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A Single-Subject Evaluation of the Treatment of Morphing Fear

Eva Zysk, *University of Reading*
Roz Shafran, *University of Reading and University College London*
Tim I. Williams, *University of Reading*

We present a single-subject prospective outcome study of a man with severe morphing fear and long history of OCD who was not helped by previous interventions, and who received an adapted form of cognitive behavior therapy (CBT) as part of this study. Treatment consisted of a cognitively focused approach tailored to address his fear of morphing and included developing a stronger sense of self-stability. We describe the details of the case, the treatment protocol, and the therapeutic outcomes as assessed over 36 weeks by questionnaires, rating scales, and semistructured interviews. The intervention was effective in eradicating the patient's morphing fears and reducing other symptoms of OCD, anxiety, and depression. The presented case illustrates the need to appropriately conceptualize, assess, and address the specific nature of morphing fear symptoms in treatment.

The current National Institute for Health and Care Excellence (NICE) guidelines (2005) recommend cognitive behavioral therapy (CBT) incorporating exposure and response prevention (ERP) for the treatment of obsessive-compulsive disorder (OCD) in the UK. Unfortunately, there remains considerable scope for improvement in treatment efficacy, with various studies showing that, following the recommended treatment for OCD, only up to one-quarter of patients demonstrate complete recovery (Abramowitz, Franklin, & Foa, 2002; Boschen, Drummond, & Pillay, 2008; Eddy, Dutra, Bradley, & Westen, 2004; Fisher & Wells, 2005). Some evidence suggests that treatment outcomes for contamination-related OCD in particular are modest; many contamination-fearful patients do not achieve symptom relief or commonly relapse following initial successful treatment (Coelho & Whittal, 2001, cited in Rachman, 2004; McLean et al., 2001). Given that contamination fears account for up to 55% of people with OCD (Calamari et al., 2004; Foa & Kozak, 1995; Rachman, 2004; Rachman & Hodgson, 1980; Rasmussen & Eisen, 1992), increasing success rates of contamination fear treatment is imperative.

One potential explanation for the poor outcomes of contamination fears is the failure to conceptualize these symptoms adequately. This may in part be due to overattention paid to contact contamination and overlooking contamination fears that arise in the absence of physical contact (i.e., mental contamination; Fairbrother & Rachman, 2004; Rachman, 2006; Radomsky & Elliott, 2009) and those that may present as more obscure symptoms (i.e., morphing fears; cf. Rachman, 2006; Volz & Heyman, 2007). It has previously been suggested that different OCD symptom profiles may require tailored CBT interventions to increase efficacy of treatment (Freeston et al., 1997; Keeley, Storch, Merlo, & Geffken, 2008; Sookman et al., 2005; Williams, Salkovskis, Forrester, & Allsopp, 2002). NICE guideline-recommended treatment for OCD may need adaptation for mental contamination and morphing fears to specifically target the key presenting symptoms of these OCD manifestations.

Mental contamination is defined by feelings of dirtiness and urges to wash that arise in the absence of direct contact with a noxious substance or following contact with something others would not deem contaminating (Rachman, 1994, 2004, 2006). Morphing fear, a type of mental contamination (Coughtrey et al., 2013; Rachman, 2006; Zysk, Shafran, Williams & Melli, 2015), involves worries that one may become tainted by and acquire unwanted characteristics of others through contagion. Patients commonly interpret this fear as becoming contaminated and harmed by others' qualities (Coughtrey et al., 2012; Monzani et al., 2015; Rachman, 2006) thereby bearing resemblance to other contamination fears, although overt washing/cleaning compulsions may or may not present. Morphing fears commonly present as avoidance of a specific person or group who may be deemed inferior or undesirable, with

[1] Eva Zysk is now at Nottingham Trent University.

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compulsions presenting in overt (e.g., washing, checking, reassurance seeking) and covert (e.g., mental cleansing, neutralizing) forms. Unlike with contact contamination, the source of mental contamination and morphing fears is cognitive; for instance, morphing fears can be elicited through looking at, hearing, or thinking about an undesirable person. Additionally, the resulting feelings of contamination are internal and psychological. As such, the site of contamination is not physically accessible, and washing is misdirected and often does not bring relief (Rachman, 2006).

