

Common Questions about I-CBT

By Mike Heady, LCPC

What is Inference-Based CBT (I-CBT)?

Inference-based CBT (I-CBT) is a specialized cognitive-based treatment developed specifically for OCD. Its goal is to target and resolve the faulty reasoning narratives and processes that lead to obsessional doubts (aka obsessions). If the doubting was resolved, what would be left of OCD?

Isn't Cognitive Therapy (CT) for OCD ineffective?

I-CBT is not a traditional CT. It does not utilize strategies to dispute or refute the content of one's obsessional doubting and it does not prioritize the challenging of post-doubting beliefs and consequences. It targets the faulty reasoning processes that generate here-and-now obsessional doubting. In this way, it is primarily a reasoning-focused cognitive therapy.

Does I-CBT utilize exposures?

No. I-CBT is a reasoning-focused cognitive therapy. Deliberate, prolonged in vivo or imaginal exposures are not a part of the treatment model and not relied upon. Its model is summarized as the knowing precedes the doing. While there is a case-series published that indicates ERP can reduce inferential confusion (obsessional doubting) it is not required.

How is I-CBT different from Exposure Response Prevention (ERP)?

The most obvious difference is that ERP is exposure therapy while I-CBT is a specialized cognitive therapy focused on reasoning. However, when we look more closely at the underlying theories, the differences become much larger. I-CBT views OCD as a doubting disorder as opposed to ERPs underlying theory, which views OCD as an anxiety disorder or exaggerated phobic disorder. From an I-CBT lens, anxiety and compulsions are all downstream byproducts of obsessional doubting and relevant to the maintenance of OCD but not the central problem. No doubting means no anxiety and no compulsions.

What is the significance of the inference in I-CBT?

This is also another significant departure from other models of OCD treatment. Historically, models (CBT/ERP and ACT) have suggested that obsessions come about by unwanted thoughts that descriptively intrude into awareness and are then negatively appraised (Thought-Action Fusion, and the 6 belief domains). It is this interaction that determines which unwanted thoughts will become obsessions and which will not. These unwanted thoughts are considered normal and not specific to those with OCD, so they are not a target for treatment/resolution. Therefore, the endgame for how other models deal with unwanted thoughts is that they must be accepted and tolerated because they are normal. This is why they all focus on the emotional and compulsive reaction to the thoughts.

I-CBT, on the other hand, does not see obsessions coming about by negative beliefs about normal unwanted thoughts. Instead, it argues that obsessions are actually the result of faulty reasoning narratives that cause one to doubt a circumstance in the here-and-now where no doubt was needed. This is referred to as an inference of doubt or a decision to doubt arrived at through a reasoning process. This process is faulty, so the doubt is false. This is referred to as inferential confusion (IC). Numerous peer-reviewed studies have demonstrated IC to be a more specific predictor of OCD than the 6 belief domains (intolerance for uncertainty, perfectionism, inflated responsibility, overestimation of threat, over importance of thoughts, and excessive concern about controlling one's thoughts) as well as thought-action fusion beliefs and IC is specific to OCD whereas the belief domains are not.

What is Inferential Confusion (IC)?

Inferential confusion is a confusion between reality and possibility during reasoning which gives undue credibility to obsessional doubts. A number of reasoning processes that have been identified in the model exemplify this confusion, which can broadly be categorized as an overreliance on possibility, or the imagination, and a distrust of the senses and self during reasoning. Fundamentally, the error in making what is irrelevant in the here-and-now seem relevant and real. There is a psychometrically validated questionnaire, Inferential Confusion Questionnaire-EV (ICQ-EV) which measures one's level of IC. Reductions in the ICQ-EV scores are also correlated to the reduction in Y-BOCS scores.

Doubt vs Uncertainty and Accepting Uncertainty

In I-CBT, the doubt that begins the OCD sequence in the here-and-now is a verb, doubting. Uncertainty is a downstream experience provoked by the doubting in the here-and-now. If one has not doubted, then there would be no OCD themed uncertainty. Moreover, because OCD is activated in moments rather than a 24/7 experience, there is a reality known through one's 5-senses and common sense prior to the doubting taking over. I-CBT aims to restore trust in one's 5 senses and common sense that was overshadowed by the doubting. In this way, I-CBT says there is certainty that one can reconnect with and trust no different than those without OCD have about their present moments. Lastly, I-CBT does not see future abstract possibilities as relevant to OCD. The doubting is activated now, trusted now, and treated as if real, now. What is happening now is where the problem is. So, while it's true to say, no one has certainty about the future, it is also irrelevant if we have doubting happening now that goes against the 5-senses reality and common sense of now.

Isn't doubting normal?

I-CBT distinguishes normal doubting from obsessional doubting. Normal doubting arises when prompted by relevant here-and-now reality. For instance, I see and smell smoke in my house and this leads me to say what if there is a fire in my house or my doctor discovers a lump and wants to biopsy it, and this leads me to say what if this lump is cancerous.

Obsessional doubt on the other hand arises from imagined or hypothetical prompts. For instance, upon receiving my biopsy results where the document states my name, dob, lab tech, and my doctor's name along with the results reading benign, I say what if they switched my labs. This doubt was not arrived at via relevant here-and-now reality. In fact, it was conjured and trusted despite it.

Is I-CBT evidence-based?

Yes. There are over 100 peer-reviewed articles published from different labs. These include theory, experimental, cross-sectional, psychometric, and outcome trials. Specifically, open-trials, 3 RCTs, and 2 non-inferiority RCTs comparing I-CBT to ERP finishing in 2024. To date, research has only looked at adult populations.

A comprehensive list of peer-reviewed published research can be found here:
<https://icbt.online/publications/>

How does I-CBTs outcome data compare to ERP?

Recent meta-analyses (Reid, et al., 2021 and Öst, et al., 2015) and a patient-level mega-analysis (Steketee, et al., 2019) found CBT/ERP to provide clinically significant change in Y-BOCS scores for 50% of sufferer's and treatment response for approximately 60% of sufferers. Open-trials and the 3 RCTs of I-CBT have all shown similar outcome results where there were no statistically significant differences in effect sizes between the two. This data prompted researchers to establish a non-inferiority RCT to demonstrate true equivalence between ERP and I-CBT. To date there are two non-inferiority trials underway. One in Canada and the other in the Netherlands. Preliminary data from the Canadian trial shows non-inferiority to ERP.

If I-CBT is evidence-based, why is it not recommended under division 12 of the APA like CBT/ERP is?

I-CBT is a cognitive-behavioral approach, which is a recommended treatment in many treatment guidelines. However, I-CBT is far more cognitive than any other approach, and so it may need more specific recommendation in treatment guidelines. Once the non-inferiority trials finish, a meta-analysis will be conducted, and I-CBT will be submitted for recommendation as an empirically supported treatment (EST). As it stands, it is an evidence-based treatment for OCD but has yet to be labeled an EST by the APA.