



Short communication

Cognitive behaviour therapy for olfactory reference disorder (ORD): A case study

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ABSTRACT

Olfactory Reference Disorder (ORD) is preoccupation with the belief that one is emitting a foul odour. It can be a distressing and substantially impairing problem. However, very little is known about its successful treatment. This study describes the treatment of a 38-year-old female with longstanding ORD using Cognitive Behavioural Therapy (CBT). Case conceptualisation focused on identifying unhelpful beliefs and maintaining factors including safety-seeking behaviours, self-focus and avoidance. These were then targeted using a variety of techniques including discussion and behavioural experiments to facilitate belief and behaviour change. Following a 12-week treatment, measures of anxiety and depression reduced to below clinical thresholds. In addition, there were reductions on a specific measure of symptoms of ORD. Issues regarding the use of CBT to treat this particular disorder are considered.

1. Theoretical and research basis for the treatment

Olfactory Reference Disorder (ORD), also referred to as Olfactory Reference Syndrome, is a persistent preoccupation with the belief that the sufferer emits a foul and unpleasant body odour despite lack of evidence to the contrary. ORD can be accompanied by olfactory hallucinations, although 59% of sufferers report not smelling the odour themselves (Begum & McKenna, 2011). It is characterised by persistent attempts to mask the odour and/or avoid social contact with others (Greenberg, Shaw, Reuman, Schwartz, & Wilhelm, 2016; Veale & Matsunaga, 2014). Evidence suggests that the symptoms of ORD are accompanied by clinically significant distress (Feusner, Phillips, & Stein, 2010; Greenberg et al., 2016), impairment of functioning (Bishop, 1980; Davidson, 1982; Greenberg et al., 2016; Malasi, El-Hilu, Mirza, El-Islam, & el-Hilu, 1990) and social disability (Greenberg et al., 2016; Pryse-Phillips, 1971). Onset tends to be in early adulthood and the problem can persist if untreated (Greenberg et al., 2016).

The precise diagnostic classification of ORD has been the subject of some debate. Following the proposal that it is best understood as a hypochondriacal form of delusional disorder, ORD was previously placed within delusional disorder somatic subtype within DSM-IV (APA, 1994; Munro, 1988). Similarly, ICD-10 refers to convictions

about emitting a foul body odour within descriptions of delusional disorder, somatic type. Ideas of reference were reported in 64% of a recent sample (Greenberg et al., 2016). However, it has been observed that ORD can occur with and without insight, and that the phenomenology of the disorder (i.e. checking, masking, reassurance seeking and avoidance behaviours) bears more in common with anxiety based disorders (Feusner et al., 2010; Greenberg et al., 2016; Veale & Matsunaga, 2014). ORD has some overlapping symptoms with body dysmorphic disorder, obsessive-compulsive disorder and health anxiety (Feusner et al., 2010). In addition, it bears some similarities to social anxiety, in that it is marked by fears of, and attempts to avoid, humiliation and social rejection (Veale & Matsunaga, 2014). However, it differs from all these disorders in terms of the cardinal preoccupation with emitting an odour. Subsequently, recommendations have been made for 'olfactory reference syndrome' to be placed alongside Obsessive-compulsive disorders within the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5; APA, 2013; Feusner et al., 2010). However, it was not classified as a distinct disorder in DSM-5 despite these recommendations. In addition, the planned 11th edition of the International Classification of Diseases (ICD 11) will have a new diagnosis of Olfactory Reference Disorder, which will be included within OCD and related disorders.

The research evidence on mechanisms and treatment of ORD is

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scant. Interventions using pharmacotherapy have been reported using SSRIs or SSRI with antipsychotic augmentation (Dominguez & Puig, 1997; Michael, Boulton, & Andrews, 2014; Stein, Le Roux, Bouwer, & Van Heerden, 1998) but only three case reports using psychological therapy have been reported, two with successful use of an exposure and response prevention rationale (Martin-Pichora & Antony, 2011, Zantvoord, Vulink & Denys, 2016) and a case series utilising EMDR (McGoldrick, Begum, & Brown, 2008). Disorder specific treatment guidelines do not yet exist. Furthermore, a comprehensive cognitive model for ORD has yet to be developed. Due to some core similarities with body dysmorphic disorder (BDD) the cognitive behavioural model of BDD and protocol for treating BDD with cognitive behaviour therapy (CBT) can be used to inform treatment (Veale & Neziroglu, 2010). Elements from the cognitive model of OCD can also be utilised (Salkovskis, Forrester, & Richards, 1997).

In brief, the CBT approach to treating BDD involves developing a shared understanding of the disorder, firstly by eliciting idiosyncratic meanings of the perceived physical deficit. Excessive self-focus and safety seeking behaviours such as social avoidance, camouflage and checking that maintain this negative appraisal are identified, explored and modified through cognitive restructuring and behavioural experiments aimed at testing assumptions.