The prominent symptom in morphing fear is an underlying concern about magical transformation, a cognitively based fear grounded in a cause-and-effect distortion that patients recognize as irrational. The intrusive recurring nature of the thoughts has led morphing fears to also be referred to as "transformation obsessions" (Monzani et al., 2015; Volz & Heyman, 2007) and these symptoms have recently been found to load onto the forbidden thoughts dimension of the Children's Yale-Brown Obsessive-Compulsive Scale checklist (Scahill et al., 1997) in children (Monzani et al., 2015). The cognitive nature of morphing fears is also reflected in patients' unstable sense of self and concurrent low self-esteem (cf. Rachman, 2006). People with OCD hold uncertain self-perceptions and are prone to experiencing ego-dystonic intrusions as personally threatening to their sense of self (Bhar & Kyrios, 2007; Ferrier & Brewin, 2005; Guidano & Liotti, 1983; Lipton, Brewin, Linke, & Halperin, 2010). Such intrusions may lead some people to fear they may become someone undesirable (O'Connor et al., 2005; Wu, Aardema & O'Connor, 2009), which may help explain morphing fears. Previous research has also shown links between feared self-beliefs and self-doubt in OCD (Nikodijevic, Moulding, Anglim, Aardema, & Nedeljkovic, 2015). In addition, self-esteem—which is thought to be linked with self-uncertainty (Campbell, 1990)—may be affected by the exaggerated importance of intrusions about patients' identity (Ferrier & Brewin, 2005) and morality (Shafran, Thordarson, & Rachman, 1996). As such, these cognitions may lead patients to engage in compulsions such as checking and neutralizing to reduce the doubt and threat and to correct any perceived deviation from the actual self (cf. Bhar & Kyrios, 2007; Guidano & Liotti, 1983). Morphing fears are thought to be uncommon, but symptoms have been found to exist in 10% of youth with OCD.

Three treatment recommendations for morphing fears have been proposed: exposure and response prevention (ERP; Hevia, 2009), standard CBT (Monzani et al., 2015; Volz & Heyman, 2007), and theory-driven cognitively focused CBT (Rachman, 2006; Rachman, Coughtrey, Shafran, & Radomsky, 2015). Hevia (2009) described a retrospective case of a male with morphing fears who was successfully treated with a course of ERP. Volz and Heyman (2007) and Monzani et al. (2015) suggested the same application of CBT for morphing fear as for other symptoms of OCD; this approach was used for children with OCD who were additionally retrospectively found to have had morphing fears, and showed comparable success in their general OCD reduction as those with OCD not having reported any morphing fears (Monzani et al., 2015). However, given the cognitive nature of morphing fears, Rachman (2006; Rachman et al., 2015) argued that morphing fears require a cognitively focused CBT approach similar to that for mental contamination. A cognitive focus allows for idiographic treatment to address specific OCD symptom presentation and target underlying cognitive processes that contribute to their maintenance (cf. Rachman, 2003; Whittal, Robichaud, & Woody, 2010; Wilhelm et al., 2009). This treatment has since been shown to be effective (cf. Coughtrey et al., 2013; Rachman et al., 2015). The concept of the self is of increasing interest in the understanding and treatment of OCD and psychopathology in general (Bhar, Kyrios & Horndern, 2015; Kyrios, 2016) and may be particularly important in morphing fears; techniques aimed to target maladaptive cognitions and key underlying beliefs and working with the patient to develop a stronger sense of self-stability could prove useful in alleviating morphing fear symptoms (Rachman, 2006; Rachman et al., 2015).

From the morphing fear research to date, Coughtrey et al.'s (2013) study is the only one to have utilized a prospective design; the retrospective nature of the research by Hevia (2009), Volz and Heyman (2007), and Monzani et al. (2015) does not permit for confidence in their findings. A further critical limitation of published work to date rests in that reduction of morphing fears was not systematically measured so it is unclear to what extent treatment gains were morphing-fear specific.

The aim of the current study is to evaluate a theory-driven cognitive behavioral intervention specifically focused on morphing fears based on Rachman's (2006; Rachman et al., 2015) treatment recommendations, and with a heavy emphasis on working to build a robust sense of self. It is hypothesized that this specialized treatment would result in clinically significant decreases in morphing fears, mental contamination, obsessive-compulsive (OC) symptoms, anxiety, and depression. This study uses a single-subject multiple baseline design to test the hypotheses. Single-subject designs are critical in testing theoretically derived interventions and establishing evidence-based practice (Agras & Berkowitz, 1980; Horner et al., 2005; Kazdin, 1982; Salkovskis, 2002), and are particularly important where there have been previous treatment failures, when no specific treatments exist, and in investigations involving unusual or rare phenomena (Blampied, 1999; Kazdin, 1982). Single-subject designs are rigorous methods for evaluating treatment efficacy (Horner et al., 2005) and are thought to provide the greatest understanding of treatment

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