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# Tactics of Application of Cognitive Behavioral Therapy in the Treatment of Distorted Perception of Smell or Olfactory Reference Syndrome

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## Opinion

Distorted perception of smell or olfactory reference syndrome over the past few years is a new psychotherapeutic challenge. The patient has a constant concern that he smells bad (for example, from the mouth, body), or may "smell bad", other people may notice it, and he will feel a strong shame ("disgrace"). This "bad" smell is difficult for the patients themselves to describe, and they note more that they "think" about the smell. The disorder may be accompanied by olfactory hallucinations, although about 60% of patients report that they do not feel a bad smell from themselves, but there is a belief that they have it. The patient has constant attempts to mask the smell and/or avoid social contacts with other people. Our observations indicate that the symptoms are accompanied by clinically significant distress, impaired functioning and social disability. The exact diagnostic classification of this disorder is still a subject of debate. For example, it can be understood as a hypochondriacal form of delusional disorder (somatic subtype of delusional disorder).

However, it has been observed that the disorder can occur both with and without insight, and that the phenomenology of the disorder (i.e., the behavior of checking, masking, seeking solace and avoidance) has more in common with anxiety spectrum disorders. It has some similarities with social phobia, as it is characterized by fears and attempts to avoid humiliation and social rejection. Also has some overlapping symptoms with body dysmorphic disorder, obsessive-compulsive disorder and health anxiety. However, it differs from all these disorders in terms of the cardinal preoccupation with the release of odor. Subsequently, the DSM-V gave recommendations for placing this syndrome next to obsessive-compulsive disorder. The ICD-11 has a category of olfactory perception disorders, which is included in OCD and related disorders.

There are no specific recommendations for the treatment of disorders yet. In addition, a comprehensive cognitive behavioral model of this disorder has not yet been developed. Due to some basic similarities with body dysmorphic disorder, cognitive behavioral protocols (CBT-BDD) can be used to treat this group of patients both in monotherapy and in combination with psychopharmacotherapy (SSRIs and or without antipsychotic enhancement). Psychological examination is recommended to be carried out using the following diagnostic scales: PHQ-SADS, Body Dysmorphic Disorder Dimensional Scale (BDD), Olfactory Reference Syndrome questionnaire (ORD-Q) and YSQ. The protocol includes 12 sessions, 1 time per week, some of which lasted more than one hour to conduct behavioral experiments. The main tactic of CBT is that the symptoms of a patient with a distorted perception of smell differ from a dysphoric disorder of body perception in that the perception of deficiency was sensory, not physical and possibly "hallucinatory". Subsequently, the focus is on the patient's assessment of this sensory experience and its predicted impact on the behavior and judgments of other people. The emphasis is on the olfactory experiences and beliefs of the patient.

The first sessions begin with studying the behavioral signals of the patient when talking to others (for example, turning their head away, frowning, touching their face with their hands) and interprets this as confirmation that they smell or maybe they smell. The patient may admit that it is difficult for him to verify his beliefs about his smell, and will assume that there may be

other, milder explanations for his behavior. However, when he was talking to others and smelled an unpleasant smell, it was harder for him to access these alternative (flexible) explanations of the situation. Alternative explanations are further explored with the patient by jointly developing two competing versions of the representation problem using the "Theory A and Theory B" technique.

The patient talks in detail about Theory "A" ("the problem is that my breath smells bad, and it disgusts and repels others"). For comparison, Theory B suggested that the problem is that the patient is overly concerned and preoccupied with the smell of his breath and spends a lot of time trying to cope with it. Initially, the patient evaluates his belief in Theory "A", for example - 70%. The evidence supporting both theories and their implications, if true, have been examined. The metaphor "builders apprentice metaphor" is used to illustrate how some of the patient's aspirations for safety and prejudice against attention prevented him from refuting his beliefs. In order to study more deeply the belief that people who turn their heads in one direction or another, touch their nose or frown, are disgusted by the patient's breathing (smell), he will be asked to follow the 2-minute interaction between two people and count how many times this happens during "normal" interaction.

Sessions 4 and 9 were devoted to reviewing and summarizing the results of this homework assignment. The patient may notice that people touched their noses, frowned and turned away from each other more than twice as often as he predicted. This observation made the patient wonder whether these "clues" reliably indicate that his breath smelled. He also shares an increased awareness of his tendency to seek out smells and observe other people's reactions. This was considered in connection with the general formulation (cognitive behavioral model) and how his main fears lead to increased concentration on smells and physical signals, which increases the likelihood of their perception. This was further illustrated by using the "anthrax" analogy (by asking how many pigeons he noticed on the way, and comparing this estimate with how many he could have detected if he thought they carried a deadly virus).

Examining the patient's beliefs about unpleasant odors, he can recall cases when his friends behaved in a way that could be regarded as "disgusting" (for example, publicly ill or kissing people on the street). This did not make them repulsive or unpleasant to him, but he believed that it was different from her own fears, since she could attribute their actions to one-time events. On the contrary, he believed that if he had bad breath, people would attribute it to something permanent and fundamental in him (that is, he was unclean, sloppy. sloppy). This led to the compilation of a list of all the actions that someone can do if they believe it about him. At the same time, the patient may notice that they have a striking similarity with his own behavior in the field of safety (i.e., avoiding physical proximity, trying to avoid sharp breaths, turning his head away during a conversation). The patient reflects on this and whether her behavior may encourage others to reflect her distance in social contacts. The patient's avoidance of physical intimacy was realized by measuring her "comfort zone" (a matter of personal boundaries). This was achieved by having a conversation, standing closer and closer until he felt uncomfortable. This exercise showed that he felt comfortable at a distance of about 45 centimeters without using reinsurance behaviors aimed at ensuring a sense of security. Next, behavioral experiments are conducted to minimize this behavior.

Sessions 10 and 11 were devoted to the treatment review. An outdoor behavioral experiment allows the patient to see that physical distance is not exclusively a sign of disgust. The patient concludes that one of her main findings was that his interpretation of other people's actions as evidence of disgust was false. Efficacy of therapy: after 12 weeks of treatment, low rates in symptoms of depression, anxiety were observed for 9 months, avoidant, reinsurance behavior and olfactory experiences were minimized (on the ORD-Q scale).


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