies →Conditional Beliefs →Core Beliefs → History

Appropriate CBT Strategies

Appropriate Interventions

Treatment of OCD or other issues will be independent. The decision which to treat first will be clinically made.

OCD

Situation = Obsession → Automatic Thoughts + Conditional Beliefs + Core Beliefs = Feared Consequences → Compensatory Strategies= = Neutralizing Rituals

CBT for OCD

Exposure & Response Prevention

CBT for distortions taking into account that almost all distortions will be subordinate to intolerance of uncertainty

Problem Presentation: OCD & Other Problems Merged

CBT Case Conceptualization

Complete evaluation of individual's problems

Other Significant Diagnoses/Issues

Situation →Automatic Thoughts →Compensatory Strategies →Conditional Beliefs →Core Beliefs → History

Appropriate CBT Strategies

Appropriate Interventions

Treatment of OCD and other issues will be concurrent – treating them independently will fail.

OCD

Situation = Obsession → Automatic Thoughts + Conditional Beliefs + Core Beliefs = Feared Consequences → Compensatory Strategies = Neutralizing Rituals

CBT for OCD

Exposure & Response Prevention

CBT for distortions taking into account that almost all distortions will be subordinate to intolerance of uncertainty