The current case study adds to the literature by guiding the reader in detail through treatment using these methods. The particular focus of this study is on belief change rather than a pure exposure rationale as in previous CBT case studies and detail is given on the client's specific beliefs and their modification. Uniquely, insight is also given into the perspective of the client. The client in this study is not on any medication and this study provides initial evidence for the effectiveness of CBT as a stand-alone treatment. Furthermore, this study presents a new clinically useful measure of ORD.

2. Case introduction

Lisa was a 38-year-old white British woman who was referred to a United Kingdom primary care Improving Access to Psychological Therapies (IAPT) service due to excessive and persistent concerns about her breath smelling.

Lisa was a researcher working in the field of education. She enjoyed and was able to function in this job with the exception of a single two-week period when her anxiety had prevented her from working. However, she found close interactions with colleagues difficult and her problems had affected her choices at work. Her fears were affecting the quality of her life. At the time of treatment, she lived alone. She had a partner of two years who she described as 'supportive' and had good relationships with her parents who separated during her childhood.

Lisa's main problem was a longstanding fear that her breath smelt. She had believed this for some time without disclosing it to anyone. Prior to treatment, she confided in significant others such as her mother who all disconfirmed this; however, her fears persisted. She described experiencing a burning sensation in her mouth and throat, which reinforced her belief. Lisa described being very preoccupied with concerns about her breath and this affected her ability to enjoy and engage in social activities. She reported avoiding intimacy and social interactions that involved any degree of close physical proximity to others. If proximity was inescapable she employed several strategies to minimise her fears, such as avoiding talking, turning her head away, holding her breath, and talking on an in breath. During such interactions Lisa closely scrutinised the reactions of others, she would monitor if they wrinkled their nose, touched their face or moved away from her. These clues were interpreted as confirmation of the problem. Lisa reported regularly checking her breath and using mints and gum to mask her breath. At the time of treatment, she was a smoker, which she

continued as she felt it provided a specific reason for her breath to smell.

In the past Lisa sought medical testing to investigate possible food allergies, and had her tonsils removed due to her unconfirmed fears of food trapping, which can lead to bad breath. All tests were negative and her fears persisted despite these procedures. Lisa's level of insight at assessment was best described as variable; although at times she acknowledged the possibility that her breath did not smell, she described complete conviction in this belief when perceiving a foul odour during a social interaction.

In terms of past treatment, she had received a 6 session course of CBT and attended several counselling sessions 3 years previously, but her symptoms persisted and continued to have a marked impact on her functioning. Lisa's description of previous treatments indicated that the therapeutic focus had been on exploring the historical causes of her symptoms and therefore current maintaining factors were not identified and challenged. The 'CBT' described may therefore not have been adequate. She was not taking any psychotropic medication for her difficulties.

Lisa did not report any current of past suicidal ideation or self-harm and did not disclose any indication of risk of harm to others. Risk was reviewed regularly and remained low throughout the treatment.

This initial assessment concluded that Lisa's difficulties were consistent with a diagnosis of Olfactory Reference Disorder (ORD) based on ICD-10 criteria and were suitable for a 12 week course of CBT. Lisa underwent a full diagnostic screening interview at assessment. She did not meet criteria for any other disorder.

3. Assessment

Symptoms were assessed weekly using the standard IAPT service outcome measures, the GAD-7 (Spitzer, Kroenke, & Williams, 2006) is a well validated and widely used measure of anxiety and the PHQ-9 (Kroenke et al., 2001) is well validated and used to measure depression. A change of 4 or more on the GAD has been found to be clinically significant across anxiety disorders (Gyani, Shafran, Layard, & Clark, 2013). In addition; the Appearance Anxiety Inventory (AAI, Veale, Eshkevari et al., 2014) and Body Dysmorphic Disorder Dimensional Scale (BDD-D, LeBeau et al., 2013) were completed at three points during treatment.

The AAI is a self-report scale developed to identify the cognitive processes and behaviours that might mediate the outcome of treatment in people with Body Dysmorphic Disorder (Veale, Eshkevari et al., 2014). The measure consists of 10 items with a range of 0–40. The AAI has been found to have good test-retest reliability and convergent validity in the measurement of appearance anxiety (Veale, Eshkevari et al., 2014).

The BDD-D is modelled on the Florida Obsessive Compulsive Inventory. It has 5 items and the range is 0–20. It has been shown to have strong internal consistency and good convergent and discriminatory validity (LeBeau et al., 2013).

Due to the lack of a validated measure specifically for Olfactory Reference Syndrome an ORS questionnaire (ORD-Q) was developed for clinical use from a list of online screening questions found on the OCD Center of Los Angeles website. (<http://ocdla.com/olfactoryreferencesyndrome>, see appendix). The list includes distress, beliefs and behaviours relevant to ORD. The measure requires respondents to rate how frequently the item has occurred over the past week on a five point Likert scale.

Measures of BDD were included due to some crossover of symptoms with BDD such as preoccupation, distress and compulsions. The BDD-YBOCS was used in the other case studies (e.g. Zantvoord et al., 2016; Martin-Pichora & Antony, 2011) and detected change.

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